1. Summary
The report outlines a 3 year project to design and implement clinical supervision at a general acute hospital. A workable model was designed by the supervision staff and implemented in several areas. However, in spite of enthusiastic staff in most areas, it was not possible to sustain supervision once the project leaders withdrew their direct involvement.

2. Aim
Implement a model of clinical supervision suitable for an acute healthcare environment with nurses who have had no previous experience with the concept. The only published research guiding the implementation of supervision in an acute setting was that of Titchen & Binnie (1995). They described the use of individual supervision by one ward sister, who has a national reputation for her commitment to clinical nursing. It was felt that this research was a useful basis, but it would be necessary to develop a model that was not dependent on the skills and commitment of one individual, so that it could be implemented throughout the hospital and, once established, would be able to maintain itself.

3. Design & Pilot
It was necessary to design and pilot a suitable model on one ward in the hospital. A ward was selected because it seemed typical and the staff had expressed a strong interest in the project. Also, they had a good track record of being able to implement changes.
Initially, work was undertaken to ensure that the staff developed a collective understanding of clinical supervision and an appropriate framework for its implementation. This involved the project leaders undertaking several workshops on the ward.
Key members of the ward team were given time away from the distractions of the ward to design a suitable model. The project leaders shared a number of frameworks used by others to implement supervision and supported the group in deciding the most suitable approach given the constraints of time on a busy ward.
The model the staff designed was;
- use of the ward's team structure as the basis for supervision groups.
- peer supervision, as this approach fitted with the ward culture
- groups facilitated at least initially, by the team leaders. This approach recognised the need for someone to organise the group whilst enabling the team leaders not to feel they were setting themselves up as experts.
The designed supervision framework was:
  - Hourly sessions to be held every month - same afternoon and clearly identified on the rota.
  - Each session would have the following structure:
    - 15 minutes - revisit issues raised in previous session so that improvements in practice could be evaluated
    - 30 minutes - each member to raise a current issue for discussion
    - 15 minutes - summarising and recording points in the group's diary
      - this informed the next session's introduction.

The method excluded the ward sister, as the group, including the sister, felt that her managerial relationship would hinder open discussion. It was thought that the best way to support the sister's professional needs would perhaps be peer supervision with other sisters.

The team leaders expressed concern that they did not have the skills to facilitate supervision, so, because of the inexperience of the project leaders, an external, experienced facilitator was used. She helped them develop appropriate skills, as well as providing the experience of being supervised. She also gave them time to address such practical issues as the timing of the sessions and methods of maximising their potential to improve practice.

The groups met as planned for several months and evaluated clinical supervision as a positive experience. In particular they noted:
  - The semi-formal structure helped the counter a tendency to get bogged down in one issue as well as giving the group a sense of progress.
  - It was apparent that real commitment and careful rota planning were essential to ensure that the meetings actually occurred

Unfortunately, the ward closed, the staff were dispersed and the sister, who had been very committed to the use of clinical supervision, left the hospital.

4. Implementation
Several initiatives were adopted in an attempt to establish clinical supervision in other areas in the hospital, learning the lessons gleaned from the pilot site. These included:

4.1 The two original supervisors were encouraged to set up supervision in their new wards.
The other staff, including the sisters, expressed interest and were willing to try. However, after several abortive attempts, the introduction of supervision was unsuccessful. The evaluation suggested:
  - the ward structure needs to support the chosen implementation model. Although the new wards used team nursing, the cohesion within the teams was not as strong as on the pilot ward.
  - the original group facilitators, although they retained their grade, were not utilised on their new wards in the same way. They became deputies to the established team leaders. This meant that their ability to influence was less strong. Also, they were very concerned with fitting into their new wards and did not have the confidence to innovate and lead. Once they
were more confident, they agreed to try again to reuse their skills and insights to establish clinical supervision. However, one of them left the clinical area and the other had a serious accident and was placed on long term sick leave.

4.2 Peer supervision for sisters.
The pilot had identified this group as needing to have a separate system of supervision. Also, it was felt that if they were to experience the benefits of supervision they would be more likely to support supervision for their staff. The project leaders held several workshops, so the sisters could gain an understanding of supervision and work together to establish a realistic framework that would meet their needs. They decided on the same structure as the one established on the pilot site.
The staff felt that they would benefit from having some time with the external facilitator so that they could develop suitable skills. The project leaders also participated in the sessions, so that they could provide the necessary internal support and training, as the project developed.
The interested sisters established two supervision groups; membership being decided on the basis of location because of the spread-out nature of the hospital site. One group disbanded after holding only a few sessions as the members found it increasingly difficult to allocate time.
The other group continued, but after several sessions found it beneficial to have the sessions facilitated by one of the specialist nurses. Having an outsider as the leader helped to maintain the agreed structure, as it had become increasingly difficult to prevent the more vocal members dominating the sessions. This method worked well for several months. However, the group eventually disbanded. The evaluation suggested that although the group found the sessions helpful, they did not feel that the benefits matched the cost involved in leaving the clinical area to attend the sessions.

4.3 Clinical supervision amongst specialist nurses
After the positive evaluation of using a specialist nurse to facilitate a group of sisters the project leaders asked the hospital's specialist nurses if they would like to develop clinical supervision for themselves as well as exploring the possibility of facilitating some groups of staff.
The majority of the specialist nurses expressed great enthusiasm and an initial workshop was very well attended. However, it became apparent that their expectations of 3-5 hours a month for supervision was unrealistic if their clinical workload was to be maintained. Also, in spite of a willingness to supervise others they could not agree to a non-reciprocal structure.
The only way of meeting their expressed needs was to endeavour to organise individual peer supervision with their counterparts at other local trusts. However, in spite of initial interest, the nurses outside the Trust did not accept this invitation. Currently we are inviting the specialist nurses to re-visit this option.

4.4 The development of clinical supervision in the wards
The project leaders asked two other wards to become involved in the development of clinical supervision in the hospital. The areas that expressed the most enthusiasm and commitment were paediatrics and a care of the elderly ward.

The project leaders again held workshops in the clinical areas to support a common understanding of supervision and to give basic training in facilitation. The care of the elderly ward elected to develop a structure very similar to that adopted in the original pilot. In spite of their commitment, the eventual result was similar to the sisters group. Supervision tended to lose its momentum unless continually supported by the project leaders. Eventually they withdrew their specific involvement, as it was felt that unless the groups became self-maintaining the implementation was not viable. The group disbanded shortly after the project leaders support was withdrawn.

4.5 Local Conference
In the autumn of 1999 the project leaders, with the help of the staff of The Foundation of Nursing Studies, attempted to run a small conference to share our experiences. It was aimed at nurses working at the Trust and at interested staff from neighbouring Trusts.

Many of the nurses who had been directly involved in the project were keen to share their experiences. Unfortunately, insufficient nurses from the Trust were prepared to use their own time or their allocation of study leave to attend the conference and it had to be cancelled.

5. Lessons Learnt
Most nurses seem to accept that clinical supervision is a tool for supporting their professional growth and are enthusiastic about adopting it. However, in practice they do not give sufficient priority to establishing it.

It is difficult to establish supervision without the dedicated support of a co-ordinator. It takes a great deal of energy to keep the groups focused and committed in an environment where there are the continual pressures of high patient workloads and frequent shortages of staff.

The partnership between education and service was extremely useful as it helped a balanced contribution of theory and practice. However, it meant that one of the partners had to meet the demands of their own organisation as well as that of the project. Also, when she left the institution that had a natural link with the hospital her involvement became increasingly difficult.

Clinical Supervision is difficult to introduce in an organisation that is also developing many other support mechanisms and opportunities for regular professional development. The Department of Nursing has developed courses or workshops every afternoon, so releasing several members of staff from the clinical area is difficult. Clinical Supervision was normally left out, perhaps because the results are often less tangible and immediate. Also, there is an increasing amount of learners to support. For instance, the Trust has introduced NVQ training for all support staff and programmes for nurses returning to practice and those from overseas all of whom require supervision and assessment.
6. Conclusion
The project had variable success. It was possible to design several models of supervision that were suitable for the acute care setting and that built on the existing structures. However, in spite of the commitment by the project leaders and the interest of the nurses, it proved difficult to maintain the implementation process. It appeared that the concept could not compete with the multitude of demands placed on adult nurses, from patients, the need for skill acquisition and the support required by a host of different learners.
It is possible that Titchen and Binnie’s experience cannot be replicated throughout an acute hospital. For although they had similar clinical pressures, supervision completely depended on the abilities and continuing enthusiasm of one individual.
The project leaders, as well as many of the nurses involved, continue to feel convinced of the benefits of clinical supervision, but were unfortunately unable to provide the continued dedicated time to continually support its use in practice. The lessons learnt are useful not only to support possible further local implementation of clinical supervision, but to nurses throughout the UK, particularly those working in the acute sector.

References: