A survey of Canterbury nurses’ perceptions of the activities, effectiveness and benefits of professional supervision

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Abstract

Effective professional supervision (PS) offers nurses the opportunity to develop both personally and professionally through formal conversations with a trained supervisor. Perceived benefits, in the situation of efficacious supervision, have included improved wellbeing, increased self-awareness, confidence levels and more client-focused, innovative care.

The aim of this research study was to ascertain the perceptions of Canterbury nurses, involved in professional supervision, of the effectiveness of and benefits from supervision activities. These activities included establishing a supervisory relationship, training, contracting and the learning gained from the supervision session.

An existing survey-questionnaire (survey), that was part of an interdisciplinary study within the mental health sector in Canterbury in 2001, was adapted to survey a group of Canterbury nurses undergoing supervision. The survey included questions for both nurse-supervisees and nurse-supervisors. Over half of the participants worked in mental health areas whilst the remainder came from a wide range of nursing specialties.

Findings from 107 surveys obtained from this study rendered a high degree of satisfaction and perceived benefits experienced by this cohort. Personal benefits included recognition of personal issues, feeling valued and having increased confidence. Joint problem-solving and creative-thinking resulted in perceived changes in the degree of therapeutic perception and the provision of more client-focused care and treatment options. In addition, the qualitative comments from the survey acknowledged further benefits through the promotion of best practice, the increased ability to manage challenges, cultivation of positive attitudes and increased efficiency.

Interestingly, the participants were forthcoming in their suggestions on how to assure the quality of supervision. Support from all levels of staff, financial backing for standardised training and ongoing education, greater numbers and choice of supervisors, evaluation of supervision and review of contractual agreements, were all identified as foundational elements for successful PS.

However, a limitation to this study was the low return rate and overall positive bias towards supervision of nurses who participated in the survey. Firstly, the positive leaning towards PS left a gap, omitting the non-survey participants experiences of
professional supervision. Secondly, disproportionate sizes of groups of participants and the different models used within the nursing specialties limited the opportunity for comparative testing. Thirdly, as a sole researcher there was a risk of bias in the interpretation of results, and any generalisations needed to be made with caution.

Along with the benefits and limitations, significant findings from this study highlighted the point of view that effective PS is required if benefits are to be realised. Noticable inconsistencies in supervision activities and overall functional arrangements were emphasised. Suggestions made included: standardisation using generic standards and guidelines that could assist in operationalising, maintaining and sustaining PS as a quality support and professional development system.

The present study indicated that further research may add to the baseline information gained from these findings. Suggested research included: (1) a study situated in one location, in a generalist setting, utilising a well recognised research tool (2) an area that endorses and supports PS at all levels could be compared with an area where PS has not been introduced (3) contrasting formats of supervision, assessing personality traits and motivational characteristics of participants attending voluntary supervision are other research areas that have emerged from this study. This research could provide additional information to encourage the expansion and development of supervision in nursing.
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Chapter One: Introduction and Overview

Professional Supervision has been acknowledged as a system that provides support and the opportunity to reflect on practice, with a trained supervisor, encouraging creativity, innovation and role fulfilment (Consedine, 2004b). Professional supervision (PS) as a vehicle to promote reflection on practice enables the nurse or supervisee to build on both practical and theoretical knowledge (Driscoll, 2007b; Lillyman, 2007; Lynch, Hancox, Happell & Parker, 2008). In White and Winstanley’s (2010) Australian mixed method, randomised controlled trial of mental health nurse-supervisors (n=24), supervisees (n=115) clients (n=82) and unit staff (n=11), they demonstrated that improved standards of client care will follow in an environment where PS is understood, encouraged at all levels of nursing and is seen as effective.

In New Zealand (NZ) the known uptake and availability of PS have largely been limited to mental health, palliative care (New Zealand Nurses Organisation [NZNO], 2005), The Royal New Zealand Plunket Society [Plunket] (Polaschek, 2007) and public health nurses (Farrell, 2003). Similarly, Brunero and Lamont (2011) reported in their evaluative research of nine supervision groups of nurses, from generalist specialties, that the situation has been the same in Australia. However, PS is now extending into other specialties outside of mental health even though its spread can only be described as patchy (Lynch et al., 2008). Studies from Britain (Davey, Desousa, Robinson & Murrells, 2006) and Scandinavia (Brunero and Lamont, 2011; Koivu, Hyrkas and Saarinen, 2011) [surveyed (n=124) Finnish medical-surgical nurses undertaking PS]; report that PS is well established in mental health nursing, relatively novel in medical and surgical sectors, and limited in other areas of nursing. In NZ, within the Canterbury region, there has been anecdotal evidence of involvement in PS by nurses from a variety of nursing specialties. My aim was for all nurses involved in PS in Canterbury to have the opportunity to participate in this study. A survey-questionnaire design was used to describe their experiences of, the effectiveness of and the benefits gained from their supervision.

In offering a background to this study I have endeavoured to demystify the terms and concepts surrounding PS. A brief historical account has been provided on the development of supervision from an international and NZ nursing perspective to assist
with this endeavour. Finally, an overview of my interest in PS and a brief outline of the thesis content in the following chapters have been covered.

**The term: professional supervision**

The term professional supervision (PS) has been used interchangeably with clinical supervision and just plain ‘supervision’ in nursing, causing a conundrum for many when attempting to describe the meaning (McKenna, Thom, Howard & Williams, 2010). Jubb Shanley and Stevenson (2006) suggested that understanding of what is meant by supervision is determined by the professional group, the historical origins of PS and the choice of term or language that is the best fit for that particular group. Whilst the term “clinical supervision” is still widely used in mental health nursing, there is a move to use PS as an alternative, the rationale being that this term is inclusive of nurses who work in the clinical arena, but also of those in education, research, management and leadership roles (McKenna et al., 2010; Mckenna et al., 2008). NZNO (2005) uses both terms together to avoid confusion. In this research study, “PS” alternating with “supervision” has been selected as the terms of choice.

**Historical background**

For this particular study it was important to follow the explanation of the selection of the term PS with a brief overview of the historical development of supervision, within nursing. This was necessary for the establishment of a working definition that articulated the meaning and that best matched with my viewpoint of PS.

PS was first developed in Sigmund Freud’s era, in the 1920s. However it was Carl Rogers in 1951 who “pioneered the person-centered therapy” (Rolfe, Freshwater & Jasper, 2001, p.76) which became a prerequisite for analysts in counselling and psychotherapy to undergo. In these disciplines, PS addressed the development of the relationship and the approaches used by the supervisee to create a therapeutic connection with the client (Rolfe et al., 2001).

In New Zealand, PS was introduced to nursing in the 1980s as a managerial strategy to maintain standards, safeguard clients, and the organisation. The supervision process during this phase involved an authoritarian and didactic approach by managers, acting as supervisors, and appraising the practice of lesser experienced nurses (Consedine, 2004a; Kelly, Long & McKenna, 2001b; McKenna, Thom, Howard & Williams, 2010). According to Consedine (2004a), at that point and time, there was little room for self-discovery through reflection and professional development.
In a similar vein to what was happening in the United Kingdom, the functions of PS, in NZ and Australia, broadened to encompass a more organisational focus of clinical governance, monitoring of standards and the provision of quality care. However, nurses continued to perceive supervision as belonging to managers rather than trained PS supervisors from varying levels of nursing.

In 1995, the United Kingdom Central Council for Nursing Midwifery and Health Visiting (as cited in Winstanley and White, 2003) extended the scope of supervision. This included the development of a relationship between two or more practising professionals, and enabled skill acquisition and innovative clinical practice, that produced benefits for the client. However, without the acceptance of a standard definition and understanding of the concepts surrounding PS, a great deal of bewilderment (Consedine, 2004a), uncertainty (Lynch et al., 2008) and scepticism (White & Winstanley, 2010) existed within nursing.

In the United Kingdom, Australia and NZ defining PS has not been clear-cut, with mentorship, preceptorship and coaching often falling under the same umbrella. Yegdich (2001), Winstanley and White (2003) and Mills, Francis and Bonner (2005), in reviewing the position of PS in Australia and NZ, allege that mentoring and PS offered support with academic advancement to ensure success, with the inclusion of improvement in clinical practice. According to the authors noted above, and together with Lynch et al. (2008), these support and professional development (S & PD) systems require a long-term commitment of months or years, however PS in contrast offers a more formalised structure that is career-long.

In contrast, preceptorship is usually limited from under a month to a year and requires written feedback in the form of appraisals (Firtko, Stewart & Knox, 2005; Cutliffe & Lowe, 2005; Lynch et al. 2008). Coaching, like preceptorship, is usually short term and focused on the achievement of goals (Donner & Wheeler, 2009). Furthermore, when addressing the facilitation of these relationships—mentoring, coaching and preceptoring—more experienced practitioners work with a lesser experienced colleague or colleagues (Lynch et al., 2008). This is not necessarily the case with PS whereby the supervisor may be a peer, as noted in the Claveirole and Mathers’ (2003) evaluative study of a group of 12 university nursing lecturers from Scotland, or even someone from another discipline as recognised in the Cooper and Anglem (2003) interdisciplinary, mixed method study of 113 mental health workers in Christchurch NZ in 2001. Another distinction, as acknowledged by Sloan and Grant
(2012) in their recent discussion paper on the implementation of PS into mental health in the UK, and the use of a database for supervisor details, was the expertise and specific training undertaken to qualify them for their role as a supervisor.

Despite the clear distinctions between these various S & PD systems, misunderstanding still surrounds the meaning of PS as a result of a plethora of descriptions (Sloan & Grant, 2012). However, Lynch et al. (2008) assert that there are three core elements interwoven into all varying interpretations of the concept. These are: reflection on practice in a safe, supportive environment; promoting learning and development; and a successful relationship between supervisor and supervisee.

How the NZNO (2005 p.1) position statement incorporates the three elements is shown in the following definition:

...a practice focused professional relationship that enables reflection on practice with the support of a skilled and qualified supervisor. Professional and clinical supervision facilitates professional growth by allowing safe and supported exploration of clinical practice.

The following definition, which was utilised in the Professional Supervision for Mental Health and Addiction Nurses’ Study (McKenna et al., 2008), included all the elements summarised above. In addition, competence in relation to the supervisees own practice was added as an additional factor (Ministry of Health, 2006, p.22 as cited in McKenna et al., 2008, p.2). This source describes PS as:

...a formal process that provides professional support to enable practitioners to develop their knowledge and competence, be responsible for their own practice and promote service users’ health outcomes and safety.... [this] involves time away from the practice environment to meet with an experienced practitioner of their choice to engage in guided reflection on current ways of practicing.

The definition above, whilst meeting the criteria outlined by Lynch et al. (2008), determines the skill and training necessary to become a supervisor. The Ministry of Health has instead utilised the term “experienced practitioner” as an alternative. This term is certainly inclusive of group and peer supervision whereby peers are supervising
one another. One would, therefore, surmise that this equates to each person being trained as both a supervisor and supervisee.

Notwithstanding all that is offered above, perhaps the most comprehensive definition of PS used in nursing is Bond and Holland’s (2010) version. Their definition provides the purpose, what happens in the session and who can avail themselves of PS. It also differentiates between other short-term S & PD systems and acknowledges that PS requires “ongoing, regular sessions which are led by the supervisee’s agenda” (p.15). It is Bond and Hollands’ definition that sits well with the scope of this study and with my position as the researcher on PS.

Clinical supervision is regular, protected time for facilitated, in-depth reflection on complex issues influencing clinical practice. Its aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through means of focused support and development. The supervisee reflects on the part she plays as an individual in the complexities of the events and the quality of practice. This reflection is facilitated by one or more experienced colleagues, who have the expertise in facilitation, and frequent and ongoing sessions are led by the supervisee’s agenda. The process of clinical supervision should continue throughout the person’s career, whether they remain in clinical practice or move to management, research or education (p.15).

In the preceding definitions in-depth reflection is central to PS. Reflection is also central to competency 2.8 of the Nursing Council of New Zealand (NCNZ) competency framework (2007) whereby all nurses are required to reflect upon and evaluate their nursing care. This evaluative framework was introduced to monitor continuing competence in response to the Health Practitioners Competency Assurance Act [HPCA] (Ministry of Health, 2003). This legislation has been put in place to ensure that practitioners are “competent and fit for practice” (on page 7 of the Act) in the interests of public health and safety. Consedine (2004b) suggested that cultivating a high level of professional functioning in nurses is the role of PS. With this in mind, a S & PD system such as PS can be perceived as a vehicle to initiate self-awareness, critical examination of practice and a linkage to theoretical underpinnings, resulting in new perspectives (Freshwater, 2007) thus improving the quality of client care (Lynch et al., 2008).
**The researcher’s interest in professional supervision**

As a student transitioning from a Registered General and Obstetric Nurse (RGON) to the Bachelor of Nursing Degree 15 years ago, I was initiated into the benefits of reflecting on my own practice. I became passionate about opportunities to formally reflect through sharing excerpts from my professional journal, on my role as a clinical lecturer, within a safe and supportive community of fellow students.

At the same time, part of my role as a clinical lecturer was to facilitate group reflection sessions, with no formal training in reflective practice or as a professional supervisor. Claveirole and Mathers (2003) believe that facilitators of reflective groups need to acquire the skills of a trained supervisor. For myself, at that point in time, it was only through further reading and writing reflective accounts of my work that I developed the effective use of reflection as a supportive learning framework for student nurses.

As my career progressed I gained an awareness when working with undergraduate students, and more recently graduate nurses and senior nurses, that people have a varying capacity to reflect (Haigh, 2000). In other words, the ability of a teacher, a student, or a registered nurse (RN) to go beyond comparing similar experiences and evaluating outcomes to analysing why something works or did not go well, may differ. As a nurse educator I had the aspiration to be an expert facilitator of learning. Therefore, I continued to further my education by completing a post-graduate diploma in tertiary teaching where my focus was firstly developing reflective practice skills in new graduate nurses. In the second part of the diploma, my research was based on working with a steering group to create an implementation plan to introduce PS. This plan was designed as a means of providing an S & PD system that enhanced the nurses’ role and job satisfaction and in turn improved the quality of care to clients.

In tandem with further education I trained as a PS supervisor, provided one-to-one supervision and group sessions and received my own supervision. I saw this ongoing experiential learning process as a means to becoming highly skilled as a supervisor and supervisee. This in turn enabled me to facilitate and support others to reflect on and learn from their practice through the process of PS.

I was fortunate to have had the opportunity to coordinate a small, one-year long, PS pilot project for the Canterbury District Health Board (CDHB) in two non-mental health hospitals utilising the implementation plan from my studies. As part of this
project fourteen nurses received five days of supervisory training. Twenty-four nurses offered to participate as supervisees in monthly supervision.

The outcomes from the six-monthly focus group evaluation were generally positive and in line with current research. PS was seen to increase work satisfaction, confidence and competence to manage change and challenging situations. The nurses involved were using reflective practice and critical thinking skills in greater depth, providing outcomes of increased care and treatment options that were more client-focused. At the end of the year-long CDHB pilot project, 70% of supervisees wanted to continue receiving PS and 84% of supervisors wished to continue in a supervisory role. A further 7% of supervisees were eager to train as supervisors.

Given the outcomes of the pilot project I was curious to ascertain the level of involvement and the effectiveness of PS in other areas. Furthermore, I felt it was especially important to draw on mental health nurses’ wealth of experience of PS, and their perceptions of what makes supervision effective. For this reason 485 surveys were distributed to nurses known to be involved in PS as supervisees in the Canterbury region.

**Structure of thesis**

The study was introduced and a context provided in chapter one. Chapter Two (the literature review) explores research studies and expert opinion on PS in relation to nursing. The focus of interest has been narrowed to incorporate information from the literature on the activities of PS: that is the effectiveness, the benefits for the nurse, client and organisation, and the ongoing challenges and areas for improvement as noted in the most recent studies. The activities are inclusive of PS training of supervisors and supervisee’s and general factors relating to the infrastructure of PS, contracting, the supervision session and the supervisory relationship.

In Chapter Three (the methodology) the utilisation of a descriptive survey design and ethical considerations are discussed. Quantitative and qualitative forms of analysis were reviewed in relation to short answer, closed, Likert scale and open-ended questions. The use of the Statistical Package for the Social Sciences (SPSS), version 19, data collection methods and ethical approval have been related. The results from the statistical analysis using SPSS and the themes from the qualitative comments from the open-ended questions have been presented in Chapter Four.
In Chapter Five the findings from this study have been discussed in relation to the literature and the activities, effectiveness and benefits of PS. The key elements—the supervisory relationship, training, contracting, and evaluation—which were perceived by the survey participants as essential for effective PS were further analysed. The limitations of this study and recommendations for further research complete the discussion. The significant findings from this research study have been summarised in the conclusion.
Chapter Two: Literature Review

Introduction

A literature review provides background and context to the research question and overall study. It presents an organisational structure on which to frame current theory, opinion and research (Tolich & Davidson, 2003). In this study the research question asked is: what are Canterbury nurses’ perceptions of the activities, effectiveness and benefits of PS?

Firstly, in this chapter the parameters of this literature review have been explained. Secondly, the types, formats and frameworks of supervision were reviewed to uncover the models and provide an overview of those used in practice. Thirdly—in line with this study’s survey questions—the activities of training supervisors and supervisees, the supervisory relationship, negotiation of the contract, creating a learning environment for PS, and the benefits of supervision have been discussed in relation to the national and international literature.

Search strategies and literature review parameters

Databases

To provide a background on the subjects outlined above, relevant literature was obtained from local libraries, through inter-library loans and via electronic article databases. The following keywords were used: clinical supervision; professional supervision; nursing; supervision training; clinical supervision contracts; clinical supervision benefits; and effectiveness. These were expanded upon to locate appropriate literature. The databases accessed included: Ebsco (including CINAHL); Ovid (including Medline, Embase, Nursing, psycINFO; Proquest Health and Medical Complete; Pub Med; Te Puna and KRIS (Kiwi Research Information Service). Reference lists were also examined for additional literature not found during the initial searches. Towards the end of the research study a further search was carried out for any new publications. Two new studies and two local unpublished theses were located.
**Timeframe limits**

A timeframe limit from the year 2000 to 2012 was generally implemented in the hope that the information had retained relevancy to today’s healthcare climate. However, in providing a brief overview of the historical elements of PS required the inclusion of some earlier literature. Also, information from other healthcare disciplines has occasionally been utilised to augment the nursing perspective and present information that is pertinent to NZ.

**Geographical limits to literature**

Writings on PS from United Kingdom (UK), Scandinavia, United States of America (USA), Australia and NZ were used, despite there being variations in understanding and practices. Divergence in interpretation also existed within varying specialties of nursing (Green, Lister & Crisp, 2005; Jubb Shanley & Stevenson, 2006). In the UK, Australia and NZ, PS usually caters for post registration nurses. The focus is to support qualified nurses to reflect on the practical aspects of their work (Lynch et al., 2008) and aid personal, interpersonal and professional development (Bond & Holland, 2010). By way of contrast, PS in the USA refers to the support, monitoring of performance and education of nurses prior to licensure or registration. This relationship always involves a more experienced person as supervisor but formal supervision training is not required according to Cutcliffe and Lowe (2005) in their discussion paper on the comparisons between USA and European perceptions of PS. This variation is also reported in Teasdale, Brocklehurst and Thom’s (2001) UK mixed method study of qualified nurses (n=211) from 11 hospitals and community National Health Service Trusts (NHS). However, according to Bishop (2007), Bond and Holland, (2010) and Fowler and Cutliffe (2011), an interpretation they have in common is that PS is a formalised meeting of two or more people for the purpose of the supervisee taking time out from work to reflect on their practice.
Research gaps

Within the literature obtained there were areas noted where further research was deemed to be necessary. Sloan (2006) in his UK illuminative evaluation\(^1\) of four interdisciplinary, mental health case groups suggested that subjects such as supervisee characteristics, length of experience, qualifications, motivational factors, reflexivity, together with environmental and operational aspects, had not been addressed to any great extent. Edwards et al. (2005) in their survey research of Welsh community mental health nurses (n=260) concurred with this viewpoint recognising that broader issues of the efficacy of supervision also required attention. According to Hyrkas (2006) it was essential to understand the foundation on which the activities of PS were built in order to comprehend why PS has been of benefit to nurses. More specifically, Jones (2003), at the conclusion of his study on a group approach to supervision for UK hospice nurses (n=5), identified the need for further research on the educational requirements, content, structure and evaluation of PS. It is these gaps in the research stated by Sloan (2006), Edwards et al. (2005) and Hyrkas (2006) that have shaped the framework of this broad-based descriptive study.

The supervisory relationship is yet another area where research is limited (Sloan, 2006) despite being alleged to be an integral part of effective PS (Kilminster & Jolly, 2000; Bond & Holland, 2010). This was noted particularly in regard to how relationships impact on client outcomes (Mernick, 2009). In Mernick’s (2009) small (n=8) qualitative study she interviewed NZ mental health nurses based in Canterbury to investigate what makes for an effective supervisory relationship. It was the time made available for supervision to enable growth of the supervisor-supervisee relationship, and a clear framework to guide the process that rendered more effective client-nurse relationships. Nurses re-entered the workplace with greater motivation, a clearer focus on their clients’ needs and the ability to collaborate with clients in a more creative way. However, an Australian mixed method, randomised controlled trial concluded that “No significant differences in patient satisfaction and quality of care” (White & Winstanley, 2010, p. 162) were found as a result of the supervisory process across the 17 locations. This study included mental health nurses as supervisors (n=24) and supervisees, clients (n=82) and unit staff (n=43) in the intervention groups and (n=71) mental health nurses, (n=88) clients and (n=11) unit staff in the control group. However, White and

\(^1\) Illuminative Evaluation: methodological triangulation that gives a comprehensive perspective. Included evaluation of interviews, session documents, critical incident journals, sessions audiotaped and comparisons made between three teams.
Winstanley (2010) evidenced, from one out of nine locations, results from the Psychiatric Care Satisfaction Scale that demonstrated noteworthy improvements over the period of a year. In this situation PS was fully embraced by all staff and well-structured and guided by a committed, well-trained supervisor.

These gaps in the PS research have been drawn on and discussed in further detail throughout this literature review. Having outlined the parameters of this literature search previously, the types of supervision were perceived as the next step in this review.

The types of supervision

Managerial supervision

In Chapter One, professional, clinical and managerial supervision were mentioned in the brief historical account of PS (see p. 2). Walsh, Nicholson, Keough, Pridham, Kramer and Jeffrey (2003) suggested that the term managerial supervision created uncertainty with the utilisation of this type of supervision often being categorised under the umbrella of professional or clinical supervision. To differentiate between these types of supervision, managerial supervision can be best described as supervision whereby the supervisor is a manager or involved in line management and the supervisee is someone who is probably deemed less important or in a hierarchical sense, inferior (Hawkins & Shohet, 2009; Lynch et al., 2008). According to Yegdich (2001), this type of supervision protects the vision of accountability through a system of appraisals thereby improving the maintenance of standards. Nevertheless, Bond and Holland (2010) contend that this hierarchical type of approach can create a very different scenario whereby performance and competency take precedence over support needs. As experts in the field of PS, they strongly recommend that managers do not take on the role of supervisors.

In clarifying this viewpoint, Sloan (2006) alleges that PS should be supervisee-driven and focuses on exploration of practice and personal performance through guided reflection, whereas in contrast performance appraisals are managerial-driven. Kleiser and Cox (2008) in their review of literature found that viewpoints differed on the utilisation of PS as a means of monitoring practice-based competency. On the one hand hierarchical type supervision was deemed less effective, however on the other hand authors acknowledged that there could be a place for linking supervision, appraisals and
professional development through involving a managerial-led monitoring system. Proposals such as this were suggested in the following studies.

The National Guidelines for the Professional Supervision of Mental Health and Addiction Nurses (Te Pou, 2009) recommended that line managers be assigned the responsibilities of developing monitoring and evaluation systems for the purposes of attendance and resource cost assessments. White and Winstanley (2010) in their Australian mixed method, randomised controlled trial, which included mental health nurses, clients and unit staff in both control and intervention groups made the following conclusion from their results. The manager needed to have an awareness of goals set by the supervisor and supervisee, in order to provide the necessary support, whilst respecting that conversations between supervisor and supervisee remained confidential. Interestingly, in a survey of mental health nurse leaders and supervisors from NZ District Health Boards (DHBs) (n=21) and Non-Government Organisations (NGOs) (n=7) and supervisors (n=73), in 19 of the organisations, supervision was linked to appraisals through the supply of attendance records. Nevertheless, managers saw this measure as ad hoc and acknowledged the need for more inclusive involvement in the process of PS (McKenna, Thom, Howard & Williams, 2010). With this in mind, the trend within nursing, therefore, seems to be for managers to be involved in supporting, operationalising and monitoring the outcomes of supervision.

Cultural supervision

Another type of supervision that is important, particularly in a NZ context, is cultural supervision. The authors of two papers (Howard, Burns & Waitoki, 2007; Walsh-Tapiata & Webster, 2004) believe that in NZ cultural supervision is generally recognised as being for Māori health professionals, whereby Māori receive supervision from Māori supervisors. It is central to knowledge acquisition of cultural issues, values, attitudes and behaviour. This concept is also applicable to other ethnic minorities (Mafie’o & Su’a-Hawkins, 2005). Members of The Supervision Steering Group [MSSG] (2005), involved in compiling the Directory of Supervisors for Canterbury and producing a resource on supervision, concurred with the above authors that the opportunity should endorse this principle for persons with the same backgrounds to develop a supervisory relationship.

However, the MSSG (2005) believe that the term cultural supervision is an outdated term and have quoted Māori and kaumātua (elders) in asserting “that we don’t carry out cultural supervision, only supervision” (p.12). Focus groups in Cooper and
Anglem’s (2003) research study disputed that the term cultural supervision was perhaps not a suitable variant category for supervision, which appeared to pertain specifically to Māori. If the term culture is to be defined in the broader sense that is inclusive of age, generation, gender, sexual orientation, ethnic origin, or migrant experience, religious or spiritual belief, and disability (NCNZ, 2009, p.5), then the term cultural supervision may very well need to be redefined.

In the MSSG (2005) Resource Document the term cultural supervision has been superseded by supervision for Māori and tangata whenua (Māori) for nurses, as part of this debate regarding terms. The group have also suggested that Māori terms below, depicting mana (respect), should be the responsibility of all supervisors and supervisees regardless of ethnicity:

...whakaaroaro (deep and thoughtful consideration); whānaukātaka (respectful nurturing and a purposeful processing); manaakitaka (caring, generous approaches); and utu (a time for giving and receiving) (p. 12).

However, the importance of having the skills and knowledge to supervise persons from different ethnic groups is reiterated by Cooper and Anglem (2003) in their interdisciplinary, mixed method study of 113 mental health workers in Christchurch NZ in 2001. The authors suggest that a mono-cultural, westernised approach to PS conversations, on race, culture and social differences, are topics that are often omitted in supervision. To add to this conundrum, there seems to be a limited understanding of the term, cultural supervision, as noted by the cohort within Cooper and Anglem’s study. As a result, the authors put forward the proposition that supervisory training needs to extend the supervisor’s thinking beyond the often mono-cultural, ethnocentric approach to consider the impact of white, European supervisors on supervisees from different cultural backgrounds. Te Pou (2009) agrees that cultural competence, inclusive of an understanding of bicultural and cultural supervision, is an area of PS that requires further development.

**Internal and external supervision**

Along a different vein, types of supervision can also be defined as internal, internal to the organisation but external to the work area of the supervisee or external to the organisation. On the one hand, internal supervision is where the supervisor and supervisee work within the same area. The supervisor may, therefore, have a greater
understanding of the supervisee, the organisational structure and related issues. However, the role switch from work colleagues to a supervisory relationship can prove to be difficult according to the Te Pou (2009) research team in their National Guidelines for the Professional Supervision of Mental Health and Addiction Nurses.

External supervision, on the other hand, can be external to the area where the supervisee works, or the organisation. This type of supervision is thought to provide greater safety, be devoid of power imbalances and can supply a greater choice of supervisors (Davys & Beddoe, 2010; Te Pou, 2009). Te Pou, nevertheless acknowledge that supervision outside the organisation comes at a substantial cost, and also supervisee or client safety issues may be seen as more of a challenge for the supervisor, who is unfamiliar with the organisation.

In support of external supervision Hyrkas’s (2005) quantitative study of Finnish mental health nurses across 14 sites (n=569) showed improved outcomes from PS where supervisors were external to the organisation and from other health related fields. Interestingly, in a further study evaluating the implementation of PS in Western Australia, 78% of the 155 mental health nurse respondents chose external as opposed to internal supervisors. Nevertheless, they were generally from the nursing profession (Taylor & Harrison, 2010). In contrast, McKenna et al. (2010), in their survey of mental health organisations (n=22), found that external supervisors were more often not from outside the nursing profession. However, they had specialist knowledge. Both internal and external supervisors were employed.

**Voluntary or mandatory professional supervision**

Furthermore, PS can also be of a voluntary or mandatory nature. According to Cleary and Freeman (2005) there is consensus that PS should be of a voluntary nature. In agreement with this stance Lynch et al. (2008) purport that it is challenging to set up a successful relationship where one is mandated to attend. Bond and Holland (2010) and NZNO (2005) put forward the opinion that those who could benefit from supervision the most, do not avail themselves of the opportunity. They allege that we all, without exception, need to be looking at ways to improve practice, however compulsory attendance is not generally considered to be the best option. In contrast to the term ‘compulsory’, an ‘expectation of attendance’ is the terminology that has been used in preference as is done in some organisations. However, graduate nurses on post-graduate mental health programmes are mandated to attend supervision. Both this option and using supervision as a “resolution tool for performance management issues” (McKenna
et al., 2010, p.273) were seen to be of benefit despite the limited motivation to attend directed supervision. Whilst types of supervision and their uses differ, formats also offer variation by way of a one-to-one, peer-reciprocal, or group approach.

**Supervision session formats**

*One to one or individual formats*

According to Hawkins and Shohet (2009) and Sloan and Watson (2002), individual PS is the most common format. With a one-to-one supervision relationship there is a greater length of time given to the supervisee’s agenda (Bond & Holland, 2010; Corrigan, 2005; Lynch et al., 2008) and a greater opportunity for critical reflection and a deep approach to learning (Biggs, 2003). Having only one supervisor can help the rapport between supervisor and supervisee, make the meeting times easier to manage, and be more comfortable for someone new to supervision (Bond & Holland, 2010). However, individual supervision can limit feedback, shared experiences, viewpoints and the additional questioning that comes from a group situation (Hawkins & Shohet, 2009). Friction between supervisee and supervisor can also be more difficult to rectify in a one-to-one situation (Bond & Holland, 2010). However, according to results collated from four Australian/NZ evaluations of PS, there was limited difference in practice benefits between one-to-one and peer group supervision (White & Winstanley, 2006).

*Group format*

Another factor that promotes the preference for group PS is the requirement for only one trained supervisor or facilitator for four to six people, as recognised by Hyrkas et al. (2003) in their qualitative study on peer group supervision, involving nurse managers (n=15) from a university hospital in Finland. In addition, Hawkins and Shohet (2009) state that a group format reduces both cost and time, provides extra support amongst peers, better opportunities to share knowledge, experiences and alternative options for client care (Driscoll, 2007a; Jones, 2003; Hawkins & Shohet, 2009). Corrigan (2005) and Bond and Holland (2010) agree with the above authors but caution that mixed levels of staff can cause a feeling of intimidation especially amongst junior staff or those with more introverted personalities. Another drawback would be the reduced supervision time apportioned to each participant (Bond & Holland, 2010).

Bond and Holland (2010) also advise that sharing practice issues is fraught with uncertainty in a group situation as the safety element with disclosure is reduced. Not
only this, others considered that a supportive group may be reluctant to provide challenge, therefore limiting critical analysis of practice in order to protect the cohesiveness of the group (Driscoll, 2007a; Jones, 2003; Hawkins & Shohet, 2009; Walsh et al., 2003). To manage group dynamics successfully it is imperative that supervisors are skilled in group facilitation, together with regular supervision and supervisee training (Bond and Holland, 2010; Lynch et al., 2008; McMahon & Patton, 2002).

These course requirements would also be essential for groups where supervision is facilitated in turn by members and not one specific supervisor (Bond & Holland, 2010) as in peer-group supervision (McNicoll, 2008). Jones (2003), given his experience as a researcher and the facilitator of group supervision with hospice nurses, stressed that both supervisors and supervisees require appropriate training to maintain safety within the group. A group of this nature is usually comprised of nurses at a similar level, specialty or role (Hawkins & Shohet, 2009). Hawkins and Shohet (2009) and van Ooijen (2003) stress, though, that without a lead supervisor it is crucial that clear frameworks are utilised to provide structure for the sessions. McNicoll (2008) concurs with this and states that peer-group supervision needs to be structured to meet the purpose of the supportive, educative and administrative functions of supervision (Kadushin, 1976). Without a purpose, adequate training and a framework, groups are likely to degenerate into informal chat or discussion groups where safety is put at risk. Boundaries are difficult to maintain thereby limiting good practice outcomes. Lakeman and Glasgow (2009) in their five-month action research project, involving psychiatric nurses (n=10) in Trinidad and using a peer-group format, gained positive feedback regarding the process. These nurses, with limited knowledge of the process of PS, valued the involvement in the project that action research offers. They felt supported and appreciated the opportunity to discuss practice issues and to gain an understanding of the “nurse’s role as a therapeutic agent” (p.209). This approach also offered the opportunity for continual evaluation and adaptation of a potentially sustainable format for PS in a place where resources were limited.

**Peer reciprocal professional supervision**

Another format that is run in a similar way to the peer-group format is peer-reciprocal supervision (Bond & Holland, 2010). This format is composed of either a one-to-one relationship or a small group where, again, each person is trained as both a supervisor and supervisee, thus enabling the exchange of roles. For Plunket, this format
allowed for a cost-effective way of providing supervision to all nurses within the service (Baldwin, Hawkin, & Patuwai, 2000). Polaschek (2007) considers that peer-reciprocal supervision provides collegial support, encourages safe practice, builds on existing communication skills and promotes professional development. However, McKenna et al. (2008) highlights the challenges that are attached to this format. They caution against the tendency for this professional relationship, with peers, to fall into the social ‘get together’ thereby avoiding opportunity to debate practice issues. Polaschek acknowledges this and in addition mentions time restraints and the lack of challenge that may exist between colleagues as having further limitations. However, this format of supervision offers an opportunity for safe exploration of practice issues, recognition and affirmation of skill mastery, the development of listening and feedback skills and practice.

Frameworks to guide professional supervision

This section gives a brief overview of function-based, psychoanalytic, process-based, relationship-based and reflective frameworks. The term framework is used, where appropriate, in preference to model. As Bond and Holland (2010) suggest, the term framework is like a basic structure on which to adapt and personalise the design. It gives the impression of flexibility whereas a model indicates permanence as it provides an exact representation of the finished product. Frameworks have been adapted from counselling, psychotherapy (Rolfe, Freshwater & Jasper, 2001), social work (Tsui, 2007) and education fields (Zorga, 2002). They also vary in purpose and the part they play within the wider frame of PS itself (McKenna et al., 2008). There are numerous frameworks that assist both the supervisee and supervisor to understand the process of PS however few have been developed specifically for nursing (Sloan, 2007).

Frameworks that define the function of professional supervision

Brigid Proctor’s (1986, as cited in Kelly, Long & Mckenna, 2001b) three-function model, that is inclusive of the restorative, formative and normative functions has been further developed and is now known as the Supervision Alliance Model (Proctor, 2001). According to Sloan and Watson (2002), Winstanley and White (2003) and McKenna et al. (2008) this model is the most utilised framework in nursing and is well recognised in UK supervision literature (Kilminster & Jolly, 2000). The framework was originally adapted from the earlier work of Kadushin (1976) in the social work field and is composed of three functions: the normative, formative and restorative. The normative function applies to promotion of, and compliance with policies, procedures
and standards; the formative component to skill acquisition and evidence based practice; and the restorative component to enabling supervisees or nurses to self-manage the stressors of their work (Winstanley & White, 2003; Bond & Holland, 2010). Bond and Holland (2010) continue to employ Proctor’s framework in nursing but with a greater understanding of the interlinking of the three functions. Their framework illustrates the need for restorative and formative functions to be addressed first, in order for the nurse or supervisee to be better positioned to address the normative function, through the acquisition of support and knowledge. In turn, standards will be raised, accountability met and quality care provided, thereby meeting the normative function. Nevertheless, Driscoll and O’Sullivan (2007) propose that all three functions require an equal weighting to best meet the complex situations that the supervisee brings to supervision. The authors claim that in reality there may be a greater emphasis placed on one particular function owing to the area of interest and work role of the supervisor unconsciously overshadowing the other functions. For example, an educator may tend to focus on the formative function, a manager on the normative function and a supervisor from the mental health area on the restorative function.

However, Driscoll and O’Sullivan (2007) perceive that these three tasks or functions of supervision are valuable in providing the scaffolding on which to build a training programme for supervisors and also in supervisee preparation for a PS session. Nevertheless, the authors do contend that whilst this framework is helpful for beginning supervisees and supervisors, the need for a greater range of frameworks that support further exploration in different areas is necessary beyond the beginning developmental stage. In contrast, McKenna et al. (2008) purports that this generalist framework could fit with most organisations, thereby providing some uniformity in the supervisory approach within NZ. Davey et al. (2006) and McKenna et al. (2008) all believe that other frameworks could act as an adjunct to Proctor’s framework to fit with different specialties of nursing. Despite this viewpoint, McKenna, Thom, Howard and Williams (2010), in their three NZ surveys of nurse leaders from District Health Boards (DHBs), Non-Government Organisations (NGOs) and supervisors in the mental health and addiction specialty, reported that 70% of the managers claimed that PS within their organisations was not underpinned by any particular theoretical framework. Nevertheless, five respondents noted that Proctor’s Supervision Alliance (2001) and the framework known as the TAPES method (Clarkson, 1992) were utilised the most frequently. The acronym, TAPES, labels the five categories of the framework: theory, assessment and intervention, parallel process and transference, ethics and professional
practice, and strategies and interventions. Interestingly, Driscoll and O’Sullivan contend that Proctor’s framework does not address the interactive relationship between the supervisee-nurse and the client, that is known to be such an integral part of mental health nursing and the supervision discussion.

**Psychoanalytic based frameworks**

The essence of the psychoanalytic based frameworks is the interpersonal relationship between the supervisee-nurse and the client, and the supervisee-nurse and their colleagues (Lynch et al., 2008). Consedine (2004b) emphasises that optimal care requires not only helpful nurse-client relationships, but also effective collegial interactions. If an interaction is of concern, this unease may be relayed to a supervisor within a PS session and role analysis may take place. Moreno’s work and concepts (1946, 1961, as cited in Consedine, 2006) have played a significant part in the development of role theory training. Moreno believed that important relationships at a significant point or points in time engendered certain behaviours. These behaviours were learnt and stemmed from the fundamental unit, the family. Role theory provides a framework on which to reflect on the impact of personality and roles we assume in our on our day-to-day relationships with people. Different roles such as “regretful apologizer, ashamed mistake maker or defensive self-justifier” are employed in response to the current environment (Consedine, 2005, Role Theory, Para 2).

During supervision, through the skilled questioning of the supervisor, the supervisee is assisted to analyse these reactions and their origins. The opportunity then presents itself for the supervisee to release those past influences, to move forward igniting varying and exciting creative options and ways of relating to, and working with clients (Consedine, 2005). According to Cowie (2011), within the CDHB Specialist Mental Health Service (SMHS), role theory is one of the major frameworks that is used, together with Heron’s Six Category Intervention Framework established in 1975 (Heron, 2001).

Heron’s framework is an evaluative tool that can assist the supervisor in the review process post-supervision session (Morrell, 2003). It has also been influential in examining the nurse-client relationship. The framework includes a supportive intervention whereby attentiveness and affirmation are key characteristics. The cathartic intervention encourages the expression of emotion whilst the catalytic enables reflection. On the one hand, prescriptive interventions offer advice and suggestions thus imposing these views onto the client. On the other hand, the informative
intervention presents new and relevant information to the client, whilst a more confrontational intervention questions existing habits of mind and explores differing options. For both the supervisor and supervisee these interventions help to conduct the assessment of interpersonal interactions and enable more effective supervisory conversations to take place (Morrell, 2003; Sloan, 2007).

**Process based frameworks**

An overall guide to the structure of a PS session, for example the TAPES framework (Clarkson, 1992), has been designed to help conduct the supervision session. In addition, this framework provides a post session evaluation tool. The theory aspect concentrates on the need for theoretical background information and assessment of knowledge levels when reviewing client situations, whilst the assessment and intervention planning stage addresses the analysis of the situation and the resulting action plan. The parallel process relates to the dynamics between supervisor and supervisee, whether or not this relationship is mirrored in the supervisee and client relationship. Ethics and professional practice tackles the delivery of the correct approach (O’Donaghue, 1998; Frawley-O’Dea & Sarnat, 2001) according to codes of conduct and/or client rights (Clarkson, 1992). The final category concentrates on the outcomes of interventions used and the alternatives available. This framework has formed the basis of the CDHB public health nurses’ (PHN) PS training in the past, however, today other courses that provide a variety of frameworks are available for PHN’s to attend (A Clarke, personal communication, October, 10, 2012).

**Reflection and reflective frameworks**

Whilst process based frameworks have been structured to help steer the overall supervision process, reflective frameworks are seen as an integral part of the more specific analytical process that occurs during a supervision session. According to Driscoll (2007), all PS involves reflection to a greater or lesser extent. The author concedes, in a similar vein to Peniket and Ghaye (2007), that reflection can also stand alone as a single entity. However, Haigh (2000) and Teekman (2000) assert that there is a realisation that all humans reflect on experiences by comparing, contrasting, recognising similarities and differences, and questioning themselves about their role and reactions to a given situation. Moon (2004) concurs with this belief. Nevertheless, she cautions that this may not always be carried out on a conscious level or even when requested.
Reflectivity or self-reflection (Orchowski, Evangelista & Probst, 2010) is undertaken on an individual basis, however, Teekman (2000), Haigh (2000) and Moon (2004) caution that self-reflection can vary in quality. This was evident from Teekman’s (2000) qualitative study of ten NZ registered nurses (RNs). The results demonstrated that while the RNs reflected when preparing for action or a procedure, and evaluated their performance in terms of competency after the event, few thought about reflection as a means of furthering their knowledge or learning. Only a small number of the participants looked beyond self and the client to inquire critically as to why they practise in a certain way, or how contextual issues impact on their practice. According to Teekman (2000), it is through the ability to self-question that movement from problem-solving to prevention of issues or difficult situations can occur. It is the development of these anticipatory skills that has greater transferability to other situations.

For this development to occur, Brookfield (2000) claims that there is a need to move beyond reflection to critical reflection. The two are different and render varying outcomes. Reflection may provide options and ultimately a decision based on existing assumptions. However, according to Moon (2004) critical reflection presents the opportunity for deep learning whereby internalised existing knowledge, often coupled with emotion, is reorganised and represented as a new frame of reference. New learning occurs and paves the way for a further external learning experience. In saying that, Moon warns that critical reflection on internalised knowledge can be like an unbroken cycle causing further turmoil, often without the opportunity to reframe points of reference or extend learning.

It is with the opportunity for external experiences that further reflective learning is triggered, particularly in instances where critical friends, or a supervisor, assist the individual to process the experience, rather than it remaining internalised. A more extensive critical approach to reflection challenges power dynamics within the situation and existing assumptions that are impacting on the wellbeing of the individual person and others in their practice or workplace (Brookfield, 2000).

Reflection on practice according to Schon (1987) comes in two forms: reflection-in-action and reflection-on-action. On the one hand, reflection-in-action happens during the work causing a break in the action to assess what is happening and providing the opportunity to re-evaluate before moving forward. This ability to call on existing knowledge with flexibility, enables us to function and perform our duties
throughout the day. Reflection-on-action, on the other hand, occurs after the event when time is afforded to critically analyse an experience with the opportunity to develop new learning. New knowledge—once utilised regularly—may then be called on when ‘reflecting-in-action’.

Reflective frameworks provide a structure to assist adults to critically reflect on practice. The process of reflection can empower nurses to explore and analyse their role in nursing actions and practice, through the use of questioning, creating the opportunity for greater self-awareness, understanding, new knowledge and change in practice (Driscoll, 2007b; Lynch et al., 2008).

Kolb’s Experiential Learning Cycle (Kolb, 1984) is a renowned reflective framework. The cycle provides a staged approach looking at how we learn from experience. One stage, depending on the style of learning, involves active participation in the ‘concrete’ or practical experience. Alternatively, some learners may prefer to begin the learning process with ‘reflective observation’ of the action. Others would rather have a theoretical understanding through the process of ‘abstract conceptualisation’ before being involved in a new experience. At the other end of the spectrum, there are various learners who will use ‘active experimentation’ as a way of commencing their learning (Baker, Jensen & Kolb, 2005; Moon 2004). Although, Atherton (2011) proposes that, for learning to occur, the supervisor, mentor or teacher need to guide the learner or supervisee around the cyclical process thus enabling the development of further knowledge. In PS this framework can be utilised commencing with the ‘concrete experience’ as the point of entry in the supervision conversation (Zorga, 2002).

Kolb’s Experiential Learning Cycle (Kolb, 1984) continues to be adapted by other experts in the field of PS (Bond & Holland, 2010) along with another reflective framework: the What? Model of Structured Reflection, designed by Driscoll (1994, as cited in Driscoll, 2007b). The focus of Driscoll’s framework is the development of exploratory questioning skills to steer the reflective process as a supervisor or teacher. This framework provides a series of useful questions to stimulate reflection on the experience, the analysis of the experience and the follow-up action.

**Work-based learning, critical reflection and professional supervision**

Whilst the discussed frameworks are useful in guiding reflection on experience, Boud (1993) suggests that certain factors influence the knowledge uptake, interpretation
of and the resulting actions from that experience. Past learning experiences, both good and sometimes flawed, may conjure up different emotions and impact on cognitive abilities determining whether or not, or how, new knowledge is transformed into action. The context of where a certain learning experience is situated and with whom, whether it be a group or one-to-one, can also influence an opportunity to gain new knowledge. Levels of fatigue, habits of mind, an unwillingness to change and a fear of knowledge deficits being discovered are other limiting reasons for the failure to engage in reflection (Carroll & Gilbert, 2011).

Interestingly, on the one hand, the term ‘experiential’, referred to in the above reflective frameworks, has been brought into contention by experts in the education field (Moon, 2005; Carroll & Gilbert, 2011). They contest that there is a difference between ‘experiential learning’ and ‘learning from experience’. From their point of view ‘experiential learning’ is the unconscious process of gaining knowledge through experience. On the other hand ‘learning from experience’ is where an experience has been set up as a learning opportunity in the workplace rendering the learning as part of a conscious process.

Work-based, or alternatively life-long learning is also seen from different vantage points. For some, work-based learning is seen as training on the job resulting in the ability to perform certain procedures and skills. However, for others this form of learning stems from real-life work experience and is assimilated with theoretical knowledge and reflecting on work experience (Williams, 2010). Davies and Beddoe (2010) and Zorga (2002) perceive PS to be a process whereby the learning, developmental and supportive elements assist supervisees—through the reflective process—to gain insight from their experiences on both a personal and professional level. This in turn assists with problem solving, decision-making skills and developing resilience necessary to function at a high level within our constantly changing workplace environments (Consedine, 2004b; Lilyman, 2007; Wilkinson, 2004).

Carroll (2009) puts forward the idea that what supervisees present in a supervision session is often ill-structured problems with no automatic answers and where solutions are not clear-cut. He sees supervision as a time to consider options through examination of our existing knowledge, intuition and the emotions surrounding the issue. In addition, supervision offers guidance in the sifting and sorting of ideas bringing our creative edge to the forefront, recognising learning and how to apply the subsequent new knowledge to practice (Bond & Holland, 2010).
To improve and maintain the quality of reflection, Driscoll (2007) alleges that PS offers the opportunity to explore practice with a supervisor who provides an environment that supports the supervisee to transform workplace experiences into new learning through artful questioning (Davys & Beddoe, 2010). Reflective frameworks can be utilised, by both supervisors and supervisees, to guide the supervisee’s own intuitive reflective process (Bond & Holland, 2010) and encourage exploration of situations or practice in greater depth.

Being able to reflect on practice, as acknowledged in Chapter One is a necessary skill for nurses to ensure continual evaluation of practice and the delivery of a high standard of care (Consedine, 2004b; NCNZ, 2007). However, as discussed previously, a person’s ability to reflect may differ for varying reasons and therefore the opportunity to be involved in PS may in turn assist in the development of those reflective skills. According to the following studies, PS has assisted nurses to reflect on their practice more effectively. In the Teasdale and Brocklehurst’s (2001) mixed method study of 211 medical and surgical nurses, based in the United Kingdom (UK), the learning gained from reflection was found to be helpful in the management of challenging situations. In addition, Williams and Irvine (2009), in another UK qualitative study of 12 supervisors, from community settings, accredited PS with encouraging nurses to reflect and learn from practice. Furthermore, Hyrkas, Koivula, Lehti and Paunonen-Illmonen (2003) in a qualitative study of 15 nurse managers recognised that PS aided in the group process of reflection in tandem with the giving and receiving of support. These studies indicate that the process of reflection may be beneficial to learning from practice.

However, Taylor (1998) purports that reflection does not rate highly as an accepted method of learning for everyone. He suggests that participants find the process difficult when reflective learning involves challenging our existing belief and value systems, emotions, and ways of practising. Rolfe (2002, p.21) also suggests that “experiential knowledge gained through the reflective process finds itself at the bottom of the hierarchy of evidence on which to base practice” and is regarded as such by most academics. Nevertheless, Williams (2010) states in her review of the literature that, despite the drive towards academic advancement in nursing, recent classroom or traditional methods of teaching of nurses has not delivered the improved standards of practice or client care that were hoped for. Zorga (2002) and McCormack and Slater (2006) concur with this viewpoint acknowledging that there is a need for work-based models that augment traditional classroom teaching and that promote life-long learning.
that goes beyond the personal and professional development of the nurse. Williams (2001) and Zorga (2002) believe that through the process of critical reflection, the resultant new meanings can transform learning into a high level of well-managed action. This could be likened to the practice of critical thinking whereby cognitive patterns are broadened through evaluation of emotions, reflection and critical analysis of current knowledge, generation of options and assimilation with procedures and protocols pertaining to a given situation (Daly, 2001; Rubenfeld & Scheffer, 2006). Self-reflection, which is encouraged through the Socratic questioning, is utilised by supervisors in PS and is noted to be instrumental in developing critical thinking and enhancing decision making processes (Rubenfeld & Scheffer, 2006; Orchowski et.al., 2010). Supervision provides an environment that supports the restorative, formative and normative functions thereby acting as an accelerator in the development of personal and professional growth (Zorga, 2002).

To date, the premise is that PS improves practice through increased problem solving abilities and a more holistic approach (Jones, 2003), enhanced organisation of care (Cheater & Hale, 2001) and improved interactions with clients (Lakeman & Glasgow, 2009; Mernick, 2009). However, the evidence remains limited. In saying that, both White and Winstanley (2010) and Lynch et al. (2008) purport that, through the provision of structured, high quality, effective supervision underpinned by a culture that supports PS, benefits to practice and clients have been realised.

Considering the need for a functional structure, as mentioned previously, Cowie (2011) stresses, from his qualitative study that a foundational framework, supervisory knowledge based on that framework and organisational support for the process of PS are all crucial elements in creating an effective supervisory milieu. In addition, Saunders (2010) found in his recent systematic review of the literature that there was consensus amongst the experts that some form of structural framework is necessary if PS is to render benefits.

**The activities of professional supervision**

The process of supervision involves a series of activities, as mentioned in Chapter One, that assist in providing the scaffolding on which to structure PS. These activities include training of supervisors, establishing the supervisory relationship, developing a contract and supervision session topics.
Supervision training

According to Gilmore (2001) the quality of the training that supervisors receive can ‘make or break’ the success of supervision. Gilmore acknowledges that PS requires specific skills and suggests that inadequate supervisory training will not bring about the desired outcomes for the supervisees or for the organisation in which they work. The supervisor requires the ability to develop reflective skills in supervisees, be able to challenge, support and provide constructive feedback. They need an awareness of and an ability to cater for cultural needs incorporating gender and sexual orientation. A proficient supervisor also recognises the requisite for an adult-centered learning approach to supervision and the importance of life-long learning (Epling & Cassedy, 2001). Van Ooijen (2003) is more specific in her outline of supervisor attributes which include: boundary keeping, active listening, providing empathy, support, ability to challenge in a supportive manner, facilitating professional development, providing feedback and making the supervisee feel valued and affirmed.

To date there is limited empirical evidence on the effectiveness of training schemes (Gilmore, 2001; Sloan & Fleming, 2011). However, Kilminster, Jolly and Van de Vleuten (2002) suggest that an overview of adult learning, supervision frameworks, processes, functions, purposes and the key components for effective supervision are essential content where a selected model does not provide the scaffolding on which to frame a programme. It is also suggested that this content is supported by empirical data and the opportunity to acquire effectual supervision skills. In addition, van Oojien (2003) proposes that supervisors need instruction on how to role model reflective skills such as the thinking, the questioning, hypothesising and referring to evidence based practice.

Lynch and Happell (2008), in their qualitative study of seven members of a supervision steering group within the Australian rural mental health sector, provided feedback on an external four-day information course. The course covered legal and ethical aspects of supervision and models and information on organisational implementation. There was a mixed response to the course as some felt that external providers allowed there to be more honesty regarding the organisational culture, whilst others felt that external trainers’ situational understanding was limited. It was also recognised that management needed to be the first attendants of the course if they were to be the supporters and initiators of this organisational change.
In the Te Pou (2010) qualitative and quantitative study of NZ mental health and addiction nurse-supervisors and supervisees (n=11), supervisors reported that it was the delivery of the content through modelling, role-plays and experiential learning that were most useful in comparison with the necessary didactic theoretical component. Participants’ assessment of the usefulness of the following content was rated as ‘satisfied’ to ‘very satisfied’. The information covered included: defining PS, the fit of cultural supervision with professional supervision; the restorative, formative and normative functions of supervision; ethical responsibilities, the supervisory relationship, learning styles, supervision skills and structuring and evaluating the PS.

In addition, ongoing updates and supervision for supervisors were acknowledged as essential for the sustainability of efficacious supervision in the Cooper and Anglem (2003), Sloan (2006), Te Pou (2010) and White and Winstanley (2010) studies.

**The supervisory relationship**

According to Cooper and Anglem (2003), Sloan (2005) and Bond and Holland (2010), an effective working relationship between supervisor and supervisee, along with creating the best possible training for supervisors, is imperative to the success of PS. Cooper and Anglem suggest that the following factors are essential for the development of a successful relationship: “trust, honesty, respect, commitment, integrity, willingness to learn, boundaries, and promotion of empowerment and enablement” (p.8).

Furthermore, Bond and Holland (2010) together with Power (2007), propose that enabling the supervisee to select their own supervisor, coupled with a negotiated contract, provides a strong framework on which to build this relationship. However, Bond and Holland recognise that a complete choice of supervisor by a supervisee is difficult in a large organisation where the number of supervisors is often limited. Nevertheless, they stress that the supervisee has the right to negotiate a change of supervisor if the relationship is problematic and limits in-depth reflection on practice.

Supervisor attributes and professional expertise are also factors that need to be considered in the selection process. According to Bond and Holland (2010) the following factors are very important in the choice of an effective supervisor: skills that facilitate in-depth reflection; professional expertise that could be useful to the supervisee; complete confidentiality and someone who is not a personal friend. More specifically, Kilminister and Jolly (2000) believe that supervisors should be able to
“provide guidance, link theory to practice, facilitate joint problem solving, offer constructive feedback, reassurance, empathy and support” (p. 834). A further attribute is good listening skills (Sloan, 2005). In addition, Hawkins and Shohet (2009) see the necessity for supervisors to be able to use a variety of supervisory interventions and be broad-minded thus enabling them to see situations from a wide range of perspectives.

The provision of emotional support, trust, shared values, confidentiality and knowledge were seen as essential in the role of a supervisor in the following studies. These studies included supervisors (n=4) interviewed in the Finnish study of Berggren and Severinsson (2003); community based nurses (n=283) in Leicestershire, UK (Cheater & Hale, 2001); and nurses (n=738) from adult, child and learning disabilities and mental health also from the UK (Davey et al. 2006).

In moving the development of the relationship forward, Te Pou (2009) proposes that the supervisees need to take time to deliberate over the purpose of their supervision, what they want in a supervisor, other than certain personal qualities, and the information they should gain from that first meeting prior to the commencement of supervision. The information sought might include supervisor experience in supervision, credentials, gender, ethnicity, and their specific supervision training, use of frameworks and their style (Cooper & Anglem, 2003; Power, 2007). Whilst there is a shortage of guidelines on how best to begin a supervisory relationship, Cheater and Hale (2001) state that the supervisors in their study were required to have a minimum of two years experience and a professional profile demonstrating reflective practice skills. Where there are no guidelines, Bond and Holland (2010) suggest that a good starting point is an open conversation between the supervisor and supervisee at a pre-supervision meeting.

**Contracting**

Providing an opportunity for discussion allows both parties to share goals, define boundaries, answer questions surrounding the supervisory relationship and lay out responsibilities before formulating a draft contract (Bond & Holland, 2010; Hawkins & Shohet, 2009; McKenna et al., 2008). Furthermore, Bond and Holland believe these measures allow for this relationship to develop on an equal footing thus alleviating anxieties that often exist in the development of a new professional partnership. However, before any decisions are made, it is suggested that a draft contract or agreement is formulated, considered, signed and a review date arranged (Bond & Holland, 2010; Te Pou, 2010).
This agreement or contract is used to establish a set of ground rules which may include the following elements: the aim of supervision, supervisory relationship boundaries, accountability, roles and responsibilities and a clear framework that outlines the general structure and content of the session (Driscoll, 2007; Lynch et al., 2008; van Ooijen, 2003). According to Power (2007) and Sloan (2005), deciding on a common purpose for supervision and the setting of mutually agreed boundaries are necessary for an effective and consistent relationship and are paramount when negotiating a contract. Clarification of the purpose is essential due to the broad scope of PS within nursing. The scale of supervision can include patient-client relationships, stress reduction (Sloan, 2005), the ongoing development of practice knowledge and skills, and the self-management of team dynamics (Lynch et al., 2008). This means that clear goals need to be outlined defining what is acceptable to bring to supervision and what is not. The general consensus from the literature seems to be that PS remains strictly within a work context (Bond & Holland, 2010; Driscoll, 2007a; Hawkins & Shohet, 2009; Te Pou, 2009) but broadly covering Proctor’s normative, formative and restorative functions (Bond & Holland, 2010; Driscoll, 2007a)—in other words—standards and competency, professional development and supportive purposes. With the purpose made overt it was interesting to assess from the available studies what supervisees actually would take to supervision for discussion.

**The professional supervision session**

Supervisee-led supervision can occur within a group or on an individual basis, but the choice of what is discussed lies with the supervisee. Usually these topics would fall within the following groupings: conflict within the work environment, concern surrounding a practice issue, self-esteem issues, or nurse-client relationships (Gilmore, 2001).

In the Cheater and Hale’s (2001) mixed method study of practice nurse-supervisees, the general focus for their supervision session was maintaining portfolios and practice issues. In Davey et al.’s (2006) evaluation of PS, from adult, child and learning disabilities and mental health diploma nurse graduates, there were mixed results on what they received and what they would like more of, in supervision sessions. For the majority, their learning needs were met in terms of setting goals and having the opportunity to discuss incidents. Others stressed that they needed more time to talk about work issues along with the opportunity to develop reflective practice skills and clinical skills. However, the majority believed that they had more than sufficient
supervision of practice and that the focus should be on evaluation, with smaller groups voicing the need for more feedback and advice on professional issues. Nevertheless, a high proportion of the participants felt that they were well supported and had the opportunity to have conversations that focused on client and staff relationships. In Ven Veeramah’s (2002) survey of UK mental health nurses (n=165), supervision was found to be both educational and supportive.

**Benefits of professional supervision**

To enable the delivery of effective supervision, and for potential benefits to be realised, organisational support for PS and the previously mentioned activities of supervision are necessary (Alleyne & Jumaa, 2007; White & Winstanley, 2010). Reviewing the literature uncovers research studies that portray the benefits of PS in relation to relief of stress, personal growth, job satisfaction and effectiveness (Hyrkas, Appelqvist-Schmидlechner & Haatajar, 2006). However, the categorisation of results is not standardised making the results confusing and inconclusive (Sloan & Watson, 2002; Buus & Gonge, 2009). As a consequence, both positive and negative findings have been reported (Hyrkas et al., 2006).

**Restorative benefits**

Most studies from 2001 onwards have provided evidence of a number of restorative outcomes whereby an increased sense of wellbeing, stress reduction, increased self-awareness and development and feeling empowered have been reported (Bond & Holland, 2010). Kalliath and Beck (2001) in a survey of NZ medical and surgical nurses (n=259) focused on the impact of PS on burnout and the resulting resignations from work. Their findings indicated that attending supervision may in some instances have lessened burnout and the desire to leave nursing. In Teasdale and Brocklehurst’s (2001) survey and evaluation of critical incidents from 211 UK nurses, randomly selected from 11 hospitals and community NHS Trusts, the supervised nurses valued the support and the feeling of being listened to by managers who were acting in the role of supervisors. These results were more evident amongst newly graduated nurses. Senior nurses preferred the more informal support of colleagues (Teasdale & Brocklehurst, 2001). In a further study, within the generalist sector of nursing in Australia, all groups across nine specialties were part of an evaluative research study that rendered high scores in the restorative domain (Brunero & Lamont, 2011). Finnish medical/surgical nurses (n=119 RNs) who were surveyed in a follow-up study from 2004 to 2007, noted being well supported by leaders, with supervision, covering the
interests of their health and well-being, and were encouraged not to feel guilt at leaving undone tasks on the ward. The participant’s self-esteem, self-awareness and ability to harness internal resources increased (Koivu, Hyrkas & Saarinen, 2012). Claveirole and Mathers (2003), in their evaluative study of peer group supervision amongst university nursing lecturers (n=12) from Scotland, found these participants benefitted from the emotional support and gained a sense of personal wellbeing as a result. Begat, Ellefsen and Severinsson (2005) similarly found, in their correlational, descriptive questionnaire involving Norwegian RNs (n=71) based in two community hospitals, that participating in PS improved both their physical well-being, levels of anxiety and coping mechanisms. Jones (2003), in a similar positive vein, reported that the five hospice nurses, in his UK mixed method study receiving PS, appreciated the affirmation and the feelings of being valued. Nevertheless, in yet another study, some practice nurses (n=283) in a UK supervision scheme had limited support from peers to enable participation. Those who were able to take part reaped the benefits of collegial support, stress reduction, increased confidence, motivation and assertiveness (Cheater & Hale, 2001).

Cleary and Freeman (2005), in their ethnographic interview of ten Australian mental health nurses, reported that support increased confidence, self-awareness and work satisfaction as key restorative outcomes. Lakeman and Glasgow (2009) found similar results in their research involving two groups of five mental health nurses from Trinidad. A UK questionnaire, with both quantitative and qualitative questions involving learning disability nurses (n=35), rendered mixed results. Sines and McNally (2007) established that for a quarter of the participants PS assisted with the management of stress, and for just under half confidence levels were improved. However, in terms of support, Cleary and Freeman acknowledged that their participants had a preference for informal, ad hoc support owing to time constraints and staffing levels making release time to attend PS difficult. In another Australian study of mental health nurses (n=165), a randomised controlled trial across nine locations revealed that the only significant finding was increased well-being (White & Winstanley, 2010). A Danish study, on nurses from nine psychiatric wards and four community MH centres (n=136) who completed several questionnaires, correspondingly produced evidence of improved overall health and job satisfaction (Gonge & Buus, 2011).
**Formative benefits**

Some of the previously mentioned studies also rendered formative results that were inclusive of reflective practice and professional and practice-based knowledge skills (Bond & Holland, 2010). In Cheater and Hales’ (2001) study communication and organisational skills coupled with creative care-based options for clients were noted outcomes. These results were mirrored in studies by Claveirole and Mathers (2003), Hyrkas, Koivula and Lehti (2003) [a qualitative group interview research of nurse managers (n=15)] and Jones’ (2003) study. Teasdale and Brokkehurst (2001) reported that skills to manage challenging behaviours were further developed through reflection on practice. These results were similar to those of another UK mental health survey (n=165) whereby the overall perceived improvement in the delivery of care was highlighted (ven Veeramah, 2002). Reflection and learning were also positive outcomes of supervision for UK acute and community based supervisors (n=12), as noted from their focus group interviews (Williams & Irvine, 2009). Sines and McNally (2007) noted that for some of their 35 participants, independent thinking and more effective decision making skills were positive outcomes. Another study, not previously mentioned in this section, is the NZ survey of mental health and addiction nurses of whom 11 were supervisors and 16 supervisees. In this study improved clinical skills, practice, documentation, knowledge base, ethical awareness and enhanced relationships were listed as reported formative outcomes (Te Pou, 2010).

**Normative benefits**

Research on the normative domain, which focuses on quality, standards and accountability (Bond & Holland, 2010) in comparison with restorative and formative benefits, has proved to be more limited. Jones (2003) and Brunero and Lamont (2011) stated that in supervision conversations stemming from their studies, there was a focus on practice standards, models of care and competencies. In the Te Pou (2010) study PS was found to heighten the participants’ awareness of organisational risk management and the need for adherence to procedures.

Whilst these studies have produced notable benefits, considerable barriers to the process, and in the activities of supervision, came to light. These include: the need for overall support for PS at all levels (White & Winstanley, 2010); difficulties with the standard and varied training for PS, and structured programmes (Brunero & Lamont, 2011; Williams & Irvine, 2009) financial constraints (Brunero & Lamont, 2011; White & Winstanley, 2006); confidentiality issues within a group format (Cleary & Freeman,
2005); and the precarious position of the manager as supervisor (Williams & Irvine, 2009). These were all considered to negatively impact on the effectiveness of supervision. These barriers have been enlarged upon in the final chapter when comparing the findings from this study with existing literature, and where further recommendations are proposed.

**Conclusion**

The review of the literature on the activities, effectiveness and benefits of PS, since the year 2000, has not made it easy to come to any general conclusions regarding the outcomes of supervision. Dogged with wide variations in terminology, research areas, topics, number of respondents, research tools, methods used and with such a broad range of expert opinion, PS is an ongoing conundrum. Nevertheless, what is evident is that there is a move away from managerial supervision to supervisee-led supervision, with more work and education required surrounding supervision for Māori and for differing ethnic groups within NZ. The literature overall supports the notion that PS involves a trusting supervisory relationship with a foundational contractual agreement that underpins effective supervision. Training in supervision is another proposed key component of successful supervision. Nevertheless, PS training is currently unregulated, without set standards or guidelines and utilises an eclectic mix of frameworks. In saying that, reflective frameworks provide the scaffolding on which most supervision sessions are based.

Evaluation of the impact of contextual factors such as length of time one has been in receipt of PS, supervisors that are internal or external to the service and the format of supervision, seems to have rendered inconclusive results to date. Nonetheless, some evidence exists that efficacious PS has afforded an increase in nurses’ well-being enabling the nurses to develop both personally and professionally.

There remains a dearth of literature documenting the effect of PS on practice and client outcomes. Further research addressing this gap, the supervisory relationship, implementation activities and the factors that influence the efficacy of PS is called for.
Chapter Three: Research Methodology

Introduction

In a quest to describe how the study aims have been met, this chapter discusses the research process. It begins with the development of the initial research question, followed by discussion on the choice of a descriptive survey design, the data collection procedures, and the analysis processes utilising both quantitative and qualitative methods. The ethical considerations and the methodological limitations have been interwoven throughout this discussion.

Rationale for choice of a descriptive methodology

In the first chapter, whilst outlining the context for this study, I expressed my interest in finding out what was currently happening for nurses involved in supervision in the Canterbury region. I was curious to know about the demographic details of nurses who participated in professional supervision. What form did their supervision activities follow, were the activities effective and what were the benefits gained from their PS? With this in mind, the following research question was developed:

“What are Canterbury nurses’ perceptions of the activities, the effectiveness and the benefits of professional supervision”?

According to de Vaus (2002), Leedy and Ormond (2005) and Patton (2008), the chosen question was descriptive in nature because it asked ‘what’ was currently happening, as opposed to ‘why’ something has occurred, to a particular population group. Given the concentration on the ‘what’ aspect, this research study has provided a factual account of the perceived experiences of supervision for nurses from a wide variety of nursing specialties. In view of this, a survey approach was utilised as it offered the most structured way of presenting descriptive detail from the collected data (Roberts & Taylor, 2002). A survey designed by Dr Lesley Cooper, Flinders University, Australia, and Jim Anglem, University of Canterbury, was adapted for this study (Cooper & Anglem, 2003). The survey was originally utilised in a 2001 research study examining the workforce needs of staff engaged in PS in the Mental Health Division of Healthlink South, now part of the Canterbury District Health Board.

A descriptive approach provides further information by describing phenomena or characteristics of a specific population group in detail (Burns & Grove, 2005;
Knupfer & McLellan, 2001; Leedy & Ormond, 2005; Tolich & Davidson, 2003). De Vaus (2002, p.18) stresses that descriptive research is valuable and is used widely to provide information from census studies, opinion polls, sociological studies and educational research (Knupfer & McLellan, 2001).

According to Elliot (2003) and Roberts and Taylor (2002), formulating the research question is the initial step in the research process. In addition, Burns and Grove (2005) purport that the research question sets the scene for establishing a purpose for the study. I believed, as a beginning researcher, that a study focusing on the variables surrounding the activities of supervision, within a group (Borbasi, Hengstberger-Sims, & Jackson, 2008) such as Canterbury nurses, would provide further information on professional supervision from a regional perspective. Also, if results were replicated in line with national and international studies, this may serve to offer additional knowledge on current and ongoing trends in supervision. Furthermore, specific demographic information on participants, together with the perceptions of this group of nurses around the activities, effectiveness and benefits of PS, could in turn help nurses and healthcare professionals who have an interest in setting up or accessing supervision, or who are currently involved as supervisees, or supervisors, or both.

To capture the information outlined above I selected the most appropriate research design. Given that there were a large number of supposed participants involved in professional supervision from different areas, or case groups, in nursing, a survey seemed to offer the most appropriate means of collating this information.

Survey research design

Through describing and interpreting this location-specific information, I built a picture of the current status (Walliman, 2010) of supervision. To summarise this information, surveys offered a structured way of presenting the descriptive detail from this study (Roberts & Taylor, 2002). The term ‘survey’ can indicate variability or changes in characteristics of different case groups and enable group comparisons by putting forward this information on a “data grid” (de Vaus, p.3, 2002; Leedy & Ormond, 2005). According to de Vaus, this information can be collected in a variety of ways. This includes not only questionnaires, which more often than not are aligned with surveys (Burns & Grove, 2005), but also from interviews, case observation and retrieval of information from old notes. However, it is the collection of data from a specific
population through “self-reporting” (p. 239), and its presentation on a grid, to enable a comparison between case groups, which is specific to survey research (de Vaus, 2002).

The grid can be utilised to provide a summary of participant information presenting it as percentages, frequencies and other more complex statistical indices. Inferences about the participating population are then described (Leedy & Ormond, 2005). In addition, Sandau and Halm (2011) suggested that short answer questions within a survey can expand on the numerical information. The text answers were entered onto the data grid so that all records were kept together, but later posted into a word document for thematic analysis and coding. This supplementary information was not converted into numerical form for entry onto the data grid, as is a requirement of surveys according to de Vaus (2002) and Leedy and Ormond (2005). Therefore, the name survey-questionnaire was a preferable term owing to the qualitative component. However, for reasons of ease and word limit requirements, the word ‘survey’ was utilised interchangeably with survey-questionnaire.

Surveys provide important data and information, but despite this, such non-experimental, self-reporting methods are often viewed by some within the scientific community as simplistic and narrow forms of research (Burns & Grove, 2005; Leedy & Ormond, 2005). In their defence, Leedy and Ormond (2005, p.184) state that designing your study using a survey places “critical demands on the researcher”. It is imperative that the descriptive survey researcher recognises that the research findings illustrate only a snapshot in time within an ongoing activity. Therefore, generalisations extending the research outcomes to a greater population, or period of time, need to be made with caution as they would be purely speculative. The researcher also requires an awareness of the issues around self-reporting. The accuracy of the participants’ memories, their personal beliefs, the requirement for on-the-spot answers, current issues with the activity, or wanting to provide a positive rather than a true response for the benefit of the researcher, are all limitations of surveys that need to be taken into account.

Having made the decision that a descriptive survey design would be suitable for this research study, I chose to use an existing survey. I was already familiar with two surveys: the Manchester Clinical Supervision Scale (MCSS) and Cooper and Anglem’s (2003) Clinical Supervision in Mental Health (CSMH) surveys. Whilst the MCSS survey is internationally recognised (White & Winstanley, 2006), the cost of acquiring permission to use this survey was prohibitive for a student study. Therefore, permission
was sought from and granted by Professor Lesley Cooper, Flinders University, and Jim Anglem, University of Canterbury, to use their survey-questionnaire.

The CSMH survey covered all the areas that I was specifically interested in. These areas included demographic information, activities, effectiveness and benefits of professional supervision. Activities, as previously mentioned in Chapter One, could be construed as training, contractual arrangements, session contents and the supervisor’s style. The survey was designed to draw information from both supervisors and supervisees and would provide the information sought in my research question. The questions were predominantly quantitative in nature, with qualitative short answer questions providing additional information, and would be subjected to two different forms of analysis.

The selected questionnaire was a quantitative survey comprised of closed and Likert style questions supplemented by some short answer qualitative questions embedded throughout the survey. The quantitative and qualitative data were collected concurrently making this study pure survey research and not mixed methods whereby data are collected sequentially in different phases of the research process (Cresswell, 2009). According to Morse, Wolfe and Niehaus (2006, p. 68), using a supplementary qualitative strategy provides “additional information about aspects of the phenomenon that is necessary to address the research question”. However, the above authors advise the researcher to be aware of the principles and the limitations of each method, and of how the intertwining of two methods of analysis can have an impact on the validity of the research. Cresswell suggests that the integration of two approaches calls for careful consideration as to how the results of the analysis are merged, or compared, to avoid inaccuracies. In addition, the power imbalance between the two methods of analysis—given the greater importance of the quantitative findings—may result in challenges when interpreting results in the final stages of the research process.

When addressing the principles of the primary quantitative approach, in a conventional sense, this form of research provides hard, descriptive, empirical evidence. This is measured by the strength of the relationship between variables, in a numerical form, which in turn determines the level of support (de Vaus, 2002; Tolich & Davidson, 2003) for the hypothesis, or a prediction regarding an expected outcome from the study (Borbasi, Hengstberger-Sims, & Jackson, 2008). In the initial stage of planning this research study a hypothesis was developed stating Canterbury nurses involved in professional supervision view the process of supervision as beneficial for nursing
practice; and personal and professional effectiveness. However, in this descriptive study such testing was not undertaken.

Qualitative research, in comparison, affords rich data from often a culmination of “interviews, written case studies, observation, and documents” (Cresswell, 2009, p.175) about living human beings’ experiences that add depth and meaning by providing greater detail and context (Patton, 2002). This type of research is often criticised because of the resulting subjective interpretations and lack of ability to generalise from the conclusions (de Vaus, 2002). In the survey designed by Cooper and Anglem (2003) the open-ended questions served to provide examples of, or further information to embellish, the preceding closed questions.

Having recognised that the Cooper and Anglem (2003) survey-questionnaire would involve two methods of analysis, it was important for me, at this stage, to address the feasibility of carrying out this study. Practical aspects such as: establishing the population of nurses involved in supervision in the Canterbury region; time, cost, experience, distribution and collection of questionnaires; as well as the interpretation of the data, all needed to be considered (Leedy & Ormrod, 2005; Roberts & Taylor, 2002).

**Preparation for the research study**

The survey had been “trialed by several professionals and reviewed by a statistical consultant at Flinders University” for the Cooper and Anglem (2003, p.15) study. The participants included interdisciplinary mental health care practitioners, working in the CDHB and two private trusts, in Canterbury. The next consideration and critical starting point was the question of how to scope the population of nurses involved in PS as I needed to know the potential size of this study when considering the feasibility. This aspect was discussed with my supervisors and a statistician, Associate Professor Elizabeth Wells, from the University of Otago. A decision was made from this meeting to target all nurses receiving supervision, as supervisees, through their supervisors. This seemed to be a workable option. Known supervisors were contacted through Directors of Nursing (DONs), managers, coordinators, supervision businesses and the Canterbury Supervision Directory. The Council of Social Services (COSS) oversees the Canterbury Supervision Directory. A notice was put in the monthly COSS news advertising the research study with my contact details, and asking the following questions:

1. Do you supervise nurses?
2. If so, how many?

A letter was also sent to DONs, managers, coordinators, supervision businesses asking the above questions. This scoping exercise rendered a purposive sample of 474 potential participants. In purposive sampling, as the name suggests, a population was chosen for the purpose (Leedy & Ormrod, 2005) of providing information on nurses who are receiving and providing supervision in the Canterbury region. Having established the approximate population of Canterbury nurses involved in supervision, the study proceeded with the assurance of resource support for costs of a postal survey, and statistical and supervisory assistance from the University of Otago.

Survey population

As a result of the scoping exercise, 389 nurses involved in supervision were targeted as potential participants from the following areas: Canterbury District Health Board (CDHB) Mental Health Division, Public Health, Plunket and a private mental health trust. However, at this stage the remaining 85 potential participants’ workplaces were unknown as a result of the private supervisors providing only the number of nurse-supervisees that they supervised. Granted that the number of potential respondents was known, and undertaking the research study was proven to be feasible, the chosen survey was then examined and adapted to fit with the information sought.

The survey questionnaire

The Cooper and Anglem (2003) survey was designed to provide demographic information on supervisees and supervisors, purpose, structure, process and effectiveness of professional supervision. Using this same survey questionnaire, I attempted to narrow the focus to be able to manage the large amount of data, from such a broad-based survey, within the timeframe and scope of a masters thesis. For the purposes of this study, the demographic information I collected, covered the following aspects:

- Supervisees: main current employment setting; current nursing practice for which supervision is received; gender, age group, years worked in nursing; highest professional qualification; ethnicity; geographical area; funding of supervision and the format.
- Supervisors: as reported by supervisees: gender, age group; years practised as a supervisor; supervisor’s latest supervision qualification; supervisor’s highest
qualification; supervisor’s attributes, supervisor’s position and relationship to the service.

I was also interested in the variations within the different activities involved in professional supervision as outlined in the questions below.

**Supervisees**

- Did the supervisee’s choose their supervisors?
- What type of contract was formed between supervisor and supervisee, and what was covered in their contracts?
- What were the supervisees bringing to discuss in the professional supervision sessions?
- Was the line manager or the service monitoring the process of professional supervision?
- How often and for what period is professional supervision occurring?

**Supervisors**

- What was the content of the supervisor’s training?
- What did the supervisors perceive the purpose of their supervision sessions to be?

To complete my research it was important to establish how effective the whole process of professional supervision had been for the nurse-participants involved in this survey. Furthermore, I also wanted to establish the nurses’ perceptions of how receiving and providing supervision benefited clients, the service and the organisation, and how the quality of supervision could be assured.

The Cooper and Anglem (2003) survey questions encompassed the information I required, however, some additions and minor changes were made. The survey was to be anonymous so the name space was removed. Questions were adapted to refer to nurses only, with their work areas being changed from specific to a choice of supplying general employment and type of nurse’s practice. Geographical areas were also included. These questions were added to the survey in the same format as is used in the guide for completing practising certificate applications (NCNZ, 2007, p. 2-3). The supervisor’s profession was omitted, as this would be included in the one line space when stating their position. An additional question was entered on the funding of supervision to
assess how many participants were receiving supervision that was paid for by their workplace. The last change was to remove the cultural supervision section, as I felt that this would include the exploration of another dimension to professional supervision, external to my purpose. Nevertheless, the closed questions on the content of both contracts and supervision sessions incorporated an opportunity to select “cultural issues” or “cultural supervision” as part of the content.

The format of the questions remained unchanged in the survey. The layout consisted of a combination of fixed responses, Likert scale closed questions, and twelve open-ended short answer questions. These question types have both positive and negative aspects. Fixed response questions do not always provide sufficient choices to allow for participants’ true opinions to be indicated. However, they take limited time to answer, can be self-administered and are easier to code for analysis. Alternatively, the Likert scales, allow for slightly more variation of opinion or attitudes with the choice of a number, on a horizontal rating scale from (1) to (5) for each question (de Vaus, 2002).

The semi-structured, short answer, open-ended questions presented even more scope for participants to put forward their opinions and ideas and provide further information in their own words (de Vaus, 2002). While this form of question does not provide the depth and meaning that stem from focus group interviews (Patton, 2002), if time is restricted, they certainly augment quantitative data (Sandau & Halm, 2011). Nevertheless, motivation by the respondent is always required to complete the questions. Articulation of the written responses may also be variable, and therefore coding, thematic analysis skills, and an unbiased and objective researcher are required for validity to be maintained (de Vaus, 2002). Validity is also in jeopardy given the two differing and unbalanced forms of quantitative and qualitative analysis required (Morse et al., 2006).

The length of the survey-questionnaire, being 60 questions for supervisees and a further 11 questions for supervisors, and the clarity of the questions for nurses, also needed to be considered. According to Boynton (2004) and Leedy and Ormond (2005), short surveys constructed to elicit only information that is pertinent to the study, with clear questions and interesting presentation, are some of the key guidelines when constructing a survey. The Cooper and Anglem (2003) survey-questionnaire was noticeably long which may have discouraged the participation of busy nurses. However, with surveys often rendering low response rates as a consequence of these factors,
Bartley (2003) suggests using a greater sample than what is required to be representative of the population being studied. By targeting all nurses involved in supervision in the Canterbury region, even with a low return rate, I was hopeful that information provided from the surveys would reach sufficient power to answer my research questions.

Data collection

The distribution of the survey-questionnaires required careful planning owing to the number of large organisations and private supervisors involved. As the researcher, I required the ‘buy-in’ from the managers, coordinators and private supervisors to draw participants’ attention to the study and assist with the distribution process. On receipt of ethics approval, a further letter was sent to this group thanking them for previously indicating the number of nurses they knew to be involved in supervision. An appointment was made to discuss, and to deliver the questionnaire packages and the poster, to promote this research. The poster extended an invitation to participate in the research study and supplied the names and contact details of my supervisors and myself as the researcher should there be any questions regarding the study.

The questionnaire packages included the information sheet, a consent form, the questionnaire (see Appendices B, C and D) and a stamped, addressed envelope (SAE). The information sheet outlined the rationale for the study as part of the Master of Health Science degree and invited nurses in the Canterbury region, who were involved in professional supervision, to participate in this study. The cover sheet on the survey clearly conveyed that participants were required to be nurses, who were either supervisees, supervisors, or both and had been in receipt of at least three supervision sessions. Instructions for completion of the supervisee and supervisor sections were also included on this page. The consent form provided a brief summary of the content in the information sheet but required a signed declaration stating that, as participants, they were given the opportunity to discuss the study, with or without a support person, and that they understood the confidentiality clause. A return SAE was included to encourage the return of completed surveys, a saving to participants on cost and time (Boynton, 2004; Leedy & Ormrod, 2005).

Coding of the questionnaires to provide anonymity for the participants was necessary but as the researcher I also needed to track response rates from the different areas. A reminder could then be sent if necessary. To allow this to occur, a checklist
was devised whereby on delivery of the questionnaire packages, by the researcher, the date of receipt was noted and checked off according to the code number. The practice supervisor’s or manager’s name and contact details were noted. The checklist was kept by the administrator, at University of Otago, Christchurch, who completed the record by entering the receipt date of returned packages. For the larger organisations where there were many supervisors, I was aware of the time involved in sending batches of questionnaire packages out to supervisors in the internal mail. I therefore offered to assist with this process and returned the checklist in a sealed envelope to the administrator.

As part of the planning, a decision was made to follow up in areas where the response rate had been low, two months post-distribution, with a phone conversation or email to DONs, managers, or private supervisors to prompt them to remind supervisees again about the study. Additional packages were offered through the University of Otago, if necessary. Further attempts were also made to provide the opportunity for nurses, involved in supervision, to participate in this study through notification in two nursing publications. These publications were Kaitiaki and the Nursing Review.

The data collection was completed in one phase allowing for the return of the surveys over a four-month period. This process was commenced on receipt of ethical approval from both the Health and Disability Ethics Committees and the Royal New Zealand Plunket Society Ethics Committee.

**Ethical considerations and the approval process**

With the initial stage of this research study designed and the feasibility ensured, approval was sought firstly from the University of Otago Board of Graduate Studies in Health Sciences and subsequently the Regional Health and Disability Ethics Committee and the Plunket Ethics Committee. The approval processes assisted with the refinement of the study and also highlighted areas that needed to be monitored closely by the researcher in conjunction with the research supervisors. The University of Otago Board of Graduate Studies in Health Sciences accepted the proposal for this research study in September 2009. However, the Board did raise concerns regarding the manageability of the study given the large data set, with so many variables and the resultant potential for complicated statistical analysis.

Regional Ethics Committee approval was granted on the 2nd of December, 2009 following minor adjustments to the information sheet and the addition of a consent
form. The consent form was requested in view of the sensitive information included in this voluntary questionnaire. As part of this process, Māori consultation was sought and ongoing advice was offered for the duration of the study. Following approval, the questionnaire packages were distributed to all areas with the exception of Plunket, where separate ethics approval was required.

The Plunket ethics application was submitted following receipt of approval from the Regional Ethics Committee so that approval from this committee could be noted in the application letter to Plunket. Plunket Committee approval was given in March 2010. Given the delay with the intervening holiday period, the period for receipt of completed questionnaires was left open until the end of May 2010.

In relation to the ethical considerations involved in this research study, privacy, and confidentiality and informed consent were addressed. With nurses involved in supervision being notified about the research study by their supervisor, the questionnaires being coded and masked prior to distribution, and the consent forms being removed and locked in a filing cabinet by the administrator, anonymity would be maintained.

To ensure the participants were fully informed about the research study, a poster advertising the study was placed in the relevant supervision venues. Supervisors were also asked to offer the questionnaires packages to their supervisees. Included in the package was an information sheet with contact details of the academic research supervisors and the researcher should there be any questions. The choice then to participate in the study remained with the individual participant.

Data analysis

In this section I have outlined the procedures used to analyse the quantitative closed questions and the qualitative open questions. Prior to commencement of the research process, advice was sought from Associate Professor Elizabeth Wells, biostatistician in relation to utilisation of the Cooper and Anglem (2003) survey, and the logistics of making surveys available to Canterbury nurses involved in PS. Further advice was sought on several occasions to provide guidance on the analysis process.

Closed question analysis

The Statistical Package for the Social Sciences (SPSS), version 19, was used to analyse the closed questions. The first stage involved setting up the codebook, naming
164 variables and entering the responses from the surveys. The short answer open-ended questions were also entered into SPSS as string variables allowing for text to be written as opposed to numbers. In total there were 60 questions to be completed by supervisees and 11 questions for nurses who were supervisors. Following data entry from 107 completed questionnaires the data was reviewed for accuracy (Bryman, 2008; Morse et al., 2006).

The second stage involved descriptive analysis of selected questions that provided the required information to answer the main research question. The responses to the questions, based on the characteristics of nurses involved in professional supervision, were presented in tables as frequencies and percentages. The mean or average levels of time spent on activities were presented in a graph. These simple methods of analysis mirrored those used in the analysis of the Cooper and Anglem (2003) survey and provided the information necessary to answer the more specific research questions. Following the entry of data into SPSS, it became apparent that comparisons between groups would not be justifiable. The groups were disproportionate in size and used a range of different formats and supervision models.

Open-ended question analysis

Whilst the statistical analysis methods, as outlined previously, remained simple, they provided a broad range of summary information on professional supervision. Furthermore, the qualitative analysis of the open-ended questions added greater depth, clarification and meaning (Patton, 2002) to the statistical data by providing further ideas, information and examples.

The qualitative analysis process involved three stages. In stage one the 12 open-ended question responses were copied from SPSS directly into word documents. In stage two the responses for each question were read and reviewed, until I felt sufficiently familiar with the content to broadly categorise the text responses. This stage was completed by hand, highlighting similar themes and words from each question, and cutting out the responses and placing each group in snaplock plastic bags. Pope, Ziebland and Mays (2000) believe that a very tactile system, such as this, encourages an in-depth knowledge of the data and is important in qualitative, inductive analysis where theories are derived from observation, confirmation of ideas and pattern recognition (Patton, 2002).
However, deductive analysis, whilst not common in qualitative research, is introduced in stage three to offer an “existing framework” (Patton, 2002, p. 453) to assist with analysis of the responses from data into “themes, categories, sub-categories and codes” (Graneheim & Lundman, 2004, p. 107). Themes are reflective of the open-ended questions in the survey; the broad categories are developed from the text responses, further refined into sub-categories and then codes (see Table 1 below).

Table 1 Examples of Theme, Broad Categories, Sub-Categories and Codes from Survey on Nurses’ Perceptions of the Activities, Effectiveness, and Benefits of Professional Supervision

<table>
<thead>
<tr>
<th>Theme</th>
<th>Circumstances Where Confidentiality Would be Broken - UNSAFE PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Safety Concerns</td>
</tr>
<tr>
<td>Sub-category</td>
<td>General Safety and Unsafe Practice</td>
</tr>
<tr>
<td>Concern for Supervisee Safety</td>
<td>Concern for Safety: Clients and Others</td>
</tr>
<tr>
<td>Codes</td>
<td>Codes</td>
</tr>
<tr>
<td>-Unsafe work practice</td>
<td>-personal issues compromising role</td>
</tr>
<tr>
<td>-Breaches competencies</td>
<td>-health issues</td>
</tr>
<tr>
<td></td>
<td>-not responding to supervision</td>
</tr>
<tr>
<td></td>
<td>-severe risk to others</td>
</tr>
<tr>
<td></td>
<td>-Criminal Offences</td>
</tr>
<tr>
<td></td>
<td>-Drug or Alcohol abuse</td>
</tr>
<tr>
<td></td>
<td>-Professional misconduct</td>
</tr>
<tr>
<td></td>
<td>-Breaches code of conduct</td>
</tr>
<tr>
<td></td>
<td>-at risk professionally</td>
</tr>
</tbody>
</table>

To maintain and protect the validity during this process, the data was managed in an identical way to any research material that stems from semi-structured interviews or open-ended questions. A code-book was established (Bryman, 2008; Morse et al., 2006) and the data entry was reviewed by the supervisors. As a researcher, my own personal assumptions regarding professional supervision also needed to be recognised, journalled and discussed with the supervisors to alleviate any bias. My personal experiences, preparation, and training in supervision have all been extremely positive. However, to maintain objectivity as the researcher I needed to acknowledge these factors and put them aside to allow for a balanced viewpoint.

Conclusion

A descriptive survey design was chosen as the most appropriate method of providing broad-based information on Canterbury nurses’ perceptions of the activities, effectiveness and benefits of professional supervision. The survey consisted of closed, Likert scale and open questions requiring both quantitative and qualitative methods of analysis. Simple analysis techniques were utilised to present the statistics as percentages and means. To supplement the numerical data, short written text answers were thematically analysed to provide greater depth and add value to the quantitative findings.
Chapter Four: Results and Analysis

Introduction

This chapter reports on the results of the survey distributed to Canterbury nurses involved in professional supervision. The findings from both open and closed questions have been reported under the following section headings: characteristics of supervisees and supervisors, training of supervisors, general factors related to professional supervision, contracting, the supervision session, benefits of and suggested improvements to supervision. In the instances where the survey contained open-ended qualitative questions, qualitative findings are reported where there are relevant sections and headed ‘Qualitative comments’.

At the time of distribution of the surveys, as a result of further advertising post-distribution, 11 additional surveys were requested. The surveys were distributed to 485 Canterbury nurses in total and 107 (22%) were returned. The participants included 41 nurses who were supervisees, 63 nurses who were both supervisors and supervisees and three nurses who were supervisors only.

Characteristics of supervisees

Supervisees were predominantly female and of NZ European ethnicity with 4 (3.8%) identifying as Māori and 2 (1.9%) as Samoan. The highest percentage of supervisees were aged between 40 and 59 years of age. The length of time in nursing was variable with the largest group, 41(39.4%), having been in nursing for 20 to 29 years and second largest, 30 (28.9%), from 30 to 39 years. The majority of supervisees, 74 (71.2%), held postgraduate qualifications, whilst 15 (14.4%) held a graduate qualification (see Table 2).
Table 2 Supervisee Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>15 (14.4%)</td>
</tr>
<tr>
<td>Female</td>
<td>89 (85.6%)</td>
</tr>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
</tr>
<tr>
<td>20-29 years</td>
<td>3 (2.9%)</td>
</tr>
<tr>
<td>30-39 years</td>
<td>14 (13.5%)</td>
</tr>
<tr>
<td>40-49 years</td>
<td>44 (42.3%)</td>
</tr>
<tr>
<td>50-59 years</td>
<td>37 (35.5%)</td>
</tr>
<tr>
<td>60 years and over</td>
<td>6 (5.8%)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>NZ European</td>
<td>89 (85.6%)</td>
</tr>
<tr>
<td>Māori</td>
<td>4 (3.8%)</td>
</tr>
<tr>
<td>Samoan</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>European</td>
<td>9 (8.7%)</td>
</tr>
<tr>
<td><strong>Qualifications</strong></td>
<td></td>
</tr>
<tr>
<td>Undergraduate Certificate</td>
<td>4 (3.8%)</td>
</tr>
<tr>
<td>Undergraduate Diploma</td>
<td>10 (9.6%)</td>
</tr>
<tr>
<td>Degree</td>
<td>15 (14.4%)</td>
</tr>
<tr>
<td>PG Cert or Diploma</td>
<td>61 (58.7%)</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>12 (11.5%)</td>
</tr>
<tr>
<td>Doctorate</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Missing</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td><strong>Years in Nursing</strong></td>
<td></td>
</tr>
<tr>
<td>1-9 years</td>
<td>7 (6.7%)</td>
</tr>
<tr>
<td>10-19 years</td>
<td>19 (18.3%)</td>
</tr>
<tr>
<td>20-29 years</td>
<td>41 (39.4%)</td>
</tr>
<tr>
<td>30-39 years</td>
<td>30 (28.9%)</td>
</tr>
<tr>
<td>40-49 years</td>
<td>6 (5.7%)</td>
</tr>
</tbody>
</table>

To ascertain the interest of nurses in supervision, within the varying specialties, the supervisees were asked about their employment and the position they held. The Canterbury District Health Board was the major employer—employing 76% (79) of the supervisees. The remainder were employed by private providers, educational institutions, or Māori or Pacific health providers. There were 54.8% (57) who practised within the mental health area; 10.6% (11) in child health; 4.8% (5) in public health; 3.8% (4) in nursing administration and management; with the remaining 26% (27) in a wide range of different nursing specialties (see Table 3).
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Employment</strong></td>
<td></td>
</tr>
<tr>
<td>DHB (Acute)</td>
<td>28 (26.9%)</td>
</tr>
<tr>
<td>DHB (Community)</td>
<td>37 (35.6%)</td>
</tr>
<tr>
<td>DHB (Other)</td>
<td>14 (13.5%)</td>
</tr>
<tr>
<td>Private Hospital</td>
<td>5 (4.8%)</td>
</tr>
<tr>
<td>Community Services</td>
<td>12 (11.5%)</td>
</tr>
<tr>
<td>Rest Home/Residential</td>
<td>3 (2.9%)</td>
</tr>
<tr>
<td>Self Employed</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Māori Health Service Provider</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Educational Institution</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Pacific Health Service Provider</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td><strong>Current Nursing Practice</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency &amp; Trauma</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Intensive Care/Cardiac Care</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Peri-Operative Care (Theatre)</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Surgical</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Medical (including educating patients)</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Child Health (Neonatology)</td>
<td>11 (10.6%)</td>
</tr>
<tr>
<td>School Health</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>District Nursing</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Practice Nursing</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>3 (2.9%)</td>
</tr>
<tr>
<td>Public Health</td>
<td>5 (4.8%)</td>
</tr>
<tr>
<td>Continuing Care (Elderly)</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Assessment &amp; Rehabilitation</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Mental Health (Inpatients)</td>
<td>24 (23.1%)</td>
</tr>
<tr>
<td>Mental Health (Community)</td>
<td>28 (26.9%)</td>
</tr>
<tr>
<td>Addiction Services</td>
<td>5 (4.8%)</td>
</tr>
<tr>
<td>Intellectually Disabled</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Nursing Administration and Management</td>
<td>4 (3.8%)</td>
</tr>
<tr>
<td>Nursing Education</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Nursing Research</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Others</td>
<td>4 (3.8%)</td>
</tr>
<tr>
<td>Missing</td>
<td>1 (1.0%)</td>
</tr>
</tbody>
</table>

**Characteristics of supervisors as reported by all respondents**

Supervisees reported on the following characteristics about their supervisors. The supervisors were predominantly female (86.5%). Supervisors who were in the 40 to 49 year age bracket made up 32.7% of the group and 49.0% were in the 50 to 59 age range. Sixty-one supervisors reported being of NZ European origin, however 36 supervisees were unsure of their supervisors’ ethnic origin. Two supervisors were known to identify as Māori and one as Samoan. Sixty supervisors had completed postgraduate qualifications, whilst 14 held undergraduate and graduate qualifications. Thirty supervisees were uncertain as to their supervisors’ educational achievements, nevertheless 83 supervisees out of 104 were aware of how long their supervisors had practised (see Tables 4 and 5).
Table 4 Supervisor Characteristics as Reported by Supervisees

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>14 (13.5%)</td>
</tr>
<tr>
<td>Female</td>
<td>90 (86.5%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>30-39 years</td>
<td>13 (12.5%)</td>
</tr>
<tr>
<td>40-49 years</td>
<td>34 (32.7%)</td>
</tr>
<tr>
<td>50-59 years</td>
<td>51 (49.0%)</td>
</tr>
<tr>
<td>60 years and over</td>
<td>5 (4.8%)</td>
</tr>
<tr>
<td>Unsure</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>NZ European</td>
<td>61 (58.7%)</td>
</tr>
<tr>
<td>Māori</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Samoan</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Non NZ European</td>
<td>4 (3.8%)</td>
</tr>
<tr>
<td>Unsure</td>
<td>36 (34.6%)</td>
</tr>
<tr>
<td><strong>Highest Qualification</strong></td>
<td></td>
</tr>
<tr>
<td>Undergraduate Certificate</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Undergraduate Diploma</td>
<td>5 (4.8%)</td>
</tr>
<tr>
<td>Degree</td>
<td>7 (6.7%)</td>
</tr>
<tr>
<td>Postgraduate Certificate or Diploma</td>
<td>31 (29.8%)</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>27 (26.0%)</td>
</tr>
<tr>
<td>Doctorate</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Unsure</td>
<td>30 (28.8%)</td>
</tr>
<tr>
<td><strong>Years since Highest Qualification</strong></td>
<td></td>
</tr>
<tr>
<td>0-4 years</td>
<td>26 (25.0%)</td>
</tr>
<tr>
<td>5-9 years</td>
<td>10 (9.6%)</td>
</tr>
<tr>
<td>10-14 years</td>
<td>8 (7.7%)</td>
</tr>
<tr>
<td>15-19 years</td>
<td>5 (4.8%)</td>
</tr>
<tr>
<td>20-24 years</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>25-29 years</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Unsure</td>
<td>52 (50.0%)</td>
</tr>
<tr>
<td><strong>Years Practised Supervision</strong></td>
<td></td>
</tr>
<tr>
<td>0-4 years</td>
<td>18 (17.3%)</td>
</tr>
<tr>
<td>5-9 years</td>
<td>12 (11.5%)</td>
</tr>
<tr>
<td>10-14 years</td>
<td>20 (19.2%)</td>
</tr>
<tr>
<td>15-19 years</td>
<td>19 (18.3%)</td>
</tr>
<tr>
<td>20-24 years</td>
<td>10 (9.6%)</td>
</tr>
<tr>
<td>25-29 years</td>
<td>3 (2.9%)</td>
</tr>
<tr>
<td>30 years or more</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Unsure</td>
<td>21 (20.2%)</td>
</tr>
</tbody>
</table>

Additional information was supplied, by supervisees, about their supervisors’ positions. The positions were divided into six categories. The first and major category included private supervisors of whom 34 (32.7%) ran their own supervision business. The second category involved supervisors 11 (10.6%) who also held managerial positions in nursing. For example they may have been unit managers, clinical leaders, or clinical coordinators. Nurse educators, nurse specialists and nurse consultants made up the third category of 20 (19.2%) nurses who had secondary roles as supervisors. Registered and enrolled nurses also formed a significantly large group with 31 (29.8%) as supervisors. Two smaller groups consisted of supervisees who utilised allied health members as their supervisors. For the three nurses, who identified as supervisors only, no information on their additional roles was provided.
Over half (51.9%) of the supervisors held positions externally to the service in which the supervisee was employed. Supervisors, who were external to the team in which the supervisee practised, but worked within the same service, made up 33.7%. However, 13.5% of nurses, in this survey, were supervised by a person from within the same team (see Table 5).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supervisors' Positions</strong></td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>34 (32.7%)</td>
</tr>
<tr>
<td>Managers</td>
<td>11 (10.6%)</td>
</tr>
<tr>
<td>CNS/CNE/Coordinators</td>
<td>20 (19.2%)</td>
</tr>
<tr>
<td>Registered Nurses/Enrolled Nurses</td>
<td>31 (29.8%)</td>
</tr>
<tr>
<td>Allied Health</td>
<td>4 (3.8%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (1.0%)</td>
</tr>
<tr>
<td>Unsure</td>
<td>3 (2.9%)</td>
</tr>
<tr>
<td><strong>Relationship to the Service</strong></td>
<td></td>
</tr>
<tr>
<td>Internal to your Team</td>
<td>14 (13.5%)</td>
</tr>
<tr>
<td>External to Team but Internal to Service</td>
<td>35 (33.7%)</td>
</tr>
<tr>
<td>External to Service</td>
<td>54 (51.9%)</td>
</tr>
<tr>
<td>Not Answered</td>
<td>1 (1.0%)</td>
</tr>
</tbody>
</table>

On analysis of this demographic information about supervisors, I realised each supervisor could be providing supervision for more than one of the supervisees or participants in this survey. Therefore, this information may indeed be duplicated. However, this information does give a good general picture of age group, ethnicity, qualifications and years of experience of their supervisors.

**Training of supervisors and supervisees**

This study has so far provided some insight into the supervisees and supervisors, that are involved in professional supervision, in the Canterbury region, and who have chosen to participate in this study. So how were these participants prepared for supervision? In this next section I have reported on the findings pertaining to the training of supervisors and supervisees.
Figure 1 clearly depicts the weighting of topics covered in the training of 65 of 66 supervisors in this study. This graph illustrates the strong emphasis placed on understanding the purpose of supervision and the ethical nature of supervision. Communication, relational, educational and socio-cultural skills, and knowledge are all essential components for the role and are covered in varying degrees as part of their training. However, the academic level of formal training in supervision varies with 16 supervisors having university qualifications, 32 receiving in-service education and 17 attending other courses. All supervisors had received their most recent training within the last five years, and 46 within the last two years. Informally there was a 64% uptake of self-directed learning and a moderate attendance of workshops and continuing professional education.

Qualitative comments

From the thematic analysis of question 57 where respondents, were asked “what do supervisors need to be effective?”, one of the main categories to emerge was training
Options for training were suggested. These included universities and particular private providers as trainers, or alternatively forming a national education team. Some respondents specified that training be based on one particular model whilst others indicated their desire for education on different methods of supervision. Some of their quotations are incorporated into the following review of results.

Emphasis was placed on teaching supervisors the art of reflecting on practice. In addition the following skill-based teaching was recommended. These options incorporated “motivational interviewing, reflective listening”; how to “grow and nurture supervisees”; and “tease out conflict and guide supervisees to understanding their actions”. On a similar theme it was suggested by another participant that supervisors receive “training to be courageous and ask the questions that the supervisee’s colleagues are too afraid to ask”. In response to this request for such broad-based education, a respondent “recognised that the integration of roles necessary to be a skilled supervisor is “a developmental process and not an event!” “Regular” and “ongoing” updates at one-to-two yearly intervals were the key coding words in the continuing education sub-category. “Mentoring of supervisors” and supervisors receiving their “own supervision” were highlighted under the sub-category of training and education.

From these results, supervisors were perceived to require comprehensive training for their role, however, there was a mixed response as to the need for formal training of supervisees. Some participants felt that “no training but a desire to participate” was all that was necessary, whilst others believed that supervisees could be “mentored into supervision” through “taking time to build a rapport” and “discussion”. Many respondents felt that training on “what is supervision so that they can come to the session prepared” was worthwhile. Suggestions as to the content of training for supervisees included the following sub-categories: personal skills, overview of supervision, models, guidelines and policies. A high priority was given to reflective practice. Some of the above ideas for training are illustrated in the following quotations. Respondents expressed that a “strong understanding of reflective practice, understanding growth—the ability to tolerate the wobbly bits when change is occurring, importance of being prepared” and being “able to identify the question to focus on in session” would be useful.
General factors related to professional supervision

From this information it can be assumed that not every supervisee receives training. Selection of their own supervisor was also variable. In this study 61 (58.7%) of 104 supervisees were able to select their own supervisor. However, it was noted that some supervisees had to wait up to “18 months” or were “unable to access a supervisor who was not a peer” or who was “external” to the service. Cost was noted as a limiting factor, however employers paid for 91 participants and part shared in the cost for two people to receive supervision. Only 11 nurses paid for their own supervision.

The greatest proportion of these participants (91) was not only funded but also received individual supervision. Eight nurses were part of a group with two being recipients of both individual and group supervision. According to the written responses, only one participant received peer supervision. As the researcher with the knowledge that a small group of respondents were receiving peer-reciprocal supervision, I surmise that ‘peer supervision’ may have been interpreted or answered as ‘individual supervision’ since it is one-to-one, but with a peer. This portion of question 33 may, therefore, have caused confusion and could be seen as a limitation (see Table 6).

<table>
<thead>
<tr>
<th>General Factors</th>
<th>Frequency (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback from Supervisor Linked to Appraisals</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12 (11.5%)</td>
</tr>
<tr>
<td>No</td>
<td>89 (85.6%)</td>
</tr>
<tr>
<td>Not Answered</td>
<td>3 (2.9%)</td>
</tr>
<tr>
<td>Did the Supervisee Choose Their Supervisor?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>61 (58.7%)</td>
</tr>
<tr>
<td>No</td>
<td>43 (41.3%)</td>
</tr>
<tr>
<td>Funding of Supervision</td>
<td></td>
</tr>
<tr>
<td>Employer</td>
<td>91 (87.5%)</td>
</tr>
<tr>
<td>Self</td>
<td>11 (10.6%)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Supervision Formats</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>92 (88.4%)</td>
</tr>
<tr>
<td>Group</td>
<td>8 (8.7%)</td>
</tr>
<tr>
<td>Individual and Group</td>
<td>2 (1.9%)</td>
</tr>
<tr>
<td>Peer</td>
<td>1 (1.0%)</td>
</tr>
</tbody>
</table>

Contracting

With all formats of supervision a contract or memorandum of understanding between the supervisor and supervisee is often agreed to or formed. Out of 104 supervisees in this study only five did not have a contractual arrangement with their supervisor. The supervisees were asked about the key elements of the contracting process. Other results are outlined in Table 7.
Table 7 Contracts

<table>
<thead>
<tr>
<th>Frequency of Supervision and Contracts</th>
<th>Frequency (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of Supervision Session</strong></td>
<td></td>
</tr>
<tr>
<td>Once per Week</td>
<td>1 ( 1.0%)</td>
</tr>
<tr>
<td>Once Every Two Weeks</td>
<td>6 ( 5.8%)</td>
</tr>
<tr>
<td>Once Every Three Weeks</td>
<td>19 (18.3%)</td>
</tr>
<tr>
<td>Once per Month</td>
<td>69 (66.3%)</td>
</tr>
<tr>
<td>More Than Once a Month</td>
<td>9 ( 8.7%)</td>
</tr>
<tr>
<td><strong>Type of Contract with Supervisor</strong></td>
<td></td>
</tr>
<tr>
<td>Written</td>
<td>85 (81.7%)</td>
</tr>
<tr>
<td>Verbal</td>
<td>14 (13.5%)</td>
</tr>
<tr>
<td>No Contract</td>
<td>5 ( 4.8%)</td>
</tr>
<tr>
<td><strong>Who Completed Contract</strong></td>
<td></td>
</tr>
<tr>
<td>Supervisee</td>
<td>2 ( 1.9%)</td>
</tr>
<tr>
<td>Supervisor</td>
<td>2 ( 1.9%)</td>
</tr>
<tr>
<td>Joint</td>
<td>94 (90.4%)</td>
</tr>
<tr>
<td>No Contract</td>
<td>5 ( 4.8%)</td>
</tr>
<tr>
<td>Not Answered</td>
<td>1 ( 1.0%)</td>
</tr>
<tr>
<td><strong>Contract Discussed with Management</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>62 (59.6%)</td>
</tr>
<tr>
<td>No</td>
<td>35 (33.7%)</td>
</tr>
<tr>
<td>No Contract</td>
<td>5 ( 4.8%)</td>
</tr>
<tr>
<td>Not Answered</td>
<td>2 ( 1.9%)</td>
</tr>
<tr>
<td><strong>Frequency Contract Reviewed</strong></td>
<td></td>
</tr>
<tr>
<td>Once Every Month</td>
<td>4 ( 3.8%)</td>
</tr>
<tr>
<td>Once Every Three Months</td>
<td>4 ( 3.8%)</td>
</tr>
<tr>
<td>Once Every Six Months</td>
<td>11 (10.6%)</td>
</tr>
<tr>
<td>Once Every Nine Months</td>
<td>1 ( 1.0%)</td>
</tr>
<tr>
<td>Once Every Twelve Months</td>
<td>55 (52.9%)</td>
</tr>
<tr>
<td>More Than Every Twelve Months</td>
<td>23 (22.1%)</td>
</tr>
<tr>
<td>No Contract</td>
<td>5 ( 4.8%)</td>
</tr>
<tr>
<td>Not Answered</td>
<td>1 ( 1.0%)</td>
</tr>
<tr>
<td><strong>Contract for Confidentiality</strong></td>
<td></td>
</tr>
<tr>
<td>Absolute</td>
<td>44 (42.3%)</td>
</tr>
<tr>
<td>Qualified</td>
<td>53 (51.0%)</td>
</tr>
<tr>
<td>No Contract</td>
<td>5 ( 4.8%)</td>
</tr>
<tr>
<td>Not Answered</td>
<td>2 ( 1.9%)</td>
</tr>
</tbody>
</table>

Sixty minutes was the main length of time that was set aside for supervision sessions for 84.6% of respondents, and 66.3% of the sessions were held on a monthly basis. Whilst most contracts were written jointly, 59.6% were also discussed with management. Over half of the contracts were reviewed on a yearly basis.

**Qualitative comments**

Two questions that may be asked when discussing the contract with management are “how does your Line Manager get feedback?” as in Question 30, and “Is feedback linked to your performance appraisal?” in Question 31. In this survey the open-ended question on “feedback to Line Managers” revealed this was given at appraisal time, in written reports, attendance records, verbally from supervisee or supervisor, or at joint meetings with supervisor and between supervisee and manager on review of contract. For others no feedback was given to managers. For 85.6% of the participants, supervision was not linked to their appraisals.
In the questions on contracts, respondents that selected “absolute confidentiality” were still of the opinion that confidentiality could be broken in cases of unsafe practice. This response may be construed as a lack of understanding of the difference between ‘absolute’ and ‘qualified’ confidentiality. With the main category being ‘unsafe practice,’ the sub-categories addressed the circumstances under which a contract could be broken. These included: general safety issues and unsafe practice; concern for supervisee safety; concerns for safety of clients and others; and ethical concerns.

The degree to which other topics were discussed and agreed to by participants in their contracts is outlined in Figure 2.

![Figure 2 Issues Covered in Contract](image)

The responses to the questions on the content of contracts depicted a strong emphasis on the purpose of supervision, the frequency, and creating a safe, confidential environment free of distractions. The preparation and setting of an agenda was covered
in less than 40% of the contracts. Relational, accountability, cultural and boundary issues were less of a priority for discussion when formulating a contract.

The supervision session

With the ‘purpose of supervision’ shown in Figure 2 to be the key element in a contract, it was interesting to observe in the only comparison made between any group, in Figure 3 below, the close agreement on the specific ‘purposes of supervision’ between supervisee and supervisors (please note that a calculation for matching pairs was not undertaken). The supervisees put slightly more weighting on personal development than role development and also the supportive element, than their supervisors. Nevertheless, role development, personal development, clinical issues and educative advancement were felt to be the major purposes of supervision.

![Figure 3 Purposes of Supervision Reported by Supervisors and Supervisees](image)

In Figure 3 where role and personal development were seen as the main purposes of supervision, the greatest percentage of time as noted in Figure 4, in the
supervision sessions, is spent on discussing clinical work and interpersonal and team issues. Considering this, if the outcome of these discussions is the development of strategies to manage challenging issues or situations, personal and professional growth could be deemed to have taken place.

Figure 4 Average Percentage of Time Spent

In addition to information on the purpose of supervision, and the time spent, views on the quality of the relationship between the supervisee and supervisor were sought.

A Likert rating scale was used with (1) being never or not beneficial to (5) being always or very beneficial. Twenty-eight supervisees rated the quality of the relationship as more than beneficial, noted as (4) on the Likert scale, and 71 as very beneficial.
Supervisees received mostly ‘no guidance’ or ‘occasional guidance’ on clinical work and only a moderate number of supervisors taught skills. However, there was a high incidence of joint problem solving, linking theory to practice and provision of feedback. An assumption could be made that the word ‘teaching’ may have been associated with direct nursing skills rather than strategies to manage the everyday challenges and facets of their work. There was a limited focus on the negative aspects of work, and a positive approach used by a high percentage of supervisors provided supportive feedback and reassurance to their supervisees.

Having supplied information on the activities of supervision, the respondents were asked to report on the effectiveness of their supervision from a personal and professional perspective as well as the perceived benefits to clients, the service and the organisation.
On a professional level, a high percentage of supervisees were given constructive feedback on practice. On a personal level, the supervision enabled 80 to 85% of supervisees to recognise their own personal issues, build their confidence and feel valued and respected. Providing this level of support seems to point towards an increased ability in supervisees to think critically about their practice. This is indicated through 75 to 78% stating that it changed their therapeutic perceptions and increased their ability to conceptualise on their delivery of care to clients. Over 55% reported that this led to increased clinical skills and over 65% reported this process has improved their professional identity.

**Qualitative comments**

The supervisees were also asked to provide further written examples of what benefits they received from supervision. Two clear categories emerged from their examples, one being personal outcomes and the other practice-related outcomes. On an individual level personal skills were developed; they felt supported and were therefore
able to build on their professional roles. One supervisee acknowledged the personal support by saying it “helped me through huge changes and massive conflict in the work environment”. On a practice-related level another supervisee affirmed that it broadened his or her perspective by stating that “when I have exhausted all avenues with a client, supervision can always show how to look at issues differently”. Another quote suggested that supervision assisted the person to transition from the loss of one role to improving the supervisee’s ability to engage in a new role. In contrast to the affirmation of supervision being a positive experience, one supervisee made the following comment: “I do not get anything out of supervision as it is done by peers facing the same management problems”.

Looking beyond personal and professional growth, the participants were asked to rate the degree to which supervision impacted on them personally, then on client outcomes and the service and the organisation.

Table 9 Effectiveness as per Supervisee

<table>
<thead>
<tr>
<th></th>
<th>1 Never/Not Beneficial</th>
<th>2 Occasionally / Beneficial</th>
<th>3 Always/Very Beneficial</th>
<th>Not Answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Satisfaction as a Supervisee</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>Effectiveness on Client Outcomes</td>
<td>2</td>
<td>2</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td>Benefit to Service</td>
<td>1</td>
<td>1</td>
<td>13</td>
<td>27</td>
</tr>
<tr>
<td>Benefit to Organisation</td>
<td>2</td>
<td>1</td>
<td>12</td>
<td>24</td>
</tr>
</tbody>
</table>

With the rating scale of 1 presented as (Never or Not Beneficial) and 5 (Always / Very Beneficial), 97 out of 104 supervisees indicated their personal satisfaction with supervision to be between 4 and 5. Ninety eight to 100 out of 104 supervisees perceived professional supervision to have a beneficial to very beneficial impact on clients, the service and the organisation.

Qualitative comments

The supervisees were asked to provide written examples of the benefits of supervision for clients. The two categories that become apparent when analysing the responses divided the benefits into direct and indirect benefits. The indirect benefits occurred through the development of personal skills with key coding words and phrases including: being a reflective practitioner, having more confidence, being able to handle stress and an increased self-awareness. These traits are illustrated in the following quotation where the supervisee acknowledges that supervision has assisted her or him to
“stop and not take unhelpful stuff into my helping role as a professional”. Together with personal skills in this sub-category is the development of nursing skills that indirectly may be of benefit to the client. Professional supervision was deemed by some respondents to encourage more regular discussion of clinical skills and enhance decision making skills. The direct impact was noted through the development of new approaches to care, choosing best practice options and having a “broader more focused analysis of care”. With the support that supervision provides, the supervisee or nurse suggests that they question their practice, review treatments, and plan more timely interventions. One example given by a supervisee that highlights the benefit of the supervision process was “a nurse who is continuing to grow in practice, develop better skills e.g. in my practice I was aware of the need for family movement thus through supervision commenced a nurse-led family screening clinic”. Another supervisee gave an example that depicted the provision of patient safety through supervision by discussing how “I was beginning to feel hatred towards a patient with a personality disorder, activated in a therapeutic relationship. Supervision enabled me to professionally demonstrate appropriate ways to manage”.

On an organisational level, the benefits as described by the respondents again were categorised into indirect and direct benefits. The indirect benefits were sub-categorised under the following headings: increased productivity, positive approach and managing challenges. These sub-categories are highlighted in the following quotation where the supervisee believes that “by providing a process that promotes healthy functioning of the individual nurse this provides a healthy, positive organisational culture, supervision promotes growth and potential”. A direct impact is related to retention of nurses and this is highlighted by the following supervisee who stated that “I have stayed in the unit and worked through issues rather than leave and have moved up to team leader position”. Another noted that a direct benefit was “the monitoring of practice through supervision acting as a safety net to promote best practice, risk reduction, professional attitudes and relationships, and ethical practice”. As acknowledged by one supervisee, “workers raise organisational issues e.g. policy gaps, workload management, resource and deficits and clinical service needs”. One respondent nicely summarised the overall impact that professional supervision can have on an organisation by stating that supervision “increases likelihood of workers performing optimally; increases staff retention and reduces sickness and stress leave”.
With the majority of supervisees, in this study, believing supervision to be—personally and on an organisational level—beneficial to very beneficial, it was interesting to analyse their responses on how the quality of supervision can be assured. A few respondents felt that there was “very little means of evaluating the quality of supervision”. However, others indicated that education for both supervisees and supervisors and ongoing updates were crucial. In conjunction with these ideas it was suggested that regular review of contracts and regulation and standardisation of training were necessary. Ongoing feedback between supervisor and supervisee, feedback at appraisal time, having a standardised process for addressing concerns regarding supervision, audits and regular evaluations would indicate where quality improvements were necessary.

In addition, the supervisees were asked for ideas on how supervision could be improved. The two key categories that emerged were ‘supervision specific measures’ and ‘involvement of management’. The need for more supervisors with suitable attributes and supervisors receiving their own supervision were noted. Other suggestions included a coordinator position being implemented to oversee all aspects of the programme. This could include the matching of supervisor and supervisee, release time and having access to alternative trainers. Ideas regarding training and education were also made. Recognition of the value of supervision, financial backing and better accessibility to supervision especially for “nurses working in isolation or autonomously” were priorities suggested by supervisees to be addressed by management.

The supervisors, in addition, were asked to comment on the relationship between supervision and service quality. The two categories that were evident on analysis of data from this question were ‘practice and client improvements’ and ‘service improvements’. The supervisors emphasised personal changes. These included: increased reflexivity; an open, calm and confident manner; professional changes, such as movement to higher positions, further education and leadership roles that had occurred with their supervisees. This is highlighted in the following comment which states that “several supervisees have reported feeling energised in their work due to supervision and becoming involved in leadership and service development”. At a service level, supervisors supported the supervisees’ beliefs that supervision assists with retention by supporting and valuing the nurses contribution. The supervisors themselves alleged that quality in service delivery was enhanced by “ensuring policies and procedures are used”
and “that staff are able to work effectively with colleagues, clients and management towards effective client outcomes”.

However, in the final question where the supervisors gave general feedback on supervision, the following limitations were highlighted: the quality of supervision was variable; workload made attending supervision stressful; there was a need for supervisors to be more accessible and flexible thus making supervision easier to organise; supervision was misunderstood by peers; supervision could be seen to reinforce supervisees’ dysfunctional view of the world; supervisors themselves were not challenged in their thinking and there was a lack of payment by management for supervisors’ own supervision. However, the supervisors stressed that supervision produced maximum efficiency and was fundamental to health and safety of staff as it “decreases the need for counselling support services and crises for clinicians is prevented”. By the time they need counselling they feel demoralised and that they are the problem”. What is more, another supervisor believed that “supervision supports practice in many ways. It can reduce isolation and promote change in working practices thus improving client care”. In summary, a third supervisor shared his or her thoughts on supervision by stating that “supervision is a primary development tool for nursing practice, the development of functional roles and application of them to practise”.

Conclusion

This chapter presented demographic information on the participants in this study, their experiences of the professional supervision activities, the effectiveness and benefits to the individual nurse, the client, service and organisation. The supervisees were for the most part NZ European with 3.8% of Māori origin, aged within the 40 to 59 year old age group and 71.2% had postgraduate qualifications. Over half of the supervisees held positions in mental health whilst the remainder worked within a wide range of specialties. The most notable demographic feature of the supervisors group was that 91% held postgraduate qualifications. Over half provided supervision externally. Internal supervisors held a mixture of positions from ward-based registered nurses to nurse specialists and educators with 10% in managerial positions.

The survey-questionnaire provided a range of information on supervisory training, contracting, session content and the supervisory relationship. A very high percentage (95%) of supervisees found the quality of their supervisory relationship beneficial to very beneficial with similar ratings of overall personal satisfaction with
their professional supervision. It was widely believed that professional supervision—in providing support for the nurse—increased their confidence, professional identity and critical thinking skills, enabling changed therapeutic perceptions and increased ability to conceptualise on the delivery of client care. Owing to these changes, it was perceived by 96% of participants that the opportunity for role development, through the provision of effective professional supervision, provided indirect spin-offs for clients. The promotion of best practice, the increased ability to manage challenges, a positive attitude and increased productivity were just some of the outcomes that were believed to indirectly have an impact indirectly on—not only the client—but also the service and the organisation.
Chapter Five: Discussion and Conclusion

Introduction

Whether or not the activities and dynamics of PS are sufficiently effective to render both personal and professional benefits for nurses is a key point of discussion in this chapter. Firstly, motivational factors that influence attendance at PS and the significant demographic features from this cohort have been examined. Secondly, the key factors that portrayed the participants’ supervision as being effective have been reviewed and contrasted with other studies. Thirdly, the perceived personal and professional benefits and the impact of these on practice were compared with the literature. Suggestions were offered as to ways to improve and maintain quality supervision. These ideas have been debated in view of the known barriers that exist with operationalising and sustaining successful PS. Implications for practice and recommendations for the development of professional supervision in nursing have been proposed. In the final section of this chapter the limitations of this study and suggestions for further research have been put forward.

Background

In this study it was hypothesised that Canterbury nurses, involved in supervision, would view the process of PS as beneficial for personal and professional effectiveness and nursing practice. For the most part, the respondents in this survey had a generally favourable experience of supervision. Only a very small minority found supervision not to be of any benefit. However, a large limitation to this study was the low response rate (p. 48) of 22% (n=107) despite measures taken to encourage participation (p. 44). Nevertheless, the findings relating to benefits for this specific group of nurses have replicated results from existing studies and presented additional information on PS. Studies where results were similar or incorporated some of the same outcomes included: Cheater and Hale (2001); Clarke and Mathers (2003); Cooper and Anglem (2003); Jones; (2003); Hyrkas et al. (2003); Begat et al. (2005); Sines and McNally (2007); Gonge and Buus (2011); and Koivu et al. (2012). The results from these studies have been discussed in greater detail throughout the chapter.

Hyrkas (2005) in her quantitative study of Finnish mental health nurses (n=569) across 14 sites, and White and Winstanley’s (2010) Australian mixed method, randomised controlled trial which included mental health nurses (n=115), supervisors
(n=24) clients (n=82) and unit staff (n=11), asserted that benefits of lower burnout and increased job satisfaction have been realised for those engaged in supervision, but only in the event of efficacious PS. What makes supervision effective has been, and is, an ongoing quandary and challenge for researchers to define. The lack of standardised evaluation tools has made this difficult in the past. However, the use of the internationally recognised MCSS has been a move forward according to Edwards et al. (2005) who undertook a UK survey of community mental health nurses (n=260) and Gongs and Buus’s (2011) paper surveying Danish mental health nurses (n=145). A locally developed and tested tool—the Cooper and Anglem (2003) survey of mental health interdisciplinary team members (n=113) of which 40% were nurses—provided valuable information on themes from supervision sessions, training issues and cross-cultural supervision that has been helpful to local mental health specialty areas in the development of PS.

Motivational factors

Both the Hyrkas (2005) and the White and Winstanley (2010) papers, referred to above, have revealed that having the opportunity to participate does not necessarily render a positive and effective experience of PS. Individual and workplace factors, in tandem, may determine that outcome. Intrinsic motivation to attend, as maintained by Gongs and Buus (2011) in their Danish study with nurses from nine psychiatric wards and four community MH centres (n=136), together with the openness to reflect and explore practice situations and willingness to trial new options, requires confidence and competence. These traits were also indicated by Jones (2006) in his UK mixed method study of hospice nurses (n=5); and put forward by Biggs (2003), Davys and Beddoe (2010) and Carroll and Gilbert, (2011). According to Biggs (2003) and Wilkinson (2004) intrinsic motivation occurs when there is an innate personal interest in an activity. Immediate external factors such as making time amidst the chaos of busy work environments, or mandatory attendance of supervision, have no bearing on this commitment. This was illustrated in the Koivu et al. (2011) survey of Finnish medical-surgical assistant nurses (n=77) and RNs (n=119) whereby work, learning demands and interpersonal conflicts were rated as being high, and yet motivation to attend work and PS despite these challenges was present. In contrast, Cleary and Freeman (2005) found—in their ethnographic study which included observation and interviews of Australian acute mental health nurses (n=10) involved in group PS—that, despite the belief that supervision was of benefit, intrinsic motivational factors were such that
informal collegial supports on an ‘as needed’ basis were preferred. It was felt that until a framework for PS, which did not disrupt client care, was introduced, informal supports were a more viable option. Furthermore, the Green Lister and Crisp (2005) findings from interviewing child protection community nurses and managers (n=99) from Scotland, where informal and formal supports were present, suggest that a request for PS was seen as an inability to cope.

Nevertheless, extrinsic factors that promote an activity, which is pitched at an achievable level and is viewed as valuable for professional development hours, may indeed impact on motivational levels (Biggs, 2003). Hykras (2005) noted from her survey that supervisors required both intrinsic and extrinsic factors for the role. Intrinsically, a very high proportion of supervisors had been internally motivated to complete postgraduate qualifications in PS. Externally, the role of being a supervisor and independent—and yet part of a community—rendered increased job satisfaction. This was also the case for UK supervisors (n=12) employed in the NHS across nine acute and three community sites, and interviewed in the Williams and Irvine (2009) study, where over half of the participants were both supervisors and supervisees. One may be led to assume from this situation that, through the supervisees’ experience of effective and supportive supervision, their resultant increased confidence and competence provided the motivation to take those acquired skills to the next level as supervisors.

As supervisors, or indeed supervisees of efficacious supervision, they are placed in an influential position to enthusiastically role model the worth of an activity such as PS. For potential participants for whom the value of PS was not initially apparent, a supervisee or supervisor may indeed encourage participation (Biggs, 2003). However, it was purported by both White and Winstanley (2010) and Koivu et al. (2012) from their survey of medical surgical nurses (119 RNs and 47 ANs) that support from within the healthcare community was needed. Support from all levels together with intrinsically motivated, competent supervisors is posited as an essential ingredient in the delivery and execution of effective supervision. Embracing effective PS may in turn encourage participation according to Gonge and Buus (2011).

**Demographic issues**

In relation to the preceding discussion regarding participation factors, one might assume, from this group of Canterbury nurses, that their level of graduate and
postgraduate qualifications (see Table 2) equated to high levels of motivation. This motivation has also extended to regular attendance of at least monthly supervision thereby obtaining more noticeable benefits from PS. A similar observation was made by Sherring and Knight (2009) in their survey of UK mental health nurses’ burnout factors (n=425). In contrast, Gonge and Buus (2011) established that individual and work environmental issues did not impact on participation with one group. However, in another group, where there were high levels of knowledge and skill required, participation was affected.

**Practice areas**

Another notable demographic factor was the range of practice areas that respondents worked in (see Table 3). Whilst over half were from mental health areas, where supervision is known to be well established (Brunero & Stein-Parbury, 2009), the remaining participants were spread, albeit in small numbers, across many specialties. It might therefore be reasoned that a variation in structural factors—such as format, internal or external supervision, mandatory and voluntary supervision, and frameworks or models—would impact on the effectiveness of their supervision. However, in spite of these differences the sample demonstrated high levels of satisfaction with their PS.

In relation to one aspect, Edwards et al. (2005) found in their survey of community mental health nurses that the format was not a factor in influencing the effectiveness of supervision. However, Hyrkas et al. (2006) in their large survey of nurses from many specialties within Finnish hospitals noted that smaller sized groups had higher ratings. For both studies facilitating PS away from the workplace did enhance the effectiveness scores. With these results in mind, it was clear that variation may exist on the impact of these factors on efficacious supervision.

**Key factors that influence the effectiveness of professional supervision**

The particular key factors that produced significant findings in relation to effective PS, from the selected survey and the literature, included different aspects within the following activities: the establishment of supervisory relationships, training for supervision and the setting up of contracts.

**The supervisory relationship**

The supervisory relationship has been acknowledged as the most important factor in effective supervision (Kilminster & Jolly, 2000; Sloan, 2005; Bond & Holland, 2010; Davys & Beddoe, 2010). As previously noted (p. 28), establishing the
relationship with a supervisor who has been selected by the supervisee appears to significantly impact on effectiveness ratings. There was evidence of this in Lister and Crisps’ (2005) qualitative study of UK child protection and community nurses and managers (n=99); the Hyrkas et al. (2006) survey of Finnish healthcare workers of whom 44% were nurses (n=799); the Davey et al. (2006) mixed method study of UK nurses from adult, child and learning disabilities and mental health (n=738); and the Edwards et al. (2005) survey of UK community nurses (n=260). However, this was not necessarily the case in the present study as just under half of the supervisees were assigned a supervisor (Table 6). Lack of supervisors, the waiting time to commence supervision, time allocation and who was going to pay for the supervision were seen as more prevalent issues. One might therefore presume that the supervisors were, more often than not, of a very high calibre in terms of their personal qualities, facilitation methods and interest in ongoing education (Tables 3 & 4) evidenced by the high ratings depicting the relationship as being more than beneficial (Table 9). As mentioned previously, supervisors were highly qualified in their specialty areas (Table 4) and sought to update their supervisory skills at least every two years. Similarly, supervisors (n=73) were found to be well qualified in the NZ survey involving mental health and addiction nurses (McKenna et al., 2008). One might assume from this evidence that the accumulation of favourable personal characteristics together with motivation, specialist experience and supervisory knowledge have all been influential factors in the establishment of successful supervisory relationships. The same aspects were reiterated by Hykras et al. (2006) in their survey of 799 nurses.

Training for supervision

Supervisees, on the other hand, may have taken an active lead in developing the supervisory relationship. Preparatory training of supervisees or self-education could have encouraged the clear articulation of expectations concerning the relationship and the purpose of their supervision (Davys & Beddoe, 2010). Clarification at the initial stages of the relationship by the supervisee would have determined the suitability of the match between supervisor and supervisee. Preparation to enable these initial conversations was one aspect that was not covered in the closed questions in this survey. However, there were mixed responses expressed in the open-ended questions with some indicating all that supervisees needed was a “desire to participate,”. Others suggested that training (on what to bring to supervision, PS guidelines and policies and reflective practice) would be of benefit in making the sessions worthwhile from the
outset. Supervisee training was a recommendation that was made in the Cooper and Anglem (2003) study. Unfortunately, research in the area of supervisee training has been extremely limited to date (Sloan & Fleming, 2011). However, Sloan (2006), in his interdisciplinary study of four case groups of mental health nurses in the UK, discussed an undergraduate supervision course that some participants had attended. A 12-week experiential modular course gave potential supervisees an opportunity to participate in individual peer supervision, supervision with a line manager and group supervision. Interestingly, Cutliffe (2011) posits that the introduction of supervisee skills into pre-registration education could be seen as a cost effective and standardised way of providing foundational PS education for all nurses.

However, to date most training is provided at a post-registration level. The cohort from the Te Pou (2010) mixed method study believed post-registration skills gained from their supervision training were beneficial and necessary if optimum benefits were to be gained from PS. The study included three surveys completed at different points in the implementation process, focus group interviews with mental health and addiction nurses—supervisors (n=11) and supervisees, (n=16)—and telephone interviews with managers.

Nevertheless, some supervisors still felt under prepared for their role despite preparatory training according to information gleaned from focus group interviews with 12 NHS supervisors (Williams & Irvine, 2009). Spence et al.’s (2002) mixed method evaluation on the implementation of PS involving five pilot sites maintained that there were limited guidelines on how best to provide educational preparation for supervisors and supervisees. More recently there has been a strong sense of conviction that a certain standard of education, with some uniformity in content with quality indicators, is required (Williams & Irvine, 2009; Te Pou, 2009; White & Winstanley, 2010, Cutliffe, 2011) for supervision to maintain credibility amidst other support systems (Rafferty, Llewellyn-Davies & Hewitt, 2007). Cutliffe (2011) purports that the quality of supervision is dependent on the calibre of training and education offered. Quality training is noted as a key element that is essential if transformative changes in supervisee practice and client care are to be measured.

The call for standardised and accredited training, that was inclusive of core supervision skills with quality indicators, was reported in the McKenna et al. (2008) research study where mental health and addiction DONs (n=21), managers of NGOs (n=7) and nurse-supervisors (n=73) were surveyed.
The need for adaptable training for different areas of nursing or other professional groups was replicated in the supervisee comments from the present research study. Feedback in the Te Pou (2010) training evaluation pilot study in Northland District Health Board was similar. However, White and Winstanley (2010) followed a high-quality, university level training, of 24 supervisors for their RCT of PS across nine locations. Their study recommended caution that all PS training needed to be of a similar standard.

Unfortunately, there is a dearth of information in the current literature on the content of training and facilitation styles. Nevertheless, in this study the main emphasis of course content in training supervisors can be seen in Figure 1. From these results it was difficult to assess whether or not any particular models or frameworks were covered in the training. However, comments were made both in this and in the Cooper and Anglem (2003) study as to the need for further education on models/frameworks and reflection. McKenna et al. (2008) in their review of current approaches to PS for mental health and addiction nurses stated that whilst DHBs and NGOs often supported one particular framework, in all reality supervisors utilised an eclectic mix of models. For this reason they posit that the use of Kadushin’s (1976) framework with supportive, educative, and administrative functions provides a basic structure which enables the flexible use of supervision frameworks that best fit within differing healthcare areas and across disciplines.

Te Pou (2010), in their highly rated evaluation of PS training in the Northland District Health Board, covered similar topics to this study. No further suggestions were made as to additional topics by supervisees and supervisors, however the areas that both found most helpful were commented on. For the supervisees knowing “what supervision is and isn’t; structure; roles and expectations especially for themselves; knowing what to do in supervision sessions; having a plan and structure; benefits for a supervisee and understanding feedback” (p. 28) was helpful. For the supervisors it was the facilitation through modelling, role-plays and experiential learning that was most useful in comparison with the necessary didactic theoretical component of their training.

In addition, ongoing updates and supervision for supervisors were acknowledged as essential for the sustainability of efficacious supervision not only in this study but in those of Cooper and Anglem (2003), Sloan (2006), Te Pou (2010) and White and Winstanley (2010). Nevertheless, even with a good quality relationship and a well-prepared supervisor and supervisee, the process of supervision can be disrupted.
by personal anxieties and workplace issues. On the one hand, fear of disclosing incompetence; fear of risk to confidentiality; being challenged; and encouragement to acknowledge one’s emotions often heightens the levels of anxiety in the initial stages of the relationship with one’s supervisor. On the other hand, providing an environment where an easy rapport is developed allowing for a balance between support and enabling self-discovery through skillful questioning can also be anxiety-producing and challenging for the supervisor (Sloan, 2006; Bond & Holland, 2010). Furthermore, additional barriers may be present. Tensions can be produced surrounding release time from busy workplaces, lack of financial support, limited support and understanding of the process and the situation, if the benefits of supervision are not realised by the immediate work colleagues and the organisation.

Davys and Beddoe (2010) suggest that a way of overcoming these barriers is to focus on how both parties can work towards the development of the supervisee’s practice utilising a professional approach in the form of a negotiated contract or agreement. For PS to be effective there was a general consensus amongst experts and researchers in the field of supervision that all parties involved in the process need to have a similar aim, objectives and clear boundaries (Power, 2007; Te Pou, 2009). Initial conversations, that enable expectations to be clarified and agreed upon, provide the foundation for the growth and maintenance of a successful supervisory relationship (Carroll & Gilbert, 2011; Bond & Holland, 2010; Sloan, 2005).

**Contracts**

In this research study, and in the Cooper and Anglem (2003) mixed method study of mental health interdisciplinary team members, all supervisees had some form of contractual arrangements (Table 7). Interestingly enough, PS was rated very highly by both groups. One might therefore assume that having a negotiated contract may be yet another factor that has contributed towards the effectiveness of PS for the supervisees in these two studies. Education surrounding contracting was also high on the agenda in the training of supervisors in both instances as with the Northland DHB evaluation of training (Te Pou, 2010). Nevertheless, the research on the process of negotiating contracts, and their content, was limited. Despite this, structural details on the opportunity to choose their supervisor, the length and frequency of the sessions, the type of format, and external or internal supervision were more often than not commented on. Albeit, in this study it was the purpose of PS, the frequency of sessions
and confidentiality that were paramount in Canterbury nurse supervision contracts (Figure 2).

As previously mentioned, such a broad array of definitions and scope on the purpose of supervision requires discussion between the supervisor and supervisee. Sloan (2005), Proctor (2011) and Carroll and Gilbert (2011) posit that this is necessary in order to establish a common aim and objectives relating to roles and responsibilities, goals, developmental levels, problem resolution, ethical responsibilities and evaluation. The degree to which these aspects were covered in the supervisees’ contracts was highlighted in Figure 2. Whatever the purpose of the contractual arrangement may be, Power (2007) asserted that —more importantly— an agreement developed together between supervisor and supervisee helps reinforce the ownership of the contract. According to Power, a formal agreement such as this bodes well for the development of effective supervisory relationship. It could therefore be surmised that this was the case with the cohort in this study considering the high prevalence of joint contracts (Table 7) and the effectiveness of their supervision (Table 9). Interestingly though, for over half of the participants in this study, the contracts were between three parties: the supervisee, the supervisor and the employing organisation. Three-way contracts may range from the supervisor reporting back to the organisation, rate of attendance, or merely an exchange of an invoice for payment (Carroll & Gilbert, 2011).

**Appraisals**

With a high percentage of participants being funded by their organisation, feedback on the effectiveness of their PS may have been required. What was gauged from the information provided by the participants was that reporting back did occur, but not for all. Mostly this information was not linked to appraisals (Table 6) but more often in relation to attendance. McKenna et al. (2010) in their survey of mental health and addiction DONs (n=21), managers of NGOs (n=7) and nurse-supervisors (n=73), found when scoping the provision of PS amongst NZ mental health and addiction nurses that feedback from professional supervisors for the purpose of annual supervisee appraisals to employers was limited. This could indicate that in both cases there was a clear understanding of balancing line-management oversight of personal performance, in relation to national competencies and organisational goals, with supervisee-driven PS whereby practice is explored and appraised with the assistance of the supervisor (Sloan, 2006). Contrary to this position, Te Pou (2009), in their national guidelines for mental
health and addiction nurses, support the evaluation of professional supervision at appraisal time. However, the form this feedback would take is not elaborated upon.

**Managerial support**

The premise exists that managerial support is essential in the resourcing of PS within a large organisation from a financial perspective and in terms of time allowance for policy development, education, release time from the workplace and replacement of staff. Evidence to support this was found by Koivu et al. (2012) in their follow-up survey of medical-surgical Finnish assistant nurses [ANs] (n=47) and RNs (n=119); and by Te Pou (2009) and White and Winstanley (2010) in their Australian mixed method, randomised controlled trial which included mental health nurses, clients and unit staff in both control and intervention groups. Therefore, evaluation of the effectiveness of the process of PS and benefits was surely not an unreasonable request by organisations with supervision programmes, organisations funding private supervision and also individuals sourcing their own supervision. The supervisees in this study focused on supervisee-supervisor feedback, reviewing of contracts and ongoing training as a way of maintaining the quality, but little was mentioned about how one would monitor outcomes. In contrast, the supervisors from this study did put forward the need for audits and regular evaluations. Lynch, Hancox and Happell (2011) purport that there is only a small number of published evaluations addressing the effectiveness within Australia and New Zealand and this threatens the potential PS has to offer nurses.

**Benefits**

To date the effectiveness of PS has more often than not been measured in terms of the benefits for the individual nurse and their practice. However, as discussed it was the intertwining of motivational habits of mind, successful supervisory relationships, quality training of supervisors and supervisees and finally negotiated contracts and feedback or evaluation systems that were key factors in providing efficacious and beneficial PS. The results from this survey have demonstrated that in both privately accessed and organisational supervision these factors were essential ingredients for effective supervision. However, one must qualify the above statement by adding that—in large organisational PS programmes—it is the full support of management and staff at all levels (as purported by Koivu et al. (2012) in their follow-up survey of medical-surgical Finnish ANs (n=47) and nurses (n=119); and White and Winstanley (2010) in their Australian mixed method, randomised controlled trial) that underpins the success of a supportive and educative system such as PS.
Perceived benefits for the individual nurse and their practice

As previously mentioned, efficacious PS is essential for personal, professional and practice benefits to be achieved. With this in mind it was interesting to compare from the survey results what supervisees deemed to be the main purpose of their supervision (Figure 4), the time that was spent on those aspects (Table 4) and the benefits gained as a result (Figure 5). For the supervisees it was professional development, with role development and support, in close succession, which was perceived as being the key focus of their supervision. Unfortunately, it is not clear as to what exactly constituted professional development and how it differs from role development. Furthermore, from the qualitative comments a ‘personal development’ category emerged under the so-called professional development/role development grouping.

With the support offered through PS, supervisees acknowledged that they developed a greater self-awareness of the impact of interpersonal issues on their practice. During supervision a significant amount of time (Figure 4) was spent on interpersonal and team issues. As a result, supervisees noted that their conflict and change management skills were enhanced, thereby dealing better with differing levels of emotion. Bond and Holland (2010) noted that emotional turmoil or discomforting feelings often stem from working in challenging and ever-changing healthcare environments.

According to Stein-Parbury (2009), gaining sufficient insight into understanding and accepting oneself, and one’s emotional responses to certain situations allows one to do the same for the clients one cares for. It is this form of emotional intelligence (Bulmer Smith, Profetto-McGrath & Cummings, 2009) that directs the way in which we recognise and manage emotional cues amidst our interpersonal connections, with both staff and clients, thus generating a more sensitive and effective approach (Clarke, 2006; Bond & Holland, 2010; Davys & Beddoe, 2010).

Bond and Holland (2010) maintain that if a nurse’s emotional vulnerability has no outlet by way of appropriate support, this risks interrupting the conscious processes of critical thinking and sound decision making (Rubenfeld & Scheffer, 2006) and interventions necessary for quality care may indeed be thwarted. As a result, Croskerry

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2 Emotional intelligence skills include the ability to recognise, assess, understand, express emotion, extract and process emotional information, and regulate emotion to facilitate emotional and intellectual development.
and Norman (2008) assert that high levels of emotion automate thinking consequently limiting the use of evidence-based practice and reducing the level of judgment. Lombardo, Milne and Proctor (2009) agree that emotional disturbances can seriously impact on performance and in addition one’s learning capacity. In response, Clarke (2006) proposes that management of emotions, that are associated with the work we do, can be developed through “workplace learning mechanisms” (p. 457).

In addition, Lombardo et al. (2009) puts forward the idea that a supervisor, as a supportive facilitator of learning, is suitably positioned to enable supervisees to self-reflect on their emotional responses to situations in order to harness and develop emotional intelligence and to refocus and to feel re-energised. However, Bond and Holland (2010) advise that if we are obliged to contain and manage our emotions as professionals within the workplace environment, without the opportunity to verbalise our feelings through a supportive system such as PS, cynicism and burnout maybe the end products (Koivu, 2011).

These abilities of release (Bond & Holland, 2010), and reversion to emotional control according to Stein-Parbury (2009), take variable lengths of time to develop and are in no way static. In saying that, PS provides the ideal opportunity for this growth and development to occur given the career-long nature of supervision as opposed to shorter, more goal focused support systems (Bond & Holland, 2010). In turn, attaining the skills of emotional intelligence could be seen to pave the way for ongoing professional and role development (Zorga, 2002).

As previously mentioned, the ability to move on from personal emotional confusion is helpful in refocusing nurses on best practice and providing quality care to clients. For the supervisees in this survey it was the overall constructive feedback on their practice, coupled with the recognition of personal issues, that seemed to have provided them with the positivity and confidence to think more laterally about their delivery of care to clients. It was evident from the survey results that this feedback was through joint problem-solving and the theoretical linkage with practice, in a discussion format, rather than a more directive and didactic teaching approach (Table 8). The qualitative comments gave an insight into their changed approach. They were questioning their own practice, reviewing treatment and care options based on best practice in a more timely manner. Personal changes in reflexivity, confidence levels and a calmer approach were also observed by supervisors in their interactions.
These critical thinking (CT) skills of analysing, discriminating, information seeking and a more timely approach to care are indicative of changes in habits of mind (Rubenfeld & Scheffer, 2006). It is suggested, by these authors, that the use of CT skills, in tandem with a more positive, creative, open-minded and reflective attitude, enables a person to be more confident and self-assured in themselves. Enhancement of CT skills and transformation in habits of mind, in turn, usually extends to developing one’s expertise in making sound and timely decisions, a larger contribution to the workplace, therefore having a greater sense of satisfaction in one’s work (Rubenfeld & Scheffer, 2006). Professional changes, extending to movement into more advanced positions, further education and being involved in service development, were mentioned by supervisors in this study when commenting on the growth observed in the nurses they supervised.

Similarly, other studies found PS provided an emotional outlet for the purposes of de-stressing, continuing to develop self-awareness, emotional intelligence, confidence and the positive open-mindedness to think critically and make timely decisions. Significant findings of PS reducing stress through recognition of personal issues and support were found by ven Veeramah (2002) in their UK survey of community mental health nurses (n=165), in Cooper and Anglem’s (2003) survey of mental healthcare workers, and Jones (2003) in his mixed method research of a small group of hospice nurses. However, for Hykras (2005) and White and Winstanley (2010) the outcomes of their large PS-based surveys of mental health nurses showed that only in the presence of efficacious supervision were these same findings present.

In the Cooper and Anglem (2003) survey of mental health practitioners and in the small Te Pou (2010) survey of Northland DHB mental health nurses, increased confidence was noted and linked to more focused care, improved and creative thinking abilities and problem solving. This was also the case in the Claveirole and Mathers’ (2003) diary recordings of the development of a peer supervision scheme for UK lecturers (n=12), and in Sines and McNally’s (2007) survey of UK learning disability nurses (n=35). From this evidence it can be assumed that effective PS can assist in the building of and development of systematic thinking processes (Carroll, 2009; Carroll & Gilbert, 2011).

As mentioned above, the ability to think strategically and consider care options for individual clients was evident from these survey results. However, there were
limited specific examples offered as to how these changes influenced client care directly.

The supervisees noted that PS reduced risks to clients through promotion of best practice. The supervisors confirmed this by their comments that supervision enhanced the quality of service delivery through a greater focus on outcomes.

**What were the key changes suggested to sustain effective professional supervision?**

To enable these improvements to be made one would assume that a set standard or benchmarking is essential. The question is: what is regarded as an acceptable standard? In a Welsh study of participants from nursing and health visiting areas, a Delphi technique\(^3\) was used whereby a consensus on specific subjects was gained from repeated surveys and the utilisation of a panel of experts. From these results, indicators for a PS standard were developed (Rafferty, Jenkins & Parke, 2003). In further writings, Rafferty, Llewellyn-Davies and Jeanette Hewitt (2007) explained that with a standard there was flexibility that allowed for adaptation and change, in light of new evidence and developments. A standard could be set in order to make supervision available at an adequate or good enough level. Standards are noted as providing consistency and low-level control, thereby forming a baseline for evaluation of outcomes. They are designed to support a policy. Policies, in contrast, provide mandatory control and are devised by management. They briefly outline the purpose, scope, roles and responsibilities, and are often mandated to meet specific strategic planning and fiscal requirements. Within policies, and standards, guidelines are often referred to and offer recommendations of best practice to support standards (Guel, 2007).

Research on PS standards, from nursing, was limited and there was little more in the way of supervision guidelines. In saying that, Rafferty et al.’s (2003) Delphi study of supervision in nursing and health visiting developed three indicators as part of their standard. These were “professional support, learning and accountability” (p.1432) and could be similarly aligned with Kashudin’s work (1976) or Proctor’s (2001) framework which offer recommendations to support standards. The elements that stemmed from these indicators included: time, environment, relationship, professional support, focus, knowledge, interventions (learning), organisational support, recording and competency (accountability) (Rafferty et al., 2003).

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\(^3\) Delphi technique- a consultative process of interviewing key experts in the field to assist with developing the proposal. Feedback and often a second round of interviews occur.
Providing allocated and recognised time for PS was an element that was also highlighted in this survey as a necessary resource for effective supervision. Rafferty et al. (2003) called for adherence to supervision appointments in their standard. Nevertheless, they recognised that not all supervision was manageable within work time, particularly in acute settings. They calculated that a hour-long session once a month over the space of a year equates to two days, if working a 12-hour shift, and could be claimed as annual leave thereby financially recognising the nurse’s involvement in PS.

Alternatively, McKenna (2008) in their review of supervision for NZ mental health and addiction nurses noted that only one NGO integrated PS into the Professional Development Recognition Programme (PDRP)\(^4\). It was intimated that for supervision to be recognised as part of professional development there needs to be relevant competencies developed and general records kept. In keeping with a similar line of thought, professional development according to Lynch et al. (2008) broadly consists of prescribed self-directed learning with objectives to be met, attendance of courses or conferences and graduate or postgraduate studies where learning outcomes are hopefully translated into practice.

From a different vantage point, reflective learning objectives, which are central to PS, are set by the supervisee to meet their own individual learning needs with the assistance of a trained supervisor. Analysis, of past and present experiences, through reflective learning can offer new insights and options for future practice (Davys & Beddoe, 2010). With PS providing ongoing and regular opportunities to build on practice knowledge and skills, an opening could exist to make an acceptable standard of supervision an optional form of documented learning that fits with PDRP programmes in New Zealand.

Te Pou (2010) in their guidelines for supervisees suggested that utilising the template offered, the dates and times of sessions, the agenda, actions and ethical concerns should all be recorded and the actions discussed with the supervisor. Records from the session would be kept by the supervisee in a safe place. Similarly, Carroll and Gilbert (2011) recommended keeping a summary of main points from the session as a reminder of action points.

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Creating a suitable learning environment, where the supervision session can be held in a room that is free of disruptions, away from the workplace and with a prepared supervisor was also seen as an essential to maintaining a good enough standard of PS (Rafferty et al., 2007). A safe environment (Te Pou, 2009) such as this requires booking systems for rooms and time that equates to the level of importance of study leave, tutorials, annual leave and being rostered regular time off (Rafferty et al., 2007). The availability of a suitable space for this group of Canterbury nurses to receive PS must have been adequate, as this was not mentioned as an area for improvement.

However, increasing the numbers of supervisors with appropriate attributes was seen as an area for attention, especially in light of developing an appropriate supervisory relationship. To encourage supervisees to take on the role of supervisor the role needs to be promoted, emphasising the evidence of increased job satisfaction and improvement in quality of care amongst both mental health nurses (Hyrkas, 2005) and in different areas of a generalist tertiary hospital (Brunero & Lamont, 2011). Robust training programmes, updates and regular, supportive supervision were seen as quality initiatives by the Canterbury nurses involved in this survey, which may also in turn encourage the uptake of the role.

Another area omitted from suggested improvements, but incorporated in the Rafferty et al. (2003) standard and Te Pou’s (2009) guidelines, was the need for a contract or agreement. A contract was seen as necessary, as previously noted, to ascertain a purpose, set boundaries and determine to what degree records are kept thereby establishing the foundations of a good working relationship with one’s supervisor. Forming an agreement of this nature, with their supervisors, was an area that was well attended to by supervisees in this study and may have, as previously noted, consequently influenced the high satisfaction levels.

Organisational support at all levels was recognised in this study as being the most crucial ingredient for creating a culture or community where PS is valued and promoted as a support and professional development system (Edwards et al., 2005; White & Winstanley, 2010; Koivu et al., 2011). The general consensus is that further support for PS needs to be generated through presenting evidence of supervision benefits for nurses and clients, education and actual experience of effective supervision (Cutcliffe & Fowler, 2011). Unfortunately, without this knowledge and a lack of consistent research evidence, McKenna et al. (2008) concede that it has been challenging to grow, maintain and sustain high quality PS programmes even within
mental health. However, guidelines and standards (Rafferty et al., 2003; Te Pou, 2009) and accredited training and robust evaluation as recommended by White & Winstanley (2010) are posited as being the best way forward if support for supervision is to be gained from management and nurses at all levels. The supervisees in this study supported this viewpoint in their recommendations.

Nevertheless, for some individual supervisees who have sourced PS on a private basis without backing from management, in terms of financial support, their ability to advance PS as a S & PD system may be considerably more challenging. To encourage greater participation in wider areas, Koivu et al. (2011) purports that managers, as leaders, play a key role in supporting and facilitating time and space to attend supervision.

As mentioned previously, given the right support to attend PS it is then the selection of supervisors with the appropriate attributes that goes partway towards the establishment of an effective supervisory relationship. Of equal importance is the need for competent supervisors. Rafferty et al. (2007) purports that preparatory training, updates and ongoing experiential learning, through practice as a supervisor and their own regular supervision, constitute the best way of maintaining competence. Again, standardisation of supervisor training was suggested as a means of improving the quality of PS in this study and this idea is a recommendation in the Northland supervision study involving mental health nurses (Te Pou, 2010). Similarly, Rafferty et al. (2007) supports a national vocational qualification to provide a basic preparatory framework as a cost-effective way of delivering in-house education. However, these authors recognise the necessity for advanced university level qualifications if PS is to be further developed as part of everyday practice and as a way of maintaining quality client care.

Support for PS, ongoing education, recognised time for supervision, good supervisors and a sound contract offer the promise of efficacious supervision. Clearly these are all necessary factors, however without monitoring and regular evaluation, the sustainability of effective and financially viable PS may be questionable (Te Pou, 2009). Interestingly enough, the majority of the recommendations from the participants in this survey was focused on monitoring systems as a way of improving what they already had ascertained to be effective supervision. The suggestions, as noted previously, ranged from the regular review of contracts, ongoing feedback between supervisor and supervisee, and manager, at appraisal time and provision of a
standardised process for addressing concerns regarding supervision. In the National Guidelines for Professional Supervision for Mental Health and Addiction Nurses, Te Pou (2009) advocate the sharing and collating of results from evaluations as a way of increasing the effectiveness of supervision. Again, this raises the need for standardised evaluation tools to enable comparisons and generalisations to be made.

Implications and recommendations, for the development of professional supervision, in nursing practice

One of the major implications that has stemmed from this study is the conundrum surrounding the purpose of PS amidst other S & PD systems. Secondly, it has been identified from the findings in this study that there may be serious implications for the maintenance, sustainability and growth of effective supervision if the inconsistency in the standard of activities and operational arrangements is not addressed. Finally, this study has highlighted implications of a possible lost opportunity to develop nursing practice across all nursing specialties, if the benefits of PS are not realised and supported at all levels.

It is the career-long and regular nature of PS that sets this support and professional development system apart from the shorter, more goal focused mentoring, coaching and other designated support systems. With an abundance of definitions, that are often aligned with supervision frameworks and different nursing specialties, confusion can exist as to the real purpose of PS. Despite this dilemma common elements exist. They include having specified time away from the workplace for the purpose of reflecting on, and improving, practice with a trained supervisor individually or with supervisors/supervisees in a peer group. Nevertheless, the term supervision often conjures up threatening thoughts of oversight and direction by managers as mentioned throughout this thesis. Instead the purpose could lend itself justifiably constructively to a supersized vision of the potential improvements nurses could take into their role, into their practice and to standards of care.

With our ever-changing healthcare environment, and the need for constant adaptation and flexibility to new situations, a nurse’s role—to say the least—is challenging and somewhat stressful. PS could serve as a pre-eminent vehicle/tool for nurses to develop self-awareness, confidence and resilience, thereby becoming better equipped to work in an emotionally intelligent way. Continual development of these traits has assisted the nurses in this study to assimilate the application of new knowledge and skills into practice. Being more client focused as a result of ongoing
attendance of PS stimulated a greater range of treatment options to be offered for clients. In turn these outcomes had a perceived improvement in the quality of client care according to the participants in this cohort.

As a S & PD system, PS has proved in situations where supervision has been effective, that it can deliver personal, professional and practice benefits. However, effectiveness, as evidenced in this study and in the literature, is conditional upon the standard of preparatory and ongoing training of supervisors, education of supervisees, the development of a successful supervisory relationship and sound contractual arrangements that establish the foundations of that relationship.

The opportunity available to assist nurses to perform at an optimum level through supervision is not widely understood. The balance between the need for emotional release and that of emotional containment, combined with the clarity of thinking needed in pressurised situations, are areas that well-trained supervisors are skilled in developing. Their understanding of adult learning principles, critical thinking, reflection on practice, the necessity to make sound and timely decisions and utilising best practice-options, all determine their success as effective supervisors and models for supervision. These skills are further developed in supervisees through the supervisor’s artful questioning and reflective listening abilities. It is this advanced and more creative thinking capability of nurses receiving supervision that is translated into more thoughtful, individualised, well-managed client care. Zorga (2002) posits that a “developmental–educational framework of PS would be one way of maintaining personal and professional competence and encouraging lifelong learning” (p.275).

For effective supervision to be sustained, with measurable outcomes for nurses and in their practice, the following recommendations have been made. The recommendations have incorporated suggestions from the participants in this survey.
1. **Further evidence.** There is a need for further researched evidence using a consistent design and tools to demonstrate the added value PS could provide to an organisation.

2. **Promotion.** The need for wide spread education and continued promotion of PS requires existing champions to step up and model the personal and professional benefits of supervision.

3. **Managerial support.** For PS to grow and develop it has been acknowledged that managerial support is essential.

4. **Promoting the role of supervisor.** To provide a pool of supervisors it is important to encourage existing supervisees to advance their knowledge and skill in supervision by becoming supervisors.

5. **Resources.** Resourcing is essential for the promotion of PS training of supervisors and supervisees to meet the demand.

6. **Administrative requirements.** There is a need for guidelines, standards, policies for operational purposes, training and the maintenance of an effective programme.

7. **Education and training.** A standard needs to be set if PS education is to be effective in meeting the needs of both supervisees and supervisors. A range of levels of accredited courses would allow for supervision to be accessible to all nurses with the opportunity to build on foundational knowledge and further develop their expertise in PS.

8. **Monitoring.** Evaluation of the effectiveness of PS with standardised tools to enable comparisons to be made is essential if significant benefits are to be recognised. Attendance records need to be kept and reviewed to enable assessment of resource utilisation.

**Limitations to this research**

As noted the return rate from this survey was limiting. In this instance participants primarily received effective supervision across a wide variety of different specialties. Unfortunately, from the data collected, it was difficult to gauge who the non-participants were. Was their supervision beneficial or was it of little use? Whilst attempts were made to encourage further participation, survey return rates are often renowned for being low. With factual information from the closed questions depth and meaning were limited. However, the open-ended questions did provide some detail and examples. Another major limitation was the lack of opportunity for comparative testing
owing to the disproportionate sizes of groups and the range of different formats and models. One also needed to be mindful of putting forward a biased perspective (as the sole researcher). However, to reduce the potential of this occurring the research process was overseen by two academic supervisors.

**Further research**

For Canterbury nurses this survey presented preliminary information, or a reconnaissance phase, on which to base further research. Whilst this research has provided only a snapshot of what could be perceived as effective supervision for the variety of participants in this study, further information could be gained by using a recognised evaluation tool in one specific location. The aim would be to address the effectiveness of supervision in an environment where PS was supported at all levels, was available to all staff and where training was of a high standard. Feedback from managers, supervisors and clients, as to the standard of practice and delivery of care in a ward where supervision is supported, compared with one where supervision is not in place could better evaluate PS as a support and professional development tool for nurses.

Further evidence on the effectiveness of different formats of supervision such as peer and group PS, using a structured framework, or tools designed for groups, would be valuable—given the promotion and the cost effectiveness of group supervision. Assessing personality traits could provide insights into what attracts certain people to take up the offer of supervision. In particular, motivational characteristics could be explored, taking into account regular attendance in voluntary supervision. Additional research in areas where there is a dearth of information, such as in the acute settings, outside of mental health, would be beneficial in light of the emerging view that supervision should be available to all nurses.

**Conclusion**

Overall, the supervisees in this study gauged their PS as being effective. Nevertheless, suggestions were offered as to how the quality of supervision could be improved. With participation in this survey being inclusive of nurses from mental health, community-based nursing to small numbers from many varying specialties, the above recommendations were identified as the key elements essential for efficacious supervision. Suggestions from the recipients in this study, for even more effective PS, highlighted inconsistencies in supervision activities and in the overall functional
arrangements. Comments were made that veered in the direction of standardisation as a means of maintaining and sustaining PS as a quality support and professional development system. Special attention was given to streamlining of training and promotion of supervision through education at all levels. Included in this was the management level, without whose support for an organisation-wide programme, PS would remain informal or sought out by only the motivated few, and in a private capacity.

For PS to be available to all nurses it would need to be effective and beneficial, for both nurses and clients, to warrant the financial and operational commitment required. Without a brief as to what constitutes effective or good enough supervision, it has been difficult to continue the development of PS within NZ beyond mental health and the community-based nursing. However, the Te Pou (2010) national guidelines for NZ mental health and addiction nurses have been written as a framework that could be adaptable to other areas of the nursing workforce.

Regardless of the limited evidence of the impact on client outcomes from this study, benefits for the nurse-participants were identified. These included the recognition of personal issues, the feeling of being valued and increased confidence. Joint problem solving and creative thinking resulted in perceived changes in therapeutic perception and the provision of more client focused care and treatment options. In addition, the qualitative comments from the survey acknowledged further benefits through the promotion of best practice, the increased ability to manage challenges, cultivation of positive attitudes and increased efficiency. The challenge remains to provide sufficient, consistent evidence that may demonstrate the real benefits of professional supervision for nurses and the clients in our care.
References


doi: http://dx.doi.org/10.1136/bmj.328.7452.1372


doi: 10.1111/j.1471-6712.2011.00913.x


McCenna, B., Thom, K., Howard, F., & Williams, V. (2008). *Professional supervision for mental health and addiction nurses: A review of current approaches to professional supervision internationally and in New Zealand mental health and addiction sector.* Auckland: Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development.


Appendices

Appendix A (i) – Qualitative Chart: Q18 Supervisors’ Positions

<table>
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<tr>
<th>Theme</th>
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<tr>
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<td>Clinical Nurse Manager</td>
</tr>
<tr>
<td></td>
<td>Unit Manager</td>
</tr>
<tr>
<td></td>
<td>Case Manager</td>
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<tr>
<td></td>
<td>Clinical co-ordinator</td>
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Appendix A (ii) – Qualitative Chart: Q29 Circumstances Where Confidentiality Would be Broken

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<td>General Safety and Unsafe Practice</td>
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<td>-Breaches competencies</td>
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### Appendix A (iii) – Qualitative Chart: Q30 Feedback to Line Managers

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<td><strong>Appraisals</strong></td>
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<td>Performance appraisals</td>
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### Appendix A (iv) – Qualitative Chart: Q34 Difficulty with Access to Supervisors

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<td>Work demands</td>
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### Appendix A (v) – Qualitative Chart: Q38 Other Personal Outcomes from P and CS

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<td>Category</td>
<td>Support and personal benefits</td>
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<tr>
<td>Codes</td>
<td>Catharsis Way forward Affirmation of practice “Ability to discuss socio-political aspects affecting my practice Re-energised Empowerment “Improved relationships with managers and authority” Conflict resolution</td>
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### Appendix A (vi) – Qualitative Chart: Q39 Examples of Outcomes

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<td>Category</td>
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<td>Personal skills</td>
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<tr>
<td>Codes</td>
<td>Confidence Ability to reflect Improved relationships Problem solving How to deal with peer conflict Increased motivation Increased self-awareness</td>
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Appendix A (vii) – Qualitative Chart: Q54 Benefits Patients/Clients

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<td>Codes</td>
<td>Reflective practitioner</td>
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<tr>
<td></td>
<td>More energy</td>
</tr>
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<td></td>
<td>Confidence</td>
</tr>
<tr>
<td></td>
<td>Can handle stress</td>
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<td>Increased self-awareness</td>
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<tr>
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<td>Insight</td>
</tr>
<tr>
<td></td>
<td>Improved professionalism</td>
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<td>Continued personal growth</td>
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<td></td>
<td>Handling difficult situations</td>
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Appendix A (viii) – Qualitative Chart: Q55 Benefits for the Organisation

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<td>Increased productivity</td>
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<td>Codes</td>
<td>Strive to work as a good team member</td>
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<td></td>
<td>Increases the likelihood of staff performing optimally.</td>
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<td></td>
<td>Less oversight, more autonomy in role</td>
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<tr>
<td></td>
<td>Greater productivity</td>
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<tr>
<td></td>
<td>More Efficient</td>
</tr>
<tr>
<td></td>
<td>Competent staff</td>
</tr>
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<td></td>
<td>Promotes healthy functioning</td>
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<td></td>
<td>Increased clinical effectiveness</td>
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<td>Better understanding or role</td>
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Appendix A (ix) – Qualitative Chart: Q56 Assuring Quality of Supervision

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<th>Category</th>
<th>Preparation/systems</th>
<th>Sub-category</th>
<th>Structure of supervision</th>
<th>General Feedback</th>
<th>Supervisee /supervisor feedback</th>
<th>Patient feedback</th>
</tr>
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<tbody>
<tr>
<td>Codes</td>
<td>Updates for supervisors Supervisor and supervisee trained in same model Supervisees who come prepared Standardised training Recognised supervisory qualifications Access to ongoing training and workshops Continuing to provide the excellent quality supervision training Monitoring the training</td>
<td>Regular supervision Time available to attend Trust supervisors work within contracts Supervision of supervisors Regular review of contracts Measurable outcomes Regulation of same types of supervision</td>
<td>Feel good factor</td>
<td>Review of contract, goals and expectations Feedback from supervisee and supervisor Feedback at appraisal time Measuring themselves against a checklist Process to address concern re supervision process Audits Regular evaluations</td>
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## Appendix A (x) – Qualitative Chart: Q57 What Supervisors Need to be Effective

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<th>Personal attributes and support</th>
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<td><strong>Providers</strong></td>
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<td><strong>Models and skills</strong></td>
<td><strong>Continuing education</strong></td>
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<td>Codes</td>
<td>Role theory model</td>
<td>Counselling Peer reciprocal Range of models Therapeutic relationships Developmental approach Psychotherapy principles Senior nurse Interpersonal skills Motivational interviewing Reflective listening</td>
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## Appendix A (xi) – Qualitative Chart: Q58 Supervisee Training

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<td>Listening skills</td>
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<td>Communication skills</td>
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<td>Reflection skills</td>
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<td>Openness</td>
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<td>Honesty</td>
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## Appendix A (xii) – Qualitative Chart: Q59 How Supervision can be Improved?

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<tr>
<th>Theme</th>
<th>Q59 How supervision can be improved?</th>
<th>Involvement of Management</th>
<th>Priorities</th>
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<td><strong>Category</strong></td>
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<td>Supervision</td>
<td>REQUIRES</td>
<td>Financial support for updates</td>
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<td>Codes</td>
<td>REQUIRE: More supervisors</td>
<td>REQUIRE: Education of people saying 'yes or no' at the funding level</td>
<td>Introductions of a national guideline check</td>
<td>Financial support for updates</td>
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<td>Own supervision</td>
<td>Updates 2 yearly</td>
<td>Recognition and valuing of supervision</td>
<td>Introductions of a national guideline check</td>
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<td>Opportunity to network with other supervisors</td>
<td>Education on a variety of models</td>
<td>Overview reports from supervisors and supervisees</td>
<td>Recognition and valuing of supervision</td>
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<tr>
<td></td>
<td>Good interpersonal skills</td>
<td>Supervisors mentored in supervision and then teach supervisees what is required</td>
<td>Staff cover for recipients of supervision</td>
<td>Overview reports from supervisors and supervisees</td>
</tr>
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<td>Perceptive and good enquiry skills</td>
<td>Alternative trainers</td>
<td>Staff cover for recipients of supervision</td>
<td>Staff cover for recipients of supervision</td>
</tr>
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<td>Right personalities</td>
<td>Cultural training</td>
<td>Staff cover for recipients of supervision</td>
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<td></td>
<td>Pool of stand in supervisors</td>
<td>Training in developmental model for supervisees</td>
<td>More people able to access supervision. e.g. all nurses working in isolation or autonomously</td>
<td>More people able to access supervision. e.g. all nurses working in isolation or autonomously</td>
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<td></td>
<td></td>
<td>Addressing negativity regarding supervision</td>
<td>&quot;ensure supervisors delivering the supervision they are trained to deliver&quot;.</td>
<td>&quot;ensure supervisors delivering the supervision they are trained to deliver&quot;.</td>
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</table>

"not a survey like this"
“can get burnout with big workloads “
“very happy, no suggestions”
“staff need to act on improvements and changes as result of reflection”.
“reducing a culture of blame to induce uptake of supervision of nurses”
“train all nurses in supervision at undergraduate level".
### Appendix A (xiii) – Qualitative Chart: Q70 Supervisor Perceptions of How Supervision has Contributed to Service Quality

<table>
<thead>
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<td>Increased thoughtful interaction with clients</td>
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<td></td>
<td>more openness and calmness</td>
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<td></td>
<td>Increased confidence</td>
</tr>
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<td></td>
<td>Movement to higher positions and further education</td>
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<td>Clinical leadership</td>
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<td></td>
<td>Looks at unhelpful repetition of roles</td>
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<td></td>
<td>Improved RN development</td>
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<td></td>
<td>More objectivity, motivation, driving change</td>
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## Appendix A (xiv) – Qualitative Chart: Q71 General Feedback from Supervisors on Supervision

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<td><strong>Codes</strong></td>
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<td>Growth and understanding of functioning in practice</td>
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Participant Information Sheet

You are invited to take part in a research study titled

Mapping the uptake, the process and the effectiveness of professional and clinical supervision for nurses participating in supervision, in the Canterbury region.

My name is Helen Shaw-Brown and I am a Nurse Educator, and a student at Otago University, Centre of Post Graduate Nursing Studies, Christchurch. I am currently enrolled in a Master of Health Science (Nursing) Degree. As part of my thesis, I am conducting a questionnaire to gather information on the process and effectiveness of professional and clinical supervision, with nurses in the Canterbury region.

As a Canterbury nurse receiving professional and clinical supervision, I invite you to participate in this research study and share your experiences of professional and clinical supervision through completion of this written, short answer questionnaire. This research study specifically aims to provide information on the demographics of supervisors and supervisees; models and formats of supervision used; areas of uptake, accessibility and funding of supervision. The questionnaire also provides the opportunity, in twelve short answer questions, for both nurse-supervisees and supervisors to put their views on the benefits and/or the limitations of the supervisory process for the nurse, client and the service.

Your supervisor will have provided this information sheet about taking part in this study, however your involvement is entirely voluntary. After you have read the information sheet and have decided to take part, please complete the consent form enclosed with the questionnaire. Please return the consent form and questionnaire in the prepaid envelope provided within two weeks of attaining the questionnaire.

Returning the questionnaire implies you have read the information sheet and are consenting voluntarily to be involved in the study. Any information you give will be treated in confidence and your anonymity will be maintained at all times. The questionnaires will be numerically coded to
ensure anonymity and also to assist with monitoring which questionnaires have been distributed and returned. The completed questionnaire will be returned directly to an administrator.

The administrator will separate the consent form from the questionnaire before forwarding the anonymous questionnaire to the researcher. Only my supervisors will have access to the information provided. Both the consent form and the questionnaire will be stored separately and securely in a locked location in the Otago University, Centre for Postgraduate Nursing Studies, Christchurch, and will be destroyed after 10 years from the completion date of the study. The questionnaire data will be entered on the researchers’ own computer and be stored in password-protected files. Please remember that participation in this research is entirely voluntary.

An executive summary of the research findings will be distributed to all supervisors, on completion of the study. A copy will be available for you to take away and read, when you attend your supervision session. The information from the study may be utilised for publication purposes and nursing conferences, however no identifiable material will be used.

If you have any queries about completion of the questionnaire or about the study please do not hesitate to contact any of the research team. Please see the details below.

Kind regards

Helen Shaw-Brown

Otago University, Thesis Student, Faculty of Health Sciences (Nursing)

<table>
<thead>
<tr>
<th>Principal Investigator/Supervisor</th>
<th>Supervisor</th>
<th>Researcher</th>
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<tr>
<td>Beverley Burrell</td>
<td>Associate Professor</td>
<td>Helen Shaw-Brown</td>
</tr>
<tr>
<td>Otago University</td>
<td>Marie Crowe</td>
<td>Tel (03) 358 7249</td>
</tr>
<tr>
<td>Centre for Post Graduate Nursing Studies, Christchurch PO Box 4345</td>
<td>Otago University, Centre for Post Graduate Nursing Studies, Christchurch PO Box 4345</td>
<td>Cell 021 2950010</td>
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<tr>
<td>Tel (03) 364 3850</td>
<td>Tel (03) 362 3850</td>
<td><a href="mailto:helenshaw@slingshot.co.nz">helenshaw@slingshot.co.nz</a></td>
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<tr>
<td><a href="mailto:beverley.burrell@otago.ac.nz">beverley.burrell@otago.ac.nz</a></td>
<td><a href="mailto:marie.crowe@otago.ac.nz">marie.crowe@otago.ac.nz</a></td>
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This study (Number URB/09/11/054) has received ethical approval from the Upper South B Regional Ethics Committee (date: 2/12/09)
Appendix C - Questionnaire

Research Study Questionnaire

titled

Mapping the uptake, the process and the benefits of professional and clinical supervision for nurses participating in supervision, in the Canterbury region.

To participate in this research you are required to be:

1. a practising nurse
   AND
2. a supervisee who has received at least 3 supervision sessions
   AND/OR
3. a nurse who is both a supervisee and a supervisor
   OR
4. a nurse who is providing supervision but not receiving supervision

PLEASE NOTE:
All nurses receiving supervision are to complete questions 1-60.
All nurses who are both supervisees and supervisors are to complete questions 1-71.
If you are a supervisor and are not receiving supervision please complete only questions 61 to 71.

Please place completed questionnaire in the stamped addressed envelope and return within two weeks of the receipt of package.

Thank you for completing this questionnaire.
Questionnaire on Clinical Supervision for Nurses in the Canterbury Region

Questionnaire to supervisees and supervisors

I hope that you take a few minutes to answer questions about your supervision. Supervision has many purposes including education, clinical or case review, support, professional development, and role development. I would like you to answer this questionnaire as you understand the concept from your viewpoint.

Coding (for admin purposes) ___________________

Firstly, here are some questions about you as a supervisee.

1. What is your main current employment setting for which you receive supervision?
   - DHB (acute) [1]
   - DHB (community) [2]
   - DHB (other) [3]
   - Private Hospital [4]
   - Primary Health Care (PHO) [5]
   - Community Services (non DHB) [6]
   - Rest Home / Residential Care [7]
   - Nursing Agency [8]
   - Self Employed [9]
   - Māori Health Service Provider [10]
   - Rural [11]
   - Educational Institution [12]
   - Government Agency (MOH, ACC, Prisons, Defense Force, etc) [13]
   - Pacific Health Service Provider [14]
   - Other (please specify) [15]

2. What best describes your current nursing practice for which you receive supervision?
   - Emergency and Trauma [1]
   - Intensive Care / Cardiac Care [2]
   - Peri-Operative Care (Theatre) [3]
   - Surgical [4]
   - Medical (including educating patients) [5]
   - Palliative Care [6]
   - Obstetrics / Maternity [7]
   - Child Health (including neonatology) [8]
   - School Health [9]
   - Youth Health [10]
   - District Nursing [12]
   - Practice Nursing [13]
   - Occupational Health [14]
   - Primary Health Care [15]
   - Public Health [16]
   - Continuing Care (elderly) [17]
   - Assessment & Rehabilitation [18]
   - Mental Health (inpatients) [19]
   - Mental Health (community) [20]
   - Addiction Services [21]
   - Intellectually Disabled [22]
   - Nursing Administration & Management [23]
   - Nursing Education [24]
   - Nursing Professional Advice / Policy [25]
   - Development [26]
   - Nursing Research [27]
   - Nurse Practitioner [28]
   - Other (please specify) [29]

Non-practice Codes
- Non-Nursing Health Related Management
  - Or Administration [29]
- Other Non-Nursing Paid Employment [30]
- Working in Another Health Profession [31]
- Not in Paid Employment [32]

3. What is your gender?
   - Male [1]
   - Female [2]

4. What is your age group in years?
   - 20 to 29 [1]
   - 30 to 39 [2]
   - 40 to 49 [3]
   - 50 to 59 [4]
   - 60 and over [5]

5. How many years have you worked in nursing? [1]

6. What is your highest professional qualification?
   - Undergraduate Certificate [1]
   - Undergraduate Diploma [2]
   - Degree [3]
   - Postgraduate Certificate or Diploma [4]
   - Masters Degree [5]
   - Doctorate [6]

7. What ethnic groups do you belong to?
   - NZ European [1]
   - Māori [2]
   - Samoan [3]
   - Cook Island Māori [4]
   - Tongan [5]
   - Niuean [6]
   - Chinese [7]
   - Indian [8]
   - Other (such as Dutch, Japanese, Tokelauan) Please state: [9]

Ko tehea momo tangata e whai panga atu ana koe?
- Paketa [10]
- Hamaoa [12]
- Māori Kuki Airani [13]
- Tonga [14]
- Niue [15]
- Hainamana [16]
- Inia [17]
- Tetahi atu (pera i Tatimana, Hepanihi, Tokelau) Tahia mai: [18]
8. What is your geographical area?

<table>
<thead>
<tr>
<th>Location</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaikoura</td>
<td>1</td>
</tr>
<tr>
<td>Hurunui</td>
<td>2</td>
</tr>
<tr>
<td>Waimakariri</td>
<td>3</td>
</tr>
<tr>
<td>Christchurch</td>
<td>4</td>
</tr>
<tr>
<td>Banks Peninsula</td>
<td>5</td>
</tr>
<tr>
<td>Selwyn</td>
<td>6</td>
</tr>
<tr>
<td>Ashburton</td>
<td>7</td>
</tr>
<tr>
<td>Timaru</td>
<td>8</td>
</tr>
<tr>
<td>Mackenzie</td>
<td>9</td>
</tr>
<tr>
<td>Waimate</td>
<td>10</td>
</tr>
</tbody>
</table>

**Supervision**

In this section that follows I would like you to answer questions about your supervisor.

9. On average, what is the proportion of time spent in supervision on the following activities?

Could you give your answer in percentages adding up 100%

<table>
<thead>
<tr>
<th>Activity</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical work (cases)</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td>2</td>
</tr>
<tr>
<td>Cultural supervision</td>
<td>3</td>
</tr>
<tr>
<td>Role development</td>
<td>4</td>
</tr>
<tr>
<td>Administration matters</td>
<td>5</td>
</tr>
<tr>
<td>Growth and self awareness</td>
<td>6</td>
</tr>
<tr>
<td>Interpersonal or team issues</td>
<td>7</td>
</tr>
<tr>
<td>Profession (standards, ethics)</td>
<td>8</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>9</td>
</tr>
</tbody>
</table>

**10. What is your supervisor’s gender?**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
</tr>
</tbody>
</table>

11. What is your supervisor’s age group?

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 to 29</td>
<td>1</td>
</tr>
<tr>
<td>30 to 39</td>
<td>2</td>
</tr>
<tr>
<td>40 to 49</td>
<td>3</td>
</tr>
<tr>
<td>50 to 59</td>
<td>4</td>
</tr>
<tr>
<td>60 and over</td>
<td>5</td>
</tr>
</tbody>
</table>

12. How many years to the nearest year has your supervisor practiced as a supervisor?

<table>
<thead>
<tr>
<th>Years</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 4 years</td>
<td>1</td>
</tr>
<tr>
<td>5 to 9 years</td>
<td>2</td>
</tr>
<tr>
<td>10 to 14 years</td>
<td>3</td>
</tr>
<tr>
<td>15 to 19 years</td>
<td>4</td>
</tr>
<tr>
<td>20 to 24 years</td>
<td>5</td>
</tr>
<tr>
<td>25 to 29 years</td>
<td>6</td>
</tr>
<tr>
<td>30 years or more</td>
<td>7</td>
</tr>
<tr>
<td>Unsure</td>
<td>8</td>
</tr>
</tbody>
</table>

13. How many years since your supervisor received their highest professional qualification as a supervisor?

<table>
<thead>
<tr>
<th>Years</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 4 years</td>
<td>1</td>
</tr>
<tr>
<td>5 to 9 years</td>
<td>2</td>
</tr>
<tr>
<td>10 to 14 years</td>
<td>3</td>
</tr>
<tr>
<td>15 to 19 years</td>
<td>4</td>
</tr>
<tr>
<td>20 to 24 years</td>
<td>5</td>
</tr>
<tr>
<td>25 to 29 years</td>
<td>6</td>
</tr>
<tr>
<td>30 years or more</td>
<td>7</td>
</tr>
<tr>
<td>Unsure</td>
<td>8</td>
</tr>
</tbody>
</table>

14. What is your supervisor’s highest qualification?

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate Certificate</td>
<td>1</td>
</tr>
<tr>
<td>Undergraduate Diploma</td>
<td>2</td>
</tr>
<tr>
<td>Degree</td>
<td>3</td>
</tr>
<tr>
<td>Postgraduate Certificate or Diploma</td>
<td>4</td>
</tr>
<tr>
<td>Masters Degree</td>
<td>5</td>
</tr>
<tr>
<td>Doctorate</td>
<td>6</td>
</tr>
<tr>
<td>No professional qualification</td>
<td>7</td>
</tr>
<tr>
<td>Unsure</td>
<td>8</td>
</tr>
</tbody>
</table>

15a. Does your supervisor have a specific cultural role in the organisation?

<table>
<thead>
<tr>
<th>Role</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

(if no, go to question 17.)

15b. If yes, can you specify that role?

________________________________________

16. What of the following is your supervisor?

<table>
<thead>
<tr>
<th>Culture</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ European</td>
<td>1</td>
</tr>
<tr>
<td>Māori</td>
<td>2</td>
</tr>
<tr>
<td>Samoan</td>
<td>3</td>
</tr>
<tr>
<td>Cook Island Māori</td>
<td>4</td>
</tr>
<tr>
<td>Tongan</td>
<td>5</td>
</tr>
<tr>
<td>Niuean</td>
<td>6</td>
</tr>
<tr>
<td>Chinese</td>
<td>7</td>
</tr>
<tr>
<td>Indian</td>
<td>8</td>
</tr>
<tr>
<td>Other (such as Dutch, Japanese, Tokelauan) Please state:</td>
<td>9</td>
</tr>
</tbody>
</table>

17. What is your supervisor’s position?

<table>
<thead>
<tr>
<th>Position</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal to your team</td>
<td>1</td>
</tr>
<tr>
<td>External to team but internal to service</td>
<td>2</td>
</tr>
<tr>
<td>External to service</td>
<td>3</td>
</tr>
</tbody>
</table>

18. State your supervisor’s position.

For example Unit Manager, Nurse Specialist, Consultant, Clinical Coordinator, Registered Nurse on Ward or Private Supervisor.
19. What are the purposes of your supervision sessions with this supervisor?
(Please tick all the relevant categories)
- Clinical
- Administrative
- Supportive
- Professional development
- Role development
- Cultural
- Educative
- Other (please specify)

20. Who funds your supervision?
- Employer
- Self
- Other

21. How often do you have supervision?
- Once per week
- Once every two weeks
- Once every three weeks
- Once per month
- Other (please specify)

22. How long is your average supervision session?
(Specify in minutes.)

23. What kind of contract do you have with your supervisor?
- Written contract
- Verbal contract
- None
(if none, go to question 30.)

24. Who completed the contract?
- Yourself
- Supervisor
- Joint (Supervisor and Supervisee)
- Other (please specify)

25. Was the contract discussed with your line management?
- Yes
- No

26. How often is your contract reviewed in supervision?
- Once every month
- Once every three months
- Once every six months
- Once every nine months
- Once every twelve months
- More than twelve months

27. What issues are covered in your contract?
(Please tick all the relevant categories)
- Purpose of supervision
- Frequency of supervision
- Recording of supervision sessions
- Setting the agenda for supervision
- Preparation for supervision
- Interruptions and cancellations
- Confidentiality
- Safety of practice issues
- Cultural issues
- Accountability for client work
- Relationships with other staff
- Management of personal issues supervision
- Feedback to manager
- Resolution of conflict with supervisor
- Review of contract
- Boundary issues between supervisor and other meetings
- Group norms for group supervision
- Other (please specify)

28. If you have contracted for confidentiality of supervision, how would you describe that confidentiality?
- Absolute
- Qualified

29. Under what circumstances would confidentiality be broken? Please specify.

30. How does your Line Manager get feedback about your supervision? Please describe.
31. Is feedback from your clinical supervisor linked to your performance appraisal?
   Yes □ 1
   No □ 2

32. Did you choose your professional supervisor?
   Yes □ 1
   No □ 2

33. Is your supervision?
   Individual □ 1
   Group □ 2
   Peer □ 3
   Other (please specify) □ 4

34. If you have any difficulties in accessing a supervisor, can you describe those difficulties?
   ______________________________________
   ______________________________________
   ______________________________________

35. Can you rate the effectiveness of your professional supervision on client outcomes?
   1 2 3 4 5
   not effective effective very effective

36. Can you rate the benefit of your professional supervision for the organisation?
   1 2 3 4 5
   not beneficial beneficial very beneficial

37. Can you rate the extent to which supervision benefits service?
   1 2 3 4 5
   not beneficial beneficial very beneficial

38. What do you get out of supervision?
   (Please tick all the relevant boxes)
   Confidence □ 1
   Professional identity □ 2
   Changed therapeutic perception □ 3
   Increased ability to conceptualise □ 4
   Improved clinical intervention □ 5
   Increased clinical skills □ 6
   Recognition of personal issues □ 7
   Feeling valued and respected □ 8
   Constructive feedback about practice □ 9
   Other (please specify) □ 10

39. Can you provide any personal examples other than those provided in the previous question of what you get out of supervision?
   ______________________________________
   ______________________________________
   ______________________________________

40. How would you rate the quality of the relationship with your supervisor?
   1 2 3 4 5
   low quality average quality high quality

   In questions 41 to 53 use the following scale to answer questions about your supervisor to circle the answers.
   1 never
   2 rarely (every twelve months)
   3 occasionally (every six months)
   4 often (every three months)
   5 frequently (every session)

41. Does your supervisor give direct guidance on clinical work?
   1 2 3 4 5
   never rarely occasionally often frequently

42. Does your supervisor link theory to practice?
   1 2 3 4 5
   never rarely occasionally often frequently

43. Does your supervisor teach skills?
   1 2 3 4 5
   never rarely occasionally often frequently

44. Does your supervisor provide joint problem solving?
   1 2 3 4 5
   never rarely occasionally often frequently

45. Does your supervisor offer feedback?
   1 2 3 4 5
   never rarely occasionally often frequently

46. Does your supervisor provide reassurance?
   1 2 3 4 5
   never rarely occasionally often frequently
47. Is your supervisor empathic?
   1 never  2 rarely  3 occasionally  4 often  5 frequently

48. Is your supervisor rigid?
   1 never  2 rarely  3 occasionally  4 often  5 frequently

49. Is your supervisor supportive?
   1 never  2 rarely  3 occasionally  4 often  5 frequently

50. Is your supervisor skilled?
   1 never  2 rarely  3 occasionally  4 often  5 frequently

51. Is your supervisor intolerant?
   1 never  2 rarely  3 occasionally  4 often  5 frequently

52. Does your supervisor focus on the negative aspects of your work?
   1 never  2 rarely  3 occasionally  4 often  5 frequently

53. Now rate your satisfaction with supervision.
   1 not satisfactory  2 satisfactory  3 very satisfactory

54. What are the benefits of supervision for patients and clients? (If you have examples, please provide).
   _____________________________________________________
   _____________________________________________________
   _____________________________________________________

55. What are the benefits of supervision for the organisation? (If you have examples, could you write these below.)
   _____________________________________________________
   _____________________________________________________
   _____________________________________________________

56. How can the quality of supervision be assured?
   _____________________________________________________
   _____________________________________________________
   _____________________________________________________

57. What training do supervisors need to be effective?
   _____________________________________________________
   _____________________________________________________
   _____________________________________________________

58. What training do supervisees need to utilise supervision effectively?
   _____________________________________________________
   _____________________________________________________
   _____________________________________________________

59. Have you got any comments about how the quality of supervision can be improved? Can you write your comments here.
   _____________________________________________________
   _____________________________________________________
   _____________________________________________________

Other supervisory arrangements

60. How many supervisors do you have in addition to principal supervisor? (If you have supervision with a peer, count this as one supervisor.)

   ☐

Thank you for your contribution to this research as a supervisee.

IF YOU ARE A SUPERVISOR PLEASE COMPLETE QUESTIONS 61-71.
Questions for supervisors

61. How many years have you supervised professionals? □□

62. How many people do you supervise? □□

63. What is your highest level of training in supervision?
   University Degree, Certificate or Diploma in Supervision □1
   University paper □2
   Inservice training course □3
   CIT course □4
   Other □5
   None □6

64. How long ago did you do your most recent training?
   Last twelve months □1
   Between 12 months and 2 years □2
   Between 2 and 5 years □3
   Later than 5 years □4
   Ongoing □5

65. What informal training have you completed in supervision?
   Self directed learning □1
   Continuing professional education courses □2
   Workshops, conferences □3
   Other (please specify) □4

66. Did your training include any of the following?
   (Please tick all issues covered in your training.)
   Understanding teaching and learning □1
   Purpose of supervision □2
   Relationship building □3
   Assessment □4
   Contracting □5
   Counselling skills □6
   Appraisal □7
   Giving feedback □8
   Career advice □9
   Interpersonal skills □10
   Ethics of supervision □11
   Professional standards □12
   Cultural issues □13
   Working with social difference □14
   Other (please specify) □15

67. What is the purpose of your supervision?
   (Please tick all the relevant boxes)
   Clinical □1
   Administrative □2
   Supportive □3
   Professional development □4
   Role development □5
   Cultural □6
   Educative □7
   Other (please specify) □8

68. What method of supervision do you use?
   (Please tick all the relevant boxes)
   Supervisee’s case files □1
   Process recordings □2
   Self reports □3
   Interpersonal process recall □4
   Analysis of critical practice □5
   Audiotapes of clinical practice □6
   Live supervision □7
   Other (please specify) □8

69. Can you score on a scale of 1 to 5 the contribution that supervision makes to service quality?
   1 2 3 4 5
   none some substantial

70. Have you got any examples of the way in which supervision has contributed to service quality?
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

71. Do you have any other comments about supervision that you would like to contribute to this study?
   Please write any additional issues in the space provided.
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

Thank you for taking the time to complete this Questionnaire.
Appendix D – Consent Form

CONSENT FORM

Title: Mapping the uptake, the process and the effectiveness of professional and clinical Supervision for nurses participating in supervision, in the Canterbury region.

Purpose of this research study

I ___________________________________________ (full name) have read and understand the information sheet dated 12/11/09 for volunteers taking part in the study designed to provide information on the demographics of supervisors and supervisees; models and formats of supervision used; areas of uptake, accessibility and funding of supervision. The questionnaire also provides the opportunity, in twelve short answer questions, for both nurse-supervisees and supervisors to put their views on the benefits and/or the limitations of the supervisory process for the nurse, client and the service.

I have had the opportunity to discuss this study and am satisfied with the answers I have been given. I have had the opportunity to use whanau or a friend support to help ask questions and understand the study. I understand that taking part in this study is voluntary (my choice).

I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study. I have had time to consider whether to take part in the study.

I ___________________________________________ (full name) hereby consent to take part in this study.

Date: _____________________ Signature: _____________________

Project explained by: Helen Shaw-Brown

Project Role: Researcher

Signature: _____________________ Date: _______ February 2010

Otago University, Thesis Student, Faculty of Health Sciences (Nursing)

<table>
<thead>
<tr>
<th>Principal Investigator/Supervisor</th>
<th>Supervisor</th>
<th>Researcher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beverley Burrell Otago University Centre for Post Graduate Nursing Studies, Christchurch PO Box 4345 Tel (03) 364 3850 <a href="mailto:beverley.burrell@otago.ac.nz">beverley.burrell@otago.ac.nz</a></td>
<td>Associate Professor Marie Crowe Otago University, Centre for Post Graduate Nursing Studies, Christchurch PO Box 4345 Tel (03) 362 3850 <a href="mailto:marie.crowe@otago.ac.nz">marie.crowe@otago.ac.nz</a></td>
<td>Helen Shaw-Brown Tel (03) 358 7249 Cell 021 2950010 <a href="mailto:helenshaw@slingshot.co.nz">helenshaw@slingshot.co.nz</a></td>
</tr>
</tbody>
</table>

This study (NumberURB/09/11/054) has received ethical approval from the Upper South B Regional Ethics Committee (date: 2/12/09)
Appendix E (i) – Scoping Letter to The Princess Margaret Hospital

Helen Shaw-Brown, RN, BN, PG Dip Prof. Nursing Practice, PG Dip Tert. Tchg.
Nurse Educator
Older Person’s Health Service
The Princess Margaret Hospital

18 August 2009

Dear

My name is Helen Shaw-Brown and I am a Nurse Educator, and a student at Otago University, Post Graduate Nursing School. I am currently enrolled in a Master of Health Science (Nursing) Degree. I am conducting a quantitative research study using a survey method to gather data on the process of professional and / or clinical supervision.

The participants in this survey will be nurses within the Canterbury Region, who are receiving clinical / professional supervision. To ascertain the numbers for my sample size I am approaching all supervisors on the Canterbury Supervision Directory, Directors of Nursing and known businesses that provide professional and / or clinical supervision. I would be grateful if you could, please indicate whether or not you are currently providing supervision to any nurses, and if so to ‘how many’? Please forward this information via email or phone. This information will remain confidential and will only be accessed by myself, the researcher, and the Otago University Postgraduate School of Nursing, administrator. The administrator will sign a confidentiality agreement.

If you do supervise nurses I will contact you at a later stage regarding having a supply questionnaires for supervisees to take away and complete, following their supervision session. However, there is no obligation to participate.

Thank you for your assistance in providing the number of nurses that you supervise. If you have any queries please do not hesitate to contact me at helenshaw@slingshot.co.nz or on 358-7249.

Yours sincerely

Helen Shaw-Brown
Appendix E (ii) – Scoping Letter to Nurse Manager/Coordinator or Supervisor

Helen Shaw-Brown, RN, BN, PG Dip Prof. Nursing Practice, PG Dip Tert. Tchg
Otago University Thesis Student
8 Brookby Crescent
Avonhead 8042
Christchurch

14 February 2010

Dear NURSE MANAGER, CO-ORDINATOR or SUPERVISOR

Re: Research Study titled: Mapping the uptake of professional and clinical supervision for nurses in the Canterbury region.

I contacted you in August/September 2009 regarding my research. Thank you for your willingness to assist with the above study. I would be grateful if you could display posters to promote the study and assist me with the distribution of a batch of questionnaires for the nurse/supervisee’s. Depending on the response I, or an administrator may contact you in the following weeks to encourage the return rate of the surveys.

If you have any queries please do not hesitate to contact me at helenshaw@slingshot.co.nz or on 358-7249.

Thank you again for supporting this study. This study (number URB/09/11/054) received ethical approval from the Upper South B Regional Ethics Committee on (date: 2/12/09).

Yours sincerely

Helen Shaw-Brown

Centre for Postgraduate Nursing Studies – University of Otago, Christchurch
P O Box 4345, Christchurch 8140, New Zealand
Tel 64 3 364 3850 Fax 64 3 364 3855
www.woc.otago.ac.nz
Appendix F – Poster

INVITATION FOR NURSES CURRENTLY INVOLVED IN PROFESSIONAL AND CLINICAL SUPERVISION TO PARTICIPATE IN A RESEARCH STUDY TITLED

Mapping the uptake, the process and the benefits of professional and clinical supervision for nurses participating in supervision, in the Canterbury region.

YOUR PARTICIPATION IN A 30 MINUTE, WRITTEN, SHORT ANSWER QUESTIONNAIRE WOULD BE GREATLY APPRECIATED

If you are interested in participating please ask your supervisor for a copy of the questionnaire package.

If you have any queries concerning the study please do not hesitate to contact the appropriate person below:

<table>
<thead>
<tr>
<th>Principal Investigator/Supervisor</th>
<th>Supervisor</th>
<th>Researcher</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beverley Burrell</td>
<td>Associate Professor Marie Crowe</td>
<td>Helen Shaw-Brown Tel (03) 358 7249 or 021 2950010 <a href="mailto:helenshaw@slingshot.co.nz">helenshaw@slingshot.co.nz</a></td>
</tr>
<tr>
<td>Otago University</td>
<td>Otago University, Centre for Post Graduate Nursing Studies, Christchurch PO Box 4345 Tel (03) 362 3850 <a href="mailto:marie.crowell@otago.ac.nz">marie.crowell@otago.ac.nz</a></td>
<td></td>
</tr>
<tr>
<td>Centre for Post Graduate Nursing Studies, Christchurch PO Box 4345 Tel (03) 362 3850 <a href="mailto:marie.crowell@otago.ac.nz">marie.crowell@otago.ac.nz</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
31 August 2009

Ms Beverley Burrell
Department of Post Graduate Nursing
University of Otago, Christchurch

Tena koe, Bev

Thank you for meeting with me and Helen Shaw-Brown at the University of Otago, Christchurch on Friday 21st August 2009, to discuss your research study titled:

Mapping the uptake, the process and the effectiveness of clinical supervision for nurses in the Canterbury Region

I note that your research is a Masters Thesis, to build on existing knowledge by gathering data through a survey questionnaire. As discussed, there it is likely to be few nurses that are Maori; asking for ethnicity details may or may not highlight the lack of Maori in the nursing workforce for Canterbury.

It was therefore agreed that there is a need to acknowledge the issues pertaining to ethnicity and to consider how ethnicity data will be collected in your study. Also, given the poor ethnicity data collection in hospital databases this information should be collected in demographic information as part of the research. Through our discussion the Census 2006 ethnicity question was considered to be the preferred tool in recording ethnicity.

It is a requirement of the ethics approval process that a final report be submitted when the research is complete. A copy of the report should be provided to me at that time as findings from this project may contribute to the development of future research hypotheses or projects. It is therefore important that appropriate Maori organisations, Maori health professionals and Maori researchers are aware of your findings. The Research Office of the University of Otago, Christchurch and in particular myself as the Research Manager of Maori health would be willing to assist in the dissemination of your findings once your project has reached a successful conclusion.

My suggestions do not necessarily relate to ethical issues with the research, including methodology. Other committee may also provide feedback in these areas. I hope this letter will suffice in terms of the application. Please contact me should you need any other information that may not have been included in the letter relevant to our conversation.

I wish you well in your research.

Kia manawanui

e noho ra,

Elizabeth Cunningham
Research Manager - Maori
Research Office, Department of the Dean
University of Otago, Christchurch
PO Box 4345, Christchurch Mail Centre, Christchurch 8140, New Zealand
Tel +64 3 364 0237 • Fax +64 3 364 0525 • Email research.unc@otago.ac.nz
18th September 2009

Helen Shaw-Brown
8 Brookby Cres
Avonhead
Christchurch 8042

Dear Helen,

Thank you for consulting with me following advice from Elizabeth Cunningham,

Re your study:

Mapping the uptake, the process and the effectiveness of professional and clinical supervision, for nurses, in the Canterbury region.

I would like to support your study and am willing to provide ongoing advice to you if required, I would also be interested in the outcomes of this work and disseminating the results to interested nursing colleagues.

I wish you well with your study

Naku noa

Na Annette Finlay
Tainui/Te Arawa
RNCpN.BHSc
23 September 2009

Helen Shaw-Brown
8 Brookby Crescent
Avonhead
Christchurch 8042
New Zealand

Dear Helen,

Research Proposal: Master of Health Sciences (Nursing)

Thank you for submitting your revised research proposal. As concerns remain regarding what is not specified in the scope of the proposal, you are encouraged to communicate regularly with your supervisors to ensure the project remains manageable, particularly in respect to the large data set arising from so many variables, and the resultant potential for complicated statistical analyses.

Your research proposal and supervisory arrangements are approved as follows:

Title: Mapping the uptake, the process and the effectiveness of clinical supervision, for nurses, in the Canterbury region.

Supervisors: Ms Beverley Burrell
Associate Professor Marie Crowe

Ethical approval

You are reminded that your research cannot begin until ethical approval, where appropriate, has been granted. Once granted, a copy of the ethics approval must be sent to the Postgraduate Programmes Administrator, Health Sciences Divisional Office, to be filed along with your research proposal.

Taking a break from study

Please complete an application for a period of temporary withdrawal if you need to take a break from your studies. This will help to protect the length of time you are allowed to complete your programme. A copy of the guidelines for temporary withdrawal (also called deferral) are attached.
I wish you all the best with your research.

Yours sincerely

[Signature]

Dr Lois Surgenor
on behalf of the
Board of Graduate Studies in Health Sciences
Appendix J – Approval from Health and Disability Ethics Committee

2 December 2009

Ms Beverley Burrell
Centre for Postgraduate Nursing Studies
University of Otago
PO Box 4345
Christchurch

Attention: Helen Shaw-Brown
8 Brookby Crescent
Avonhead 8042
Christchurch

Dear Beverley

Ethics Reference Number: URB/09/11/054

Mapping the uptake, the process and the effectiveness of professional and
clinical supervision, for nurses, in the Canterbury region
Ms Beverley Burrell, Ms Helen Shaw-Brown, Dr Marie Crowe
By Ethics Committee

The above study has been given ethical approval by the Upper South B Regional Ethics Committee.

Approved Documents
Information sheet version 3 dated 12 November 2009
Consent Form version 2 dated 12 November 2009
Questionnaire on Clinical Supervision for Nurses in the Canterbury Region
Letter to private businesses regarding study
Letter to organisations regarding research study
Poster

Certification
The Committee is satisfied that this study is not being conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is being carried out.

Accreditation
The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.
Progress Reports
The study is approved until 29 April 2011. The Committee will review the approved application annually and notify the Principal Investigator if it withdraws approval. It is the Principal Investigator's responsibility to forward a progress report covering all sites prior to ethical review of the project in November 2010. The report form is available on http://www.ethicscommittees.health.govt.nz. Please note that failure to provide a progress report may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

Requirements for SAE Reporting
The Principal Investigator will inform the Committee as soon as possible of the following:
- Any related study in another country that has stopped due to serious or unexpected adverse events
- withdrawal from the market for any reason
- all serious adverse events occurring during the study in New Zealand which result in the investigator breaking the blinding code at the time of the SAE or which result in hospitalisation or death.
- all serious adverse events occurring during the study worldwide which are considered related to the study medicine. Where there is a data safety monitoring board in place, serious adverse events occurring outside New Zealand may be reported quarterly.

All SAE reports must be signed by the Principal Investigator and include a comment on whether he/she considers there are any ethical issues relating to this study continuing due to this adverse event. It is assumed by signing the report, the Principal Investigator has undertaken to ensure that all New Zealand investigators are made aware of the event.

Amendments
All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

Please quote the above ethics committee reference number in all correspondence.

The Principal Investigator is responsible for advising any other study sites of approvals and all other correspondence with the Ethics Committee.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.
The committee would like to take this opportunity to wish you all the best with your research.

Yours sincerely

Mrs Diana Whipp
Upper South B Regional Ethics Committee Administrator
Email: diana_whipp@moh.govt.nz
Appendix K – Approval from Plunket

Ms Helen Shaw-Brown
8 Brookby Crescent
Avonhead 8042
Christchurch

9 March 2010

Dear Ms Shaw-Brown

Mapping the uptake, the process and the effectiveness of Professional and Clinical Supervision for nurses involved in supervision in the Canterbury Region

I am pleased to inform you that the Plunket Ethics Committee has approved your proposal. The following are minor points that we think could help improve some aspects of your study.

1. The information sheet and consent form should add a reference to Plunket ethics approval.
2. There is mention of a transcriber confidentiality agreement; ensure that this is provided.
3. You should bear in mind that the questionnaire is based around a model of supervision that does not reflect supervisory practice within a Plunket context. While this is not an ethical issue it could potentially influence the reportable outcomes of the research.
4. It may be more straightforward to amend the poster and state that those interested should contact their supervisor or a researcher.
5. Look closely at the wording of the questionnaire:
   Q16 – only asks for one ethnicity
   Q26 – ‘contact’ should be ‘contract’
   Q35 – extra ‘I’ on vey effective
   Q50 – ‘Is you supervisor skilled?’ This is ambiguous.
   Q55 – what organization?
   Q54 – options are not mutually exclusive
   Q68 – spelling of ‘relevant’
   Throughout – check the apostrophe in ‘supervisee’s’; it is being used incorrectly.
On behalf of the Committee I would like to wish you well with this study and with your thesis.

Yours sincerely

PP R J Murna

D Gareth Jones
Chair, Plunket Ethics Committee