To be or not to be clinically supervised: authentic accounts of inauthentic behaviour in two NHS Trusts.

A thesis submitted to the University of Manchester for the degree of PhD in the Faculty of Medical and Human Sciences

2006

Louise S. May

School of Nursing, Midwifery and Social Work

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346

(EPHRA)

List of contents

Final word count: 91008

Lists of figures and tables

ABSTRACT

THE UNIVERSITY OF MANCHESTER

ABSTRACT OF THESIS submitted by Louise S. May
For the degree of PhD and entitled `To be or not to be clinically supervised: authentic accounts of inauthentic practice in two NHS Trusts`. September 2006

The thesis presents an interpretive study of the lived experiences of clinical supervision of 34 individuals; of these 19 undertook clinical supervisor training, 9 were senior managers and 6 were supervisees. The study is guided by Heideggerian phenomenology. The initial purpose was to discover the individual lived experiences of the nineteen course participants (from one community and one acute Trust), before and after undertaking a clinical supervision `supervisor` course in a North West higher education institution. Course participants were interviewed on at least three occasions and the data which emerged suggested that whilst many valued clinical supervision they were unable to operationalise it during their working day. This led to a broadening of the focus of the study to include senior managers' and supervisees' experiences of clinical supervision. From a total of 34 participants, 75 individual one-one taped interviews were undertaken.

A phenomenological approach was taken to the interpretation of the data; this process was guided by the writings of Martin Heidegger. Transcripts and field notes were examined to identify emerging themes. Three themes were developed; `Time`, `Trust` and `Disclosure`. Those not undertaking clinical supervision cited; lack of time, distrust and fear of disclosure, whereas those engaged in clinical supervision, created the time (as a supervisor or supervisee), trusted the process, and valued the opportunity to disclose in a non-threatening supportive environment.

Overall course participants and manager participants found it difficult to implement clinical supervision; barriers appear to have existed on both individual and organsiational levels. These problems served to relate to the issues of `Time`, `Trust` and `Disclosure`. However, the supervisee participants were positive about having clinical supervision and this may have been because they worked at senior autonomous levels, which enabled them to create the time to engage in the process. They also appeared to have been more comfortable in their role and disclosure was not something which they feared. It would appear that professional socialization and the constant politicizing of the NHS may have created difficulties for clinical supervision. The thesis concludes with a series of tentative suggestions that may improve the uptake of clinical supervision by nurses.

DECLARATION

That no portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

COPYRIGHT STATEMENT

(i) Copyright in text of this thesis rests with the Author. Copies (by any process) either in full, or of extracts, may be made **only** in accordance with instructions given by the author and lodged in the John Rylands University Library of Manchester. Details may be obtained from the Librarian. This page must form part of any such copies made. Further copies (by any process) of copies made in accordance with such instructions may not be made without permission (in writing) of the author.

(ii) The ownership of any intellectual property rights which may be described in this thesis is vested in The University of Manchester, subject to any prior agreement to the contrary, and may not be available for use by third parties without the written permission of the University, which will prescribe the terms and conditions of any such agreement.

(iii) Further information on the conditions under which disclosures and exploitation may take place is available from the Head of School of Nursing, Midwifery and Social Work.

Acknowledgements

1. Christine Hallett and Alun Jones for excellent academic supervision. They helped me to maintain focus, provided support and had a belief in me and gave me strength.
2. Barbara Jack for reading chapters, giving constructive feedback and support.
3. Ruth Williams and Joan Abbott for encouraging me to undertake an MPhil and convert to PhD.
4. Participants for their honesty and allowing me to enter their lived experience of clinical supervision. A collaborative effort.
5. Personal, Colm my husband who has lived with this thesis and has learnt about Heidegger through my many discussions with him. He has been supportive and given me the space to think and write as well as be a proof reader.
6. Thomas and Charlotte, my children who have only ever known me to study. For giving me time to be away from them and their weekend activities.
7. My friends and colleagues Catriona and Janet for supporting me and keeping me sane in our shared office. Barbara who has shared Heidegger on our many lunchtime runs and Linda who has saved all those novels that I may at some point read.

Introduction

The last decade has been witness to enormous change in healthcare in the United Kingdom. When the current Government was first elected in 1997 it inherited poor standards of care and failings in the National Health Service (NHS) (Devlin, 1998, King's Fund, 1998, Morris, 2002, Clouder and Sellars, 2004, Wood, 2004). High on the Government's initial agenda appears to have been a desire to modernise, improve efficiency and enhance quality of care whilst also introducing the concept of accountability (Sweeney, 2001). The White Paper, *A First Class Service: Quality in the new NHS* (DoH, 1998) and a position statement *Clinical Governance* (DoH, 1999) stated that the Government's aim was to change the NHS (Carter, 2002) so that it would become more transparent and provide better quality of care (Clouder and Sellars, 2004).

It appears that the Department of Health (DoH) appreciated quite early on that the NHS workforce was the key to successful reform and that increasing resources was not likely to bring improvement in itself. Having placed additional demands on healthcare professionals through the pace of change, restructuring, improved "productivity" and auditing (Tovey and Adams, 1999) the Government began to turn its attention to the nature of the workforce and how to get the best from its staff. The Nursing Workforce Data report (2000) indicated that there were indeed increased demands on a nursing population that was ageing. It found that only 13% of registered nurses were under the age of 30 compared with 26% in 1990 and one in three nurses within the private sector was over 50 years old. In an attempt to encourage more entrants into nursing and to retain and support those already in practice, the Government realised it had to take the initiative. The publication of *Improving Working Lives* (DoH, 2000b), although primarily focused on modernising employment practices, was clearly aimed at creating a more supportive working environment. More recently the DoH (2005) published

Improving Working Lives in Midwifery which further echoes the need to support clinicians in practice.

One potential form of support that emerged in the 1990s was Clinical Supervision (cs). This involved nurses having a supervisor with whom they could have regular meetings to discuss issues around their professional practice. From 1992, cs became increasingly topical with many journals discussing and arguing its worth (Bishop, 1994, 1998a, Carthy, 1994, Fox, 1994, Burrow, 1995, Farrington, 1996, Northcott, 1996, Porter 1998, Clifton 2002). Furthermore, Butterworth, Bishop and Carson (1996), and more recently Corrigan (2005), indicated that it would not only support nursing staff but ultimately the patients they cared for and the organisations that they served. It is likely that such conclusions developed from the belief that well supported and supervised nurses are more likely to have thought through issues around patient needs, care planning and various practice difficulties. Such nurses are likely to have discussed these issues with their supervisors, thus promoting best practice and professional development. Brown and Bourne (1996) writing in a social care context lent support to these conclusions by stating that:

> "...clinical supervision provides a route to developing and maintaining emotionally healthier individuals in an emotionally healthier work-force culture...effective systems of clinical supervision can bring benefits not only to practitioners but also to the organisation and its clients."(p1)

Within an overall framework of clinical governance and the health profession being properly supported, supervised and quality driven, it is clear that cs is a key component. In 1998, the DoH stated that the means to achieve quality in the NHS would come from systems such as cs, continuing professional development (CPD) and the development of clinical leadership skills. CPD has been defined as a process of lifelong learning for all those engaged with the healthcare needs of the public, (Lugon and Seeker-Walker, 1999) and has also been described as being fundamental to the success of clinical governance (Weight, Phipps and Jackson, 1999, Sweeney, 2001, Clouder and Sellars,

2004). In order to facilitate CPD, cs is seen as a means of integrating it into everyday practice (Wood, 2004, Jones 2005b) and a way of interpreting the whole framework of clinical governance (Brocklehurst and Walshe, 2000, Cheater and Hale, 2001, Butterworth and Woods, 2002, McSherry, Kell and Pearce, 2002, Jukes, Millard and Chessum, 2004, Wood, 2004). The latter points out that cs and clinical governance are two separate entities although they "...encompass the principles of continuous quality improvement" (p30)

In order to properly implement and oversee their clinical governance strategy, the DoH has introduced organisations such as the National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI) now known as the Commission for Health Care Audit and Inspection (HCC). Their role is to advise, report on and audit the quality of healthcare, to monitor initiatives such as the National Service Frameworks (NSF) and to implement the latest NHS Plan (DoH, 2000a). However in relation to cs and the Government agenda, as far back as 1998 Rodriquez and Goorapah (p664) stated that it could lead to suspicion, as clinically based practitioners may not feel that they "own" the concept. This might lead to a "wariness" and "reservation" towards its introduction.

More recently, Barriball, While and Munch (2004) warned that:

> "...there is a danger that clinical supervision could descend into yet another human resource procedure as health-care organisations concentrate on ticking the clinical governance box, to the neglect of developing the potential of clinical supervision as a continuing professional development initiative". (p396)

Since its inception in the early 1990s the popularity and support for cs has not waned and continues to be reported upon (Driscoll and Cooper, 2005). However, despite over fifteen years of comment and exploration there is still some confusion over the concept (Bush, 2005) and a dearth of empirical studies. My particular interest and concern was

that neither the implementation of cs nor its effectiveness had been examined or evaluated, (Sloan, 1999b, Gilmore, 2001, Gray, 2001, Sloan, 2005).

Nationally, it would appear that there is still no agreed framework for the training of either clinical supervisors or their supervisees and whilst there have been many training courses available, there have been limited empirical studies which have specifically addressed in detail the type of training which is likely to be most relevant and effective. The initial purpose of this study was to explore the training of cs supervisors (qualified nurses) and to discover the lived experiences of individual course participants, before and after undertaking the cs course. I also wanted to provide these individuals with an opportunity to discuss the concept and whether or not they felt equipped for their role in enabling and empowering supervisees within the process. A higher education institution (HEI) was selected which provided cs courses for numerous private and NHS Trusts. At that time two Trusts (one acute and the other community) had purchased two and three day cs courses respectively. The courses were being run consecutively, with a total of forty attendees and I wrote to all 40 of the potential attendees to seek volunteers for the study. A total of 19 course members volunteered to take part (acute Trust n=10 and community Trust n=9).

A series of three interviews took place over an eight to twelve month period with each participant. The first individual interviews were scheduled a week before their respective course commenced. This was to ascertain how they had come to take part in the cs course and their experience of cs to date. Following completion of the course a second interview was organised one week later. The aim of that interview was to explore the participants' experience of undertaking the cs course and how they envisaged using their newly acquired knowledge. Approximately six to eight months later, the third interview took place to discover whether the individual participants were actually engaged in cs, either as a supervisor or supervisee. Whilst my initial plan was to undertake three interviews, the experiences of seven of the participants led me to

undertake (with their agreement) a fourth interview. These particular participants were chosen because of their very distinct views towards cs. One participant was clearly positive six others were negative and I wanted to gain an in-depth appreciation of why they held these views.

As the lived experiences of the course participants unfolded, what emerged was a greater need to understand the experiences of cs in relation to senior managers/strategists and supervisees within these two Trusts. Following further ethical approval from the two Trusts, nine senior managers and six supervisees agreed to take part in a one-to-one audio-taped interview. What appeared to emerge was that the nursing profession had been unable to put mechanisms in place to overcome nurses' fear and distrust of cs. As a result, cs had not been effectively implemented.

This study is unique because it has provided insight into different life worlds in relation to the same phenomenon over a period of time. Whilst not claiming to be generalisable, the work is transferable and will serve to enhance, add to and question the concept in nursing referred to as clinical supervision. It is a phenomenological study guided by some of the works of Heidegger and Gadamer. Numerous excerpts from the interviews have been utilised to demonstrate how the language of the participants framed the interpretation of their lived experience of cs, which Heidegger would describe as an attempt to reveal the "matters" *(die Sachen selbst)* as they manifest themselves (Moran, 2000 :227).

Chapter 1

Literature review: perspectives of clinical supervision, historical, theoretical and interprofessional

The purpose of this literature review is to explore the concept of clinical supervision (cs). There is an explanation of the literature search strategy undertaken, as well as the search terms used and how the literature has been organised.

The review has been divided into two parts. The first part includes definitions of cs, an overview of its historical development, its purpose, reasons for its introduction within the nursing profession and its relevance to other groups including pre-registration student nurses.

The second part of the literature review is a critical analysis of the implementation of cs in relation to the education and training approaches used. There is also a focused examination of relevant research from the 1990s to 2006.

1.1 Literature search strategy

Following the identification of a research question a detailed review of the literature was undertaken (Holloway and Wheeler, 1996, Polit and Beck, 2006). Burns and Grove, (1993) described the literature review as central to the research process, as the reader is provided with the justification of the purpose and/or design of the study, a view supported by Gillies (2002). However, Polit, Beck and Hungler, (2001) advised, that whilst the literature review is a crucial early task for the *quantitative* researcher, the *qualitative* researcher should be aware that an initial search might result in their subsequent research being guided by prior thought. Bearing this in mind, I initially undertook a limited search to examine whether any studies had been undertaken in relation to the training of clinical supervisors. As the study progressed and data were

collected and analysed, I continued to search the literature on many occasions, not only to update my knowledge but also to discover whether the findings that were emerging from the study related to anything already written (Nieswiadomy, 1998).

1.2 Search terms and databases

Literature sources were located using on-line databases, search engines, library catalogues, indexes, abstracts and manual searching. Over the duration of this study, information technology and retrieval advanced significantly, which allowed quick and easy access to a wealth of literature. Those most frequently used included, Cumulative Index to Nursing and Allied Health Literature, (CINAHL) 1982-2006, Academic Search Elite, PsycINFO and Professional Development Collections. PubMed (on-line medical literature from 1983-2006) was used initially however the results generated in relation to the search terms "clinical supervision" were significantly higher than all the other databases. On further examination it would appear that this database was more medically focused and the bulk of the results related to "clinical" trials rather than clinical supervision. I valued the fact that CINAHL focused on cs specifically within the field of nursing, whilst the other databases could be used to gain a more general understanding of the concept within the allied professions.

A variety of search terms were used including *"clinical supervision"* and *"clinical supervision and nursing"*. As the study progressed the search terms changed to reflect the emerging findings, which included *"trust and nurses"*, *"trusting and nursing"*, *"time and nurses"*, *"disclosure and nurses"*, *"whistle blowing and nurses"*.

(Please refer to Appendix 1 for a visual presentation of the volume of results for a twenty year period 1980-2000 and from 2001 on a yearly basis).

Whilst the number of results have been identified for differing years it is important to comment that not all necessarily related to the area under scrutiny. For example the

search term *"trust"* may also refer to a hospital Trust rather than the concept of trust between people. This led to each result being individually examined by their title and/or the abstract. I then decided whether they were of relevance to the study.

1.3 Broadening the search

In view of the relatively recent historical development of cs in nursing, the literature from allied professions was also examined. Whilst supervision is inherent in the work of these professionals (and usually incorporated into their job description), it was important to explore what the term "supervision" meant to all of them.

1.4 Organising and sorting the literature

Once the literature search was completed all abstracts were reviewed. The primary sources were then located from a variety of libraries and inter-library loans as well as on-line electronic journals listings. The full texts of the documents were then critiqued. The literature was grouped into subject areas. This provided a more workable and focused understanding of the literature currently available.

The main areas that have been addressed within the literature include definitions, comment and editorial, models, legal and ethical issues, supervision related to specialities, education/training and research (both quantitative and qualitative). Whilst all areas of the literature pertaining to cs and nursing were reviewed, I chose to focus on the ones that impacted on my own study, namely, definitions, models, education/training and research.

The literature review has been formatted to take the reader on a journey in which they are introduced to broad topics of cs. Incorporated within each topic is an examination of the anecdotal, commentary and editorial alongside the empirical evidence of studies that have been undertaken.

Chapter One of the literature review concentrates on the historical, theoretical and interprofessional perspectives of cs. Chapter Two specifically examines empirical studies that have been undertaken; it also focuses on the training and preparation of supervisors. The justification for this approach was to encapsulate the topics more fully, as well as providing my own interpretation of what the literature means.

1.5. Definitions of clinical supervision

There is no universal definition of clinical supervision (cs) (Gray, 2001, Howatson-Jones, 2003, Sellars, 2004, Cutcliffe and Lowe, 2005). Indeed, when reviewing the literature there were no fewer than forty published definitions. A selection has been included here to demonstrate the breadth and depth that have been offered to readers over the last two decades.

> "A quintessential interpersonal interaction (whereby)...the supervisor, meets with another, the supervisee, in an effort to make the latter more effective in helping people.".
>
> Hess (1980:17)

> "An ongoing educational process in which one person in the role of supervisor helps another person in the role of supervisee acquire appropriate professional behaviour through the examination of the supervisee's professional activities."
>
> Hart (1982:15)

The language of these initial definitions tended to be humanistic, in that helping and support were dominant, but as the years have passed the language has changed. The definitions have become more concerned with the need to monitor performance and protect the public (accountability), a view supported by Sloan (2005).

> "...a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations."
>
> DoH (1993)

> "A designated interaction between two or more practitioners, within a safe/supportive environment, which enables a continuum of reflective, critical analysis of care, to ensure quality patient services."
>
> Bishop (1998b:8)

Bishop's (1998) definition appears confusing, she expressed the need for support of the supervisee at the same time as the need for "critical analysis". Could cs be guaranteed as "safe" if the aim is patient care or public protection? Latterly the definitions concentrated on the need to reflect:

> "Clinical supervision is a practice focussed professional relationship that enables you to reflect on your practice with the support of a skilled supervisor. Through reflection you can further develop your skills, knowledge and enhance your understanding of your own practice."
>
> NMC (2001)

> "A confidential, formal and voluntary process that examines and reflects upon professional practice and supports clinical practitioners, while enhancing professional practice and development."
>
> Hancox and Lynch (2003:13)

Clouder and Sellars (2004) suggested that linking the definitions of cs to reflection conveys a belief that this will result in learning from practice. However, they conceded that this may be because the UKCC (1996) and DoH (2000a) have "embedded" reflection and clinical supervision together in their policy documents.

Howatson-Jones (2003) supported the view that the many definitions emphasised interpersonal relationships, with supervision being seen as a two-way process, whereby supervisee and supervisor shared a common goal. Barriball et al (2004) believed that the consensus within the definitions came from the fact that in any discipline it is a practice-focused process. Sloan (2005) however, argued that whilst several definitions exist, they vary in focus and that within the last ten years the remit of cs

> "...has extended from the development of therapeutic proficiency to the acquisition of professional skills, the protection of healthcare consumers from nurses and reflecting on the diversity of professional practice." (p918)

Interestingly, Bishop (1994) felt that these far reaching expectations could be addressed when she sought to find a consensus definition, identifying three overall aims: safeguarding standards, the development of professional expertise and the delivery of quality care. This links with the work of the British Association of Counselling and Psychotherapy, whose primary purpose in supervision has always been protection of the interests of the client. However, nursing has chosen not to adhere to any one formal definition. Jones (1998) believed that a definition was difficult as the concept appears to be multi-dimensional and is viewed in different ways by different theorists.

It is noticeable that the definitions predominantly appeared in 1994 when discussion about cs was at its height. Furthermore, Jones (1998) stated that for any new concept within the nursing profession there will be

> *"...an almost encyclopaedic deliberation."* (p560)

1.5.1 Defining clinical supervision for nursing

The term "supervision" itself denotes overseeing, inspection and control (Schwartz, 1993). Titchen and Binnie (1995) liken this to the industrial model and believed that nurses have traditionally followed this format. However with the emergence of cs there has been a move from the industrial model towards defining supervision more akin to academic supervision. They described the relationship as being supportive, challenging and helping the supervisee to explore new ways to work effectively, rather than being criticised for any errors or omissions. If nurses have typically regarded supervision with such negativity it is not surprising that the literature still continues to discuss the confusion and distrust towards the concept, a view supported by Teasdale (1998). This was also evidenced within Kohner's work in the King's Fund Centre report of 1994. In this report a manager of one of the units stated that whilst community nurses were familiar with supervision, it still remained uncomfortable and threatening. Furthermore,

> "...most community nurses have picked this sphere of nursing to get away from control and lack of autonomy over their own practice."(Kohner, 1994: 31)

The nursing literature has offered a plethora of definitions in relation to cs, some of which have derived from counselling and the allied professions (Power, 1994). Most articles have tended to focus on those definitions offered by authors who are seen as high profile in relation to cs in nursing (Butterworth, 1992, Butterworth and Faugier, 1994, UKCC, 1995).

Overall the definitions within the literature appeared to emphasise the need for; (a) A formal process (DoH, 1993, Webb, 1997) *whereby,* (b) there is an exchange between two or more professionals (Hess, 1980, Hart, 1982, Butterworth and Faugier, 1993, Barton-Wright, 1994, Ritter, Norman, Rentoul and Bodley, 1996, Begat, Severinsson and Berggren, 1997, Bush, 2005). *During which* (c) reflection on work issues takes place (Simmons and Brooker, 1986, Northcott, 1996, Nicklin, 1997, Bond and Holland, 1998, Driscoll, 2000, Pfund, Dawson, Francis and Rees, 2004, Berggren Barbosa da Silva and Severinsson, 2005). *Furthermore that* (d) Standards are enhanced and the public is protected (Kaberry, 1992, Catmur, 1995, Bishop, 1998b, NMC, 2002a, Clouder and Sellars, 2004, Wood, 2004)

Howatson-Jones (2003) following an examination of definitions and the suggestions from the authors, McKeown and Thompson (2001) and Spence, Cantrell, Christie and Samet (2002), derived the following definition:

> "Clinical supervision is a designated reflective exchange between two or more professionals in a safe and supportive environment which critically analyses practice through normative, formative and restorative means to promote and enhance the quality and practice of patient care". (p38)

Thus, Howatson-Jones (2003) embraced earlier definitions and in addition included a model to facilitate the process, with the overriding aim of improving the quality of patient care. She stated the importance of having a definition and commented on the confusion and suspicion related to the term "supervision". A criticism of this definition is its use of the words "normative" and "formative" which may foster ongoing

confusion. For example "formative" is also a term used in nursing education as a way of describing a form of assessment that is not awarded a grade or percentage.

1.6 Historical development

Many authors introduced the concept of cs by espousing the ratification that it had already received from key bodies including the Department Of Health, National Health Service Management Executive, United Kingdom Central Council for Nurses as well as prominent authors on the subject (Timpson, 1996, Jones, 1998, Driscoll, 1999, Knutton and Pover, 2004a, 2004b, Cutcliffe, 2005). However, relatively little has been written to provide nurses with an overview of its historical inception within the profession and the rationale for its introduction. Cutcliffe and Proctor's (1998a) historical perspective cited Butterworth as the pioneer for introducing formalised support mechanisms for nurses in the form of cs in the early 1990s. Additionally, they alluded to the influences of the Code of Conduct (UKCC 1992a), the Scope of Professional Practice (UKCC 1992b), the findings of the Allitt inquiry (Clothier, MacDonald and Shaw, 1994) and its affirmation by the Chief Nursing Officer (DoH, 1994b) following the Department of Health 1993 document "A Vision for the Future".

1.6.1. National support for clinical supervision

1.6.1.1 The Department of Health "A Vision for the Future"

"A Vision for the Future" (DoH, 1993) resulted from four policy initiatives: Caring for People (DoH, 1989), Health of the Nation (DoH, 1992), The Children Act (1989) and The Patients Charter (1990). Following wide consultation within the nursing profession, it described good practice in key areas with 12 targets. Clinical supervision was specifically highlighted in target 10 which stated that:

> "Discussions should be held at local and national level on the range and appropriateness of models of clinical supervision and a report made available to the professions by the end of the year." (DoH, 1993).

However, this target appeared to lack clarity with regard to what models to use, because no definition was offered. Generally the nursing literature appeared to link models with ways of carrying out cs, such as one-to-one or group supervision (HVA, 1995, Sloan, 1999a, Todd and Freshwater, 1999) as well as academic models like Proctor's (Proctor, 1986).

The evaluative report undertaken the following year "Testing the Vision" (DoH, 1994b), failed to provide an in-depth answer to what was written within target 10. It stated that 86% of units had held discussions and that the Chief Nursing Officer (1994) showed her endorsement of the concept by commending the report by Butterworth and Faugier (1993) in a letter to the professions. It did not address the issue about which model to employ and, whilst questionnaires were sent out to nurses, they tended to be returned by senior nurses with little feedback from clinically based nurses. There was limited evaluation of the concept in the written document.

Evidence to raise the profile of cs came in the form of conferences for Trust nurses (Wilkin, Bowers and Monk, 1997) and a 23-site evaluation project in England and Scotland (Butterworth, Carson, White, Jeacock, Clements and Bishop 1997). However as Wilkin et al (1997) pointed out:

> "The response by nurses has been tepid with many openly rejecting what has been hailed as an integral part of practice". (p48)

Apathy towards cs was further highlighted in the response rate of 0.6% readers to the collaborative survey undertaken by a DoH funded agency and Bishop (1998a). Whilst those who did respond provided detailed and positive feedback to the questions posed, the survey tended to suggest that the majority of nurses were not interested in cs, despite its high profile in the political, organisational and nursing education arena. It may be suggested that the method of data collection was flawed. Instead of designing a specific survey which could have been sent to all practitioners, they used a survey

which was concealed within a nursing journal (Nursing Times) limited to specific readers and possibly undermining its external validity and representativeness of the sample.

1.6.1.2 The Allitt Inquiry

(Please refer to Appendix 2 for a brief resume of the Allitt Inquiry)

The Allitt inquiry has been widely reported to support cs in the literature (Jones, 1997, Bishop, 1998a, 1998b, Cutcliffe, Epling, Cassedy, McGregor, Plant and Butterworth, 1998, Kell, 2002, Winstanley and White, 2003, Clouder and Sellars, 2004). On further examination, the report itself emphasised the need to safeguard practice but it did not state emphatically the need for cs. Indeed, Yegdich (1999:1198) argued that the Allitt Inquiry (Clothier, MacDonald and Shaw, 1994) highlighted the need for managerial-organisational supervision and not the "new idea of clinical supervision based on an equal exchange". The misinterpretation of other authors regarding the Clothier report could serve to confuse practitioners, as it may lead people to believe that if support in the form of cs had been in place, Beverley Allitt may have disclosed to her supervisor and children's lives may have been saved. Yegdich (1999), who suggested that Allitt's personality problems would have got in the way of effective cs, supports this view. However, an alternative personal view is that if Allitt's peers and not least her supervisor had been engaged in cs then they may have felt enabled or empowered to disclose their concerns regarding her practice and she may have been stopped earlier.

Thus, the findings of the Clothier inquiry and the authors who link it to cs may strengthen the argument for a more accountable profession in which standards and quality of care are enhanced.

1.6.1.3 The UKCC/NMC

When this study commenced, the UKCC was the regulatory body for Nurses, Midwives and Health Visitors. However, in 2001 this changed to the Nursing and

Midwifery Council for the UK (NMC). The NMC (2001) provided a definition and broad principles in relation to cs congruent with an earlier statement by the UKCC in 1995.

The UKCC (1995:3) was clear in its endorsement of cs, as it seemed to fit with their philosophy for the continuum of practice in which "practitioners have no end point in their need to maintain and develop standards of practice". This statement appeared to express several ideas, which remained consistent with contemporary and later developments such as, the 1996 European Year of Lifelong Learning, as well as the UKCC's Post-Registration Education and Practice, (1995) and The Code of Professional Conduct, (NMC, 2002a).

The UKCC went on to state that cs was not managerial supervision, performance review or intended to be hierarchical (UKCC, 1996:3). This position was undermined however when the paper discussed the process as being determined by practitioners, according to local needs and circumstances, with a "light touch" management influence (UKCC 1996). This "light touch" proposal seemed ambiguous and as such may have been misinterpreted within the nursing profession.

Whilst the UKCC has been non-prescriptive in its position on cs it was keen to consult practitioners regarding, who should be a supervisor, selection of supervisor and terminology. In January 1995, the UKCC Registrar's letter was sent to all nurse registrants. It clearly identified that the Council had deliberately chosen not to produce a prescriptive policy on cs, but instead broad principles which practitioners could interpret. However the letter did wish to consult the registrants concerning the term cs. Annexe 1 to Registrar's letter 4/1995 paragraph 20.4 stated:

> "The Council believes that the term clinical supervision may in itself be either misleading or unhelpful. Would use of the term "clinical support" be more acceptable? What other alternatives might there be?"

This indicated that there was concern regarding the terminology, and whilst it was sent out for consultation, the term "clinical supervision" has remained. When the UKCC (1996) released their position statement they clearly defined that cs was **not** hierarchical, management control or therapy.

Given that there are currently 660,480 registered practitioners on the NMCs register (NMC, 2004b) it is unlikely that there will be a consensus of views, even if these views could be easily ascertained. Consequently, it would not be unreasonable to expect or at least encourage the NMC to issue guidance on a structure or desirable fundamentals of cs and a general statement of intent.

It was not until key statement 5 (out of a total of 6) that the preparation of supervisors was addressed by the UKCC. It highlighted the need for in-house or external education programmes. However it offered no suggested format or duration for the training. Again this sheds little light on how to introduce the concept successfully within the nursing profession (UKCC, 1996). It might have been of benefit to practitioners and academics if the UKCC had provided examples of good practice from other disciplines, which already have supervision. In this way cs might have been seen as being of more relevance to the nursing profession rather than just an idea that could be brought in to support practitioners whilst leaving individuals to decide how to implement it in practice. Whilst the UKCC fully supported and endorsed cs, they did not wish for it to be a statutory requirement for nurses, although they stated that, "this position may be reviewed if the need arises" (UKCC, 1996:2). There is little evidence that the new NMC proposes to take a different view.

The reluctance to make cs mandatory may mean that nurses pay little attention to it and treat the concept as something other nurses may need, but not themselves (Porter, 1998). There are supporters advocating the need for cs to be mandatory but Morcom and Hughes (1996) advised that care should be taken in deciding when this happens, as

it may be untimely and lead to damage and destruction of the practitioner. Sadly they offer little in the way of an explanation to justify this statement.

To conclude, national support and the development of cs in nursing appear to have emerged through a variety of political and respected organisational channels. Castille (1996) believed that this may have helped reaffirm to practitioners its importance on the nursing agenda and its valuable contribution to the provision of quality care. Conversely, the origin of cs may have resulted in nurses being reluctant to embrace the concept as they may not be fully "convinced of its usefulness" (Rodriguez and Goorapah, 1998:664). However, there is no evidence to substantiate whether this is true or, as White (1996) and Wolsey and Leach (1997) argued, the real reason was the confusion amongst practitioners as to whether or not cs was managerial supervision or therapy. Whilst Jones (1998) believed that cs was neither therapy nor management control, he did accept that there was the potential for exploitation. However, he did not explore how this could take place or provide the empirical evidence to support his view. Furthermore, Teasdale (1998) remarked on the amount of "jargon, hype and cynicism" surrounding the concept, blaming academics and "evangelistic" writers for the confusion and adding that many also saw cs as a cure for all ills within the nursing profession. Teasdale's observations appear to be reminiscent of Carthy's in 1994 when he criticised nursing commentators, educationalists and leading lights

> "It jumps on the bandwagon, over-complicating and over-intellectualising the concept." (Carthy, 1994: 48).

However, examples to justify this criticism were not offered.

1.6.2 Criticism of national support for clinical supervision

Timpson (1996) suggested that even if cs were offered to nurses in a supportive way, the profession would tend to confuse the idea of support with control, and that this comes from:

> "An acknowledged apologist tradition, related closely with the role as fostered under a prejudicial patriarchal medical system, and an almost sacrosanct reluctance to admit an inability to cope." (p45)

This may suggest that the UKCC or the profession itself would need to invest further effort in dealing with this scepticism. Furthermore, Smith (1995) argued that a cultural shift was required if cs was to reach the whole NHS. Nine years on, Hancox, Lynch, Happell and Biondo (2004) stated that if cs was to be effective, then it required a clear strategy and that the attitudes of the supervisees were crucial. The supervisee's would also need to be receptive to the process, otherwise it is unlikely that cs would become a reality. Earlier, Butterworth and Woods (2002) had argued that organizational culture needed to fully support the implementation of cs, (a view also supported by Price and Chalker, 2000, Barriball et al, 2004).

Spence et al (2002) stated that, because the healthcare system in the UK operates in a frequently changing environment, ultimately implementing a concept such as cs needed to be carefully planned with close collaboration between clinicians, managers and educationalists. They cited Bedian (1980) who examined organisational change and declared that the four most common causes of resistance to change in an organisation were, parochial self interest, misunderstanding and lack of trust, contradictory assessment and low tolerance of change, some of which I believe my study demonstrates. Furthermore, Barriball et al (2004) have also expressed the need for clear leadership and commitment from management if cs is to take place within nursing. This would then result in a culture within nursing that encouraged staff participation and innovation (Hyrkas, 2005). Indeed Bevington, Deighan, Stanton and Hichliffe (2004) examined the concept of trust within the health service and concluded that staff would engage with leadership decisions (even those they disagreed with) if they perceived the process to have been fair. Whilst Faugier and Woolnough (2002) commented that the reality within the NHS is that initiatives tend to be imposed on staff rather than them being able to create their own vision. Clinical supervision may be seen as a "classic

case" in which there had been an attempt at a universal implementation of the concept nationally. If practitioners have felt that the concept has been foisted upon them, it may be wise to remember a quote from Wright as far back as 1989 when he argued that:

> "Many nurses are damaged humans as a result of change forced upon them, leaving them able only to react and resent." (Wright, 1989:4)

Indeed, Clegg (2000) stated that if leaders valued their employees, consulted with them and clarified their role, then the environment would be one of a shared vision. The NMC could argue that this was why their position statement was vague as they did not want to stifle creativity and that cs is a broad concept that should be developed locally. However, authors such as Farrington (1996) believed that a clearer national framework should be offered to all qualified nurses to allay the confusion. He was vehement in his criticism of the UKCCs attempt at introducing cs within the profession, believing that the idea was attractive but so far its introduction had been "sporadic and piece meal". He argued that for the concept to become a reality it would require "clear definitive leadership and direction from the UKCC" as opposed to the "sit on the fence statements that have so far come" (Farrington 1996:716). This suggested lack of a strategic direction and has been interpreted in different ways, with Morcom and Hughes (1996) concluding that there will never be a universal definition or model of cs for the nursing profession. Conversely, Coleman (1995) implied that a lack of prescription by the regulator has given practitioners the freedom to choose a model, which they feel, is most appropriate to their needs.

Despite criticisms and difficulties implementing cs within the mid to late 1990s the nursing press witnessed many publications relating to how nurses were introducing cs. This included a plethora of publications from specialities, including, accident and emergency departments, (Castille, 1996, Marrow, Macauley and Crumbie, 1997), community psychiatric nursing (Oxley, 1995), ear nose and throat (McGibbon, 1996), palliative care (Jones, 1997), acute medical wards (Titchen and Binnie, 1995) and other

clinical settings (Kohner, 1994). This may have been as a direct result of the support that cs had been given by key organisations such as the UKCC and the DoH, although the reasoning is unclear.

Interestingly, whilst cs appeared to have been introduced sporadically throughout the UK, the literature in the 1990s tended to address the need for guidelines in respect of the potential legal and ethical dilemmas that practitioners may face, (Cutcliffe and Proctor, 1998a, 1998b, Dimond, 1998a, 1998b). This suggests that the concept may have been poorly conceived and that a degree of guidance could have been issued previously by the UKCC before advocating its worth nationally. This might have allowed practitioners the freedom to develop cs pertinent to their area and to anticipate likely problems.

I believe that the criticism levelled in the literature regarding national support of cs has not been sufficiently empirically tested. This thesis goes someway towards addressing the need for such investigation. In doing so, it highlights a need for a cultural shift in the profession, if cs is to be implemented nationally.

1.6.3 Mentorship and preceptorship

Prior to cs the nursing profession had witnessed the advent of preceptorship and mentorship. I thought it important to include these two concepts as they were part of the historical development of cs and have been equally fraught with difficulties in their introduction.

Some authors suggested that the introduction of preceptorship and mentorship was the result of a change in nursing practice towards holistic care, and the move into Higher Education with the arrival of Project 2000 (UKCC, 1986, Morcom and Hughes, 1996, Hadfield, 1998, Andrews and Wallis, 1999, Watson, 2004). Marrow and Yaseen (1998) identified that the English National Board (ENB) in 1989 were the driving force behind

the implementation of mentorship for students nurses in the clinical environment. Preceptorship, on the other hand emerged as a result of the Post-registration education and practice [PREP] report (1990), instigated by the UKCC (Marrow and Yaseen, 1998). Similarly to cs, mentorship and preceptorship were theoretically introduced by the UKCC and ENB but again, left to the Trusts to translate and effectively implement at local level.

Despite the UKCC (2000) issuing guidance for the standards of both roles in the practice setting (reprinted by the NMC, 2002b), there still appears to be generalised discussion regarding the nature and purpose of both mentorship and preceptorship (Andrews and Chilton, 2000). The debate is now widening with discussion focusing on third year students providing peer mentorship support to the junior student nurses (Aston and Molassiotis, 2003) and the need for preparation of the mentor (Watson, 2004) and preceptor (Billay and Yonge, 2004).

Although cs, preceptorship and mentorship use different terminology and differ according to the times when they might occur in a nurse's career, essentially they share a common theme which is about support, and utilise the same skills and principles (Northcott, 1996). Differences between the three concepts relate to the "educative and authoritative functions of the respective roles", (Bond and Holland, 1998). Fowler (1996a) on the other hand, commented that whilst nurses are experienced in supervising students

> "...it is not the same as supervising qualified staff as their needs and experiences are very different." (p476)

Fowler likened the role of a clinical supervisor to that of supervising a nurse undertaking a post-registration course where the aim was professional development and support. However, it could be argued that there would still be a power differential when one person is supervising or assessing another (Cutcliffe and Lowe, 2005). Within cs

this should not apply because the supervisee should be at liberty (within limits) to choose their supervisor (Jones, 2001a, Spence et al, 2002). Furthermore, an adequately trained supervisor would meet the very differing needs of a supervisee undertaking cs, rather than if they were having mentorship or preceptorship.

There are similarities of confusion within the literature in relation to mentorship, preceptorship and cs, issues such as who should have it, who should facilitate it; the training that is required and the appropriate length of training time are still being discussed. The UKCC (2000) saw the three as a continuum in which all nurses, whether qualified or not, required support and assistance. Indeed, Morcom and Hughes (1996) incorporated the three and stated that:

> "It (cs) will embrace aspects of preceptorship and mentorship dependent upon the developmental stage of the supervisee." (p118)

It is suggested that nursing has tended to be fairly maternalistic in its approach to guiding the student nurse and that therefore the profession may embrace mentorship for students more easily than preceptorship or cs (Bishop 1994).

1.7 Relevance of clinical supervision in nursing

1.7.1 Benefits of clinical supervision in the UK

The historical changes that have taken place within the nursing profession may have resulted in an increase in occupational stress and "burnout" (Butterworth and Faugier, 1992, Berg, Welander-Hansson and Hallberg, 1994, Williamson and Dodds, 1999). During the 1980s and 1990s a wealth of literature, indicated that nursing was a stressful occupation. Nurses working within an environment with little or no support may exhibit self-hatred, low self esteem, a strong resistance to change, a retreat from initiative, awe of authority and attraction to routine, (Power, 1994). However, it was not until the 1990s that more evidence has emerged which has indicated that cs is of benefit to the nursing profession (Sloan, 1999b, Cleary and Freeman, 2005, Hyrkas, 2005, Stevenson,

2005). Studies have shown that nurses "highly value" having regular cs (Bulmer, 1997), that it improves job satisfaction and well being (Begat, Ellefsen, Severinsson, 2005), increases self esteem and confidence (Arvidsson, Lofgren & Fridlund, 2001, Hyrkas, Appelqvist-Schmidlechner and Kivimaki, 2005,) as well as offering an opportunity to reflect on practice (Clouder and Sellars, 2004, Brearley, 2005). Furthermore, cs assists nurses in their ethical decision-making (Lyth, 2000, Berggren, Begat and Severinsson, 2002, Magnusson, Lutzen and Severinsson, 2002, Berggren et al, 2005). (These studies have some limitations in that they have a narrow focus (mental health) and small sample size however a thorough critique has been undertaken in Chapter Three).

Wheatley (1999) who supported the introduction of cs, believed that whilst the caring professions are *"labour intensive"* and a *"costly resource"* that *"this resource is valued by developing and supporting staff to enable them to provide effective and efficient work"*. Furthermore, Butterworth and Woods (2002) linked cs to an improvement in quality of care and clinical standards. However, they offered no empirical evidence to support this view. Similarly, Swain (1995) saw the benefits from both nurse and public perspective noting how it could reduce sickness and burnout rates and improve standards of care. Again no empirical research was offered to support this fact. Kopp (2001) advised caution as some of these benefits would be difficult to measure by being reliant on one factor i.e. cs. Experimental research in this area is limited due to the difficulty in isolating cs as an independent variable (Fowler, 1996b). At the same time the extraneous variables (such as staff personalities, speciality, resources, environment, gender and culture) could influence the outcomes.

The literature has commented positively on cs, it would appear that on balance there is national and international support with criticism from a minority (Sloan 1999b). This thesis further evaluated the argument that there are benefits to practitioners who engage in cs. Furthermore, it also suggests that those who wish to partake in the process need

to be practising at a certain autonomous level, to reap the benefits, an area which has until now been poorly researched.

1.7.2 Clinical supervision worldwide

Changes in health care provision are not unique to the United Kingdom. Nursing academics in countries such as, Sweden (Hallberg, 1994, Palsson, Hallberg and Norberg, 1994) and Australia (Hancox et al, 2004) have commented on the organisational changes, which have placed practitioners under increased pressure. Cs has been recognised as a mechanism to minimise the effects of high workloads and increase competence development and organisation, (Severinsson and Kamaker, 1999, Driscoll and Cooper, 2005). The two regions of the world, apart from the UK, which have produced the greatest amount of literature on cs are North America and Scandinavia.

1.7.2.1 North America

According to Gray (2001), cs began in North America in the 1930s and may have been the result of the transformation in nurse education at that time. He drew similarities between the nursing education in North America in the 1940s and 1950s and in the UK since 1991, specifically the move into Higher Education and linkage of theory to practice. He contended that cs has been heralded as a key to changing the culture in both countries during these periods.

Recently, Cutcliffe and Lowe (2005) have published findings in regard to how cs is conceptualised and organised within North America and European countries. They argued that there were not only differences across countries but also within them. They concluded that in North America cs was seen as a more experienced nurse monitoring, supporting and educating a less experienced nurse in skill performance. As a result, all supervisors needed to be more skilled and experienced than the supervisee.

1.7.2.2. Scandinavian countries

External to the UK the majority of literature is from the Scandinavian countries[1]. Whilst this might suggest that cs is more prevalent in that part of Europe, on further examination it would appear that there is a small group of researchers with a keen interest in this subject who have published widely to a small readership. There are also a number of limitations to the aforementioned studies; in particular, some of them took place in a psychiatric setting using small sample sizes and this may influence their statistical significance (Paunonen and Hyrkas, 2001, Olofsson, 2005).

Whilst there have been inconsistencies in the conceptualisation and organisation of cs within the UK, this was also noticeable worldwide (Cutcliffe, 2005, Hyrkas, 2005). It would appear that broadly speaking the UK and the Scandinavian countries share a common understanding of the term cs, as a supportive exchange between two or more practising professionals (Cutcliffe, Butterworth and Proctor, 2001, Hyrkas, 2005). In contrast, the United States of America have focused predominantly on cs being used as a support mechanism for students during their training or new practitioners prior to licensure (Butterworth, Bishop and Carson, 1996, Bernard and Goodyear, 1998, Hyrkas, 2005)

1.8 Models of supervision

According to Sloan and Watson (2002)

> "A supervision model is a conceptual framework that can assist in the delivery of clinical supervision."(p41)

[1] (Paunonen, 1991; Hallberg and Norberg, 1993; Hallberg, Hanson and Axelson, 1993; Severinsson and Lindstrom, 1993; Berg et al, 1994; Palsson et al, 1994; Severinsson, Hallberg and Ingalill, 1996; Begat et al 1997; Severinsson and Kamaker, 1999, Berg and Hallberg, 2000; Hyrkas, Appelqvist-Schmidlechmer and Paunonen-Ilmonen al, 2002, Haggstrom, Skovdahl, Flackman, Kihlgren, and Kihlgren, 2005, Hyrkas, 2005, Olofsson, 2005 ; *not exhaustative*)

Throughout the literature, reference is made to different theoretical models for effective cs to take place[2]. However Fowler (1996a) commented that few of the models offered within the nursing press are well defined.

> "Many... are fairly imprecise, conveying only a philosophy of approach rather than details of a working model."(p475)

Whilst numerous theoretical models of cs exist it would appear that the similarity between them is that they have tended to originate from a counselling/psychotherapy background (Farrington, 1995). Indeed, Davies, Tennant, Ferguson and Jones, (2004) utilised three models from the aforementioned professions when they implemented a framework for multi-professional cs.

Generally the models from counselling and psychotherapy emphasised the use of self, which would fit in relation to how cs has been defined earlier within the literature review (Young, 2004, Stevenson, 2005). Farrington (1995) suggested that these models (currently in existence in mental health) may be transferred and used in general nursing. However, earlier Faugier (1993) had stated some models are not tailored to the needs of the nursing profession and added that the few nurses who do attempt to develop their own models are ostracised, although no evidence is provided to support this comment. Faugier (1992) advocated the use of her eclectic "growth and support" model for nurses, this encompassed the diverse theories, impacting on the practitioner's role. Whilst it may provide the user with a framework to facilitate growth and support, it is lengthy and reads more as a series of skills.

Although, several models are referred to within the literature there is limited evidence to evaluate their effectiveness for nurses undertaking the role of clinical supervisor (Todd and Freshwater, 1999). Whilst analysis and empirical evidence provided on the

[2] (van Manen, 1977, Hunt, 1986, Proctor, 1986, Heron, 1990, Johns, 1993, 1997, Faugier, 1993, Cutcliffe and Burns, 1998, Hawkins and Shohet, 2000, Fulton and Oliver, 2001, Beinart, 2003, Sellars, 2004)

usefulness of models is limited, there has been a method devised to categorise them by Faugier and Butterworth (1993). Fowler (1996a) used this classification to examine supervision models in his literature review, although he gave no rationale for their use and admitted that there were models that whilst convenient, did not fit only one category. He then proceeded to provide the reader with two examples, one, which fell within two categories, (Fish, Twinn and Purr, 1989) and the other all three, (Johns 1993). He did not offer any further method or ways that this could be addressed, but suggested that a single model and theory of supervision within nursing and midwifery may emerge in the future. Whilst not stating whether he was in support of one model in this paper, he wrote in another article the same year that:

> "There is no one model of supervision that will suit the needs of the great variety of clinical situations found within our profession. An attempt to impose a model that works well in one area on a different area has many disadvantages."
> (Fowler, 1996b:385)

More recently Cutcliffe (2005) warned that:

> "...to attempt to force one model of clinical supervision upon every supervisee in every specific care context and every different country appears to me to be the height of folly."(p471)

Since 1999, the literature has tended to move away from discussion and emphasis on models and has tended to focus more on the operationalisation of cs in practice (Knutton and Pover, 2004a, 2004 b, Deery, 2005).

1.8.1 Proctor's model

When reviewing the literature the most popular model referred to was Proctor's (1986) three-function interactive model[3]. Interestingly, this model appears to be a revised

[3] (Faugier, 1994, Fowler, 1996a, Nicklin, 1997, Waterworth, Pillitteri and Swift, 1997, Cowe and Wilkes, 1998, Todd and Freshwater, 1999, Bowles and Young, 1999, Darley, 2001,Gray, 2001, Willson, Fawcett and Whyte, 2001, Sloan and Watson, 2002, Winstanley and White, 2003, Sellars, 2004)

version of Kadushin's (1976) model for social work supervision but using differing terminology.

Proctor's model encompasses three areas which include:

- Normative (care delivery, managerial)
- Formative (helping people to develop skills, ability and understanding, educative)
- Restorative (helping everyone to validate each other)

(Farrington, 1995, Nicklin, 1997).

The supervisor can utilise these three functions when undertaking cs with a supervisee. Although described by Bowles and Young (1999, p959) as *"the dominant UK model"*, there have been limited reasons offered within the literature to justify its popularity. Sloan and Watson (2002) suggested that it has been utilised in a variety of nursing contexts, whilst Butterworth et al (1997) described its flexibility as making it a popular choice.

Proctor's model emerged from her own experience of supervision within the probation and counselling services. Interestingly, all the aforementioned authors described their understanding of each of the three functions; formative, normative and restorative. There does not appear to be any explanation/rationale offered to readers for these terms. This may cause confusion, as the words seem alien to the nursing profession and the writers blamed for using academic or "jargonistic" language. However, the literature has tended to be unanimous in its agreement that; *normative* describes monitoring and quality control, *formative* relates to education and *restorative* is concerned with support for the supervisee. Essentially this model provides the supervisor and supervisee with a useful way of conceptualising the process of cs (Williamson and Dodds, 1999), and whilst Butterworth (1996) and Butterworth et al (1996) feel that this model could be used as a strategy to evaluate cs, the evidence for its usefulness is limited.

1.8.2 Reflective models

The use of a reflective model (Maggs and Biley, 2000, Willson, Fawcett and Whyte, 2001), was also popular within the literature, examples of which included Schon, (1987) and Johns, (1995). It is not within the scope of this literature review to address reflective practice in detail but to provide an overview of how the literature related it to the process of cs. Todd and Freshwater (1999), offered a definition of what reflective practice meant in relation to nursing.

> "Reflective practice is a multidimensional process that seeks to problematise a broad range of professional situations encountered by the practitioner in order that they can become potential learning situations. This enables a continuation of learning, development and growth, both cognitively and emotionally, in and through their practice". (p1384)

This suggests that practitioners who engage in the process of reflection would develop a degree of self-awareness and understanding of themselves and their behaviour. Thus, reflection may be seen as a vehicle to improve learning and practice (Moon, 1999). Kohner (1994) believed that the main purpose of cs was to facilitate reflective practice, a view supported by Johns (1993). However, there appeared to be words of caution from several authors regarding the use of reflective practice within the cs process. Bond and Holland (1998) as well as Faugier (1994) discussed the need for skilled supervisors, who would question supervisees appropriately. This highlighted the importance of the depth of training that would be required. Gilbert (2001) described reflective practice and cs as a "confessional" practice, which he linked to the Foucauldian framework of surveillance. Furthermore, Fowler and Chevannes (1998) warned that some practitioners may not be able to cope with such intense scrutiny of themselves and their work. Indeed, it may cause some nurses increased anxiety, (Clouder and Sellars, 2004) and lead to unresolved conflicts (Teekman, 2000). I believe that this thesis will support this and demonstrate that it can act as a barrier to practitioners becoming a supervisor and/or supervisee.

It could also be argued that nurses are not recruited into the profession for their ability to reflect, whereas other professionals such as psychotherapists are. Indeed Smith and Jack's (2005) study, which was to ascertain whether degree level nursing students found reflection to be a meaningful activity, concluded that:

> "It is interesting to note that certain students seem more comfortable with the process (of reflection) than others. Perhaps one explanation for this is the students' preferred learning style."(p37)

The students in the sample completed a learning styles inventory devised by Honey and Mumford (1989). The results indicated that those whose learning styles were reflective were the most comfortable with utilizing this activity. Cs has been described as a reflective episode (Teasdale, 2000, van Ooijen, 2000, Howatson-Jones, 2003, Bush, 2005). Would this suggest that those who were actively engaged in the process were also those who had a greater reflective learning style? Driscoll (2000) appeared to support this notion as he commented that those who had difficulty with reflection found cs particularly difficult to embark on as a supervisee. This I feel raised an important question; whether cs should only be offered to practitioners with the ability to reflect. The NMC (2001) may not agree as they stated that cs is an integral part of practitioners' lifelong learning. Howatson-Jones (2003) supported this adding that if it is to be achieved then empowerment of individuals is required and that

> "...clinical supervision should be available to all practitioners, not just the selected few."(p39)

Dimond (1998b) commented that reflection was essential to the practice of cs and that by ensuring the practice of reflection takes place within the supervisory relationship it would prevent a "blurring" of the process. She added that line managers would supervise immediate care, whilst clinical supervisors assisted the supervisee in reflection on care.

1.8.3 Heron's model

John Heron's (1989) six-category intervention analysis framework was designed initially to assist in the understanding of interpersonal relationships, (Sloan and Watson, 2002). According to Chambers (1990) it became prominent within the arena of mental health as a framework to assist nurses in their interactions with patients. It comprises six categories; prescriptive, informative, confronting, cathartic, catalytic and supportive. Heron then subdivided the six into authoritative (enable practitioner to maintain a degree of control) and facilitative (locus of control remains with supervisee). Sloan and Watson (2001) critiqued the use of this model for cs, concluding that it was of relevance within nursing, and a useful resource for supervisors as it empowered supervisors with a "considerable repertoire of interventions" (p206), whereas they argued Proctor's model lacked detail. Whilst this model may be of use, Heron himself recognised that it would require the supervisor to challenge and that this is a difficult skill to use appropriately (Bond and Holland, 1998, Heron, 2001). More recently, Knutton and Pover (2004b) provided a framework using honest disclosure to challenge appropriately within the cs session which in some ways complements Heron's model.

1.9 Supervision in the helping professions

Despite the establishment of supervision in the allied professions (including social workers, counsellors, psychotherapists, psychologists and midwives), there is limited analysis of what supervision means to these professions and how it may differ from or complement cs in nursing. Even more noticeable is the lack of writing by social workers in the nursing press compared with that of counsellors (Casement, 1985, Swain, 1995) and psychologists relating to how their knowledge of the concept could help nurses (Bond and Holland 1998, Power 1999, Hawkins and Shohet, 2000). Recently other healthcare professions, such as dietitians (Burton, 2000) physiotherapists (CSP, 2000, Sellars, 2001, 2004), occupational therapists (Clouder and Sellars, 2004), podiatrists (Weaver, 2001) and radiographers (Hussain, 2004) have also begun to discuss the relevance of cs within their professions. Sellars (2004) concluded

that whilst supervision offered physiotherapists formal support, overall the uptake was not widespread and was difficult to sustain, which she believed "mirrors" opinion in the nursing profession. However to date there have been no comparative studies.

1.9.1 Supervision and social work

The literature regarding social work supervision appears to present it as managerial with the supervisor being legally accountable (Morrison, 1993, Clifton, 2002, Cohen, 2004). This supervision tends to focus on caseload management whereby the supervisor would function from an experienced and insightful perspective (Westheimer, 1977). The relationship, whilst based on trust, meant that the supervisee was accountable to the supervisor who had authority over him/her. Whilst Hill (1989) believed this form of supervision enabled supervisors to act as a "buffer" between practising social workers and management, she argued that advocating this form of supervision to nurses may serve to confuse and increase suspicion of management control.

There are also difficulties with its format as the reflective practice element is at times non-existent (practitioners are concerned more about the case management aspect) and therefore less time is spent on professional development (Woodhouse and Pengelly, 1991). Linking this format to Proctor's model the "normative" aspect is addressed, but the restorative and formative are marginalised. Furthermore, Brown and Bourne (1996) discovered that the preparation of the supervisors to undertake the task was also inadequate with widespread dissatisfaction. This has been highlighted recently following the Victoria Climbie Inquiry (Laming, 2003) when the child's social worker, Lisa Arthurworry was reported to the Protection of Children Act register for a series of failings in the case. However, a decision to register her as unfit to work with children was subsequently overturned by the Secretary of State as it was felt that Arthurworry had not been adequately supervised.

Social work supervision appears to have little by way of a national strategy. It is therefore likely that the quality of what is offered to these practitioners will depend on their manager's particular idiosyncrasies and the policy of the particular local authority they work for. In addition, some areas of social work are highly stressful and in the public arena (e.g. child protection). It is possible therefore, that some managers will see the accountability element of supervision of greater significance than others. As a consequence there may also be considerable distrust and suspicion of some social work supervisors, which has been previously alluded to in the work of Fineman (1985). Indeed, the literature offered conflicting opinion relating to social work supervision and the impact of the supervisor. On the one hand, work by Coady, Kent and Davies (1990) suggested that when the supervisor was supportive then burnout in social workers tended to decrease. On the other hand, Collings and Murray (1996) discovered that when social work supervision is either manager or managerially led, there were higher levels of stress, as supervisors were perceived as using the relationship to protect themselves, rather than acting in the interest of the supervisee.

1.9.2 Supervision and counselling/psychotherapy

The supervisor in this field is not necessarily the supervisee's organisational manager and there tends to be less written concerning lack of trust, confusion and anxiety. However the supervisory relationship appears to be more in-depth, with the supervisor assisting the supervisee to explore the inner and outer world of their clients. The main role of the supervisor is to support and develop the supervisee (Hawkins and Shohet, 2000). The British Association for Counselling and Psychotherapy (BACP, 2002) consider supervision as ongoing and essential for all practitioners irrespective of experience. Indeed Feltham (2002) explained that because it is mandatory accredited BACP members have certain requirements relating to frequency, amount and boundaries. Bond and Holland (1998) suggested that the relationship was more of a "therapeutic alliance" in which there was support, reflection and analysis. In some ways this echoes previously described definitions within the nursing literature, which may be

because of the nature of the three professions being essentially about relationships and the need to develop self-awareness and interpersonal skills.

The literature in relation to psychotherapy/counselling suggests that there are also difficulties, with little attention being paid to the training of supervisors (Pocknell, 2001, Proctor, 2002, Saptya, Riemer and Bickman, 2005). Pocknell (2001) highlighted that greater attention to training was now required due to the increased demand for counselling provision in the workplace.

Some of the most influential literature related to the theory and practice of supervision has come from the disciplines of counselling and psychotherapy (Proctor, 1986, Hawkins and Shohet, 2000). This may provide the answer to the earlier suggestion of confusion amongst nurses as to why the concept has been linked to therapy. Little has been written within the nursing literature to allay these fears and explore the difference between cs and therapy. Furthermore, the purpose of cs within psychotherapy/counselling has been described by Platt-Koch (1986) as three fold: to increase knowledge, improve skills and assist in the development of autonomy and self-esteem. Whilst this may be true in counselling and psychotherapy, the literature tends to suggest that in nursing the ultimate aim is to improve patient care (Cutcliffe and Proctor 1998a). However, if Platt-Koch's areas are addressed, then ultimately patient care will improve as the nurse would be more knowledgeable, less stressed and a more competent practitioner. This view was supported by Driscoll (1999) when he emphasised that quality care was not solely concerned with the delivery of something to someone but also about

"...taking something for themselves during work-time."(Driscoll, 1999:29)

It is interesting to note that the literature in relation to cs and counselling/ psychotherapy tends latterly to discuss the training/accreditation of supervisors

(Wheeler, 2001a, Weaks, 2002, Bowes,2003, Bailey, 2004, Weston, 2004) as well as discussing the ethical and personal dilemmas that have arisen (Peyton, 2004). In some ways the nursing literature tends to be anachronistic, still discussing the importance and possible value of the concept with anecdotal evidence being used to support its introduction. Furthermore, Butterworth (1996: 100) emphasised that the "demand for evidence based activity", is in some ways forcing practitioners to justify why cs is needed within the nursing profession and how it impacts on patient care. Is he suggesting that practitioners should just undertake cs? Indeed, there is scant empirical evidence justifying the need for supervision within the fields of psychotherapy and counselling and to support the view that supervisees practice more effectively when they have regular supervision. Feltham (2002) stated:

> "...there is no evidence- empirical or logical- that supervised experienced practitioners (counsellors and psychotherapists) practice more effectively, creatively or safely than unsupervised experienced practitioners. Indeed, within BACP no such comparison can be made (no control group could be made available), since everyone must be supervised." (p26)

This suggests that these professional groups do not see that there is a need to justify having cs and that it is simply inherent to their discipline.

To conclude, the nature of the supervisory relationship that these non-nursing professionals have adopted is close and emotive with supervision viewed as assisting in the task of remaining objective, whilst still being able to offer help and guidance (Weaks, 2002).

1.9.3 Clinical supervision and midwifery

Supervision has been part of midwifery practice for over one hundred years, and is a mandatory requirement (NMC, 2004a). Bishop (1994:36) suggested that *"qualified midwives will be one step ahead of the game"* implying that midwifery already has an established position regarding cs. However what Bishop failed to provide the reader

with was the format in which midwifery cs takes place. Other authors provided a more detailed description and explained that it is more in keeping with managerial supervision (HVA, 1995, Devine and Baxter, 1995, UKCC, 1996, Bond and Holland, 1998, Clifton, 2002). Overall, it would appear that a local supervising authority ensures that each practising midwife has a named supervisor of midwives (either chosen or allocated) and that they meet at least once a year to review practice and identify training needs (NMC, 2004a). Furthermore, each practising midwife should have twenty-four hour access to a supervisor. Rodriquez and Goorapah (1998) commented that because midwifery supervision is mandatory this has in effect resulted in a "double standard" and that this inconsistency between various disciplines may possibly result in the destabilisation of the concept of cs in the nursing profession.

Devine and Baxter (1995) stated that:

> "Supervisors of midwives are in a position to suspend and investigate their supervisees where practice is deemed to be unacceptable. Midwife supervisors are often managers and carry up to 40 supervisees. Supervisory meetings occur annually, during which the supervisees practice is audited." (p32)

The ability to monitor report and act on poor performance led Deery (2005) to contend that midwifery supervision differs from cs. The latter she sees as support to practitioners, which is currently missing within the midwifery profession. She acknowledged that stress and burnout in midwifery have been identified and proposed that cs should now be introduced to provide a support mechanism for midwives. However, Hughes and Richards (2002) provided 219 midwives with a study day on the role of the (midwifery) supervisor and found that once the training was provided, midwives began accessing supervision on a more regular basis, with 83% (n=182) citing it was helpful and supportive. Furthermore giving midwives the choice of supervisor rather than allocation led to 92% (n =201) supporting this mechanism. This echoes the original ethos of the midwifery supervisor role when the Departmental

Committee in 1929 recommended that the inspector of midwives should be regarded more as a friend and enabler, rather than a critic (Bent, 1992).

It would be pertinent to add that midwifery supervision is not cs as advocated for the nursing profession, thus contradicting Bishop's previous quote. Indeed the UKCC (1996) and the HVA (1995) actively deter nurse practitioners from following this approach. Furthermore, it is noticeable in the Professional Code of Conduct (NMC, 2002a) that the reference to supervision is only in the context of midwifery.

1.9.4 Clinical supervision and mental health nursing

In 1943 the Horder Committee recommended supervision in psychiatric nursing (Cottrell and Smith 2002). Furthermore, *Working in Partnership* (DoH, 1994a) explicitly stated that mental health nurses should be in receipt of regular cs. Cutcliffe and Lowe (2005) contended that within the UK mental health nurses have embraced cs more than any other speciality of nursing. The literature offered two reasons for this. It may have been because mental health nurses were the first to practice cs (Critchley, 1987, Hill, 1989, Burrow, 1995, Smith, 2001) or due to the links that mental health nursing had with psychotherapy and counselling (White, 1990, Bond and Holland, 1998).

Wilkin (1988:33) advocated the worth of cs to community psychiatric nurses, emphasising that the loneliness in the community for a professional was *"engulfing"*. Furthermore he highlighted the RCN report (1978), which suggested that extreme stress was a reason why many nurses have left the profession. Through cs, support and caring of colleagues would help, he believed, to retain staff and create a more enlightened nurse who would provide a better service to clients. He briefly discussed types of supervision and concluded by expounding that cs required awareness, basic understanding and enthusiasm by nurses and their managers. Whilst Wilkin's comments offered no empirical evidence, Hughes and Morcom (1998) to some extent

substantiated his claims using a longitudinal study. They identified factors that hindered or enabled cs to become established and maintained in a mental health in-patient area of one NHS Trust, concluding that a level of support by both nurses and their managers was a key factor in successful implementation of cs. Despite these claims Hughes and Morcom (1998) conceded there were limitations to this study. Primarily the sample size was small but did not provide any percentages or numbers for the reader to concur with this view. Secondly, although the authors had, initially, wished to use a combination of questionnaires and semi-structured interviews, due to time constraints the interviews were not undertaken. Instead, their results were reliant on the postal questionnaires which may have reduced the reliability and validity of their overall findings.

Whilst mental health nurses may be more used to working within a therapeutic environment, this does not necessarily mean that cs is commonplace throughout the whole of this speciality (Carson, Fafin and Ritter, 1995, Thomas, 1995, Butterworth, 1998, Storey and Minto, 2000) or that they have the expertise to undertake it (Faugier, 1994). Indeed Bond and Holland (1998), using anecdotal evidence of their experiences facilitating supervision workshops, expressed the need for mental health nurses to re-evaluate cs, as well as not assuming it is working successfully in established areas. Power (1999) agreed to a large extent, stating that cs undertaken by mental health nurses was piecemeal and limited. Whilst not providing any empirical evidence to support his statements he noted an increasing trend of developing training courses to enhance nurse's supervisory skills and that strategic plans were being formulated in order to provide mental health nurses with a minimum amount of cs each year.

The need for cs in secure mental health settings may be considered to be greater following the publication of the UKCC report which examined nursing in secure environments (UKCC and University of Central Lancashire, 1999). The report concluded that cs was not available to nurses working in this area, but if it was in place, it would be one intervention that could support, nurture and develop nurses within the

prison environment and ultimately help staff retention and increase job satisfaction (Freshwater, Walsh and Storey, 2001). Their argument was further strengthened by previous studies, Minto and Morrow (1999) and Storey and Minto (2000), which examined the use of cs within secure mental health and learning disability environments. They concluded, due to the complexity of these client's needs that cs should be routinely available for all staff. Furthermore Dale and Storey's (2004) study emphasised that if cs is to become a reality then it required management commitment, in the form of offering nurses the time to undertake it during their shift. This study was based on a postal questionnaire sent out to 852 nurses working within high, medium and low security care. They cited the number of returned questionnaires as being 276 and whilst they did not indicate that the actual percentage was 32%. This suggests that the results should be viewed with care.

The fact that allied professions have traditionally embraced the concept of supervision does not necessarily indicate that the nursing profession should also. Faugier (1993) urged an examination of how allied professions undertake supervision because

> "...without this, we are in danger of re-inventing the wheel, and possibly a wheel of inferior quality."(p19)

Bond and Holland (1998) suggested that nurses should learn from social workers' experience of supervision in their attempts at implementation. To continue the wheel analogy, this means that nursing needs to ensure that it develops the right wheel for its particular vehicle and planned journey.

1.9.5 Clinical supervision and pre-registration student nurses

The Working in Partnership Report (DoH, 1994a) and the ENB (1994) both endorsed the view that the process and preparation of what to expect from cs should be introduced as best practice into pre-registration nursing in the UK. More recently other authors, (Canham,1998, Cutcliffe and Proctor, 1998a and 1998b, Ashmore and Carver, 2000, Aston and Molassiotis, 2003, Pfund, et al, 2004) have not only supported its

integration into the student curriculum, but also emphasised the benefits that students would gain, in the transition to being a qualified practitioner.

Despite this growing support, there is limited evidence that Higher Education Institutions have actively included cs into the Making a Difference curriculum, which was introduced in the early twenty-first century (Ashmore and Carver, 2000). It could be argued that students receive support in practice from their mentors but this is dependent on the motivation of both and the degree of objectivity that could be afforded to the student working directly with their supervisor (Aston and Molassiotis, 2003).

Interestingly, Cudmore (1996) discussed her experience of having cs as a student nurse. She described the training that her supervisors undertook and how it focused on Project 2000 training and student documentation, rather than effective supervision and the responsibilities of a clinical supervisor. It appeared that she may have confused the terminology and perhaps she was describing the experience of being assessed or mentored as a student nurse rather than having cs. Furthermore she wrote that her supervisor changed when she changed placement area. This again is not consistent with the concept of cs. Indeed, whilst students are transient, changing supervisors regularly would possibly be unsettling. As Page and Wosket (1994) pointed out, in relation to student counsellors that a period of twelve months is required to permit a trusting relationship to develop. Similarly Grealish and Carroll (1998) appear to have used the terminology cs in its most literal sense in which student nurses receive cs from academic staff in the workplace. They are directly supervised and instructed in small groups with the authors conceding that the least experienced academic faculty member being delegated to perform the task.

Pertab (1999), collected data from 50 pre-registration (third year) students to ascertain their views regarding cs. He used a combined approach of quantitative and qualitative methods in the form of questionnaires (n=50), followed by interviews (n=10) with a

100% response rate in each instance. He stated that all fifty students were assigned a named supervisor during their penultimate practice allocation. However the reader is not furnished with the information as to whether the supervisor is from practice, education or a qualified nurse. Furthermore, he commented that this one named person acted out the three roles of "supervisor", "mentor" and "assessor" which tends to add more confusion regarding the roles. One of his concerns within the discussion was the lack of supervisory support during periods of inactivity; this appeared to suggest that cs is informal and can take place on an ad hoc basis, which is contrary to the writings of other authors.

Pfund et al (2004) stated that, whilst educational staff are supportive of students, clinical staff would be better placed to offer the student valuable advice in relation to reflection on practice issues. Although they successfully demonstrated the role of a clinician who supported a pre-registration student following the unexpected death of a child, they then contradicted themselves when they stated that:

> "Subsequent reflection with the health lecturer examined the wider context, assisting the student to examine her feelings and pull together the whole situation." (p 109)

As a result, whilst the clinician assisted the student to reflect, (as Schon, 1983 would describe) "in-action", the lecturer facilitated reflection-on-action, which is more in keeping with cs.

Whilst there is limited evidence evaluating cs of pre-registration students in the UK there has been attempts in the Nordic countries to introduce supervision models in nurse training to assist students within their personal and professional development to become qualified nurses (Holm, Lantz and Severinsson, 1998). Recently Lindgren, Brulin, Holmlund and Athlin (2005) have evaluated student nurses perceptions of group supervision during the last eighteen months of nurse training. From an initial total of 51 student nurses, 49 agreed to take part in monthly one and a half hour group supervision

facilitated by a nurse teacher trained in group supervision. Data were collected by means of questionnaire in two stages, the first measured their expectations and fears of participating in group supervision before it commenced and the second stage was undertaken at the end of their training. Again a questionnaire was used, but this time the questions focused on the process which the authors described as "structure, climatic factors and the experience of having group supervision" (43 students remained at this stage). The results from the first questionnaire indicated that whilst 98% reported some kind of positive expectations, 25% commented that they had fears which included being misunderstood and revealing their weak points. Whilst the authors failed to comment on this, it was interesting that after having had group supervision, 100% perceived it as supportive to them. In some ways I am not surprised regarding their initial fears as this would be possibly an unknown experience, facilitated by nurse lecturers which may have resulted in anxiety by the student to perform well. Other significant findings were that the supervisor needed to be able to facilitate the student's exploration of themselves through sensitive challenge and not just support. Also, the structure (for example confidentiality) and climatic factors (for example room accessibility) were important for the success of group supervision. One of the areas that was not reported upon was the type of issues that were discussed and any difficulties within the group.

1.10 Summary

The aim of this chapter was to provide a review of the literature from three perspectives; historical, theoretical and interprofessional. What appears to be apparent is that there has been and still is wide debate about where cs has come from, how it is operationalised and best practiced. There does not appear to be a "blueprint" for cs and as such there has been to date a wide range of arguments with and without empirical evidence to suggest what should happen, who should supervise and when and where cs should take place.

My study is unique in that it moves cs forward. Whilst it echoes some of the past literature, for example the supervisees' right to choose their supervisor, it also provides

clear empirical evidence of the reasons why some nurses choose to reject cs and others embrace it.

Chapter 2

Literature review: preparation and training of supervisors and major studies

Thus far, the literature has been reviewed from an historical, theoretical and inter-professional perspective. Whilst the scarcity of literature regarding the training and preparation of clinical supervisors has been mentioned, what follows is a review of the literature to date, which will emphasise the importance of the present study. The intention is to focus on the gaps within the literature specifically in relation to the preparation and training of clinical supervisors. In addition there is a review of the empirical research selected for two reasons: either it is of major importance due to its rigour or national perspective, or it is specific to the training and preparation of supervisors within nursing.

2.1. Preparation and training of clinical supervisors

Literature concerning the practice of clinical supervision (cs) has tended to focus on defining the concept, describing the process and evaluating the skills of the supervisor. Little emphasis seems to have been placed on the training and preparation of both supervisor and supervisee. Authors have expressed the importance of supervisor training and suggest that it is crucial to the success of cs[4]. Indeed, Mackereth (1997) and Jones (2001a) stated that without adequate training, psychological damage to individuals may occur. Earlier Cutcliffe and Proctor (1998a) commented that:

> "Clinical supervision is a specific skill...clinical supervision goes beyond the basic interpersonal skills, and has its own unique set of skills...There is consequently a need for specific clinical supervision training. Yet there is no standardised [sic]

[4] (Faugier and Butterworth, 1993, Butterworth, 1994, McCallion and Baxter, 1995, Johns, 1996, Northcott, 1996; Bulmer, 1997, Fyffe, 1997, Roden, 1997, Cutcliffe and Proctor, 1998a, 1998b Porter, 1998, Sloan, 1998, White et al, 1998, Duarri and Kendrick, 1999, Sloan, 1999b, Heath and Freshwater, 2000, Teasdale, 2000, Kelly et al, 2001, Mc Feely and Cutcliffe, 2001, Clifton 2002, Clough, 2003, Davies et al, 2004, Hancox et al, 2004).

> minimum quality and no widely accepted definition of what constitutes clinical supervision training." (p282)

In 2006, there is still limited empirical evidence on what constitutes best practice for the training and preparation of clinical supervisors. Interestingly this also appeared to be the case in relation to the preparation and training of qualified staff for teaching and assessing Project 2000 students (Fowler, 1996a). Fowler (1996a:476) highlighted that whilst there were a variety of courses to prepare staff for the supervision of students there was however an "ironic dearth of training" in relation to cs. Following on from Fowler's conclusions within Project 2000, it may be questioned whether the same law of "supply and demand" operates for cs. If so, it could be argued that there is the potential for the recruitment of clinical supervisors who were not of sufficient calibre, simply in order to fulfil the demand. Clearly this might force some individuals into a role for which they may be ill equipped. Indeed, in relation to cs several studies have indicated a shortage of supervisors (Bulmer, 1997, Scanlon and Weir, 1997, Bishop, 1998a, Barriball et al, 2004).

2.1.1 Evaluation of training courses in clinical supervision

The initial aim of this study was to evaluate the lived experience of qualified nurses who had undertaken a cs course in a higher education institution. Thus it was important to review and critique the literature which had already been undertaken before and during the years of this study in relation to evaluating cs training. Overall to date there is a limited number of serious studies that have evaluated training courses in cs.

Rafferty and Coleman (1996) provided an overview of their fifteen-week diploma level module in cs in Wales. They explored the design, module activities and assessment, but failed to provide details related to how students accessed the course, for example did they volunteer due to interest in becoming a supervisor or were they nominated by their line manager? This may have had an effect on their evaluation in which they commented that some of the students were confused and overwhelmed by too much

information. There is limited discussion with regard to who should undertake the courses (Timpson, 1996) and thus inappropriate candidates may result in the negative comments which Rafferty and Coleman (1996) referred to. Furthermore, whilst the training was perceived as worthwhile, there was no evaluation of how the practitioners would use the module within their nursing practice or indeed if they were followed-up to see if they were able to function as supervisors.

Education in the form of training does not in itself ensure that cs will take place in practice or make any impact on patient care. Training alone does not result in change in a practitioner's behaviour (Fadden, 1997) and this phenomenon has been attributed to the so called "theory-practice gap" (Hewinson and Wildman, 1996).

A longitudinal study (12 month duration), was undertaken by Hughes and Morcom (1998). The aim was to identify factors which hindered or enabled the process of cs to take place in a mental health in-patient area. Participants were invited from four main areas; four acute admission wards, one continuing care ward, a drug and alcohol unit and a secure unit, (although the actual number of participants is not stated by the authors). Utilising a questionnaire, specific questions were asked which related to the supervisors three day training programme. The majority of supervisors felt that they received adequate and useful training and that the course had increased not only their individual knowledge and skills but also self confidence. However the authors omitted to provide the format of the three days or to say whether there was any follow-up of the supervisors to discover if they were taking the skills back to the clinical area and acting as clinical supervisors. Furthermore, whilst they suggested that the training was suitable, they also commented on the fact that they were both employed by the Trust and this could have had some bearing on the answers that the participants chose to give.

Overall the study highlighted the value of cs to both supervisee and supervisor, that managers could have an impact on the implementation of the concept and having a mix

of supervisors/supervisees from different clinical areas was more helpful. However the reader is not furnished with any actual numbers of participants other than the fact that there was a small sample size and therefore the results should be viewed with caution.

Palsson et al (1994) studied a group of Swedish nurses from both hospital (n=10) and community (n=62) who worked within the speciality of cancer care. The study focused on how these nurses experienced social support and systematic cs. The participants were offered a training programme of 40 hours duration to assist their understanding of women suffering from breast cancer and how they could help and support them emotionally. From the initial sample size of 72 participants 49, (n=39 in the community and n=10 in hospital,) undertook the training. The authors then gave a smaller number of the participants the opportunity to have cs (community n=24 offered, n=23 participated, hospital n=10 offered and n=9 participated).

The aim was to focus on the systematic cs that had been offered as well as analysing the implementation of the nursing model over a fourteen month period. Clinical supervision was provided by two of the authors who also collected the data one month after the supervision finished. Using semi-structured interviews the authors questioned the participants in relation to their experiences of social support within demanding care areas and of the systematic cs that they received and how this supervision influenced their handling of emotionally difficult care situations. The interviews were tape-recorded, transcribed verbatim and then analysed using a phenomenological hermeneutic approach. The authors were able to categorise the participant's experiences of both the model and cs as "relief", "confirmability" and "development". They stated that the results demonstrated a need for the participants to unburden themselves from the work-related thoughts and feelings as well as obtain support. The two authors not only facilitated the cs sessions, but also interviewed the participants at the end of the study creating a potential bias that may have influenced the responses of the participants. Palsson et al (1994) did acknowledge the involvement of the

researcher/author and stated that they attempted to minimise bias by using an anonymous, structured questionnaire. Whilst this may appear to provide rigour to the study they did not justify the fact that the authors, who facilitated the supervision sessions, also undertook the thematic analysis, creating another opportunity for researcher influence. They also studied two different concepts within the same study (nursing model and clinical supervision) leaving readers to wonder which had the most profound effect on the nurses. Nevertheless, they concluded that this part of the study identified that those participants who received cs appeared to have been provided with support, relief, confirmation and professional development, but suggested that more research is needed to discover further ways to support staff.

A qualitative study by Severinsson (1996), using a hermeneutic approach, examined nurse supervisors' views of their supervisory styles in cs. This added a depth of enquiry and examination into cs that had not been witnessed in the United Kingdom, where previous studies had focused on justifying its importance to the nursing profession (Wilkins et al, 1997). Severinsson's (1996) study incorporated a sample of eighteen supervisors from Sweden, all of whom had worked as clinical supervisors within nursing for at least two years with on-going education into aspects of cs. The study aimed to explore supervisor's views of the supervisory process, including their style of supervision, attaining the level of the "ideal" supervisor and ethics, rules and values. The results indicated that supervisors felt their performance generally depended upon their level of preparedness for the process obtained through reflection. All respondents expressed the need for education for their role. However there was no indication in the research about what format this education took other than the fact that it was ongoing. Severinsson (1996, p198) concluded, that this willingness of all the supervisors to receive further education in supervision *"underlies the importance of improving quality of care."*

2.1.2 Duration of training for clinical supervisors

The UKCC (1995)/NMC (2001) stated that where cs training occurs, the duration and content should be agreed locally. However, there has tended to be a wide variation in the available courses to prepare supervisors from half day meetings to university validated courses (Swain, 1995, Butterworth et al, 1997, Fyffe, 1997, Willson et al, 2001) with two to three days being the most common over the past ten years, (Butterworth et al, 1997). The literature offers examples of training courses that have been facilitated in-house or using educationalists (Rafferty and Coleman, 1996, Bulmer, 1997, Clifton, 2002) but there remains a scarcity of guidelines regarding the duration and content of preparation programmes (Porter, 1998, Driscoll and Cooper, 2005).

In relation to the duration of training, the only rationale provided in the literature to justify the length of a course was that offered by May, Williams and Gorman (1997). They stated that the lack of confidence of supervisors to successfully fulfil the role had resulted in extending a course in one Trust from one to two days. However, Cutcliffe (1997) contended that short courses might not necessarily sufficiently equip new supervisors. He argued for a formal register and accredited training which he believed would be helpful for future evaluation as this should ensure that:

> "...they will be measuring the effects of the same practice and not what could be a diverse range of practices, all under the banner of clinical supervision." (p725)

It would be interesting to scrutinize whether the length of courses are decided on cost, rather than quality of the training provided. Unfortunately there are no studies available which have examined the cost-effectiveness of this training. In some ways this is not a surprise because there is limited evidence that the concept reduces sickness and absence. When and if evidence becomes available that sickness and absence are reduced through cs then it would be easier to make some assessment of cost-effectiveness.

2.1.2.1 Quality or quantity of training for supervisors?

Cutcliffe (1997) proposed that it would be useful to explore whether there is a direct link between the amount and intensity of training given and beneficial outcomes. Webb (1997) attempted this when she audited a training programme designed to assist the implementation of cs within a community Trust. This Trust bought in a training package of five, three-day courses. However, Webb (1997) failed to provide the reader with the structure or content of the course. Following the commencement of the training the Trust then ratified the cs nursing policy, which appeared to suggest that the training and the policy were two separate entities. Following completion of the training, the audit investigated whether nurses who had attended the training had adhered to the Trust policy. Given the lack of clarity about the content or the quality of the training, the fact that the training preceded the Trust's policy by some three months and the paucity of the information provided regarding the study, the results have to be interpreted with caution.

Bulmer (1997) facilitated a three day course with a two day follow-up. He stressed that continuing support was required for supervisors following the initial training, which is a view also supported by Farrington (1995). However there is little evidence within the literature to suggest that this is necessary or in place within other courses.

2.1.2.2 Training for supervisees

Bulmer (1997) identified the need to train the supervisees as well as supervisors. If a group of supervisors are "trained" to facilitate cs then the supervisees should also have an understanding of the process that they are taking part in and feel empowered to own their supervision session. A year later, Cutcliffe and Proctor (1998b) also concurred with this view but added the need for formal training programmes for the supervisees and the suggestion that this should be extended to second and third year student nurses. Whilst their views appear more radical than most authors in relation to training, they do examine the benefits for student nurses of being involved in the process of cs, including

the use of reflective practice, self-examination and assertiveness. If cs was to become a reality then it was argued, this could have been the beginning of the change in culture in the nursing profession that Smith (1995) argued was required.

More recently, Davies et al (2004) described the training and preparation of supervisees and supervisors when introducing multi-professional cs. Whilst new staff attended an introductory two-day workshop, in-house and external training was also available to existing staff with an "accreditation" of supervisors being developed (but no details provided). Furthermore, there was open encouragement that staff did not choose colleagues or their line manager as this may "contaminate" the supervisory experience. There was an expectation that the supervisee would receive an hour of contractual cs per fortnight which would be jointly reviewed by both supervisor and supervisee. This article provided the reader with an insight into how The Peaks Unit in Rampton Hospital, using a clinical strategy, developed and introduced cs. However this service is still in its infancy and has not yet been evaluated.

Following the implementation of the Enterprise Bargaining Agreement of August 2000 in Victoria, Australia, cs was identified as a strategy that would support and retain staff as well as improve quality of patient care. For these positive effects of cs to be achieved a specific "Clinical Supervision for Health Professionals" programme was designed by the University of Melbourne Centre for Psychiatric Nursing Research and Practice School of Postgraduate Nursing. In 2004 Hancox et al, evaluated this educational programme. Questionnaires were distributed to the sixty-three students on completion of the course; there was a 100% return rate. What is ambiguous is the duration of the course, as in their writing they state that it was:

> "The evaluation of participants from the first two years of the programme." (p198)

This leaves the reader wondering what the actual duration of the course was two years or less? And if less, did the researchers consciously decide to wait two years before the

course was evaluated? Notwithstanding these issues, the results indicated that a large proportion of the participants felt that the programme was effective (n=57) as they now had greater awareness and were more likely to give (n=55) and receive cs (n=56). Although there was no follow-up to check whether this actually occurred. The interactive and practical elements of the course (such as the role play and group discussions) was valued by (n=41) of the participants. This could help to inform others who are designing cs courses to make them practice focused. The least helpful parts related to the environment (n=14) and organisation (n=11) rather than specific content. Indeed, (n=11) stated that all aspects of the programme were helpful. Within the limitations of the study the authors recognised that there was no follow-up of the participants to see whether they actively engaged as supervisee and/or supervisor at a later date. This would possibly provide the evaluation results with greater credibility if a follow-up revealed that a high percentage of the participants continued to engage in cs several months after the programme had ended. Indeed, Driscoll and Cooper (2005) commented that:

> "Clinical supervisors are rarely assessed or followed-up after in-house or externally facilitated supervisory programmes to find out whether they are competent. It is small wonder therefore that many "trained" supervisors fail to supervise in practice." (p20)

Private correspondence with Cottrell (2001) provided some interesting unpublished data. However I could not identify any specific published studies. In 2001, Cottrell surveyed 230 members of an employing Trust who had undertaken an RCN accredited two day clinical supervision training course. The results available focused on the mental health and learning disabilities directorate with n=75 questionnaires sent out and n=44 completed (59%). From the questionnaires completed 29% of staff actively engaged in cs. In relation to the question concerning any obstacles to implementing cs ten themes emerged with the two most significant being; lack of time (39%) and lack of competence (16%). Anecdotally, Cottrell (2001) offered that the reason cs was

unsuccessfully implemented in this particular Trust was as a result of manager apathy and confusion.

In regard to cs preparation and training Cutcliffe and Proctor (1998a) commented that:

> "Clinical supervision is a specific skill.....There is consequently a need for specific training. Yet, there is no standardised minimum quality and no widely accepted definition of what constitutes clinical supervision training". (p282)

They also suggested that inappropriate or insufficient training will affect the quality of the supervision and thus be unhelpful to both supervisee and the patients within their care. Indeed, without appropriate training Farrington (1995) warned that organisations could be accused of being tokenistic towards the whole concept of cs. This is a view, which appears to be in contrast to the Department of Health (1994b) guidelines for cs. They stated that time, energy and commitment is required as well as adequate planning and resources. Whilst NHS Trusts may wish to purchase the training and send practitioners on it, is this sufficient for the concept to filter through and does it require a more management led and proactive involvement to become a reality?

The question that appears to remain unanswered is how cs and the training of supervisors links into the Trust's commitment to safeguard standards, and ultimately to improve patient care through the development of the reflective and knowledgeable practitioner. Wheatley (1999) justified the need for research into cs when she stated that:

> "Implementation of clinical supervision has cost implications which need to be monitored, and it is desirable to have a clear research base to evaluate its effects on service provision." (p28)

As a result of national implementation of cs within the UK, it is essential that a full evaluation is undertaken. Currently there are no agreed training programmes for cs or assessment of the impact cs is making. In light of the current emphasis on cost effective

clinical governance, it is essential that a detailed evaluation of cs within the UK NHS is undertaken.

2.2 Major evaluation studies of clinical supervision

Within the UK, the latter part of the 1990s (1997-1999) was a productive time for research studies[5]. However as Hyrkas (2005) pointed out:

> "The number of studies exploring supervisor/supervisee practice and educational background and how this effects their clinical supervision is quite low today." (p533)

She provided the reader with a detailed appraisal of the empirical evidence available not only in Europe but also in the North American countries concerning evaluation of cs. In relation to the UK, she suggested that many of the studies that had already been undertaken were of short duration considering cs which had not long been implemented. Notwithstanding this, Hyrkas (2005) still saw relevance of the work to date as it has provided studies from a variety of perspectives, but she advised caution in terms of how readers treat the findings at such an early stage.

In January 1999 Gilmore published a report which reviewed the UK evaluative literature on cs in nursing and health visiting. Commissioned by the UKCC her task was to examine progress in relation to implementation and impact of cs. Similarly, this literature review also focuses on significant evaluative studies that have been undertaken in cs. But I have chosen to focus on those studies that are frequently reported upon and others in which the findings are related to my own study.

Tony Butterworth, an ardent supporter of cs within nursing, has had work commissioned by the DoH and published by the University of Manchester ("Clinical

[5] (Butterworth et al, 1997, Bishop, 1998a, Hughes and Morcom 1998, Teasdale, Thom and Brocklehurst, 1998, White et al, 1998, Bowles and Young, 1999)

Supervision: A position paper", 1992). He has worked with many nurse leaders and academics producing numerous published articles and books (Butterworth and Faugier, 1992, 1994, Butterworth and Bishop, 1994, Butterworth et al, 1997, Butterworth, Faugier and Burnard, 1998, Butterworth and Woods, 2002, Butterworth, 2004).

However, by far the most widely reported study was undertaken by Butterworth et al in 1997 "It is good to talk". This was a national evaluation exercise, over an eighteen-month period to evaluate the effectiveness of cs and mentorship. The study was funded by the Department of Health, London and the Scottish Home and Health department, Edinburgh. Letters were sent to all Trust Nurse Executives by the NHSE inviting them to apply for pump priming funds to take part in the study. It resulted in the participation of twenty-three sites across England and Scotland (Butterworth et al, 1997). The aim was two-fold: to evaluate the implementation of cs and to analyse the impact of the measuring tools used within the study.

This was a mixed-method study using both qualitative and quantitative approaches. The most important element was a case/control design, in which the authors offered clinical supervision to groups or practitioners and then devised measures to evaluate its outcome. Overall, the study provided a wealth of data (both quantitative and qualitative), identified organisational and management issues, clinical casework, professional support and personal matters. It would appear that this study has been one of the largest undertaken to examine cs (Gilmore, 1999, Winstanley and White, 2003). The initial sample size was n=586 at the end of the first data collection period, which fell to n=504 (86%) at nine months and n=373 (64%) at eighteen months. From the 23 sites, four cohorts were created using a controlled design (fig one, p69) but, as Bradshaw (1999) pointed out it was unclear how participants were selected for these groups. The test group had some restrictions placed upon them in relation to the supervision which they received. This ensured that a contract was devised between the supervisor and supervisee, for no less than 45 minutes of supervision every four weeks

and that Proctor's model would be actively used within the supervision process. The authors provided no rationale for these stipulations and did not provide any evidence of the educational preparation that both supervisor and supervisee received pre-study.

Fig. one: Four sample cohorts in the 23-site clinical supervision project

Group A (control)	**- Not exposed to clinical supervision but tested twice in 9 month period**
Group B (test)	**- Exposed to clinical supervision, tested three times in 18 month period**
Group C (nested)	**- Group A became third group exposed to clinical supervision after 9 months**
Group D (supervisors)	**- Exposed to clinical supervision and tested three times in the following 18 months.**

(Butterworth et al., 1997)

The findings indicated that the control group A (who were not in receipt of cs) showed higher levels of emotional exhaustion and depersonalisation than those receiving cs (groups C and D). In the groups which received supervision these issues stabilised or reduced.

Quantitative testing took the form of assessing the participants using a series of standardised instruments to measure burnout (Maslach and Jackson, 1986), stress (Cooper, Sloan and Williams, 1988, Harris, 1989), job satisfaction and coping skills.

Qualitative data were collected using questionnaires and semi-structured interviews. The questionnaires were completed by the 23 site co-ordinators. However there was no statistical breakdown of how many sites answered the eight items, which adds little weight and importance to the data from these questionnaires. It would have been beneficial to include a visual display of the questions posed and how many sites

answered in a particular way, instead of subsuming the results in the text. Within the analysis of the questionnaires, the authors stated that the sites were motivated to participate in the study as well as receiving financial recompense. One questions whether there was any kudos attached to taking part in a research study that originated from a respected University. The methodological implications and ethics associated with pump priming monies for a research project can also be questioned.

The semi-structured interviews involved 34 participants from six sites but no explanation was provided for how this selection was undertaken and it was apparent that they had limited experience of cs. The researchers did not divulge their selection criteria or explain why they incorporated a higher proportion of practitioners with limited experience.

It is apparent in the summary of the lived experiences by the interviewees, that concern was expressed regarding the education and preparation of supervisors. Indeed one of the recommendations within the study stated that:

> "Attention must be given to the preparation and education of clinical supervisors and mentors. Employers will need to attend to these needs through their own training resources or approach educational purchasing consortia for additional support." (Butterworth et al, 1997:19)

Whilst the study sought the experiences of those supervisors and supervisees involved, it did not address the impact of cs on patient care (Wolsey and Leach, 1997, Cutcliffe and Burns, 1998).

Butterworth et al's (197) study was a seminal piece of work undertaken across two countries (England and Scotland) using a large sample size (initially 586 and latterly 373). They assessed participants using a variety of standardised, reliable instruments (including:-The Minnesota job satisfaction scale, The General Health questionnaire, The Maslach burnout Inventory, The Cooper Coping Skills Questionnaire, The Harris

Nurse Stress Index) and were able to obtain both quantitative and qualitative data. The study culminated in a ten point summary of recommendations for both employers and clinicians.

In relation to the training and education of supervisors there appears to be very little information to have emerged from this particular study, with respondents stating that courses for supervisors ranged from one to six and a half days with two to three days being the norm. Supervisees tended to receive minimal training (in four sites none at all). However, there is no evidence within the study as to whether the researchers examined the training that was offered, and this may have been significant to the results collected. Interestingly only one site had additional funding for training during the project and 13 of the 23 had no further funding to continue the training after the project finished. This may indicate that the Trusts were not committed to the concept which is further highlighted in the answer to item 3.1 (Butterworth et al 1997:16) within the questionnaire *"is clinical supervision written into the Trusts business plan, if so, how?* From a total of 23 sites only two indicated that it was already, and five indicated that it would be the following year. Thus there appeared to be a lack of organisational commitment in the form of training or inclusion of the concept within business plans, ultimately indicating that the concept was of low profile within the Trusts.

Generally, the findings of the study suggested that staff can be supported in their professional career through cs, which may also protect them from the negative effects of work-related stress (although this was not demonstrated on all the outcome measures). Those not having cs initially had higher emotional exhaustion and depersonalisation. Furthermore it highlighted the need for supervisors themselves to have supervision. Interestingly, Butterworth et al (1997) both in this report and in further published articles from the same study (including White, Butterworth, Bishop, Carson, Jeacock and Clements, 1998) omitted to discuss the limitations of the study design.

Working in collaboration with *NT Research* and *Nursing Times*, Bishop (1998a) undertook a postal survey. A total of 410 questionnaires was sent to all Trust Nurse Executives across England and Scotland with a final usable response of n=273 indicating a 67% response rate. This study included Community and Acute Trusts but excluded were the 23 sites that Butterworth et al (1997) were already reporting on and the independent sector. Indeed, Bishop commented that the latter (the independent sector) would be worthy of consideration by policy makers in the future, but gave no reasons for this comment.

In relation to cs being on business plans of the trusts involved in the study Bishop (1998a) discovered that:

> "Only a little over half of the responses to the question on business planning indicated that clinical supervision was written into the corporate agenda or trust business plans. Resources had rarely been identified."(p144)

Following the advent of Clinical Governance it would be of benefit to examine whether the results from Butterworth et al's (1997) and Bishop's (1998a) studies have now changed, and whether the cs is more noticeable within business plans.

In answer to the question *Is there a designated lead person identified within the Trust*, there was a designated lead in 80% of both community and "new" cs sites (less than 6-12 months), 78% acute and 71% in mixed trusts. However the study did not provide information on the level of expertise of the identified lead person.

In relation to selection of suitable supervisors this appeared ad hoc with a mixture of self selection, management selection and supervisee request. However no percentages or figures were provided for the reader to judge the significance of these results. She did identify key problems in setting up and implementing clinical supervision which related to:

- Workload and time shortage

- Money for staff time and staff training
- Management and staff perceptions-unsuitable terminology
- Training options and facilities

Whilst again no percentages were given, Bishop (1998a) identified that staff shortages and increased workloads following the reduction in junior doctor's hours, had been instrumental in preventing the implementation of cs. For clinical supervision to take place in a Trust she believed that there had to be genuine commitment and capacity for it to occur. An organisational culture which supported and valued staff was paramount for its success. Without this and adequate preparation Bishop (1998a) believed it would be "a recipe for failure of the nursing profession" (p149)

In 2001, Teasdale, Thom and Brocklehurst undertook a study which was designed to assess the effects of cs and informal support on qualified nurses. Commissioned by the NHS Executive Trent region of England, it comprised of an opportunistic sample survey of n=211 qualified nurses from both acute and community settings. In the same way as Butterworth et al's (1997) study, quantitative and qualitative data were collected.

The quantitative tools used were the Maslach Burnout Inventory, MBI (Maslach and Jackson, 1981) and the Nursing in Context Questionnaire (NICQ). The latter was a new measure which had been designed by one of the authors, Neil Brocklehurst. The results of the MBI indicated that there were no significant changes in burnout between supervised and unsupervised qualified nurses (supporting Hallberg, 1994 and Butterworth et al's, 1997 findings). Interestingly the NICQ showed statistically different results in junior nurses receiving cs. This category of nurses particularly hospital based were more positive regarding cs, in terms of the support and listening they received and if their manager was their supervisor. It would appear from the literature that this was a fairly unique finding as Lyle (1998) for example explored the tensions created from such a complex relationship. Teasdale et al (2001) however did not explain the relationship between managers and the junior nurses within this study to

allow the reader to completely understand this finding. They did provide some of the numerical results in which, 56% (n=118) were able to choose their own supervisor (many chose their colleagues, although an exact figure was not provided). However, 44% (n=93) were unable to choose their own supervisor. Of these 65% (n=137) were managers and 35% (n=74) peers. Previously Teasdale (2000) discovered that the ability to choose one's own supervisor has advantages (increased trust and understanding) and disadvantages (unchallenging mutual support). Teasdale et al's (2001) survey also discovered that group supervision was the most popular, which he commented could save time, but is less effective than one-to-one supervision.

From a qualitative perspective Teasdale et al (2001) used a critical incident questionnaire based on three previous studies (Flanagan, 1954, O'Driscoll and Cooper, 1994, Teasdale, 1998). Participants were asked to write about a critical incident that they felt would be useful to discuss within either formal cs or during informal support. A total of 156 forms (74%) were completed and returned. Whilst the analysis highlighted those who had formal support and discovered that 40% of these continued to utilise informal support, they failed to comment on the significance of this finding. Whilst their analysis discovered that 75% of the critical incidents related to patients and their care, they stated that 10% of the figure did not concern patient issues but related to inadequate resources. They failed to explain how patient care and insufficient resources were not linked.

Following on from the Butterworth et al study in 1997 and White et al (1998) the Manchester Clinical Supervision Scale (Winstanley, 2000) was developed. This seminal piece of work was the first internationally validated research instrument designed to measure the effectiveness of cs (Winstanley and White, 2003). Initially a 56 item, five point likert scale was designed which questioned respondents' experience of receiving cs. However, following a replication study using a sample of 467 nurses from five pilot UK centres (Winstanley, 2000), this was later refined to 36 items. The

total score ranged from 36 to 180. The scale is developed and validated on a mixture of negative and positive responses. From a score of 1-5 (the highest being 5) participants are asked 36 questions and will answer either positively towards clinical supervision or negatively against it. When analysed the negative answer scores are deducted from the potential maximum of 180 thereby reducing the overall score. Winstanley states that low scores on the scale "confirm the general dissatisfaction with the lack of effectiveness of cs." Furthermore, the scale has been translated into Finnish and, following replication, the validity and reliability were once again tested and found to be "preserved" (Winstanley and White, 2003). Despite this evidence Winstanley and White (2003) did identify limitations to the use of the scale which included small evaluations, instead they supported the use of semi-structured interviews and focus groups. Also, they advised it should only be used after the intended respondents have undertaken a reasonable period of cs, although no specific time duration was suggested.

Findings following the utilisation of the scale with a sample size of 1027, respondents have so far indicated differing needs dependant on whether the nurse works in the acute or community setting but overall include the suggestions that:

- Longer sessions are better (max one hour in acute setting, maybe longer in community)
- Frequency of sessions (monthly to bimonthly in both settings)
- Choice of supervisor (ability to choose own supervisor more effective to both settings but acute state also about finding time)
- It may be better if the sessions took place away from the workplace

(Winstanley and White, 2003:32)

Whilst these recommendations have been made insufficient data were offered to enable the reader to make a judgement.

Recently Hyrkas (2005) completed a detailed historical literature review of all the earlier studies of cs among psychiatric and mental health nurses in Scandinavia. The review spanned the period from 1991 to 2005 and included empirical studies of cs in the Scandinavian countries which have been reported in international journals. Hyrkas (2005) concluded that whilst the results of the effects of cs on burnout and job satisfaction are "interesting" overall, there are contradictions and methodological flaws within the literature, which include small sample sizes and researcher bias due to dual roles as supervisor/researcher. This has led her to conduct a large-scale study focusing on 14 sites in Finland. These sites were selected particularly to represent a wide geographical spread of Finland. Following agreement from 12 out of the 14 sites to take part, a site co-ordinator was recruited to select potential respondents and who had responsibility for cs within their organisation. The criteria set for participant inclusion were that, they were a healthcare professional and currently having cs (supervisee) for at least six months. What is unclear is the total number of respondents who were selected and the number that declined to take part, or the attrition rate, although a sample number of 569 eventually took part.

The aim was to evaluate the effects of cs. The study utilised a variety of questionnaires as data collection tools including; demographic background, Manchester Clinical Supervision Scale (MCSS, designed by Winstanley, 2000), The Maslach Burnout Inventory and the short version of the Minnesota Job Satisfaction Scale. The findings were detailed and led Hyrkas to make comparisons with the first Finnish national survey of cs (Sosiaali-ja Terveysministerio, 1983). Similarly the number participating in one-to-one supervision is significantly higher than those practitioners engaging in group supervision, a finding also supported in Kelly, Long and McKenna's study undertaken in Northern Ireland (2001). Furthermore, the 1983 study identified that, on average, supervisees accessed clinical supervision for twenty minutes each month, whereas Hyrkas's 2005 study showed a significant rise in the time with 67.6% of the sample having cs for a duration between one and two hours, although she does not offer

a reason. Other findings suggested that the supervisors for mental health nurses tended to come from psychotherapy (28%). They were more likely to support cross discipline cs compared to Kelly et al's (2001) and also suggested that overall, supervisees wished to choose their supervisor rather than being allocated by their manager. She concluded by emphasizing the need to invest in education for clinical supervision and that supporting the concept can ultimately relieve burnout and have a positive effect on job satisfaction.

Also in 2005 Hyrkas published another study which again focused on Finnish nurses. However, this time the sample size was smaller (n=32) and focused on the effects of peer cs on first line nurse managers over a two year period, (Hyrkas et al, 2005). The rationale for choosing this group was two-fold; Finnish health care management had received major criticism in recent years for poor working staff conditions and weak management style. Clinical supervision had been heralded as a support for managers but this tier of management had rarely been reported on. The findings suggested that cs had a positive long-term effect on the participants' communication, self awareness and leadership skills. However the sample size did drop to 11 participants from an initial 32 and, whilst they admitted that there were initial difficulties with cs which were resolved by the end, it may be that the positive participants remained throughout the study and the negative participants dropped out.

In a study by McEwen, Cooper and Clayworth (2005), using questionnaires, ward sisters and charge nurses (n=93) were asked about their ability to fulfill their role, in relation to clinical, managerial, professional and ward organisation duties. The response rate was 48% (n=45). The authors indicated that cs would be an "obvious arena" for these senior nurses to discuss quality issues. Developments from this study led the Trust to reconfigure the sister's/charge nurse's role, with the modern matron taking on some of their tasks (although they do not state in what way). The majority of staff attended the RCN Leadership programme and ward meetings had been extended to

allow time for updates, debate and networking. However, whilst 50% of the staff cited insufficient time to take part in cs, there is limited evidence that this was a specific area the Trust wanted to develop.

2.3 Conclusion

The aim of this literature review was to provide the reader with an overview of the development of cs within the nursing profession in the UK. This has necessitated the examination of the rationale for its implementation as well as its historical roots in social work, counselling and psychotherapy. It is interesting to note from the literature that there is no nationally agreed framework for supervision in any of the aforementioned professions and it would appear that the professional body governing nursing, health visiting and midwifery (NMC) has similarly not provided such guidance. Whilst the UKCC/NMC and Government have advocated the worth of the concept within nursing, they have insisted that the strategy to take it forward should be agreed locally rather than via a national framework. This has led to an inconsistent and mixed response within nursing and this is reflected in the literature. Nevertheless there have been recognised pockets of excellence and a steady increase in the number of examples within the literature of nurses developing and sharing best practice.

The major evaluative study (Butterworth et al, 1997) may have been undertaken after a relatively short time before cs had become accepted within nursing. Despite this, in 2006, there is still confusion nationally regarding the conceptualisation and operationalisation of cs in nursing. Although there are pockets of excellence there are also areas which have struggled to introduce it. Whilst numerous empirical studies have been undertaken, there still remains a paucity of research which examines the lived experiences of those involved in cs. Of particular interest are the experiences of those who attend clinical supervisor courses, those who receive supervision and strategic managers who can influence the implementation of the approach.

Recommendations within the literature appear to suggest a commitment to training the first generation of clinical supervisors is required. This should be undertaken in a way that will ensure consistency across the health service, with an agreed strategy to include the nature, content, duration and evaluation of the training for supervisors. As far as I am aware, my study is unique in that it examines the lived experiences of cs from three perspectives; course participants, supervisees and senior managers. Furthermore, it addresses issues relating to why supervision may not be more widely adopted in the UK.

Chapter 3

Methodology

van Manen (1990) argued that methodology is the philosophy of a study, whereas method is the way in which the study is undertaken (the technique and the procedures for carrying out the research). This chapter introduces the reader to the philosophical and methodological approach that forms the foundation of this study. An explanation will be given regarding the choice of the qualitative paradigm and also the reasoning behind why the study has been guided by the writings of Martin Heidegger, utilising a hermeneutic phenomenological approach.

I will discuss the theoretical concepts as well as offering justifications for these and relating them to the actual study. The rationalisation for this linkage is that the study concerns lived experiences. I aim to provide the reader with a reflexive account, rather than a clinically compartmentalised read. This is in keeping with Heidegger's style of offering a concept and then moving backwards and forwards between data and theory.

3.1 Qualitative research methodology

Traditionally research within the health care environment, has been an attempt to predict and control care using scientific methods (Oiler, 1981). However, the role of the researcher within this thesis runs counter to this positivist paradigm, which Smith and Hunt (1997) see as:

> " ...reducing human beings into small quantitative units which give no clue how they fit into the dynamic living whole." (p116)

Whilst historically the quantitative approach has been, and still is viewed with a great deal of respect, it is not able to address all research questions. Polit et al (2001) give examples of ethical and moral questions that this method fails to adequately deal with, which include euthanasia and legalisation of abortion. However, the qualitative

approach can give participants a voice, as it seeks their opinion regarding something that may have happened to them. For example, Randle (2003) studied the changes in self-esteem during a three-year period of student nurse training. Through a series of interviews, students were able to disclose bullying that they had witnessed and the effects that it had had on them personally. This led the author to conclude that whilst there are localised and national strategies (citing the RCN as an example) the phenomena of bullying and harassment at work need to be scrutinised from a socio-cultural perspective. By utilising a longitudinal qualitative approach, Randle (2003) was able to build rapport and trust with the students. As a result they felt able to disclose rich data, which ultimately added to a body of knowledge and had the potential to change the way nurses are educated and supported in practice.
Furthermore Spichiger and Prakke (2003) suggested that phenomenology:

> "...allows insights into the daily world of the ill or disabled people and their families. The articulation of their experiences gives them a voice and has the capacity to bring about positive changes in nursing practice." (p128)

With regard to my own study, a qualitative method of inquiry was utilised to gain an understanding of how cs training/preparation equipped qualified nurses to become clinical supervisors. In this way the focus is on the individual's distinct experience, providing a much deeper insight into complex human behaviours than would have been gathered simply from questionnaires or surveys (Lincoln, 1992).

3. 2 Rationale for chosen research paradigm

There is a lack of consensus in the literature around research paradigms. Polit and Beck (2006) acknowledged that in general there are two paradigms: positivist and naturalistic, whereas Lincoln and Guba (2000) cited five paradigms, positivism, postpositivism, critical theory, constructivism and the participatory approach. Furthermore, Cresswell (2003) discussed the paradigms as four schools of thought regarding claims about knowledge. Initial reading of the literature with regard to

paradigms, suggested that Cresswell's approach might be the most helpful, because it was current and appeared to encompass what other authors alluded to.
The four approaches to knowledge included by Cresswell are

- Post positive -such as experiments in which reductionism takes place
- Socially constructed -(interpretivism) in which individuals seek understanding of the world
- Advocacy/participatory - in which inquiry relates to a political agenda
- Pragmatic - in which mixed methods are utilised to discover/understand the problem. (Cresswell, 2003)

The original aim of this study was to understand the experience of qualified nurses who had undertaken a course in clinical supervision (cs). Consequently the socially constructed knowledge claim appeared to be best suited. This seeks out how humans understand their world, and the researcher is pivotal in collection of the findings. This is deemed to be an interpretative approach because the researcher generates meaning from the findings through interaction with those being researched (Crotty, 1998). This knowledge claim focuses on the manner in which participants construct meanings from social interactions and the understanding that they assign to social systems, such as language. There are a number of methodologies which adopt this theoretical framework on of the most commonly used of which is a grounded theory approach in which theory is generated from the data.

Grounded theory is a valid research approach developed by Glaser and Strauss (1967). Its main aim is to generate theory from the data collected (McCann and Clark, 2003). However I rejected this approach believing that a phenomenological study would be more appropriate and valuable. I was interested in the participants as unique human beings who had experienced the phenomena of cs. The aim of a phenomenological approach would be to understand and interpret the participants' individual experiences and offer the reader my own findings, and interpretations. This moves away slightly

from social constructionism emphasising individuals lived experience over their construction of the world

From my own perspective, I was interested in the fact that there was training of supervisors, but no subsequent post course follow-up to assess whether or not nurses were indeed acting as supervisors. Further, I wished to explore why they may not choose to have or give cs. Thus the initial aim was to describe, understand and interpret the lived experiences of a sample of nurses who had undertaken the clinical supervisors' course. The proposed outcome would be a subjective account of what the individuals had shared with me. The relationship between researcher and participants needs to be close so that this subjective interaction will lead to an in-depth discovery and interpretation of knowledge. This resulted in the adoption of an interpretive paradigm which sees reality as a changing entity, constructed by individuals involved in the research. Indeed there are no definites or truths but rather multiple interpretations.

When the terminology is further examined it would appear that naturalistic relates to in the "field". Whilst the interviews for this thesis were mainly undertaken in the participants' workplace I felt that the term "interpretative" or, as more commonly used "interpretive" was more appropriate for the paradigm. This is in keeping with other studies that have also used this terminology to describe their research (Richardson, 1995, Cox, 1998, Higginbottom and Jackson, 2002, Roe-Shaw, Gall, Jones, Lattey and Sainsbury, 2003).

Once the initial data were gathered, transcribed and analysed, the lived experience could be approached. The "findings" chapters present and begin to interpret these lived experiences. The focus was on understanding the participants' lived experience of "being a supervisor" and "being a supervisee". In relation to Heidegger, this was an

attempt by the researcher to involve certain "relatedness backward and forward" (*Ruck oder Vorbezogeheit,* BT 2, 28; 8).

For the purpose of this research study a phenomenological approach using semi-structured interviews was adopted. By utilising a qualitative inductive research approach within the philosophy of phenomenology, I studied the lived experiences of nineteen course participants (from a total of forty) undertaking two forms of cs training. Subsequently the interviews extended to nine senior managers within two NHS trusts and six practitioners who regularly accessed cs with a named supervisor.

3.3 Phenomenology

Historically, phenomenology is a branch of philosophy from which a methodology has emerged and been adapted (Ray 1994, Holloway and Wheeler 1996, Lowes and Prowse,2001). According to Burns and Grove (2001):

> "Phenomenology is both a philosophy and a research method. The purpose of phenomenological research is to describe experiences, as they are lived – in phenomenological terms, to capture the lived experiences of study participants." (p65)

Priest (2002), defined the term phenomenology, as deriving from the Greek *phainen* meaning "*to appear*". Walters (1995) further explained that phenomenology derives from two Greek words: *phainomenon* denoting appearance and *logos* denoting reason. Thus, appearance and reason strongly suggest that phenomenological research will not only describe an experience, but will also attempt to understand and interpret it. Fleming, Gaidys and Robb (2003:114) add that the Greek word phenomenon: "Stands for something which shows itself by bringing itself into the daylight". The literature appears fairly consistent in defining phenomenology as an attempt to understand and interpret human lived experiences (Elfert, Anderson and Lai, 1991, Rather, 1992, Cohen, Kahan and Steeves, 2000, Todres and Holloway, 2006).

Phenomenology is concerned with the "here and now" of living (Moran, 2000), or as Heidegger (1927, 1967) would state *being-in-the-world.* Cody (1999) described phenomenology as an approach, which values people's individuality and rationality when describing and explaining their uniqueness in everyday life. Moran (2000) goes further with his explanation stating that the approach is a:

> "...*radical* way of doing philosophy a *practice* rather than a system. Phenomenology is best understood as a radical, anti traditional style of philosophising, which emphasises the attempt to get at the truth of matters to describe *phenomena* in the broadest sense as whatever appears in the manner in which it appears, that is as it manifests itself to consciousness, to the experiencer. " (p4)

Phenomenology as a philosophy and methodology attempts to interpret human beings living in the world. As such this philosophy rejects the traditional objectivist ideology of modern science, which was characterised by a formal system of inquiry. Essentially, in the Husserlian sense it is an attempt to understand the experience as it stands, without the burden that may have been placed upon it from, for example, religion, culture, science and everydayness. Moran (2000:5) suggests that this gives a sense of "freedom from prejudice" allowing a return to the basics of human beings as they live their everyday life. I believe that, this when reinterpreted in a Heideggerian sense, makes this philosophy relevant to nursing, as it provides the reader with an understanding of patients, relatives and health care professionals within the healthcare environment (Cohen 1987, Taylor 1994, Munhall 1994, Miller 2003).

Within the last decade there has been an upsurge in the number of studies using phenomenological approaches, (Anderson, 1991, Hallett, 1995, Burke Draucker 1999, Koch, 1999, Caelli 2001, Fleming et al 2003, Todres and Holloway, 2006). Indeed, Beck (1994) conducted a ten-year review 1983-1993 of CINAHL and discovered that there is an increasing movement towards conducting phenomenological research studies. She pointed out that this trend had risen sharply in the 1980s and was still continuing in the 1990s. When searching CINAHL in 2005 using the search terms

"phenomenology" between the years 1983-1993, I found three hundred and ninety nine phenomenological studies. However, when the dates are changed to 1994-2005 there is a considerable rise to eight hundred and thirty nine studies. This supports Beck's opinion that phenomenological research is becoming more prevalent within nursing. However, whilst this may indicate certain popularity, in the 1990s there were key authors who not only advised caution, but who criticised nursing studies for the way in which the philosophy and methodology of phenomenology had been undertaken (Crotty, 1996, Paley, 1997, 1998, Burke Drauker, 1999, Corben, 1999, Koch 1999, Lowes and Prowse, 2001).

Crotty (1996) randomly reviewed thirty pieces of research, which claimed to use a phenomenological methodology. He identified that they provided a mine of information when taken as a whole, but when examined individually and against each other they were confusing, contradictory and not always true to the methodology of phenomenology. He suggested that researchers should return to the original philosophy especially advocating the Husserlian method of phenomenological reduction, in which the researcher suspends their own preconceptions in an attempt to bring the essence to the forefront. Whilst it could be argued that Crotty adds little to the debate regarding phenomenology in nursing, he does provide the reader with some significant points to consider when undertaking or reading research claiming to be philosophically and methodologically underpinned by a phenomenological approach. More recently, Corben (1999) added to the debate with her discussion regarding the use of the phenomenological method. She provided the reader with clear guidance of how to avoid misusing phenomenology in nursing research as well as admitting that the philosophy is somewhat complex and the language is at times difficult to understand, a view supported by Caelli (2001) and Miller (2003). Ultimately the widening of this debate may serve to assist and encourage nurse researchers to undertake and read phenomenological research and so add to greater understanding of patients (Garret, 1998, Burke Drauker, 1999). Indeed Maggs-Rapport (2001) stated that:

> "Without adequate understanding of methodological precepts and the relationship between methodology and method, researchers will fail in their pursuit of "best research practice." (p374)

3.3.1 The phenomenological movement

The German philosopher Husserl (1859-1938) developed phenomenology as a philosophy. Whilst the literature tends to describe Husserl in terms of the "father" or "founder" of the phenomenological movement (Spiegelberg, 1984, Stewart and Mickunas, 1990, Chinn 1995, Crotty, 1996, Smith and Hunt 1997, Beech, 1999, Corben, 1999, Grbich 1999, Moran 2000), it did in fact begin somewhat earlier. Priest (2002) explained that historically, Immanuel Kant first described the term in 1764. However, Moran (2000) discussed how the term phenomenology was first noticed in eighteenth century philosophical texts written by Lambert, Herder, Kant, Fichte and Hegel. Spiegelberg (1984) Crotty (1996) and Moran (2000), credit Franz Brentano as first employing the term "phenomenology" in 1889 as the title of a course he was teaching on "Descriptive Psychology".

Spiegelberg (1984) has written a comprehensive history of the phenomenological movement dividing it into three phases; the preparatory, the German and the French. Describing phenomenology as a "movement" tends to imply that Speigelberg recognised it as a philosophy, which had developed and changed. Cohen et al (2000) explained that this change was not only between philosophers but also within philosophers themselves citing Husserl as an example.

For the purpose of this thesis a brief explanation will be given of the preparatory phase to show the development of phenomenology. The German phase, which essentially consists of the works of Husserl and Heidegger, will be discussed in greater depth. This will provide the reader with an overview of these two differing philosophers. It will also furnish the reader with a rationale for using the work of Heidegger rather than Husserl,

to guide this study. As it has little bearing on this study, the French phase will only be briefly discussed to show how the Phenomenology movement progressed.

3.3.1.1 The preparatory phase: Brentano

This phase consisted of the works of Franz Brentano (1838-1917) and his student Carl Stumpf (1848-1936). Brentano's use of phenomenology was an attempt to provide answers to questions that he felt organised religion had failed to respond to (Cohen et al 2000). This led him to look for truths and absolutes especially within the field of descriptive psychology, where he would use experiments to study the psychological effects of sound. The origin of Brentano's writings was in his reading of the work based on Rene Descartes (1596-1650) a modern philosopher who espoused that a human being consisted of discrete parts: a body and a mind, and was in fact, an entity. He goes on to suggest that non-human animals are mere bodies without either a soul or a mind, whereas humans are a unique combination of body, mind and soul. According to Descartes, God would have created the soul. Brentano further explored the issue of the nature of the mind and what distinguished between mental and physical phenomena. This resulted in one of his most famous doctrines in which his thesis was that all mental phenomena are intentional (Grossman, 1984). This rejected the possibility that there may be unconscious mental acts (Moran 2000).

3.3.1.2 The German phase:

3.3.1.2.1 Husserl

Husserl, a Jewish born German, considered phenomenology to be not only a philosophy but also an approach and a method (Morse, 1994). He sought rigour, criticised naturalism and positivism (linking it to scientific enquiry) and was concerned with the discovery of "universal truths". He drew on the work of Rene Descartes, using subjectivity, but rejecting any external influences to understand a phenomenon. Husserl's ideas fit within the rationalist tradition of Cartesian mind-body split and may have grown from his attempts to understand the nature of mathematical and logical

truths. His seminal work Logical Investigations (1900-1901; translated 1970) has been deemed to be:

> "...one of the most influential works of philosophy of the twentieth century, though more for its announcement of Phenomenology than for its logical discoveries." (Moran, 2001:91)

Philosophically, Husserl took phenomenology forward, but *Logical Investigations* has not been without its critics who have commented upon it being poorly written and constructed (Bell 1991). The work itself appears to have been conceived through his quest to understand mathematical problems. The theories and philosophies of that time failed to provide Husserl with the clarification he needed and so *The Logical Investigations* sought to provide epistemological and logical explanation.

Husserl's aspiration was to examine how things presented to human beings consciously and from which they could reflectively describe the experience or "intuit". In this way the essence of a phenomenon could be exposed. Husserl wrote that to reach the essence "we must go back to the things themselves" (*Wir wollen auf die "Sachen selbst" zuruckgehen,* Husserl 1900-1901 translated 1970: 252). Husserl called the ability to direct the mind in a state of consciousness "intentionality" (Koch 1999).

According to Thompson (2003):

> "Husserl suggested that every mental act is directed towards an intentional object; what the mind is thinking about whether or not that object actually exists." (p183)

One example could be that a person out running on a hot day might want a cold drink. A physical drink will be needed for their thirst to be quelled. Because the object (drink) is not present on the run, it does not actually physically exist, but the mental act of thinking about its existence makes it an intentional object. Furthermore Husserl's work was not just about awareness but he also wanted:

> "...to make intelligible how the forming of all those mentally produced formations takes place in the performance of this internal logical lived experiencing." (Husserl 1925 translated 1977:14).

Husserl's philosophy is concerned with objects of consciousness. He was aware that this state of consciousness could be tainted and lead to a distortion of the experience, preventing the discovery of truth. To combat this and reach the pure form of essences, he devised a method, which he referred to as the "epoche" (translated from Greek meaning "suspension of belief"). To reach this there were two stages, consisting of the "eidetic reduction" and "phenomenological reduction proper" (Holloway and Wheeler, 1996). According to Cohen (1987:32) the eidetic stage related to a "reduction from facts to general essences" and the second stage was achieved by the researcher bracketing out their own thoughts, feelings and attitudes towards the phenomena being researched. Only after suspension has occurred would the "eidos" or the pure essence of the subjective consciousness be left (Husserl, 1965). He argued that the essences were intuitively known. In relation to Husserlian phenomenology the need of the researcher to bracket, was paramount in the discovery of the essences of phenomena, as participants intuitively experienced them. An example could be the lived experience of breast-feeding a baby. A Husserlian phenomenologist would argue that the researcher, (if she previously breast-fed her own babies) would need to bracket her own presuppositions. If not she would be unable to reach the pure essence of the lived experience of breast-feeding. Suspending their own acquired beliefs from the outer world the researcher would then be able to view and interpret the phenomena in its primordial state. According to Swingewood (1991) a researcher following this approach would essentially "stand outside the research process" and in this way objectivity would be achieved at all stages of the research. Furthermore Husserl contended that for consciousness to happen it required three things; the self (which he described as the "transcendental ego"), the mental act and an object of that mental act. It would appear that the transcendental ego is of paramount importance because all objects and mental acts will come from the meanings and interpretations that the self

places upon them. Crotty (1996) and Caelli (2001) considered that it was not only the researcher who should bracket but also the participants within the study. LeVasseur (2003) and Beech (1999) rejected this view. Whilst an advocate of the use of bracketing, Beech (1999) believed that realistically it was the responsibility of the researcher and the participants' presuppositions should be accepted as their "life-world".

I initially pondered the possibility of being guided by the work of Husserl in relation to "bracketing". However this evolved into an unrealistic proposition for several reasons. To some extent I am already "enmeshed" in clinical supervision as a recipient, as a clinical supervisor to three qualified nurses and as a co-ordinator of a level three module in clinical supervision. Consequently I felt that bracketing may be unrealistic and that my own presuppositions should be viewed as integral to the research process rather than be set aside, a position supported by the literature (Beech, 1999). Furthermore, Merleau-Ponty (1962) asserted that whilst the researcher's consciousness was engaged in the world it could not be transcended and as such complete bracketing was not achievable. Interestingly Lowes and Prowse (2001) suggest that the results of a phenomenological interview are reliant upon both the participant and the researcher and that:

> "The demonstration of rigour and trustworthiness depends upon the researchers fully explicating their preconceptions and their contribution to the interview process." (p472)

Annells (1999) was clear in her understanding of Husserl and the use of bracketing stating that it should:

> "...not be attempted as it is either seen to be impossible to achieve, unnecessary, or actually counterproductive." (p12)

This echoes Gadamer's (1975) comments that

> "...to try to eliminate one's own concepts in interpretation is not only impossible but manifestly absurd."

I concur with both statements because, although the nursing literature provides evidence of studies that have followed Husserl and the use of bracketing (Dobbie 1991, Lethbridge, 1991, Gallagher and Jasper 2003), it is still a monumental task to unknow what one already knows. Indeed, Crotty (1996) and Paley (1997) criticised nurse researchers who use the term bracketing, but fail to remain true to this Husserlian method. Lowes and Prowse (2000) argued that whilst many nurse researchers adapt Husserlian phenomenology, the major weakness in their work is the lack of clear descriptions as to how bracketing has been achieved. Indeed, a study by Gallagher and Jasper (2003), claimed to use a Husserlian phenomenological approach to explore health visitors experiences of family group conferences stating that:

> "Bracketing was not easily achieved as the researcher already held a considerable amount of knowledge about child protection and had attended a Family Group Conference." (p386)

However, whilst they conceded that bracketing was difficult, they omitted to mention any steps that they took to make it possible. Furthermore although they made reference to their knowledge base, they failed to state that both researchers were health visitors which is significant as the aim of this study was to explore health visitors experiences of family group conferences. van Manen (1984) warned that if researchers were not open and explicit about their beliefs, biases and assumptions, then these issues would return within their conscious reflections and have potentially negative effects on research interpretation.

To conclude, the need to "bracket" may be described as a technique within Husserl's philosophy designed to achieve the viewing of phenomena or experience within one's own consciousness without the influence of prior knowledge. He believed that all experience resulted in humans gaining knowledge about their world, which has been

likened to building of layers (Oiler 1986). Stripping away these layers enables the person to examine the phenomena without allowing their preconceptual knowledge to hinder the process. This then facilitates the reaching of the true essence. Thus, the ultimate aim of Husserlian phenomenology according to Solomon and Higgins (1996) is to use the individual in a way that the essence can be unfolded and eventually reached. From here the phenomenon can be described, thereby allowing one to approach an ultimate truth or certainty. The importance of Husserl cannot be overestimated as he was fundamental in freeing philosophers to explore other facets of life such as emotions and experiences, rather than being largely concerned with language (Thompson 2003).

3.3.1.2.2 Heidegger

Martin Heidegger was born in 1889 at Messkirck in the Black Forest, Germany. He studied Greek, Latin and German but it was philosophy that appeared to capture his interest. Reading the work of Franz Brentano on *the Manifold Meaning of Being according to Aristotle* led him to the original texts of Aristotle (Waterhouse 1981). In 1909 having read *On Being: An Outline of Ontology* by Carl Braig a Professor of Systematic Theology at Freiburg University, Heidegger enrolled at the same university to study theology. It was here that he became aware of Husserl's *Logical Investigations* (1900-1; trans.1970). It is possible that, reading philosophical texts led Heidegger to transfer from theology to philosophy. Waterhouse (1981) asserts that this was not as a result of loss of religious faith and suggests that Heidegger continued to attend some theological courses and write papers on the subject.

Whilst much of the literature tends to begin by emphasising that Heidegger was the student of Husserl (Cohen et al, 2000) this was not immediately the case. With the change in his course studies Heidegger came into direct contact with Heinrich Rickert (Professor at Freiburg) and it was he who was instrumental in Heidegger's exposure to the hermeneutic tradition (Spiegelberg, 1984). It was during his time at Freiburg that

Heidegger read, listened and talked with Husserl regarding his work. On 21st January 1919 Heidegger became Husserl's salaried assistant and remained so until 1923 when he became Professor Extraordinarius at Marburg University (Moran 2001). He subsequently succeeded Husserl as professor of philosophy at Freiburg University.

Whilst Husserl has been credited as the founder of Phenomenology, it was Heidegger who caused a major shift in its philosophical stance with his important work *Being and Time.* Published in Germany in 1927 with one influential English translation being produced in 1962, this work created the concept of Heidegerrian Hermeneutic phenomenology.

According to Annells (1996):

> "...he moved from the epistemological emphasis of Husserl to an emphasis on the ontological foundations of the understanding which is reached through being-in-the-world, and thus to what is postulated as the pivotal notion of human everyday existence." (p706)

Epistemology leads one to question "how we know what we know" whereas ontology seeks to understand the answer to the question "What does it mean to be a person" (Koch, 1999). The latter functions on a more humanistic level of enquiry (Todres and Wheeler 2001) and as such makes Heidegerrian phenomenology a favourable choice of philosophy to guide this study.

3.4 Hermeneutic phenomenology

The term hermeneutics appears to have been derived from the myth of Hermes, the Greek messenger, whose responsibility it was to convey messages from the Gods to the people. In doing so Hermes needed to be able to interpret the messages into language that humans could understand (Addison 1992). Whilst hermeneutics has been in existence since the seventeenth century, it was predominantly used to explain the scriptures (Crotty 1996) as well as legal, historical and medical studies (Waterhouse

1981). However it was not until the latter part of last century that hermeneutics began to change. Waterhouse (1981) explains that this was as a result of people theorising "about this art of understanding."(p5)

In the eighteenth century, the theologian, Friederich Schleiermacher (1768-1834) developed the idea of "general hermeneutics". Following on from this in the nineteenth century it was used to interpret human sciences (Addison 1992). Dilthey has been credited with being the first to attempt this (Todres and Wheeler, 2001), albeit from an epistemological stance. Heidegger on the other hand brought a differing approach, which was interpretative and thus ontological. According to Heidegger (1927/1962), the aim of hermeneutics is to appreciate that by existing in the world, a person understands, interprets and makes sense of experience(s) which will relate to their own state of being. This results in a break from Cartesian tradition that views mind and body separately. Instead hermeneutics leads to interpretation through existentialism in which the mind and body are one (the self) who has to exist in the world to be able to interpret and make sense of it. As nursing has developed it has moved towards a holistic approach to care and embraces the physical, psychological and spiritual needs of an individual. By doing so, this in effect moves away from the Cartesian tradition (Todres and Wheeler 2001) and helps to support the rationale for choosing Heideggerian hermeneutic phenomenology. Furthermore, Heidegger (1962) emphasised that interpretation would take place utilising language, history and culture. Within this study, because I am a nurse, this provides me with a greater understanding of the language spoken by the participants, the context of their experiences and the culture of their profession. Ultimately I see this as highly beneficial to the process of interpretation.

Koch (1999) suggests that Heidegerrian phenomenology relates to people being self-interpreting and when the researcher has asked them to tell their story, this story must be accepted as:

> "...their construction of reality. Together with participants, you would create constructions (a research product or story), and perhaps you would reach consensus about the construction that makes the most sense." (p24)

Thus, Heideggerian phenomenology rejects the writings of Husserl, which argues for a search for essences. Instead Heidegger sees people existing in the world and interpreting it from within, rather than being detached from it. Indeed having interviewed the course participants for my own study on three occasions, (some a fourth), as well as the managers and supervisees, I became aware that the story is the participants own understanding of reality. By using this approach, a more complete picture in relation to clinical supervision was obtained. This I believe is unusual within the literature pertaining to the concept of clinical supervision.

It is not within the scope of this thesis to examine and link all the writings of Heidegger to the research undertaken in this study. However there are several key themes within Heidegger's works, which have particular resonance. The themes include being-in-the-world, Dasein, falleness, authenticity/inauthenticity, thrownness and temporality, which will now be discussed. By examining these themes I will also provide the reader with a clear understanding of why a Heideggerian phenomenological approach was chosen.

According to Waterhouse (1981), Heidegger wrote in excess of seventy published pieces of work. However it is his publication of *Sein und Zeit* (Being and Time, 1927) which appears to have been the most notable and celebrated.
Moran (2001) commented that:

> "*Being and Time* is appreciated as one of the strongest anti-Cartesian, anti-subjectivist, anti-dualist, and anti-intellectualist explorations of what it is to be human, and how it is that humans encounter the world in concernful dealings which are bound up in situations yet project forward from those situations." (p193)

This philosophical work espoused another approach to phenomenology that was significantly different from Husserlian phenomenology. Towards the end of the work it

appears in some ways rushed, which Waterhouse (1981) concedes may have been the result of his necessity to publish in order to secure his full professorship (prior to this work, he had not published in ten years).

For the purpose of this thesis the translated version of Being and Time by Macquarrie and Robinson (1980) has been used. This account is the most widely referred to in the English literature with the authors appearing to remain as faithful as possible to the translation of Heidegger's work.

3.4.1 Dasein and being-in-the-world

Fundamental to Heidegger's work is the term *Dasein,* which he himself translates as: "...purely an expression of its being" (Heidegger 1962:13). Dreyfus (1987) offers that the word is literally a combination of two German words "da" and "sein". Interestingly van Deurzen-Smith (1997:35) argues that Heidegger's use of German terms was at times confusing. She identifies Dasein as an example, the original translation she provides as "simply being there". Heidegger saw Dasein as being related to existence and with it came choices of how a being wishes to exist in the world. As a result Dasein refers to human existence "being there" and "being-in-the-world". Heidegger was interested in the questioning of how beings existed and this led him to write that beings exist in the world that they live in. This signifies that beings are connected to the world, hence the usage of hyphens which Walters (1995:793) explains, is Heidegger's attempt "to symbolize its unified nature". Similarly van Deurzen-Smith (1997) states that it represents the notion that human beings always live in a world and never in isolation.

Heidegger purports that the two (being and world) cannot exist independently and that there is a dialogue between them. This has been described as the person and the world co-constituting each other (Holloway 1997, Todres and Wheeler 2001). This co-constitutionality is referred to by Koch (1995), as being an indissoluble unity. Existence in the world leads human beings, according to Heidegger, to be questioning beings-in-

the-world of "entities", which encompasses both human and non-human beings. In some ways this suggests that human beings are on a journey of self- discovery within the world. According to Burke Drauker (1999) co-constitution in relation to research guided by the works of Heidegger means that not only should the voice of the participant be heard but also the researcher's own perspective should be stated. A study by Koch (1996) exemplifies how the researcher has provided research findings, which demonstrate true co-constitution of data. She described elderly patient's experiences of falling out of bed. Whilst she was trying to interpret their being-in the-world she also disclosed that her own father had died in hospital following a fall. She states that as a result of this experience:

> "...it was inevitable that falls became very important in my interpretation of the data." (p179)

Koch's experience might suggest that the impetus for her study came from her father's fall. However of greater significance is the possibility that she was trying to understand and interpret her own father's experience of falling, or his-being-in–the-world. In some ways Koch's decision to undertake such a study may be due to her caring for her father as a being which links strongly to the works of Heidegger who suggests that the most fundamental way of being in the world is *Sorge.* According to Walters (1995)

> "This word is usually translated into English to mean "care". Care is about being and it is about caring for things and other people." (p793)

Similarly, within my own thesis I am attempting to interpret the experiences of nurses who have undertaken cs training as to why they did or did not subsequently become a supervisor (their being-in-the-world of clinical supervision). Whilst I have an understanding of my own being-as-a supervisor and being-as-a supervisee, I am aware that not everybody wishes to engage with the concept of clinical supervision. This has led to the usage of Heideggerian phenomenology in an attempt to interpret what being a supervisor or supervisee means to others.

3.4.2 Throwness

"Being" and "being-in-the-world" are both fundamental and significant to the works of Heidegger. However one also has to understand how beings live within their world. Heidegger (1962) refers to this as a state of throwness (*Geworfenheit*), in that human beings are "thrown" into their world and in some ways are already self-interpreting. This leads one to contend that as a being one can only interpret something from one's own world view, which consists of language, culture, beliefs, experiences and preconceptions.

3.4.3 Falleness, authenticity and inauthenticity

Whilst human beings are thrown into their world Heidegger (1962) contends that they are also in a state of "falling" or *"Verfallen"* which signifies that beings belong to "everydayness". He draws on these terms, encapsulating them when he writes:

> "Falleness" into the world means an absorption in Being-with-another, in so far as the latter is guided by idle talk, curiosity, and ambiguity. Through the Interpretation of falling, what we have called the "inauthenticity" of Dasein."(p175)

Thus, by being-in-the-world one has been thrown into it and predominantly functions or communicates with others having fallen into the everydayness of life, in a state Heidegger describes as inauthenticity. Moran (2001) clarifies this state succinctly, when he writes about authenticity and inauthenticity

> "It is absolutely *not* the case that humans can dwell in the authentic all their lives. Most of the time, we are just passing information along, not too caught up in things, not dwelling on the significance of events but living in the vague average understanding of everydayness."(p239)

Neither he nor Heidegger offered concrete reason(s) as to why humans cannot exist authentically all their lives and one can only assume that they would contend that it would be unrealistic and possibly damaging for the individual to do so. Whilst predominantly we live our lives inauthentically, Heidegger contends that authenticity is

something that every Dasein should strive towards. However, he also stresses that authenticity is an ideal for beings, even though inauthenticity may be more readily accepted.

Nursing as a profession has evolved over the centuries (Kuhse, 1997). Since the late twentieth and now in the twenty first century there has been a move towards reflective practice and the need for all nurses to be engaged in reflection on critical incidents (Johns, 2000). During clinical placements students are encouraged to analyse their own and their patients' experiences, to look at events from all perspectives in a critical, reflective and open manner. They are then encouraged to express what they witness and what they feel and are asked to try to make sense of it all. Thus I contend that there is a move towards greater authenticity within the profession.

In relation to becoming a nurse, the capacity of individuals to make this life choice suggests that at that point in their lives they were not in a state of thrownness. However once that choice has been made, it could be argued that the individual enters into a state of throwness and falls into the culture and practice of nursing, with all that implies.

The concept of being-with–others also led Heidegger to explore this relationship specifically in relation to how we care about people, which he described as "solicitude" (Fursorge). He states that humans' concern and care for others "solicitude" is different from the "concern" (Besorgen) we feel for things. He explained that there were two types of "solicitude". Firstly there is the superficial living alongside another being, but not fundamentally caring about each other at all. Secondly there is a type of "solicitude" when a person wants to show another how to care for himself which Waterhouse (1981:81) describes as "liberating for the other". The idea of "solicitude" has particular relevance for nursing and also for supervision as both are concerned with "enabling" and "liberating" others.

3.4.4 Temporality

Whilst Heidegger's writings deal significantly with the question of being and existing in the world, he also wrote about the temporality of existence. He stated that the study of Dasein "being there" is unequivocally linked to temporality. As a result Heidegger is suggesting that Dasein is in part itself, temporality. Solomon (1972) explains that according to Heidegger:

> "There could be no time except for Dasein; conversely, there can be no Dasein without there being time." (p223)

Furthermore, whilst he linked Sorge (care) to the three existential structures of "existenz", "facticity" and "falleness", the same was true with temporality. He viewed Existenz corresponding with future, facticity with past and falleness with present. He explains that human beings relate to the world in which they live according to these three structures:

> "The fact that the structure of datability belongs essentially to what has been interpreted with the "now", the "then", and the "on that former occasion", becomes the most elemental proof that what has thus been interpreted has originated in the temporality which interprets itself. " (Heidegger, 1962:408)

Interestingly, Heidegger also described time as *Weltzeit* or "everyday" worldtime in which beings function on a daily basis inauthentically, with time pressures being placed on individuals. However authentic time describes beings who live in a world, incorporating and interpreting life not from the here and now, but by being-in-the-world and seeing it from the context of their entire life including the future. The issues of being-in-the-world and time are fundamental to the role of a nurse. If the profession is committed to providing and improving the care that it delivers to patients, the process by which it may do so involves nurses becoming aware and understanding and interpreting the role in which they function in relation to the past, present and future temporality.

In addition to exploring temporality this thesis must also explore the phenomenon of being-a-supervisor and being-a-supervisee within the confines of temporality. The thesis will consider what the participants experienced in relation to clinical supervision over a period of time, (thus linking Dasein to temporality) the reader will be reassured that this thesis remains true to Heidegerrian phenomenology.

3.4.5 Heidegger and Nazism

It would be remiss not to mention Heidegger's links with Nazism (National Socialism) prior to and during the Second World War, which have been criticised by several authors (Cushing, 1994, Thompson, 1994, and Holmes, 1996). National Socialism promoted the superiority of one particular race of human beings. As such it was, and would still be fundamentally juxtaposed to the value base of the nursing profession. However I will offer an understanding of Heidegger's level of involvement with the National Socialist party and a rationale for why, despite his Nazi links, his philosophy remains a legitimate choice.

It would appear that Heidegger benefited professionally during the years of Nazism, 1933-1945 (Waterhouse 1981, Holmes, 1996, Moran 2000). He became rector of Freiburg University on the 16th April 1933 after the Nazis removed the incumbent rector due to his refusal to proclaim anti-Semitism. On 3rd May 1933 Heidegger joined the local Nazi party. However, other than a pro Nazi speech later that month in Heidelberg, he appeared to engage in no other political activity according to most of the literature. In 1934, he resigned as rector of Freiburg although he maintained his financial support for the local Nazi party until the end of the war (Crotty, 1996). Although he may not have been politically active it would appear that the evidence for Heidegger being a member of the Nazi movement is irrefutable. In 1935 in his work the *Introduction to Metaphysics* he referred to the:

> "...inner truth and greatness of this (the National Socialist) movement." (IM,1935:166)

Although a Nazi, Heidegger did not espouse the most notorious Nazi beliefs with regard to anti-Semitism and racism (Waterhouse 1981). A small number of authors are more unequivocal about Heidegger's involvement with the Nazis. For example Farias (1989), in his book "*Heidegger and Nazism*" clearly states that Heidegger's links with the National Socialists was more than fleeting. Furthermore Holmes (1996) adds that once Heidegger became rector of the University of Freiburg:

> "...he enthusiastically embraced the process of Nazification, militarising student life, shunning former friends because of their racial or political affiliations, denouncing Jewish and Marxist colleagues and actively making life difficult for Jewish students. He joined the Nazi party in a carefully orchestrated blaze of publicity and continually wore his swastika label pin." (p580)

The literature on Heidegger's involvement in Nazism is inconsistent and contradictory. It ranges from describing him as minimally involved in Nazism and perhaps politically naïve, to describing him as a calculating and manipulative anti Semite who exploited his Nazi connections to enhance his career.

Whilst this thesis does not "champion" Heidegerrian phenomenology it does assert that using his philosophy remains legitimate for several reasons. Holme's (1996) argument is anti-intellectual and full of assumptions. He suggests that nurses are a homogenous group with a homogenous set of values and a universal belief system. In reality nurses come with all sorts of differing views and values, from a multitude of cultures in which individuals have their own political and religious beliefs that may not be akin or acceptable to others.

Furthermore, it could be argued that Heidegger was living his life authentically and whilst he may have loved Hannah Arendt, a Jew, he was also true to his own beliefs. Indeed it would appear that he supported the National Socialist movement because he saw (mistakenly) that this would be a way of taking Germany back to its very being. In

1934 he wrote *Follow the Fuhrer* in which he identified that a country that followed the Fuhrer would reap benefits for all workers (Heidegger *1934* trans 2003:12)

A further testament to his own authenticity could possibly be seen in the post war years when students of Heidegger such as Herbert Marcuse, pleaded with him to renounce his involvement with the Nazi party (Ettinger, 1995) but this was something he steadfastly refused to do. This has ultimately remained a contentious element of Heidegger's life to the present day.

I suggest that when one chooses to be guided by a philosopher, it is their work that informs that choice and not their personal, political, cultural or spiritual viewpoint. Solomon (1972) supported this approach when he discussed the very differing personal beliefs of the existential philosophers; Kierkegaard, Nietzsche, Heidegger and Sartre:

> "Kiekegaard was a devout Christian and the other three were atheists; Heidegger was a Nazi, Sartre a Communist, and Kierkegaard and Nietzsche antipolitical. Kierkgaard insisted that the meaning of life could be found only in God, Nietzsche found it in the art, Sartre in political commitment and Heidegger in philosophy itself. Nietzsche was an ethical "naturalist", while the other three were resolutely antinaturalists."(p1)

Consequently, I believe that the political persuasions of Heidegger should not prevent nurses from using his work and this thesis from being guided by some of his writings. It is a perfectly legitimate position to accept Heidegger's philosophy about how human beings interact with each other whilst rejecting his own personal and political belief system, a view supported by Miller (2003).

3.4.6 Gadamer

This thesis could have been solely guided by the writings of Martin Heidegger. However following multiple readings of the transcription interviews within the study I became aware of the expressive language used by participants when they explained to me how they interpreted clinical supervision. This resulted in further reading of other

German philosophers and a decision that some of the writings of Hans-Georg Gadamer (b1900) would also guide this thesis.

Gadamer appeared to draw heavily from the works of Heidegger (his former mentor). He too rejected positivist science and the use of bracketing. Instead he highlighted the concept of historical awareness as a way of increasing knowledge and understanding. He emphasised the need for beings to be aware of their presuppositions which he referred to as "prejudices" and suggested that they are necessary for pre-understanding to take place. The concept of prejudice usually has negative connotations but in Gadamer's writings he meant that beings always come to a situation with pre-understanding (Gadamer 1975). It is the responsibility of the researcher to recognise their own pre-understanding if they are to make sense of and understand the meanings before them. Gadamer explained in his seminal work *Truth and Method* that language is the medium through which understanding and interpretation take place. He linked language to speech and argued that speech exists within a conversation. It is only through dialogue, that things can reveal themselves. He also emphasised the notion of historical awareness, which was essential for understanding. Like Heidegger he used the metaphor of the hermeneutic circle. However, Gadamer's emphasis was on the links between language and history and the experience moving within it. According to Bleicher (1980) the position of the researcher in philosophical hermeneutics is that:

> "The hermeneutic circle cannot be avoided, rather it is a matter of getting into it properly." (p103)

Koch (1996) and Spence (2001) similarly concurred with this view. In relation to this thesis these views suggest that I should become involved with the historicity of the participants' experience, and pay particular attention to the language that they use, to interpret and understand fully how the researched phenomenon affected them. In this way I endeavoured to achieve what Dowling (2004) described:

> "...the hermeneutic process becomes a dialogical method whereby the horizon of the interpreter and the thing being studied are combined." (p36)

Thus the writings of Gadamer appear to offer further valuable insights into how this thesis could develop a deep understanding of the text. Fleming et al (2003) argued that Gadamer does not offer either a methodology or a method to undertake this understanding. However, I believe that Gadamer does offer areas such as language and linguistics, historical awareness, the hermeneutic circle and fusion of horizons which the researcher may use to address the text.

3.5 The French phase

Heidegger was a major influence on the French (third) phase of phenomenology (Solomon 1972, Moran, 2000, Jones 2001b). According to Cohen et al (2000) this phase began shortly after Husserl's death in 1938 when papers of his were moved to Louvain. The philosophers key to this phase included Gabriel Marcel (1889-1973), Jean-Paul Sartre (1905-1980) and Maurice Merleau Ponty (1908-1961). They were described as "existentialists", who believed in beings becoming self-aware, and questioning themselves and how they exist in the world. They drew heavily on Heidegger's writings and they likewise rejected Husserl's views concerning the use of bracketing in an attempt to reach the essence or "absolute truth" of a phenomenon. Possibly the most renowned of these French phenomenologists was Sartre. His seminal work *Being and Nothingness* (1943) showed that human beings wanted the freedom to exist in the world but argued that this also caused them to fear existing in this way.

It is not within the scope of this thesis to explore this phase in any depth but simply to refer to Jones's (2001b) description of the three French philosophers work which states

> "Marcel and Merleau-Ponty viewed phenomenology as a way through which to understand human *reality* in a metaphysical sense, while for Sartre, it offered a means to explore philosophy and politics through the medium of art and literature." (p368)

3.6 Summary

To conclude, this chapter has addressed my rationales for using a hermeneutic phenomenological approach within the qualitative naturalistic paradigm. Particular emphasis has been placed on the differences between Husserl's and Heidegger's philosophy in an effort to explain the rationale for choosing Heidegger over Husserl to guide this thesis. Attention has also focused on the suitability of Heidegger's writing within the nursing profession, not only from an ontological perspective but also in light of his Nazi political sympathies.

Heidegger is fundamentally concerned with "being" and how that being exists in the temporality of the world. This concern is further rooted in a desire to understand and interpret or "make sense of the world" that beings exist in. Nursing as a profession has evolved in the later twentieth and the emerging twenty-first century and has attempted to become more holistic in its approach to providing care. An emphasis on holism has resulted in nurses attempting to care for the person in relation to not only their physical, but also, social, spiritual and psychological needs.

Whilst a large number of studies focus on the lived experiences of patients this thesis explored lived experience from the nurse's perspective in relation to "being-in-clinical supervision". Whilst I currently have and give clinical supervision as well as provide clinical supervisor training, in my experience it became apparent that very few nurses actively engage in the process. This motivated me to attempt to understand and interpret the experiences of those who had undertaken cs training. Husserlian phenomenology was rejected due to the need for the researcher to bracket and reach the essence. I felt strongly that my own presuppositions and exposure to the concept of cs could actively assist the research process of interviewing and analysing the data.

Chapter 4
Research methods

This chapter discusses the rationale for the study, its aims, how they were later modified and the processes that evolved as the study progressed. It explains and justifies the methods of data collection and the analytical approach adopted to guide the interpretation of the data. This incorporates the rationale for using semi-structured audio-taped interviews to collect the data, which includes consideration of the process of data collection (incorporating ethical considerations), access to the participants and the interpretive approach. The chapter considers the rigour of the study as well as my own reflexivity and concludes with what I have identified as the study's limitations.

To remain true to the philosophy and methodology throughout this chapter, there is reference to the writings of both Heidegger and Gadamer. The chapter is written using the first person because I wish to convey the work that I have undertaken to date and justify my research actions a view supported by Webb (1992). Furthermore writing in this way will provide the reader with what Koch (1994) described as a "decision trail". Having chosen a hermeneutic phenomenological approach, this has resulted in me revealing the personal and professional prejudices which I have brought to the study. Following on from this I explain how this affected my interpretation of the data. Indeed, Koch (1994) stated that:

> "Readers may not share the author's interpretation but they should be able to follow the way in which the author came to it."(p977)

4.1 Reflexivity and preconceptions

According to Payne (1999b) reflexivity is when:

> "...one attempts to produce credible and trustworthy evidence by being honest about one's biases and feelings." (p7)

Holloway (1997) suggested that it is a self-critical appraisal of one's own assumptions and actions. Similarly, Pellat (2003) described it as an acknowledgement of her "taken-for-granted values" and how they impinged on her research and practice. Whilst reflexivity has been defined in many ways, overall the literature is fairly consistent in explaining the term (Ersser, 1996, Carolan, 2003, Finlay and Gough, 2003, Horsburgh, 2003). The fact that the researcher is part of the data (reflexivity) and does not keep their own views in abeyance is I believe consistent with Heidegerrian Hermeneutics, a view supported by Todres and Wheeler (2001). Furthermore, Gadamer (1975) also wrote that hermeneutics was the philosophy of not only understanding and interpreting texts but also self-interpretation.

In relation to this study I have interwoven "reflexivity" within the methods chapter as a whole as well as giving it a defined category. I wished to convey to the reader that I did not see being reflexive as a one-off event but something that I addressed throughout the research process. I believe it enhanced the trustworthiness of the findings.

I have chosen Heideggerian phenomenology to guide this study, thus the findings, (data extracted from the interviews), were my interpretation of what the interviewees said. To interpret their lived experiences, I needed to be clear about my own preconceptions of clinical supervision (cs). I see that by addressing my preconceptions this relates strongly to being reflexive (Todres and Wheeler, 2001, Finlay, 2003). Indeed, Gadamer (1975) debated this when he discussed the relationship between "reflexivity, method and insight".

My preconceptions were two-fold; those I already held before undertaking the study and those that arose during the interviews with the participants. I had previously felt that whilst the course I chose to study was entitled "Clinical supervisors training course" my experience led me to believe that some people attending did not know what the concept meant, had never had cs themselves and may have been directed to attend

by their manager. Due to these issues, many courses which I and colleagues facilitated were challenging. I wanted to test these preconceptions and also to discover if the courses did result in qualified nurses actively becoming clinical supervisors or seeking out cs.

My preconceptions within this study were governed by the fact that I supported cs and saw its value for practitioners. Whilst I previously cited that nurses may be too busy to engage in cs, from my own lived experience as both supervisor and supervisee I saw that it was essential to me personally and professionally. Holding this view meant that I must remain aware of the possible effects that my positive views could have on the interviews, participants' responses and how I then interpreted their lived experiences (a view supported by Kvale (1983) and Finlay and Gough, (2003). I became aware of the actual effects of my positivity when I undertook two "pilot" interviews with colleagues, I found it difficult to hear them criticise cs (ironically rather like myself in 1993, when I first encountered the concept). I wanted to challenge their negativity by pointing out that I too was cynical about the concept but nevertheless I sought exposure to cs before disregarding it. In some ways I felt personally attacked when they disputed the concept and its role in the nursing profession. Fortunately, I recognised this very early on in the study and, through discussion with my academic supervisors, I was able to harness these emotions as part of the hermeneutic process. Kvale (1996) described this as listening without prejudice. However, I would describe it as listening with awareness of prejudice. This resulted in me allowing participants to more fully express their experiences and thoughts with regard to cs. This degree of self-awareness was sustained throughout the study through the use of regular academic supervision and maintaining field notes. Through writing notes I was able to document my thoughts and feelings pre and post interviews. This included how I interpreted the participant's body language, as well as my own thoughts about the interview questions and how participants responded to them and to me. In being reflexive about my own prejudices and preconceptions (Ashworth, 1997), I was able to interpret the participants more fully and reach what

Gadamer describes as "fusion of horizons". Thus interpreter and interpreted came together and the hermeneutic process or circle was created (Gadamer, 1975).

4.2 The role of the researcher

Within qualitative research and a methodology that is underpinned by hermeneutic phenomenology, the researcher is an integral part of the research process (Kvale, 1996, Todres and Wheeler, 2001). According to Byrne (2001) the researcher should:

> "...provide an overview of his or her personal and professional perspectives and assumptions. At a minimum, it is important for the research reviewer to know the gender, class and ethnicity of the researcher." (p 208)

Byrne (2001) suggested that by providing this information the reviewer will have a clearer understanding as to why a particular phenomenon has been chosen and make the interests of the researcher visible. For example Moustakas' (1990) phenomenological study on "loneliness", came at a time when he had to make a decision whether or not his daughter should have cardiac surgery and the life/death dilemma this posed. Furthermore, Carolan (2003) and Pellat (2003) both identified their personal and professional interests which led to them researching respectively, older first time mothers, and decision making within spinal injuries patients. In keeping with this, I would inform the reader that I am a white female, from a working-class background, a qualified nurse (previously a senior nurse manager in intensive care) and I am currently a lecturer in nursing. Furthermore, this concept was selected because of my interest in the phenomena being investigated. This personal interest in a subject is a theme, which is reportedly common in doctoral nursing studies (Drew, 1989, Lowes and Prowse, 2001).

4.2.1 Becoming a supervisee

In 1993 cs, was first presented to me as part of a module for a degree course. The presenter stated that it had support from the UKCC and DoH and that it could take

place in the working hours. I expressed the view that the concept was unrealistic as nurses were too busy to have cs during their working day. I believe my view was influenced because I was then working full-time in an inner city intensive care unit with real time pressures (high workload and staff shortages). However, there was something about the concept that intrigued me. I believe I am flexible and open-minded and this resulted in me seeking a supervisor and commencing cs.

Initial sessions were challenging for me, with my supervisor expecting me to give some thought to the work related issues chosen for discussion. This supervisor was rather prescriptive (for example, telling me where I had made mistakes and how to act in future). At that time I felt I needed a more reflective and supportive supervisor. As a result I changed supervisors after twelve months.

My second supervisor undertook the role very differently. I began to feel that this was my time to openly discuss my practice, sharing my strengths and weaknesses, and seeking ways of improving practice. This was the first time that I had felt both supported and yet challenged by another professional. I have now been having cs for thirteen years and fully endorse the concept. Personally and professionally it has helped me to develop my reflective skills and be more objective about the way I functioned as a nurse at that time and in my current role as a lecturer.

4.2.2 Becoming a supervisor

Commencing as a lecturer in nursing in a HEI, my experience as a supervisee led me to undertake the cs training that my employers facilitated to local Trusts (both NHS and PCT). Following this training I was able to offer cs to the healthcare staff for the surrounding Trusts. Initially, I used my own supervision to enable me to develop as a supervisor, providing my supervisor with selective issues that had been discussed with my supervisees. As my confidence grew in the role of clinical supervisor I used my own supervision session less to confirm my actions. I continue to act as a supervisor

and see it as a two-way discussion on practice issues. Furthermore, I began teaching on the two and three day cs courses as well as writing the curriculum and gaining accreditation for a level three degree module in clinical supervision for qualified health care professionals.

Having decided to undertake a PhD, the idea of a study, which would combine my interest in cs with a research study, appealed to me. Initially, I saw the proposed study as an opportunity to evaluate the impact the clinical supervisors training course had on participants who had attended. My original aim was to interview staff prior to commencement of the course (to ascertain why they were undertaking the course), immediately post course (to enquire what the experience had been like) and three to nine months later (to see whether or not they were now acting as clinical supervisors). I felt that the shorter duration courses (two and three days) would be the most appropriate to examine, as this format of training is most widely offered nationally (Butterworth et al 1997).

To conclude, Burke Drauker (1999) criticised how authors of Heidegerrian hermeneutic research rarely discussed any self-reflection of personal experiences, which would contribute to the interpretation. Using reflexivity in this way I hope to achieve rigour Carolan (2003) describes this process:

> "Self reflection or reflexivity, as a means of understanding the impact of the researcher's views and values, is increasingly seen as a valid means of adding credibility to qualitative research."(p8)

4.3 Rationale for the focus on clinical supervision

I think that my preconceptions support the rationale for choosing to research cs. Whilst my own motivation and enthusiasm were a major driving force for this project it would

have been a pointless journey if it had been widely researched and reported upon already within the nursing literature. Indeed, one of the major reasons for undertaking this study was the limited work to date, particularly in terms of longitudinal studies. I was not aware of any existing studies in which course participants, senior managers and supervisees have been interviewed to ascertain their "lived experience" of clinical supervision.

4.4 Research aims

The original aim of the study was to interpret the lived experiences of qualified nurses who had undertaken the cs training. However, after transcribing and analysing the initial nineteen interviews, I became aware that the focus of the study was changing. My aim shifted to interpret why some nurses do and some do not wish to engage in cs. This resulted in a fourth set of interviews in which I purposely selected from the nineteen participants, those whom I believed might provide the reason or information of why they did or not wish to be involved in cs.

In line with Heideggerian phenomenology, as these interviews progressed and were subsequently analysed I became aware that there were other questions from other types of participants, which might explain this phenomenon of the reluctance of nurses to actively engage in cs. This led to further interviews, this time with nine senior managers. The aim was to capture and interpret their experiences of cs and ascertain whether they sensed any resistance in establishing the concept in the Trust. Whilst these managers provided a different perspective, overall there remained a negative response and reluctance towards embracing cs.

I was aware that there were nurses who were actively engaged in cs. As a result I sought a third phase to the study in which I interviewed six recipients of cs to understand what their experience was like and why they engaged in the process.
The successive sets of research aims were to:

- understand how participants experience clinical supervisor training.
- understand the process and experience of senior managers who had the authority to either implement cs or choose staff to attend training
- interpret the lived experience of cs from a supervisee perspective
- understand why individuals may or may not engage in cs

The fact that the aims became modified during the study I believe to be consistent with an interpretative phenomenological study (Kvale, 1996).

4.5 Sample

In an attempt to make this research honest and reliable, importance was attached to the sample (Miles and Huberman, 1994, Hammersley and Mairs, 2004). Higginbottom (2004) has criticised qualitative studies, which have lacked transparency in the sampling technique. As a result, in this study, attention focused on the type of sampling (which links with the methodology of phenomenology), as well as providing the reader with the characteristics of the sample and how they were accessed. The sample of participants within this study was obtained purposively. According to Streubert and Carpenter (1995):

> "...purposeful sampling is used most commonly in phenomenological inquiry." (p43)

This means that they had been specifically chosen because they had experienced the phenomenon of cs either as course participant, manager or recipient and hopefully would provide rich sources of data. Price (2003) further explained that selection for a phenomenological study results in the researcher being:

> "...concerned to find the right participants who can tell an authentic story about the phenomenon experienced. To this end ideal participants have experienced the phenomenon, can give an articulate account of their experiences and are content and comfortable to share their observations with the researcher."(p26)

The sample identified came from two urban Trusts, a community PCT and an acute NHS hospital, both of whom purchased clinical supervisor training courses from the same HEI provider in the North West of England. Access to the sample was negotiated in conjunction with the HEI and at Director of Nursing level with both Trusts.

Awareness that there was potential for researcher bias (a criticism which I have levelled in the literature review at other studies including those by Rafferty and Coleman, 1996, Morcom and Hughes, 1998), led to the decision not to teach or take part in any of the planning of the two identified courses. However, I must acknowledge my prior historical involvement in developing the two and three day courses may have had an impact on any negative remarks participants made. In my defence of this potential bias, I would argue that I was aware of it at the onset of the data collection and so took steps to maintain my neutrality (Cutcliffe and McKenna, 1999). Hand (2003) argued that neutrality is impossible in qualitative research, as the researcher cannot be separated from the investigation. Nevertheless, I attempted to do so, by being aware that the interviews were an opportunity for me to understand and interpret the participants' individual experience of cs, whether this was positive or negative. Furthermore, I consider myself flexible in regard to any course and recognised the need for evaluation.

Following the first stage of data collection the study culminated into three distinct stages with all participants originating from either the Community or the Acute Trust.

Stage 1	19	Course participants	(C)	from a total of 39 approached
Stage 2	9	Senior Managers	(M)	from a total of 10 approached
Stage 3	6	Supervisees	(S)	from a total of 6 approached

All the participants other than one (an occupational therapist) were qualified registered nurses with clinical experience ranging from one month to over twenty five years. Please see table on pp120-122 indicating range of specialities.

Nieswiadomy (1998) reviewed sample sizes for phenomenological studies in 1996 and concluded that they usually varied from six to twelve participants. Similarly, Payne (1999b) stated that a smaller sample size is more acceptable in qualitative research as one is more concerned with the richness of the data rather than representativeness. Sobal (2001), concurred with this view but also stated that because of the richness required, the term sample size should be viewed as an oxymoron.

The total number of interviews undertaken for this study was seventy-five, which is acknowledged to be high for a phenomenological study (Gom, Needham and Bullman 2000, Brink and Wood 2001, Higginbottom, 2004, Donovan and Sanders, 2005). However, I believe it was of necessity and relevance to the study itself, to respond to the initial findings and seek further clarification regarding the phenomenon of cs thus extending the sample size to include the managers and the supervisees. Indeed, Coyne (1997) and Higginbottom (2004) have both commented that there is no perfect way of sampling and that the process evolves as the study progresses.

My intention was to immerse myself in the data and from it identify significant statements which would then enable me to provide the reader with an exhaustative interpretation of the phenomenon of nurses' reluctance to have or give cs. This ultimately supports why I chose to undertake so many interviews with different groups of nurses within the two Trusts. The result was that the sample size increased from 19 to 34 participants.

Whilst the initial participants appeared to enjoy the course, I also interpreted an overwhelming sense of reluctance to implement, but no solid reasons as to why this was

so. This reluctance I believed was an important aspect to the whole concept of cs. However, despite re-interviewing six participants on a fourth occasion I was again left with new questions. It resulted in seeking other participants who could provide a different perspective, the managers and later the supervisees.

By extending the interviews to include, managers and supervisees and tracking the course participants, I was provided with rich data that I believe gives this study a unique perspective.

4.5.1 Sample stage one: Course participants

4.5.1.1 Recruitment

Two courses were scheduled to commence a month apart. Both courses potentially had twenty students enrolling. I was provided with a list of course members and subsequently wrote to them all, seeking volunteers for the study (please refer to Appendix 3). I followed the letter up one week later with a telephone call. It was at this point that I ascertained whether or not the potential participants had received the letter, understood the request and if they had considered taking part in the study, as well as to answer any initial questions they had about the study. I emphasised, not only in the letter but also through the telephone conversation, that the interviews would be audiotaped, would last for approximately 60 minutes and that there would be a series of three interviews over a twelve-month period. I stressed that confidentiality and anonymity would be of paramount importance and that, although I may highlight their role within nursing (e.g. district nurse, surgical nurse), their names would not be used and the employing Trusts would not be identified. The participants would be referred to in the thesis by means of a code consisting of a letter and a number and that, whilst the interviews would be audio-taped, they would be destroyed following transcription. I also explained that their participation was entirely voluntary, with them being able to withdraw at any time without detriment. With those who agreed over the telephone to take part, I was able to gain verbal consent and schedule the first interview, which I

followed up with a letter of confirmation. To protect the dignity, rights, safety and well being of research participants ethical approval was sought. Furthermore, written consent was also achieved at the first interview. (Please refer to Appendix 4).

Ethical considerations and ethical approval is discussed separately within this chapter.

4.5.1.2 Course participants

From the nineteen participants, sixteen took part in all three interviews, one participant left the Trust immediately following the course whilst the other two participants were only able to give two interviews due to work commitments and working across sites. Whilst no participant actually refused to take part, several course members were difficult to make contact with, either because they were community-based, or because they could not schedule the pre-course interview with me hence they were not involved in the study.

Time and other resource constraints governed the data collection as I was the sole researcher and, in addition to conducting the interviews I was transcribing them. I understand that this is not an unusual phenomenon (Holloway and Wheeler, 1996).

Price (2003:28) recommended data collection until such time as "similar accounts seem to recur again and again". However he also warned that whilst there is no fixed number of participants, it is the end quality of the depth of description to the phenomenon that will judge its worth. I feel that whilst a purposive sample was used in this study a point where no completely new ideas were emerging was also encountered.

4.5.1.3 Extending sample one interviews

Through consultation with my academic supervisors following the reading of the previous transcripts and analyses, eleven of the course participants were selected for a fourth interview. It was thought that these individuals may provide further rich data

with regard to their attitude to cs. From these eleven participants, six were positive and five negative. The five participants negative towards cs appeared confident in their rejection of the concept and willing to discuss their reasons for these views. By choosing these particular participants I was utilising a strategy which Polit and Beck (2005:272) referred to as following on "confirming" and "disconfirming cases" and they further stated that:

> "The sampling of individuals who can offer conflicting viewpoints can greatly strengthen a comprehensive description of a phenomenon." (p334)

I decided to stop at the five negative accounts, as I believed they were all offering the same information and no new information emerged. In regard to positive accounts, I was looking at a balance of opinion and whilst I noted six (from the eleven) as being positive I was only able to interview one of these participants as one was on maternity leave, two off sick and two had other logistical problems which prevented scheduling a fourth meeting. This resulted in six participants who agreed to the fourth interview (one positive and five negative).

4.5.2 Sample stage two: Manager participants

Having interpreted the lived experience of course participants, I became intrigued by the fact that cs had not been fully implemented within both Trusts. I believed it valuable to interpret the lived experience of cs from the perspective of the senior managers from the same two Trusts. These participants were selected on the basis of the data collected and interpreted in Stage 1. Polit and Beck (2005:271) would describe this sample Stage 2 as an example of homogenous sampling in which there is: "...a deliberate reduction of variation to permit a more focused inquiry."

4.5.2.1 Recruitment

Initially I chose two Directors of Nursing from the two Trusts, an assistant director of nursing and three senior strategic managers whose remit it was to introduce cs and

purchase training. Following the same format as the course participants, I wrote to all six and followed up with a telephone call. Five of the six agreed to take part. The sixth participant manager had moved Trusts and declined to reply to letter or telephone messages. A further four managers of directorates were also included in this group because they all had responsibility to sanction whether or not staff could attend particular courses (including clinical supervision). This resulted in a total of nine managers participating in this part of the study. The manager interviews were similarly audio tape recorded, field notes maintained and analysis undertaken.

4.5.3 Sample stage three: Supervisee participants

Overall the managers expressed favourable opinions about cs as a concept, but in reality it was felt that clinically based nurses were not actively engaging with it. I wondered whether my own experience of cs was as usual as I had first thought. Was I the only person who had cs as well as acting as a supervisor? I wanted to interview further and this time chose qualified nurses who did have cs. This was partly to understand what they felt about it and if they saw any value in participating in the process.

Initially I thought it would be difficult to identify supervisees as there was no database available within the two Trusts indicating who was having regular cs. However, I was aware that some individuals offered cs to nurse practitioners within the two Trusts. As a result I sent an email to a range of individuals indicating that I was seeking participants for my study. I asked if they offered cs to any staff members of the two Trusts and, if these individuals might be interested in taking part in my study. Three individuals responded within the following two weeks and stated that they had two supervisees each, all of whom were interested to hear from me and had agreed to their supervisor providing me with their name and contact details. Again, as in the other two stages, a letter was sent out to these six potential participants and followed-up one week later with a telephone call. All six agreed to be interviewed individually and meetings were

arranged. This form of sampling has been termed "snowballing" (Streeton, Cooke and Campbell, 2004), and was reliant on individuals referring others to me. I sought further (and was granted) ethical approval before interviewing these supervisee participants (please refer to appendix 6).

To conclude, the sample within this study comprised of nineteen course participants, nine managers and six supervisees (three of whom also acted as clinical supervisors). This provided me with participants who could discuss cs from a training (course participants), organisational (managers) and direct (supervisee) perspective.

The tables below provide the reader with a visual record of the number of participants in relation to the two Trusts as well as the numbers of males and females who took part. There was no conscious decision to attempt to represent both genders and from the tables it can be seen that the gender differential tends to mirror qualified nurses nationally (NMC, 2005).

Table 1 Number and gender of Course participants

Trust	Total Number (19)	Gender Male	Gender Female	Interviews 1-3	Interview 4
Acute	10	0	10	8	3
Community	9	2	7	8	3

Table 2 Number and gender of Manager participants

Trust	Total Number (9)	Gender Male	Gender Female
Acute	5	1	4
Community	4	1	3

Table 3 Number and gender of Supervisee participants

Trust	Total Number (6)	Gender Male	Gender Female
Acute	3	1	2
Community	3	1	2

The following table indicates the speciality to which the participant belonged and clinical grade at the time of the study. This I believe demonstrates the diversity of specialities among those who took part in the study.

Table 4 Speciality of Course participants

Acute			Community		
Speciality	Grade	Total No	Speciality	Grade	Total No
Midwife	G	2	District Nurse	E,G	2
Occupational Therapist	Senior 1	1	Community specialist nurse	I	1
Medicine	E	1	Mental Health	G	3
Surgery	F	1	Health Visitor	G	3
Gynaecology	E	1			
Mental Health	D,E F	3			
Intensive Care	G	1			

Table 5 Speciality of Manager participants

Acute Community

Speciality	Grade	Total No	Speciality	Grade	Total No
Director of Nursing	SM	1	Training and development	SM	2
Assistant Director Nursing	SM	1	Mental health	H	1
Special projects	SM	1			
EMI	SM	1			
Intensive care	I	1			
Theatres	I	1			

[Only clinical grades added all others SM= senior manager NHS scale]

This table does appear to be skewed towards the acute Trust however there were difficulties accessing the community Trust at the time due to reorganisation.

Table 6 Speciality of Supervisee participants

Acute Community

Speciality	Grade	Total No	Speciality	Grade	Total No
Orthopaedics	G	1	CPN Manager	G	1
Palliative Care	H	2	CPN	E	1
			Intermediate Care Manage	G	1

4.5.4 Participants

Cohen et al (2000) identified that the term "subjects" should not be used in phenomenological research. They stated their preferred term was "informants" as they inform the researcher about their experience. Streubert and Carpenter (1995) on the other hand argued their preference was either "informant" or "participant". I see the

term informant as being one-sided, in that they tell something to the researcher who then unravels it. I believe that the term "participant" more suitable within this study because it gives a sense that they are not only sharing their information but by relating their lived experiences they have become part of the analysis. This partnership between researcher and participant enabled me to share tentative analysis, checking out whether this was a true interpretation of their experiences. Therefore for the purpose of this thesis they are referred to as, "participants".

4.6 Timetable for data collection

I have included a timetable of dates when the interviews for particular participants took place.

Table 7 Stage, code and number of interviews

Stage	Participant	Transcript Code	Number
1	Course	C	1-19
2	Manager	M	1- 9
3	Supervisee	S	1- 6

Table 8 Interview Timetable

Date	Stage	Acute	Community	Total Interviews	Cumulative Total
	STAGE 1				
April 1999	Pre course	10	9	19	19
May 1999	Post	10	9	19	38
Oct 1999-April 2000	6-12mnths	7	9	16	54
Oct 2000	18months	3	3	6	60
July-Dec 2002	Stage 2 Managers	7	2	9	69
Dec 2002-Feb 2003	Stage 3 Supervisee	3	3	6	75
Total		40	35	75	

4.7 Interviews as a method of data collection

According to the literature regarding data collection approaches, the research interview is the most appropriate method for data collection in phenomenological research (Diekelmann, 1992, Rose, 1994, Baillie, 1996, Holloway, 1997, Lowes and Prowse,2001, Wimpenny and Gass, 2000, Kvinge, Gjengedal, Kirkevold, 2002).

Clifford (1990) defined the research interview as a face-to-face meeting in which the interviewer questions the interviewee and this can take place in-groups or as individual interviews. More recently interviews have been described as a time of verbal communication, which also takes account of the increasing use of telephone interviews (Burns and Grove, 2001, Smith, 2005). I chose qualitative semi-structured interviews with open ended questions.

By deciding on a hermeneutic approach I felt that a one-to-one interview would focus solely on that individual's experience. This meant that I could concentrate specifically on what that participant was saying before formulating my next individualised question (Rose, 1994). Furthermore the interviews at phase one were sequential which meant that they occurred over different time points which Todd (2006:343) described as an opportunity to capture "the evolving experience."

4.7.1 Organisation of the interviews

Overall the literature describes the types of interviews that are used in qualitative research in relation to how tightly structured they are (Robson, 2002). They may be unstructured, semi-structured or structured to the point that they can resemble a questionnaire, (Rose, 1994, Holloway, 1997, Wengraf, 2001, Polit and Beck, 2006). For the purpose of this study a semi-structured interview approach was adopted, as it appeared to have more relevance to how the experiences of the participants could be captured.

Clarke (1999) suggested that there is no such thing as an unstructured interview because the researcher will come to any interview with some broad areas to discuss with the participants. Bearing this in mind, whilst not employing a list of questions, I focused on some broad areas in relation to the participants experiences of cs, but I was also guided throughout by what individual participants wanted to disclose. Thus I was seeking to explore the person's subjective interpretation of the phenomenon of cs.

4.8 Interviewing the participants

For any interview there needs to be preparation beforehand (Rose, 1994). I wanted the participants to talk about their actual experiences taking me along their journey without my guiding them excessively. Then, as the study progressed and recurrent themes emerged I began to develop key areas that I wanted to ask the participants, a view which is supported by May (1991).

4.8.1 Preparing for the interviews

When I was preparing for the interviews, I found the advice of Easton, McComish and Greenberg (2000) regarding use of equipment beneficial. They cautioned against the use of complicated equipment to audiotape interviews. Furthermore they stated that human error or ignorance in using the equipment could potentially result in the non-recording of the interview, frustration of the interviewee and embarrassment to the researcher. Bearing this in mind, I made a checklist of the equipment, which I used prior to each interview.

4.8.2 Initial telephone contact

During the telephone conversations with the participants, once they had agreed to take part in the study, I requested a face-to-face meeting at their convenience and in the location of their choice. I hoped that, in letting the participants choose the location for interviews, I would minimise their anxieties about the process, although it sometimes heightened my own!

4.8.3 The interview process

I was conscious of the need to be punctual (Wengraf, 2001) but found that participants (especially those working in the community) were considerably further away than others and often in quite isolated areas.

I explained again that the interview would be audio-taped and that we would have to be somewhere relatively quiet and free from interruptions. All, except two interviews, (the third with a course participant and one with a manager) were undertaken in the participant's place of work. The other two interviews were undertaken in the HEI at the participants' request because they felt that this would involve less disruption and greater available time.

On reflection, although I successfully minimised equipment failure, environmental hazards in the workplace were less within my control. This was sometimes problematic resulting in pagers, bleeps and telephones sounding as well as other interruptions. When this happened the interviewees tended to apologise and request that the interview continue when the noise stopped. Alternatively they spoke to people who interrupted pointing out that they were busy speaking with me.

Whilst all the participants within the study appeared keen to take part I was aware that there was a degree of apprehension. I reassured them and used open-ended questions to enable richness in the data (Price, 2003). This resulted in them being able to take control within the interview and I was able to convey to them my interest in their lived experience of cs. In this way I wanted to understand the subject area from the participant's frame of reference as well as allowing them to:

> "...voice their genuine views, opinions and feelings without constraint."
> (Hallett, 1995:56).

All the interviews were audiotape-recorded and then transcribed. This method was preferred due to the difficulty envisaged in note-taking whilst listening attentively (Clarke, 1999). Although some participants were initially anxious with regard to being taped I found that this was soon forgotten and that, as advised by Bowling (1997) it had minimal effect on the research.

The interviews were interactive. I was attempting to gain as much information as possible from the individuals by a process which has been termed "guided conversations" by Schatzman and Strauss (1973). However, as the study progressed the interviews became increasingly focused and I sometimes probed in response to what participants said in relation to particular areas (Sullivan, 1989/99). For example, some participants were concerned about the legal and ethical responsibilities of the clinical supervisor. Morse (1989) supported the use of focus by researchers and described it as an attempt:

> "...to explore areas of special interest, begin to test preliminary findings or begin to look for areas of commonality and differences in respondents' stories." (p192)

4.8.4 Being an Interviewer

The success of any research interview is dependent on the ability of the researcher to interact with the participants (Kvale, 1996, Wimpenny and Gass, 2000). Consequently the researcher requires proficient interpersonal skills (Beck, 1994, Todd, 2006). Indeed Jasper (1994) commented that these skills comprise:

> "...the use of reflection, clarification, requests for examples and description and the conveyance of interest through listening techniques." (p311)

When I first commenced this study I thought that I had good interpersonal skills. This related to my clinical experience as a qualified nurse in intensive care, I believed I had developed my skills in a way which made me an effective communicator. I not only communicated with patients but also with their relatives (at a time of crisis) and with

other health professionals. Furthermore in my current role as a lecturer in nursing I facilitate both practical and theoretical sessions with students on how to communicate effectively. As a result, whilst relatively new to research, I felt that I had sufficient interpersonal skills to undertake one-to-one interviews and to be able to actively listen and encourage others to share their thoughts and feelings. In reality, I had limited experience as an interviewer. As a result I piloted my first two interviews with colleagues who were going to undertake the clinical supervisor's course in the near future. I became aware of my own verbal cues and tone when playing back the tape. One participant was looking forward to the challenges of the course but the other indicated that they were being sent by their manager and had little interest in the concept. As a novice researcher, I realised that I was very positive towards the willing participant, smiling and nodding when she spoke and possibly affirming that what she said was the "right answer" to the questions posed. In comparison the other participant appeared to be resistant towards cs and I found myself becoming irritated, and unsure about how to question in the correct manner to avoid disclosing this irritation. Whilst I was unable to find any reference to this problem within the literature, I did discuss my difficulties within academic supervision.

Following these pilot interviews I learnt to adopt a more non-committal, non-judgemental approach to my interview technique (using neutral expressions such as "umm", "uh" or simply slight nodding rather than expressing "yes", nodding vigorously or smiling when a participant said something that I agreed with). Schatzman and Strauss (1973) have provided researchers with an overview of these "tactics" in qualitative interviewing.

So whilst I initially felt competent to communicate with the participants, it was only when I began interviewing that I started to learn how to be an effective interviewer. Having now completed seventy five interviews, I think that my skills to listen and probe developed over this period of time, a view supported by Wengraf (2001).

4.8.5 Field notes

I kept field notes of my own thoughts, feelings and reflections as the data were collected. This helped me to preserve an increased level of responsiveness throughout the research process (Drew, 1989, Beck, 1994, Tuckett, 2005). Initially the notes tended to reflect my anxieties in relation to meeting with the participants and using the equipment correctly. However, as my confidence grew and I began meeting the participants for the second and third time, anxieties became minimal. I wrote in the notes my perceptions of how the interview was conducted and highlighted any new ideas/thoughts that were shared by the participants. This is in keeping with Koch (1994) who refers to this as a "decision trail" in which the researcher is clear about how and why the research progressed in a particular way.

4.8.6 Coding of interviews

Each interview was recorded on a separate tape and coded using a numerical system for each participant and an alphabetical letter. The first stages of data collection the course participants (C) were numbered 1-10 for the two day course (Acute Trust) whilst numbers 11-19 were the three day course (Community Trust). They also had a letter a, b, c or d to indicate first, second, third or fourth interview, (this lettering was for my own benefit in handling the data and was not used within the findings). The managers (M) were also numbered 1-9 and the supervisees/supervisors (S) numbered 1-6. In regard to the ethical considerations of confidentiality, I was the only person to have knowledge of the participant's names and numbers, which were kept separate from the tapes in my locked study. Their names were not linked to what they said and only I and a secretary (for the last eleven interviews) listened to the tapes. This is in accordance to the Data Protection Act (1998) and the Research Governance Framework (DoH, 2001d)

4.8.7 The data collection process

Initially I attempted to undertake three interviews a day. However I found that the process was more physically and psychologically demanding than I had first

anticipated. This was because I was concentrating, actively listening and responding with further questions as well as being highly aware of my own and the participants' body language. Ensign (2003) recognised that qualitative researchers, due to the nature of the role, were at real risk of burnout. As a result after the first six interviews, I reduced the schedule to undertaking only one interview per day. Whilst this slowed the pace of data collection, it gave me time to reflect, listen to the tape and to be "fresh" for the next interview.

Interestingly, during the first stage of data collection, I was apprehensive when I began interviewing and this was also evident with the course participants. However, following our first interview they and I settled quickly and the subsequent interviews were more relaxed with both the interviewer and interviewee having what I would describe as an open dialogue about cs. Field and Morse (1985) support this view that sequential interviews increase trust and the richness of that data.

Having completed this stage I thought that stage two with the managers would be less stressful, but this was not the case. I was more conscious of being a researcher and wanted to be viewed as a competent researcher who asked the right questions. I discussed my feelings of being overawed by my manager interviewees with my clinical supervisor, and this helped to alleviate some of my fears, especially the likelihood that they too (the managers) may have felt insecure with my questions.

The third stage of the data collection was the easiest set of interviews to undertake, possibly because it was, from my personal point of view, the least contentious. I was now asking supervisees to relate their experiences of cs, a subject they were eager to share with me.

4.9 Data analysis and interpretation

Kvale (1983:186) described data analysis and interpretation as a continuous *back* and *forth process between parts and the whole*, which is in keeping with the hermeneutic circle. According to Payne (1999b):

> "The objective of processing and analysing these qualitative data is to transform them into text and, as with quantitative processing, to categorise and code the text so that it may be interpreted to produce evidence and understanding."(p140)

As I chose one-to-one interviews as a method of data collection, ultimately the process of interpretation was one in which I examined all the transcripts and field notes, looking for consensus and themes (Jasper, 1994). In this way I attempted to interpret and understand the experience of clinical supervision from the participants' perspective.

The transcriptions for each tape took considerably longer than I had first envisaged, for example a forty-five minute tape took approximately five to six hours to transcribe, a view supported by Dearnley (2005). Transcription time appeared to be dependant on things such as a person's accent and the volume of individual voices. Wilson (2002), agreed, stating that the norm for a one-hour English interview transcription should take between three and six hours. As a result I found it impossible to transcribe each tape within a twenty four-hour period of having completed the interview, as suggested by Polit and Hungler (1991) or as soon as possible (Tarling and Crofts, 1998). Therefore, I set a time limit of one week to transcribe each audio tape, and this ensured that I was able to replay all the tapes prior to transcription and pay particular attention to the content, questions asked and responses given including the tone (Morse and Field, 1996). This also served to minimise transcription errors such as inaccurate punctuation and mistyped words because Easton et al (2000) warned that:

> "Mistakes can change the meaning of the phrase, making it appear to be the opposite of what is actually said. This could be due to missing or misinterpreted words." (p706)

Due to a combination of wanting to immerse myself in the data and lack of secretarial support I personally transcribed sixty-four (from a total of seventy-five interviews). Latterly, funding from my employer was available which resulted in a secretary completing the remaining eleven. Consent from these eleven participants was sought prior to the secretary transcribing the audio tape. The audio tape was labelled only with a number and the secretary agreed to maintain confidentiality from what she heard on the tape and remove any names if they arose during the interview (Cerinus, 2001).

Although transcription was laborious, it had a two-fold positive impact on the study. Primarily, it immersed me in the data, a view which Sullivan (1989/99) concurred with when she transcribed one-to-one interviews with seventeen participants detailing the phenomenon of bereavement for the partner in a same sex relationship. Secondly, it reduced the pitfalls of transcribing (Kvale, 1996). Bearing this in mind, I paid particular attention to the eleven transcriptions undertaken by the secretary to ensure the accuracy of what was said and what was subsequently transcribed, as recommended by Easton et al (2000).

During the transcription of each audio tape I made notes about my experience and the ideas that were stimulated upon hearing the participants' views. Wengraf (2001) writes that this process can only take place once declaring that:

> "In subsequent listening, the flow of stimulated memories and ideas is much less." (p209)

On completion, each participant received a letter thanking them for their participation, a hard copy of their transcription, which they were requested to verify and answer any questions that I may have posed to seek further clarification (Appendix 8). With regard to the course participants I found it of great value to re-read their last interview before the next. This helped me to focus on the individual, their last thoughts and feelings and to see if there had been any change and, if so, to seek further clarification.

4.9.1 Computer software

The literature has tended to advise readers that data may be analysed in two broad ways, manually or through the assistance of computer software (Nieswiadomy, 1998, Benton, 2000, Hutchinson, 2005). I did first consider utilising the latter but felt that having typed sixty three transcripts, I came to the following conclusions, primarily that I was suitably immersed in this manual process that I decided this traditional method was the better option, a view supported by both Morse and Field (1996) and Polit and Beck (2005). Secondly, I did undertake brief training using the NUD*IST Vivo (NVivo) computer package, and recognised that I would need a considerable time to use this package effectively, a view supported by Tait and Slater (1999). Furthermore, it would still leave me with the notion that I must also manually analyse the data to give it full credibility. Thirdly and possibly most importantly I decided that the manual technique was more in keeping with the authenticity of Heidegger and Gadamer and whilst computer programmes may be able to unravel and code text it may reduce the meaningfulness of the whole data.

In broad terms my views concurred with the work of Sandelowski (1995) who indicated that the use of computer software could adversely affect the art of qualitative work and warns researchers to be cautious when choosing to use computer technology.

4.9.2 Phenomenology and data interpretation

In relation to phenomenology, it would appear from the literature that there are different approaches for data analysis dependent upon which philosopher one wishes to be guided by (Fleming et al, 2003, Polit and Beck 2005). Researchers utilising a Husserlian approach would tend to analyse their descriptive data using the methods of van Kaam (1966) Colaizzi (1978) and Giorgi (1985) whereas the Hermeneutic schools of phenomenology would be more inclined to follow van Manen's (1990) method.

This study is being guided by the writings of Heidegger and Gadamer; as a result, an interpretive analysis is required. Diekelmann, Allen and Tanner (1989) appeared to offer an appropriate data analysis process to meet these needs. It comprised seven stages in which reading of the text, preparing interpretative summaries, and identifying common meanings as well as discussion with other researchers is undertaken. Fleming et al (2003) have criticised this work stating that:

> "...team discussion of the interpretation is used as a method to control bias, rather than identifying the biases that interpreters held, which Gadamer (1975) considers necessary for full understanding." (p116)

Bearing this in mind I was able to discuss my interpretations within academic supervision, but I would not use this team discussion to form the basis of my analysis. Instead I have utilised my academic supervisors to enrich and develop my understanding. This process Fleming et al (2003) consider useful in a Gadamerian approach to analysis.

4.9.3 Reflection on data analysis and interpretation

When I look back on the process of data analysis it was never a single one off event which would take place following all the interviews. Instead I undertook data analysis throughout the research process. Not only was I attempting to interpret during the interviews in which I was seeking clarification and understanding, but also when I was transcribing each interview, a view which Newshan (1998) concurred with. This style of ongoing analysis made the thematic/categorisation process less daunting, in that I was not suddenly faced with reams of text that I had not considered before. Tarling and Crofts (1998) agreed that ongoing analysis is expected, but warned of the danger that this may prejudice the data by either confirming a "hunch" or that a particular theme becomes of greater relevance because it "excites" the researcher. In regard to my own research I have already stated that initially I was against the cs due to time pressure and being busy and one could argue that I have fallen in to the trap that Tarling and Crofts (1998) warned of as, "time" and being "busy" did become a theme in the findings

chapters. However having been in receipt of cs this was no longer in the forefront of my mind and I genuinely believed that it did not prejudice me, but was a legitimate theme from what the participants had said in their interviews. Raw data are provided to support these interpretations.

Immediately post interview, I made field notes regarding key areas that the participant highlighted, as well as phrases they had used and their body language. I would then listen to the tape several times over a number of days, but on the first occasion I would make notes of anything that I felt was significant at that time. Next, following suggestions in the literature, I transcribed the interview in full (Wengraf, 2001). This was a particularly onerous task due to my limited typing skills. Once fully completed I would re-read the transcript as well as listen to the tape at the same time, this has been suggested in the literature as a way of the researcher becoming immersed in the data, (Holloway, 1997, Tarling and Crofts 1998, Wengraf, 2001). It also provided me with the opportunity to check that the transcription was a true reflection of the interview, as well as allowing me the opportunity to interpret the tone of what was said and add it to the margin of the transcript. Having re-read the transcription I would then highlight in red significant sentences and phrases. This included analogies and metaphors that the participants used. This attention to the linguistics is relevant to the writing of Gadamer and I believe that people in general use analogies and metaphors as a powerful vehicle in which they can "voice" their opinion. Whilst I claim within the findings chapters that participants at times were being inauthentic (eg p177-179, 211 qnd 242) and demonstrate this with excerpts from the transcripts, it must be remembered that these judgements were not solely made from these isolated comments but from the interviews as a whole.

One of my fears was that by undertaking this study on a part time basis I would not become fully engaged in the process. However, I believe that studying part time enabled me to be more reflective to my interpretations and prevented total immersion

which Riley (1990) warned could result in being too close to the data and not fully hearing what the participants are saying.

The process culminated in an analysis of the interview which would be my personal interpretation of what the participants had said. To ensure the trustworthiness and integrity of my initial and all subsequent interpretations, I sent each participant their transcript to comment on (McNiff, 2002) and for some I added questions in which I sought further clarification to aid my own understanding. Kvale (1996) commented that returning transcripts to participants is not without potential problems such as shock at reading their own words and feeling somewhat less intellectual. Within the study this happened on one occasion. A participant telephoned me regarding the transcript and expressed that they felt their accent came across quite powerfully and that this may be read by others as them being "less bright". I was surprised at the effect that the transcript had had on this individual as I did not make this inference within the interview; indeed, quite the contrary. Bearing in mind my ethical obligations to all the participants, I asked whether they wished to withdraw from the study alternatively I would remove the sections that they were unhappy with. The participant stated that this was not necessary; their main concern was that the whole transcript would be published. I reassured the participant that confidentiality and anonymity would be upheld and only selective verbatim comments would be published. This culminated with the participant agreeing to remain in the study and to allow any parts of the transcript to be used.

The analyses were not included as I believed that sending them might be counter productive and time consuming (Hammersley and Atkinson, 1983). In relation to participant feedback or "member checking" the literature appears confusing with some authors supporting the process and others opposed to it (Tuckett, 2005). Fleming et al (2003) stated that different researchers adopt different strategies, some returning the transcript, others providing initial analysis. Whilst I chose not to seek participant

validation of my findings, I have provided sufficient verbatim quotes and interpretation that the participants would be able to recognise and comprehend as pertaining to them, (Horsburgh, 2003).

My main concern was to be true to Gadamer's hermeneutic circle, which resulted in an open dialogue with the participants in which we both shared our understanding of cs. Ultimately I must accept responsibility for the final interpretation of the interviews which took place with all the participants and, as Price (2003) warned, as a researcher, I should be:

> "...extremely tentative about what can later be claimed about the phenomenon." (p26)

Both the transcripts and the analyses were sent to my academic supervisors; these were subsequently discussed during academic supervision as well as via email. Cutcliffe and McKenna (1999) gave arguments for and against this process. They stated that there maybe a false sense of security (if more than one person agrees with the categorisation then it must be right). On the other hand, it could be seen as challenging which would ultimately increase the robustness of the emerging categories and themes (McNiff, 2002). When I reflect on the experience of sharing my analysis with my supervisors (and supervision notes made at the time), I believe that whilst challenging, it was a positive decision which has strengthened my findings.

Once the interviews at Stage One had been transcribed and interpreted following academic supervision, the result was further data collection with senior managers; this became Stage Two. Likewise Stage Three following data analysis of Stage Two. This is in keeping with hermeneutic research which Gadamer (1975) describes as a movement from the whole to the part and back to the whole.

Having transcribed and analysed Stage One I began to search for themes or recurring regularities within this stage. This process was repeated for Stages Two and Three

respectively. Having now formulated themes from each stage I then searched for any key themes across all the stages; this has ultimately become the findings chapters. This final analytical step according to Polit et al (2001) means that:

> "...the analyst tries to weave the thematic strands together into an integrated picture of the phenomenon under investigation." (p400)

To conclude, the process of data interpretation was meticulous, with a plethora of authors suggesting different ways to handle the data. It culminated in me making key decisions that included;

- manually analysing the data.
- simultaneously collecting the data as well as making an initial analysis.
- coding all the interviews and identifying themes which would be identified not only at each stage but from an overall analysis.

4.10 Ethical Considerations

4.10.1 Ethical approval: The process

When this study commenced in 1999 obtaining ethical approval for studies involving NHS employees was less stringent than currently. Ethical approval was sought and granted from the University of Manchester and management approval was sought and granted from the two Trusts involved in the study (please refer to Appendix 5 for copies of letters from University of Manchester at and the two Trusts involved. To maintain the anonymity of these Trusts their names have been deleted).

As the study progressed and further interviews were identified with senior managers and supervisees, the rules about ethical approval had changed with the advent of Research Governance, (D.O.H, 2001d, and 2002b). It was now imperative to have full ethical approval for any research being undertaken within the NHS, even if this did not necessitate the involvement of patients. Management approval alone was no longer sufficient as the Department of Health, now required all researchers to complete an

ethical approval application from April 2002 (Please refer to Appendix 6 for extension of ethical approval). The participants in this study were all employed as either, midwives, qualified nurses or health visitors as well as one occupational therapist. However they fell within the catchment of two different ethics committees. I applied for ethical approval from one of the committees and (when granted) I then sought local approval from the other. Furthermore, a letter of explanation regarding the study and the ethical and local approval paperwork was also sent to the Data Protection Programme Manager in line with the Data Protection Act, (1998). Having agreed not to identify the participants and the Trusts involved in the study (thus maintaining anonymity) this resulted in my data collection falling outside the scope of the Data Protection Act (please see Appendix 7).

4.10.2 Ethics and research

In relation to research in the twenty first century I believe it should always include the four principles as outlined by Beauchamp and Childress (1994) which include:

- The principle of respect for autonomy
- The principle of non-maleficence (doing no harm)
- The principle of beneficence (doing good)
- The principle of justice

Throughout the study I was concerned to maintain Beauchamp and Childress' four principles. I will now explain as openly as possible the steps that I undertook throughout the research process to ensure that they were adhered to.

4.10.2.1 The Principle of respect for autonomy

A question and answer letter was sent to all those attending the two courses four weeks before commencement (please see Appendix 3). The aim was to provide participants with enough information to be able to understand, if they wished to take part, what would be required of their time and disclosure. It stated that, one-to-one interviews

would take place, their duration and following transcription the audiotape would later be destroyed and that anonymity and confidentiality would be maintained. Taking part was entirely voluntary and that the participants may later choose to leave the study without any coercion, (Brent, 1990).

It was followed-up one to two weeks later with a telephone call in which I enquired if they had received the letter and whether or not they wished to take part. If they decided to decline at this point they were thanked for their time and no further pressure was placed on any individuals to take part. If the participants requested more information this was readily given as well as explaining that the time involvement would be over a series of three interviews but again emphasising their choice to withdraw at anytime (Brink and Wood, 2001). At this point some participants readily agreed whilst others asked about the use of the audiotape and how I would maintain confidentiality. Written consent was also obtained from all participants before the interviews commenced (Please see Appendix 4)

In relation to confidentiality, Morse (1989) and Ensign (2003) believed that this is difficult to achieve in qualitative studies, as verbatim quotes from transcripts will be seen on publication. Whilst I concur with this view, I did explain this to the participants but guaranteed that I could provide anonymity through protection of their identity. I decided to code the participants rather than give them pseudonyms. In addition, to provide the managers (which included directors of nursing) anonymity, I refer to the Trusts only as an Acute or Community Trust in the North West Region.

Whilst none of the participants were distressed or disturbed by the interviews, several of the course participants did wish to speak to me after the interview about incidents that they would discuss, if they were in receipt of regular cs.

4.10.2.2 The principle of non-maleficence

The questioning or indeed the process of interviewing the individuals may have resulted in them being unhappy with my line of questioning or the answers that they gave me. Again I attempted to reassure them, by being as sensitive as possible, without causing detriment to the production of rich data. I also explained that if they did make a disclosure, then their comments would be anonymised to maintain their confidentiality or if they so wished these areas of the transcript would be omitted. This was requested once by a participant who felt that her comments would be read in a negative way. Through discussion with her I ascertained which areas she was unhappy with and these were then omitted from the thesis, she then gave her consent for me to use the rest of the interview transcript. Being facilitative, enabled me to respect her right of non-maleficence as well gaining her consent to use some of her comments within the thesis.

4.10.2.3 The principle of beneficence

The overall aim was to give nurses the opportunity to speak about cs in their own words from which answers and further questions may emerge. Ultimately, I saw the study "doing good" or being of beneficence to the profession in general. Furthermore I concur with Spradley (1980) in that I hoped that all the participants could gain something from the research experience itself. It was an opportunity for the participants to express their thoughts, feelings and experiences, as well as being listened to and valued as research participants, thus adding to the empirical research to date on cs. Nevertheless, I made it clear to participants that the research had not been intentionally designed to be of direct use to the participants.

4.10.2.4 The principle of justice

Whilst a novice researcher prior to this study, I did take relevant steps to safeguard the integrity of the research process through attendance at a level three research module, in-depth reading of major research texts and regular academic supervision in which the correct strategies were discussed prior to data collection. Following data collection the

process of transcription was adhered to fully so that all dialogue was recorded and I maintained field notes which included the non-verbal communication of the participants.

I believe that I have acted in accordance with Beauchamp and Childress' (1994) four principles. I have maintained confidentiality, anonymity, informed consent (Appendix 6) and the interpretation remains true to the interviews undertaken with all the participants within this study.

4.11 Rigour

In quantitative studies the need to demonstrate "rigour" has tended to focus on the reliability and validity of the findings. However, Hallett (1995) pointed out, qualitative research does not need to conform to these scientific terms and she, like many qualitative researchers referred to the work of Lincoln and Guba (1985, 1989) and an interpretation of their work by Sandelowski (1986). Lincoln and Guba (1985) offered the term trustworthiness as a way of providing rigour to qualitative research. By doing so it is suggested by Holloway and Wheeler (1996) that this will ultimately represent the reality of the findings. Although many of these writings are now twenty years old, they remain relevant and valuable for qualitative research.

4.11.1 Trustworthiness

Lincoln and Guba (1985) stated that trustworthiness can be achieved through four criteria; "credibility", "transferability", "dependability" and "confirmability". Whilst many authors refer to these criteria, there tends to be confusion with what they exactly mean. The term "credibility" for example is seen by many to relate to being a true reflection of what the participants understand of the phenomenon (Hallett,1995, Ashworth,1997) which is enhanced with the use of direct quotes (Fleming et al 2003). However, Newshan (1998) has tended to focus on the credibility of the researcher and their involvement in the field. Interestingly Koch (1994) wrote that credibility involves both. She stated that the researcher must be self-aware in their description and

interpretation (which may be achieved through the use of a journal), as well as being in consultation with the participants in relation to the analysis.

For the purpose of this study I have provided the reader with the evidence of both my own credibility and how the participants recognised the truth of the findings. The ultimate aim was to avoid misinterpreting what the participants have said during the interviews. Through the use of textual direct quotes, my aim was to provide the reader with enough material so that they could make a judgement on the credibility of the findings, a view supported by Fleming et al (2003).

In relation to transferability, again there is some confusion with some authors referring to it using the term "fittingness" (Sandelowski, 1986, Fleming et al, 2003). Overall, Bogden and Biklen (1992) describe transferability as being the thick description of the phenomena and that this is clearly understood by the reader in a way that permits them to "transfer" it to be of relevance to their own practice. I believe this will be demonstrated in the findings and discussion chapters, whereby, I give verbatim extracts from the transcriptions with detailed interpretations, some of which have been discussed with the participants but all with my academic supervisors.

"Dependability" appeared to be a less contentious term with authors describing it as a clear audit trail (Sandelowski, 1986, Koch, 1996, Holloway 1997, Newshan, 1998) from which the reader can follow the path the researcher chose to take. Finally, "Confirmability" relates to the ability of the researcher to demonstrate neutrality and awareness of their own potential bias (Hallett 1995). Holloway (1997:161) described this as "the equivalent of objectivity". I have addressed this throughout the thesis particularly within the sections relating to my presuppositions and reflexivity. Addressing my own prejudices and preconceptions will, according to Lowes and Prowse (2000), demonstrate the rigour and trustworthiness of a study which claims to be underpinned by Heideggerian phenomenology.

For the purpose of this study and their prevalence within the literature, I decided to follow Lincoln and Guba's (1985) four criteria to demonstrate the trustworthiness of my thesis. However, I also felt that Watson and Girard's (2004) work was worth some consideration. They argued that it is inappropriate to use language from the quantitative paradigm to focus on rigour in the qualitative paradigm. Furthermore they commented that the language used must reflect the research method. They offered "*Integrity*" as a more suitable term for researchers utilising the works of Gadamer and they stated that:

> "Integrity, for us, is congruent with a Gadamerian tradition in that it represents the notion of wholeness: wholeness as interpreted by both the researcher/interpreter and the participant."

Furthermore:

> "...language is the fundamental mode of expression our being-in-the-world, so when the participant shares his or her story of an experience with the researcher, it is expressed with honesty as long as there is openness in the approach to the dialogue. As researchers, we bring our own preunderstandings or prejudices to that story, so we, too, are interpreting and sharing our understanding of the experiences with honesty." (p877)

By demonstrating integrity I concurred with Watson and Girard (2004), that I and the participants brought our own preunderstandings/prejudices to the fore during the interview. This resulted in what Gadamer (1976) referred to as *"fusion of horizons"* which resulted in clarity of meaning and understanding.

To conclude, a sense of trustworthiness and integrity are interwoven throughout this thesis. I feel that these relate not only to the qualitative paradigm but more importantly to the works of both Heidegger and Gadamer which have been used to guide this study.

4.12 Limitations of the study

Hammersley and Mairs (2004) stated that there is no perfect research and that all projects are open to some criticism but there must be an aim by the researcher to demonstrate:

> "...our research as honest and reliable as possible within the restraints of time, budget and human resources." (p4)

Bearing this quote in mind, this study was no exception. Before commencing this study I had limited knowledge of the research process and as a result on many occasions I felt that I was on a steep learning curve. However, through undertaking a research methods training, attendance at Masters and PhD student presentations and regular in-depth academic supervision I kept limitations to minimum. The main limitations to this study include the following areas;

4.12.1 Sample

Being a phenomenological study the findings cannot be generalisable, However, I would defend the fact that I used a larger sample of participants than would usually be seen in this form of research methodology and although not generalisable I did reach a level of "saturation", whereby I was confident no new findings were being added.

The sample overall consisted of the course, manager and supervisee participants and it may have been beneficial to interview the supervisee's supervisors as well. However, from the six supervisees interviewed, five also acted as supervisors thus I contend that I probably captured the supervisors experience as well, given the time constraints and the fact that I was the sole interviewer.

Another limitation related to the supervisee sample is that four of the six engaged in one-to-one cs, whilst the other two had triad supervision and so I did not capture the lived experience of group supervision other than S5 and S6 disclosing difficulties that they experienced leading to their rejection of group clinical supervision.

4.12.2 Heidegger and Gadamer

As I cannot speak German I was reliant on book translations of Gadamer and Heidegger. According to Fleming et al, (2003) this can sometimes result in misinterpretations of the translated word. It would also seem that there are numerous interpretations of how phenomenological studies should be undertaken with no definitive structure. However having read authors such as Crotty (1996) and Corben (1999) criticism of nurse researchers who have claimed to follow phenomenology, I was in some ways forewarned.

Another potential limitation is one which Pellat (2003) referred to, as the tension that can arise when a researcher studies their own culture and is unable to remain objective. Whilst I openly admitted that cs was something I was familiar with as a supervisee, supervisor and facilitator of courses, what I was studying was not my lived experience but those of the participants in the study. Whilst I reflected on my own experiences I believe that this demonstrated my reflexivity and a Heideggerian approach in which I was also part of the research process.

4.13 Conclusion

The aim of this chapter was to provide the reader with a clear rationale and explanation of why and how the data were collected and interpreted for this research study. To fulfill this aim I have guided the reader along my decision making trail. This began with the rationale for choosing to study cs, my own involvement in the concept and my initial aim to understand the lived experience of course participants who have undertaken clinical supervisor training. From the initial data collection the aim changed and developed, I wanted to understand senior managers and supervisees experience of cs in two Trusts. This ultimately resulted in my interpretations of why some practitioners might or might not engage in cs.

Throughout the research process I have provided the reader with an analytical and honest account of the decisions I chose to make. As far as I am aware I have upheld my ethical responsibilities and I have been mindful of the limitations of this study.

Chapter 5

Findings: Trust

> "Most of the time we trust without being consciously aware that we do, for none of us is self sufficient, and we rely on persons, objects and institutions to help us obtain and retain those things in our life that matter to us. Trust is of central importance to the lives that we lead, since it forms the basis of all interpersonal relationships..."
>
> (Pask, 1995:190)

"Trust" is nebulous and includes objects/concepts and institutions. In relation to clinical supervision (cs), the notion of "trust" or "distrust" was described by the majority of participants within this study.

Through handling the data when I examined all quotes which pertained to trust a series of themes emerged which were subsequently divided into

- The idea or concept of cs
- The supervisory relationship
- (Lack of) trust within the organisation

This chapter presents these sub themes of trust using excerpts from the transcripts to support my interpretation. The three groups of participants (course, managers and supervisees) will be discussed within each sub-theme.

5.1 The idea or concept of clinical supervision

Whilst cs has been widely reported on, there is evidence which suggests a lack of understanding concerning its nature and purpose (Basset, 2000, van Ooijen, 2000 and 2003, Bush 2005). In relation to this study it would appear that the lack of clarity in defining cs resulted in some participants rejecting the concept.

5.1.1 What is a concept?

Concepts are not solely ideas but mental pictures constructed in the mind (Walker and Avant, 1996). Jasper (2002) agreed and commented that concepts are abstract in nature. He demonstrated this by asking the reader to explore the word "marriage" as an example of a concept. Jasper (2002) argued that

> "The words you have written are likely to have arisen from your own experiences of marriage...So although we have an understanding of the concept of "marriage", the word and its meaning are likely to possess different components for each individual." (p497)

Similarly the concept of cs within this study appeared to result in differing mental images by participants which was problematic for some, due to their linking the terms with negative connotations. In the context of this study "concept" overlaps with "phenomenon", as both consist of ideas which can exist in the mind.

Course participants suggested that they did not trust the concept because of the name it has been given. These participants likened the term "clinical supervision" to:

- Overseeing, inspection and management
- Counselling

Indeed, the manager participants, whilst understanding the concept themselves, believed that practitioners would reject it, citing that it would be misinterpreted and some would view it as counselling.

5.1.2 Trust and Terminology

5.1.2.1 Overseeing, inspection and management

Course participants adopted a literal translation of the word "supervision" and overall it appeared to have negative connotations.

"...but supervision means someone supervising you. That means somebody who supervises is in a position of control where it should be an equal relationship, a partnership." (C2)

"I suppose it is not a very good term because supervision implies you are going to be disciplined if you have done something wrong..." (C15)

These quotes tend to link cs with control and with the supervisor being in a powerful position over the supervisee, rather than in a partnership.

Many course participants linked cs to management and for some this may have led to rejection as they feared their managers might want to oversee their practice and criticise, rather than make an attempt to incorporate a supportive concept into their working lives.

"I know some of the group I trained with, when I did the course, were having to have it off their managers. They were just told they were going to and that is what clinical supervision to me suggests and it is not very useful because you wouldn't tell anyone anything that you thought you were going to be disciplined about would you?" (C15)

Interestingly, as far back as 1992 Kaberry warned that if line management and supervision were not clearly defined then:

"...nurses may fear that showing their mistakes, failures and negative feelings about patients would be detrimental to future promotion." (p39)

Conversely, some course participants did not find the terminology confusing and provided me with their interpretation of the concept.

"I think clinical supervision is about getting people to think through the incidents or problems more themselves and probably be less prescriptive and allow them to sort of reflect back what has happened without the emotions being involved...People can think through something logically about why something happened, what can happen in the future." (C18)

I believe this quote demonstrates the participants understanding of cs and how it relates to the time to reflect-on-action. She suggested that the concept is a way of improving the person. In my third interview with this course participant she had attempted to set-up cs with a group of health care assistants and was herself actively seeking a supervisor. Some manager participants also echoed that the terminology had negative connotations, which could then lead to distrust by practitioners.

> "I also think that clinical supervision is the wrong title. Whenever you ask people about clinical supervision they always say it's about someone watching my practice."(M3)
>
> "Yes I think the word supervision itself has always been a problem...But yes the word supervision has connotations that someone's supervising you telling you what to do, which is not what presumably it's all about." (M5)

Using the term "presumably" may suggest that this manager is unsure about cs and that it may possibly be about control. Later in the interview he admitted his own confusion and suggested that if, as Director of Nursing, he had difficulty, then "frontline staff" would probably be bemused by the concept.

> "After a year I said "what is this all about sort of thing" and I guess if I thought that the frontline staff must have had a bit more difficulty...I can remember people saying this is another way of appraising, another way, another big stick you know."(M5)

He appeared to be aware of the negative views people held regarding the terminology but was unable to explain what steps he took to dispel them.

The supervisees also recognized that the terminology probably led to a diminished uptake.

> "There seems to be this lack of understanding of what clinical supervision is. I feel that people feel that clinical supervision is something scary, something that they have to feedback to ...I think that they're missing the real point, that, it's about support. I see it and I use it as support for me. Somebody there, somebody that can offer me whatever I feel, whatever I bring to it..." (S6)

She described her cs as an opportunity to discuss practice and a space to explore, examine and possibly make sense of her work in a constructive and helpful way. So, whilst many course participants and managers perceived cs as potentially being a negative experience this supervisee saw it as support.

One supervisee described the cs he received literally, as being supervision of his clinical work.

> "Well in my case it's exactly what is said. It's supervising my clinical work. It's a critique of my clinical work hopefully constructive critique... sometimes it's very valuable to say you're leaving yourself wide open there, you really should do something about that, that's very, very useful." (S2)

This participant was a manager working within a community mental health team and the cs he received appeared to be case supervision. From the literature, case cs (in which supervisees would discuss a small caseload of clients and seek to discover ways of improving or changing the care they provided) is very much the norm within mental health (Duncan-Grant, 2001).

5.1.2.2 Changing the terminology

As a result of the confusion engendered by the words cs, many participants provided me with their ideas of more appropriate alternative titles. In relation to the course participants an alternative terminology emerged during their cs training

> "...the OT Department have renamed it "practitioner support" and I quite like that."(C3)

> "What both teams call it is 'practitioner's support' and I think that sounds really nice. "(C7)

> "Clinical support might be... but "peer support's" better, even if you are just with one colleague or a group, something like support." (C15)

Similarly Willson et al, (2001) identified that in their study, the community nurses of North Argyll changed the title to "practice support". One course participant offered that

for cs to take place it would be better not to give it any label or description but for the process just to begin. Her rationale was that other nurses may simply copy behaviour.

> "...not even saying "this is clinical supervision", just doing it, just letting it happen and see if people will copy because people copy good things, people copy bad things as well."(C2)

The manager participants were aware of the confusion that the name created (and its potential rejection by nurses within their Trust). I then asked what strategies they employed to clarify the concept.

> "Terminology we had a very wide ranging debate very early on about this terminology thing and about what clinical supervision was...probably it was a mistake at the time but we fudged it and I came up with a term "practitioner support". If nothing, I guess it reflected what its name was about which was about supporting practitioners."(M9)

> "I don't think the senior managers promoted it and I think you need to promote and reinforce... but they decided to change its name and I think that was the biggest mistake. It changed from clinical supervision...and called it practitioner support and that was a disaster. Everybody got totally confused so they then had to change it back to clinical supervision..."(M8)

The last quote indicates that changing the name to practitioner support resulted in even further confusion. Was this because the practitioners felt "conned" with managers repackaging a concept that they had previously promoted to them, thereby resulting in suspicion?

The terminology was of considerable interest to the participants of this study and for some participants it clearly resulted in their rejection of the concept as something they were unable to trust. Interestingly the terminology meant little to the supervisees. They appeared more mindful that they received regular and worthy cs with a supervisor who they could trust.

5.1.2.3 Terminology linked to counselling

Some course participants also highlighted the link between cs and counselling but the confusion may have stemmed from the course tutors.

> "I don't think the actual two things were explained it was very much saying that it wasn't counselling but there wasn't a "this is this and that is that". I think they were pretty confident that we all knew what the difference is."(C13)

> "They referred to it....they kept saying that it was not counselling but then every now and again saying about counselling you know, one of the tutors actually mentioned it quite a few times about counselling and even some of the terms, and that we used were things that are used during counselling and I just felt that put me off a bit as well."(C9)

> "Then another tutor said something about counselling "...and when you are counselling the clinical supervisee" and I thought well maybe she mentioned counselling so maybe that's what it is." (C2)

The course participants seemed to suggest that they wanted clarification of how the two concepts (cs and counselling) differed. Further confusion followed when a tutor on the course used the terms "counselling the supervisee". Is it significant that there was no clear distinction between the two concepts by the tutorial staff? And would this ultimately lead to a rejection of undertaking cs? Perhaps it was used as a barrier "I'm confused so I can't begin to have or give cs".

> "I definitely felt like when I came out of it and quite a few people felt the same that it was more like a counselling course, a cheap counselling course." (C9)

This notion of cs training being a "cheap counselling course" is interesting as a counselling supervision course tends to be modularised over a period of twelve months (Pocknell, 2001). In comparison this clinical supervisor training was facilitated over a period of two to three days dependent on the Trust. As a result the participants appeared cynical and suspicious that anyone could be fully trained in such a short period of time.

The issue regarding counselling and cs appeared to make a significant impact on participant C3 as she discussed it on successive interviews.

> "Like they said it definitely isn't counselling and then they brought somebody in to talk about Heron and all about counselling and then you thought hang on a minute the last session was all about how it isn't counselling and then next thing like they did a scenario of clinical supervision, it was counselling...They could have said here are the models and you may look at this one and say well that is all about counselling that's Heron's model. If you don't like that if you don't want it to be about counselling well okay lets have a look at this one here. Maybe if there was more of a structure to it, it could actually be more beneficial. Judging from people's reaction (on the course) those that had been confused before looked even more confused and those that had it clear cut felt more confused." (C3)

It would appear that she wanted to be taught the concept in a more consistent and truthful way. When the tutorial staff failed to meet her expectations, she indicated that it had an effect on other participants as well as her.

Participant C9 (who also viewed cs as counselling) believed that it was an attempt by the trust to provide counsellors.

> "I don't know I got the feeling at the end of it that the Trust was saying "there's no money for counselling courses. Right get them on a clinical supervision course. Right, you're now counselors."(C9)

Not all participants felt as strongly about the difference between counselling and cs and accepted what the tutorial staff told them.

> "We did discuss counselling. Some people did feel that supervision was similar to counselling, but it was pointed out that it was different but you do need some of the same skills."(C7)

> "The concept wasn't that easy to grasp, I understand it better now. I thought that it was more counselling than it really is." (laughs) (C18)

The next course participant recognised that cs was not counselling but the skills of a counsellor, namely active listening would assist an individual when they acted as a supervisor.

> "It's not counselling it's being there as an ear and a supporter. But you know I think a clinical supervisor without the skills of counselling the act of listening the empathy the congruence, you know wouldn't be an effective clinical supervisor." (C6)

A similar view was held by a course participant who was currently undertaking a diploma in counselling.

> "I think counselling looks at psychology and feelings and thoughts...I think in all aspects of our work we use counselling skills but not counselling that's therapy as such. Clinical supervision, I think, incorporates some of those counselling skills but at the same time I think it looks at problem solving."(C12)

So it would appear that the similarities between the two concepts, counselling and cs, polarized the views of the course participants. Those participants who were unhappy with its connotations of counselling showed a degree of reluctance to undertake cs. Participant C2 suggested that counselling focused on personal issues and her concern was that during cs personal problems may surface.

> "Yes I think so as counselling is more to do with personal things, relationships. But then again, I think a lot of that can arise within clinical supervision process as well, so I think it's a fine line really."(C2)

Furthermore she added

> "I don't know this is really judgmental but I think people still have the impression that there is like a stigma around people going for counselling as if that is somebody who can't cope or sort out their own life or their own problems...and then when you bring in clinical supervision people think that I'm going for this because I can't cope with a certain situation."(C2)

The participant gives an account of what "people" think of counselling and this leaves me to wonder whether she is being inauthentic. If she had been being authentic she may have spoken in more personal terms. Conversely, another participant saw that having

counselling in the shape of cs could be of benefit. She saw the role of a nurse as stressful and cs as providing some support to practitioners.

> "People think that counselling is when you're mad and there's something wrong with you whereas I think that you're brave enough to admit that you need some support and I think most of us do because I think in our job we would benefit from, like counsellors have to have supervision."(C15)

My own understanding is that the clinical supervisor may use skills, such as empathy and active listening which are normally associated with counselling. They might even utilise a counselling model, but the difference is that cs is concerned with practice issues and not the supervisee's personal problems.

The supervisees described how they saw the boundaries of both cs and counselling becoming blurred and this was acceptable to them.

> "...counselling supervision is more about what I think; it's more about me as an individual, personal problem. Although I have used clinical supervision for personal problems because I am a great believer if you've got personal problems you can't move on in development. So I suppose that I say that I've used it in both." (S6)

> "...for clinical supervision a clinical supervisor needs to have counselling skills. I suppose it's difficult isn't it trying to tease out what's what. If I'm having clinical supervision I suppose I can quite clearly put into categories things that I think are counselling supervision and the things that I think are clinical supervision."(S5)

From the nine managers transcripts only two quotes (from the same manager) identified any specific mention of counselling.

> "I know the difference, you know you're not a counsellor and that's again what goes back to why people are a little bit fearful of it because they think it is a counsellor that they're going to see or a manager as well, you know. How far will they go with disciplinary? "It's an issue I am uncomfortable with I don't want it to go to disciplinary I want to talk about it." (M1)

> "I think a lot of people see a counsellor as someone who taps the hand and don't worry dear it will be alright type of thing. I think the word counsellor gives them a different picture in their head really." (M1)

This manager suggested that practitioners may be reluctant to have cs as they see the supervisor as either a counsellor or a manager both of which they believe would result in fear. Furthermore, if practitioners see their supervisor as a counsellor this may be a fairly innocuous, possibly patronising relationship.

Few managers discussed the possible link (and sometimes confusion) between cs and counselling. This may be because cs had originally been introduced nationally, within the confines of the document *A Vision for the Future- the Nursing , Midwifery and Health Visiting Contribution to Health and Health Care* (DoH, 1993). The terminology within this document was that cs was described as a formal process with outcomes to include competence and accountability. It did not appear to be linked with counselling and personal therapy.

5.2 The supervisory relationship

5.2.1 Defining "trust"

In cs "trust" is a major requirement for both supervisor and supervisee (Bulmer,1997, Consedine, 2000, Gilmore, 2001, Weaks, 2002, Knutton and Pover, 2004a, Cerinus, 2005).

According to Collins English dictionary (2001) the term trust can be defined as:

> "*noun*...confidence; firm belief; reliance; combination of business firms; care; property held for another...*verb*...rely on; believe in; expect; hope; consign for care."(p575)

This suggests that for a person to trust another requires a high level of confidence that they will be treated humanely, sensitively and with respect. The findings from this

study identified that those participants who were not having cs, either did not trust anyone to be their supervisor or did not trust themselves to be a suitable supervisor. In contrast, the supervisees were able to trust their supervisor and some became supervisors because they believed they could be trusted to act in the appropriate way.

Trust between individuals and people cannot be undervalued as Bevington et al (2004) state:

> "Trust retains employees, reduces transaction costs, inspires loyalty and builds morale. If people trust one another and their leaders, they are more likely to share information and work through disagreements, take smarter risks and be more innovative, admit mistakes and give or receive constructive feedback." (p28)

Having considered the data relating to trust and the supervisory relationship these were again refined and further subdivided into the following areas

- Choice of supervisor
- Informal/formal supervision
- Discipline of the supervisor

5.2.2 Choice of supervisor

If the quality of the relationship is pivotal to cs then choice of supervisor is clearly an important consideration. The majority of participants within the study discussed the need to choose someone that they could trust with the issues they brought.

> "Well I think it's important to get on with your supervisor not as a friend but have some rapport with, I think that's important." (C11)

> "I think you need somebody who you feel able to discuss things with and somebody who will be non-judgmental that will be able to guide you."(C7)

> "...the girl that I would pick is very very approachable very trustworthy and very laid back, she's got a couple [supervisees] so I think I'd talk to her."(C9)

> "Put it this way not everybody you would find approachable. I know in clinical supervision you're supposed to be able to choose your supervisor, but what if there were one or two people and you think yeah I could go to them and tell them

> something and it wouldn't go any further. But there are certain people and you think there's no way even though they've got their name down on the register." (C2)

This participant indicated that there were certain qualities that she would look for in a supervisor but she had concerns about confidentiality and alluded to the fact that the existence of a register of staff who had undergone training did not necessarily mean that these were suitable supervisors. Potential supervisees require reassurance before making an informed choice. They need to be satisfied that the person that they choose is trustworthy and without this they are reluctant to have cs. Interestingly this participant may also have been verbalising her own fears that having undergone the training, her name is now on the register and she worries that if chosen as someone's supervisor, she will have to maintain confidentiality.

One participant explained that she knew what qualities she was looking for in a supervisor and suggested that it was a process of identifying a practitioner's suitability for the role before making her choice.

> "I just hung back and waited and watched how they did their work and I found somebody who I felt I could have a good conversation with, who understood my sense of humour, (laugh), as well, and whose work I felt was, you know, was of good order."(C7)

Taking the time to carefully consider a suitable supervisor was something another participant, new to the Trust, failed to do. This appeared to have led her to make a wrong choice.

> "I thought about changing my supervisor...It's just the way the supervision is going, it isn't really my way to go and maybe we need to have a conversation. So I thought what I'll do is give it a period of time. I am going to say this to him say about 6 months and if he doesn't improve you know.... if I am not getting anything out of it..." (C16)

This participant disclosed that her supervisor was in fact her manager. Due to her "newness" in a middle management role she wanted to have cs so much that when he offered, it seemed to be her best option. Undertaking the training led directly to her reflecting on and appraising her own supervision, a view supported by Jacobs (2001).

A course participant explained that she had chosen a potential supervisor who was also on the same course as herself.

> "I have actually.... the boy [name] who was on the course and I am hoping to start with him. He is in our Trust anyway... just because I felt really comfortable with him and I think he did with me as well."(C15)

She referred to her peer as a "boy" which does not seem to "fit" with how others choose their supervisor. He was in fact her peer who she had chosen to be her supervisor because he was enthusiastic and she felt a certain amount of comfort with him. This implies the potential for conflict or misunderstanding.

Over a series of interviews with the course participants they took me along a journey of doubts that they would find a suitable person who they could trust. Some admitted that they had not tried to find anyone because there was either no one that they believed would be a good enough supervisor or they themselves were too busy.

Two course participants, having recognised that there was distrust in choosing a "good enough" supervisor, suggested a vetting procedure prior to staff being allowed to attend the supervisor's course.

> "I am not sure if there maybe should be some sort of interview for it but there certainly should be people who are interested in carrying it forward, otherwise it seems a waste and a shame for other people not to have had the opportunity and maybe it would be with an understanding that your name will go somewhere and something positively done about it."(C15)

> "I think that people who are to be supervised should be more closely chosen, ...but I think there should be some process and I think possibly you think there is

with the management but I don't think there is so there should be a sort of process of assessment which makes the person doing it think about it."(C19)

Neither participant indicated who should undertake this process of interviews. If there was greater selection of attendees, would this necessarily raise the status of the supervisor? Possibly, names that were entered on to a register would be viewed with greater credibility by the staff within the Trust. Would they then be satisfied that a stringent process of supervisor identification prior to training had taken place and would this result in greater trust of the supervisor?

Another possibility is that staff may not trust the format of cs that they receive. A course participant identified that staff may feel less trustful of having group supervision.

".....but there are people, especially in health visiting, there's a lot of people in their fifties and older who are suddenly going to retire in a few years and then there is people like me fairly newly qualified and I know a lot of those people do look down on us as "we are the ones with the experience and you are not". So in a forum like that you wouldn't dream of saying "oh I've seen this child, what do you think". They would say "oh that's because she is only newly qualified and yet she is doing this, that and the other." (C15)

This quote from a health visitor five years qualified indicated that she was fearful of having group supervision with more experienced health visitors because that might highlight her own inexperience and make her feel she is being treated negatively.

Whilst some managers within the study saw that group supervision would be of benefit to staff they did recognise that the seniority of staff supervising needs to be similar to the supervisees for it to be effective.

"If I introduce it, it will be more group supervision and I don't see me as the supervisor because I smack too much of management even though I'm the clinical lead. So it needs to be someone nearer to them and I don't necessarily think it should be the ward manager possibly an F grade or an E grade but I think it should happen and the students should see it happen. The students should be involved so that it

becomes an in-built culture. But I think it should be group and realistically once every three months." (M8)

Interestingly three supervisee's comments did not appear to concur with this approach. Their initial experiences of peer group supervision led them to abandon it and seek one-one supervision instead.

"The group supervision I think, I personally think is a bit of a waste of time only because I see it as a forum for people to sit down and have a natter rather than do anything constructive. I would much rather receive one-to-one or small group like this with one or two people."(S2)

"...the people there had different needs that needed to be met and they couldn't be all met in that group because there was some conflict. We tried it once, we all agreed at the end that it wasn't really helpful to us. People are different in culture, in attitudes and I certainly felt that I couldn't come with my little piece of me, it wasn't safe." (S6)

"Suddenly there was a forum to be open and honest and some people were open and honest and other people didn't want to hear the open and honest people and I think that it was desperate, it really was desperate, it was a terrible time....and we decided that we couldn't go down that route anymore. I think we did two sessions and then that was it we called it a day, the people in fact there were in tears, there were tears and hurt and sadness...I think that I would be very reluctant to try group supervision again because of that experience." (S5)

Whilst these experiences led them to all reject group format it did not deter these particular participants from having one-to-one cs.

Whether course, manager or supervisee participant it would seem that those actively having cs all had had initial poor experiences of it but had persevered in choosing the "right" supervisor:

"I had a clinical supervisor originally whom I must admit I wasn't terribly comfortable with, I think as a supervisor this person was good but because I'm a person that needs a good two way interaction and a person that cares I think that person put more energy into doing the clinical supervision ie supervisor and I didn't feel that I was getting that...erm.. personal contact." (S6)

"Their approach was quite authoritative and it wasn't sort of a nurturing experience. It was more I had to report back to this person as to what I had been doing. So that all had negative bells ringing." (C5)

The "bells" appeared to act as an alarm for her to change supervisors. However, it did not stop her seeking more effective cs from a more senior occupational therapist.

This study suggests that the choice of supervisor is pivotal to cs and that many of the course participants did not wish to undertake it in case they chose the wrong supervisor. Despite this, others were still prepared to undertake cs (even following poor experiences). Interestingly, five of the supervisees were in fairly senior roles and I wondered whether their professional resilience meant that they were better equipped to seek out a supervisor who would meet their individual needs.

Managers also saw that the supervisor required certain qualities if they were to be effective:

"I do think whoever is your supervisor has really got to be somebody that wants to do it and the person I chose did want to do it."(M2)

"...to be a supervisor you've got to be a good listener. I also think that you could also experience difficult situations and dilemmas and have to make difficult decisions and then you've got this responsibility and I think people shy away from that." (M8)

Another manager was able to give an example of how the initial set-up of cs resulted in the wrong match of supervisor and supervisee.

"Even in the pilot we found a really good example of two people thrown together that really didn't want to be together and it was disastrous. It just fell flat, issues were never brought, issues were never discussed and the blame culture was built into those two people." (M7)

This manager recognised that the "right match" needs to be made between both supervisor and supervisee. He later verbalised that he saw value in the concept, wanted staff to undertake cs, but was unsure how this could be appropriately facilitated.

A different manager stated that nurses know who they can trust and that undertaking the supervisor's course would not necessarily result in a change in someone's behaviour. Furthermore she did not think that practitioners could gain the skills from a two or three day course, but that these qualities were inherent.

> "There does seem to be a theme that you can take people through the programme. They can offer themselves as supervisors but at the end of the day if they're not seen as an approachable person, a nice person, a decent person, nobody's going to go and put themselves forward and have a relationship with them... So in other words the two day programme doesn't change someone's personality." (M6)

Interestingly these quotes from the managers are a result of their own lived experience of cs, either as a supervisee or in the implementation of the concept within the Trust. This could be construed as them offering a more rounded opinion.

The supervisees having gone through the process of choosing a supervisor disclosed that they looked for a supervisor with certain intrinsic worth. Overall their supervisor should be non-judgmental, respected in their role and have a sound knowledge base.

> "She's someone I'm not afraid to offload to who won't judge me in any way and she doesn't." (S3)
>
> "I know there is actually someone there that I can go to and be quite truthful knowing that I won't be judged on that and knowing that that support is there. It's also my space for exploring where I'm going to and exploring it and having a sounding board and having someone who'll challenge some of the things that I'm thinking of doing but will also pat me on the shoulder if I'm sort of going the right way."(S5)
>
> "I think a good supervisor needs the human touch... I think they need to be able to let go of outside influences and lead that person according to their individual needs. I think they need to have good listening skills good knowledge"... "I know who I

can trust and go that step further with and I certainly find that in clinical supervision." (S6)

It would appear that a certain amount of deliberation and thought is involved in the process of choosing a supervisor. Some supervisees wished to have cs outside of their field. Initially some did not know the supervisor and the qualities that they may or may not possess. Furthermore, the supervisees highlighted this when they discussed how they made their decision.

"It was somebody that I was aware of and had known for some time during my professional career as a Staff Nurse, who I didn't work with that closely but from my contacts with them, I always found them to be quite challenging. Actually, I suppose in some ways I was quite in awe of them. I respected them greatly for their work. But I didn't go straight there because there was an element of me not wanting to have that challenge I thought would come with that if that person agreed to be my supervisor."(S1)

This supervisee appeared authentic in how they chose their supervisor. They clearly identified the positive qualities (of the supervisor) but this also conjured up some apprehension that they may not be ready for the challenge that may take place during cs. Likewise, the next supervisee knew of their supervisor beforehand.

"...well in actual fact she was my ex team manager but I must stress that it was me that approached her for clinical supervision it was very much on my part. The reason I went to her is because she had a very good reputation."(S2)

Conversely this next participant was at lengths to describe her lack of pre-existing knowledge of her supervisor and that having entered into the relationship it would seem that knowing them personally was not important. However, what was important to this supervisee was that the relationship worked and from her perspective she was receiving effective cs.

> "I don't know her socially, I don't know her personally, I don't know her at all really you know I only see her an hour every six weeks. I don't know anything about her apart from that, her position but I've had more from her than any line manager that's without a doubt."(S3)

Knowing their supervisor beforehand suggested that not only did they trust them but there was also professional respect that whilst this person would challenge them within cs they would support, acknowledge and affirm them as well. Knutton and Pover (2004a) supported this view, although cautioned that it could lead to difficulties in the relationship as the supervisee may feel inhibited from taking responsibility to learn.

Overall, the supervisees were extremely positive about their chosen supervisors and needed minimum prompting to disclose positive features of the relationship.

> "I've got a wonderful supervisor, she's understanding she's knowledgeable, she's got a broad base of understanding, you know experience and I've found her both helpful in support and in guidance and development...I think I would be lost without her." (S6)

> "I've been having clinical supervision for probably a year now and I have to say I was quite sceptical before that and my knowledge base wasn't great. But I went into a new role and I felt quite threatened in the new role and quite challenged and I thought I needed some assistance and it was recommended to me. So I sought out a supervisor and I went through that process and I found it to be very positive. I found it at the beginning to be quite daunting and quite challenging. It was a bit scary really to actually go along and tell people or disclose to people some of the fear about your own professional abilities..."(S1)

This supervisee appeared honest and open in terms of recollections about first seeking cs and the fear it engendered within him. But despite his scepticism and the challenges, he still decided to undertake cs. I wondered whether the overriding reason was the change of role and with it recognition that formal support was the only option. This was demonstrated by another supervisee who appeared to be drawn towards cs as a way of support and an attempt to understand her new role:

"I didn't do anything for a long long time and then I'm a job share and my colleague was going through the same feelings that I was going through. We were very lost I suppose. We didn't really have a lot of direction, nobody gave us any objectives...So she was feeling it as well, so I thought God one of us is going to have some sort of help here as we were both going along blind really." (S3)

Unfortunately the supervisors of these supervisees were not interviewed to ascertain their views regarding the relationship and if they valued the experience as well. Five of the six supervisee participants also acted as supervisors and they stated that by having cs themselves was helpful to how they functioned as a supervisor (for example, understanding the need to challenge in a constructive and supportive way).

One supervisee in palliative care acted as a supervisor to ward-based nurses caring for the terminally ill. She believed the supervisees had chosen her because they saw from a distance how she worked with patients and relatives and respected her. Also, they appeared to trust the fact that she had a sense of objectivity because she was not part of the ward staff.

"...I'm also a clinical supervisor and I like being there with that person...I would like to think that's because I've built up a relationship.... and they think that they can share with me and that they can trust me and that they feel that I will be good for them and I often get stopped on the ward and asked have you got a space for clinical supervision". (S6)

Overall the participants appeared to be in agreement in relation to the qualities of the supervisor: ability to listen, be non-judgemental, challenge and support. What is unclear is why some participants actively engaged in the process and others did not.

As the interviews with individual managers and supervisees were undertaken only once, I feel that I have captured only a "snapshot" of their opinion and experience. In comparison the course participants were interviewed on at least three and sometimes

four occasions. Whilst the majority of the course participants did not subsequently engage in cs many did explain their attempts and failure to do so. This suggests they did not simply reject the concept. However, my field notes, recollections of the interviews and audio-tapes left me with the view that these participants not only valued the cs training, but also saw the concept as being worthy of exploration. Whilst some did not try to find a supervisor, they explained that it was due to either their inability to choose the right supervisor or lack of time.

Whilst the literature discusses at length the types and models of cs, little to date has been reported on how supervisees choose their supervisor, although there is agreement that the supervisees make the choice. Indeed, Cerinus (2005) observed from her two year study on the role of relationships in effective cs that choice was fundamental to comfort in the supervisory relationship. Once comfort was established this led to trust and confidence between supervisee and supervisor. However, it could be argued that the only choice taken by the majority of nurses is not to undertake cs. The reluctance of nurses to have or give supervision may be partially explained by the following quote.

> "It's difficult challenging yourself and it's very difficult gaining that personal insight into where you are and what.....That takes maturity, not about age about maturity and I'm not sure that everybody wants that. I think that we have some good nurses out there and some want to just come to work and do their job and go home, you know. I suppose should we expect the same from every single nurse like "what's caring?". Caring can be putting a drip up or caring can be the surgeon cutting it out with no communication skills, I suppose it's about getting a balance and clinical supervision may not be right for everybody no matter how we might parcel it up." (S5)

5.2.3 Informal/formal clinical supervision?

The formality of having cs, on a set agreed date and time, served as a barrier to some course participants. They argued that they felt that they already had cs regularly on an ad hoc basis from their peers.

> "I think that nurses have always done it in their own way in the tea room and I think that goes on, you know and I think that's a help to most people getting it off their

chest talking amongst themselves. I mean there may come a time when something mega happens when you really need someone to go to and that's to me there should be somebody there but you shouldn't be forced to go." (C9)

"I do yes and I feel that I get a lot from it because it isn't formal, ... "I think it occurs usually at coffee times or break time and people will just throw something into the ring."(C13)

These quotes link directly to the literature in which practitioners have written about cs being nothing new as previously they used the "tearoom as a sanctuary" to "vent problems" with colleagues (Mahar, 2005) or that it already exists on an ad hoc basis (Kopp, 2001).

The health visitors within the sample appeared more likely to state that they have regular informal cs.

"It didn't seem to warrant speaking to management about it so as a first port of call I spoke to one of my colleagues we had about an hour together to look at the issues and in fact we did resolve them." (C12)

"Yes, because we sound things off amongst ourselves. So we're quite a tight knit clinic here. We have that ability and I think probably looking at it, I've done Health Visiting for ten years and if you look at the sickness rates and things within this clinic they're a lot lower than in other areas. I think that's because we can offload and you are getting input from your colleagues and ideas." (C13)

However, this is only these participants' opinions based on their experiences of working within a small team of health visitors. In comparison another health visitor did not feel that where she worked there was effective informal cs.

"I think if someone was referred to me for clinical supervision I'd be happy but in our group because we get on so badly personally and professionally, I don't think that we could have a constructive hour long session without pulling people to pieces." (C15)

Furthermore, she disclosed that the atmosphere was so bad within the team that she felt bullied. By the fourth interview, she had moved teams and appeared happier, stating that she was having informal cs from one of her colleagues.

The acute Trust participants also felt that cs was practiced informally amongst colleagues. But was this simply professionals seeking clarification and support rather than something more tangible and as formal as cs? The course participants' views tended to favour informal support. This is contrary to the writings of Kaberry (1992) who stated that informal supervision arrangements are

> "Unreliable, chancy and unprofessional." (p38).

Some course participants (supervisee, manager and course) clearly preferred to have formalised cs.

> "I go with a client that I want to discuss how I plan to solve a particular problem or look for suggestions of how I solve their particular problems." (S2)

This suggests that formal supervision provides structure and allows the supervisee the opportunity to focus on a particular client and problem solve to ensure quality of care. A manager participant concurred with this:

> "I think if it's done in a less formal way I think it can become a moaning session with a coffee rather than, right we've got this amount of time lets really get into a subject, let's really talk about what's happening out there in practice." (M3)

Conversely, another manager participant, whilst supporting cs and the need for managers to promote the concept within the Trust, added that she had external, informal supervision with friends.

> "Erm in a very informal way mostly I have friends who I can trust. It's loosely based, I wouldn't call it clinical supervision but it is along those lines. Erm but not from internally no... I don't think I would want anyone from another or within this Trust supervising me."(M1)

L "Why is that?"

Silence

"I'm here now as a manager now not a nurse manager which is very different and so I handle that I'd like to think in my own way outside of the Trust really as opposed to internally."(M1)

I did not manage to find out why friends outside the Trust were of benefit to this manager.

5.2.4 Discipline of the supervisor

The managers offered very little information about whether the supervisor should come from the same discipline. This may be because they placed more emphasis on their own individual and organisational thoughts about the concept. Similarly, the majority of supervisees placed little relevance on the discipline of the supervisor as long as they received supportive and challenging supervision, a view supported by Corrigan, (2005). Interestingly the supervisees all chose senior lecturers who they knew through previous courses or were recommended as being a good supervisor. Only one supervisee participant had a set view on the need for his supervisor to come from the same field of discipline (mental health) as himself, he explained:

"...I will stress this is only a personal opinion, that I would not go outside the mental health field for my supervisor. If I'm explaining to you that I'm having problems with this man's psychosis or these delusional ideas I don't want to be having to say to you this is what it is this is what it means and this is the problem."(S2)

Conversely, the course participants' views were mixed as to whether or not the supervisor should be from the same discipline as the supervisee. Indeed, Cutcliffe and Lowe (2005) commented that this is an area, which is underdeveloped requiring further empirical work.

A course participant (health visitor) explained why they would not want a supervisor of the same discipline.

> "I found from the training when we did the actually experiential thing I was with an RMN and I thought that was really useful doing it with someone different ...but I always feel as if it's of the same discipline as a hidden agenda in a way because obviously people either want to advise you or they say what they'd do whereas, if there's someone that isn't in your field they are just listening to you and they're not trying to tell you what they would do in the same situation." (C15)

She suggested that a same discipline supervisor may encourage inauthentic communication by discouraging the supervisee to reflect in an in-depth manner. Whereas if the supervisor is not from the same discipline they need to listen and possibly provide the supervisee with a more general, balanced response that may be seen as more authentic.

However, having undertaken the training, one of the course participants became aware of the potential to give advice and tempered their supervision with supervisees accordingly.

> "It's helped me to supervise them (health care assistants). I would have supervised them differently if I hadn't done the course. Probably I would have given them more advice. Whereas now I make myself not give advice, I bite my lip. Sometimes it can be difficult but it's something that I don't do... In the work they do themselves there are things that come up in the supervision ideas that have been generated. I hear them putting them into place in their everyday work so yeah I think its working okay and there's respect that's my reasoning."(C7)

She also provided a positive element to supervising junior staff in her department in that she saw them acting out ideas that they had discussed with her in cs and how it is enhancing practice.

Some participants who thought the supervisor should come from the same discipline offered the following comments.

"But I think it helps if it's somebody who's got knowledge of what your job is because I think it's much harder for them to appreciate your job or what you're trying to say about your skills if they don't have those skills themselves...But it would have to be you know it would be better if it was somebody who had the same skills as you and worked in the same environment."(C18)
"I'd like it to be someone who works in medicine, you know maybe they can understand more of what my role is on the ward and the problems I may have....But I don't think it will be somebody I actually worked with on the ward because I think that may be a bit too close and in a situation like that it may get a bit personal and gossiping or whatever..." (C10).

These participants appeared to believe that a supervisor from their own discipline would have greater knowledge of issues that supervisees may choose to bring. Nevertheless, the last participant mentioned that she would not wish the supervisor to work directly with her, implying that it could become less productive (or even threatening).

One participant chose a supervisor from her own discipline (district nursing), but recognised that fulfilled her needs. Ultimately she thought the decision of supervisor should be based on having the choice.

"I wanted someone from my own field. But I wouldn't dismiss someone who wasn't because you have got the choice... I think it probably depends on the issues that they want to bring up. Whether they want them within their own field or whether they just want the sounding board and it wouldn't matter it's an individual choice, which I think having been given the choice is something." (C17)

Within the training the participants were asked to re-enact issues in one-to-one cs sessions observed by other course participants. This appeared to have a significant impact on some. It enabled one participant to experience what it was like to have cs from a supervisor of a different discipline.

"When I did my supervision session when I was a supervisee the lady I had was a health visitor. Her problems are completely different problems than my problems. It was nice even though a lot of people say I couldn't have a health visitor supervising

me because coming from a different background they wouldn't understand but they do understand or at least if they don't understand they try very hard to understand." (C16)

Other participants had less positive experiences during the role re-enactment. For example, one supervisee discovered that the supervisor was junior in grade than she was this left her with the impression that the supervisor felt intimidated.

"When I said I was a care manager (acting as supervisee), I didn't realise the person I was speaking to (acting as supervisor) was a staff nurse and she said she felt a bit threatened by that. She sort of sat back when I said, but it was only because I was trying to explain my scenario and hadn't met before, I didn't say it to intimidate her."(C17)

Interestingly, a similar incident occurred within the acute sample, and led to the course participant feeling that they would rather supervise someone from the same discipline (mental health) but junior to her.

"I think it is lack of confidence yes, but I think its nice to start off not that I am sort of lowering the nursing assistants to me but obviously it doesn't make me feel as threatened." (C8)

However, it was not until the third interview that I possibly discovered why she held this view. It may have been as a result of her experience of role re-enactment on the course, whilst acting as supervisor she became aware of the seniority of the supervisee. The effect of this was that she believed she had performed poorly as a supervisor.

"I would like maybe to have another little role play because my first one I just didn't enjoy. I felt like crying afterward I thought "why didn't you give different answers?"(C8)

Another participant, present during this exercise, commented that whilst she herself learnt from witnessing this incident, she believed that this experience would have had a profound negative effect on C8

"Yeah the girl who brought the problem was fine she just went ahead and told her the problem, but after a couple of minutes, the girl broke down [supervisor, C8] she said "I can't go on", you know "I don't know what to say to her" and I think in a way that completely knocked her you know. From, then on she was saying "I'd never be able to do that". So I found it beneficial ... I don't think she'll ever forget it."(C6)

As a result of this experiential exercise it would appear that the course did not serve to empower this participant (C8) to become a supervisor.

Other course participants thought that a supervisee would be looking for cs from a supervisor who was either their peer or senior to them. Again would this indicate that supervisees are expecting a supervisor who can guide them?

"I think there is still a thing in nursing if you are speaking to someone junior than yourself then people don't feel comfortable with it. They want to speak to someone who's a peer or senior, that's what people have said to me I can't speak to them because they're only whatever grade."(C3)

Another course participant shared her views.

"For instance I know a health visitor that works with CPNs and I don't feel competent enough to tell them what to do. But having said that maybe it's not about telling people what to do maybe it's about listening to them and suggesting ways around problems... I think I feel more comfortable with people under me, doing it with me, rather than equal. Which I suppose is because I'm rather newly qualified."(C15)

The issue of not giving advice as a supervisor seems pertinent and a difficult task. This may not be too surprising as work by Morrison and Burnard (1989) indicated that nurses predominantly functioned in a prescriptive advisory role when they examined Heron's six category analysis. Is a learned behaviour within nursing to give advice to not only patients and relatives, but also to professionals in the multi professional team? It may be that this is a method of maintaining a distance and as such nurses can remain

inauthentic. Having undertaken the supervisors' course and being told that the role is not as an advice giver, would this act as a barrier in them becoming a supervisor as they would experience difficulty in not doing so?

The seniority of the supervisor also related to managers being present during the clinical supervision session. A course participant disclosed her early experiences of being a supervisee in group supervision, in which her manager chose to be present.

> "At the beginning our manager sat in the clinical supervision and I felt, well it was felt by the three of us who took part that we felt a bit uncomfortable because there were issues we wanted to bring up." (C8)

I considered that she may have been placed in a situation of "throwness" with her manager choosing to sit in on her supervision. As a result she may have defended herself by acting inauthentically during the sessions. She may have wished to avoid disclosure of any difficulties she had because in some ways she feared her manager's reaction and needed to protect herself. Acting inauthentically (bringing innocuous material to cs whilst her manager was present) I think was this participant's attempt at protecting herself and colleagues and avoiding appearing incompetent. Another participant (although not receiving cs at the time) appeared to suggest that she would protect herself similarly, if the supervisor was either her manager or chosen for her.

> "I'd rather not have it but if I did I'd think of a really superficial issue which I wouldn't really need any advice but just go through the motions of doing it."(C15)

Furthermore, a manager within the study shared a comparable example but this was from the perspective of herself as a manager who (like the course participants' manager) decided to sit in on her own staff clinical supervision.

"...this is going to sound awful to my junior colleagues that I have, but I felt sometimes that I'd sat in on their clinical supervision because when they started doing it I was helping them get things off the ground and I just didn't think a lot of the stuff they were bringing was appropriate for the clinical supervision setting."(M3)

Her intention was to help them commence cs although she recognised that her staff were being inauthentic with the material that they brought. This ultimately led to the cs sessions ceasing to take place. This may suggest that she did not trust her staff to actively engage in peer supervision which was something that she was in receipt of herself and valued.

"...I have peer group supervision and that's what we chose to do and the trained staff now they have peer group supervision. I find that a better way to go about things because I feel then you've all got to take equal responsibility for your group meeting and whatever, you're not sort of coming in and expecting someone to sort of give a judgment on your work or what you're bringing to it you know you're responsible for what you talk about."(M4)

In this study it would appear that the choice of supervisor usually lies with the supervisee. The supervisee's choice is personal, with them either choosing a supervisor from the same or differing discipline. Effective cs in this study seemed to develop through the supervisees knowing the supervisor either as their previous colleague, manager or someone they have witnessed at work within the helping profession. Furthermore, the qualities of the supervisor are important, they expressed the need for someone that they can trust, who will listen and be supportive to them. The following quote by a senior manager within the study possibly epitomises this subtheme.

" You can lead a horse to water can't you and so you can drag everybody to say an office and say they're going to engage in clinical supervision. But unless the person wants to do it and is committed to the process and trust the person in the relationship it's not going to be meaningful." (M6)

5.3 (Lack of) trust within the organisation

Attention will now focus on participant's capacity to trust their organisation in relation to cs. From data analysis two distinct areas emerged in relation to participants (lack of) trust within the organisation:

- The presence of the register
- Participants perceptions of their organisation in relation to cs

5.3.1 The register

The HEI, where this study was conducted suggested that individual Trusts should maintain a register of staff who had undertaken the cs training. The reason was two-fold; the Trusts would have a database of staff who had completed the training and any member of the nursing staff could access a clinical supervisor. The format for the register comprised the supervisor's name, contact details and a brief précis of their current role and why they wanted to become a supervisor. The training facilitators would mention the register on the last day of each course and explain that the course participant's name would subsequently be added and that they could also access it to find a suitable supervisor for themselves.

From a total of nineteen participants, nine commented about the register.

> "There is a register of clinical supervisors; it's just a thing in a folder, which gets left in the office."(C2)

Whilst aware of the presence of a register, it was not something that appeared to have a great deal of significance. Conversely other participants were not even aware that the register existed or who had access to it.

> "... apparently there is a list but I didn't enquire about that."(C13)

The next participant knew of the existence of the register but she noticed that other participants from the same Trust were totally unaware of its existence:

"But there was a lot of people in the room that sort of said "what does it look like" and never actually been made aware of it." (C17)

Furthermore, because the register was not updated by their Trust, practitioners saw little value in utilising it to find themselves a supervisor:

"...looking through the copy (the register)...everyone around the room was saying, "oh well they've left, they've left and so have they". So I think it is something that needs updating more regularly."(C3)
"I think the register that needs to be regularly... a bit more updated what have you. I haven't even ever seen one myself, so I would be interested to see it. I know locally people who have done the clinical supervisors course but perhaps how you put the information you put down there would be quite, needs updated and it needs accessing to people..."(C17)

This participant not only commented upon the currency of the register but also the difficulties accessing it. Others were able to access the register on completion of the course, only to discover that their name had not been added.

"My name isn't on the list but I suppose if somebody actually phoned me and said they wanted to talk to me I wouldn't say no to them."(C10)

Whilst not unhappy that her name was not entered, in subsequent interviews she conveyed the fact that she was relieved not to be on the register and not being asked to be anyone's supervisor. However other course participants were "hoping" that their name would be on this register.

"I asked for a copy of it but that was never sent so I am hoping my name has actually been added on to the copy but you wouldn't really know. Half the people that are on it don't do it apparently don't do it anymore anyway."(C15)

Being unable to access the register and her uncertainty as to whether or not her name had been entered onto it, may have led to her losing her motivation to take part in cs. Had the organisation that she had trusted failed to provide what she viewed as the basic requirements to begin cs, namely the register?

"They leave it very much to the individual to go and seek it, you can never find an up to date list and you don't know really who the people are on the list, if you do find it and we don't have to have it and there is always something else to do. So even though it is talked about, I think it is low on the list of priorities."(C15)

Similarly, C16 (fairly new to the Trust) spoke of her difficulty of not knowing the names on the list and as a result was also unable to choose a supervisor that she could trust.

"... but I still think it's a bit hard to pick up a telephone and say "hi I am such a body and I am ringing you to see if you will be my supervisor". I think you have got to be a special type of person to do that. "(C16)

When she says to choose someone from the register "you have to be a special type of person"; I wonder if she means that to do this one would have to be a trusting individual. Her words suggest that the HEI and Trusts may have been being naive in their expectation that practitioners would readily use the register to choose their supervisor. Other participants recognised names on the register but felt that they would be unsuitable supervisors.

"...and you think there's no way even though they've got their name down on the register."(C2)

By being out of date and inaccessible, some of the participants suggested that the register lacked credibility. Furthermore, they saw the register as the Trust's responsibility, does this suggest that if they could not trust the currency of the register it followed that they could not trust their employing Trust/organisation in relation to cs? In some ways this is demonstrated by the participants who offered suggestions as to how the Trust could use the register more effectively.

"I think it should be pinned up on the notice board, so it's there, if I want to have a look I just go over and have a look I don't have to hunt around for it." (C17)

"Maybe if some of them (*supervisors*) could have come to the school and said if anyone wants to come to me I'll be there. So you could remember them and say to yourself "oh okay I'll go to that person". But I mean a piece of paper, I suppose

some people may take it up but I'm the type that throws things in my bag and months later it's still there you know."(C10)

This participant possibly does not see the register as being valuable and reliable, whereas an actual practitioner personally attempting to sell their skills as a supervisor would be more appropriate.

"This legendary list no-one ever finds."(C15)

It would appear that the training, which many found stimulating and interesting, fell short in encouraging them to seek an appropriate supervisor. Not only did the participants not trust the currency of the register but they questioned whether those names (that had been entered onto it by the Trust) would be "good enough" as supervisors.

Three (from a total of six) supervisee participants had similar complaints as the course participants about the register being outdated and the format not inspiring confidence.

"We have a clinical supervision register with people that have been through the course that couldn't supervise a labrador having its dinner. Which means that at one stage we had a huge register with lots of names of nurses and people that have been sent by their managers to go on a course who have got the communication skills of a gnat... and nobody would want them to be their supervisor... or in fact they've gone along and done the course because it's been a couple of days out with no intention of doing anything with it."(S5)

The language appeared to suggest that anyone could attend the course and their name would be added to the register. Furthermore she did not think that it indicated or reflected anything about the calibre of supervision they may provide.

"We had at that time a register of clinical supervisors, I found that wasn't very useful because the information it gave you about the individuals didn't help me make my mind up whether they would be suitable person for me to approach. A lot of people on that register weren't here anymore or weren't supervisors."(S1)

Furthermore like the course participants, he offered a suggestion for improving the register.

> "I think if we have a register it's got to be up to date, with the actual people who are doing it with their different experiences."(S1)

However, one supervisee participant was positive about the register and saw it as a way in which nurses chose her to be their supervisor.

> "Our names are listed in nursing and quality and the register and they come through that or sometimes someone will stop me on the ward."(S6)

Whilst S6 was accessed via the register, it may be because she was known to many staff on the wards as palliative care specialist nurse. She was in contact with many nurses but had no managerial control over them which may have made her a "safe" choice.

Managers offered similar complaints regarding the register to those discussed by the course and supervisee participants

> "We've declared we've got the book (register) but even that was out of date. 1997 was when I first put my spiel in and when it was republished it still said exactly the same now."(M3)
>
> "When I arrived last year it was evident that the register was fairly well out of date for various reasons. A lot of the supervisors had originated from the field of mental health or women services and they were no longer part of the Trust." (M6)
>
> "But I don't think it's up to date. I can probably say in two years. There should be one in here (*opens drawer, no register*)"..."I can't actually say that it's been updated the last time was probably when I was in the small office at least twelve months ago now." (M2)

Although recognising that the register was out of date M2 also stated that it was a good idea, as staff would be able to choose someone outside of their speciality:

> "...but it's nice to have a list of who would be available if someone doesn't want to access somebody within the department and I think that that's nice to say well there's somebody in cardiology or A&E."(M2)

M3 suggested that because she and other managers had the register in their possession, staff needed to ask to see it which possibly made it less accessible to all:

> "... but because people had to come to you to ask for it you sort of put your name on the board and said I'm here and I'm willing but the onus was for them to come to you and ask for clinical supervision."(M3)

Indeed some manager participants although aware of the presence of the register, did not know whether staff accessed it and in what way:

> "...I do know that it goes to the ward managers on the email now. I don't know whether it's on the intranet or emailed directly I don't know but I do know it goes out."(M1)

Although aware that the register "goes out", it was only to the ward managers whom she later stated were not cascading it to clinically based staff. Even if information such as the cs register was available on the intranet it may not be sufficient for individuals to take the responsibility to access it. Do managers have a greater responsibility to raise the awareness (of cs and the register) using a variety of options?

Three manager participants were instrumental in setting up the register for their Trusts. One of these managers gave a full account of how the register was formatted and how the fusion of theory with practice did not quite occur. She recognised that staff could ask for a copy, but that there were significant problems in keeping it updated:

> "I was a party to setting the register up and developed a format, a simple form that they give me their details, name, clinical area, address, contact phone number and a very, very small mini C.V and I gave them guidance around that and tried to get a register going which we kept in the staff development training centre and so if somebody wanted a supervisor they could ask for a copy and they could choose. That was the theory of it. Not everybody returned the forms that were sent to them, people left. To actually maintain the register was difficult because the secretary got cheesed off with constantly updating and changing it. People didn't inform us if they moved and eventually we started giving hard copies out, but then that wasn't a good idea. They weren't intranet friendly, there was no intranet."(M8)

I wondered if it was realistic to expect individuals to alert the Trust to remove them from the register when they moved or left. It could also be argued that the size of the Trust made this an insurmountable task and would therefore ultimately fail.

A second of the three managers shared his experience of the register:

> "It was a bloody nightmare that was."(M9) (*When asked about the register*)

What follows is a lengthy quote by this manager but I felt that this was appropriate as it demonstrated his "nightmare", from the rationale for its introduction to how it became problematic.

> "I think it was a self-created issue in many ways. I think that there was always a notion, like all training, to know who's done what. So there was always that issue and if you look at other training issues it's comparable. If you said to the Trust at that time "tell us who's done manual handling?" they could give you percentages but they couldn't tell you who. There wouldn't be a notion that at any one time who is doing what. So I think the register was a suggestion if nothing else at least we should have that. Again we asked for some resources to try and do that, it ended up on its back. We agreed a format for it to go out to people who had done the course to try and pickup primarily the basic details, background, what they were interested in... erm it was quite funny really we were interested in their professional interests and we got things like knitting and whatever. A load of rubbish that had to be filtered out. It never actually got into any systematic way of getting to everyone's environment... I know that on site for example we had display boards up for a while, lists went round of people who had done the course. Because they had done the course that was the agreement they were available...So the list was an agreed list I have to say I don't think it was an agreed list everywhere, so what was put into this register I'm not sure was an agreeable audience shall we say, there were problems with that."(M9)

Overall the majority of the participants strongly linked the register with their Trust/ organisation. There was limited support for it mainly due to it being out of date and this resulted in a lack of trust by the participants. Furthermore, placement of a practitioners name on a register did not necessarily mean that they had the appropriate skills to be a suitable clinical supervisor which again led to distrust.

5.3.2 Participants perceptions of their organisation in relation to clinical supervision

For cs to be adopted by a Trust there needed to be a strategy- "a way of making it happen". This part of the chapter will report on how the participants (course, supervisee's and managers) within this study perceived the introduction of cs within their Trust.

Some participants were cynical and distrusting of the organisation and their managers, whilst others trusted or began to trust their organisation more following the introduction of cs.

Having analysed the data with regard to the participants (lack of) trust for their organisation, I was able to subdivide their experiences into three areas:

- The visit (from a senior manager of their Trust)
- How managers imposed or developed cs
- Suggestions about how to introduce the concept into the Trust

5.3.2.1 The visit

Participants of previous cs training courses positively evaluated the opportunity to discuss with a senior manager the Trust's perspective on cs. Both Trusts were eager for this to continue and subsequently the person with the strategic lead for cs in their particular Trust attended each course, hence this title "The visit". A half hour was scheduled on the final day of both courses for this to take place. From a total of nineteen course participants five, from both the Acute Trust (C1, 3, 5, 6, &9) and the Community Trust (C12, 13, 14, 15 & 17) commented on the visit by these senior managers.

Whilst this subheading was particularly pertinent to and emerged from what the course participants discussed, I will also comment where possible in relation to the supervisee and manager participants.

"...it was brought up by XXX (senior manager) the Trust perspective and that was quite nice to hear how much value and emphasis the Trust was putting on clinical supervision."(C5)

"I must say (names Trust manager) was very good...Yes I thought she was very easy to listen to. I think its just her presentation she's quite bubbly isn't she and still you know very easy to talk to and I think she's got a good knowledge of the whole idea." (C1)

She appeared to value that this manager (by taking the time to come to speak with the group as well as the content of what she said) demonstrated to her the Trust's commitment to the concept. Other participants commented that the time slot should have been longer because of the many issues participants wanted to discuss about cs.

"I think (what) I got the most out of was the manager of Trust with responsibility for taking clinical supervision forward talking about it for an hour. They were the most concise who had their idea of what it was and how it was done the rest became more confused at the end of the two days."(C3)

"...her's could be longer *(Trust manager)* because so many people wanted to ask questions of her and in the end she had to stop. I think it went on for nearly an hour more than it should but only because people wanted to ask her."(C6)

Possibly participants wanted more time with this manager because their previous experience had been that concepts were brought into being at management level and that often clinically based staff struggled to make sense of them. However, on this occasion they had someone that they could not only question but also receive answers from and not only from a Trust perspective, but also as a supervisor (which she disclosed to them during her session).

The Community participants also commented on the senior manager who came to speak to them on the course.

"He sort of spoke about briefly about how he started off and where the Trust are with it. We asked questions and he answered them."(C14)

"His lecture was quite good again. I thought that might have been pretty boring but it wasn't he didn't really give any guidelines of what the future was going to be."(C13)

Unlike the Acute Trust manager this manager was less warmly received by some participants. What differed was the fact that during the course, participants from a particular directorate had disclosed that their manager was imposing cs on them. Many saw the session with the Trust's strategic manager as an opportunity to question him about this matter:

"I think he was aware that that had happened in that discipline, (names directorate)" *but* "...he didn't really say anything to people who were concerned that it was going to be imposed on them and he didn't really give them any reassurance."(C13)

"He was saying exactly what I think, that it shouldn't be enforced on you and it should be with someone that you feel comfortable with and yet they were saying that our managers were saying that we've got to have it with them. He laughed and said that he knew who they were and that he couldn't do anything about it. He knew what directorate they where from straight away and so he's obviously been in some form of discussion with that manager. And so on the surface he seemed on our wavelength, but then when he said that I thought obviously he's willing to let it carry on being something that it shouldn't be then. So I felt that he was quite contradictory in what he was saying."(C15)

This manager's attitude seemed to disappoint C15 because he conceded he knew cs was being enforced in one directorate but was powerless to stop it. Whilst C15 hoped that he took on board what the participants had said she was still left with the impression that he would not do anything about the problem and that it was something that participants in that directorate should address themselves.

"...he seemed to be leaving it for the people from the course to go back and sort that out themselves."(C15)

Jones (2001a) commented on organisations allocating supervisors, he viewed the supervisory relationship as integral to the process of cs and felt that if choice was

removed then the relationship could not flourish and that this would lead to disempowerment of the participants.

Other participants were less irritated by the manager's response, although they recognised that he was aware of the problem of a manager imposing themselves as clinical supervisor to their staff and depriving them of making a choice.
One participant appeared impressed with the Trust's commitment to cs.

> "...they (Community Trust) were quite supportive of the provision of clinical supervision and that they are prepared to give people time for it and paid and not having to do it out of work. But I think the guys name is XXX. He said he'd been involved with clinical supervision for quite a number of years, it was about 5 years. He was quite keen to encourage people to keep up their supervisors responsibilities."(C17)

However, even though the Trust was overtly supportive in what it said, the reality was that people were not freed from other duties to engage in cs.

Overall these participants suggested that "the visit" from a manager offered the Trust perspective regarding cs. Whilst the Acute manager was well received, this was slightly less so for the Community manager. His acknowledgment that a directorate was imposing supervisors on staff could be interpreted as him being authentic, but some participants viewed his response as contradictory and weak and saw this as "typical" Trust management style.

In relation to the manager participants, it was interesting to note that some were aware of the key individual who was in effect "driving" the concept of cs forward in their Trust, whilst others only had a vague idea of what was happening. They had the following comments to make:

> "Internally I think it was really led by and pushed by XXXX and she worked very hard going round all the directorates, speaking individually to the managers, like she came and spoke to me and together we arranged for her to talk to ward based

managers. She then offered the ward managers if she can go through to the staff on her ward at a group meeting or whenever was convenient really. I think for one person to have that responsibility with hindsight, because we have so many nurses it's awfully hard for that person to get around, so we rely internally on a filtration process and some people are good with things like that and others perhaps there were pockets of areas where things didn't move on as quick as they should have." (M1)

This indicated that attending the training of supervisors was not the only way in which the strategic manager was trying to sell cs. They seemingly worked at ward level raising staff awareness of the concept. But as this participant stated it was probably unrealistic to think that one person could be successful with this task. Furthermore, another manager from the same Trust saw the strategic manager's role as fairly dilute and felt that there needed to be ongoing training:

"She did have some input, but I didn't think it was enough as much as what it should have been. I think that you have to have ongoing training and awareness sessions of it because people do move on."(M2)

One manager saw it as her's and her fellow colleagues' responsibility to "flag-up" the concept and was only vaguely aware that there was a strategic manager in place from the Trust.

"I think it was from Nursing and Quality apparently the DNS had said XXX was the lead for it" (M3)

From the two samples, I was only able to interview one Director of Nursing who had the overall responsibility of introducing cs into the Trust. In hindsight, he admitted that they may have been too quick to set-up cs. He suggested that the initial introduction was more to do with training supervisors than ensuring that the correct people became a supervisor in the first place.

"We put too much emphasis on just churning out supervisors and thought that was going to be the end of it. I guess that many, if not most of the supervisors didn't do any clinical supervision." (M5)

> "From memory now five years ago probably who wants to do it, who can be released to do it? Rather than look at what sort of people do we want to do this in terms of what skills have they already got, what is their job? Where do they sit in the organisation? Do they have to be a manager? Could a staff nurse provide it? So I'm not sure that we even set out criteria." (M5)

This quote, possibly an admission that whilst training was provided and staff were able to access it, there was limited strategic thought about how cs would actually occur within the Trust. Furthermore, in relation to that limited strategy a senior manager new to the Trust stated:

> "There may have been a clear strategy but if there is I'm not aware that there was and I've certainly not received any evidence to demonstrate that's the case..."(M6)

Her opinion was, that for that to change in the future, there needed to be a culture change as well.

> "We've spent years and years concentrating on what we're putting in and not really translating that into what we're getting out of it. So there's a huge culture shift to go on in that."(M6)

Overall the three strategic managers' visits had a positive impact to staff being able to question and seek answers regarding their Trust's perspective on clinical supervision.

5.3.2.2 Implementation of clinical supervision

Clinical supervision was new to the nursing profession and was being recommended nationally. However just because it was on the national agenda did not automatically mean that senior managers agreed with the concept or had ownership of it. It would seem that initiatives were "foisted" onto the two Trusts and it was left to key people to take them forward. There did not appear to be a cohesive management structure or any strategic thinking about how to sell the concept to nurses.

> "I don't think the senior managers promoted it and I think you need to promote and reinforce, I think we could have done far more in terms of valuing best practice and rewarding best practice and I don't think we did that."(M8)

To introduce cs the strategic managers from both Trusts implemented strategies, such as awareness raising and posters (at times on a limited budget).

> "They received quite a bit of information around clinical supervision. Because leaflets, posters, presentations at professional forums around supervision, going to the ward managers meetings."(M7)

> "We had "lunch and learn". We had half day sessions and they were not well attended, we had briefing sessions, cascade sessions to try and get the message down. " (M8)

> "I can say hand on heart as I arranged a series of roadshows for senior managers and senior nurses at the time of which I facilitated at which many came to and we had an open discussion around clinical supervision, the concept."(M9)

Needing to have his "hand on heart" tended to suggest that he wanted me to believe that he made an honest and deliberate attempt at educating the senior managers. Despite the apparent publicity one of the supervisees from the same Trust was not aware of the cs education that had been offered by the Trust:

> "Maybe to have some workshops to tell them what it is and what it's about, nonthreatening, all of that. I think some people do see it as threatening."(S6)

Similarly a course participant from the Acute Trust was also unaware:

> "I think that it would be quite helpful if people go into clinical areas... I think that if they actually went round and did some sessions or ran sessions to dispel the myths of clinical supervision, you know question and answers and increase interest in it or cascade it in areas."(C3)

Furthermore, even if training and awareness sessions were delivered, it would appear from the strategic manager's perspective that many of the staff were not committed and/or enthusiastic towards cs. I wondered whether the ability to trust the concept and the reasons why the organisations wanted to implement it come first, and then, the commitment and enthusiasm would follow.

However, some course participants, (generally the community sample) saw the introduction of cs merely as a way of complying with Clinical Governance.

> "...firstly the reason why I have probably been sent or allowed to go is that the clinical governance is the thing of the present and it is incorporated in that and you have got to been seen to be sending so many people to say "yes that's in place in the trust."(C12)

> "I think from the Trust point of view, I think clinical governance meant that they have to be seen to be putting up supportive clinical supervision and so that's probably where their emphasis had come from."(C17)

The participants tended to view cs as something introduced as a way of satisfying a national agenda rather than having a clearly useful purpose.

> "They have got something they can talk about, we do provide all this and it probably looks very good in the business report or the annual report."(C13)

> "I felt that we were being trained up, because I'd heard that the Trust is really hot on clinical supervision, part of the "Investors In People". So obviously they want clinical supervisors dotted all around the Trust. So they were getting as many people trained up as possible. Which maybe is wrong, I don't know."(C2)

Not only was cs seen as a way of ensuring clinical governance was being adhered to, but also providing evidence for the "Investors In People" award. This was a business development tool introduced in 1991 and revised in April 2000. Its aim was to measure processes and outcomes at all levels within an organisation and demonstrate improvement. The award lasted for three years and after that the organisation could choose to be reassessed. According to Nazarko (2000)

> "This enables organisations to build on the momentum generated by IIP and to continue improving services by ensuring staff continue to build their skills."(p10)

The "Investors In People" award appears to have been important to Trust managers and that generally speaking organisations will want to keep this accolade. Being seen to promote cs might assist that perception.

When concepts were discussed at a national level, and advocated as good practice, it would appear that they then filtered through to the Trusts to be implemented. As a result, both Trusts identified key individuals to roll out cs. The three strategic managers suggested that they did try to bring cs into the Trusts and saw training of supervisors a vital facet. The reality appeared to be that they may have been given an impossible task.

The following quotes tend to demonstrate their reflections of trying to implement cs at that time:

> "I don't know maybe we didn't educate enough, maybe the organisation is too big, maybe there weren't enough committed. Maybe the priorities there were too many priorities and because this involved giving staff time it..." (M7)

> "The fact that there were zero resources attached to it even complicated it further. Which meant that whatever system that evolved, developed had to be at zero cost and based more on a professional attitude of wanting to get professional support for your role as opposed to the system saying you will have this." (M9)

> "We did attempt to audit [clinical supervision] but it's a very big Trust you know we had about 3500 staff and it wasn't as an Acute Trust in one site it was a Community Trust so was spread over a bigger geographical area and many different types of units...The people that were very enthusiastic did continue to provide clinical supervision but I couldn't say it was a success." (M8)

These quotes tend to suggest that these managers were being authentic in their reflections. Their task was difficult and interestingly all three later moved roles and no longer had lead responsibility for cs. They all disclosed to me with much relief, but with enough hindsight to explain, that whilst there was never a mass uptake, there were "pockets" of practitioners that had undertaken the training and became supervisors. Furthermore, to their knowledge these nurses were still having regular cs despite many who distrusted the organisation's motives for its introduction.

In relation to the supervisee participants, they were fully aware of cs from its inception in their Trust. This may be because five of the six were senior managers within the

Trusts and had been in attendance at management meetings when the concept was discussed.

> "I've been involved in clinical supervision for years and years now, from the time the Trust started taking forward clinical supervision..."(S5)

However S5 did remark that, if all practitioners wished to access the concept then this would need to be reflected in the strategy and it would be unworkable.

> "...if it was expected for everyone (cs) we need a bigger strategy because we wouldn't have enough people to deliver it. So we're going about it half cocked really aren't we? You know here we are, here's clinical supervision it's really good everybody should do it. Right where's my supervisor? No you can't have her because she's got too many and we haven't trained enough people up."(S5)

She also believed that the Trust she worked within were possibly more advanced in their initial implementation of the concept compared to other Trusts.

> "It seemed years ago that there was a strategy when I was a staff nurse and things were sort of started if you like. I was actually interviewed on the BBC and I never saw it. It seemed to be that there was a strategy and it seemed to be we were way ahead in the lead here in XXX at one stage. But I think as with an awful lot of things that happen here in XXX people at the coal face aren't always consulted and it sort of sold as it's wonderful without having the resources to support it as well."(S5)

One supervisee disclosed that before he entered into cs that he distrusted his organisation in general:

> "I did have this very negative image of the organisation and that's probably due to some of my experiences within the organisation of the past ten to fifteen years. Particularly over the last five to six years, I felt that it would be very difficult to trust people in a certain position and if I wanted to disclose something that would find its way out and I was very concerned ...and I also knew that the supervisor that I had chosen also had links in... interactions with those and similar people. So it wasn't that I distrusted the individual, it was the culture of the organisation that I felt that I didn't have any faith in."(S1)

This distrust appeared to relate to a degree of insecurity within his role. When he moved into a more senior position his insecurities seemed to reach another level which led him to choose to undertake cs. In doing so, his understanding and interpretation of the Trust and colleagues changed. Entering into cs and the "reflection-on-action" may have provided him with "thinking" and "analytical space". It may be that cs results in a greater trust of an organisation and the people working within it, so enabling a greater level of authenticity to be achieved. For those not having cs, do they choose to remain inauthentic and unprepared to confront their thoughts and feelings?

5.3.2.2.1 Volunteer or volunteered?

Some course participants had requested to undertake the training (volunteers) and others had been chosen by their manager to attend (volunteered).

> "If the manager hasn't identified what the aims are, and the person who is going hasn't clearly identified what her aims are then you wonder what are the aims at the end of the day or I am sure there are but are they mish mash or are they of any use?"(C19)

This participant identified that some course participants had no clear aims for attending the three day course and, likewise some managers just sent someone simply to fill a place. She had asked to undertake the course and had waited for two years for the opportunity to do so.

Another participant (a senior Occupational Therapist) provided a rationale for choosing to undertake the course.

> "Well it could be that this course was identified by me to help the service really, because I'm already supervising in quite a big way but I haven't done the course and I don't know the Trust perspective and the ideas that are going around the Trust at the moment, the methods and the mechanisms."(C5)

She already acted as a supervisor and supervisee, but being new to the Trust wanted to understand cs from the Trust's perspective. She had identified this course during her

appraisal as one of her training needs. Overall cs in this Trust was not too dissimilar from what she was used to.

> "I think the course gave me more insight to what was going on in the Trust and made me re-think how we offer it..."(C5)

Before the audiotape began one participant explained that her manager had sent her on the course when someone else could not attend. As the participant had only been qualified for a few weeks, this choice, by the manager seemed possibly inappropriate:

> "...our wing commander tends to organise everyone's supervision really. I think that it's just something that she has taken on because she wants people to have clinical supervision and I think she feels that if its left to the individual then they won't have it."(C4)

The language used is intriguing; "wing commander" gives connotations of the Air Force and the need for control. Is the manager an authoritarian figure who is trying to get their "squadron" into some sort of order (using cs)? Possibly her manager was positive towards clinical supervision and reluctant to lose a course place and although C4 was newly qualified, her manager may have seen it as a means to educate her about cs.

Other course participants recognised that people were sent by their managers:

> "There was one girl in the group and particularly definitely only sent there under duress you know. Because, right from the beginning, she was like, you know, "I was sent here", "you will go", because, right, she was you know saying, "I can't see the point in this" and you know "I don't see why", you know," we should have to do it" and all the rest." (C6)

> "I don't think everybody went with the intention of wanting to be a supervisor. I think some people were put forward to do it, rather than asked to do it..."(C7)

It is worthy to note that, even if they had been directed, some course participants actually enjoyed and valued the experience.

> "I did enjoy it. I thanked our manager. I said "thank-you for putting my name down" because, you know, sometimes some courses are for me and some aren't. I know that sounds soft, saying that, but some I will benefit from and others I won't. But I really did enjoy it and felt sad, I wish it really would have been extended."(C8)

I wondered as to the authenticity of this participant's response towards her manager. She had previously disclosed that she felt forced to attend the course, experienced difficulties with the role-play and when on her return from the course her manager chose supervisees for her to begin cs with. Furthermore, she expressed apprehension when her manager chose to sit in on her own group cs sessions.

Another participant commented that whilst it was not a course she had at first considered undertaking, she did find it useful.

> "I think I was a place someone dropped out. I was only told the week before but was keen to go, but to be honest, it wasn't one of the things I had pin-pointed to do...but there were people there that seemed to want to be there genuinely. And then there was other people that weren't and as you know it's human nature to want to do another course and add another string to your bow."(C2)

The language, "another string to your bow" appeared to signify that attendance on courses in some ways equipped staff. Furthermore, the use of language led me to think about the manager participant who quite graphically described nurses and attending courses as "scalp hunting" and their managers either encouraging or discouraging this to take place.

> "I think we've got into a culture of scalp hunting...and scalp hunting is I've attended this that and the other course and I've got certificates in this that and the other. I think part of that has been driven by PREP in that people have become very focused about having a certain number of study days and they've translated that into a certain number of courses to attend so that they can then report on CV's that they've done this that and the other"..."I think, it's often a quick-fix solution, you know, and, some managers will look at it as how many scalps can my tribe go out and collect this year. Others will look at it from the point of view how can I restrict the number of scalps my tribe want to go and get so that I can tether them to the bedside and get some buffalo hunting out of them."(M6)

The words used by this participant evoke imagery for me of training courses (scalps) seen as trophies. Some managers are keen for their staff to collect as many as possible, but does attendance on courses mean that learning has taken place? Furthermore, this manager suggests that some managers may even deprive their staff of developing in the correct way and give them other tasks simply to occupy their time.

A course participant seemed to concur with this manager regarding staff collecting courses.

> "Since PREP a lot of people are going on courses and then not doing anything with them like cannulation as an example."(C2)

5.4 Suggestions: how to introduce clinical supervision into the Trusts

For cs to be more effective some course participants stated that there needed to be more dialogue between the managers of the Trust and the HEI course facilitators. They believed that this would result in a set of policies being created, and that possibly the participants would feel that the introduction of cs by their organisation was more "trustworthy".

> "I think that if the trainers could speak to managers, and say "well we've trained so many people". A percentage of people have been trained to do this for others or each other. We need to get it off the ground and have a policy. It may be something around the policy and how it is managed." (C12)

Some course participants gave simplistic suggestions

> "I think they will have to keep pushing it."(C17)

However (C17) does not state who should be "pushing it"; Senior managers? Middle managers? Course participants? Supervisors? Supervisees? Bishop (1998a) reported in her study that the respondents believed that this "push" should come from nurse managers to achieve the change for cs to take place. In my study, a course participant indicated that the responsibility lay, also with participants who had attended the course,

(although she was honest in her acknowledgment that she had failed to do this herself and even expressed a degree of guilt having attended a course and not utilising the training).

> "I think it needs to be sold more and encouraged more ...Really I don't think it's enough to sort of say the ward managers should be the one to encourage this. Because obviously nurses have been on the course and so they should be the ones taking it back to their area. I mean I'm guilty myself I suppose of not taking it forward, you know the Trust paid for the course so why aren't we taking it up?"(C2)

She also indicated that the concept probably would have been more widely embraced if it had been led by junior staff.

> "I think if it would have been given to nurses, or the seed to be planted sort of lower down in the hierarchy, it might have grown, where it has been sort of thrown from above ..."(C2)

The language used gives the idea of something being planted and then growing out of the soil. This would possibly give it stronger roots and stability than if it had been thrown from above.

From the manager's perspective, some felt that it failed to be successfully implemented because senior personnel did not promote the concept enough.

> "I don't think the senior managers promoted it and I think you need to promote and reinforce. I think we could have done far more in terms of valuing best practice and rewarding best practice and I don't think we did that." (M8)

Furthermore, M8 believed that a "good" manager would be encouraging staff to undertake cs and provide time for it to take place:

> "Yeah, I'd like to think, if you had a good ward manager for example or a manager in service, they would meet with their staff and know that their staff were taking clinical supervision on a regular basis, say once every quarter, every three or every four months. They would ask "have you had your clinical supervision, if not well you need to have it in the next four weeks" and "let me know when you're having it and I will cover you. I will provide alternative staffing arrangements so that you can go off and have your clinical supervision". Then they would feedback some of the issues, so at least....if you did it like that it would happen." (M8)

Possibly M8 is being idealistic, when the experiences described by course participants clinically based were, that they were too busy whilst on duty.

M6 provided many suggestions for how cs could be more effectively embraced by the Acute Trust. Although she was not working for the Trust when it was first introduced, she gave me her opinion as an outsider "looking in" as to how the Trust had attempted to implement it. She emphasised the need for a change in culture to take place.

> "I think that the emphasis within my working relationship to clinical supervision should be exploring what alternative things we can do and getting other arrangements in place for people to take it up and working with the rest of the managers in the organisation and changing the culture."(M6)

Furthermore she suggested that cs would require leaders to implement it rather than managers, who she saw as being more target driven than people orientated. She implied that cs is a person centred concept.

> "Whereas, if it's leader driven, then that's about people who are leaders of nursing who aren't necessarily managers of nursing that can influence people of the benefits of engaging in this type of activity and can influence the managers into the benefits of encouraging your staff to engage in this type of activity and that will therefore bring about a culture change and nurses themselves will come to trust the activity... the other thing we can do is get staffing levels right in these areas and make sure there is enough nurses in the first place so that this type of activity can be engaged in..."(M6)

She expressed not only a need for a change of culture but an increase in resources, (such as adequate staffing levels) which would allow nurses to access cs during their work routine. Furthermore, she did not see the implementation of cs in isolation from other issues. She was also keen to develop the concepts of "preceptorship" and "mentorship" which links with the literature (Butterworth, Faugier and Burnard, 1998).

> "I think that there are other relationships that need to be explored at the same time. In some ways, they have some overlap with clinical supervision and in some ways, they have a different focus. That's like preceptorship type arrangements, mentorship

type arrangements, that sort of thing. So we have to address all of them rather than just one of them and have a whole gambit of different opportunities for people to dip in and out of. The problem with that is the organisation as you end up with spinning plates just going from one to another trying to keep them going. Yes it's about willingness and motivation."(M6)

She appeared to be expressing a need for a whole rethink regarding continuing professional development. She recognised that there were competing demands for differing concepts but essentially they did have some commonality. Her analogy regarding spinning plates gives an indication that perhaps the organisation wants to introduce many concepts but fears that some concepts (plates) may consequently fall and some may even smash!

From the supervisees perspective their suggestions tended to focus mainly on the education of staff, so that they understood the concept and what would be expected of them as supervisor and or supervisee.

"I'd explain about clinical supervision. What it is and we would expect that they attend clinical supervision; they should really make an effort to gain something from it. That they will be given time to attend it and then essentially say to them who you choose is up to you."(S2)
"I think we need more supervisors, I think we need to spend more time.....getting people to understand and people to be aware that it isn't an issue that's going to be fed-back to the manager. That it should be in a place away from an area that is going to feel threatened. A better understanding what it really means to the individual I really do."(S6)

However one supervisee questioned whether staff needed to undertake the clinical supervisor's course to act as a supervisor.

"...I also wonder about, I don't know whether it's correct but are we limiting the number of people we can put as supervisors? Because, d'you have to do the course to be a supervisor? Because I'm sure there must be people...I've not done the course but I think quite honestly I could act as a supervisor."(S1)

He argued that the Trust may have inadvertently deprived staff of cs because there were simply not enough supervisors who have undertaken the limited amount of training that the Trust had purchased from the HEI. Indeed, although the UKCC at the time stated that training would be required, it left the detail to be decided at local level rather than stating a definitive period.

> "I firmly believe that the way we sell clinical supervision is from people who have been involved in clinical supervision and had a positive experience. That's how we'll influence it so I do try and act as a role model and I try to promote it." (S1)

5.5 Conclusion

It would appear that cs had been met with resistance throughout the two Trusts. One possible reason for this is the notion of "trust" associated with cs. Three areas regarding trust have been explored; (a) the idea or concept, (b) the supervisory relationship and (c) perceptions of the organisation. Some course participants demonstrated through the interviews that they distrusted cs from all three areas and, as a result, did not undertake it. The manager participants showed that, they were aware of the lack of trust within their organisations, but seemed powerless to address the issues. The strategic manager's aim was to introduce the concept across two large Trusts with virtually no resources, other than purchasing the clinical supervisor training from the HEI, in-house roadshows and posters. Participants implied that they may have been set a task that could never result in the full implementation of cs until, as M6 stated, there was a change of culture.

The supervisees also explained their own feelings of vulnerability (can I trust?) before they started to have cs. They talked about taking the step forward to engage in the process and their concerns regarding the "correct" choice of supervisor. Even if their initial supervisor was ineffective, they still trusted the concept and changed supervisor until they eventually received "good" supervision.

Maybe the experience of undertaking the course was undervalued by managers, participants and educators. Some participants appeared to have found it too much of a challenge. I believe this final quote from a course participant demonstrates this, with their explanation of why she was not acting as a supervisor:

> "It's a bit like you don't give someone a loaded gun if they don't know how to use it.... So in effect you could have a damaging impact on the other person (supervisee) if you don't know what you are doing I mean."(C2)

The analogy is vivid and provides a powerful argument that nurses may see the role of a supervisor as being of such significant importance that they would see a poor supervisor as being potentially irreversibly damaging (like a bullet wound) to the supervisee.

Chapter 6

Findings: Disclosure

Early on in my interviews with course participants the notion of "trust" as a prerequisite for a healthy supervisor/supervisee relationship emerged as a central theme, as did a fear of "disclosure". Many participants voiced concerns about imparting information to a supervisor which might set in motion a chain of events over which they had no control. Likewise, acting as a potential supervisor they expressed fears that, should a supervisee disclose something of concern to them, they would be duty-bound to initiate an investigatory or even disciplinary process. Conversely those participants in the study who were actively engaged in cs used the same terminology of "trust" and "disclosure" but from a more open and positive perspective.

6.1 Shaping the themes and chapters

The preceding chapter has shown "trust" as a central theme. The reality was that "distrust" was also powerful. Many course participants seemed to convey a general distrust of their employing organisation. Some of their colleagues, their managers and potential clinical supervisors had coloured their view so detrimentally that it became enmeshed with the whole concept of clinical supervision (cs) and led to a general distrust of that also. Interestingly the manager participants suggested that the notion of distrust is how they perceived practitioners would view cs and it would ultimately lead to their rejection of it.

When shaping this chapter I initially thought that the main theme would be "trust" and that disclosure would be a sub-theme. However having re-visited the participants' transcripts and collated all quotes pertaining to "trust", I recognised that the issue of "disclosure" was such a significant theme that it merited separate consideration.

6.2 What is disclosure?

According to the Collins dictionary (2001) to "disclose" means "To make known." (p158)

Interestingly the thesaurus offers the alternatives to "disclose" as:

> "...broadcast, communicate, confess, divulge, impart, leak, let slip, make known, make public, publish , relate, reveal, tell, unveil and utter."(p158)

If participants see that cs is a form of disclosure then from the above list it would suggest that the supervisee or supervisor may be potentially exposing themselves. This may lead to a sense of vulnerability, which some participants reject and others embrace.

6.2.1 Types of disclosure

In developing these emerging themes I have categorised disclosure into two main areas:

- Inadvertent disclosure
- Whistleblowing

6.2.1.1 Inadvertent disclosure

6.2.1.1.1 Defining inadvertent disclosure

There appeared to be numerous definitions of whistleblowing, but little in the literature relating to inadvertent disclosure. My own understanding of this term and from what the participants have described to me is that it relates to an unintentional/ accidental dialogue with another person(s).

Many of the course participants were concerned that if they were acting in the role of supervisor then the supervisee may inadvertently disclose poor practice, which they may be required to act upon. This, they felt would be unfair to the supervisee who they saw as placing them in a position of trust.

> "Well in a way I could be quite fearful of it all, as a colleague may say something that you felt you know it would need to be reported on and that puts you in a very awkward position wouldn't it?" (C13)

This participant used words such as "fearful" and "awkward" to describe how she may feel if a supervisee disclosed professional misconduct.

Another course participant also highlighted this potential "fear".

> "Well it's the fear and also I would not like to be put in the position if somebody told me that they had done something that I then had to act on. I really wouldn't like to as they were saying that you had to give them a time limit that if you haven't done something in twenty-four hours then you know I will. Well I don't know whether I could, depending on the circumstances you know, but it's something that I wouldn't like to put myself in that position unless I really, really had to." (C9)

Within this quote "wouldn't like to" was used on three occasions. This may suggest that they did not wish to be a supervisor, because they did not want to be in a position of having to deal with professional misconduct. Not becoming a supervisor may have represented an attempt to protect both themselves and the supervisee, which tends to imply that if one does not hear, then they cannot be put in the position of being accountable for someone else's inadvertent disclosure.

Participants tended to view the role of supervisor as being placed in a position of trust. If a supervisee inadvertently disclosed a serious issue, the participants suggested that they could possibly let the supervisee down by having to act on that issue.

From an educational perspective, I wondered whether the course fully equipped them to deal with inadvertent disclosure and if their organisation was equally prepared. Examination of the programme (both two and three day) revealed that dealing with disclosure was not timetabled as a specific issue but that is not to say that it may not have been discussed during group experiential work. This issue will be considered further in the discussion chapter.

Whilst the previous participants explored the potential implication for them personally as a supervisor, others tended to view the role more from a third person perspective.

> "Well you know we have to talk about the confidentiality and about you know being responsible. If someone did disclose something and people don't necessarily want to get involved with that if they are going to get told something they don't want to know about because then they have to act upon it don't they?" (C15)

By couching it in more global terms, this may be a way of protecting their views. However in later interviews with C15 she disclosed more about her own lack of trust of her colleagues. She explained how she had difficulty working with her peers in the office and would be loath to disclose even positive issues such as a change in her role, which she felt, would be treated negatively:

> "...but it's a horrible situation in that you have to be careful what you say whether professional or personal. Personal doesn't matter so much but professional like for instance no-one knows that I've got on the mentor programme... because I know that people would kick up a stink as I'd need a little desk as the student needs to have a desk as the UKCC says that they're supposed to be organising their case load." (C15)

Despite these experiences she was positive towards the concept of cs and appeared to actively wish to become a supervisor and a supervisee. Furthermore she also discussed why she thought supervisees would fear disclosure within cs (returning to the use of the third person):

> "I don't know whether it is because we are nurses or health visitors, but I think everyone always like to think they know what to do and you are frightened that you will be judged as not knowing what to do as bad."(C15)

This suggested that nurses may inadvertently disclose gaps in their skills or knowledge, which this participant believed was "bad". It may be that this fear of being judged by

others due to a lack of knowledge or skill is actually a fear of being seen as professionally incompetent.

Whilst (C15) looked from supervisor and supervisee viewpoint, others discussed implications of disclosure solely from a supervisee's perspective.

> "Yes it's about you may say something you shouldn't or something like that I don't think that would really happen much because on the whole....apart from minor things I don't think many people do things that they shouldn't. You see you might have to admit to things you've done." (C11)

Interestingly this quote "you may say something you shouldn't" suggested a need to be cautious when having a dialogue with another health professional. This appeared to be paradoxical to the role of the nurse when engaging with patients, when that relationship should be founded on trust, openness and honesty. However Wright (2005) explained that nurses:

> "...are not psychologically-sealed containers, but leaky mental sieves, that, try as we might, will often let through what is going on inside us." (p25)

Possibly some of the course participants recognised this could happen to them in cs and so they rejected taking part in the process.

Fear of disclosure was not confined to the supervision session, but by also attending the course, some course participants saw as potentially threatening and they expressed a need to be defensive.

> "...you always go into things with your guard up a little bit, I'll wait and see what this is about you know." (C17)

"I don't know what quite to expect. I'm going in with almost a blank page if you like. To sort of find out more about it because it's...I think there's a certain amount of suspicion about opening up to other people."(C17)

What do nurses fear from a supervisor's course? Is it that they might disclose something that has happened to them and they are concerned how others may react?

Following on from this, the next quotes further added to the potential for someone disclosing something which is then passed on to others.

"I don't really know whether it will be any help or what I mean maybe I'm just cynical about everything you say will be in complete confidence but everyone's human aren't they? Things may come out...Well I don't know you might say to somebody "I'm not coping on the ward" or "I'm feeling stressed out" and it then gets mentioned to other people."(C10)

"...I think it maybe the whole thing of Big Brother watching you. Things like that."(C10)

This participant fails to mention whether the identity of "other people" and "Big Brother" is related to senior managers or anyone else. She recognised that her views may be as a result of being "cynical". This may relate to her lived experience of how disclosure has been dealt with by the organisation in the past. The quotes suggested certain vulnerability, that if she acted authentically, admitting any issues she may be unsure of, that this would increase her anxiety levels. To protect herself she could be described as being inauthentic, hiding her fears. However from a Heideggerian perspective this is her lived experience and how she sees the reality of her being in the workplace. This resulted in what she described as her own cynicism and thus fear of disclosure.

The supervisee participants, suggested that prior to having cs they also thought they may risk inadvertent disclosure, but it was no longer an issue once they had started the process.

"I didn't want it to be too intrusive I was worried that I may say something...because I sort of wear my heart on my sleeve I was a bit worried that I would say too much and although I knew it was confidential it's very difficult not to feel disloyal to a place..."(S3)

Whilst worried about inadvertent disclosure, her fears differed to the course participants. She was concerned about being "disloyal" to her organisation, whereas the course participants appeared to be more fearful of the impact to themselves and others if inadvertent disclosure occurred. The need to be loyal and not betray the organisation (by an employee) is something, which Johnstone (1994) described as a result of a history of paternalistic control (particularly in hospitals). However another supervisee explained that he saw cs as an opportunity to disclose, although he did talk about his initial reluctance and fears of disclosure.

"I found it [clinical supervision] at the beginning to be quite daunting and quite challenging it was a bit scary really to actually go along and tell people or disclose to people some of the fear about your own professional abilities as they were the issues I was taking and whether I would be able to perform better in a new role and also some of the ways some of my behaviours from previous roles erm so I suppose it's been very positive ..."(S1)

"...I also had a fear about what I would say in those sessions, how confidential that would remain. That had always put me off and there had always been an element, a big element of mistrust of the organisation, people within the organisation. Which again was one of the issues clinical supervision helped me work through actually." (S1)

Whilst there was an initial mistrust and worry about disclosure he admitted that through having cs he had become more trusting, open and honest with his own staff and managers to the point that he is less worried about what he might disclose.

"...also it's around professional integrity as well I think that's happened to me in the last twelve months clinical supervision has helped me achieve that. If you have professional integrity then you shouldn't really be too worried with what you disclose. For instance if I have conversation with my boss the CSM I don't really worry now as to what I'm saying to him, is that going to be repeated to somebody

else because what I say to him is what I feel and what I understand and all the evidence that I have to support that, that might be not quite right or may well alter or there maybe a bigger picture but I can only give as I see really." (S1)

The next quote from a supervisee suggested that to her, disclosure was more about openness and accountability, rather than a fear of possible recriminations. She appeared to embrace the process, and it served to empower her.

"It's very much time for me, time to share time to look at anything that I feel is bothering me... I feel that if I have a difficult patient or something that I want to check out I can do that there as well. I can look at just me as a person with the stressors and strains of the day, I can look at development and that's been a great help to look at where am I going, what am I doing what should I be doing and just have time to be able to sit and know that that time is for you and that person is listening and guiding that's a great help." (S6)

Supervisees tended to suggest that the opportunity to disclose practice issues was a cathartic experience for them both professionally and personally. From examining their quotes I sensed that they appeared safe in their professional roles and that cs was valued because it provided them with strength and security. Thus they did not fear disclosure, seeing it, rather, as a positive experience.

Interestingly, one of the course participants appeared to echo the catharsis described by the supervisee participants, when she told me about the role re- enactment which took place on the course. This was when one practitioner acted as supervisee bringing to another practitioner (acting as supervisor) an issue that had previously occurred within their own practice.

"I don't know it was as if they got a lot off their chest really..... and then it put things into perspective if they had done something well even though they hadn't recognised that they had done it well in a difficult situation it made them say yes well I did." (C18)

Similarly a course participant, who had introduced cs into intensive care, commented on the positive effects she observed in two practitioners following cs sessions.

> "No, no there's been no embarrassment and I think that two people felt immensely better after being able to talk about it and it being confidential and able to look at ways of dealing with it and coming back to me to update me on how they're dealing with it." (C3)

Overall, whilst many course participants feared disclosure, when they actually undertook the process there was a certain degree of unburdening that took place ("got a lot off their chest") and this left them with a feeling of enhanced self worth.

6.2.1.2 Deliberate disclosure (whistleblowing)

Whilst the course participants and to some extent the supervisee participants, referred to the issue of inadvertent disclosure within cs the manager participants tended not to discuss or use this term. Instead the managers spoke about deliberate disclosure and used the terminology of "whistleblowing" and "blame culture" to describe why they thought practitioners were reluctant to have cs.

6.2.1.2.1 Defining a "whistleblower"

The notion of whistleblowing derives from the idea of one person (the whistle blower) using a whistle to alert another that something untoward has happened. One possible analogy relates to the referee on a football pitch "blowing the whistle" when they believe a foul has been committed. However it could be argued that in the football analogy the referee is alerting not only the person who is fouled but also the fouler, the team and the spectators, whereas in reality whistleblowing may not be as transparent.

Macdonald and Ahern (2000) defined a whistleblower as:

> "A nurse who identifies an incompetent, unethical or illegal situation in the workplace and reports it to someone who may have the power to stop the wrong."(p314)

They recommended that whistleblowers should be commended for maintaining standards and Faugier and Woolnough (2002) have argued that all qualified nurses, midwives and health visitors have a, "professional duty to blow the whistle". The reality is very different.

> "...I guess they also think that they're in a blame culture. If I mention something that happened in my practice like you know I'd be ashamed to say that there might be recriminations for that ... I guess there will be situations where the supervisor will say now that you've told me that I've got to act you know can't let this go sort of thing..." (M5)

M5 does not offer whether she is referring to a specific incident. However, the use of language such as "ashamed" and "recriminations" suggested that whistleblowing has negative connotations rather than being about openness and upholding standards. They used the term "I guess" which could imply that whilst the manager was aware that practitioners fear cs she can only make assumptions about why this is so. The data suggested that if cs is to be taken forward then it has to be supported by managers, whose aim would be to demystify and promote the concept rather than perpetuate the insecurities around it.

Another manager participant described their reply to practitioners who have raised concerns about whistleblowing in cs.

> "...if somebody discloses something to you in clinical supervision then you've got a moral, ethical responsibility to disclose it providing the other person doesn't disclose it first... if you don't and you don't give me reassurance that you've done that then I will disclose it on your behalf and that's your consequence not mine. I think people understood that but then you come back to the view of well if people know that's going to happen what are they going to disclose and I think you have to say probably very little."(M9)

They appeared to propose that the role of the supervisor is to ensure that supervisees are accountable for professional standards. If standards are contravened then the supervisor has a responsibility to act. Whilst the initial response is to encourage the supervisee to blow the whistle this manager conceded that if the supervisees were aware of the action that a supervisor must take (if they contravene the Code of Conduct) then they would not divulge these types of issues in the first place. If the reality is that supervisees will not disclose to a supervisor in cs, why are participants still fearful of disclosure?

> "If you chose not to reflect your poor practice and we recorded then in a sense that's my defence you know in terms of poor practice being highlighted later on and people say well you were supervising this person. I would say yes I was in a supervisory relationship, here are my recollections of what we discussed. None of those were about that particular area of poor practice that's your issue not mine. So I think people are reserved and anxious about it but I think there are ways to overcome it." (M9)

This manager suggested that unless the supervisee chose to disclose poor practice within the supervisory relationship the supervisor cannot subsequently be held accountable. However, they do not address the issue that it is not just the supervisee who sets the agenda; rather it is a two-way process, in which part of the supervisors role is to probe and to challenge.

> "...the supervisor may not necessarily be working in the same areas some may not know the practice that you're coming up with and it really would depend on your disclosure. But we know that if you don't disclose something and it's later found out then you're equally culpable. So I think that's the professional risk you take I guess isn't it." (M9)

The concern that supervisees may inadvertently disclose and the fears that this engenders, appeared to have similarities to how deliberate disclosure would be handled. Indeed the same manager then openly discussed how individuals in the organisation perceived deliberate disclosure (which he terms as whistleblowing).

> "I think there is a suspicion in the organisation that if you whistleblow or reveal a poor practice you'll be scapegoated, you will cop for it, the other person will not. You will be the person that will have to move away, bow your head and get all the flack from colleagues because you were the one that disclosed. There is still that issue going on and clinical supervision perhaps is part of one of those." (M9)

Whilst participant M5 earlier discussed the shame and recriminations that might occur if poor practice was exposed. Interestingly participant M9 used similar language including "scapegoated", "cop for it", "move away", "bow your head" and "get all the flack". However this is in relation to the supervisor whistleblowing and the implications for them personally.

Another manager also recognised the potential dilemma of the supervisor.

> "...if somebody disclosed poor practice or misconduct then you've got the situation what do I do? Ideally you'd say this is all theoretical then you would encourage that person to go to see their line manager. That's not always easy, so then do you say as a supervisor "whistleblow" and that's not always easy. So sometimes it's better not to hear, than to manage a situation." (M8)

This last sentence suggested that the easiest response to disclosure is to ignore it. Acting as a supervisor could create potential difficulties, but there appeared to be no clearly defined strategy from both Trusts to protect staff that responded to issues that have been disclosed to them. She further added:

> "I think it's mixed priorities I think the aim of the whistleblower is to protect the patient. That's what it's all about but then you've got all the personalities in a team who are the staff and if that whistle...say... if it's a serious issue and if that person who is accused loses their job or they are disciplined whatever then you've got other staff and their perceptions..." (M8)

There is clearly a contradiction or at least a tension in this position. On the one hand disclosure or "whistleblowing" is seen as a way of protecting patients but the

consequences are that this might be at the expense of close colleagues, perhaps even friends within the nursing team. How far people may go to protect their colleagues might depend on the nature, type or even severity of the alleged malpractice. McDonald and Ahern (2000) investigated the professional consequences of whistleblowing and non-whistle blowing in nursing. They concluded that:

> "Those who had the courage to report misconduct suffered profound professional effects. Unfortunately this was an expected finding because a common theme in whistleblower literature is that organisations retaliate against whistleblowers with professional reprisals."(p319)

As a result, the nurse who upholds the Code of Professional Conduct by disclosing poor practice, can become a pariah within an organisation and perhaps even within the wider profession. The aforementioned study suggests that the consequences of whistleblowing are not a myth, but there are just a few isolated incidents which have gained a great deal of publicity within the national and nursing press. One example which is often quoted relates to Graham Pink who was dismissed from Stockport Health Authority for disclosing to the Guardian newspaper that there were staff shortages on the elderly wards at Stepping Hill Hospital, (Edwards, 1996b, Payne, 1999a).

Possibly the participants within my own study may have direct knowledge or experience of the effects of disclosure or they may simply have heard or read about someone else's experience. The fear engendered about disclosure can be so overwhelming as to prevent supervision from happening. Potential supervisors may shy away from becoming a supervisor, in case they hear at first hand about poor practice. Alternatively, as a supervisee they fear the reprisals from the organisation of disclosure (whether deliberate or inadvertent) and therefore avoid cs in the first place. One participant summed-up their own understanding of the effect on someone who has disclosed:

"I think in the past people have been hung out to dry." (M3)

It would appear that the course participants had a fear of cs, which tended to focus on inadvertent disclosure, whereas the manager participant's believed that practitioners' reluctance to undertake cs was (they thought) because of the implications of whistleblowing.

Whilst these two groups viewed disclosure negatively, the supervisees offered a different perspective. Although initially "fearful" once they had commenced cs they found the opportunity to self disclose as a positive, possibly cathartic experience. Inadvertent disclosure and whistleblowing did not appear to feature in their dialogue.

6.2.2 Consequences of disclosure

Those not having cs talked about its possible negative consequences whereas those in receipt provided me with the positive effects it had on them, not only professionally but personally.

Although the majority of the course participants were not having cs they were still able to offer their views in relation to potential consequences. However, these views tended to relate solely to the prospect of the consequences if their manager became their supervisor.

Participants were able to suggest why a manager as supervisor would not be appropriate or welcome.

"...I would not feel comfortable going to a manager with what's perceived as a problem unless I wanted to go and say "This is the problem. What are you going to

do about it?" But I wouldn't like to go to a manager with my innermost thoughts you know what I mean and I think quite a lot of people felt that."(C9)

" I think it might get a bit confused perhaps you wouldn't like to admit to something that you've done badly to your line manager, or you may share some things with your line manager but not in any great depth."(C11)

The course participants tended to perceive a manager acting as supervisor having a negative impact on the supervisee, depending on what they chose to share with them. Similarly in Scanlon and Weir's (1997) study they discovered that there was suspicion and lack of trust by participants when their immediate manager became their supervisor. Furthermore, Williamson and Harvey's study (2001) which evaluated cs training in a large NHS Trust highlighted that 91% (n=20) of supervisees in the pilot would not want their manager as their supervisor, although they failed to explain why this was so. Corrigan (2005) however was more categoric in her warning to managers who were considering clinically supervising their own staff that it could lead to "sub-optimal supervision" due to role blurring or conflict.

Disclosing any negative issues about themselves to a manager was viewed by course participants as placing them at risk of "professional death". They felt that they would be perceived as being incompetent and thus, any career opportunities would be jeopardized. I wondered whether this is an actual consequence or a hangover from a history of hierarchy and oppression within the nursing profession.

Interestingly, one course participant on her return from the course was asked by her new locality manager her views of cs. She used this opportunity to advise against using managers as supervisors.

"...should it be managers doing it or people like myself so I did have some input saying that if it was managers, my information that I had gained from other people

whilst I was on the course that if it was managers then it was more of a policing exercise..." (C12)

Participant C8 was able to share her experience of her manager deciding to become her supervisor within a small group of staff nurses and the tension this created.

"...can you imagine how I felt when our manager became our supervisor? It was so intimidating I nearly had a coronary I used to hate it and couldn't wait for it to end."(C8)

"Hating" the event and wishing for something "to end" are perhaps terms that Butterworth and Faugier did not envisage being used to describe the cs when it was first promoted in the UK nursing literature. C8 further offered that within supervision sessions,

"I felt uncomfortable because if I had an issue with a client she would say well you know you're a qualified nurse you should know that and you know it should be done that certain way and I would go out and I would feel demeaned and say to colleagues wait a minute I thought clinical supervision was about helping people you see and that when we found out that we didn't need to have our manager it was a big relief for all of us. Don't get me wrong she's not an ogre but when it is your manager you're very much aware of what you're saying." (C8)

Unlike the supervisee participants, this supervisor was not only her manager but also enforced cs on her. It appeared that there was little empowerment of the supervisee taking place but much in the way of disempowerment, this left C8 regarding herself as a failure and from the above quote it seemed that when she stepped out of cs she was angry with the manager for using it in such a way. She disclosed off audiotape that she and her colleagues hated the sessions so much that they would pre-plan items for discussion, which they knew they had dealt with correctly. This was possibly an attempt to regain some control and protect themselves from the manager within the cs

session. In doing so were she and her colleagues acting inauthentically? As she suggested that if she acted authentically, her manager may have perceived her and her colleagues to be incompetent. In subsequent interviews with the same participant the effect of her manager being her supervisor, criticizing her knowledge base, contributed to her feelings of inadequacy when she undertook the role of supervisor in the role re-enactment session of the course. She became tearful in the interview when she reflected on the course experience of being a supervisor. I wanted to rescue her as I perceived her as, a quiet diligent nurse, who lacked assertive qualities (she asked me throughout the interviews if she was saying the right things). Eventually she explained that as a group of staff nurses they did ultimately exercise a choice about their manager supervising them.

> "She stopped because the group didn't want their manager doing their supervision, so the group made the decision." (C8)

Other participants also offered their opinions regarding managers indicating that there may be hidden agendas to why their manager would want to be their supervisor.

> "If it's your line manager and that you've got issues about their practice that's not quite right and very difficult to talk about that and things are very difficult it would be easier to talk to somebody objectively whereas if it was their practice they'd be very difficult to be detached about something that they're doing if you wanted to change that." (C18)

> "I felt that there are too many boundary issues over manager doing it. No matter how nice they are no matter how empathetic... there are huge issues because they are the ones that are going to be doing the appraisals. They're the one if there are any problems they are actually going to be the ones disciplining so there is something not right there."(C19)

Two of the course participants were managers themselves and they commented on their own suitability of being a manager and supervisor for their staff.

"What I did do when I finished the course, because it made me think about how we offer supervision because I think I have said before in OT it's quite a structured system and it did make me query whether that was the best option and is that what people want. So I did an audit with the people that work in my team and came back. So I've got sort of control over them, really at the moment as to what they wanted out of supervision and how they felt it was going and who they would choose if they had a choice, who they would like to be supervising them and the sort of issues that they would like to bring up and it was what we were doing anyway. So that was quite reassuring, so that was good. So obviously I am supervising a few less individual people because I think I was doing about six."(C5)

"...they should look at me as a clinical supervisor and not as a manager and that I would try my best to be a supervisor rather than a manager. It is difficult though and that I have now got the supervisors head on and you know all the things that you say. They have been open and frank and stuff or seems to have been anyway, so I mean I know, there have not been any problems I mean big problems that I am unaware of. I get the feel that there isn't." (C16)

If I had interviewed these participants' supervisees would they have agreed with their comments? However at least these two course participants were able to reflect on the experience and "check out" with their supervisees the appropriateness of also being their manager.

Overall, from the course participants' perspective most appeared cynical as to their managers becoming their supervisor. Whilst they used terms such as managers having "a hidden agenda" and "judging performance", they did not clarify how managers might use or misuse this information.

Some course participants alluded to the fact that working with someone and becoming their supervisor/supervisee may make it difficult to have daily contact as the supervisee may feel under constant scrutiny.

"I'd rather be supervising somebody that I didn't see on a daily basis, I don't think it's fair to the other person because they must feel that they are you know under a magnifying glass or something."(C7)

The majority of the feared consequences were unsupported by any firm examples or evidence. Interestingly Lyle (1998:8) discussed the issue of whether managers can supervise and concluded that whilst the role "crossover" may be difficult it is not insurmountable as long as the managers have an understanding of the concept of cs. Furthermore, whilst she recognised that there was suspicion there is little if any discussion within the literature of the managers own vulnerability as a supervisor.

6.2.2.1 Consequences of the "scenario"

In relation to the consequences of disclosure one of the lecturers introduced a scenario into the course (I am unsure whether this was based on actual events), which had a significant impact on three course participants, all from the Acute Trust (C6, C8 and C9). All three were able to graphically describe the "scenario". I have incorporated one extensive quote which I believe demonstrates the negative effect it had on these individual participants.

> "Well (tutors name) gave a case about somebody that she knew. There was a young lad on her ward that had been diagnosed with cancer. All his family knew but he wasn't to be told. This lad kept hassling her all the time. So she went to her clinical supervisor and said that she felt that he should be told because he was the patient so he should be told... the clinical supervisor gave her advice and said that if she feels like that maybe she should do it. So the next day comes, along comes the lad he asks her and she tells him. She went to get a doctor to clarify and he jumped out of the window and she said that she was up in court and so was the clinical supervisor...and I was saying that you've said in one breath you know that you can't be liable for somebody else you know by saying I told you so, why was the clinical supervisor in court but it was obviously just to say that she'd brought the problem to her and that I found a bit... if you say something and somebody acts on it."(C9)

This scenario resulted in an action by a nurse which had the worst possible outcome to patient, supervisee and later on in court for the supervisor. In some ways it is not surprising that some course participants would have an apprehension of undertaking the role of supervisor. To be aware of the potential implications of their actions is

important, but for them to be as traumatic as described in the scenario would possibly cause anyone to have second thoughts about putting themselves in this position.

Having a formal session on legal aspects in relation to cs rather than empower appeared to heighten course participants' fears of the consequences of disclosure. Some were unsettled following a session on setting a contract with a supervisee and the legal implications associated with cs.

> "I think that ethics can also make you a bit frightened can't it and you think should I really be doing this and how legal you know what if I put my foot in it and say the wrong thing to somebody?" (C10)
>
> "I know that they do it every time you go they do the legal issues and I think that that scared a little bit you know... every time I do a course at the school you have the legal lecture and every time you come out of it and apply for a job in Marks and Spencer's. It's just one of those you know it's, you come out, you put it into perspective but no legal issues need to be in."(C9)

This course participant jokingly remarked that the potential stress associated with the legal aspects of nursing could lead to her resigning and undertaking work in a department store. Conversely other course participants indicated that they were used to hearing sessions on the legal responsibilities that come with extending one's role such as cannulation and venepuncture.

> "No it didn't really because I think everything you do everyday in your job as a qualified nurse you've always got to be aware of your accountability and I think the legal issue is there and as (tutor) was saying to open your eyes it wouldn't be right for her not to let you know what you're letting yourself in for and it is in every aspect of your job whether you delegate something who you delegate it to things like that. You need to know the position you are putting yourself in really for your own protection. So I didn't let it put me off I mean it just raised my awareness." (C17)
>
> "So it's good generally to be reminded of your legal boundaries but the more courses you do they talk about legal issues in a way I think it releases the tension you have fear of litigation..... I don't think she frightened people. I think she tried to alleviate any problems we may have...and if you stand back you realise that we're a

lot more aware now of litigation now and your boundaries and you will be aware if someone discloses something to you won't feel so threatened."(C1)

It would appear from the quotes that the legal aspects session did highlight the gravity of the role of supervisor to the course participants. The incorporation of legal aspects and the supervisory relationship was a matter, which Jenkins (2001) stated could be viewed negatively by those in attendance. Indeed, whilst the lecturers may have had a responsibility to incorporate this session into the course, I wondered whether it increased anxiety rather than empowered the participants to feel safe through increased knowledge of the legal implications of cs.

With regard to the supervision notes (although it is only the view of two participants), I believed it to be a significant reason why one person was particularly reluctant to become a supervisor and the other stated that she was aware that it made other course members feel uncomfortable.

"It wouldn't put me off but I know some people were saying they would write everything they said and one of the lecturers said "well I just keep a note in my diary" and I thought to myself that I wouldn't write anything down because then you might get something wrong. I think it is safer not to write anything as a supervisor and maybe both sign to say these are our ground rules and apart from that just see how it goes during the session." (C15)

"I actually thought there would be an initial sort of contract that you would do between you and supervisor you know regarding each other and respect and what you would say would be confidential or that sort of thing. But I didn't think every time and to be honest that would be the biggest thing that would put me off because at the moment you are writing reports and some times it's hard to get out of the office to actually visit and that's what would put me off." (C13)

So whilst C13 believed there should be a contract in place she was more averse to keeping notes post supervision. She stated that she saw record keeping as an onerous

task but this maybe as a result of her being a health visitor and report writing is more akin to this specialized area.

> "I feel sometimes in nursing there is too much paperwork and people are put off and I think some of the things that people want to discuss they don't want a record of. Especially issues around conflict and critical incidents I think its something that you can learn from but you don't particularly want it documenting...I think that people feel that the idea of writing something down is quite threatening in a sense it's a bit like a diary where people put in all their inner most thoughts, it's not to everybody's taste."(C13)
>
> "I also think that if you're in a quite stressful job anyway you don't want to be taking on the stress of all this note-keeping and worrying that somebody is going to tell you something that you are going to have to report." (C13)

C13 saw keeping notes as a threat and if there was a record then she was duty bound to act on it. In relation to the Code of Conduct if you are aware that someone is not upholding it then as a qualified practitioner one has a duty of care to act appropriately, whether there are records or not.

Indeed, Cutcliffe (2000) discussed the need for recording within the cs process. He offered that there was no "one perfect way" to keep notes but that both supervisor and supervisee should be mindful of the issues related to it at the outset. Furthermore, he appeared to favour minimal recording as this was less supervisor focused and would avoid overlapping with managerial supervision.

From the managers' perspective the consequences of disclosure tended to relate to supervisors having to deal with issues raised in cs by supervisees.

> "I think it comes down to people feeling that they may be out of their depth if other people bring issues of concern to them to discuss."(M1)
>
> " ...but I think people are probably frightened because (a) they don't want to lose their job, (b) it pays the mortgage and they get a salary at the end of it and it's a

development career. So why would someone want to put that in jeopardy and I can see why people would not want to take clinical supervision up if that's how it may be viewed."(M2)

It would appear from this manager's response that there was a potential risk of loss (monetary, employment and career), if disclosure took place and practice was subsequently investigated. What was unclear was what steps if any managers took to reduce these fears and raise the profile of the concept, so that it was viewed as supportive and empowering to practitioners.

"There is a great deal of nurses that report to me that they are not going to do it because at the end of the day people are going to report back to their managers about problems or something that they had felt that they had done wrong and action will be taken. In other words there's a feeling whether they're real or imagined that we are part of a blame culture and that clinical supervision is enabling that process to identify people to become scapegoats for various things."(M6)

Thus practitioners not only feared whistleblowing when engaging in cs, but also by disclosing issues within a session that they may be reported back to their managers, who could take potentially detrimental action towards the supervisee.

Conversely, another manager commented on nurse's perception regarding how managers deal with poor practice. He explained that even when incidents are dealt with satisfactorily, the nurses within that Trust will only remember the harshness with which a practitioner is dealt, not the support that they may have been given.

"Because there are a lot of examples where there is a blame culture in nursing. A good example is we try when a nurse makes a drug error to say, look you're not necessarily going to be disciplined for this it may be something that we may need to look at and need to improve the system of drug administration. To reduce the risk of that error happening again you can report that mistake anonymously, we can do something to make the whole system safer. But you get one incident where a nurse makes repeated silly mistakes through carelessness and gets disciplined and that gets all around the Trust, nurse disciplined for making a drug error. So therefore no-one is going to report drug errors again or mention they've made a mistake. So it's about

perception really I guess, you know they have a perception that some managers are disciplining people for making mistakes without really going into why did they make that mistake. So nurses are fearful and there are a lot of examples of where there are not good managers and where managers are blaming and not supporting staff and they tend to remember the bad examples.... rather than the three or four nurses that have all the support in the world when they made a mistake."(M5)

Furthermore one of the managers discussed why she thought that nurses in general feared disclosure and the action of managers:

"In other words you don't trust any of your employees; you know you look for what they're doing wrong rather than the other aspects. So definitely I think it's a NHS culture. Having said that nurses are the biggest numbers in the NHS so it's obviously going to be replicated within nursing and within the nursing hierarchy."(M6)

Whilst she admitted that there are inherent problems with managers historically fostering a blame culture within the NHS, she did however see that change is taking place. There is a greater focus on leaders rather than managers within the NHS (Casteldine, 2000), which can be seen in the "LEO" (Leading an Empowered Organisation, Jones, 2005a) and the "RCN" Leadership programmes that have become popular in the last three years. However, M6 did not see that all NHS changes were positive, such as the introduction of the "modern matron". This appeared to be a political, populist idea that would reinforce to the public and nurses in general that the matron was what was needed to reinforce and improve standards within the NHS. However this manager viewed the matron's image historically as one of discipline, control and autocracy.

"...we're trying to get away from the blame culture...getting creative and innovative leaders into nursing rather than suppressive and autocratic managers and the whole ethos around modern matrons is conflicting with that. Because we've got the image of the security of somebody who's big and butch who will come in and tell you off and you know that something you know that politicians idealise as the root of.....the cure of the NHS and yet that's reinforcing subconsciously the old agenda which is basically the bullying and controlling agenda rather than the empowering and supportive."(M6)

A manager within the same Trust explained that the organisation liked to describe itself as having a no blame culture but she suggested that, that was not quite true.

> "...but I don't think that we're at a no blame culture. We advocate in this Trust and it comes down from the Chief Executive a no blame culture but I don't think we're there yet we're a long way from it and I think senior managers and Trust board members have to accept that first before it will end...I do think it will change eventually in the Trust and I think it will only happen if you've got people who will accept change." (M2)

Another manager envisioned that supervisees would disclose and as a result she would only choose senior staff to attend the supervisor's course. In so doing, she believed that this could ensure the correct procedure would be followed, if disclosure were to occur.

> "It is going down the whistleblowing route but I think that's one of the reasons we chose more senior people because if there was anything disclosed you hoped that they were at a level were they could deal with it sensitively and know the answers." (M3)

Overall the manager's perspective discussed how nurses would possibly distrust the concept and likened it to whistleblowing and working within a blame culture. Whilst they highlighted that there was a climate of change within both Trusts, I wondered whether this change would lead to a greater level of trust within the nursing profession and signal a more positive response to cs in the ensuing years.

The course members expressed their fear of disclosing poor practice (as supervisee) and having to deal with disclosure (as supervisor). Similarly the managers also recognised that this could be a problem, which could prevent cs from being embraced.

Having examined excerpts that I used within this chapter, I became aware of not only the negative terminology, but also avoidance of undertaking cs, as it was perceived as a potential confrontation regarding nursing standards and professionalism.

A compilation of some significant words, which both the course participants and managers expressed, included:

- "Awkward", "fearful", "horrible situation", "be careful", "say something you shouldn't", "guard up a little bit", "suspicion", "Big Brother watching over", "recriminations", "fear", "scapegoated", "cop for it", "better not to hear", "done wrong", "blame culture".

In comparison the supervisees described their initial reluctance to having cs as

- "Daunting", "bit scary", "apprehensive"

However, when the supervisee's described the experience of being actively engaged in the process they used more positive terms such as;

- "Professional integrity", "support", "non-judgemental", "get things off my chest", "feel better", "gain insight"

From a concept that was developed to enable and empower nurses within their professional role, this study has exposed an emphasis on the accountability of the nurse. If nursing or all caring is guilt based trying endlessly to make something right that could not be put right, then this state of affairs would be psychologically traumatising for nurses- flooding them with anxieties with all that entails.

The supervisee participants were able to speak objectively that there was a fear and vulnerability in being a supervisee, but the benefits outweighed any lasting fears that they had. This was in spite of some of the supervisees previously having poor cs, but moving to a more suitable supervisor.

"I don't think that we're trained to accept that we don't know everything and we're supposed to be in charge, in control, sorting everything out and it doesn't feel like that sometimes." (S5)

This participant identified like (C15) that nurses believe that they should know everything, but her honest response went further, when she stated that the way in which nurses have been educated has led to their own high expectation of themselves. She appeared to be in a state of acceptance that nurses, herself included, are human and so could and would make mistakes. Initially she tended to talk from a general perspective. However as the interview progressed she expressed her own feelings of vulnerability.

"Over three or four years I've had lots of difficult situations and sometimes have left clinical supervision feeling very vulnerable, but my supervisor has identified that and suggested other strategies that I've used as well."(S5)

Again this seemed to suggest that she accepted her human frailties but also looked (through having cs), for ways to overcome any difficulties. This supervisee went on to disclose a complaint made against her and how, through having cs, it resulted in her seeking counselling:

"...a complaint a number of years ago now which was a terrible... and there wasn't an element of truth in it...it was absolute hell and clinical supervision then was very difficult...It is so difficult because you know it's like somebody stuck a knife in and having a supervisor say to you well actually I think you need some help here's the number for the counselling centre... it's felt negative sometimes but there has always been a positive sort of spin off from it."(S5)

Her description of the complaint I felt was very graphic ("somebody stuck a knife in"), her use of this language provided me with an insight into her pain and suffering at that time and how her supervisor recommended she sought counselling. Would she have identified the need for counselling without having cs? She demonstrated that cs can act as an opportunity for nurses to reflect and examine strategies to help them in the future. By accessing therapy, it also demonstrated that cs was not counselling, which was a criticism

that course participants highlighted in some interviews, as discussed in the previous chapter.

It may be argued that without disclosure, there will be no reflection on action and without that there will be no change to how a practitioner functions. Supervisees in this study appeared to understand the boundaries within the cs relationship and that inadvertent or deliberate disclosure would not necessarily result in action by the supervisor, but may begin with the supervisee.

Another supervisee explored feeling threatened as a practitioner and suggested that in the past it would have resulted in him, as well as others feeling the need to apportion blame. This seemed to be a coping mechanism that nurses used to protect themselves. He now appeared to view most nurses as people that do not set out to make mistakes and it should not lead to practitioners being blamed, instead he recognised through cs that nurses need to be helped and supported.

> "Certainly I feel threatened but yes you can blame...often it's much easier to blame someone when something has gone wrong than to actually look and say why has it gone wrong, what could that person...I genuinely don't believe that there are many people in a hospital this size who come to work to generally do ill to people, deliberately make peoples lives a misery by missing things out. Things happen either through lack of knowledge, lack of experience, lack of resources around the place."(S1)

6.3 Conclusion

To conclude on the findings related to disclosure, it would appear that those who were not in receipt of cs, despite the training, believed that, by taking part, they were potentially placing themselves in a vulnerable position. This was a risk that many were not prepared to take. However those who did choose to have cs, whilst similarly expressing terms such as "vulnerable", "miss things", "difficult situations" also offered that they needed to explore their worries, fears and poor practice. Thus they were able

to take the risk of entering into cs in spite of their own previous reservations and whilst at times painful, they saw that the positives far outweighed the negatives. This "leap of faith" into having cs in spite of potential concerns is also evident within the literature (Eltringham, Gill-Cripps and Lawless, 2000). Through a series of reflective conversations they explored their perspectives both "then" and "now" regarding becoming a supervisee and entering into the supervisory relationship. All three authors were in senior nursing and educational roles undertaking a BA Ed (Hons) in reflective practice. Similarly within this study all but one of the supervisee participants were in senior nursing roles and this may be a reason for a greater feeling of security within their role and less vulnerablity. Participant S5 alluded to this when she discussed disclosure and feeling potentially vulnerable during cs:

> "I think it's only when you get more knowledge, more confidence, more experience that you're likely to admit to it and that comes with insight into what happened at different times in your career. But unfortunately it's like the chicken and egg isn't it I think that clinical supervision helps you gain the insight, so if you're not having the clinical supervision will you ever gain that insight to sort of choose a supervisor..." (S5)

According to Sellars (2001), the way cs is presented to practitioners will result in its adoption or rejection. They emphasised a transparent means of enhancing quality if the concept is to be embraced and this was how I viewed the supervisees' responses.

The course participants verbalised to me over a series of interviews that one of their main concerns was that of disclosure. Disclosure has been explained as falling into two possible areas: inadvertent and whistleblowing. The former is what was most expected by the course participants, who were concerned that supervisees would disclose something that they or their colleague(s) had done, it would then need to be acted upon by the supervisor.

The managers however suggested that a possible reason for course members not wishing to act as a supervisor was that they would have to deal with deliberate

disclosure, which they termed whistleblowing. I wondered whether disclosure was a real issue in the profession or something that was not talked about, but was always in the background and something that nurses developed a fear of. Alternatively it may be that nurses have witnessed negative aspects of how disclosure has been dealt with by colleagues and management and it is something that they wished to steer clear of, to protect themselves from uncomfortable consequences.

Chapter 7
Findings: Time

The lives of human beings are, to a certain extent, governed by the phenomenon of "time". Time to wake, sleep, eat, work and socialise are all part of our daily routine and more so if there are dependants to care for.

Generally, nurses tend to work shifts, with their time on duty normally being for a set amount of hours. However, it is the pressure of time whilst "on duty" which appears to make the most demands on nurses (Boykin and Schoenhofer, 2000). Furthermore, healthcare professionals have witnessed and had to respond effectively to the significant changes in the NHS (Crouch, 2001) coupled with the emergent NHS internal market in the 1990s which brought added pressures. This Tovey and Adams (1999) described as being:

> "...associated with new roles, role conflict, lack of job security, "tight resources", using new technology, a perceived lowering of standards of patient care, coping with increased amounts of paperwork and the experience of working in a rapidly and constantly changing environment."(p150)

7.1 Defining Time

Hendry and Farley (2004) described "time" using two Greek words *"chronos"* and *"kairos"*. "*Chronos*" refers to the familiar everyday time which they described as

> "...time moving relentlessly forward or as time passing." (p81).

Whereas *"Kairos"* was described as:

> "...a propitious moment, a golden opportunity, a time not to be missed or wasted." (p81)

Similarly Heidegger described time as

"Human existence [*sic...which]* always runs ahead of itself in expectation and lingers behind in memory"

(Being and Time 69,498n.xxxiii Moran 2000:231).

7.2 Initial emergent sub-themes related to time

Time emerged as a significant finding in relation to how there was a "lack of time" to engage in clinical supervision (cs) or the importance of "making time". Through my handling of the data I was attempting to fully understand how "time" impacted on the participants and furthermore how it may have prevented many from having and/or giving cs.

Initial emergent sub-themes, included the following:-

- Too busy, not enough time in the day to have cs (time running away)
- More time required for the course
- The importance of time as supervisor and supervisee
- Time was used informally for cs
- Time being invaluable
- The organisation and time

During the process of interpretation I developed more abstract categories into which these sub-themes could fit. This resulted in three major sub-headings in relation to time;

1. Too busy, not enough time
2. Practice/ experiential time
3. Quality time; reflection and problem solving

7.3 Too busy not enough time

The course participants saw the value of cs, but a major logistical problem was being too busy, resulting in insufficient time. They provided analogies of "running around headless" and to access cs they would require a replacement to cover their workload. Many identified that this "busyness" was due to providing patient care, fulfilling an extended role and as a result of staff shortages. It could be argued that it may be easier to highlight lack of time as an issue, because this is difficult for others to challenge. Furthermore, the media image of the NHS is that it consists of overworked, poorly paid nurses (Hart, 2004). Several authors within the nursing literature have cited lack of time as a major barrier to practitioners implementing or accessing cs (Duarri and Kendrick, 1999, Howatson-Jones, 2003, Sellars, 2004, Stevenson, 2005). Indeed, Kell and McSherry (2002) stated that:

> "Spending time discussing practice issues is often seen as a luxury rather than a necessity. Unless staff are doing something that is visibly performance-related they are not seen as doing the work they have been employed to do."(p29)

Furthermore a study by McEwen, Cooper and Clayworth (2005) also demonstrated time pressures on senior clinically based ward staff. The results indicated that one third (no numbers provided) had insufficient time to evaluate current clinical practice, two thirds were unable to support staff and over half the staff that responded did not have time to have cs. Within my study the senior manager participants also saw nurses as being constantly busy. One manager participant suggested that with the introduction of non-nursing managers they may perceive giving staff time away from the clinical area to reflect on practice as a strange concept.

> " ...allowing somebody time to go and discuss things that must have sounded very strange to non-nursing managers really." (M1)

She cited a culture within the profession, which does not embrace the need for nurses to reflect on practice through cs.

> "It's not the culture to allow people time to go somewhere to discuss something. Unless it's a meeting as in a formalised meeting and as I say that was the culture to change a barrier to be broken down and that's a professional issue really. Nurses are just not used to being allowed just a little bit of space (whispers last 4 words)." (M1)

Instead, it would appear that when a nurse comes "on duty" they are confronted with a plethora of tasks to complete:

> " ...nursing staff come in (On duty) they see what has to be done and as in patient care and then off they go, they're running in all directions to make sure the patients are washed, dressed, fed, pressure sores, dressings and medicines."(M1)

Burnard (1991) described an analogy which marries with M1's view of nurses "running in all directions" but failing to take time to reflect on the wider picture when he commented that:

> "This pressure of work and limit of time relates to a person rescuing people from a raging river but being unable to stop and go further up the river to see what is causing the people to fall in." (p6)

The busyness within the ward environment did not appear to be about face-to-face contact with patients, but more to do with tasks and dealing with doctors. This resulted in a course participant reminiscing on her nursing role years earlier and the fact that nurses are now more technologically driven through their extended role.

> "The people who are talking with the patients is the cleaner who comes on in the morning, who's just going about her work and they see a person upset. They will be the one's who sit down and have a little gab to them for about ten minutes. Whereas the nurses are doing doctors rounds, dressings, answering the telephones all these clinical things... You know I think it's possible for some nurses to go on duty and not even see a person on their shift or pass the time of day with anyone."(C2)

As a result of being busy the participant stated that nurses were too tired to have cs, whereas managers, unlike nurses, did have more time in the day.

> "The managers aren't in a clinical role but what are they doing, they're walking around in mufti in the wards asking everybody if they're alright when the rest of the Indians are running around like scalded cats."(C2)

It could be argued that the managers like the cleaner were at least taking the time to speak to the patients. During the study this particular participant changed roles reducing her grade to work nights as a bank nurse. When I asked her why she did this "time" appeared to be a significant factor. Not only greater time with her family, (as she was now in a position to choose nights she wished to work), but also she saw working night shifts as being an opportunity for more time to give direct patient care, compared with day duty.

> "I've worked on night duty for some years and one of the attractions is that I feel that there is more time to speak to the patients and we sort of work in the older way. We go round the ward every night you talk to each patient and make them comfortable." (C2)

However, in subsequent interviews she admitted to being busier generally and that time again was now running away.

> "The nights are now starting to go the same way as the day as they put less staff on as I was on a busy surgical ward recently there were 36 patients I've got half the ward so I've got 18 patients and I'm working with a HCA. There were eight epidurals, we had problems with three and had to get the anaesthetist down three times during the night. One little man started vomiting all this faecal fluid everywhere. Another little lady in the side room started to have a P.E, she was very breathless. Another man arrested and this all happened within the space of an hour."(C2)

She like other participants provided me with actual examples of how busy she had been on a shift. I wondered whether the participants were sharing these examples with me in

an attempt to justify why they had not started cs post course. Their examples were always told at a fast speed, with few pauses.

> "I have been busy. As regards clinical supervision I must admit I haven't, which I feel is a shame but I have been doing nurse prescribing, institute supervisory management course and a diabetes thing. So I have been really bogged down." (C17)

> "...like today I'm the only trained member of staff on this side and I've got a trained bank on who hasn't done this ward before and I wouldn't be able to go to clinical supervision for an hour... as you can't just leave." (C10)

This gave me a valuable vision of how they felt under pressure from a variety of sources and how cs was seen as being potentially an extra burden, which could further drain their precious time. C10 described staff shortages which resulted in her being unable to leave the ward area, she reiterated this again in another excerpt. Her body language was closed with her arms and legs crossed.

> "I think really we have just been unfortunate on the wards with a lot of staff off sick and we have had three or four members of staff that have left and I think we have just been so busy. I didn't have the time to ring around you know to find someone to (I have even forgotten the word it's been so long) you know to talk to and I think I am just going to have to start again. You know when the ward is a little bit less hectic...I have not had the chance to get round to doing clinical supervision. I make myself sound like I am running around headless but I am not, I am alright."(C10)

However, it was not only the acute course participants who were time pressured. C12 commented:

> "In health visiting in particular it's not as if anyone else does your work. You come back to that mountain plus the regular stuff that's coming in. "(C12)

I interpreted this as being that ward nurses may have more opportunity to have cs because there would be others to undertake the work on the ward, whereas health visitors carried their own case load. Conversely, another course participant (also a

health visitor) initially suggested her role gave her more autonomy to be able to manufacture time to undertake cs if she wished to do so.

> "...I have worked on a ward and I've been absolutely rushed off my feet and not had space. Here you can make your own space you might not have it for three days of the week but there's always sometime within those five days you can get space. We work on our own; it's a different way of working." (C13)

However following the course she commented:

> "I think it would be quite difficult within the community because of the fragmentation of the staff and the actual logistics of getting to destinations and the time out of your workload and all the time you are looking at more and more being added to your actual working day." (C13)

Other participants spoke in terms of bargaining:

> "But it's having time to do it. I just wish we could have another half a staff nurse (laughs) but no-one is going to wave a magic wand so." (C18)

> "If they give me a few more months, experience, because at the minute I haven't got time to fit it in, you know I only just about have time you know to have my own supervision." (C4)

For C18 bargaining came in the form of more staff, whilst for C4 it was for more experience and then she would become a supervisor. I wondered whether they were trying not to hurt my feelings by reacting inauthentically, just saying, "there is no time, I'm too busy". Interestingly, the next participant explained that she had been busy, but now staffing levels were near normal she would be able to commence cs (a view supported by others). Again I wondered whether this was to appease me and whether my initial interviewing technique may have demonstrated that I supported the concept, resulting in the participants not wishing to offend.

> "I did start doing some clinical supervision but because of staff shortage this year there really wasn't any time to fit it in. I mean there just wasn't any time. All the time had to be spent out there on the floor, with the patients. Now that we've got our full quota of staff back we've just started our clinical supervision again." (C8)

I did become aware of my own reactions and body language within subsequent interviews and I did feel that the participants became more open and at times forthright about why they were not having or giving cs.

> "... initially I was keen and I thought I'll get sorted next week (with a supervisor) but as the weeks and months went on I haven't done anything about it." (C10)

> "I feel as if "do I really want to have the hassle of somebody else's problems?" (laughs) (C13)

This suggested that participants were concerned not only with the time commitment, but with the potential for additional stress as well.

Further to being busy, many participants also implied that there was a need to prioritise their workload. As a result, cs was one of the first casualties, so whilst they accepted the role in principle, ultimately they may not have seen cs as that important.

> "It's taking us away from our area and there's work we could be getting on with like doing more important things." (C8)

> "I know myself with time pressures and all these people; it would probably be the first thing that I'd cancel." (C15)

> "I must admit I didn't get round to doing it because you put yourself at the bottom of the pile I suppose don't you? If someone rang me and said "can we start doing it", I wouldn't say no but what I'd probably ask them to do is book six months in advance every month so that nothing came up." (C15)

Time pressures seemed to have been a barrier to setting up clinical supervision. Putting herself "at the bottom of the pile" was a graphic response, which conjured an image of a nurse constantly time controlled and always prepared to "give" but not "receive". Is this how most nurses see themselves?

> "We set three dates and each time, one of them he booked a week's holiday something he had to book because he was having family problem and that was.... supervision was cancelled. Then I got called for a meeting an important meeting with... so I had to cancel."(C16)

Again this suggested that it had a lower priority and led me to wonder what the supervisee thought when their cs session was cancelled over a meeting.

The need for nurses to prioritise was a strategy identified by Waterworth (2003), which, when in place helped nurses to manage their time effectively to meet the demands of their role. Manager participants also discussed competing demands and admitted that concepts like cs could become fashionable and, as such, were only considered a priority for a short duration, but then lost their appeal.

> "The other problem is other priorities take over you know. It was flavour of the month five years ago but seventeen thousand other flavours of the month have come out since and so it tends to drop down the list." (M5)

> "If you have crisis situation then things like training and clinical supervision become a lesser priority and I think it was the everyday realities." (M8)

Being busy also meant that participants frequently finished late from a shift. Intrinsic to the role of the nurse appeared to be that they give freely of their own time to care for others, but it was an alien concept to take time back for themselves.

> "I went home my head was spinning and it took me ages to wind down. I should have finished that shift at 0745hrs but I ended up getting home at 10am ...I think nurses tend to give more than they receive. I think that's always been the case. People, even though they may be sick or tired, they will still work these long days and end up getting all stressed out because they can't say "no that's enough."(C2)

One manager participant suggested that nurses being busy was due to the socialisation or culture within the nursing profession and that this may be management driven.

> "...the busier people are on the wards then the greater the need for clinical supervision and the less chance of that being made available. Because they're encouraged to tether themselves to the beds and get on with the daily grind as it were..." (M6)

Glouberman (2003) supported these findings when interviewing "Janey" a health consultant and editor for her book the "Joy of Burnout".

"Nurses are expected endlessly to put their own needs second. They're at the front line of dealing with so much distress and pain and abuse...So they give themselves protective shields. In the long run this is very dysfunctional and alienating. It's a lot to do with why people don't care for each other within the system." (p117)

Paradoxically these "protective shields" may also prevent practitioners from seeking or accessing support mechanisms such as cs. By being time pressured, some participants suggested that the only alternative would be to undertake cs in their own time.

> "Maybe we discussed on the course doing it out of hours but people just want to go home, sort out their family, do their own thing. Time doesn't seem to be set aside for it. Limited time anyway." (C2)

Others however, understood why this should not be so, a perspective commented upon by Howatson-Jones (2003) who stated:

> "Staff are often expected to undertake such activity in their own time, possibly contradicting the ethos of a learning organisation, and due to high work demands are reluctant to do so." (p42)

Indeed the UKCC (1994) stated that cs should be undertaken in work time. Hawkins and Shohet (2000) agreed and likened cs to the mining industry. Miners would have their shower in works time, after they left the coal face and before they clocked off. Similarly cs, the essence of which is a discussion of practice issues, should take place in work time.

Several managers suggested that, because cs was not mandatory or indeed a "target", this meant that nurses would always cite lack of time and it would never be fully embraced within the profession. They cited the implementation of new matrons and suggested that if cs was a target, then they would ensure that time was made available to practitioners.

"We don't drive it whereas if it was a target that 100% of staff had to have clinical supervision and had a book signed we would then say well here's a timetable you're going Monday for clinical supervision." (M2)

It would seem that both Trusts had a strategy to implement cs in the workplace, but it may have been poorly planned and possibly unworkable.

"Well I think the original policy for our Trust was unrealistic. So to release somebody from the work area for nine half days per year in addition to training and holidays that's got an impact on service." (M8)

In contrast another manager believed nurses cited lack of time too easily and commented that:

"So I think the argument about insufficient time.....is if everything else is working okay is a little bit of an excuse that people can throw up very easily." (M9)

Lack of time did not deter all course participants, as some actively engaged in cs and compromised by undertaking it within their own time because they saw it as valuable for themselves and others.

"I came in early and I stayed a bit later and we sort of compromised, did half an hour each of our own time." (C3)

A supervisee who also acted as a supervisor supported this view stating.

"I think it's about people having that time out, time off even now with some of my supervisees it's in their time or after work or lunchtime." (S5)

Further support came from a manager who discussed how she had attempted to set up cs in her department, by incorporating it within the working day or by giving time back to practitioners:

> "...are they given time in their workplace? Is it rostered into their duties or is it negotiated with the manager and then at the end of the month you have time back and that's what I offer the staff here." (M2)

However a course participant raised the fact that if she was providing cs to a group she believed it would have a high cost in time for her to undertake this task

> "If three people come to me for three hours a month then I have to then go and offload on to somebody else you know how are they going to manage the time on that I really don't know, it'll be interesting to see if that really works." (C9)

Whilst some participants could organise time within their working day, one participant had a dual role as an educator for one day per week and was community based for the rest of the time. She was positive towards the process, but there was a tension in that her training manager provided time and support, but time was limited in clinical practice:

> "My manager (training department) there is very good. She's very interested in training and development and so I do get quite a lot of support from her and things and a lot of advice as well. My manager (community) here is very good but obviously time and things are tighter you know because of the work environment and because it's a very busy caseload." (C18)

The supervisee participants also recognised that time might be a common reason that nurses would cite for not engaging in the process:

> "Time is a big issue for everyone. I think that's why a lot of people when they have done the supervisors course say it's not that they don't want to supervise, that they don't feel comfortable it's the time and the commitment. Everybody's time is precious." (S4)

Whilst there was an appreciation that time was an issue, the supervisees also offered a different perspective. Time was two-fold; allowing supervisees to make time to have cs and then spending time within the supervisory relationship to discuss pertinent issues.

> "To look at where am I going, what am I doing, what should I be doing and just have time to be able to sit and know that that time is for you and that person is listening and guiding that's a great help."(S6)

Interestingly, the next supervisee participant disclosed that his role as a middle manager provided him with greater flexibility with his time.

> "I think it's easier for people in my position you know. I'm not on the ward delivering care seven and a half hours a day. So I have a degree of control over my diary and I'm quite adamant that that time has to be in." (S1)

When interviewing the senior managers (n=9), five admitted to having regular formal cs, three had informal peer supervision and one did not disclose either way. Like some of the supervisees they had greater flexibility and autonomy because of their seniority.

> "I have clinical supervision now with my lead director...I find it effective yeah I do really probably because it's my one opportunity to talk to people outside the directorate about issues I think are relevant. I guess it's also my time to blow my top and have a moan and a groan as well like everyone else does to a point where it's constructive rather than destructive. It's not about slagging but about venting your feelings and trying to get rid of it. So I think it's been very helpful." (M9)

> "I wouldn't be without it personally because I make sure I have it and that's my responsibility. Maybe I've cottoned on to the fact that I need it and I make sure that I have it and I make sure I've got time in my diary." (M8)

She saw that for cs to be a reality then it required commitment from management level:

> "I don't think the senior managers promoted it and I think you need to promote and reinforce. Again we keep going back to time. It's time, it's motivation, it's encouragement and audit. This is important this should happen and also to create the right atmosphere... where does it take place? Making sure that there is a room available, it's one hour, it was too open too flexible."(M8)

This manager later disclosed that she felt she could be trusted to use the time more appropriately than less experienced practitioners. This suggested that whilst nurses are reluctant to take time, some managers may also prevent staff from accessing cs, perhaps doubting that they will use their time wisely.

> "You do feel better if you have somebody and also on the one-to-one, I'm not saying this would happen on the wards but at my level it's very civilised. We meet at twelve and we have lunch and then we spend the entire afternoon talking and clinically supervising each other so it's something to look forward to as well....I think if you're going to make it happen with D and E grades I think it would be difficult... because then you can lose a bit of control."(M8)

Was this because they would be unable to control what was discussed or audit its effectiveness? Were managers being careful introducing cs, so that it did not appear too attractive to practitioners that they would all wish to undertake it?

A supervisee, (manager within a community mental health team), explained that he saw it as his responsibility to make time for his staff to have cs. He was less apprehensive about staff using the time constructively and somewhat philosophically commented:

> "If they want to use it or abuse it when all is said and done all I'm going to lose is an hour...There are precious few perks in this job. The fact that you've been given an hour off to actually go and get something out of it and come away feeling a bit better about something then take it with both hands...and then say to them you make the approach you find out, you tell me when it is and I'll give you the time off to attend." (S2)

7.3.1 The guilt of taking time

Overall, the supervisees allowed themselves time for cs. However, one participant felt guilty about not only going to cs (she had to drive there) but the fact that she should have it as she worked part-time:

"I work two days a week and it was part of those days you know I was very aware of time. You know it's weird I have clinical supervision and I'm only part-time. People who are working full-time are not having it so I still went along for the first meeting." (S3)

Ironically, to lessen the burden of guilt she worked longer hours on the days that she had cs.

"I know it's stupid but I still think it takes me half an hour to get there and back again and then an hour of supervision. That's two hours so I always generally stay late that day. I think it's a part time-thing. I think it's guilt as a part time worker."(S3)

Her guilt suggested that she did not see cs as part of her working day and that whilst she had decided to choose a supervisor from outside the Trust, the travel time was necessary if she was to gain meaningful cs. She assuaged her guilt, by working extra hours, which implies authenticity, in that she viewed the cs as a significant element of her day, yet she was prepared to "pay" (in hours) to have the opportunity of cs.

Guilt for taking time was also alluded to by two of the course participants (C5 & C6).

"I hope I am going to gain something out of it, you know otherwise I'll just feel, you know so guilt-ridden. I could have been doing something else that was a waste of time, have I stopped myself doing an opportunity to do something else..." (C6)

A participant manager also continued with the same issue, suggesting that if managers were aware of practitioner's fears, but not actively doing anything to address these then they were perhaps perpetuating the guilt.

"It's a bit of a guilt feeling as they're off having a jolly and the ward is really busy." (M7)

However, one course participant's guilt was not in relation to taking time away from practice but rather the cost to her employer of her undertaking the course.

> "... I felt a bit of guilt as they stressed that it was costing two hundred pounds for us to be there and if we weren't going to act as clinical supervisors you know so I had a little bit of a guilt pang there." (C9)

She disclosed off tape that she would be commencing midwifery training in another Trust and that there was little likelihood that she would become a supervisor.

This sub-theme "Too busy, not enough time" emerged because course informants constantly cited lack of time as preventing them from having cs. Many of them struggled or made compromises to allow supervision to take place but overall they did not wish to undertake cs in their own time. Quite understandably, participants felt that supervision was part of the work and should take place in work time. However, those who understood and embraced the concept tended to reap some positive rewards and subsequently became so committed to the concept, that they were prepared to allow supervision to encroach into what should have been their own leisure time. Ironically, the managers seemed determined to ring-fence supervision time for themselves whilst failing to champion the value of cs for practitioners, perhaps fearing that they could not provide the resources for it to happen in practice.

Whilst time was held to be the biggest logistical barrier, the supervisee participants had regular formal cs and saw making time a priority. Furthermore these participants (except for S4 and the managers) were all G grade and above. Their roles as such provided them with greater autonomy to manage their diary and take time. Participant M6 being an Assistant Director of Nursing spoke candidly about the difficulties within the nursing culture and the need for leaders within organisations to make changes. She explained she had introduced cs, through the "backdoor", as learning sets in which staff, instead of attending courses, were experiencing at first hand the practical benefit of support.

7.3.2 Being too busy not an issue

Whilst I have provided evidence as to why time became a significant theme, I must also comment on those participants who never referred to time as an issue.

(C1) was a G grade midwife working within an acute Trust and was also a Midwifery Supervisor. Her attendance on the course was to gain understanding about how cs and midwifery supervision may differ. In some ways, I felt that she was already an advocate for taking time to have supervision and unlike others I did not see that the concept was alien to her. Post course, she admitted that midwifery supervision did differ considerably to cs, but she saw both forms of supervision as being supportive to the practitioner and necessary.

Being an advocate of cs was also relevant to the second participant (C7). She worked within a community mental health team as a newly promoted F grade. She admitted to having regular cs before undertaking the course and immediately post course a supervisee was designated to her. It would appear that she viewed cs as something important and "part and parcel" of her daily practice.

The final participant (C11) was the manager of a day mental health unit, at the first interview. However, following completion of the course he felt that his position meant that he could no longer act as a supervisor for his staff. His only reference to time was in relation to one of the staff nurses from the day centre who also attended the course, but was not able to take cs forward due to her academic commitments. He later changed role and Trust and became a practitioner on a lower grade. Again, time was not an issue for him and because he was no longer a manager he suggested that he was more willing to provide cs for peers and more junior staff.

Finally C19, a specialist practitioner working autonomously within a General Practitioner's surgery wished to learn more about cs. Following the course she sought a supervisor and was fully able to take the time within her working day.

7.4 Practice/experiential time

Time was needed not only to practice cs but also to acquire training. Many participants stated that there was insufficient time during the course to practice. This resulted in them being unable to experience at first hand what having cs was like.

Training for the two Trusts was delivered by the same HEI but of differing duration. The Acute Trust purchased a two-day course whilst the Community Trust opted for three days. The courses were virtually identical. The course participants from both Trusts suggested that the duration was too short and this was a barrier to them implementing cs in practice.

All course participants commented that there was too much information conveyed to them and that this was not conducive to their learning.

> "I thought a lot was crammed in to those two days and your mind was a bit boggled." (C2)
>
> "We seem to sort of cram a lot in, into two days I think maybe, and it was very intense, you know there was a lot to think about, you know every session was you know bum, bum, bum after each other." (C4)

They both used the term "cram" which suggested that the course was intense and that the educationalists covered a range of issues in a short period. Whilst many course members commented that they enjoyed the course, the examples relating to time running out due to pressure of content continued.

"…. but it was very squashed in but the tutors did keep saying that there was a lot to pack in" (C15)

This would suggest that the tutors were aware of the extent of the content but did not refine the course accordingly. Was this because they wanted to provide the course participants with as much information as possible, so that they would feel more equipped in taking on the role of supervisor?

"I think that there was a bit too much put into two days…The first day I just wanted it to end, I felt like we were getting all this stuff bombarded at us and I think it was all too much." (C9)

"It was really interesting and even though I understood that we had three days and some colleges have only two. I thought three days was packing it in really." (C15)

The language used in the aforementioned quotes ("rushed", "crammed", "bombarded", "packing it in" and "all too much") implied that the course participants were being overloaded with information and that this had a negative effect. Thus, the tutors may have created an environment that was not conducive to learning, which in turn could possibly have reduced the number of participants who felt able or willing to become supervisors. This resulted in a suggestion from one of the course participants, to extend the course.

"I think it could have gone over three days (as opposed to two) because they were having to rush some things, you know and you tend to think you were against the clock, but then on the other hand it's funding and time and everything and that can be a problem." (C10)

Ironically, the community course participants who had undertaken the same course but over three days felt similarly.

"I don't think we had enough opportunity to explore that. The person that I was with was from midwifery and we were so short of time… We didn't have time to do all the roles with each other because that bit was shortened."(C5)

Like the first theme it would appear that experiential time is strictly governed by measured time. This resulted in some of the course participants feeling that it hindered their opportunity to practice the skills of being a supervisor.

> "Practice... just to practice...Because there was only a short space of time the group I was in, I acted as supervisee, and somebody acted as supervisor we didn't have the chance to reverse the roles." (C7)

Overall the course, (whether two or three days) required a great deal of information to be imparted in a short space of time. The course members indicated that this had a negative effect on their ability to fully appreciate and absorb the concept of cs. The length of training was also commented on in the evaluation forms by the other course attendees. Whilst I am aware that the education providers conveyed the need to extend the training in response to these and subsequent evaluations, the Trusts declined to do so.

Whilst the Trusts purchased training, however, there appeared to have been very limited discussion between education providers and the purchasers with regard to value for money. Sending staff on a course does not necessarily mean that they will take the concept forward and if the length of training was too short, as the participants implied, then the Trusts may have wasted their money. This view was supported by a senior manager fairly new to the Acute Trust

> " ...but I think there was possibly some naivety on behalf of both the providers the trust and the education provider. Can a two day course actually do that?" (M6)

Would a course of longer duration have led to better prepared staff to take on the role of supervisor? A longer course would have been more costly, but may have been of greater benefit to the organisation in the long term. One senior manager explained that

the rationale for the two days appeared to have been dictated solely by cost and the time in replacement of staff from the clinical arena.

> "Three days I thought at the outset was too much and I thought I argued it down to two days something like that even one day maybe... It seemed an awful long period and that's probably come from me with my managerial hat on. Like that's a very expensive thing and it's not quite clear what we're going to get from it, and I have to see that if I put an investment in what am I going to get from it. We weren't quite sure what we would get, what was the uptake, what would the benefits be....now that wasn't a very informed judgment because I didn't really understand what was on the course the programme. I just thought well three days is too long so they can have two days sort of thing. ...But maybe I've got that wrong maybe to be a supervisor you need more skill than I understood it to be and they will need proper training to do it." (M5)

This manager gave me the impression that there was little, understanding within the management team from the outset about cs, the resource implications or the likely benefits to the organisation. Inevitably this led to an arbitrary decision about the type and duration of the training required. This was unfortunate because as van Ooijen (2003,) pointed out:

> "If an organisation is willing to spend adequate resources on the implementation of clinical supervision, it gives its workers the message that they are important."(p4)

Similarly other authors (Duarri and Kendrick, 1999, McKeown and Thompson, 2001) have suggested that organisational planning which includes time, resources and training are fundamental to cs becoming a reality.

Given that the two Trusts had invested money on training and had given staff the time to undertake the course it could be argued that they were attempting to show practitioners that they are important. However the key phrase is "adequate resources" and as such the course participants did not feel that the duration of training was sufficient to enable them to become clinical supervisors. Furthermore, a manager participant admitted that there were no criteria for who should attend, but decisions

tended to be based on who had the time available to be released, rather than the suitability of an individual to become a clinical supervisor.

> "... probably "who wants to do it", "who can be released to do it". Rather than look at "what sort of people do we want to do this in terms of what skills have they already got, what is their job where do they sit in the organisation", "do they have to be a manager could a staff nurse provide it". So I'm not sure that we even set out criteria that...we might have done but I can't remember that we did."(M5)

It would appear that there is a difference between measured time and experiential time and that measured time takes precedence over experiential time. This issue and the nature of measured and experiential time are discussed more fully in the Discussion Chapter (Chapter 8).

The difficulties with time were further supported by other managers within the same Trust who indicated that there was little strategy in relation to CPD and it would appear that it was more a case of numbers and throughput, rather than meeting individual's and ultimately patient's needs.

> "I think people want to go on courses not fully understanding what they're about not fully realising what the benefits to them or their ward would be... and sometimes it can be a numbers game. As in you've got seven staff nurses, five or six of them have all been on something all different and it's a bit of a numbers game really. Who can we get to do that so I think that there is an element of that going on. We don't have to send everybody on courses it's got to be for them but I think people have to be seen to be doing and then they're doing it for the wrong reasons..."Yeah and the ward managers are slotting into that because they're being asked how many courses do we need? How many are you sending and it's just purely a numbers game. It's not reflecting the needs either of the patient care, which is required, the needs of the staff as whole on the ward or the individual. So that's really disappointing that."(M1)

M1 referred to attendance being a "numbers game" which suggests a limited CPD strategy. The community Trust did have criteria for staff to obtain a place on the course but the senior manager admitted to it being "flawed".

"One thing that was very clear to me was that it wasn't a notion of everyone being able to do clinical supervision. But that there would be some selectivity in it and well I put in place some agreed criteria, which would inform people's managers, senior nurses. If you like criteria for selection and they were fairly broad I think but recognising that this person is capable, they're interested, they're enthusiastic those sort of things and managers, senior nurses' support people on that basis. Having said that there was numerous examples of people turning up to the very earlier courses and probably some of the subsequent ones and said I don't know why I'm here I've been sent. So I think it was flawed."(M9)

The course participants offered suggestions about how the course could be better structured to enhance their understanding. Overall shorter days over a longer period of time were favoured.

"I think that it might have been better done say over four weeks on a half-day or something like that. I know it's hard getting staff off the wards and that but quite a few of us felt that it was just too much at once, you know it needs to be spaced out a little bit more. We sort of lost track.....time the way you always do and tried to catch up on time and it felt like it was getting compressed even more." (C9)

"I think that it might be helpful to have it once a week for three weeks rather than three consecutive days because it might give you a chance to digest it a bit more as it was really concentrated and have a bit more of a practice of the group [supervision]." (C15)

Another suggestion was to increase the length of the course, which this participant felt would demonstrate commitment by the Trust.

"I think it should be longer. I think a week would be better and I know that's going to cost. But I think if the Trust are serious about ordering clinical supervision then people need to feel comfortable actually doing clinical supervision and the only way to do that is with the support of a facilitator who is promoting you and looking at what you are doing and are there to point you in the right direction and at the end of the week perhaps we would feel more comfortable then doing that."(C16)

A further suggestion was to incorporate a follow-up day.

"I think I would have liked another day and they did say that they did have another day in the past, but it hadn't been well attended. Which is a shame as the last day seemed a bit rushed and a bit crammed and so it would have been better to spread it out over another day."(C18)

When Spence et al (2002) facilitated a similar course, they agreed that there should be follow-up training after the initial preparation, which could incorporate more in-depth examination of supervisory skills. When provided, this extra day was poorly attended with practitioners blaming the inability to be released from the clinical area (time) and pressure of work (time). It resulted in this fourth day being abandoned.

A final point relating to suggestions came from two of the community course participants who felt concerned that people having attended only a three-day course would then be able to offer themselves as a supervisor.

> "For myself, what I found is concern that a group of people going out after three days to deal with quite a significant role...But if you are going to supervise three people that does require perhaps a more in-depth knowledge more awareness of things like confidentiality more awareness of boundaries..." (C19)

Furthermore she added:

> "I think I would make it a ten week module. I think if you really want to do it then do it properly...But I think if you are going to do it seriously if you are really going to take that responsibility on and actually be able to evaluate it in a way that makes sense I think you have to do something a lot more substantial."(C19)

Another participant who had previously undertaken a clinical supervisor course in another part of England also supported her comments.

> "To be quite honest with you I felt the course there (previous employment) was better than the one here. Simply I think mainly because what we did was longer and there was more time spent practising supervision. On this course we only had one session where you supervised each other in a group and my personal view is that time isn't long enough. I am lucky I have done it before and I feel fairly comfortable about doing it. But I know lots of people said afterwards in private not in front of the group it was not something you would involve in. It's not something you would go away and do clinical supervision ...So I am being honest and not everyone will tell you that." (C16)

In relation to "time" and duration, overall the course participants did not feel that the length of the course gave them sufficient time to fully understand the concept or the

confidence to act as a supervisor. Being able to practice being a clinical supervisor would possibly have given many of the course participants the opportunity to test out their skills.

The course participants supported this argument in their post course interviews

> "If they give me a few more months, experience, because at the minute I haven't got time to fit it in, you know I only just about have time you know to have my own supervision."(C4)

> "I think I would be [*a supervisor*] but I wanted some experience of somebody supervising me before I actually started. Just to sort of get in practice, as it were, know what to talk.... if I have had a few sessions myself I think well you know take my role from somebody else and see how they managed it." (C10)

The participants suggested the limited time to practice failed to prepare them sufficiently to become clinical supervisors. When practice did occur it was highly praised, but the time was still viewed as insufficient to meet their needs in feeling confident to act as a supervisor. This echoes the literature where there is a evidence (van Ooijen, 2000, Rafferty and Coleman, 2001, Sloan, 2005) which stated that nurse's reluctance in acting as a supervisor was due to them not feeling "good enough" to fulfil the role. This may be more to do with the culture/socialisation of nurses rather than the duration of training and as a result the length of training may be superfluous. This has to some extent been addressed by the DoH (2001b) in the *Working Together: Learning Together* guidance that emphasised the need for Trusts to develop individual personal development plans and protective time for CPD. However if cs is part of CPD it may become subsumed and ultimately lost due to the competing demands of CPD.

7.5 Quality time to reflect and solve problems

It would appear that the course participants' role as a nurse was constantly time pressured. They attempt to meet the needs of the patients, families and the multi

disciplinary team, as well as undertaking the everyday tasks of maintaining the ward environment and record keeping. With no clear division of their labour this appeared to result in similarities with Bowers, Lauring and Jackobson's (2001) study. Interviews and participant observation were undertaken over a twelve month period with a sample of 18 qualified nurses from Midwestern America. The results showed that the nurses split the work into "must do" and "should do". The "must do" incorporated all the tasks in which they could be held accountable such as, medicines, record-keeping and wound care. Unfortunately the "should do" encompassed the less tangible aspects of the nurse's job such as talking to people. In relation to my study, whilst the course participants echoed similar time pressures they did however speak with unease and dissatisfaction that they were no longer able to spend "quality time" with patients.

> "I recently went round the ward with the pain nurse specialist, you know those patients are "made-up" to see her when she goes round. I thought this is a lovely job I'd love to do it. She gives patients her time even if it's just five-ten minutes to talk. They tell her all kinds things they wouldn't tell the staff on the ward as people think that nurses are too busy to talk to them." (C2)

Having taken time out from her normal calibrated shift she "shadowed" a pain specialist nurse. I sensed she saw this nurse as someone who had been able to utilise her role to give quality "time" to the patients. She believed the patients dearly valued this as they were "made up to see her". The participant suggested that her current role left her unable to give quality time to her patients, due to other demands. She was able to reminisce about periods within her own career, in which she also shared such precious moments with her patients.

If the role of a nurse in the modern health service deems the need to talk to patients as a lower priority than undertaking technical tasks, then it may be that being seen talking within the confines of cs is equally of little relevance.

Whilst the findings from the interviews with the course participants mirror those of studies undertaken by other authors (Bower et al 2001, Waterworth, 2003), in relation to the pressure of time on managing care, the supervisees on the other hand painted a different picture. They appeared to have prioritised their time differently and gave cs greater credence. This seemingly helped them to manage their time more effectively resulting in them achieving not only the "must do" but also the "should do" tasks in their working day. They spoke about time as being valuable and precious. When utilised correctly it could/can have considerable positive outcomes to others as well as themselves.

This third sub-theme examined how creating the time and space for cs has benefited those participants. The data quoted in this section were derived predominantly from interviews with the supervisees as they were the individuals who were actively engaged in the process of cs.

A supervisee participant demonstrated how having quality time had resulted in changes to his practice. He recounted an issue that took place with a junior nurse and how he would have dealt with it before he had cs and how he now dealt with it differently, after undertaking regular supervision.

> "Maybe two years ago when I was a ward manager it would have been a telling off I wouldn't have been reflective at all and that comes from the supervision I've had on listening being able to listen. My listening skills have improved so much over the last year but I did make that a conscious effort."..."Clinical supervision enabled me to stop and think about other strategies and that's had a big impact on me as well, because now I feel quite confident." (S1)

This account suggested that previously he would manage staff in a less considered fashion, perhaps making impulsive decisions. He now appeared to have slowed his responses down forcing himself to listen more, to think and reflect before making a judgement. It appeared that time was now being used more effectively, with him stating that he felt that he was performing better following cs. Taking time to stop and think

appears to have helped this participant to reflect and reduce "knee-jerk" reactions to problems. He further stated:

> "I do need time to sit and reflect and that's another thing which clinical supervision helped me with... I need to go away and look at that paper think about it and then come back and that's...I wouldn't have known that prior to clinical supervision because you know it was just through discussion with my supervisor and she suggested that it might be useful to go and explore and do some further reading around styles and that's been very helpful." (S1)

Furthermore, through reflection within cs this supervisee believed that staff would be helped to manage tension and dissatisfaction better and possibly avoid some of the typical misunderstandings and opportunities for conflict which arise in any organisation.

> "If you've got people involved in clinical supervision then they are involved in reflection then complaints will come down they will understand by having a bigger picture of why we manage beds in a particular way they will have a bigger picture of peoples' role in the directorate. Why this chap called XXX comes on the ward everyday bothers us for surgical beds and why we have to move people around you know I think that's how it links in." (S1)
>
> "I won't let people just dump things on me, I'll seek clarification, I'll ask. I challenge a lot... perhaps I used to jump into things too quickly to make a good impression and now I'll think about things more and not rush in. Different things about my personality as well. I wanted to be popular I suppose I try to step back a little bit from that now."(S3)

Whilst these supervisees discovered that cs could offer them the space to reflect, other supervisees suggested that having the time meant that they could discuss an issue within the session. They would then be able to plan how to tackle the problem. This appeared to have resulted in cs offering them tangible solutions.

> "I just go with an issue. I discuss the issue and then she will pick up on bits and start with explain that again and so I'll have to go over things and then she'll make me come out with the answer."(S3)

"I would say for the majority of the time I leave feeling that I've got a new direction okay. That I have actually managed to sift through things and I've probably found that there is more than one solution to, to whatever taken. Over three or four years I've had lots of difficult situations and sometimes have left clinical supervision feeling very vulnerable but, but my supervisor has identified that and suggested other strategies that I've used as well."(S5)

The terminology used within these two quotes "pick" and "sift" suggests that the supervisors are paying attention to the details and then they try to interpret to find possible solutions with the supervisees.

One supervisee appeared to suggest that the time within cs was too short and that she wanted greater opportunity to discuss issues. She admitted that she found prioritising issues difficult, as she wanted to use the time to discuss all her clients. This lack of security regarding her practice may be as a result of her being fairly junior compared to the other supervisees interviewed and that the area in which she worked offered her limited support.

"Sometimes I feel like I want to sit there for four hours and discuss every case, as I've got to pick and prioritise and pick the case I think is the most urgent the most pressing. I sometimes think I don't want to just take one I'd like to talk about them all but we haven't got time."(S4)

Having the time to reflect suggested that this resulted in a more structured and considered approach to their thinking and subsequently their actions (practice). However, it was interesting that four out of the six supervisees regarded this time as so valuable, that they only wished to bring potential problems.

"The time I know and it sounds ridiculous but because there is always an issue coming up to that six week period I don't I wouldn't put a positive thing above it because I want to get the problem sorted basically. "(S3)

"I've never actually taken somebody that I'm entirely comfortable with and said look how well I've done with this. Only because me personally would feel that was a waste of time I would much rather deal with the next problem." (S2)

On the other hand the other two supervisees did on occasion take positive outcomes to their cs.

> "Mmm so to explore those things (positive issues) with a supervisor who says gosh that's enormous you've made a big difference there, Good Lord where would you have been a year ago. I think that's really good so there is a buzz there as well as things aren't all bad." (S5)
>
> "I don't like ever to praise myself because I think I'm a nurse and I'm like that's what I do. But when a patient tells me I've done well or something has gone well I like.... I don't feel I can talk about that to my colleagues it's just not what I would do and I like to go along to clinical supervision and be able to say what that person has said and it makes me feel good and it gives me strength to go on. To be able to actually voice it to somebody I don't know it just makes me feel good." (S6)

Both supervisees offered an explanation as to why sharing good practice was important to them during cs. S5 saw it as the supervisor validating her achievements. Similarly S6 offered not only a sense of achievement but also direction.

> "I come out feeling good about the job and I feel I can get on. When I talk about something that I have done well in clinical supervision the clinical supervision seems to direct me into what I am really good at offering and good at doing and because it's brought that out of me and we've talked about it I go away with better direction of what I'm good at and what I can do and maybe let go of the other stuff. Because this is what really matters to me and that feels really good I go out a foot taller!"(S6)

The practitioner who leaves supervision feeling a "foot taller" appears to be conveying a sense of pride and achievement which is both rewarding and motivating. However, one wonders how common an experience that is for practitioners who frequently report feeling the stresses and strains of increased scrutiny, ever-increasing demands on their personal and professional resources and the fears that they are working in an increasing litigious complaint culture of care. To be rewarded or praised in such a climate is of inestimatable value.

Are these two supervisees, by taking both positive and negative issues, being more authentic compared with the other supervisees, who have a tendency to focus on areas that they have difficulty with? Or is it dependant on the individual's personality, that some like to hear positive reinforcement and congratulation for aspects of their work, whilst others see cs as a time to "problem-solve".

It may be of note that these two supervisees were from the field of palliative care and had the same supervisor. It could be that their ability to discuss positive aspects may have been due to the nature of their role, which I saw as a truth teller, working with a high degree of honesty. Alternatively it could be because of the particular supervisor who may emphasise the need for them to address this area within the supervision process.

Overall within this third sub-theme I have examined the impact that taking the time to have cs has had on the supervisees. It appeared to have equipped some of them with the opportunity to reflect and examine their practice, as well as make changes to how they function within their clinical role. Some supervisees suggested that they saw cs as an occasion for them to discuss issues and plan ways to deal effectively with them, thus providing them with tangible outcomes. Finally, two of the supervisees admitted that as well as taking clinical problems, they also took issues that they felt they had dealt with well. They felt that the process of being validated in supervision gave them additional feelings of self-worth, which motivated them to continue to strive for best practice in their current role.

7.6 Conclusion

To conclude, concept of time had significance for most of the participants in this study. Whilst some course participants talked about having insufficient time on the course to practice supervisory skills, other course participants spoke about lack of time being a barrier to them having or giving cs during their working day. Similarly, the managers

appeared to understand the time demands that nurses were experiencing and recognised that this could be why cs was poorly implemented. The supervisees on the other hand, whilst working in equally demanding clinical roles, saw cs as important enough to warrant as *"Kairos"* (golden time) and they made the effort to "ring-fence" this time viewing it as important to their clinical role.

Chapter 8

Discussion

In-depth interviews and analysis of the material provided by thirty-four participants (course participants, managers and supervisees), has provided understanding of some of the issues surrounding clinical supervision (cs). I have secured a unique insight into the themes of trust, disclosure and time and the complex interaction between them. This study has been directed to themes by the lived experiences of the participants and has attempted to report them as authentically as possible. To some extent this means that my major contribution to the debate has been to highlight the "messy reality" of cs in practice.

Seventy-five semi-structured audio taped interviews were conducted during the period 1999-2002. My overriding aim was to develop a rich description of the lived experience of cs amongst qualified nurses. Initially, the focus was on nurses who had participated in two supervisors' training courses. A desire to further explore and explicate the initial course participants' findings, led to the collection of further data. The approach to sampling was therefore guided by the principles of naturalistic, interpretive research. The use of approaches elucidated by the philosophers Martin Heidegger and Hans Georg Gadamer has enabled me to explore cs in relation to participants' being-in the world, their throwness and authenticity/inauthenticity towards cs. Indeed the tension or difference between authenticity and inauthenticity has emerged throughout this study as a significant finding. Moran (2000) interpreted Heidegger's description of authenticity as

> "...moments when we are most at home with ourselves, at one with ourselves." (p240)

And when we,

> "...have a deep, concrete experience of mineness or togetherness."(p240)

Inauthenticity on the other hand Heidegger described as the way in which most people live their everyday lives, not thinking or allowing themselves to be affected too deeply by events happening around them. Moran's commentary on Heidegger's ideas is useful

> "Most of the time we are just passing information along, not too caught up in things, not dwelling on the significance of events, but living in the vague average understanding of everydayness." (Moran, 2000:239)

Solomon's (1972) interpretation of Heidegger's authenticity views the authentic man as one who sees, examines and understands himself, whereas the inauthentic man acts blindly "substituting means for ends".

Although sample sizes were small and findings cannot be generalized, within this study participants descriptions of their lived experiences suggested there may be a contrast between those who choose to engage in cs and may therefore have the opportunity for a deep or concrete experience and those who shunned that engagement and may therefore have less opportunity to gain understanding. This contrast is interrelated with the three defined themes of "Trust", "Disclosure" and "Time" and provides what I believe to be a novel approach to a much debated subject.

Overall, it would appear that those not having cs cited the reasons as (a) the busyness of their working day, leaving them with no time to be either a supervisor or supervisee and (b) the terminology "clinical supervision" being poorly defined and leaving them confused and not being able to find a "suitable" supervisor. There was furthermore an undercurrent of distrust within the two organizations in their attempt to introduce cs. The Trusts were seen either as, responding to a new national "catchphrase" (with limited resources to fully implement it) or as attempting to increase accountability, problems which have been cited previously in the literature (Bishop, 1998a, Grant, 2000, Walsh, Nicholson, Keough, Pridham, Kramer and Jeffrey, 2003, Knutton and Pover, 2004a, Cleary and Freeman, 2005). If these perceptions were accurate it could

be argued that the Trusts were being inauthentic and consequently the "wholesale" adoption of cs would be unlikely, due to distrust. Furthermore, the two organizations' apparently "piecemeal" approach to cs appeared to reflect the picture nationally. It was unclear whether the Trusts had a strategy, other than purchasing the courses from the Higher Education Institution. If this was the case, is it sufficient to deliver the theory and provide some skills over two or three days and then expect a participant to access a register and "pick" a supervisor as well as becoming a clinical supervisor themselves?

What emerged from this study was that there were also more subtle reasons for poor take-up, which have been infrequently discussed in the literature to date (Jones, 1999). These included a fear of inadvertent disclosure by supervisees and the potential requirement of a supervisor to "act on" disclosures of poor practice. This led me to question the suitability of the cs training, as it would appear that it did not serve to empower some participants who feared that these scenarios could arise, yet felt unable to deal with them.

The managers within the study identified similar reasons why cs was not fully embraced within their organisation. If these managers understood the barriers to cs were they acting inauthentically in their attempts to introduce the concept without taking barriers into consideration? Was the attempt to introduce cs, as the participants described, "piecemeal" and "lip service" and if so why?

It was also interesting to note that whilst the managers understood why there was resistance to cs from clinically based staff, it did not appear to deter most of the managers interviewed from being actively engaged in cs. They seemed to be able to create time for cs and valued the opportunity to be involved in the process.

From the interviews with the course participants and managers I was left with a sense of their negativity and ambivalence about being either a supervisor or supervisee, but

the true source of this remained unclear. If these were authentic responses, the source may be the reasons cited above, as well as the reality of working in a time-pressured environment. However, the source could just as easily be an inauthentic response from practitioners, resistant to or frightened of change.

If the study had ended at this point I do not think that I would have uncovered the tension between authenticity and inauthenticity, but the study did progress to interviews with the supervisees. These participants raised similar concerns about not finding a suitable supervisor and available time. Despite these concerns this group chose to engage in cs. They shared their early anxieties relating to their choice of supervisor or the format supervision took (group or one-to-one), this group persevered and all six were actively engaged in a process of cs that they valued, trusted and created time for. Whilst they experienced problems they emphasised that these were not insurmountable.

In this chapter, the findings relating to trust, disclosure and time are reviewed in the same order as in the earlier findings chapters (an approach recommended by Holloway and Walker, 2000), with authenticity/inauthenticity as a thread running through all three. I recognise that the themes that have emerged from the data and the excerpts that I have chosen to use are based on my own interpretation of what is relevant and I acknowledge that another researcher might identify different themes (Todres and Wheeler, 2001). Furthermore, the aim was to construct what Horsburgh (2003) described as:

> "...an account which remains true to the data from participants, but is also subject to analysis and interpretation by the researcher." (p308)

I believe that my approach demonstrates my reflexivity and trustworthiness in relation to the research process.

Due to the small scale exploratory naturalistic approach taken in this study, guided by some aspects of interpretive phenomenology, the intention is not to provide any definitive answers to the questions surrounding cs. On the contrary it is likely to provide areas which require further explication, or as Moran (2000: 246), suggests, it may offer opportune time for "thoughtful questioning".

8.1 Trust

The nursing literature, even a decade after the introduction of cs, is still discussing misinterpretations of the term (Bush, 2005). Similarly in this study, many course participants commented that they had difficulty "trusting" cs, associating the terminology with negative connotations such as control and oppression. They felt that it was not only hierarchical (i.e. someone overseeing their practice), but it was also linked to counselling. In some ways this demonstrates the consistency of my findings with the literature implying that the study is transferable (Teasdale, 1998, Heath and Freshwater, 2000, Cheater and Hale, 2001, Fulton and Oliver 2001, Smith, 2001, Cutcliffe and Lowe, 2005, Driscoll and Cooper, 2005).

Many participants also linked the terminology as being a "buzzword", something that was in fashion at the time. Possibly those who participated in the study had seen the introduction of many popular concepts over the years, which had later disappeared. This may have created the cynicism and reluctance which I witnessed during some of the interviews (not only with the course participants such as C13, but also the managers, such as M5). Indeed, the belief that cs was only being promoted in order to meet targets or win awards led C13 to conclude that there must be no "meat" to the bones of the concept. If there was limited management strategy and resources available to implement cs in the Trusts then this perception may increase, as a result it was hardly surprising that the cynicism of C13 was allowed to develop.

Nationally, Teasdale (1998) recognised that there had been a "barrage of top-down changes" which had resulted in nurses being skeptical and averse to engaging in cs. It is clear that throughout the period covered by this study there was continuing change in nursing and within healthcare in general. It is possible that cs was not a strong enough competitor in the healthcare market and became marginalized, due to other competing demands on nurses. Nonetheless, the supervisees who engaged seemed not to care what it was called, or how it was introduced, as long as they felt that it helped them in their practice.

The question "is clinical supervision the same as counselling and if not how do they differ?" was a significant issue for the course participants. There may be a number of possible explanations; one could be that those wary of being "counselled" used this as a barrier, a way of preventing themselves from actively having cs. Furthermore, C3 noted (with irritation) that the teaching staff on the course kept stating that cs was not counselling, but they then confused her by using Heron's model (used in counselling) to demonstrate cs. This again linked to the literature. Ven Veeramah (2002) conducted a study to explore the use and perceived benefits of cs. From a sample of one hundred and sixty five community mental health nurses, 98% reported the use of a particular school of counselling or psychotherapy as a framework for their cs sessions. It would appear from the literature that supervision will often follow the model of counselling or psychotherapy and this has historical antecedents.

In an attempt to introduce cs into the nursing profession, it was felt important by many authors to state that it was not therapy, as this may have caused nurses concern and a reluctance to undertake it. There can be no denial that there is a link between therapy/counselling and cs and that confusion now exists because of this fact.

The terminology surrounding cs and the connotations it evoked had varying effects on the course participants. Some openly attacked the confusion created on the course by

the facilitators, in relation to cs and counselling (C2, C3, C9, C13 & C15). Despite this C3 (possibly the most vocal on the subject) actually set-up cs in her work area and C15 did have an initial meeting with someone from the course who she identified as a potential supervisor. C2, C3, C9 and C13 rejected cs, but I am unsure whether it was as a direct result of their perception of its link with counselling. A clinical supervisor may use skills normally associated with counselling such as listening, empathy and a non-judgemental approach. However, the goal is not to "treat" the supervisee in a therapeutic sense, but to help a practitioner to reflect and understand the professional world he/she is in, ultimately supporting his/her practice and enhancing the care of others. A supervisor might also offer guidance about specific areas of practice or suggestions based on knowledge and experience. In counselling I believe the core of a session is essentially what the person brings and the process rarely moves beyond reflection, with the counsellor relying on the subject to find their own solutions to problems.

The nursing profession does not have a culture of "therapy" which some of the other helping professions such as psychotherapy and counselling have in place. There is a body of evidence that sees those in the caring profession as wounded healers (Wheeler, 2004), who function in a prescriptive manner. It could be argued that many nurses work in environments in which they witness at first hand, a high degree of pain and suffering. Not reflecting within a supervisory relationship means that they can keep their real feelings hidden, in an attempt to cope with the everydayness of being a nurse. This links into the work of Menzies (1959) who stated:

> "Nurses are confronted with the threat and the reality of suffering and death as few lay people are. Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening. Intimate physical contact with patients arouses strong libidinal and erotic impulses that may be difficult to control. The work situation arouses very strong and mixed feelings in the nurse: pity, compassion and love: guilt and anxiety: hatred and resentment of the patients who arouse these strong feelings; envy of the care given to the patient." (p46)

She not only described the nursing context, but she also offered that nursing as a social system has developed a defence against the anxieties that nurses may encounter in their everyday role.

> "A social defence system develops over time as a result of collusive interaction and agreement often unconscious, between members of the organisation as to what form it shall take. The socially structured defence mechanisms then tend to become an aspect of external reality with which old and new members of the institution must come to terms. "(p50)

She suggested that nurses distance themselves from their patients in an attempt to reduce their own anxieties. Pask (2001) explained that the work of Menzies:

> "...suggests that nurses are driven to act as they do; driven by an uncontrollable need to avoid the anxiety that is potentially engendered in situations of patient care." (p50)

The findings presented here support Menzies' conclusions that nurses mobilize psychological defences to protect themselves against anxiety. Experiencing the openness of a cs session can expose the participant to a range of anxieties. Possibly distancing themselves from cs may be an unconscious attempt by nurses to distance themselves from their patients. Furthermore some nurses may avoid cs because they do not wish to become more self-aware, or expose themselves to scrutiny. If this is an accurate picture, then the introduction and implementation of cs will face major challenges because, by its very nature, it encourages self-examination, reflection and authenticity. These aspects of cs may represent "a bridge too far" for a profession which is perceived as rigid or stuck in its own inauthenticity. Perhaps this inauthenticity is systemic in our society and the nursing profession simply reflects societal values or the perception/experience of real people, leading real lives, in what are often challenging and complex human situations. It may be psychologically easier to be inauthentic to protect one's feelings and mental health and cs represents a threat to this.

It could be argued therefore that managers and organisations themselves are tokenistic towards the concept. Ironically, those who engage in regular cs seem to have adopted a different perspective and feel liberated to search for real meaning, for answers and for authenticity. Interestingly some participants volunteered suggestions as to how the concept could be introduced and translated into something useful for practitioners whereby it would be less likely to be rejected.

Overall there has been confusion regarding the terminology related to cs and it is an issue that has prevented some nurses from receiving it. Indeed Ghaye (2000) warned:

> "... if we do not recognise and address the ambiguity of the term and the surveillance tactics that it connotes; if we do not try to customise and own it in some way, then we may fall for the agendas of others that we might otherwise have rejected on the grounds that they are in fact manipulative, managerialist and oppressive." (pxv)

I believe that it is pertinent to highlight some of the language that participants used to describe the term cs. Whilst not complete metaphors, their words did evoke imagery, for example; "very cold, very cold" (C2), "position of control" (C2), "telling you what to do" (C5), "as if you've done something wrong" (C7), "no meat behind it" (C13), "someone watching my practice" (M3 & M5), "another big stick" (M5), "watching us watching what we do" (M7). These all convey an image of the supervisor being in control, holding power and imposing criticism.

Interestingly the supervisees provided no examples of language imagery in relation to the terminology, possibly because they knew and understood what it meant, it was not the unknown and therefore they were not fearful or apprehensive about it. I wondered whether the course participants were verbalising their own anxieties about adopting an additional role, in which they would be perceived as authoritative and controlling.

The first major hurdle engaging with cs appeared to focus on choosing the right supervisor. Many participants spoke of their inability to find a suitable supervisor who they could trust and this became their argument for why they could not have cs. Other professions such as psychotherapy and counselling have to be in receipt of supervision to fulfill their role and it would appear that this issue has been discussed (Weaks, 2002). Henderson (2002) provided insight into how four individuals chose their supervisors. Overall the person needed to be supportive, non-judgemental and challenging with a sound knowledge base. Similarly, Rafferty, Jenkins and Parke (2003) discovered in their study of seventeen experienced clinical supervisors that the relationship between supervisor and supervisee was:

> "...the bedrock of the supervisory alliance and governed by factors that would likely lead to its having an egalitarian dynamic (trust, respect, and mutual negotiation). (p1445)

Being able to trust the supervisor appears to be fundamental to the whole process and this was reflected in the findings of Bulmer's study (1997). He identified that through trust came a sense of safety, which could lead to open communication. If trust was developed within the relationship it meant that the supervisees felt accepted and this would create an honest dialogue. Knutton and Pover (2004a) also addressed this issue and recognised that honesty and trust within the supervisory relationship could be difficult to achieve, leading to "withholding". As a result they advised the need for time and space to formally reflect on the relationship. This suggests that both supervisor and supervisee need to be authentic within the relationship, if it is to be a worthwhile experience. Inauthenticity could result in idle chatter and prattle, which would ultimately serve little purpose. This may be why some nurses within this study rejected cs because they realised the need to be authentic with another individual and thus, move out of their comfort zone and into a potentially less safe environment.

Knutton and Pover (2004b) also explored the "difficult" skill of challenging and being challenged in cs. When challenge is used effectively, learning takes place for both supervisor and supervisee. However, to effectively undertake this task time is required (Pask, 1995).

In my own cs, there were key points at which I felt challenged and this engendered fear, but my desire to understand myself made this sometimes painful process, a necessity. Others may reject it because it may be too painful an encounter, but if the relationship is safe and honest, learning will take place. I wondered whether the course discussed this issue of challenge to any great degree.

Trust is central to interpersonal relationships. Possibly the many changes within healthcare over the last half of the century have led to inherent distrust and unless this area is discussed issues such as cs may only be a "pipe dream". Hancox et al, (2004) supported this. They stated that:

> "If the introduction of clinical supervision was to prove successful, the attitudes of potential supervisees must be considered crucial. Unless nurses were receptive to the idea of receiving supervision and viewed the strategy positively, it would be unlikely that the widespread introduction of supervision would take place." (p199)

What has become evident in my study is that a change of attitude alone will not lead to an uptake of cs. What is required by supervisees and supervisors is training that is effective in building confidence, so that practitioners will be able to function in either of the roles effectively. Interestingly Duncan (2003) explored the notion that the emotional labour of a nurse's role led them to protect themselves unconsciously, by presenting themselves in a calm and non-judgemental way. This they described as a learned behaviour, acquired through the socialisation of nursing as they imitated their prestigious role models. Parker (2004) concurred with Duncan. She believed that nurses within the field of medical nursing were under an increased amount of stress and anxiety, as opposed to nurses working in a psychiatric environment in which

surveillance, conflict and aggression management were more explicit, with appropriate training also being given. She concluded that medical nurses needed more support, which could be addressed through cs, whereby talking could help the practitioner work through their difficulties.There is evidence within my own study to support this view. Supervisee (S2), a community psychiatric nurse, stated that mental health nurses would be more open to cs for this very reason and that general nurses may be more guarded.

Possibly in an attempt to help qualified nurses to choose a suitable supervisor and as a way of maintaining a record of who had attended the clinical supervisor's courses, both Trusts maintained a register. Theoretically any member of staff could access the register. What the participants disclosed within this study was that the register was out of date and poorly disseminated. This resulted in reluctance among course participants to trust the organisation. Similarly Barriball et al (2004) reported on an audit on cs, that confusion occurred when the Trust failed to provide an up-dated list.

In my study trust was so important that, when the organisation the course participants worked for, failed to up-date the "register of supervisors", some participants lost faith in their employers completely. This was mirrored by some participants who felt the trainers confused them over whether cs was counselling or not and, as a result, lost faith in them as trainers and ultimately in the whole concept. It would appear therefore that trust is a very powerful concept and there is no doubt that it has strong implications for the successful implementation of cs and probably current and future concepts or policies.

As referred to earlier, trust within the supervisory relationship was crucial to its effectiveness. In addition even the terminology, with its confusing double meanings, parallels with counselling and overtones of control and surveillance, held significant negative connotations for many participants.

Inevitably some participants viewed cs with some suspicion and the invitation to enter into a relationship in which they may have to give an authentic account of themselves or their practice must have been at best challenging, and at worst alarming. Some participants in the study revealed, that as a result of these fears, they had arranged an informal process of supervision with peers and others. Possibly the notion of formality created the perception that the supervisory process was serious and that the supervisee would be under more pressure to disclose. Any disclosure would inevitably lead to a fear that it would have to be acted upon by either the supervisee or supervisor and (I suppose) a belief that there would be some negative consequences. If this was the reality for the nurses within the study, I wonder why this level of distrust exists within the profession and/or whether the lack of capacity to trust, is borne out of a cultural popular myth that no one "in authority" can be trusted. This is a question which cannot be answered within this study, but is worthy of further debate elsewhere. Nonetheless it is a powerful clue as to why the introduction of cs has been so difficult and why trust is a central theme.

It would appear that cs faces a number of obstacles in becoming accepted practice, if these commentaries are correct. If nurses have learned the social defence mechanisms as asserted by Menzies, they are unlikely to welcome the questioning and reflective nature of supervision as it could be too challenging and possibly disconcerting. To question one's care of patients may serve to empower the patient but not the nurse, and the anxiety described by Pask (2001) may surface. Educating nurses about the benefits of cs may not be enough to counteract this. In any event Fabricius (1991) explained that the work of Menzies suggested that this social defence mechanisms of nurses, are largely unconscious and adds that:

> "The significance of this is that they cannot be undone by merely telling people to do things in a different way: they are derived from the most primitive psychic defence mechanisms and reinforced to a high degree by being part of the organisational structure." (p136)

This suggests that a more effective way of introducing any new concept would be through experiential learning. For example whilst the course participants verbalised an anxiety that they may inadvertently disclose within cs, the supervisee participants explained that this was no longer an issue, when they actively engaged in cs. The course participants' reaction to cs and the "social defence" mechanism described by Menzies (1988) appears to have some resonance within this study.

In relation to Heidegger, it would seem that the supervisee participants wished, through cs, to be on a journey of self-discovery and attempted to act authentically in order to understand themselves and others more fully. Many course participants, rightly or wrongly, and for whatever reason, felt unable to engage in cs and therefore it may be asked; are they choosing to be inauthentic? Furthermore I wondered if some of the course participants and managers found themselves in a state of "throwness"; some course participants were sent on the course because their manager did not want a place to go to waste and hence may literally have felt "thrown" into cs. Similarly managers explained their reasoning for purchasing the cs training as a need to be seen to be responding (or in a state of throwness) to a national agenda at that time.

8.2 Disclosure

> "Making mistakes in a world where the perception of health care providers is perfection can be a devastating experience to a nurse who has erred." (Crigger, 2004:571)

If nurses are correctly trained, then they should not make mistakes. However Crigger (2004) further explains, mistakes are human experiences which take place throughout life. Although part of normal life, mistakes in healthcare have been viewed negatively over many decades by society, the employing organisation and peers. In Britain nursing has enjoyed a positive public image for many years as part of popular culture. If nurses disclose and possibly admit that they are not the "angel" the general public has personified them as, then they know that there could be serious negative consequences.

If there is such a negative impact to disclosing poor practice, is it any wonder that the cs will be treated by many nurses as something to avoid? Even the simple act of admitting to a clinical supervisor that they do not have competence in a particular task, or perhaps did not like nursing a particular patient, has inherent risk of being judged or of shattering the illusions that appear to have served the profession so well. In addition the growth of professional regulation, a new Code of Professional Conduct (NMC, 2002a) and an increase in the numbers of practitioners being reported for misconduct, might have served to focus the minds of some on the risk of losing their registration status (Edwards, 1996b).

Possibly, what I have discovered is that there are practitioners who see cs as a time to disclose, confess, and be scrutinized throughout their career. Cs came at a time when there had been major medical and nursing high profile cases of misconduct. Thus some practitioners may fear the process and the formalization of cs, as something to be avoided or even resisted at all costs. Gilbert (2001) suggested that cs is perceived as "a wolf in sheep's clothing". Does the nursing profession need to take this on board and change the culture, so that nurses feel less threatened and more willing to disclose? Perhaps if the prevailing culture accepted human frailty and reacted less punitively, nurses would be ready to embrace cs. Indeed Crigger (2004) suggested that whilst nursing practice strives to avoid and prevent errors, that it would be better placed:

> "...to adopt a realistic view of mistakes as unavoidable and as universal outcomes of the human condition." (p575)

Crigger (2004) emphasized, that what could help the health care worker when mistakes have arisen, would include honesty and an expectation that they would be understood rather than humiliated. However, nursing does not appear to demonstrate these virtues in times of adversity and perhaps they need to be in place before cs can be accepted. Indeed, Alavi and Cattoni (1995) in their paper *"Good nurse, bad nurse..."* admitted:

> "It has taken us almost two years to put together this paper, knowing that if one speaks critically or takes a questioning stance then one is positioned as disloyal, ungrateful and a bad nurse." (p344)

From this quote it would appear that it is not only fear of disclosure that some nurses are concerned about, but that by simply speaking and giving an opinion that they may feel judged in a negative way. Alavi and Cattoni (1995) believe that the historical hierarchical origins of nursing (religious and military models) have led to a culture of control, surveillance and attack, which has pervaded the profession of nursing. Furthermore, Randle (2002) studied a group of student nurses (over their entire training) and identified that whilst they commenced with a healthy sense of self, by the end of the course, 95% of the students had below-normal-self-esteem. She believed that the erosion of self-esteem was the effect of professional socialization, in which the students ultimately let their authentic selves "go to ground", possibly as a need to "fit in" and be accepted within nursing. She supported her findings by citing numerous studies which indicated a form of tribalism which pervades the nursing profession, from the education of nurses, to the day-to-day work in clinical practice. (Interestingly the language used by manager M6 supports this, when she expressed the need for "scalp hunting" as nurses attempt to engage in numerous post registration courses).

Has the quest for professional socialization resulted in some nurses suppressing their sense of self and would taking part in cs potentially re-awaken that sense? Is there also a fear that by engaging in cs they will become more authentic beings, but that this may result in professional isolation, as their peers distance themselves? Indeed the supervisees and managers who actively embraced cs (and who were in senior positions) seemed to view professional isolation as nothing to fear, possibly they had already experienced the rites of passage in "becoming a nurse".

The themes trust and disclosure were so powerfully expressed, that I formed the view that without "trust" and a degree of "disclosure" a clinical supervisory relationship

probably could not (and perhaps should not) be embarked upon. If there was active "mistrust", as opposed to just a fear of the concept, then it seemed unlikely that supervision would be initiated in any circumstances. Ultimately those individuals who are able to manage their fears and allow trust to develop, would seem to be practitioners who already felt professionally confident and secure and for whom "disclosure" represented very little threat. The Code of Professional Conduct (NMC, 2002a) is an example of this. It reads as a list of essential minimum standards, which are set so high that nurses must fear that they will fail to meet at least some of them during the course of their professional lives. Edwards (1996a:34-35), when he reviewed the previous code of conduct (UKCC, 1992a), commented that these standards were "extraordinary" and "too high and unrealistic". Furthermore Pask (1994) explained that whilst it was the intention of the nurse regulator to provide all nurses, midwives and health visitors with a "guide" to professional practice in the form of the Code of Professional Conduct, she believed that it is perceived as:

> "...a book of rules that must not be broken" and "... a disciplinary "stick" that waits on the side lines."(p82)

It follows, in my view, that if an individual believes they cannot attain the standards which they believe have been set for them, they are hardly likely to want this issue laid bare, and in that context, a supervision session becomes threatening.

8.3 Time

Within this study, time and lack of it was identified as a reason for not engaging in cs. Perhaps some participants in the study wanted to remain inauthentic by claiming that there was lack of time and this resulted in an inability for trust to develop. Were they consciously protecting themselves from being authentic? The issue of whether remaining inauthentic, is a better way of defending oneself, than being authentic has already been considered. Authenticity may expose people. Alternatively those citing lack of time, may have also been acting authentically, expressing genuinely, competing,

work time pressures. It was interesting to note that five of the six supervisees were in senior, possibly autonomous positions, in which they could create time in their working day, whereas more clinically based nurses did not have this opportunity. It would be interesting to explore whether or not nationally, those actively engaged in cs come from more senior roles.

The notion of creating time was also discussed by Sellars (2004). Her study found that physiotherapists who were having cs described it as "quality time" and "identified time set aside". They not only valued having the time, but also they recognised that there was a need to take that time.

In relation to my study, time and its sub-theme "too busy, not enough time" has been of significance. I examined the transcripts and identified key phrases and language, which emphasised the meaning of time to the participants. Below is a selection of the statements I found most significant. Interestingly, all but one come from the course participants. However, this may not be too surprising, as it was this group who argued that pressure of work resulted in insufficient time to have cs.

"My head was spinning and it took me ages to wind down" (C2)

"Running around like scalded cats" (C2)

"I'm running round with me head up me bum" (C4)

"...one minute we felt that we were galloping..." (C5)

"...you tend to think you were against the clock" (C10)

"I spend most of the week rushing around like a maniac." (C12)

"Running around headless" (C10)

"I've been rushed off my feet" (C13)

"I feel like I need to clear my head a little bit. I feel like there are too many things" (C17)

"I have been really bogged down" (C17)

"I think you get swamped with things....things just get shoved onto the back burner and further back they go" (C17)

"They're encouraged to tether themselves to the bed" (M6)

Their words suggest that their busyness was leaving them with little time to think and that they were stuck. Paradoxically the aim of cs is to provide practitioners with time to think, to reflect and to analyse or possibly even an opportunity to become "unstuck". Some nurses may fear that becoming "unstuck", may lead to "tripping up" as having time could lead them to expose areas of their practice that they may feel uncertain about?

The language within these quotes evokes imagery of measured time rather than experiential time. This should not be surprising as Waterworth (2003:432), when citing Elias (1992), stated that:

> "In the Western world, time has been constructed around devices of measurement, such as clocks, calendars and schedules and these are a representation of particular symbolism."

As a result measured time may be a secure way of living in the world and less demanding than experiential time. This implies that living predominantly by measured time is to live less authentically, than if people sometimes choose to embrace experiential time.

Heidegger (1972) referred time as being "four-dimensional". Amongst these dimensions there is, "true time" which is "nearing nearness" or "nearhood" (p15). Is this what the supervisees have recognized? That having cs allows them to experience

the full dimensions of time? The supervisees as a result, do not continually live in the present, but utilise their time in cs to move backwards (into the past) and forwards (into the future). This Solomon (1972) described as authentic time:

> "The authentic Dasein does not live in the present, tackling whatever task presents itself to him; he rather always sees these tasks in the context of his entire life." (p225)

Perhaps those participants who argued that there was insufficient time, were only viewing it from one dimension "the present".

> "Time-space now is the name for the openness which opens up in the mutual self-extending of futural approach, past and present. This openness exclusively and primarily provides the space...The self-extending, the opening up, of future, past and present is in itself prespatial; only thus can it make room, that is, provide space." (Heidegger, 1972:14)

According to Becker (1992) experiential time is of greater importance than measured time. She suggests that phenomenologists believe:

> "That if people become preoccupied with measured time and dismiss experiential time, they lose touch with an important quality of the life world." (p25)

Linking Becker's quote with some participants within this study, suggests that they were preoccupied with measured time and deprived themselves of cs as a consequence. For example, many course participants stated that there was insufficient measured time available during a shift to undertake cs. To support their claim it may be argued that the lack of clarity within the role of the nurse, means that they are constantly aware of measured time. When they are on duty they are subjected to a routine which is by and large dictated by measured time, such as meal times for patients, breaks for staff, operation lists, visiting times, doctors rounds, insulin injections, discharge planning and

recovery time. Furthermore, as previously stated, the NHS is target driven, with dates (or measured time) for improvements and changes to take place (examples include waiting time initiatives and the introduction of the new matron).

Not having available measured time, ultimately meant that participants felt that they could not engage in experiential time (through the cs relationship). Ironically I see cs as an opportunity for practitioners to have enriched experiential time. Instead of "running around headless", this experiential time should allow practitioners some thinking time during which their head (or at least their brain) is used constructively and effectively to help them to practice authentically.

During the course, there was much information giving, which left insufficient measured time available to pursue the experiential time component of practicing cs. Thus, some course participants rejected becoming supervisors after undertaking the training, stating that they needed more experiential time to practice. However, there may have been an expectation by the course participants and in some ways the educationalists, that learning is only confined to the classroom. As a result, the educationalists may have attempted to cover too much material in a short space of time, and the course participants may have believed that they must learn everything during the classroom contact. Similarly Smythe's (2004) study of the teaching/learning experiences of twenty six health care professionals led her to comment that "teachers are often more engrossed in supplying information than inviting thinking." (p329)

In relation to the theme "Time", some areas emerged from this study which includes:

The role of the qualified nurse is constantly time-measured. This tends to create a barrier, which nurses can utilize to avoid engaging in cs. In some ways this protects practitioners from examining their own emotional labour. Perhaps the demands on time

differ for nurses, in comparison to other health care professionals. Nonetheless, it may be that the latter see taking time for their professional development as equally important to providing care for their patients, whereas maybe nurses do not.

The two-three days of training of clinical supervisors in this study may have been insufficient time to sufficiently prepare supervisors who are "fit for purpose". Furthermore, training of supervisors may not have been the only option and instead it may have been of benefit to train supervisees first. The reasoning would be two-fold, that those wishing to undertake the supervisors' course would understand cs and that the course would attract participants who had sufficient knowledge of the concept and want to become a supervisor.

In an attempt to increase individual and organizational commitment to cs then potential course participants may wish to identify a supervisor. As well as gaining management approval for time, to undertake the course and become involved in experiential cs.

As Wheeler (2001b) explained:

> "Supervision is a multi-faceted process that needs to be understood in order to be performed effectively" (p28-29)

8.4 Working with wet clay

The introduction and implementation of cs nationally has been largely unsuccessful. Whilst there have been pockets of areas and disciplines that have accepted the worth of the concept, by and large it has been misunderstood, poorly resourced and implemented only rarely. This has resulted in limited numbers of nurses choosing to undertake the process. I suggest that cs could be viewed as similar to "working with wet clay". The raw material is grounded in practice. It is something that can be shaped and moulded to become what the potter intends, and the current model is perhaps not yet the finished

piece. However, just like clay, cs is a "sticky" phenomenon and can become misshapen, if the potter is clumsy or spins the wheel too fast or too slow. Ultimately the potter should have an idea of what shape is desired and in what timescale the finished item can be completed. If the potter's hands are experienced and creative, much can be achieved, but attention to detail is essential, as is a completely "hands-on" approach.

The profession and employers may not have made a genuine focused attempt to introduce cs; they may have failed to invest the resources that would allow staff the time to undertake regular cs. Any training should be negotiated in order to meet fully the needs of practitioners, so that there is a suitable duration and a period of probation for new supervisors. Just as, if clay starts to move in the wrong direction, the potter should take command, slow the process and even be prepared to begin again, so senior managers have the option to rethink the implementation of cs.

8.5 Summary

From the interviews with the participants (course, manager and supervisees) there seemed to be no clear decision making process regarding the implementation of cs in both Trusts. Instead, it appeared to have been thrust upon staff and they "reacted to its presence", rather than being proactive. These Trusts appeared, therefore, to have lacked the capacity to implement Bevington et al's (2004) recommendation of a proactive process to include *involvement* of staff in the decision making process, *transparency,* by explaining how a final decision was reached and *clarification of expectations.*

It would be fair to contend that there was a high degree of apathy towards cs at both an individual and organisational level. Interestingly, whilst the managers cited organisational difficulties, on an individual level they sought out their own supervision and appeared to value it. Furthermore, the supervisee participants worked mainly at a senior autonomous level and could create "time" for cs. Unfortunately this study highlights, that the clinically based practitioners, who one could argue possibly were in

most need for cs, appeared to reject it on several levels; lack of understanding and being time limited during their working shift were among the most frequently cited reasons for rejection. This may have in some ways helped the Trusts as if all practitioners had wanted to engage in cs this would have had an enormous cost implication in relation to training and giving staff the time.

Chapter 9
Conclusion

In relation to my study, clinical supervision (cs) within both of the Trusts studied may have been better received if the course was structured differently, to incorporate supervisee as well as supervisor training and involving open discussion in regard to the terminology and the need to challenge within nursing. Furthermore, there could be more emphasis on how nurses could take effective time for themselves and this may empower them through experiential work to seek cs. Possibly then, practitioners would have been more likely to act as a supervisor, rather than seeing cs as another drain or added burden on their "measured time". Allowing themselves the opportunity for the experience to wash over them in a more subtle way, may help nurses to reflect on the concept in a more relaxed fashion. This would be in keeping with Heidegger's thoughts from the "present-at-hand" to the "ready-to-hand" which Horrocks (1998) described as an "ontological shift from theoretical thinking to practical thinking". He argued that if a person followed Heidegger's philosophy then all theoretical knowledge needed to be grounded in practice. He implied that theory emerges from practice and is in some ways "parasitic" to it. In this study the "ready-to-hand" were the skills of being a supervisor and the "present-at-hand" was the theoretical course input. Following Heidegger's thoughts it is no surprise that the participants who claim that they were given insufficient time to pick-up these "ready-to-hand" skills were reluctant and later chose not to become supervisors and that there was insufficient linkage with the "present-at-hand" to underpin the skills. Indeed Horrocks' paper (1998) in which he examined the "ontological shift" and the implications for nurse education stated that Heidegger's ideas:

> "...imply that practice and the experience of practice are absolutely essential components of any educative programme. Furthermore they suggest that it is the practical rather than the theoretical components of education which are the most crucial." (p 134)

Nevertheless, Heidegger has written that practice is not enough and that a person also has to develop the ability to be "circumspective". In this way they have to be able to "look around" their environment and make sense of it. In relation to the study, the course participants' reluctance to act as supervisors seemed to be born out of the limited opportunity to practice the "ready-to-hand" skills. This possibly left them lacking confidence to undertake the role of supervisor in the clinical arena (to be circumspective) and as a result they remained in a state of inauthenticity.

The difficulties experienced by some participants went further than lack of time. Individual participants explained that it would be difficult to trust clinical supervision as a process that would be of benefit to them. These participants saw it as having potential to do them harm, particularly where issues of disclosure were concerned.

9.1 Tentative Recommendations

This study has attempted to interpret qualified nurse's individual lived experiences of cs. The sample of participants has ranged from, cs course participants, senior managers' within both Trusts and supervisees. The sample is not representative of all nurses' views and it is not generalisable. However, some of the findings overlap with some of the nursing literature. This relates particularly to the fact that nurses believe that time pressures and lack of clarity are preventing them from undertaking cs in the workplace. I have tried to move past these issues and discover other barriers such as lack of trust and fear of disclosure, and have been left with a notion that professional socialisation and constant political changes within the NHS, may be at the core of the problems with the implementation of cs.

Below are some tentative suggestions that may improve the uptake of cs by nurses:

- **Change of terminology:** participants in this study felt strongly that the terminology was confusing and had negative overtones of surveillance and inspection. The participants offered (unsolicited) alternatives, e.g *practitioner support.* It would be possible for the NMC to canvas opinion.
- **Trust:** was a significant factor and it would possibly be helpful if there was greater clarity that supervisees could and should choose their supervisor from their own or the multi professional arena.
- **Resourcing:** The managers within this study identified that if cs was to become a reality there needed to be greater investment to permit training of supervisors and supervisees (a view supported by Hyrkas, 2005)
- **National Commitment:** Currently the NMC leaves cs to be decided at local level; as a result there are pockets of excellence. However, if the implementation of cs were to become a target for every NHS Trust, as well as in the independent sector; there could be greater uptake at a National level. It could then be seen as a quality indicator and described as best practice.
- **Accreditation:** The role of a clinical supervisor could become accredited and a national database could be developed and maintained. Nurses seeking to become accredited could undertake a recognised national (standardised) training programme and demonstrate that they have the skills to perform the role. This may result in more staff "trusting" the process, if they saw the training to be more rigorous.
- **Culture change through education** Clinical supervision will not take place on any mass scale within the nursing profession, without a change in culture. There should be a clear aim to empower nurses to undertake cs as a positive and quality issue. This could begin by introducing cs for student nurses throughout their three-year training, facilitated by their personal tutors (a view supported by Wood, 2004, Cleary and Freeman, 2005). The first year could be an opportunity for reflection-on-action with students bringing scenarios that they have been

involved with (positive and negative) and discussing them in a small group. By year three the personal tutor would be taking less of a supervisory role and more of a facilitative role, allowing peer supervision to occur.

I had chosen to investigate two cs courses because I was, and had always been, aware that some "participants" had been volunteered by their manager or had requested to attend the cs course, possibly as a way of "escaping" from the clinical arena for a few days. Possibly, the reality is that there is lack of trust between the managers, nurses and educators, all of whom tend to function inauthentically, possibly unconsciously so. However, somehow, perhaps individuals believe that we are being authentic; the managers sending or allowing staff to undertake cs courses, the participants who attend and the educationalists who facilitate the training.

I have provided examples that the course participants have shared with me of their lived experiences during their working day. In addition there is evidence that the manager participants appeared to be aware of the demands on nurses' time and appreciated why nurses may not be taking cs forward. However, the managers offered few strategies or suggestions as to how practitioners could make supervision a reality for themselves, and at times, even though they could see the theoretical value of supervision, they were cynical about the concept. This was best illustrated by M5 who suggested that it was a "flavour of the month five years ago, but there have been seventeen thousand other flavours since then". This may be an indicator of general disillusionment in an organisation like the NHS, which is subjected to changes in national, regional and local political strategies, has become increasingly target-driven and in which the only certainty is change. But there is a strong argument to suggest that the manager participants demonstrated a high degree of inauthenticity, because they could verbalise the positive aspects of supervision, and secure time for their own supervision, whilst very discreetly failing to facilitate it for their practitioners.

Howatson-Jones (2003) recommended that the selection of potential supervisors should be from a joint self and other's assessment, wherein the other is the self's supervisor. This indicated a natural progression from supervisee to supervisor, when both the supervisee and the supervisor agree that they are ready to take on the role. This may be difficult to achieve, when first developing cs due to the limited number of supervisors available. The importance of either self and/or joint selection would, I believe, result in the time during the course being utilised more effectively, with those attending better understanding the implications of the role of the supervisor as they would have had previous experiential insight as supervisees. Staff attending the supervisor's course with no previous experience, must come to terms with the role of supervisee, as well as supervisor, within a short course.

To conclude, having been a nurse since 1985 I would offer the following observations and assertions about the role. This is written solely from my own personal perspective and understandings and I offer it as a reflexive account, based on my experience of conducting this study, my reading and my longer term experience in practice, management and education.

I think that the very nature of being a nurse means that there is an exposure on a regular basis to human suffering, death and distress. In addition, nurses cannot simply observe such psychologically traumatic events, but are required to intervene dynamically, and if possible, to effect change by helping patients, relatives and others. Consequently, I contend that it would not be realistic for nurses to exist authentically the majority of the time, as that would be potentially a physically and psychologically draining way of existing in the world. I wonder whether cs is an attempt to move individuals from the "normal everydayness" of inauthenticity towards a state of authenticity. If this is so, does this mean that individuals are expected to move away from the "idle chatter" and towards understanding, interpreting themselves, patients and relatives and ultimately reaching a state of enlightenment?

Nurses appear to accept the socialisation of the profession unquestioningly (Jolley and Brykczynska, 1993). Historically this has given rise to a profession that is virtually apolitical (examples are a refusal to strike and subservience to other professions, particularly medicine) (Kuhse 1997). Gamarnikow (1991) argues that "medical men" from 1860 used their dominance within healthcare to maintain nurses as female subordinates. As a result of this history of nursing, I wonder whether metaphorically speaking this may have lead to some nurses feeling disempowered and not wanting to speak out or share their own thoughts, fears and ideas. This thrownness may have led to some nurses hiding from the potential conflict and pain which authenticity would bring. This may more recently have resulted in them seeing cs as threatening, rather than enabling; because without it they may continue to act inauthentically, remaining "safe and secure" as a result.

Possibly the supervisees within this study may consciously recognise their thrownness within the profession and seek cs, so that they can begin to develop self-awareness, interpret life events and in so doing, practice more authentically. By actively seeking regular cs, supervisees may be likened to the people Heidegger (1962) describes as being "devoted to the common cause":

> "they...become *authentically* bound together, and this makes possible the right kind of objectivity, which frees the other in his freedom for himself." (p159)

In this way, it could be argued that those who have cs are taking the opportunity to be-with-others authentically rather than just existing. I wondered whether many nurses merely exist in the workplace, by working alongside one another but not really understanding or caring for each other and furthermore avoiding cs, because it may force them to face that issue. If the nursing profession could find a way to implement cs which is acceptable to its practitioners, this difficulty could be overcome, permitting nursing to emerge from the constraints of its past as a fully effective profession of confident and autonomous individuals.

REFERENCES

Addison, R.B (1992) — Grounded Hermeneutic Research. IN B.F Crabtree and W.L Miller (eds.) Doing Qualitative Research. London: Sage.

Alavi, C (1995) Cattoni, J — Good nurse, bad nurse... Journal of Advanced Nursing 21(2):344-349.

Anderson, J.M (1991) — Current directions in nursing research: toward a post-structualist and feminist epitemology The Canadian Journal of Clinical Research 23 (3): 1-3

Andrews, M (2000) Chilton, F — Student and mentor perceptions of mentoring effectiveness Nurse Education Today 20(7):555-562

Andrews, M (1999) Wallis, M — Mentorship in nursing: a literature review Journal of Advanced Nursing 29 (1):201-207

Annells, M (1996) — Hermeneutic Phenomenology: philosophical perspectives and current use in nursing research Journal of Advanced Nursing 23 (4):705-713

Annells, M (1999) — Evaluating Phenomenology; usefulness, quality and philosophical foundations Nurse Researcher 6 (3):5-15

Arvidsson, B (2001) Lofgren, H Frilund,B — 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

Ashworth, P.D (1997) — The variety of qualitative research. Part two: non-positivist approaches. Nurse Education Today 17(3): 219-224

Ashmore, R (2000) Carver, N — Clinical supervision in mental health nursing courses British Journal of Nursing 9 (3):171-176

Aston, L (2003)
Molassiotis, A
Supervising and supporting student nurses in clinical placements: the peer support initiative
Nurse Education Today 23(3):202-210

Audit Commission (1999)
First Assessment: a review of district nursing In England and Wales
ISBN 18624001497

Bailey, C (2004)
Reflecting on supervision training courses- the heart of the matter
CPJ (December):36-39

Baillie, L. (1996)
A Phenomenological study of the nature of empathy
Journal of Advanced Nursing 24 (6):1300-1308

Barriball, L (2004)
While, A
Munch, U
An audit of clinical supervision in primary care
British Journal of Community Nursing 19 (9):389 397

Barton-Wright, P (1994)
Clinical supervision and primary nursing
British Journal of Nursing 3 (1):23-30

Bassett, C (2000)
Nice idea, shame about the name
Nursing Times 96 (13):38

Beauchamp, T.L (1994)
Childress, J.F
Principles of Biomedical ethics.
New York: Oxford University Press.

Beck, C.T (1994)
Phenomenology: its use in nursing research
International Journal of Nursing Studies
31 (6):499-510

Becker, C.S (1992)
Living & Relating. An introduction to Phenomenology.
London: Sage publications.

Bedian, A.G (1980)
Organisational Theory and Analysis.
Illinois: Dryden Press.

Beech, I (1999)
Bracketing in phenomenological research
Nurse Researcher 6 (3):35-52

Begat, I.E (1997)
Severinsson, I
Berggren, I.B

Implementation of Clinical Supervision in a Medical Department: Nurses Views of the Effects
Journal of Clinical Nursing 6(5):389-394

Begat, I (2005)
Ellefsen, B
Severinsson, E

Nurse's satisfaction with their work environment and the outcomes of clinical nursing supervision on nurses experiences of well-being- a Norwegian study
Journal of Clinical Management 3 (3):221- 230

Beinart, H (2003)

Models of supervision and the supervisory relationship and their evidence base. IN I Fleming and L Steen (eds.) Supervision and Clinical Psychology: Theory, Practice and Perspectives.
East Sussex: Brunner-Routledge.

Bell, D (1991)

Husserl.
London: Routledge.

Bent, E.A (1992)

Preparation of supervisors of midwives: an Open Learning Programme module 1: The statutory Basis to the role of the supervisor IN S Cammerloher and J Sleep (eds.) Preparation of Midwives: An Open Learning Programme Module.

Benton, D.C (2000)

Computer-assisted data analysis IN D Cormack (ed.) The Research Process in Nursing
London: Blackwell Science.

Berg, A (2000)
Hallberg, I.R

The meaning and significance of clinical group supervision and supervised individually planned nursing care as narrated by nurses on a general team psychiatric ward
Australian New Zealand Journal of Mental Health Nursing 9 (3):110-127

Berg, A (1994)
Welander-Hansson, U
Hallberg, I.R

Nurses' creativity, tedium and burnout during 1 year of clinical supervision and implementation of individually planned nursing care: comparisons between a ward for severely demented patients and a similar control ward
Journal of Advanced Nursing 20(4):742-749

Berggren, I (2002)
Begat, I
Severinsson, E
Australian clinical nurse supervisors' ethical decision-making style.
Nursing and Health Sciences 4(1/2):15-23

Berggren, I (2005)
Barbosa da Silva, A
Severinsson,E
Core ethical issues of clinical nursing supervision
Nursing and Health Sciences 7 (1):21-29

Bernard, J (1998)
Goodyear, R
Fundamentals of Clinical Supervision
Boston: Allyn & Bacon.

Bevington, J (2004)
Deighan, M
Stanton, P
Hinchliffe, S
Follow my leader
Health Service Journal 10th June:28-29

Billay, D. B (2004)
Yonge, O
Contributing to the theory development of preceptorship
Nurse Education Today 24(7):566-574

Bishop, V (1994)
Clinical supervision for an accountable profession
Nursing Times 90 (39):35-38

Bishop, V (1998a)
Clinical supervision:What is going on? Results of a questionnaire
NT Research 3 (2):141-150

Bishop, V (1998b)
Clinical Supervision:What Is It? IN V Bishop (ed)
Clinical Supervision in Practice
London: Macmillan.

Bleicher, J (1980)
Contemporary Hermeneutics: Hermeneutics as a method, Philosophy and critique
London: Routledge and Kegan Paul.

Bogden, R (1992)
Biklen, S
Qualitative research: An Introduction to theory and methods.
Boston: Allyn & Bacon.

Bond, M (1998)
Holland, S
Skills of Clinical Supervision for Nurses
Buckingham: Open University Press.

Bowers, B.J (2001)
Lauring, C
Jackobson, N
How nurses manage time and work in long-term care
Journal of advanced Nursing 33 (4):484-491

Bowes, (2003)
Reflections on supervisor accreditation and training
CPJ (February): 26-27

Bowles, N (1999)
Young, C.
An evaluative study of clinical supervision based on Proctor's three function model
Journal of Advanced Nursing 30 (4):958-964

Bowling, A (1997)
Research Methods in Health.
London:Open University Press.

Boykin, A (2000)
Schoenhofer, S.O
Is There Really Time to Care?
Nursing Forum 35(4):36-38

Bradshaw, A (1999)
The virtue of nursing: the covenant of care
Journal of Medical Ethics 25 (6):477-481

Brearley, K (2005)
Reflection. Appreciating the benefits of effective clinical supervision
Nursing Times 101 (10):39

Brent, N.J (1990)
Legal Issues in Research: Informed Consent
American Association of Neuroscience Nurses
22 (3):189-191

Brink, P.J (2001)
Wood,M.J
Basic Steps in Planning Nursing Research
London: Jones and Bartlett Publishes.

British Association (2002)
for Counselling and
Psychotherapy
Ethical Framework for good practice in counselling and psychotherapy
www.bacp.c.uk/ethical_framework/index.html
(accessed 26th May 2005)

Brocklehurst, N (2000)
Walshe, K
Quality and the new NHS
Nursing Standard 13 (51):26-34

Brown, A. (1996)
Bourne, I
The social work supervisor
Buckingham: Open University Press.

Bulmer, C (1997)
Supervision: how it works
Nursing Times 93 (48):53-54

Burke Draucker, C (1999)
The critique of Heideggerian hermeneutical Nursing research
Journal of Advanced Nursing 30 (2):360-370

Burnard, P (1991)
Coping with stress in the Health Professions a practical guide
London: Chapman & Hall

Burns, N (1993)
Grove, S
Practice of Nursing Research. 2nd Edition
London: J.B Lippincott Company.

Burns, N (2001)
Grove, S.K
The Practice of Nursing Research
London: W.B.Saunders Company.

Burrow, S (1995)
Supervision: clinical development or management control?
British Journal of Nursing 4(15):879-882

Burton, S (2000)
A critical essay on professional development in dietetics through a process of reflection and clinical supervision
Journal of Human Nutrition & Dietetics
13 (5):323-332

Bush, T (2005)
Overcoming the barriers to effective clinical supervision
Nursing Times 101 (2):38-41

Butterworth, T (1992)
Clinical Supervision as an Emerging Idea in Nursing.IN TButterworth. and J Faugier (eds.)
Clinical Supervision and Mentorship in Nursing
: 3-17
London: Chapman and Hall.

Butterworth, T (1992)
Faugier, J
Clinical Supervision and Mentorship in Nursing
London: Chapman & Hall.

Butterworth, T (1993)
Faugier, J
Clinical supervision: a position paper
School of Nursing studies University of Manchester

Butterworth, T (1994)

Preparing to take on clinical supervision.
Nursing Standard 8 (52):32-34

Butterworth, T (1994)
Bishop, V (Eds)

Clinical supervision : A Report of the Trust
Nurse Executive Workshops
NHSEHMSO, London

Butterworth, T (1994)
Faugier, J

Clinical supervision in nursing, midwifery and health visiting: a briefing paper.
School of Nursing studies, University of Manchester

Butterworth, T (1996)

Primary attempts at research-based evaluation of clinical supervision
NT Research 1 (2):96-1

Butterworth, T. (1996)
Bishop, V
Carson, J

First steps towards evaluating clinical supervision in Nursing and Health Visiting Theory, policy &. Practice development A review
Journal of Clinical Nursing 5(2):127-132

Butterworth, T (1997)
Carson, J
White, E,
Jeacock, J
Clements, A
Bishop, V

Clinical Supervision and Mentorship: An Evaluation study in England and Scotland
School of Nursing, Midwifery & Health Visiting
University of Manchester

Butterworth, T (1998)
Faugier, J
Burnard, P

Clinical Supervision and Mentorship In Nursing
Cheltenham: Nelson Thornes.

Butterworth, T (2002)
Woods, D

Clinical Governance and Clinical Supervision: Working together to Ensure Safe and Accountable practice
The School of Nursing, Midwifery and Health Visiting University of Manchester

Butterworth, T (2004)

Lend me your ears
Nursing Standard 19 (13):16-17

Byrne, M (2001) Linking philosophy, methodology, and methods in qualitative research
Association of Operating Room Nurses Journal 73 (1):207-209

Caelli, K (2001) Engaging with Phenomenology: is it more a challenge than it needs to be?
Qualitative Health Research 11 (2):273-281

Canham, J (1998) Educational clinical supervision: meeting the needs of specialist community practitioner students and professional practice.
Nurse Education Today 18(5):394-398

Carolan, M (2003) Reflexivity: A personal journey during data collection
Nurse Researcher 10 (3):7-14

Carson, J (1995)
Fafin, L
Ritter, S.A
Stress and Coping in mental health
London: Chapman& Hall.

Carter, M (2002) Clinical Governance what does it mean for counsellors and psychotherapists?
CPJ (June):19-21

Carthy, J (1994) Bandwagons Roll.
Nursing Standard 8 (38):48-49

Casement, P (1985) On Learning from the Patient
Tavistock, London

Castille, K (1996) clinical supervision: from rhetoric to Accident and Emergency Practice
Accident & Emergency Nursing 4(1):2-4

Catmur, S (1995) Clinical supervision in mental health nursing
Mental Health Nursing 15 (1):24-25

Cerinus, M (2001) The ethics of research
Nurse Researcher 18 (3):72-90

Cerinus, M (2005)
The role of relationships in effective clinical supervision
Nursing Times 101 (14):34-37

Chambers, M (1990)
Psychiatric and mental health nursing; learning in the clinical environment IN W Reynolds and D Cormack (eds.) Psychiatric and Mental Health Nursing:Theory and Practice
London: Chapman and Hall.

CSP (2000)
Clinical Supervision- Information Paper No PA45.
Chartered Society of Physiotherapy (CSP)
London

Cheater, F.M (2001)
Hale, C
An evaluation of a local clinical supervision scheme for practice nurses
Journal of Clinical Nursing 10 (1):119-131

Chinn, P.L (1986)
Nursing research methodology issues and implementation
London: Rockville Md. Aspen Publishers.

Clarke, A (1999)
Data Collection: The Research Interview.
Professional Nurse 14 (4):246-248

Cleary, M (2005)
Freeman, A
The Cultural Realities Of Clinical Supervision In An Acute Inpatient Mental Health Setting
Issues in Mental Health Nursing 26(5):489-505

Clegg, A (2000)
Leadership: improving the quality of patient care
Nursing Standard 14 (30):43-45

Clifford, C (1990)
Nursing and Health Care Research
London: Prentice Hall Nursing series.

Clifton, E (2002)
Implementing clinical supervision
Nursing Times 98 (9):36-37

Clothier, C (1994)
MacDonald, C.A
Shaw, D.A
The Allitt inquiry. Independent inquiry relating to the deaths and injuries on the Childrens ward at Grantham and Kesteven General Hospital during the period Feb-April 1991
London. HMSO

Clouder, L (2004)
Sellars, J
Reflective practice and clinical supervision: an inter-professional perspective.
Journal of Advanced Nursing 46 (3):262-269

Coady, C (1990)
Kent, V
Davies, P
Burnout among social workers working with patients with cystic fibrosis
Health and Social Work May:116-124

Cody, A (1999)
Health Visiting as therapy a phenomenological perspective
Journal of Advanced Nursing 29 (1):119-127

Cohen, M.Z (1987)
A Historical overview of the phenomenologic movement.
Image.Journal of Nursing Scholarship 19 (1):31-34

Cohen, M. Z (2000)
Kahn, D. L
Steeves, R.H
Hermeneutic Phenomenological Research
London: Sage.

Cohen, R.I (2004)
Clinical Supervision: What to Do and How to Do It
California: Brook/Cole.

Colaizzi, P (1978)
Psychological research as the phenomenologist views it. IN R Valle and M King (eds.) Existential Phenomenological alternatives for Psychology.
New York: Oxford University Press

Coleman, M (1995)
Using workshops to implement supervision
Nursing Standard 9 (50):27-29

Collings, J (1996)
Murray, P
Predictors of stress among social workers: An empirical study
British Journal of Social Work 26(3):375-387

Collins gem (2001) Dictionary and Thesaurus
London: Harper Collins.

Consedine, M (2000) Developing abilities: the future of clinical supervision
Journal of Psychiatric & Mental Health Nursing
7 (5):471-474

Cooper, C (1988)
Sloan, S
Williams, S
The Occupational Stress Indicator
Windsor:NFER-Nelson.

Corben, V (1999) Misusing phenomenology in nursing research: Identifying the issues
Nurse Researcher 6(3):52-67

Corrigan, P (2005) A Magical factor
Nursing Management 12 (1):15

Cottrell, S (2001) Personal Correspondence

Cottrell, S (2002)
Smith, G
The development of models of nursing supervision in the UK
www.clincalsupervision.co.uk

Cowe, F (1998)
Wilkes, C.
Clinical supervision for nurse specialists
Professional Nurse 13 (5):284-287

Cox, K (1998) Investigating psychosocial aspects of participation in early anti-cancer drug trials: towards a choice of methodology
Journal of Advanced Nursing 27 (3):488-496

Coyne, I.T (1997) Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries?
Journal of Advanced Nursing 26 (3):623-630

Cresswell, J.W (2003) Research Design
London: Sage publications.

Crigger, N (2004)
Always having to say you're sorry: An ethical response to making mistakes in practice
Nursing Ethics 11 (6):568-576

Critchley, D.E (1987)
Clinical Supervision as a learning tool for the therapist in the milieu setting.
Journal of Psychological Nursing 25 (8):18-22

Cronbach, L (1951)
Coefficient alpha and the internal structure of tests
Psychometrica 16:297-334

Crotty, M (1996)
Phenomenology and Nursing research
London: Churchill Livingstone.

Crotty, M. (1998)
The Foundations of social research: Meaning and perspective in the research process
London: Sage publications.

Crouch, D (2001)
The same, but different
Nursing Times 97 (40):22-23

Cudmore, J (1996)
As good as the supervisor
Nursing Standard 10 (27):52

Cushing, A (1994)
Historical and epistemological perspectives on research and nursing
Journal of Advanced Nursing 20(3):406-411

Cutcliffe, J (1997)
Evaluating the success of clinical supervision
British Journal of Nursing 6 (13):725

Cutcliffe, J.R (1998)
Epling, M.
Cassedy, P
McGregor, J
Plant, N
Butterworth, T
Ethical dilemmas in clinical supervision:
A need for guidelines
British Journal of Nursing 17 (15):920-923

Cutcliffe, J. R (1998)
Burns, J
Personal, professional and practice development: clinical supervision
British Journal of Nursing 7 (21):1318-1322

Cutcliffe, J. R (1998a)
Proctor, B
An alternative training approach to clinical supervision: 1
British Journal of Nursing 7(5):280-285

Cutcliffe, J.R (1998b)
Proctor, B
An alternative training approach to clinical supervision: 2
British Journal of Nursing 7 (6): 344-350

Cutcliffe, J.R (1999)
McKenna, H.P
Establishing the credibility of qualitative research findings: the plot thickens
Journal of Advanced Nursing 30 (2):374-380

Cutcliffe, J (2000)
To record or not to record: documentation in clinical supervision
British Journal of Nursing 9 (6):350-355

Cutcliffe, J.R (2001)
Butterworth, T
Proctor, B
Introduction IN J R Cutcliffe, T Butterworth and B Proctor (eds.) Fundamental themes in Clinical Supervision: 1-5
London: Routledge.

Cutcliffe, J (2005)
From the guest editor- Clinical Supervision: A Search For Homogeneity Or Heterogeneity?
Issues in Mental Health Nursing 26(5):471-473

Cutcliffe, J (2005)
Lowe, L
A Comparison of North American and European Conceptualizations of Clinical Supervision
Issues In Mental Health Nursing 26(5):475-488

Dale, C (2004)
Storey, L
High, medium, and low security care: Does the type of care make any difference to the role of the forensic mental health nurse?
Nursing Times Research 9 (3):168-184

Darley, G (2001)
Demystifying supervision
Nursing Management 7 (10):18-22

Davies, J.E (2004)
Tennant, A
Ferguson, E
Jones, L.F
Developing models and a framework for multi-professional clinical supervision
The British Journal of Forensic Practice
6 (3):36-42

Dearnley, C (2005) A reflection on the use of semi-structured interviews
Nurse Researcher 13 (1):19-28

Deery, R (2005) An action-research study exploring midwives' support needs and the affect of group clinical supervision.
Midwifery June 21 (2):161-176

Department of Health (1989) Carer support in the community: Evaluation of the Department of Health Initiative "demonstration districts for informal carers" 1986-1989
London: HMSO.

Department of Health (1992) The Health of the Nation- A strategy for Health in England
London: HMSO.

Department of Health (1993) A Vision For The Future: The Nursing, Midwifery and Health Visiting Contribution to Health and Health Care
London: HMSO.

Department of Health (1994a) Working in partnership: A Collaborative approach to care. Report of the Mental Health nursing review team.
London: HMSO.

Department of Health (1994b) [CNO letter 94 (5)] Clinical Supervision for the Nursing and Health Visiting Profession.
London: HMSO.

Department of Health (1998) A First Class Service: Quality in the new NHS
London: HMSO.

Department of Health (1999) Clinical Governance: Quality in the new NHS
London: HMSO.

Department of Health (2000a) The NHS National Plan-A plan for Investment: A Plan for Reform
London: HMSO.

Department of Health (2000b) Improving Working Lives Standard. NHS employers committed to improving the working lives of people who work in the NHS. London: HMSO

Department of Health (2001b) Working Together: Learning Together London: HMSO.

Department of Health (2001c) Governance arrangements for NHS Research Ethics Committees London: HMSO.

Department of Health (2001d) Research governance framework for Health and Social care London: HMSO.

Department of Health (2002b) Research Governance: Responsibilities of Research Sponsor London: HMSO.

Department of Health (2005) Improving Working Lives in Midwifery. A guide for midwives and managers London: HMSO.

Devine, A (1995) Baxter, T. Introducing clinical supervision: a guide Nursing Standard 9(40):32-34

Devlin, B.H (1998) Clinical governance: another stick to beat manager with? British Journal of Health Care Management 4(7): 318-319

Diekelmannn, N.L (1989) Allen, D Tanner, C The NLN criteria for appraisal of baccalaureate programs: A critical hermeneutic analysis New York: NLN Press.

Diekelmann, N.L (1992) Learning-as-testing: A Heideggerian hermeneutical analysis of the lived experiences of students and teachers in nursing Advanced Nursing Science 14 (3):72-83

Dimond, B (1998a) Legal aspects of clinical supervision, part 1: employer vs employee. British Journal of Nursing 7 (7):393-395

Dimond, B (1998b)
Legal aspects of clinical supervision, part 2: Professional accountability
British Journal of Nursing 7 (8):487-489

Dobbie, B.J (1991)
Women's mid life crisis: an evolving consciousness of self and children
Journal of Advanced Nursing 16 (7):825-831

Donovan, J (2005)
Sanders, C
Key issues in the analysis of qualitative data in health services research In A Bowling and S Ebrahim, (eds.) Handbook of Health research Methods investigation, measurement and analysis
London: Open University Press.

Dowling, M (2004)
Hermeneutics: a exploration.
Nurse Researcher 11 (4):30-39

Drew, N (1989)
The interviewer's experience as data in phenomenological research
Western Journal of Nursing Research
11(4):431-439

Dreyfus, H. (1987)
Husserl, Heidegger and modern existentialism IN B Magee (ed.) The Great Philosophers: An introduction to Western Philosophy
London: 254-277 BBC Books.

Driscoll, J (1999)
Getting the most from clinical supervision
Part one: The Supervisee
Mental Health Practice (March) 2 (6):28-35

Driscoll, J (2000)
Practicing Clinical Supervision: A Reflective Approach
Edinburgh: Bailliere Tindall.

Driscoll, J (2005)
Cooper, R
Coaching for clinicians
Nursing Management 12 (1):18-23

Duarri, W. (1999)
Kendrick, K.
Implementing clinical supervision
Professional Nurse 14 (12):849-852

Duncan, R (2003) Shaped to care: A study of subjectivity and emotional labour in nursing theory and practice. PhD Thesis. University of Melbourne

Duncan-Grant, A (2001) Clinical supervision activity among Mental Health Nurses
Portsmouth: Nursing Praxis International.

Easton, K.L (2000)
McComish, J.F
Greenberg, R
Avoiding Common Pitfalls in qualitative Data Collection and Transcription
Qualitative Health Research 10 (5):703-707

Edwards, S (1996a) Are nursing's "extraordinary" moral standards unrealistic?
Nursing Times 92 (43):34-35

Edwards, S (1996b) What are the limits to the obligations of the nurse?
Journal of Medical Ethics 22 (2):90-95

Elfert, H (1991)
Anderson, J.M
Lai, M
Parents perceptions of children with chronic illness: a study of immigrant Chinese families
Journal of Paediatric Nursing 6 (2):114-120

Eltringham, D (2000)
Gill-Cripps, P
Lawless, M
Challenging values in clinical supervision through reflective conversations IN T Ghaye and S Lillyman (ed.s) Effective Clinical Supervision the role of reflection
London: Quay books.

E.N B (1989) Preparation of Teachers, Practitioners/ Teachers, Mentors and Supervisors in the Context of Project 2000
London: E.N.B.

E.N.B (1994) Creating Lifelong Learners
London: E.N.B.

Ensign, J (2003) Ethical Issues in qualitative health research with homeless youths
Journal of Advanced Nursing 43 (1):43-50

Ersser, S (1996) Ethnography in clinical situations; an ethical appraisal. IN L, De Raeve, (ed.) Nursing Research. An Ethical and Legal Appraisal
London: Bailliere Tindall.

Ettinger, E (1995) Hannah Arendt-Martin Heidegger
London: Yale University Press.

Fabricus, J (1991) Learning to work with feelings-psycho dynamic understanding and small group work with junior student nurses
Nurse Education Today 11(2):134-142

Fadden, G (1997) Implementation of family interventions in routine clinical practice following staff training: A major concern
Journal of Mental Health 6 (6):599-612

Farias, V (1989) Heidegger and Nazism (Burrell P & Ricci G trans)
Philadelphia: Temple University Press.

Farrington, A (1995) Models of clinical supervision
British Journal of Nursing 4 (15):876-878

Farrington, A (1996) Clinical Supervision: UKCC must be more proactive
British Journal of Nursing 5 (12):716

Faugier, J (1993) The supervisory relationship In T Butterworth and J Faugier (eds.) Clinical Supervision and Mentorship in Nursing
London: 18-36 Chapman and Hall.

Faugier, J (1994) Thin on the ground
Nursing Times 90 (20):64-65

Faugier, J (1993)
Butterworth, T Clinical Supervision: A Position Paper
University of Manchester, Manchester

Faugier, J (2002)
Woolnough, H Valuing "voices from below"
Journal of Nursing Management 10(6):315-320

Feltham, C (2002)
A surveillance culture?
Counselling Psychology Journal (February):26-27

Field, P.A (1985)
Morse, J.M
Nursing Research: the application of qualitative approaches
London: Chapman & Hall.

Fineman, S (1985)
Social Work Stress and Intervention
Hants: Gower Publishing.

Finlay, L (2003)
The reflexive journey: mapping multiple routes IN L Finlay and B Gough (eds.)Reflexivity A practical guide for researchers in health and social sciences
Oxford: Blackwell Science.

Finlay, L (2003)
Gough, B
Introducing Reflexivity IN L Finlay and B Gough (eds.) Reflexivity a practical guide for researchers in health and social sciences
Oxford: Blackwell Science.

Fish, D (1989)
Twinn, S.
Purr, B
How to enable learning through professional Practice
London: West London Press.

Flanagan, J.C (1954)
The critical incident technique.
Psychological Bulletin 51:327-358

Fleming, V (2003)
Gaidys, U
Robb, Y
Hermeneutic research in nursing: developing a Gadamerian-based research method
Nursing Inquiry 10 (2):113-123

Fowler, J (1996a)
The organisation of clinical supervision within the nursing profession: a review of the literature
Journal of Advanced Nursing 23(3):471-478

Fowler, J (1996b)
Clinical supervision: what do you do after saying hello?
British Journal of Nursing 5 (6):382-385

Fowler, J (1998)
Chevannes, M
Evaluating the efficacy of reflective practice within the context of clinical supervision.
Journal of Advanced Nursing 27(2):379-382

Fox, J (1994)
Clinical Supervision: a real aspiration?
British Journal of Nursing 3 (16):805

Freshwater, D (2001)
Walsh, L
Storey, L
Prison Health care: Developing leadership through clinical supervision
Nursing Management 8 (8):10-14

Fulton, J (2001)
Oliver, D
Clinical Supervision: A Psychodynamic Approach
Research for Nursing Practice (Spring):

Fyffe, T (1997)
Clinical supervision an exploratory study of staff experiences and perceptions
Unpublished Masters of Medical Education thesis
University of Dundee

Gadamer H-G (1975)
Truth & Method (Barden G, Cumming J, Trans)
London: Sheed & Ward.

Gadamer, H-G (1976)
Philosophical Hermeneutics (D. Linge, Trans & ed.)
Berkeley: University of Califoria Press.

Gallagher, F (2003)
Jasper, M
Health Visitor's experiences of Family Group Conferences in relation to child protection planning: a phenomenological study
Journal of Nursing Management 11(6):377-387

Gamarnikow, E (1991)
Nurse or woman: Gender and professionalism in reformed nursing 1860-1923. IN P Holden and J Littlewood (eds.) Anthropology and Nursing
London: Routledge.

Garret, C (1998)
Michael Crotty's phenomenology and nursing research.
Annual Review of Health Science 8:36-40

Ghaye, T (2000)
Introduction. Colleague-centred care: The reframing of clinical supervision IN T Ghaye and S Lillyman (eds.) Effective clinical supervision
London: Quay Books.

Gilbert, T (2001)
Reflective practice and clinical supervision: meticulous rituals of the confessional
Journal of Advanced Nursing 36 (2):199-205

Gillies, A (2002)
Using Research in Nursing
Oxford: Joshua Associates Limited.

Gilmore, A (1999)
Review of the United Kingdom evaluative literature on clinical supervision in nursing and health visiting
London: UKCC.

Gilmore, A (2001)
Clinical supervision in nursing and health visiting. A review of the UK literature IN J Cutcliffe, T Butterworth and B Proctor (eds.) Fundamental Themes in Clinical supervision
London: Routledge.

Giorgi, A (1985)
Phenomenology and psychological research
Pittsburgh PA: Duquesne University Press.

Glaser, B.G (1967)
Strauss, A
The discovery of grounded theory
Chicago: Aldine.

Glouberman, D (2003)
The Joy of Burnout
London: Hodder Mobius.

Gom, M (2000)
Needham, G
Bullman, A
Evaluating Research in Health and Social Care
London: Sage Publishers.

Grant, A (2000)
Learning Curve. Why clinical supervision is not so super in reality
Nursing Times 96 (24):42

Gray, W (2001)
Clinical Governance Combining clinical and management supervision.
Nursing Management 8 (6):14-22

Grealish, L (1998)
Carroll, G
Beyond preceptorship and supervision: A third teaching model emerges for Australian nursing education
Australian Journal of Advanced Nursing
15 (2):3-11

Grossman, R (1984) Phenomenology and existentialism
London: Routledge and Kegan Paul.

Hadfield, D. (1998) Exploring the effects of clinical supervision on pratice, through the perceptions of paediatric nurses
Unpublished M.S.c Manchester Metropolitan University

Haggstrom, E (2005)
Skovdahl, K
Flackman, B
Kihlgren, A.L
Kihlgren, M
Work satisfaction and dissatisfaction-caregivers' experiences after a two-year intervention in a newly opened nursing home
Journal of Clinical Nursing 14(1): 9-19

Hallberg, I.R (1994) Systematic clinical supervision in a child psychiatric ward satisfaction with nursing care, tedium, burnout and nurses' own report on the effects of it.
Archives of Psychiatric Nursing 8(1):44-52

Hallberg I.R. (1993)
Norberg, A.
Strain among nurses and their emotional reactions during one year of clinical supervision combined with the implementation of individualised care in dementia nursing.
Journal of Advanced Nursing 18(12):1860-1875

Hallberg, I.R (1993)
Hansson, U.W
Axelson, K
Satisfaction with nursing care and work during a year of clinical supervision and individualised care. Comparison between two wards for the care of the severely demented patients
Journal of Nursing Management 1 (6):297-307

Hallett, C (1995) Understanding the phenomenological approach to research
Nurse Researcher 3 (2):55-67

Hammersley, M (1983)
Atkinson, P.
Ethnography, Principles in Practice
London: Tavistock Publications.

Hammersley, P (2004)
Mairs, H
Sampling Methods
Nurse Researcher 12 (1): 4-6

Hancox, K (2003)
Lynch, L
Clinical supervision for healthcare professionals: Book of readings
The Centre for Psychiatric Nursing Practice and research.
Melbourne. University of Melbourne

Hancox, K (2004)
Lynch, L
Happell, B
Biondo, S
An evaluation of an educational programme for clinical supervision
International Journal of Mental Health Nursing
13 (3):198-203

Hand, H (2003)
The mentor's tale: a reflexive account of semi-structured interviews
Nurse Researcher 10 (3):15-27

Harris, P (1989)
The nurse stress index
Work and Stress 3 (4):335-346

Hart, C (2004)
Nurses and politics
London: Palgrave Macmillan.

Hart, G. M (1982)
The Process of Clinical Supervision
Baltimore: University Park Press.

Hawkins, P (2000)
Shohet, R
Supervision in the Helping Professions 2nd Ed
Buckingham: Open University Press.

Health Visitors (1995)
Association
Clinical Supervision: Essential Qualities
Health Visitor 68 (1):28-31

Heath, H (2000)
Freshwater, D
Clinical supervision as an emancipatory process: avoiding inappropriate intent.
Journal of Advanced Nursing 32 (5):1298-1360

Heidegger, M (1962)
Being and Time
Oxford: Basil Blackwell.

Heidegger, M (1972)
On Time and Being (trans. J.Stambaugh)
London: Harper & Row.

Heidegger, M (1980)
Being and Time (trans. J. Macquarrie and E. Robinson
Oxford: Blackwell.

Heidegger, M (2003) Follow the Fuhrer 1934(trans D.D Runes ed. M. Stassen in Philosophical and Political Writings) London.Continuum London

Henderson, P (2002) Choosing a supervisor CPJ (December):22-23

Hendry, C (2004) Farley, A Making the most of time Nurse Researcher 12 (2):81-88

Heron, J (1989) Six-Category Intervention Analysis (3rd edn) Guilford Human Potential Resource Group, University of Surrey

Heron, J (1990) Helping the Client: A Creative Practical Approach London: Sage.

Heron, J (2001) Helping the Client: A Creative practical guide London: Sage.

Hess, A K (1980) Training models and the nature of psychotherapy supervision. In Hess A, K (ed.) Psychotherapy Supervision: Theory, Research and Practice New York: 5-25 John Wiley.

Hewinson, A. (1996) Wildman, S. The theory practice gap in Nursing: a new dimension Journal of Advanced Nursing 24(4):754-761

Higginbottom, GMA (2002) Jackson, A.K African Caribbean children's views on heart health Community Practitioner 75 (5):176-179

Higginbottom, G.M.A (2004) Sampling Issues in qualitative research Nurse Researcher 12 (1):7-19

Hill, J (1989) Supervision in the caring professions: A literature review Community Psychiatric Nursing Journal Oct: 9-15

Holloway, I (1996) Wheeler, S Qualitative research for nurses London: Blackwell Science.

Holloway, I (1997) Basic concepts for qualitative research London: Blackwell Science.

Holloway, I (2000) Walker, J Getting a PhD in Health and Social Care London: Blackwell Science.

Holm, A-K (1998) Lantz, I Severinsson, E Nursing students' experiences of the effects of continual process-oriented group supervision Journal of Nursing Management 6(2):105-113

Holmes, C.A (1996) The politics of phenomenological concepts in nursing Journal of Advanced Nursing 24(3):579-587

Honey, P (1989) Mumford, A Manual of Learning Styles London: Peter Honey.

Horrocks, S (1998) Heidegger and the nurse curriculum, IN S.D Edwards (ed.) Philosophical Issues In Nursing Suffolk: Palgrave Macmillan.

Horsburgh, D (2003) Evaluation of qualitative research Journal of Clinical Nursing 12(2):307-312

Howatson-Jones, I.L (2003) Difficulties in clinical supervision and lifelong learning Nursing Standard 17 (37):37-48

Hughes, A (2002) Richards, J Accessing midwifery supervision British Journal of Midwifery 10 (3):161-164

Hughes, R (1998) Morcom, C Clinical Supervision in a mental health In-patient area NT Researcher 3 (3):226-234

Hunt, D (1986) Mentorship a career training development tool Academy of Management Review (3):475-485

Hussain, M (2004) Clinical supervision: Implementing the framework from the College of Radiographers Synergy (November):19-24

Husserl, E (1900-01)
Logical Investigations
2 vols. Trans J.N Findlay 1970.
New York: Humanities Press.

Husserl, E (1925)
Phenomenological Psychology
Trans. J.Scanlon, The Hague: Nijhoff, 1977.

Hutchinson, A (2005)
Analysing audio-recorded data: using computer software applications
Nurse Researcher 12 (3):20-31

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 (2005)
Appelqvist- Schmidlechmer, K
Kivimaki, K
First line managers' views of the long-term of clinical supervision: how does clinical supervision support and develop leadership in health care?
Journal of Nursing Management 13 (3):209-220

Hyrkas, K (2002)
Appelqvist- Schmidlechmer, K
Paunonen-Ilmonen, M
Expert supervisors' views of clinical supervision a study of factors promoting and inhibiting the achievements of multi-professional team supervision
Journal of Advanced Nursing 38 (4):387-397

Inskipp, F (1993)
Proctor, B
Making The Most of Supervision: Professional Development for Counsellors and Trainees
London: Cascade.

Jacobs, M (2001)
Supervisor's can change
CPJ (February):26-27

Jasper, M.A (1994)
Issues in Phenomenology for researchers of nursing.
Journal of Advanced Nursing 19(2):309-314

Jasper, M (2002)
Challenges to Professional Practice IN R Hogston, and P.M Simpson (eds.) Foundations of Nursing Practice 2nd edn
Bath: Palgrave Macmillan.

Jenkins, P (2001) Supervisory responsibility and the law
CPJ (July):34-35

Johns, C (1993) Professional supervision
Journal of Nursing Management 1(1):9-18

Johns, C (1995) Framing learning through reflection within Carper's fundamental ways of knowing in Nursing
Journal of Advanced Nursing 22(2):226-234

Johns, C (1996) Visualising and realising caring in practice through guided reflection
Journal of Advanced Nursing 24(6):1135-1143

Johns, C (1997) Becoming an effective practitioner through guided reflection.
Open university unpublished PhD submission, May 1997

Johns, C (2000) Becoming a Reflective Practitioner: A Reflective and Holistic approach to Clinical Nursing, Practice Development and Clinical Supervision
Oxford: Blackwell Science.

Johnstone, M.J (1994) Nursing and the injustices of the law.
Orlando Fl: Harcourt Brace & Company.

Jolley, M (1993) Nursing its hidden agendas
Brykczynska, G London: Edward Arnold.

Jones, A (1997) Communication at the heart of supervision
Nursing Times 93 (49):50-51

Jones, A (1998) Getting going with clinical supervision an introductory seminar
Journal of Advanced Nursing 27(3):560-566

Jones, A (1999) Clinical supervision for professional practice
Nursing Standard 14 (9):42-44

Jones, A (2001a) The influence of professional roles on clinical supervision.
Nursing Standard 15(33):42-45

Jones, A (2001b)
Absurdity and being-in-itself. The third phase of phenomenology: Jean Paul Sartre and existential psychoanalysis
Journal of Psychiatric and Mental Health Nursing 8 (4):367-372

Jones, K (2005a)
Leading an Empowered Organisation (LEO): Does the course work?
British Journal of Community Nursing 10(2):92-96

Jones, M (2005b)
Developing medication through mental health
Mental Health Practice 8 (5):20-23

Jukes, M (2004)
Millard, J
Chessun, C
Nurse prescribing: a case for clinical supervision
British Journal of Community Nursing 9 (7):291-297

Kaberry, S (1992)
Supervision- support for nurses?
Senior Nurse 12 (5):38-40

Kadushin, A (1976)
Supervision in Social work (3rd Ed)
New York: Columbia University City Press.

Kell, C (2002)
Can counsellors adequately supervise non-counsellors?
CPJ (August, 2002)

Kell, J (2002)
McSherry, R
Clinical supervision
Nursing Times 98 (23):29-32

Kelly, B (2001)
Long, A
McKenna, H
A survey of community mental health nurse' perceptions of clinical supervision in Northern Ireland
Journal of Psychiatric & Mental Health Nursing 8 (1):33-43

King's Fund NDU (1994)
Clinical Supervision in Practice
London: King's Fund.

King's Fund (1998)
Health Care UK 1997/1998
London: King's Fund.

Knutton, S (2004a)
Pover, J
The importance of honesty in clinical supervision Part 1 Developing and maintaining honest relationships
Nursing Management 10 (9):29-31

Knutton, S (2004b)
Pover, J
The skill of challenging
Nursing Management 10 (10):23-26

Koch, T (1994)
Establishing rigor in qualitative research: the decision trail.
Journal of Advanced Nursing 19(5):976-986

Koch, T (1995)
Interpretative approaches in nursing research: the influence of Husserl and Heidegger.
Journal of Advanced Nursing 21(5):827-836

Koch, T (1996)
Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation.
Journal of Advanced Nursing 24(1):174-184

Koch, T (1999)
An interpretative research process: Revisiting Phenomenological and hermeneutical approaches
Nurse Researcher 6 (3):20-35

Kohner, N (1994)
Clinical Supervision in Practice
London: King's Fund Centre.

Kopp, P (2001)
Clinical supervision
Nursing Times 97 (27):47-4

Kuhse, H (1997)
Caring: Nurses, Women &Ethics
London: Blackwell Publishing.

Kvale, S (1983)
The qualitative research interview: A phenomenological and hermeneutical mode of understanding
Journal of Phenomenological Psychology
14 (2): 171-196

Kvale, S (1996)
Interviews: An Introduction to qualitative Research Interviewing
London: Sage.

Kvinge, K (2002)
Gjengedal, E
Kirkevold, M
Methodological issues in nursing research gaining access to the life-world of women suffering from stroke: methodological issues in empirical phenomenological studies
Journal of Advanced Nursing 40 (1):61-71

Laming, H (2003)
The Victoria Climbie` Inquiry Report of an Inquiry by Lord Laming
London: HMSO.

Lethbridge, D.J (1991)
Choosing and using contraception: toward a theory of women's contraceptive self care
Nursing Research 40 (5):276-280

LeVasseur, J.J (2003)
The problem of bracketing in Phenomenology
Qualitative Health Research 13 (3):408-420

Lincoln, Y.S. (1992)
Sympathetic Connections Between Qualitative Methods and Health Research.
Qualitative Health Research 2 (4):375-391

Lincoln, Y.S (1985)
Guba, E.G
Naturalistic Inquiry
Newbury Park, CA: Sage.

Lincoln, Y.S (1989)
Guba, E.G
Fourth Generation education
Newbury Park, CA: Sage.

Lincoln, Y.S (2000)
Guba, E.G
Paradigmatic controversies, contradictions emerging confluences. In N.K. Denzin and Y.S Lincoln (eds.) Handbook of qualitative research
CA.: Sage Thousand Oaks.

Lindgren, B (2005)
Brulin, C
Holmlund, K
Athlin, E
Nursing students' perception of group supervision during clinical training
Journal of Clinical Nursing 14(7):822-829

Lowes, L (2001)
Prowse, M
Standing outside the interview process?
The illusion of objectivity in phenomenological data generation.
International Journal of Nursing Studies
38 (4): 471-480

Lugon, M (1999)
Seeker-Walker, J
Clinical Governance: making it happen
London: Royal society of Medicine Press Ltd.

Lyle, D (1998)
Can managers supervise?
Nursing Times Learning Curve 2 (7):8

Lyth, G (2000)
Clinical Supervision: a concept analysis.
Journal of Advanced Nursing 31(3):722-729

McCallion, H (1995)
Baxter, T
Clinical Supervision: How it works in the real world
Nursing Management 1(9):20-21

McCann, T (2003)
Clark, E
Grounded theory in nursing research: Part 1 Methodology
Nurse Researcher 111 (2):7-18

McDonald, S (2000)
Ahern, K
The Professional Consequences of whistleblowing by Nurses
Journal of Professional Nursing 16 (6):313-321

McEwenk A (2005)
Cooper, S
Clayworth, S
Are ward sisters and charge nurses able to fulfill their role?
Nursing Times 101 (29):38-41

Mc Feely, S (2001)
Cutcliffe, J
Clinical Supervision
Practice Nurse 21 (7):16-2

McGibbon, G (1996)
Clinical Supervision for expanded practice in ENT
Professional Nurse 12 (2):100-102

McKeown, C. (2001)
Thompson, J
Implementing clinical supervision
Nursing Management 8 (6):10-13

McNiff, J (2002)
Action Research: Principles and Practice
London: Macmillan.

McSherry, R (2002)
Kell, J
Pearce, P
Clinical supervision and clinical governance
Nursing Times 98 (23):30-32

Mackereth, M (1997)
Clinical supervision for "potent" practice
Complimentary Therapies in Nursing and Midwifery 3:38-41

Maggs, C (2000)
Biley, A
Reflections on the role of the nursing development facilitator in clinical supervision and reflective practice
International Journal of Nursing Practice
6 (4): 192-195

Maggs-Rapport, F (2001)
"Best research practice": in pursuit of methodological rigour
Journal of Advanced Nursing 35 (3):373-383

Magnusson, A.B (2002)
Lutzen, K
Severinsson, E
The influence of clinical supervision on ethical issues in home care of people with mental illness in Sweden
Journal of Nursing Management 10(1):37-45

Mahar, P (2005)
Nurse's space
Australian Nursing Journal 12 (9):3

Marrow, C.E (1997)
Macauley, D.M.
Crumbie, A
Promoting reflective practice through structured clinical supervision
Journal of Nursing Management 5(2):77-82

Marrow, C (1998)
Yaseen, T
Developing supervision in adult/general nursing IN T Butterworth, J, Faugier and P Burnard, (eds.) Clinical supervision and Mentorship in Nursing
Cheltenham: Nelson Thornes.

Maslach, C (1986)
Jackson, S
Maslach Burnout Inventory
California: Consulting Psychologists Press.

May, K (1991)
Interview technique in qualitative research: concerns and challenge. IN J M Norse (ed.) Qualitative Nursing Research: A Contemporary Dialogue.
London: Sage Publications.

May, L. (1997)
Williams, R.
Gorman, T
Clinical supervsion: evaluation of a Pilot study
Unpublished report. Edge Hill College/ Aintree Trust

Menzies Lyth, I.E.P (1959)
Containing anxieties in institutions. IN I.E.P. Menzies Lyth (ed.) Selected Essays (1988)
London: Free Association Books.

Merleau-Ponty, M (1962)
Phenomenology of perception (C. Smith, Trans.)
Routledge & Kegan Paul, Boston (original work published 1945)

Miles, M.B (1994)
Huberman, A.M
Qualitative Data Analysis
London: Thousand Oaks Sage.

Miller S (2003)
Analysis of phenomenological data generated with children as research participants
Nurse Researcher 10 (4):68-75

Minto, C (1999)
Morrow, M
Clinical supervision for nurses in a learning disability forensic sevice IN D Mercer, T Mason, M, McKeown and G McGann (eds.) Forensic Mental Health Care: A Case Study Approach:341-347
Edinburgh: Churchill Livingstone.

Moon J.A (1999)
Reflection in Learning and Professional Development
London: Kogan Page.

Moran, D (2000)
Introduction to Phenomenology
London: Routledge.

Morcom, C (1996)
Hughes, R
How can clinical supervision become a real vision for the future?
Journal of Psychiatric and Mental health Nursing 3:117-124

Morris, J (2002)
Current issues of accountability in physiotherapy and higher education: implications for physiotherapy educators.
Physiotherapy 88:354-363

Morrison P (1989)
Burnard, P
Students' and trained nurses' perceptions of their own interpersonal skills: a report and comparison
Journal of Advanced Nursing 14(4):321-329

Morrison, T (1993)
Staff supervision in social care:an action learning appproach
London: Longman.

Morse, J.M (1989)
Cross-cultural nursing: anthropological approaches to nursing research
Philadelphia: Gordon and Breach.

Morse, J.M (1994)
Critical Issues in Qualitative Research Methods
London: Thousand Oaks.

Morse, J.M (1996)
Field, P.A
Nursing Research: The application of qualitative approaches
London: Chapman and Hall.

Moustakas, C (1990)
Heuristic Research. Design, Methodology and Applications
Newbury Park, CA: Sage Publications.

Munhall, P (1994)
Revisioning Phenomenology: Nursing and Health Science Research
Jones and Bartlett Publishers, London

Nazarko, L (2000)
Good Investments
Nursing Management 7 (7):8-11

Newshan G (1998)
Is Anybody Listening? A Phenomenological study of pain in hospitalized persons with AIDS
Journal of the Association of Nurses in AIDS Care 9(2):57-67

Nicklin, P (1997)
A practice- centred model of clinical supervision
Nursing Times 93 (46):52-54

Nieswiadomy, R.M (1998)
Foundations of Nursing Research
Stamford, Connecticut: Appleton and Lange.

Northcott, N (1996)
Supervise to Grow.
Nursing Management 2 (10):18-19

Nursing Workforce Data (2000) Chamberlain Down Associates http://www.nhsworkforceprojects.org.uk/assets/downloads/4th March 2005.ppt, accessed 17th May 2005

NMC (2001) Clinical Supervision London: NMC. www.nmc.uk.org/nmc/main/advice/clinicalsupervision.htm (last accessed May 2003)

NMC (2002a) Code of Professional Practice London: NMC.

NMC (2002b) Supporting Nurses, Midwives and Health Visitors through lifelong learning London: NMC.

NMC (2004a) Midwives rules and standards London: NMC.

NMC (2004b) Nursing and Midwifery Council Annual Report (2003-2004) December 2004 London: NMC.

NMC (2005) The Nursing and Midwifery Council: Statistical analysis of the register 1st April 2004- 31st March 2005 London: NMC.

O'Driscoll, M.P (1994) Cooper, C.L Coping with work related stress: a critique of existing measures and proposal for an alternative methodology Journal of Occupational and Organisational Psychology 67:343-354

Oiler, C.J (1981) The Phenomenological Approach in Nursing Research. Nursing Research 31 (3):178-181

Oiler, C.J (1986) Phenomenology- the method in nursing research. IN P.L Munhall and C.J.Oiler (eds.) A Qualitative Perspective Norwalk, Connecticut: 69-84: Appleton-Century-Crofts.

Olofsson, B (2005) Opening up: psychiatric nurses' experiences of participating in reflection groups focusing on the use of coercion
Journal of Psychiatric and Mental health Nursing 12:259-267

Oxley, P (1995) Clinical Supervision in community psychiatric nursing.
Mental Health Nursing 15 (6):15-17

Page, S (1994) Supervising the Counsellor: A Cyclical Model
Wosket, V London.Routledge

Paley, J (1997) Husserl Phenomenology and Nursing
Journal of Advanced Nursing 26 (1):193-197

Paley, J (1998) Misinterpreting phenomenology: Heidegger, ontology and nursing research
Journal of Advanced Nursing 27 (4):817-824

Palsson, M.B.E (1994) Systematic clinical supervision and its effects
Hallberg, I.R Nurses handling demanding care situations
Norberg, A. Cancer Nursing 17 (5):385-394

Parker, J.M (2004) Nursing on the medical ward
Nursing Inquiry 11 (4): 210-

Pask, E.J (1994) Guilt and nursing Practice: Implications for nurse education and the climate of care
Nursing Ethics 1(2):80-85

Pask, E.J (1995) Trust: an essential component of nursing practice-implications for nurse education
Nurse Education Today 15(3):190-195

Pask, E.J (2001) Nursing responsibility and conditions of practice: are we justified in holding nurses responsible for their behaviour in situations of patient care?
Nursing Philosophy 2 (1):42-54

Paunonen, M (1991) Changes initiated by a nursing supervision programme an analysis based on log-linear models
Journal of Advanced Nursing 16(8):982-986

Paunonen, M (2001)
Hyrkas, K
Clinical Supervision in Finland- history, education research and theory IN J. Cutcliffe T. Butterworth and Proctor, B (eds.) Fundamental Themes in Clinical Supervision: 284-302 London: Routledge.

Payne, D (1999a)
Decent disclosure
Nursing Times 95 (16):16

Payne, J (1999b)
Researching Health Needs
London: Sage Publications.

Pellat, G (2003)
Ethnography and reflexivity: emotions and feelings in fieldwork
Nurse Researcher 10 (3): 28-37

Pertab, D (1999)
Clinical supervision in Diploma in Higher Education (Nursing) Programmes
Journal of Clinical Nursing 8 (1):112-113

Peyton, P.R (2004)
Bullying in supervision
CPJ (July):36-37

Pfund, R (2004)
Dawson, P
Francis, R
Rees, B
Learning how to handle emotionally challenging situations: the context of effective reflection
Nurse Education in Practice 4 (2):107-113

Platt-Koch, L.M (1986)
Clinical Supervision for psychiatric nurses
Journal of Psychological Nursing 26 (1):7-15

Pocknell, C (2001)
Tutoring on a supervision training course
Counselling Psychology Journal (May): 32-33

Polit, D.F (2001)
Beck, C.T
Hungler, B.P
Essentials of Nursing Research
New York: Lippincott Williams and Wilkins.

Polit, D.F (2005)
Beck, C.T
Nursing Research Principles and Methods
London: Lippincott Williams and Wilkins.

Polit, D.F (2006)
Beck, C.T
Essential of Nursing Research: methods Appraisal and Utilization
New York: Lippincott Williams and Wilkins.

Polit, D.F (1991)
Hungler, B.P
Nursing Research Principles and Methods
New York: J.B Lippincott Company.

Porter, N (1998)
Providing Effective Clinical Supervision
Nursing Management 5 (2):22-23

Power, S (1994)
A unique source of support and advice; the benefits of supervision in clinical practice
Psychiatric Care 1 (3):105-108

Power, S (1999)
Nursing supervision; a guide for clinical practice.
London: Sage Publications.

Price, B (2003)
Phenomenological research and older people
Nursing Older People 15 (5):24-34

Price, A.M (2000)
Chalker, M
Our journey with clinical supervision in an intensive care unit.
Intensive and Critical Care Nursing 16(1):51-56

Priest, H (2002)
An approach to the phenomenological analysis of data
Nurse Researcher 10 (2):50-64

Proctor, B (1986)
Supervision a co-operative exercise in accountability IN M Marken and M Payne (eds) Enabling and Ensuring.
Leicester: Leicester National Youth Bureau and Council for Education and Training in Youth and Community Work.

Proctor, B (2002)
Towards an autonomous and accountable profession
CPJ (March):36-37

Rafferty, M. (1996)
Coleman, M.I
Educating Nurses to Undertake Clinical Supervision in Practice
Nursing Standard 110 (45):38-41

Rafferty, M (2001)
Coleman, M
Developmental transitions towards effective educational preparation for clinical supervision IN J.R Cutcliffe, T Butterworth and B Proctor (eds.) Fundamental themes in Clinical Supervision London: Routledge

Rafferty, M (2003)
Jenkins, E
Parke, S
Developing a Provisional Standard for Clinical Supervision in Nursing and Health Visiting: The Methodological Trail Qualitative Health Research 13 (10):1432-1452

Randle, J (2002)
Transformative Learning: Enabling Therapeutic Nursing. In D Freshwater (ed.) Therapeutic Nursing London: Sage Publications.

Randle, J (2003)
Bullying in the nursing profession Journal of Advanced Nursing 43 (4):395-401

Rather, M.L (1992)
Nursing as a way of thinking: Heideggerian hermeneutical analysis of the lived experience of the returning RN Research in Nursing and Health 15 (1): 47-55

Ray, M.A (1994)
The richness of phenomenology: philosophic, theoretic, and methodologic concerns. In J Morse (ed) Critical Issues in Qualitative Research Methods. London:Thousand Oaks, Sage.

Richardson, B (1995)
Qualitative approaches to evaluating quality of service Physiotherapy 81 (9):541-545

Riley, J (1990)
Getting the Most from your Data- A Handbook of Practical Ideas on how to Analyse Qualitative Data. Bristol:Technical Educational services.

Ritter, S (1996)
Norman, I
Rentoul, L
Bodley, D
A model of clinical supervision for nurses undertaking short placements in mental health care settings Journal of Clinical Nursing 5(3):149-158

Robson, (2002) Real World Research2nd Edition
Oxford: Blackwell.

Roden, H. (1997) Clinical Supervision the outcomes using a grounded theory approach
Unpublished BSc dissertation, May 1997

Rodriguez, P (1998)
Goorapah, D
Clinical Supervision for nurse teachers: the pertinent issues
British Journal of Nursing 7 (11):663-670

Roe-Shaw, M (2003)
Gall, A
Jones, L
Lattey, M.E
Sainsbury, N
Approach and preparation for clinical placements: final year physiotherapy students.
New Zealand Journal of Physiotherapy
31 (1): 17-23

Rose, K (1994) Unstructured and semi-structured interviewing
Nurse Researcher 1 (3):23-32

Saptya, J (2005)
Riemer, M
Bickman, L
Feedback to Clinicians: Theory, Research, and Practice
Journal of Clinical Psychology 61 (2):145-153

Sandelowski, M (1986) The problem of rigour in qualitative research
Advances in Nursing Science 8 (3):27-37

Sandelowski, M (1995) On the aesthetics of qualitative research
Image: Journal of Nursing Scholarship
27:205-209

Scanlon, C (1997)
Weir, W.S
Learning from practice: mental health nurses perceptions and experiences of clinical supervision.
Journal of Advanced Nursing 26(3):295-302

Schatzman, R (1973)
Strauss, P
Field Research: Strategies for a natural sociology
Englewood Cliffs, New Jersey: Prentice Hall.

Schwarz, C Ed (1993) Chamber's Dictionary
Edinburgh: Chambers Harrap.

Schon, D (1983)
The Reflective Practitioner: How Professionals think in action
New York: Basic Books.

Schon, D (1987)
Educating the reflective practitioner.
San Francisco: Jossey-Bass.

Sellars, J (2001)
An exploration of clinical supervision in physiotherapy
Unpublished Master's Degree Dissertation Coventry University Coventry

Sellars, J (2004)
Learning from contemporary practice: an exploration of clinical supervision in physiotherapy
Learning in Health and Social Care 3 (2):64-82

Severinsson, E.I (1993)
Lindstrom, J
Supervision in Nursing in the Light of Applied Hermeneutics[In Swedish]
Sweden: Student Litteratur, Lund.

Severinsson, E.I (1996)
Nurse Supervisors Views of Their Supervisory Styles in Clinical Supervision: a Hermeneutical Approach.
Journal of Nursing Management 4(4):191-199

Severinsson, E.I (1996)
Hallberg, I.R
Ingalill, R
Clinical Supervision: Views of their Leadership Role in the Clinical Supervision process within nursing care
Journal of Advanced Nursing 24(1):151-161

Severinssson, E (1999)
Kamaker, D
Clinical supervision in the workplace- effects on moral stress and job satisfaction
Journal of Nursing Management 7(2):81-90

Simmons, S (1986)
Brooker, C
Community Psychiatric Nursing: A social perspective
London: Heinemann.

Sloan, G (1998)
Focus group interviews: describing clinical supervision.
Nursing Standard 12 (42):403

Sloan, G. (1999a) Good characteristics of a good clinical supervisor: a community mental health nurse perspective. Journal of Advanced Nursing 30 (3):13-722

Sloan, G (1999b) Understanding clinical supervision from a nursing perspective
British Journal of Nursing 8(8):524-529

Sloan, G (2005) Clinical supervision: beginning the supervisory relationship
British Journal of Nursing 14(17): 918-923

Sloan, G (2001)
Watson, H 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

Sloan, G (2002)
Watson, H Clinical supervision models for nursing, structure, research and limitations
Nursing Standard 9 17 (4):41-46

Smith, C (1995) Evaluating nursing care: Reflection in practice
Professional Nurse 10 (11):723-724

Smith, D (2001) Introducing Clinical Supervision; the pitfalls and problems
British Journal of Perioperative Nursing 11 (10):436-441

Smith, P (1997)
Hunt, J.M Research Mindedness for Practice
London: Churchill Livingstone.

Smith, A (2005)
Jack, K Reflective Practice: a meaningful task for students
Nursing Standard 19 (26):33-37

Smith, E (2005) Telephone interviewing in healthcare: a research summary of the evidence
Nurse Researcher 12 (3):32-41

Smythe, E.A (2004) Thinking
Nurse Education Today 24 (4):326-332

Solomon, R.C (1972) From Rationalism To Existentialism
London: Harper and Row.

Solomon, R.C (1996) A short History of Philosophy
Higgins, K.M Oxford: Oxford University Press.

Sobal, J (2001) Sample extensiveness in qualitative nutrition education research
Journal of Nutrition Education 33 (4):184-192

Sosiaali-ja Terveysministerio (1983) Tyonohjaustyoryhman muistio.
[Ministry of Social Affairs and Health. Report on the working group on clinical supervision]
Helsinki. [In Finnish]

Spence, D (2001) Hermeneutic notions illuminate cross-cultural nursing experiences.
Journal of Advanced Nursing 35 (4):624-630

Spence, C (2002) A collaborative approach to the implementation
Cantrell, J of clinical supervision
Christie, I Journal of Nursing Management 10 (2):65-74
Samet, W

Spichiger, E (2003) Interpretative phenomenology: a research
Prakke, H method for nursing
Pflege16 (3):128-134 June

Spiegelberg, H (1984) The phenomenological movement: A historical introduction
Dordrecht: Kluwer Academic Publisher.

Spradley, J (1980) Participant observation
New York: Holt, Rinehart and Wilson.

Stevenson, C (2005) Post-modernising clinical supervision in Nursing
Issues In Mental Health Nursing 26(5):519-529

Stewart, D (1990)
Mickunas, A
Exploring Phenomenology: A guide to the field and its literature
Athens Ohio: Ohio University Press.

Storey, L (2000)
Minto, C
The use of clinical supervision in secure environments
British Journal of Nursing 9 (21):2226-2232

Streeton, R (2004)
Cooke, M
Campbell, J
Researching the researchers: Using a snowballing technique
Nurse Researcher 12 (1):35-45

Streubert, H.J (1995)
Carpenter, D.R
Qualitative Research in Nursing
Philadelphia: J.B.Lippincott Company.

Sullivan, K (1989/99)
Managing the "sensitive" research interview: A personal account
Nurse Researcher Winter 6 (2):72-86

Swain, G (1995)
Clinical supervision the principles and process
London: Health Visitors Association.

Sweeney, K (2001)
Introduction In M Dixon and K.Sweeney (eds.) A Practical guide to Primary Care Groups and Trusts
Cornwall: Radcliffe Medical Press Ltd.

Swingewood, A., (1991)
A short history of Sociological thought (2nd Edition.ed)
Basingstoke: Macmillan education Limited.

Tait, M (1999)
Slater, J
Using computers in nursing research
Nurse Researcher 7 (1):17-30

Tarling, M (1998)
Crofts, L
The Essential researchers Guidebook
London: Bailliere Tindall.

Taylor, B (1994)
Being Human: Ordinariness in Nursing
Melbourne: Churchill Livingstone.

Teasdale, K (1998)
Clinical supervision for all
Professional Nurse 13(5):278

Teasdale, K (1998)
Thom, N
Brocklehurst, N
The value of clinical supervision in Nursing: A research study commissioned by the NHS Executive in Trent
Boston, Lincs: Pilgrim Hospital.

Teasdale, K (2000)
Practical approaches to clinical supervision
Professional Nurse 15 (9):579-582

Teasdale, K (2001)
Thom, N
Brocklehurst, N
Clinical supervision and support for nurses: an evaluation study
Journal of Advanced Nursing 33 (2): 216-224

Teekman, B (2000)
Exploring reflective thinking in nursing practice
Journal of Advanced Nursing 31 (5):1125-1135

The Children Act (1989)
London: HMSO.

The Patients Charter (1990)
London: HMSO.

Thomas, B (1995)
Clinical supervision in Mental Health Nursing
Dept.of Health, NHSME clinical supervision-conference proceedings.November 1994, London.

Thompson, J (1994)
Hermeneutics and its shadow: contradictions of tradition and community in nursing. Unpublished seminar paper, School of Nursing University of Southern Maine, Portland, Maine

Thompson M (2003)
Teach yourself philosophy
London: Hodder and Stoughton Educational.

Timpson, J (1996)
Clinical supervision: a plea for "pit head time" in cancer nursing
European Journal of Cancer Care 5(1):43-52

Titchen, A (1995)
Binnie,
The art of clinical supervision
Journal of Clinical Nursing 4(5):327-334

Todd, G. (1999)
Freshwater, D
Reflected practice and guided discovery: clinical supervision.
British Journal of Nursing 18 (20):383-1387

Todd, A (2006) Interviewing IN K, Gerrish & A Lacey (Eds) The Research Process in Nursing London: Blackwell Publishing.

Todres, L (2001) Wheeler, S The complementarity of Phenomenology, hermeneutics and existentialism as a philosophical perspective for nursing research International Journal of Nursing Studies 38(1):1-8

Todres, L (2006) Holloway, M Phenomenlogical Research IN KGerrish and A Lacey (eds.) The Research Process in Nursing London: Blackwell Publishing.

Tovey, E.J (1999) Adams, A.E The changing nature of nurses' job satisfaction: an exploration of sources of satifaction in the 1990s Journal of Advanced Nursing 30 (1):150-158

Tuckett, A.G (2005) Part ll. Rigour in qualitative research: complexities and solutions Nurse Researcher 13 (1):29-41

UK Parliament (1998) The Data Protection Act London: HMSO.

UKCC (1986) Project 2000. A New Preparation for Practice. London: UKCC.

UKCC (1992a) Code of Professional Conduct for Nurses, Midwives and Health Visitors London: UKCC.

UKCC (1992b) The scope of professional practice London: UKCC.

UKCC (1994) Proposed Position Statement on Clinical Supervision for Nursing and Health Visiting London: UKCC.

UKCC (1995) The Council's position statement on clinical supervision for Nursing and Health Visiting London: UKCC.

UKCC (1996) Position Statement on Clinical Supervision for Nursing and Health Visiting
London: UKCC.

UKCC/UCL (1999) Nursing in Secure Environments
London: UKCC.

UKCC (2000) Standards for the preparation of teachers of nursing and midwifery
London: UKCC.

van Deurzen-Smith (1997) Everyday Mysteries
London: Routledge.

van Kaam, A (1966) Existential Foundations of Psychology
Pittsburgh:.Duquesne University Press.

van Manen, M (1977) Linking ways of knowing with ways of being
Curriculum Inquiry 6 (3):205-228

van Manen, M (1984) "Doing" phenomenological research and writing: An introduction
Alberta Canada: Department of Secondary Education.

van Manen, M (1990) Researching Lived Experience
New York State: state University of New York

van Ooijen, E (2000) Clinical supervision: a Practical Guide
London: Churchill Livingstone.

van Ooijen, E (2003) Clinical Supervision Made Easy
London: Churchill Livingstone.

Ven Veeramah, V (2002) The benefits of using clinical supervision
Mental Health Nursing 22 (1):18-23

Walker, L.O (1996)
Avant, K.C Strategies for Theory Construction in Nursing
3rd edn. Norwalk, CT: Appleton and Lange.

Walsh, K (2003)
Nicholson, J
Keough, C
Pridham, R
Kramer, M
Jeffrey, J
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

Walters A.J (1995)
The phenomenological movement: implications for nursing research
Journal of Advanced Nursing 22(4):791-799

Waterhouse, R (1981)
A Heidegger critique
Sussex: Harvester Press.

Waterworth, S (1997)
Pillitteri, L
Swift, F
Clinical Supervision empowerment in practice
Nursing Management 3 (9):14-16

Waterworth, S (2003)
Time management strategies in nursing practice
Journal of Advanced Nursing 43 (5):432-440

Watson, S (2004)
Mentor preparation: reasons for undertaking the course and expectations of the candidates
Nurse Education Today 24(1):30-40

Watson, L.A (2004)
Girard, F.M
Establishing Integrity and avoiding Methodological Misunderstanding
Qualitative Health Research 14 (6):875-881

Weaks, D (2002)
Unlocking the secrets of good supervision: A phenomenological exploration of experienced counsellors perceptions of good supervision
CPR 2(1):33-39

Weaver, M (2001)
Introducing clinical supervision
British Journal of Podiatry 4:134-143

Webb, B (1997)
Auditing a Clinical Supervision training programme
Nursing Standard May 14 11 (34):34-39

Webb, C (1992) The use of first person in academic writing; objectivity, language and gatekeeping
Journal of Advanced Nursing 17(6):747-752

Weight, T (1999)
Phipps, K
Jackson, N
Clinical Governance and Education and Training IN M Lugon and J Seeker-Walker (eds.)
Clinical Governance: making it happen
London: Royal Society of Medicine Press Ltd.

Wengraf, T (2001) Qualitative Research Interviewing
London: Sage Publications.

Westheimer, I (1977) The practice of supervision in social work: a guide for supervisors
London: Ward Lock Educational.

Weston, H (2004) Developing a supervision training course- the practicalities
CPJ December: 39-41

Wheatley, M (1999) Implementing clinical supervision
Nursing Management 6 (3):28-32

Wheeler, S (2001a) Supervisor accreditation is it time to apply?
Counselling & Psychology Journal March:30-31

Wheeler, S (2001b) Are supervisors born or trained?
Counselling Psychology Journal December: 28-29

Wheeler, S (2004) "Supervising the Wounded Healer" Key note address at the London BASPR conference

White, E (1990) Report of The Third Quinquennial National Community Psychiatric Nursing Survey
University of Manchester, Manchester

White, E (1996) Clinical supervsion and Project 2000: the identification of some substantive issues.
NT Research 1 (2):102-111

White, E (1998)
Butterworth, T
Bishop, V
Carson, J
Jeacock, J
Clements, A
Clinical supervision: insider reports of a private world
Journal of Advanced Nursing 28 (1):185-192

Wilkin, P (1988)
Someone To Watch Over Me
Nursing Times 84 (33):33-34

Wilkin, P (1997)
Bowers, L
Monk, J
Clinical Supervision: Managing the Resistance
Nursing Times 93 (8):48-49

Williamson, G.R (1999)
Dodds, S
The effectiveness of a group approach to clinical supervision in reducing stress: a review of the literature
Journal of Clinical Nursing 8(4):338-344

Williamson, L (2001)
Harvey, G
Implementing clinical supervision in a large acute NHS Trust IN J Cutcliffe, T Butterworth and B Proctor (eds.) Fundamental themes in clinical supervision London: Routledge.

Willson, L (2001)
Fawcett, T.N
Whyte, D.A
An evaluation of a clinical supervision programme.
British Journal of Community Nursing 6 (12):614-623

Wilson, R (2002)
Research notes: Transcribing interviews is no easy task -it takes time and money
Nursing Standard 17 (5):24

Wimpenny, P (2000)
Gass, J
Interviewing in phenomenology and grounded theory : is there a difference?
Journal of Advanced Nursing 31 (6):1485-1495

Winstanley, J (2000)
Manchester Clinical Supervision Scale
Nursing Standard 14 (19):31-32

Winstanley, J (2003)
White, E
Clinical supervision: models, measures and best practice
Nurse Researcher 10 (4):7-38

Wolsey, P (1997)
Leach, L
Clinical Supervision: A Hornets Nest
Nursing Times 93(44):24-27

Wood, J (2004)
Clinical Supervision
British Journal of Perioperative Nursing
14 (4):51-156

Woodhouse, D (1991)
Pengelly, P
Anxiety and the Dynamics of collaboration
Newcastle: Aberdeen University Press.

Wright, S (1989)
Changing Nursing Practice
London: Arnold.

Wright, S (2005)
Hidden tension
Nursing Standard 19(20):25

Yegdich, T (1999)
Clinical Supervision and Managerial supervision; some historical and conceptual considerations
Journal of Advanced Nursing 30 (5):1195-1204

Young, R (2004)
Cross-Cultural Supervision
Clinical Social Work Journal 32 (1):39-49

Appendix 1 On-Line Database searches

CINAHL
(January – December)

Search Terms	Hits 1980-2000	Hits 2001	Hits 2002	Hits 2003	Hits 2004	Hits 2005	Hits 2006-Aug
Clinical Supervision	631	191	166	189	176	209	63
Clinical Supervision and nursing	1046	256	240	247	243	264	83
Trust and nurses	1134	315	323	382	371	400	127
Trusting and nursing	1	Nil	1	1	34	22	8
Time and nurses	5721	1250	1308	477	1625	1672	493
Disclosure and nurses	336	89	84	100	80	101	36
Whistle blowing and nurses	36	14	12	6	14	14	1

Appendix 1 **Academic Search Elite**

Search Terms	Hits 1980-2000	Hits 2001	Hits 2002	Hits 2003	Hits 2004	Hits 2005	Hits 2006-Aug
Clinical Supervision	192	30	32	26	27	45	16
Clinical Supervision and nursing	87	19	14	17	17	30	10
Trust and nurses	163	63	83	145	421	417	280
Trusting and nursing	28	6	13	6	15	11	6
Time and nurses	1113	197	301	340	545	534	319
Disclosure and nurses	28	5	3	9	13	16	12
Whistle blowing and nurses	3	1	4	Nil	3	2	Nil

Appendix 1 **PsycINFO**

Search Terms	Hits 1980-2000	Hits 2001	Hits 2002	Hits 2003	Hits 2004	Hits 2005	Hits 2006-Aug
Clinical Supervision	411	55	42	42	60	60	32
Clinical supervision and nursing	25	10	6	5	3	17	3
Trust and nurses	83	23	20	14	34	28	12
Trusting and nursing	16	2	1	6	5	3	1
Time and nurses	873	97	116	143	181	211	79
Disclosure and nurses	40	1	6	4	1	10	2
Whistle blowing and nurses	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Appendix 1 **Professional Development Collections**

Search Terms	Hits 1980-2000	Hits 2001	Hits 2002	Hits 2003	Hits 2004	Hits 2005	Hits 2006-Aug
Clinical Supervision	75	6	8	2	5	6	4
Clinical Supervision and nursing	1	Nil	Nil	1	Nil	Nil	Nil
Trust and nurses	7	0	2	1	4	4	5
Trusting and nursing	1	Nil	1	Nil	2	1	Nil
Time and nurses	78	6	16	13	24	17	16
Disclosure and nurses	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Whistle blowing and nurses	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Appendix 2

The Allitt Inquiry

In May 1993, on the instructions of the Secretary of State for Health, an independent inquiry on behalf of Trent Regional Health authority began, "The Allitt Inquiry". It was established in response to the deaths and injuries on the children's ward, Ward our, at Grantham and Kesteven General Hospital during the period February to April, 1991. Enrolled nurse Beverly Allitt, who was working on ward four at that time, was convicted of the murders of four children, nine attempted murders and nine counts of causing grievous bodily harm with intent to the same children (Clothier et al, 1994).

Appendix 3 Letter to course participants

Dear colleague,

In April 1999 you are due to undertake the Clinical Supervisors two-day course at XXXX. I am currently undertaking a MPhil at the University of Manchester and would like to invite you to be involved in the study exploring your views with regard to Clinical supervision and its training/education.

What will I have to do if I choose to take part?

Taking part is voluntary, it will require a one-one interview with myself on three occasions (pre-course, immediately post-course and four months later). These interviews will take place in private at a time and place which is convenient to you. The interview will be audiotape-recorded, however following transcription the tape will be destroyed and all details related to the interview will be dealt with in the strictest confidence. I envisage that the first interview will take approximaetely 20 minutes and the second and third may take up to 45 minutes.

Are there any possible benefits?

It is hoped that your contribution to the study will help to increase knowledge of how clinical supervision may become a reality within the nursing profession and what training will be of most benefit to staff.

What do I do now?

I will contact you in the near future to ask if you are willing to take part in the study. You will be able to ask further information about the study at this time to help you to decide whether to take part, or you may wish to telephone me on xxx. If you take part but later change your mind you can withdraw from the study at any time without hinderance or detriment.

Thank you very much for considering taking part in this research.

Yours sincerely

Louise May

Nurse Researcher

Appendix 3 Letter to manager participants

School of Health Studies

Aintree Campus
University Hospital Aintree Site
Longmoor Lane
Liverpool
L9 7AL

0151 529 3130
e-mail: mayl@ehche.ac.uk

Dear

I am currently studying for a PhD at the University of Manchester and I am inviting you to take part in this research study. For the last 3 years I have been interviewing qualified nurses from two Trusts who have undertaken a clinical supervisors course at Edge Hill. They have been interviewed on three occasions pre, post and 3-9 months later to explore their experiences of the course and whether they have been able to take the concept forward in practice. I now wish to interview senior managers to ascertain your views regarding the concept of clinical supervision.

What will I have to do if I take part?

Taking part is entirely voluntary. It will require a one-one interview with myself. These interviews will take place in private at a time and place which is convenient to you. The interview will be audiotape-recorded. These tapes will then be transcribed and any names of individuals or the Trust will be removed to ensure anonymity and confidentiality. Following transcription the tape will be destroyed and all details related to the interview will be dealt with in the strictest of confidence. I envisage the interview will take approximately 30 minutes.

Are there any possible benefits?

It is hoped that your contribution to the study will help to increase understanding of the concept of clinical supervision within an organisation.

What will happen to the results of the research study?

Following transcription the audiotaped interview will be analysed and a copy of both transcription and analysis will be sent to you for verification. I aim to submit my PhD thesis in the summer of 2004 and will then hope to publish some of the research findings in nursing publications.

What do I do now?

I will contact you in the near future to ask if you are willing to take part in the study. You will be able to ask further questions about the study at this time to help you decide if you wish to take part, alternatively you may wish to telephone me on 0151 529 3130. If you take part but later change your mind you can withdraw from the study at any time without hindrance or detriment.
Thank you very much for considering taking part in this research.

Yours sincerely

Louise May

Appendix 3 Letter to supervisee participants

School of Health Studies

Aintree Campus
University Hospital Aintree Site
Longmoor Lane
Liverpool
L9 7AL

0151 529 3130
e-mail: mayl@ehche.ac.uk

Dear

I am currently studying for a PhD at the University of Manchester and I am inviting you to take part in this research study. For the last 3 years I have been interviewing qualified nurses from two Trusts who have undertaken a clinical supervisors course at Edge Hill. They have been interviewed on three occasions pre, post and 3-9 months later to explore their experiences of the course and whether they have been able to take the concept forward in practice. I now wish to interview supervisees to ascertain your views regarding the concept of clinical supervision.

What will I have to do if I take part?

Taking part is entirely voluntary. It will require a one-one interview with myself. These interviews will take place in private at a time and place which is convenient to you. The interview will be audiotape-recorded. These tapes will then be transcribed and any names of individuals or the Trust will be removed to ensure anonymity and confidentiality. Following transcription the tape will be destroyed and all details related to the interview will be dealt with in the strictest of confidence. I envisage the interview will take approximately 30 minutes.

Are there any possible benefits?

It is hoped that your contribution to the study will help to increase understanding of the concept of clinical supervision within an organisation.

What will happen to the results of the research study?

Following transcription the audiotaped interview will be analysed and a copy of the transcription will be sent to you for verification. I aim to submit my PhD thesis in the summer of 2004 and will then hope to publish some of the research findings in nursing publications.

What do I do now?

I will contact you in the near future to ask if you are willing to take part in the study. You will be able to ask further questions about the study at this time to help you decide if you wish to take part, alternatively you may wish to telephone me on 0151 529 3130. If you take part but later change your mind you can withdraw from the study at any time without hindrance or detriment.
Thank you very much for considering taking part in this research.

Yours sincerely

Louise May

Appendix 4 Consent form for course participants

MPhil Research Study

I hereby consent to take part in a series of three one-to-one interviews undertaken by Louise May.
I understand that these interviews will be audiotape recorded and subsequently transcribed, a copy of the transcriptions will be sent to me to comment upon.
Confidentilaity will be of paramount importance and I understand that Louise May will remove all names in the transcribed material and at no time will I or person(s) I discuss be identified from the interview.
The tape will be the sole responsibility of Louise May and she has assured me that it will be kept secure at all times and on completion of the study the tape will be destroyed.
I am aware that I am able to withdraw from this study at any time without hinderance or detriment.

Signature of volunteer Signature of Researcher

Name Name

Appendix 4 CONSENT FORM

Senior managers and supervisees

PhD Study: Clinical supervision.

Researcher : Louise May

1. I confirm that I have read and understand the information sheet dated ..... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is entirely voluntary and that I am free to withdraw at any time without hindrance or detriment. ☐
3. I understand that the interview will be audiotaped recorded and subsequently transcribed a copy of the transcription will be sent to me to comment upon. ☐
4. I understand that Louise May will remove all names in the transcribed material and at no time will I or person(s), that I discuss be identified from the interview. ☐
5. I understand that the audiotape will be the sole responsibility of Louise May and she has assured me that it will be kept secure at all times and on completion of transcription the tape will be destroyed. ☐
6. I agree to take part in the above study. ☐

Name of Participant	**Date**	**Signature of Participant**
.....	.....	.....
Researcher	**Date**	**Signature of Participant**
.....	.....	.....

Version 1 April 2002

Appendix 5 Ethical Approval Letters (Acute Trust)

Research & Development Directorate

MEMORANDUM

To: Louise May – Senior Tutor / School of Health Studies

From:

Date: 20.04.99

Re: R&D Project Registration Forms: 99GN002 – Clinical Supervision evaluation of training and education for supervisors

---

I am writing to acknowledge receipt of the above fully completed form received in this Unit on 26 February 1999.

I am pleased to inform you that the R&D Committee has granted management approval and the project has been entered into the Trust's R&D Project Database. The Trust's indemnity is in place for staff working on the project.

I look forward to receiving a copy of your appropriate project progress and outcome report in due course.

Best wishes,

Yours sincerely

R & D Manager

Appendix 5 Ethical Approval Letter (Community Trust)

Monday, 7 June 1999

Louise May
School of Health Studies
Aintree Campus
University Hospital Aintree Site
Longmoor Lane
Liverpool
L9 7AL

Dear Louise

Re: MPhil Study: The Role of Clinical Supervision

Thank you for providing me with a copy of your proposal concerning the above study. After reading your proposal I am pleased to confirm that your proposed research study with …….. Community (NHS) Trust can proceed with nursing practitioners in this Trust. I note that your study does not involve contact or research with patients of the Trust.

Best wishes with your study and I look forward to finding out more about your progress and findings. Please contact the Department if you require any further information and guidance at any stage of the study.

Yours sincerely

R & D Lead/Head of Department

Appendix 5 Ethical approval (University of Manchester)

9 June 1999

Louise May
9 Belle Vue Road
Gateacre
Liverpool
L25 2QD

Dear Louise

Re: Clinical Supervision: an Evaluation of the training and education required to enable supervisors to be fit for the purpose

Thank you for attending the Research Ethics Committee on Monday, 7 June 99, no major ethical concerns were identified, and therefore ethical approval has been granted.

However, the committee made the following recommendations:

a) that the letter of consent should have the option to consent or not to consent
b) that consent should be given before the first interview, and not during it
c) that the research supervisor should be included in the consent
d) the letter of consent should make clear that participation in the project is voluntary and participants can withdraw at any stage

Following our recommendations, you must gain permission from the Associate Dean for Diploma and Undergraduate Education.

On behalf of the Research Ethics Committee may I wish you good luck with your research.

Yours sincerely

Chair, Research Ethics Committee

Appendix 6

Extension of Ethics approval 2002

21 May 2002

Ms L May
Senior Lecturer (Edge Hill)
School of Health Studies
University Hospital Aintree Campus
Liverpool
L9 7AL

Dear Ms May

Re: EC.73.02 Clinical Supervision: an evaluation of the training and education required to enable supervisors to be fit for the purpose

Many thanks for sending the above named application to the .... Research Ethics Committee for review.

Members of our Sub Committee have recently reviewed your research proposal. Approval was given to the above named study and documentation listed below, *subject to the following provisos:

- Participation Invitation Letter and Consent form (to be referenced Version 1 April 2002)

  *Members recommended that study tapes should be transcribed and destroyed as soon as possible within 6 months

  *The title on the Consent Form should be the same as either the short or long title as stated in Section 1 of the application form. Please will you provide an amended version for our records.

Conditions of ethical approval

- Approval is given for an initial period of eighteen months. Applications for an extension to the period of ethical approval accompanied by a study progress update will be considered

- You are reminded that as lead investigator for this study, you are responsible for ensuring that the study protocol is followed and informed consent is obtained. Any alleged failure to follow the agreed protocol will require the lead investigator to appear before the Committee to provide an explanation. In the event of withdrawal of ethical approval for the study, the matter will be referred to the appropriate Clinical Director

- Proposed amendments to the protocol must be notified to the Committee for approval before implementation

- All serious adverse events must be reported promptly to the Committee

- In accordance with ICH GCP guidelines, an annual study update must be provided to the Committee where applicable. Failure to file the annual report by the due date will result in automatic suspension of the study without further notice

- A copy of the final report must be submitted on completion of the study

Please note that management approval is a separate matter to be taken up directly with the appropriate Research Directorate before the study may proceed.

Please will the lead investigator sign and return one copy of this letter to acknowledge the conditions of approval.

Yours sincerely

Research Ethics Committee

I accept the conditions as set out in the Committee's letter of final approval dated 21 May 2002.

Signed ..... Date .....

Lead Investigator

Appendix 7

Data Protection Approval

Ms Louise May
School of Health Studies
Aintree Campus
University Hospital Aintree
Longmoor Lane
Liverpool
L9 7AL

15 April 02

Dear Ms May

Re: Sample Collection for PhD Study

Thank you for your letter of 5 April 2002. Based on the information you have provided it would appear that your data collection falls outside of the scope of the Data Protection Act 1998. The Act defines personal data as,

'data which relate to a living individual who can be identified from those (sic) data or from those data and other information which is in the possession of, or likely to come into the possession of, the data controller (i.e. yourself)'

If the ability to convert the allocated number of each volunteer back into identifying data does not exist, then your data is truly anonymous and beyond the scope of the Act.

Your intention to collect further data in the same way will equally be excluded from the scope of the Act. I am aware the use of the term 'chief executive' as opposed to 'grade D nurse' could potentially identify one individual, however, if there is no explicit reference to the Trust location then I think we agree that anonymity is maintained.

The consequence of this is that you are not required to comply with neither the Act nor the principles to the Act. However, it is essential that no changes to your data collecting take place to compromise the complete anonymity of it. I would therefore, suggest that audiotapes be destroyed as soon as possible following transcription to ensure that identifiers of any kind are removed from your data.

I hope this advice is of benefit to you. Please do not hesitate to contact me if you require any further guidance in this matter.

Yours sincerely
Data Protection Programme Manager

Appendix 8 Verification of Transcript (Course, manager and supervisee participants)

Dear colleague,

Many thanks for taking part in the research study investigating clinical supervision. Please find enclosed the transcription related to the interview(s) that we undertook. I would be grateful if you could read through and feel free to make any corrections and identify any key areas that appear to be coming out as a theme.

May I also request that you either return the transcriptions to the School of Health or telephone me to conmfitm that the transcriptions are a faithful representation of the interview(s).

Once again many thanks for allowing me to impinge on your already busy working day.

Yours sincerely

Louise May