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Establishing Clinical Supervision in Prison Healthcare Settings

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Project team:
Dawn Freshwater, Professor of Mental Health and Primary Care
Les Storey, Senior Lecturer
Liz Walsh, Lecturer/Practitioner

Contact details:
dfreshwater@bournemouth.ac.uk

Summary of project
This project aimed to establish and evaluate a strategy for the effective implementation of clinical supervision within a group of prisons and subsequently to make recommendations for good practice, identifying real and perceived barriers. Five prisons and thirty-five health care staff were involved in a training programme that prepared staff to facilitate clinical supervision. Evaluative data were collected and analysed at various points throughout the implementation process using a variety of methods. Findings indicate that in order to effect a successful strategy for the implementation of clinical supervision, the mode of educational provision, methods of establishing standardised practice and ways of overcoming perceived and real barriers need to be taken into account.

Nursing in the prison service
There are currently 1000 registered nurses working alongside health care officers in prisons in England and Wales, undertaking a role which incorporates both nursing and security, thus demanding skills and competencies in both areas. Nurses and health care officers working in prison have to care for patients with a wide range of complex needs. Prison nurses have to manage chronic disease, mental illness, drug and alcohol abuse, acute medical problems and trauma as well as offering health screening for new prisoners and well-person clinics. Nursing in prison therefore requires a workforce with a variety of skills which draw upon all branches of nursing and indeed, other disciplines. As a result, health care staff have considerable continuing professional development and clinical supervision needs. This presents both a professional and personal challenge to practitioners, educationalists and researchers alike.

Clinical supervision
Recent developments have seen nursing practice assigned the task of implementing clinical supervision and evidence based practice (UKCC, 1996). Whilst clinical supervision is a relatively new concept for some areas of nursing, its development is more advanced in others, mental health nursing, midwifery and health visiting are examples. However, even in areas where it is acknowledged as part of everyday practice, it is not always actively linked to critical reflection or innovations in practice (Freshwater, 2001; Bishop and Freshwater, 2000; Bond and Holland, 1998).

Interest in clinical supervision in general nursing has developed as a direct result of two notable publications, the Vision for the Future document (Department of Health, 1993) and the Faugier and Butterworth (1994) position paper on clinical supervision (Rolfe, Freshwater and Jasper, 2001). The Allitt inquiry did much to raise the issue of professional standards in the public arena, and the Clothier Report (Department of Health, 1994) highlighted the necessity for adequate standards of supervision, training and education. However, as many recent reports demonstrate where clinical supervision is implemented it is patchy. There continues to be debate about the practicalities of implementing the clinical supervision process in ways which meet the needs of all parties concerned (including professional bodies, practitioners, managers and consumers) (see, for example Bishop and Freshwater, 2000).

Defining clinical supervision

Various definitions exist to describe clinical supervision. Although there may be a different emphasis on elements within this process, all the definitions acknowledge the dynamic nature of the shared experience.

> '…a term to describe a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations.' (The Vision for the Future, Department of Health 1993, 3)

> ' Clinical supervision is a regular, protected time for facilitated, in-depth reflection on clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through

> the means of focused support and development' (Bond and Holland 1998, 77).

practice is recognised as a central tenet of clinical supervision.

> '…reflection plays an important role in the clinical supervision process. The use of a reflective framework facilitates a structured approach to the agenda of the supervisory meeting and helps to maintain the focus on practice whilst enabling a questioning approach' (Fitzgerald 2000, 155).

Clinical supervision and the prison service

The findings of the UKCC report which examined nursing in secure environments (UKCC and University of Central Lancashire, 1999) presented a number of conclusions and recommendations that are relevant to the development of clinical supervision within the prison service, some of which are identified below:

- There is a low level of acceptance of clinical supervision, possibly because practical problems and lack of management support create difficulties in its implementation.
- Clinical supervision is not readily available to nurses who are working in conditions that test their professional resilience. The patient groups and professional isolation experienced in some secure environments, in some instances, would suggest that this is an area where nurses would benefit from the rigorous and systematic application of clinical supervision.
- Systems of either formal or informal mentorship and preceptorship are not widely used within the prison service.

In summary, the report recommended that there should be a mandatory requirement for all nursing staff working in secure environments to receive clinical support and supervision on a regular basis (UKCC and University of Central Lancashire, 1999). However, it is crucial that the views of practitioners and managers are ascertained in this regard in order that effective implementation can be provided.

While implementation of clinical supervision is becoming more widespread, a significant number of nurses are not aware of the guidance provided by the UKCC (Bishop and Freshwater, 2000). The prison service is not clear whether clinical supervision should be provided by prison service nurses or by nurses in local NHS organisations, and there is a feeling that the prison service lacks identified leaders who can drive these nursing agenda forward (UKCC and University of Central Lancashire, 1999). The focus of this project, therefore, was the implementation of a work-based training programme in clinical supervision with the intention of developing and progressing a strategy for effective clinical leadership.

Project outline

The project was undertaken with practitioners and managers from five prisons (three inner city large local prisons; one high security prison and one young offenders' institute) with the aim of implementing a clinical supervision strategy through the provision of a training programme and subsequent support to establish minimum standards for clinical supervision across the five prisons.

Establishments were chosen and invited to participate in this project to enable the evaluation of models of clinical supervision across a variety of different contexts. Each establishment was asked to identify staff interested in becoming clinical supervisors. The project team undertook the educational preparation of

supervisors within four of the prisons. It comprised three days training over approximately one month. An external consultant provided the preparation of supervisors in the high security prison. The external consultant was contacted so that comparisons could be drawn across the programmes to ensure parity of training.

The newly trained supervisors in two of the prisons had access to an external supervisor who facilitated group supervision on a regular basis, following the period of initial preparation. This support was provided in an attempt to augment the initial training with ongoing support to enhance the participants' confidence. Follow-up support sessions were provided by the project team subsequent to the training and interview process.

Evaluation of the implementation of clinical supervision in these establishments, and of the provision of training, was undertaken using semi-structured interviews, telephone interviews and the use of the Manchester Clinical Supervision Scale (MCSS) over a one-year period.

Findings

Whilst the majority of responses to the MCSS demonstrated a positive view in relation to clinical supervision and its benefits to individual practitioners and the level of care they provided, several key issues emerged as a result of the overall evaluation of this project. These concerned education, practice and barriers to implementation, with issues relating to clinical leadership being reflected throughout. An overview of these issues is provided below.

Education

Confidence to facilitate supervision and become a supervisor was a clear concern of the staff involved. In the main this appeared to be related to the amount of time it takes to become competent and confident as a supervisor, and the importance of having experience of supervision prior to becoming a supervisor. This was pertinent to the provision of a three-day training programme, which, whilst short, aimed to provide experiential opportunities for the potential supervisors through role-play and case scenarios. In general, supervisors who undertook the training felt that more role-play would have been useful.

There was evidence to suggest that perceptions and understanding of clinical supervision were diverse.

Practice

Several issues centring on the organisational and operational factors seen to influence the practice of clinical supervision were highlighted. These included: timing of supervision, time for supervision, venue/setting, trust/safety, confidentiality, source of supervision, mandatory/voluntary, managerial/peer supervision, one to one/groups, leadership and previous experience.

The individual needs and perceptions across both the staff and the institutions are disparate, which might be expected given the lack of understanding of purpose and task of supervision previously identified.

Barriers to implementation

Participants identified cultural and institutional issues such as suspicion and cynicism as barriers to implementation. Organisational difficulties, for example, shift patterns and low staffing levels were also highlighted. In one prison poor communication was seen as a block to effective implementation of clinical supervision. Other personal issues, such as inability to take responsibility, staff relations, apathy and lack of motivation were also acknowledged to have an effect.

Conclusions

Whilst recognising the relatively small nature of this project, it is felt that the findings could be applied to other prison establishments. Despite involving a wide range of prison establishments, the findings suggest the type of establishment was less of an issue than the organisational culture of the individual prison itself.

Recommendations for a national framework for clinical supervision in prison health care settings and future areas for research and development for improvements in practice have been identified. These emphasise the significance of effective clinical leadership in the management of change for practice improvement.

Recommendations

- Leadership programmes for nurses and health care officers in prison health care should be based on a model that includes clinical supervision
- The significance of clinical supervision as a tool for the development of leadership needs to be highlighted
- On induction into prison health care, nurses and officers should be given the opportunity to embark on clinical supervision either within the establishment or from an external source
- Governors and non-nurse health care managers need to be appraised of the need for and benefits of clinical supervision and of the recommendations from the Future Organisation of Prison Healthcare, Nursing in Prisons, Making a Difference and from the UKCC
- Appropriate training should be provided for both supervisors and supervisees in line with other national developments. This includes reflecting on the process of being in supervision as a learning and teaching approach, for example utilising action learning sets
- A strategy for developing the clinical leadership role in establishing clinical supervision within the operational constraints of the prison environment is required
- Minimum standards for clinical supervision should be set at a national level and adapted at local level in negotiation with relevant parties to achieve ownership

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32 Buckingham Palace Road
London SW1W 0RE
Tel: 020 7233 5750
Fax: 020 7233 5759
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