Clinical supervision could get no further than rhetoric or become a gun held at the head of the profession, says Peter Nicklin, who presents his model for turning the idea into action.

Ever since target ten of the Vision for the Future (1) decreed that discussions be held on the range and appropriateness of models of clinical supervision and a report be made available to the professions, nursing has been inundated by conferences, research papers and reports on the issue. This culminated in the UKCC's Position Statement on Clinical Supervision for Nursing and Health Visiting (2).

The concept of clinical supervision has simultaneously excited and bewildered the profession in a manner reminiscent of the introduction of the nursing process in the late 1970s. As a veteran of that campaign, I have no desire to participate again in promoting professional and political rhetoric that creates the illusion of innovation without producing change (3). But clinical supervision is intuitively such a good idea that UKCC's initial, and admittedly anxious, declaration on the issue not only invites, but merits a response.

The UKCC is clear that 'clinical supervision will play an increasingly important part in ensuring safe and effective practice' (4). It is not sure, however, what this process or system should be called or who should do it, nor sure, however, what this process or system should be called or who should do it, who is responsible – the nurse, their manager, or their clinical supervisor?

I wish here to contribute to the debate by outlining my personal position statement. It would seem the fundamental questions to be addressed are:

- What purposes does clinical supervision seek to achieve?
- What systems and techniques might achieve these purposes?
- What should this system be called? (This assumes that if you give something the right name, the right meaning will follow)

Butterworth (5) describes clinical supervision as 'an exchange between practising professionals to enable the development of professional skills'. It is postulated that such an exchange or relationship has a range of benefits, and these include:

- Improved patient and client care. Clinical supervision promotes the skills of critical reflection and enables practitioners to develop creative, efficient and evidence-based solutions to patients' problems. An effective system of supervision enables the practitioner to operate within their code of professional conduct.
- Improved staff performance. Clinical supervision is an adjunct to quality systems such as Total Quality Management (TQM) and Investors in People (IIP). Supervision empowers practitioners and enables them to participate fully and effectively in appraisal systems. It also contributes to personal development planning.
- Improved managerial performance. Nurses make a major contribution to the NHS. Simultaneously, they are its major expenditure item. The managerial task is to make nurses work smarter rather than harder. Clinical supervision should improve confidence and efficiency. Additionally, nursing has a high incidence of occupation-related stress and associated absenteeism. The support provided by supervision has the potential to reduce sickness absence, misery and costs.

- Reduced Risk. The NHS reforms, and the government's concern for consumers and their rights, have also brought risks. Complaints by patients or their relatives, while always a cause for concern, now bring the attendant risk of costly litigation. If clinical supervision increases competence, it will reduce errors and contribute positively to so-called risk management strategies.

Intuitively this all makes good sense, but providing conclusive scientific evidence that clinical supervision adds value to nursing's contribution to the NHS agenda will prove elusive. Good management, good training and good pastoral support could yield similar benefits. However, my argument is that while clinical supervision may be not only the glue that holds managerial, educational and support systems together, it has the potential to be the critical axis that enables these otherwise disparate systems to function effectively.

Clinical supervision therefore appears to be potentially a panacea for all ills and something to offer everyone – the classic soft construct. But this one has a hard centre. Nursing, having prescribed clinical supervision for itself, now confronts potential iatrogenic consequences, for example:

- In the event of a nurse's negligence, incompetence or criminal conduct, who provides an explanation to an innocent public – an NHS trust chief executive, or the offender's clinical supervisor?
- How confidential is the clinical supervisory relationship, and how will participants know?
- If a nurse's performance is below expectation, who is responsible – the nurse, their manager, or their clinical supervisor?
- What records of supervision should be kept and how should they be used? Who should have access to them?

And so on. In the words of Pirsig, we have 'spinning mental wheels, and nowhere finding any place to get traction' (6). The resolu-
tion is possibly to be found, not in the prescription, but its route of administration.

Earlier I claimed that clinical supervision could provide a critical axis for managerial, educational and pastoral support systems, a view that is consistent with Proctor’s three-function interactive model of supervision (7):

- Managerial—normative—promoting and complying with policies and procedures, developing standards and contributing to clinical audit
- Educational—formative—skills development, developing evidence-based nursing practice
- Pastoral Support—restorative—enabling practitioners to understand and manage the emotional stress of nursing practice.

These interactive systems are represented in Figure 1.

It is, however, my strongly held conviction that clinical supervision should not seek to replace, subordinate or undermine these systems, and that its purpose is to enable practitioners to access, influence and utilise them more effectively in pursuit of improved patient care. In particular, it must not be a vehicle for diluting or fragmenting managerial responsibility.

How might these purposes be achieved? In Figure 2, I propose the location and boundaries of clinical supervision. The process of supervision is not distinct from, but integral to the other systems. Supervision is a facilitated process during which the nurse reflects on their practice, analyses issues and problems, clarifies goals, identifies strategies for goal-attainment and establishes an appropriate plan of action.

There is no evidence for this assertion, unless of course the role of supervisor is to tell the supervisee what to do or how to do it. In my model, those responsibilities reside elsewhere.

Pragmatism seems to dictate, however, that most nurses will be supervised by a nurse, simply because of the proportion of nurses in the workforce—though in my view, which merely reiterates that of Kohnert (8), it is the supervisory skills rather than professional expertise that are of primary importance.

On the issue of selecting a supervisor, I endorse the UKCC’s belief that ‘practitioners should have a key influence in determining who acts as their clinical supervisor’. I would go further and permit choice, the only criteria being that the supervisor is genuine, empathic, nonjudgmental, and can listen actively and challenge constructively.

Now comes the contentious and potentially malignant issue of confidentiality. It would seem to me, however, that this is adequately covered by the Code of Professional Conduct.

Clinical supervision should seek to do no more or less than operate within nursing’s own professional code. Consequently if, during supervision or elsewhere for that matter, a practitioner discloses a violation of the code, confidentiality cannot be assured.

In all other cases, nothing that happens or is said during supervision should infringe the public domain without the explicit consent of the supervisee. If a record of supervision is to be maintained, then it is the property of the supervisee and is most likely to be retained in their professional portfolio.

What should this system be called?

If something is called the right name, the right meaning will follow. The UKCC says it believes that the term ‘Clinical Supervision’ may in itself be either misleading or unhelpful. In my view, it is both. The literal meaning of the title reads as: Clinical—treatment, dispassionate, detached; Supervision—to superintend, to oversee. These terms do not accord with the model that I have described.

I tentatively suggest that a more helpful term might be practice facilitation (an activity undertaken to improve skill—a process, an opportunity for doing something). This feels nearer the mark, and has the additional benefit of embracing nurses who are not engaged in direct clinical care, such as managers, researchers and teachers, who also need to reflect systematically on their practice which impacts significantly, albeit indirectly, on patient care.

So-called clinical supervision simultaneously provides the profession with an opportunity and a threat. I have concerned myself in this article with the former by commending a system of practice facilitation that has the potential to improve nursing practice and enrich the practice of nursing.

But there is a dark side—the threat that it will be merely a hobby horse that will preoccupy the profession in an orgy of ritual and rhetoric. Worse still, it could be a Trojan Horse, a means of making individual practitioners accountable for circumstances over which they have limited control or authority.

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References

Nursing Management Vol 2 No 5 September 1995