# Good characteristics of a clinical supervisor: a community mental health nurse perspective

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**Good characteristics of a clinical supervisor: a community mental health nurse perspective**

A qualitative methodology was adopted using a questionnaire and focus group to identify characteristics of a good supervisor from a supervisee perspective (staff nurses working in a mental health setting). Findings from the questionnaire and focus group were used as a basis for the nominal group technique to establish a prioritization of those characteristics identified. Thematic content analysis of the focus group generated five major categories: who provides clinical supervision; what happens during supervision; factors affecting the choice of supervisor; characteristics of a good clinical supervisor; and limitations caused as a result of how supervision is conducted. The ability to form supportive relationships, having relevant knowledge/clinical skills, expressing a commitment to providing supervision, and having good listening skills were perceived by the staff nurses as important characteristics of their supervisor. Supervisees viewed their supervisor as a role model, someone who they felt inspired them, whom they looked up to and had a high regard for their clinical practice and knowledge base. Nonetheless, limitations to the supervisory process were identified. Having their clinical supervisor allocated to them, their supervisor also being their manager, and having supervision sessions documented and stored by this manager threatened the full utility of the clinical supervision. In this paper three categories will be discussed: what happens during clinical supervision; good qualities of a clinical supervisor; and limitations caused as a result of how clinical supervision is conducted. In light of the study's findings, recommendations are offered to develop the provision of clinical supervision.

*Keywords:* clinical supervision, community mental health nurse, focus group, good characteristics, nominal group technique, thematic content analysis

## INTRODUCTION

The Department of Health's (DoH) document *A Vision for the Future — The Nursing, Midwifery and Health Visiting*

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*contribution to Health and Health-Care* (DoH 1993), the review of mental health nursing (DoH 1994) and the United Kingdom Central Council for Nursing, Health Visiting and Midwifery (UKCC 1996) position statement on clinical supervision all argue in favour of all nurses having access to a clinical supervisor. Until recently no such formal acknowledgement of the need for clinical supervision in nursing had been made. There is certainly an under-developed base of empirical evidence to suggest the benefits of clinical supervision to both nursing and client care (Paunonen 1991, Hallberg & Norberg 1993, Hallberg 1995, Palsson & Norberg 1995, Palsson *et al.* 1996, Jones 1998). Instead, there is acknowledgement that the nature of nursing generally (Rankin 1989), and mental health nursing specifically (Everitt *et al.* 1996), has changed to an extent which requires remedial action.

The most frequently reported aspect of clinical supervision in nursing is the expectation concerning its far-reaching benefits, and particularly its use in resolving nursing's discontent. While there are many anecdotal accounts of the benefits and outcomes of clinical supervision in a wide variety of nursing situations, comparatively few detailed empirical studies have been published. These benefits have, according to Jones (1995), become a mythologized element of supervisory practice.

So far, by introducing formalized clinical supervision, it has been implied that: nursing staff will develop their clinical competence and knowledge base (Barton-Wright 1994, Bishop 1994, Chambers & Long 1995, Friedman & Marr 1995, Nicklin 1995, Lowry 1998); the quality of patient care will be improved (Bishop 1994, Timpson 1996); nursing staff will feel supported (Benfer 1979, Farrington 1995, Cutcliffe & Epling 1997), experience less stress (Firth 1986, Wilkin 1988, Faugier 1994), and be less inclined to leave nursing (Bishop 1994); the number of complaints to the health service will be reduced (Farrington 1995, Nicklin 1995); and there will be an increase in nurses' confidence (Bishop 1994, Cutcliffe & Epling 1997).

Despite these accolades, little is understood about aspects of the supervisory process, such as the relationship between the supervisor and supervisee, and more specifically, the characteristics of the supervisor which create good clinical supervision. Some policy-makers and academics share the notion that supervisees should be given the freedom to make a choice regarding who provides their supervision (DoH 1994, Butterworth & Faugier 1994a, b). But upon what basis do supervisees make this choice? Little has been done to illuminate the supervisee's perception of the good characteristics of a clinical supervisor. In the nursing literature, studies by Pesut and Williams (1990), Fowler (1995), Severinsson (1995) and Severinsson and Hallberg (1996) begin to unravel this complex aspect of clinical supervision.

In acknowledging the paucity of empirical knowledge concerning those factors which may have some influence over the supervisee's choice of supervisor the author felt it important to conduct further study. With an absence of any such work conducted in British mental health nursing the author believed that such a study was now necessary. Specifically, there was a need to focus on identifying what characteristics the supervisee values in the supervisor.

## LITERATURE REVIEW

Despite the relationship between supervisor and supervisee being viewed as the key to effective clinical supervision and the supervisor's behaviour as one of the most important characteristics of the process (Ellis 1991, Rich 1993), there is a lack of emphasis on the evaluation of those characteristics in the research literature. While there has been some work on identifying good supervisor characteristics from the supervisor's perspective, there is a dearth of research which concentrates on seeking an understanding of those characteristics deemed essential from the supervisee's point of view (Gaoni & Neumann 1974, Holloway 1984). With few such studies in the nursing literature, it was necessary to draw on the work done in counselling, psychology and psychotherapy.

### Effective supervision: counselling, psychology and psychotherapy perspectives

Worthington and Roehlke (1979) attempted to identify what specific supervisor behaviours are perceived as most effective by both the supervisor and supervisee. A list of 42 supervisor behaviours was compiled from a number of informal interviews with experienced supervisors. Both supervisors and supervisees used this to evaluate supervisor behaviour.

An interesting finding from this study is the discrepancy between what behaviours the supervisors and supervisees believed to be important. For example, supervisors perceived good supervision being predominantly based on giving feedback about the supervisee's counselling ability. Supervisors did not perceive some of the more educational aspects as being vital to good supervision, for example allowing the supervisee to observe the supervisor counselling clients, role-play during the supervisory session and providing literature about therapeutic interventions. On the other hand, supervisees rated supervision better when the supervisors taught them more directly on how to counsel, provided a supportive relationship, and encouraged them to use newly acquired counselling skills.

Since the data-collection tool was developed by asking experienced supervisors what they felt were important supervisor behaviours, its reliability in illuminating good supervisor behaviours from the supervisee's perspective must be considered with caution. Furthermore, the rating scale almost exclusively lists desirable behaviours,

  

making it subject to possible response bias due to a positive response set.

Results from Heppner and Roehlke's (1984) study share findings which are similar to those of Worthington and Roehlke's (1979) study, that is, the supervisees rated supervision as better when their supervisors provided a supportive relationship as well as promoting the effective use of counselling skills. Furthermore, this study begins to highlight that the characteristics of a good supervisor as identified from the supervisee vary depending on the level of their training and experience.

Rabinowitz *et al.* (1986) designed a two-part supervision checklist based on Heppner and Roehlke's (1984) 12-item critical incident list to identify important issues raised during supervision. They also used a 7-item checklist to ascertain the most important interventions as perceived by the supervisee (Loganbill *et al.* 1982). The report does not offer findings from any pilot study. The intention had been to explore supervisees' perception of important issues in supervision and important supervisory interventions and supervisor behaviours. Instead of constraining the respondents in their expression of what is important to them by the completion of rating scales, in-depth interviews may have yielded richer data. The most important issues and interventions endorsed by participants, regardless of the level of experience, appeared to be those related to supervisory support, guidance with treatment planning and advice and direction about interventions from their supervisor. Although previous studies identified supervisor support and advice on interventions as requisite for beginning counsellors, the results of this study suggested that these behaviours may, in fact, be regarded as fundamental by all supervisees irrespective of their level of experience.

## A nursing perspective

Pesut and Williams (1990) conducted a survey on the experiences of clinical nurse specialists in mental health and their supervisory role in psychotherapy practice. Findings from a questionnaire did highlight that these supervisors identified the following as being characteristics of a good supervisor: giving specific ideas about intervention; providing feedback on performance; creating a warm and supportive relationship; promoting autonomy; and being competent as a therapist. These results paralleled the descriptions of an ideal supervisor found in the psychotherapy literature (Carifio & Hess, 1987) and the findings from Allan *et al.*'s (1986) study identifying the 'best' supervisor characteristics, suggesting that supervisors in psychiatric nursing value many of the same attributes as those in the counselling, psychotherapy and psychology professions.

In contrast to Pesut and Williams (1990), Severinsson (1995) and Severinsson and Hallberg (1996) highlighted, from both a supervisee and supervisor perspective, that the most important quality in a supervisor's style is his or her ability to confirm the supervisee's professional practice. Using a structured interview with 18 clinical nurse supervisors, Severinsson and Hallberg (1996) also illuminated supervisors' willingness and preparedness to show understanding and their ability to bring out genuine feelings during supervision as important characteristics.

Fowler (1995) used a blend of quantitative and qualitative methods when he explored the 'characteristics of a good clinical supervisor' from the perspective of the supervisee. In the first stage a questionnaire was used to tease out issues relating to (a) the supervisor and (b) the supervisor–supervisee relationship. Stage two concentrated on clarifying the characteristics of a good supervisor and prioritizing these qualities. This information was then used to construct a questionnaire (stage three) which was distributed to a larger sample (stage four).

During the first stage a short questionnaire was given to 30 post-registration students who were doing a 24-week full-time English National Board (ENB) clinical award course. Only six of the 30 (20%) opted into the study. For the second stage, the researcher used a focus group discussion involving the six participants. Interestingly two categories, namely the ability to form supportive relationships and having relevant knowledge and clinical skills, have been identified elsewhere in the health care literature (Worthington & Roehlke 1979, Heppner & Roehlke 1984, Rabinowitz *et al.* 1986).

Characteristics of a good supervisor, as perceived by the supervisee, include: allowing supervisees to observe their supervisors' clinical practice; utilizing role-play during supervision to demonstrate interventions; providing relevant literature; encouraging the use of newly acquired skills (Worthington & Roehlke 1979); giving guidance with treatment and direction with interventions (Worthington 1984, Rabinowitz *et al.* 1986); and having the relevant knowledge, skills and specific teaching ability (Fowler 1995). In all of the above studies, the ability to provide a supportive relationship was also identified as being an important characteristic. Importantly, findings from these studies highlight the variance of 'good characteristics' across the level of supervisee skill and length of experience. While supervisees' perceptions of 'good characteristics' differ in relation to skills acquisition and extent of experience, there are also opposing viewpoints between supervisees and supervisors.

Supervisor-identified 'good characteristics' include: giving feedback about the supervisee's counselling ability (Worthington & Roehlke 1979, Pesut & Williams 1990); giving specific ideas about interventions; creating a warm and supportive relationship; promoting autonomy; being competent as a therapist (Pesut & Williams 1990); and the ability to confirm the supervisee's professional practice (Severinsson & Hallberg 1996). Supervisee-focused

research in nursing has so far remained at an embryonic stage. Fowler (1995) has not only begun to nurture this body of knowledge but has also made an important shift from previous studies. Instead of using supervisor designed rating scales to measure supervisee identified good supervisor behaviours, Fowler (1995) has incorporated qualitative and quantitative methods to illuminate the supervisee's perspective of the characteristics of a good supervisor.

## METHODOLOGY

A qualitative methodology was used to identify and answer the research question: what are staff nurses' (E-grade), working in community mental health teams, perceptions of the characteristics of a good clinical supervisor. The three main aims of the study were first, to identify, from the supervisees' perspective, characteristics of a good supervisor, second, to prioritize these characteristics, and third, to explore staff nurses experience of the supervisory process. By using this approach the author hoped to maximize an exploration of staff nurses' subjective experience and perceptions of important supervisor characteristics. Choosing this option is particularly appropriate when the study's focus is to seek an understanding and investigation of the interpretation people give to events they experience (Morse & Field 1996).

### Study setting

The study was conducted in a community health care trust involving six adult community mental health teams. Each team provides broad ranging mental health services to one of six localities. The staff nurses involved in this study each had a community mental health charge nurse as their immediate line-manager. Clinical supervision was provided by this person.

### Sample

A convenience sample of 13 participants were sent invitations requesting that they participate in the study. From the 11 who initially agreed to participate, eight completed the questionnaire. Six staff nurses participated in the focus group discussion.

### Method of data collection

#### *Questionnaire*

Appendix 1 shows the questionnaire used in the project which was developed from that used by Fowler (1995). A questionnaire was felt to be more suitable than individual in-depth interviews. In recognizing the existing work commitments of those involved in the study the researcher felt it important to use data collection methods which would be least disruptive to their normal work routine, but at the same time be appropriate to answer the research question. The revised questionnaire was piloted and deemed to be appropriate and relevant to the study's focus.

#### *Focus group*

The focus group interview is a qualitative approach used to learn about population sub-groups with respect to their psychological and sociological characteristics and processes (Stevens 1996). Although focus groups have been used in social research since the 1920s, their extended use has only escalated during the past 30 years. As a qualitative technique, their initial use was in marketing research (Millar *et al.* 1996). More recently the focus group interview has been used in health service research to examine people's experience of disease and their attitudes towards the health service (Dilorio *et al.* 1994). Health education research and sociological studies have used focus groups to explore attitudes and the needs of communities. Organizational systems have used them to improve communication networks (Stevens 1996).

When performed in a permissive non-threatening group environment focus groups, according to Nyamathi and Shuler (1990) and Dilorio *et al.* (1994), allow the investigation of a multitude of perceptions on a defined area of interest. In order to achieve this Basch (1987) argues that the researcher should provide a supportive environment, encourage all group members to share their views, facilitate interaction and summarize the discussion at various stages. The author believed that the focus group discussion would be of considerable value when exploring the complex area of supervisees' perceptions of a good supervisor. The schedule shown in Table 1 was used in the present study and was developed from an initial pilot-study.

The focus group can also be used to explore the results obtained by other data-collecting methods (Kitzinger 1995). For example, the results from the questionnaire

**Table 1** Schedule for focus group

1. Welcome participants, introduce self and facilitate introductions of group.
2. Thank members in agreeing to be involved in the focus group.
3. Explain the purpose of todays group.
4. Explain issues of confidentiality and anonymity.
5. Request members assistance in reading over initial analysis of transcriptions.
6. Provide opportunity for questions.
7. Identify format of clinical supervision.
8. Explore the characteristics of a good supervisor.
9. Explore the behaviours demonstrating these qualities.
10. Prioritize the characteristics of a good supervisor.

which was used in the present study (see Appendix 1) were examined during the focus group discussion. This mechanism has been described by Robson (1993) and Cormack (1996) as triangulation and can help towards validating the results of qualitative data. Denzin (1989) labels this as data triangulation (subtype-person) and methodological (within-method) triangulation.

## Data analysis

In the main study the researcher used the nominal group technique (Carney *et al.* 1996) to prioritize the characteristics identified during the focus group. The procedure consists of five stages: (i) individual silent generation; (ii) individual round robin feedback; (iii) group clarification of each idea; (iv) individual voting and ranking of each idea; and (v) discussion of group consensus results. This aspect of the focus group was highly structured with the researcher initially seeking clarification on the ideas generated from the questionnaire and the focus group discussion (stage three). Stages one and two, as outlined above, were substituted by completion of the questionnaire and the researcher writing all characteristics identified on a flip-chart. Following stage three, the participants were asked to vote their 10 most important characteristics and then rank them from least to most important. Discussion on the group consensus followed.

The nominal group technique was considered useful for this study for a number of reasons. First, it allowed supervisee-generated important characteristics of supervision to be prioritized. This was an important aim of the study. Second, it ensured that all members had an equal opportunity to contribute to both the group discussion and consensus. Last, the outcome from this aspect of the focus group could be fed back to the participants immediately, with misunderstandings and ambiguities clarified without having to encroach on their already over-stretched clinical time.

The discussion which emerged prior to carrying out the nominal group technique was analysed using thematic content analysis (Burnard 1991). The researcher progressed through the guiding principles for this method of analysis indicated in Table 2.

**Table 2** Stages of thematic content analysis

1. Notes are made following the focus group, a contact summary sheet.
2. The transcript is read through and notes are made on the general themes.
3. 'Open coding' where as many headings are written down to describe all aspects of the content. Categories are generated freely at this stage.
4. These categories are grouped together under higher-order headings.
5. Similar headings are removed to produce a final list.
6. Validity is enhanced by asking one or two colleagues to generate a category system independently and without seeing the researcher's list.
7. Transcript and audio-recording is reviewed again alongside the final list of categories.
8. The transcript is coded according to the list of categories.
9. Each coded section is cut out of the transcript and collected together according to the category it belongs with.
10. The cut-out sections are pasted onto sheets headed up with appropriate category headings.
11. Selected participants are asked to check the appropriateness of their quotations in the various categories.
12. Writing-up process begins.

### *Trustworthiness and rigour*

First, the triangulation methods described previously were used to enhance the rigour of the findings. Second, the researcher asked two colleagues to develop their own categorization which was used to help construct a final list of categories. Last, the researcher returned to the participants and asked them to comment on the transcripts, the categories emerging from them, and how well their quotes 'fitted' within each category. The audio-recording of the focus group and the subsequent transcript satisfy issues related to the trustworthiness of the data.

## Protection of participants

Ethical considerations for this study were managed by adhering to the necessary fundamental procedures, that is, seeking appropriate access to the site, submitting the proposal to the relevant ethics committees, and ensuring all participants gave their informed consent (Royal College of Nursing 1998).

# FINDINGS AND DISCUSSION

Findings from the questionnaire and focus group will be discussed in light of the emerging categories identified during the thematic content analysis of the focus group transcript and the relevant literature in order to establish the extent to which they corroborate or dispute previous work. In this paper three categories will be discussed: (i) what happens during clinical supervision, (ii) good qualities of a clinical supervisor, and (iii) limitations caused as a result of how clinical supervision is conducted.

## What happens during clinical supervision?

All participants perceived the supervision session as being divided between clinical business, emotional support and professional development. An agenda would be set at the beginning of the session and

depending on the supervisee's need on any particular day, the remainder of the session would focus on one of the above areas.

My supervisor does not use a model, but he uses very much a clinical, a supportive and a personal development approach. We always kind of touch on these three areas and he leaves it up to me to decide, whichever is causing the most concern at any particular time. He lets me make the agenda. (Speaker 2)

We touch on the educational side of things as well. Any personal developments or courses or whatever… but also the kind of supportive and clinical things, that I personally raise as well. (Speaker 3)

These descriptions of what happens during supervision, closely resemble Proctor's (1987) three-function model. In this model: the formative function is primarily concerned with developing skills and expanding the practitioner's knowledge base by reflective practice, exploration of interventions and exploration of the nurse–client relationship; the normative function assures quality by on-going assessment and evaluation of the standards of practice; and the restorative function is where emotional support attempts to alleviate the stress inherent with a caring role such as nursing. Participants generally preferred to have one-to-one discussions regarding specific clients with their supervisor. While this format does have its merits, it can create considerable bias (Hawkins & Shohet 1989). Ultimately, the supervisee may restrict the extent of their development by censoring what is disclosed during supervision. Furthermore, by restricting the supervision process to a one-to-one discussion, the benefits of other methods, for example live observation, role-play demonstration and supervisor-supervisee co-therapy (Padesky 1996), are thwarted.

Reluctance from the supervisee in the use of observed practice (live-supervision) may be associated with the particular understanding both supervisee and supervisor have of the term clinical supervision. Certainly, in the nursing press various misconceptions have resulted from the wide-ranging use of the term (Platt-Koch 1986, Jones 1995, 1996, Cutcliffe & Proctor 1998). There is also further confusion created when clinical supervision is equated with a mentor, preceptor and assessor role. Thus, if qualified nurses have the misconception of clinical supervision being the same as preceptorship or mentorship they may feel their role is being undermined. This may create in them a resistance to having their practice observed.

## Good qualities of a clinical supervisor

In response to the question 'Reflecting on your experience in this job, can you identify any qualities demonstrated by your clinical supervisor that you consider to be good qualities in terms of their clinical supervision role?', a total of 32 characteristics were identified by the eight participants. During the focus group, clarification of these characteristics reduced the list to 25 items. Individual voting, ranking and discussion of group consensus generated the 10 most important good characteristics (Table 3).

The ability to form supportive relationships and having relevant knowledge and clinical skills, as being examples of the characteristics of a good supervisor, have been identified elsewhere (Worthington & Roehlke 1979, Heppner & Roehlke 1984, Rabinowitz *et al.* 1986). These qualities were identified as important in the present study. However, in the present study, the participants differentiated between the supervisors having the ability to form supportive relationships and actually providing a supportive relationship with the supervisee. Insight into how this support was conveyed became apparent during the focus group

You're gradually becoming more confident and able to challenge yourself as opposed to constantly saying, what do I do about? You know the answers, but I think its just basic reassurance you need in the early stages. Someone to say to you 'that's good'. (Speaker 3) Confidence builder. (Speaker 5)

Sometimes you need to be told that you're going along the right road. You are working very isolated and you think 'what am I doing here?' You need somebody just to sit down and say, 'listen I'm doing this and that' and you just need to hear 'that's right', just to reassure you. (Speaker 2)

**Table 3** Good characteristics of clinical supervisor

| Position | Quality | Score | No. of scores |
|---|---|---|---|
| 1= | Supervisor makes me feel comfortable enough to discuss my own limitations. | 40 | 10/5/6/6/5/8 |
| 1= | Ability to develop supportive relationships encouraging trust, empathy and mutual regard. | 40 | 10/10/10/10 |
| 3 | Supervisor inspires by his knowledge base and clinical skills. | 36 | 9/8/8/7/4 |
| 4 | Role model. | 28 | 9/7/5/4/3 |
| 5 | Commitment to provide c/s. | 22 | 10/5/4/3 |
| 6 | Perceptive to the needs of the supervisee, clients and the team. | 19 | 9/7/3 |
| 7 | Supportive with me. | 18 | 9/9 |
| 8= | Good listening skills. | 17 | 9/6/2 |
| 8= | Supervisor acknowledges his own limitations. | 17 | 7/7/2/1 |
| 10 | Supervisor allowing supervisee to set agenda. | 15 | 8/6/1 |

As previously highlighted, insufficient consideration has been given to important supervisor attributes in the nursing literature. Those authors who do refer to this aspect of the supervisory process, use a variety of terms when referring to supervisor characteristics. For example, Catmur (1995) suggests the supervisor should have communication skills, supportive skills, general skills and specialist skills. On the other hand, Devine and Baxter (1995) include more precise attributes when considering criteria for supervisors, in that supervisors should receive supervision themselves, have had some form of educational preparation for the role, and have a registered mental nurse qualification.

Kohner (1994) documents what qualities are preferred by staff working in an acute mental health unit. Descriptions of supervisors include qualities such as compassionate, wise, kind, honest, knowledgeable, available and approachable. Unlike Catmur (1995) and Devine and Baxter (1995) this description emphasizes the personal qualities of the supervisor, rather than the number of qualifications and length of experience they have. Certainly, findings from the present study confirm the importance supervisees place on personal qualities and interpersonal competence, over and above any specific qualification.

## Limitations in how clinical supervision is provided

While listening to the audio-taped recording of the focus group the researcher became aware that there were two segments of the session where the level of interaction and the degree of excitement intensified dramatically. The first when discussing how supervisors are allocated, and the second when highlighting issues related to the supervision session being documented.

Who decides on who your supervisor is? (Researcher)

Team Leader. (Speaker 6)

You are told by the Team Leader. (Speaker 5)

I don't think you challenge it. I think you accept it, basically because your told. (Speaker 6)

There are so many issues about challenging that. I think my first morning it was the secretary who took me in and said this is … , he is going to look after you. (Speaker 5)

But there is not any selection of who your supervisor is. It is just the appointed person. (Speaker 3)

I suppose if you were having problems, then they would have to address it. I don't know how that would be received. (Speaker 1)

I think that is always an issue about being given a supervisor because it limits the relationship in some way. (Speaker 5)

This method of allocating supervisors would seem to detract from creating the most effective supervisory relationship since, from the supervisees' perspective, a good supervisor is identified as 'good' because of the personal characteristics the supervisee views as important (Goorapah 1997). Furthermore, discussion with supervisees in this study indicated that they want a supervisor who inspires them, someone they look up to, and who they respect for their knowledge base and clinical skills. However, it was not only 'how' the supervisee's supervisor was allocated that was considered as limiting but also 'who'.

Some of the problems are even caused by the hierarchical supervision because there are two agendas. There is your personal development on how you feel you do your job, then there is a management agenda there as well, and what … said about weaknesses. That trust takes a long time, and it possibly takes longer if you're not given a choice. (Speaker 5)

And if you do, does he slip from the supervisor's role to his manager's role and maybe act on something that you said. (Speaker 2)

Yes, where does one stop and the other start? (Speaker 5)

Three of the respondents pointed out how limiting this actually is:

I think generally… it's probably negative. I think it does inhibit you, it inhibits what you're going to say and what you're going to disclose. (Speaker 6)

I think it would get to the situation as … said, that it just kind of becomes a mechanical thing… you're not divulging anything. (Speaker 3)

You're just talking about anything to take up the time. (Speaker 5)

As a result of the supervisor having a managerial role to fulfil, management tasks would be brought to the supervision session. From the supervisor's perspective, an agenda for supervision might include performance appraisal, personal development planning and clinical supervision. Attending to the first two emphasizes the manager's management task whereas the latter belongs to a separate clinical supervisor role (Pollock 1988, Scanlon & Weir 1997).

The nature of this superior–subordinate relationship is a potential source of discomfort (Mahood *et al.* 1998). For example, if career mobility is dependent on the positive evaluation from this superior it is unlikely that 'problems' or 'weaknesses' will be conveyed for managerial perusal since the sharing of these dilemmas may give the impression that the subordinate (supervisee) is incompetent. On the other hand, offering solutions or innovations may threaten and undermine the position of the superior (supervisor). Crozier (1984) refers to this as the 'keeping quiet' game and it is thought to occur frequently in organizational settings (Obholzer & Roberts 1994) where there is confusion about the function and boundaries of a relationship. Seen in this way, this imposing administrative

aspect of clinical supervision may detract from its fundamental task, that is, to facilitate analysis of nursing interventions through reflective practice.

## CONCLUSION AND RECOMMENDATIONS

This study was confined to eight staff nurses each working in one of the six community mental health teams. While this was a small convenience sample from which no generalizations can be made, the study does give a highly descriptive insight into staff-nurses' perceptions of the good characteristics of a clinical supervisor. In using a qualitative methodology, the researcher set out to give them the opportunity to express their own perceptions of important supervisor characteristics. Findings from this study, in part, reflect knowledge obtained from existing health care literature.

Nonetheless, this study does have limitations. The short questionnaire may have constrained participants' initial expression of their supervision experience. Instead, semi-structured in-depth interviews may have been more suitable. Furthermore, the way in which the researcher involved the key players (team leaders) by informing them of the study may have caused them to have some influence on behaviour change in the supervisors during the study. However, the timing between involving the team leaders and conducting the research was felt to be insufficient to allow this form of subject bias.

The possibility for future research focusing on the supervisory process is vast. One suggestion might be to carry out a series of focus groups involving a larger sample of community mental health nurses with the primary aim to identify effective supervisor characteristics. From this, a supervisor behaviour rating tool specific to mental health nursing could be developed. This could then be used to evaluate clinical supervision in a variety of mental health settings, but more importantly, guide supervisor training. Ultimately, a research study designed to evaluate the consequences of supervision would be desirable, although difficult to execute.

From the findings of the study, the following recommendations were made to progress clinical supervision at the location where the study was conducted:

- Establish the explicit nature of clinical supervision, highlighting its dissimilarity with a managerial role.
- Training days should be organized for supervisors and supervisees providing education on the supervisory process, supervision models, guidelines on how to get started, and perhaps discussion on the strengths and weaknesses of clinical supervision, highlighting the existing research literature.
- Introduce a process where supervisees have a degree of choice on who their supervisor is. This will require acknowledging the limitations with the existing system, stopping it, providing educational input as outlined above and then introducing an alternative. Implementing such a change in a systematic way may help to minimize the anxieties experienced as a result of this shift. Evaluation of this alternative process is imperative.
- Supervisees should be given the freedom to set the supervision agenda. The supervisory process should be supervisee-led with the supervisee bringing to each session whatever they wish to focus on but within the confines of professional work.
- Give supervisees the responsibility for documenting whatever is necessary from the supervision session.
- Establish on-going training for supervisors. This might include supervision models, development of interpersonal skills, education on facilitative supervisor behaviours and conveying the need for supervisor support.

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## APPENDIX 1: QUESTIONNAIRE

*Thank you for agreeing to participate in this study. I would be grateful if you would write clearly and in black ink. I anticipate being able to utilise the results of the study to influence the on-going development of clinical supervision within the Community Health Care Trust.*
*Please return the completed questionnaire by - ———*

1. Please list your professional qualifications:
2. How long have you been qualified in mental health nursing?
   ———years ———months
3. What length of experience have you had in this current post working as a community mental health nurse?
   ————years ———months
4. How often do you meet with your clinical supervisor for clinical supervision?
5. How long does your clinical supervision meeting last?
6. What format does your supervision take? [i.e., individual, group, other]
7. Do you feel your supervisor provides good clinical supervision?
   Yes [ ]
   No [ ]
   If you answered no — please go straight to question 10.
8. Reflecting on your experience of clinical supervision in this job, can you identify any qualities demonstrated by your clinical supervisor that you consider to be 'good' qualities in terms of their clinical supervisor role?
   If you have any more please continue.
9. In relation to your list of 'good' qualities from question 8 can you give examples of how this quality was demonstrated by your clinical supervisor?
   If you have any more, please continue.
10. Can you list qualities of a good supervisor [even though you may not have experienced this in your current post]?
    Any other comments?

Once again thank you for taking the time to complete this questionnaire. Please return this to me in the addressed envelope provided.