Exploring the Use of Telephone Group Clinical Supervision to Support the Work of Practice Development Nurses in the Developing Practice Network (DPN)

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Summary of project
Literature exploring clinical supervision by telephone is surprisingly lacking (Driscoll and Townsend, 2006). This alternative, but innovative way of undertaking group clinical supervision provided an opportunity for ten members of the DPN from England, Wales and Northern Ireland to meet regularly over a six month period. This paper discusses the processes involved in forming, engaging in and evaluating the monthly telephone group clinical supervision. Tentative guidelines for undertaking telephone group clinical supervision have been proposed.

Background
The Developing Practice Network (DPN) formed in 2002 is a national network for healthcare practitioners, that exists to promote, support and enable the development of practice in health care settings. It provides formal and informal opportunities for practitioners to share knowledge and learning about a wide range of practice development and change activities.

This project was an innovative and practical response to a number of members from England, Wales and Northern Ireland questioning the possibility of accessing clinical supervision through the DPN. Clinical supervision might be described as a formal method of supporting practitioners and enhancing clinical practice through a process of action orientated reflection on practice whether as a group, or individually, but more often than not as a 'face to face' activity. The latter did not appear feasible due to the geographical distance and it was therefore agreed to explore an alternative method for group clinical supervision.

Aims of the project
The project proposed five key aims:

1. To widen the access to clinical supervision for up to ten self selecting DPN members.
2. To explore the efficacy of telephone group supervision in practice development as an alternative method to the face-to-face encounter.
3. To offer self selecting DPN members an experiential opportunity of time limited telephone group supervision, with an expectation that they will then develop expertise and the confidence to cascade this method to others across the DPN.
4. Identify how the use of the telephone method of group clinical supervision impacts on practice developer activities and disseminate those findings.
5. Publish *DPN Guidelines for Telephone Group Supervision* for members wishing to access this method of clinical supervision in the future.

Processes
The project was divided into four phases that were carried out over a six month period.

Phase 1: Project preparation and costing
It was agreed that all of the six monthly clinical supervision meetings would be held in the evenings from 1930-2100 with participants making the telephone calls from their own homes.

An external telephone company was identified that could provide the audio-conferencing facilities required. Each participant was provided with a telephone number to dial into on agreed dates and codes to authenticate the users. One participant was made responsible for liaising with the telephone company and paying for the resultant telephone bills from project funding and issuing out essential information via email to those involved in the project.

The cost of calls for each participant was ten pence per minute. On average the audio-conference (telephone group clinical supervision) lasted ninety minutes, at a total

cost per meeting for ten participants of £90.00. The total cost to the project for six meetings was estimated at £540.00 but became less as the project was only charged for participants that used the facility and as the project rolled out not everyone was able to attend the telephone group clinical supervision for a number of reasons. In the project team's view, this represented sound value for money for clinical supervision when compared to the cost and travel time for getting ten participants together in a central location from three countries in the UK

It was not possible for the group to physically meet together beforehand. This presented the dual challenge of not just exploring the telephone group clinical supervision method, but needing to establish rapport with a largely unknown group on a telephone line. However, preparatory documentation including a brief guide to the method, the project aims, a provisional group clinical supervision contract and individual reflective sheets (that formed the basis for ongoing evaluation) was circulated via email for comment before commencement of the meetings.

Phase 2: Orientation to the telephone group clinical supervision method

The use of the telephone has previously been piloted in the UK as a method of clinical supervision to increase accessibility to clinical supervisors in an urban NHS Direct Call Centre for nurses in community settings (Thompson and Winter, 2003). One of the participants met with one of these authors (Thompson) prior to the project commencing to explore ways of becoming orientated to the telephone method. The same participant also had experience of international one-to one telephone clinical supervision (Driscoll and Townsend, *in press*), but not in the group situation. It appeared that the telephone method as a form of clinical supervision in UK healthcare had not been widely reported upon and formed part of the initial rationale for the pilot project.

As a number of participants had also participated in action learning, a continuous process of learning and reflection in groups who work on real issues with the intention of getting things done (McGill and Beaty, 2002; NATPACT, 2005), it was agreed that a modified form of action learning should initially form the basis for structuring the group supervision encounter (see Box 1) and a way of reviewing what happened during the life of the project.

Box 1: The telephone group clinical supervision structure based on a modified form of action learning.

- Group introductions
- Agree roles including which supervisee(s) is presenting, facilitator and co-facilitator, peer supervisors and observers and allocate timings to include reviewing the group learning process at the end
- Brief review of last supervisee actions and reflection on learning and what else needs to happen (if anything)
- New supervisee describes issue or concern ending with a key question he/she would like help with from the group, group listen without speaking, take notes etc.
- Group challenge and support through questioning perceptions, understandings assumptions, reviewing options etc. *(no leading questions designed to suggest or 'tell' the supervisee how to act are permitted)

- Reflection on practice by supervisee in light of new understandings, possibilities and agrees specific actions for experimenting with in practice in between meetings (for next time …brief overview of what worked, didn't work, why this might be so…further reflection)
- Review of the effectiveness of the group task and processes e.g. facilitation, quality of presentation, co-supervision, what worked, what hindered and reflection on the telephone method
- Agree and record what actions need to be taken to improve the group supervision next time
- Close

It was agreed that each participant would complete reflective reports on the telephone group clinical supervision method after each meeting. These were returned to one participant for collation and a summary of these was made available before the start of the next meeting. A mid-point review of the project was also agreed.

Phase 3: Implementation and emerging themes through reflection on the telephone group clinical supervision method

Much of the discovery of utilising the telephone method of group clinical supervision and its impact on the participants was dependent upon the commitment to being reflective both individually and as a group. From the summaries of each of the meetings, five key elements emerged relating to the learning gained from evaluating this method of group clinical supervision.

Having the correct equipment and environment
Lengthy group supervision meetings in the evening and in the home environment proved challenging for some participants. One participant persisted in using a hands free headset to be able to make notes at the same time as talking but other participants found that the voice was distorted and affected others being able to hear:

"I will consider purchasing some decent headphones for use with my phone or at least getting some advice about what to buy that is compatible with my own equipment…I persevered as long as I could before throwing them out because of my poor voice quality to others."

Many participants described hearing background noise on the telephone that affected listening as well as other auditory distractions such as dogs barking or family members entering the room where the telephone meeting was taking place. Engaging in group clinical supervision at home in the evening where a level of attentive listening and concentration was required had not been taken into account prior to the project commencing and for some presented an intrusion in their personal lives:

"Getting the home and work balance is important, and my enthusiasm for this project enabled me to commit to it, but in reality it didn't work very well for me as once I was at home I felt torn between home commitments and this project."

Important environmental factors to consider included finding somewhere comfortable to sit for long periods close to a landline telephone (rather than use an extension or a mobile telephone that tends to distort voice quality) and avoiding cramp whilst holding the phone close to the ear for over an hour. Physical tiredness possibly because of the time of day the meetings took place and the physical effort of needing to concentrate on

what was being discussed was also prominent. Individual access to a computer was also identified as an essential part of the project to provide reflective evaluation and support to the supervisee.

Communicating effectively with one another
Communicating effectively is a prerequisite for any clinical supervision meeting but was magnified as a group that could not see each other or in some cases did not know each other:

"At first I was concerned about not being able to see people, and no clues from body language etc, but I was surprised at how quickly I overcame this!"

Naming one another before speaking and having a round of introductions each time and checking everyone could hear each other, was evaluated positively and gave the opportunity for everyone to participate in the group.

Whilst some participants reported early in the life of the group that it was easier to express feelings to others you did not know on the telephone, other self reports of meetings contradicted this, suggesting that the group appeared 'cosy' and could have challenged each other more. Towards the end of the project the latter had begun, evidenced by increased levels of reflective questioning, but is suggestive that the telephone group clinical supervision method takes three to four meetings before participants can gauge others levels of comfort or discomfort and use questioning techniques and silences effectively:

"…silences in the group can be unsettling...and can be just as thought provoking as chatter."

Rotating different roles and responsibilities within the group and experimenting with a modified form of action learning in the clinical supervision meetings seemed to become a catalyst for rapid development of group rapport, as all participants were co-learners in the process together.

Personal attributes for undertaking telephone supervision
The reflective reports completed after each session revealed key personal attributes for being involved in telephone group clinical supervision. A recurring theme that surprised participants and may have led to two individuals dropping out of the group in the early stages was the level of personal commitment required to the group supervisory process and the project as a whole. Other attributes included being relaxed; simply being yourself and a willingness to rely on others you could only hear but not see:

"…there was a need for confidentiality and being able to trust others in the group…and the willingness of participants to receive and accept feedback on their roles in the reflection phase."

It might be argued that the skills of group clinical supervision using the telephone method might require higher levels of experience and facilitation skills than in a one-to-one, or face-to-face clinical supervision encounters. It is worth noting that although many of the participants were already using, or had experience of, facilitating change or being part of groups as practice development nurses they still found this method challenging.

Getting the process established to suit all
As participants were unable to meet face-to-face before the group supervision commenced, it could be suggested that on reflection there was a lack of active participant involvement in the preparatory stages of this project:

"…ensure where possible that the project commenced with a face to face encounter beforehand to clarify project aims as well as clarify different roles during the session, as well as being helpful to establish rapport and put names to faces…"

"…formulate ground rules early and have these renegotiable…"

The project might have benefited from having more frequent sessions in the early stages e.g. fortnightly to allow participants to get more used to the process than having to wait a further four weeks. However this was managed or perhaps mis-managed through the use of email to maintain an ongoing dialogue, but created an increased workload for participants.

Despite agreeing a group contract at the beginning, the project revealed how some participants challenged such boundaries by not attending or sending apologies beforehand, reducing the intended time allocated to the process by waiting and wondering whether they would attend and affecting not just the group itself, but then making it more difficult to re-enter the group after a four or eight week absence. Of the original ten participants, eight regularly attended the telephone group supervision meetings.

The facilitator and co-facilitator for each meeting were seen as important figures who managed the process and co-ordinated the evaluations and were agreed either at the end of a meeting for next time or on the evening of the meeting. However, by the end of the project it was felt that further clarification needed to be sought on both of these roles.

All roles were rotated as it was felt that all participants were co-learners in a new method of group supervision. The observer or process reviewer agreed not to take an active part in the group process and summarised and documented what had taken place at the end of the meeting for around 15 minutes:

"I liked having to provide evaluation feedback at the end of each session as it greatly enhanced my learning and focused me to reflect more structurally and systematically and as a means of learning from the rest of the group."

Part of the evolving nature in observing the meeting was to learn to focus on feeding back key points from the meeting rather than promoting an in-depth discussion. It was generally felt that following up the meeting using email was important when no face-to-face support was available.

Individual outcomes of undertaking telephone supervision
For all participants, using the telephone method of group clinical supervision was a new method. It was described by some as:

"….like speaking into a black hole…talking into a void…"
"….like sitting in a group with a blind fold on and no spatial awareness…"
"…takes longer to bed in and connect as a group…"

One participant made a distinction between engaging in face-to-face and telephone clinical supervision:

"I think that although this is perhaps not ideal as a method when compared to meeting face to face, it is a useful and cost effective mechanism of instigating group clinical supervision when none exists."
Despite this, all participants in their role as practice

developers seemed to have personally gained from engaging in this method of clinical supervision. In many ways the self reporting of individual outcomes using the telephone method are not dissimilar to meeting face-to-face in clinical supervision. Examples of individual outcomes from this project are:

- Feeling supported and subsequently more energised.
- A realisation that others in the group faced similar issues.
- A way of getting to know others personally as well as professionally.
- Concerns about attendance and commitment in the group situation.
- More accepting of other points of view.
- More able to challenge personal contradictions in practice.

The structured process as a modified form of action learning, in which time was also taken to review learning and act upon this and then followed up using email whilst seemingly cumbersome at the beginning, did contribute to meeting the project objectives in addition to personal outcomes.

Phase 4: Evaluation of the pilot project against the intended project outcomes

Taking into account summative evaluative reflective reports from seven of the ten participants and the ongoing clinical supervision documentation from each of the meetings including process reviews, the project outcomes can be summarised as follows:

- The access to group clinical supervision was widened and met a real need for eight practice developers.
- Participants in the project have indicated their willingness to cascade, lead and where necessary support the method in other DPN regions.
- The project and its findings have contributed to the literature on group clinical supervision.
- The telephone group clinical supervision method would seem a viable alternative to more traditional face-to-face encounters but to be effective requires thorough preparation and where possible meeting as a group to gain an agreement and clarify roles beforehand.
- The modified form of action learning used as a group clinical supervision format appeared to offer structure to meetings but more time could have been spent clarifying each of the different roles.
- Unlike face-to-face clinical supervision in practice in which services are given freely and in work time, the infrastructure required with the telephone method will incur a cost each meeting.
- The timings of the meeting (up to ninety minutes) and selection of a suitable environment are critical in preserving a work-life balance for participants.
- The project was not long enough to take a full account of how the method impacts on practice development activities as much of this time was spent in developing the process itself, although personal outcomes were reported.
- Based on the project data and themes emerging from directly engaging in the process, DPN Guidelines have been published.

Conclusion

One of the most cost efficient and simplest forms of technology for linking individuals or groups is the telephone. However, its use remains surprisingly under reported in the clinical supervision literature. This project emerged from the needs of geographically isolated nurses working in practice development and has advanced tentative guidelines and further discussion for the use of this method.

Whilst the paper focuses on the practical realities posed by the telephone group clinical supervision process, a broader and unanswered question is whether the use of technology generally (but in this case the telephone), might become a future challenge to the often held assumption that for it to be effective, group clinical supervision needs to be a face to face encounter.

References

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Further reading

A copy of the full project report including the Proposed DPN Guidelines can be downloaded from the FoNS website: www.fons.org/ahcp/grants2004/telephone.asp

Acknowledgements

How to reference this report

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