An evaluative study of clinical supervision based on Proctor's three function interactive model

Nick Bowles RMN BA(HONS) MA
Lecturer, School of Health Studies, Division of Nursing, University of Bradford

and Christine Young RGN RM DN BSc MA
Professional Development Officer, Bradford Community Health

Accepted for publication 9 February 1999

BOWLES N. & YOUNG C. (1999) *Journal of Advanced Nursing* **30**(4), 958–964
An evaluative study of clinical supervision based on Proctor's three function interactive model

This paper reports on a study of the benefits reported from participation in clinical supervision by registered nurses ($n = 201$) working in a large English community and mental health NHS Trust. It summarizes the emergent practical and theoretical 'key ingredients' of clinical supervision in the United Kingdom and argues that these provide a basis for generalizable research practice. The study is based on Proctor's three function interactive model previously commended as a guide for supervisory practice and evaluation. Within this study, the three functions underpin instrument design but are also a primary focus of evaluation. The development of this instrument through semi-structured interviews with supervisors and supervisees is described. The study aims to assess and compare reported benefits in each of the three functions of accountability, skill development and support in order to examine the effects of contract use, length of experience of clinical supervision and length of service as a registered nurse on reported benefits by using non-parametric statistical analysis. The results indicate that reported benefits are experienced in almost equal proportion across each of these three functions. Statistical analysis indicates a significant positive correlation between experience of clinical supervision and its reported benefits. An inverse correlation is reported between length of service and overall benefits; however, no similar reduction over time against normative benefits was found. There was no relationship between contract use and reported benefits. Limitations of the study are discussed with reference to bias, interview transcription and overlap between the three functions. The paper concludes that nurses report clear benefits from clinical supervision in each of the three functions. This validates the three function interactive model and demonstrates that clinical supervision is used to critically examine and change nursing practice. The content and usage of contracts is identified as an aspect that merits further study.

Correspondence to: Nick Bowles, 69 Wetherby Road, Harrogate, North Yorks, HG2 7SG.
E-mail: n.b.bowles@bradford.ac.uk

Keywords: boundaries, clinical governance, clinical supervision, contracts, dual role relationships, instrument development, proctor's three function interactive model, nursing

BACKGROUND

Clinical supervision became an established part of the United Kingdom (UK) nursing landscape with the publication of *A Vision for the Future* (NHS Management Executive (NHSME) 1993). Its importance was highlighted by the mental health review team in 1994 (Department of Health (DoH) 1994), while Butterworth and Bishop (1995) argued that its practice is a feature of optimum practice for all nurses, a view supported by the United Kingdom Central Council for Nurses, Midwives & Health Visitors (UKCC 1996). Recently it has been argued that clinical supervision is becoming 'increasingly important' in NHS Trusts (Farrington 1998), a trend that may be further encouraged by clinical governance.

Many claims for the benefits of clinical supervision have been made despite the 'paucity of empirical evidence' (Yegdich & Cushing 1998 p. 12) to substantiate these claims, indeed Wolsey and Leach (1997 p. 24) have described the research literature as 'dismal'. Whilst criticisms of this nature may be partially answered on the basis that clinical supervision is still relatively new to UK nurses, an absence of outcome studies remains one of the most convincing arguments against widespread implementation of clinical supervision. The need to meet the challenge of 'defining the parameters of effectiveness in terms of benefits to nurses or benefits to patients' (Yegdich & Cushing 1998 p. 12) is clearly urgent.

Despite the lack of an evidence base or clear guidance on what makes for effective clinical supervision (Jones 1998), some principles appear to be emerging as 'key ingredients' for practice. These include the use of formal agreements (or 'contracts') between supervisee and supervisor (Proctor 1998b, Nicklin 1997), a clear distinction between managerial performance appraisal and clinical supervision (UKCC 1995, 1996), the importance of voluntary participation (Cutcliffe & Proctor 1998) and agreement that the appropriate focus of clinical supervision is the job content of the supervisee (Marrow *et al.* 1997, Wolsey & Leach 1997).

Similarly, if one theoretical framework is becoming predominant it is likely to be the three function interactive model proposed by Proctor (1988a). The three functions 'formative', 'restorative' and 'normative' are elements that are held to occur within clinical supervision, potentially at the levels of process and outcome (or 'benefit').

The 'formative' element is concerned with skill development, the 'restorative' element is concerned with supporting personal well being (Butterworth *et al.* 1997 p. 3), which might include the management of work-related stress, and finally the 'normative' element concerns accountability, awareness of and adherence to accepted standards and professional norms. Numerous references to this model appear in the nursing literature, suggesting widespread acceptance. These include Nicklin (1997), who reports familiarity with Proctor's model in over 30 NHS Trusts, and Fowler (1996), who suggests adaptations (a sure sign that the model has become established). Butterworth *et al.* (1996) suggest that it enables an elegant resolution of managerial concerns (e.g. of standards in practice) with supportive and educative aspects for the practising nurse. Certainly it has been commended as a framework for evaluation (Butterworth *et al.* 1996, Cutcliffe & Proctor 1998).

In summary, implementation of clinical supervision has necessarily preceded the development of a research base to guide practice or facilitate evaluation. Yet the growing consensus on how clinical supervision might be structured and evaluated creates the conditions for larger, increasingly generalizable studies in which these key ingredients and the benefits of clinical supervision can be tested. It is against this background that the present study was conducted.

THE STUDY

Objectives

This study was based on Proctor's three function interactive model (Proctor 1988a), which provides both a framework for instrument design and a primary focus of evaluation. As the dominant UK model it is appropriate that it provides the primary focus of this study. In addition there are three further elements of evaluation within this study, these are: contract usage, length of service as a registered nurse, and length of experience with clinical supervision. These issues are briefly discussed below.

The impact of contracts on the outcomes of clinical supervision in nursing has not previously been examined. If relationships based on a contract helped supervisory partners to achieve more from their time together, then their usage should be commended vigorously. Conversely, if no significant benefits accrue then further questions on their use arise.

Individual characteristics of participants in clinical supervision have not been examined with reference to their experience of clinical supervision. It might be argued

that clinical supervision has been uncritically accepted as *being good for every nurse* and likely to be of *equal good for every nurse.* Yet, it is likely that length of service and the length of experience with clinical supervision may contribute to quite different experiences of clinical supervision. For example, nurses who have been qualified for several years may derive different benefits than recently qualified nurses. Similarly, nurses with the greatest experience of clinical supervision may experience clinical supervision differently to those who are relative newcomers to its practice. In short, this study addresses the following objectives:

1 to examine whether clinical supervision is reported to facilitate benefits in each of the Formative, Normative and Restorative dimensions, and if so, in what proportion;
2 to determine if benefits from clinical supervision were affected by length of service since first registration;
3 to determine if benefits from clinical supervision were affected by length of participation in clinical supervision;
4 to establish whether the use of formal, written contracts affected reported benefits.

The latter three objectives gave rise to the following null hypotheses:

1 there will be no relationship between length of participation in clinical supervision as a supervisee and its reported benefits;
2 there will be no relationship between length of service since first registration and reported benefits;
3 nurses who use formal, written contracts do not report greater benefits than those who use a verbal contract or those who do not use any form of contract.

Method

The potential benefits of clinical supervision have been the subject of much opinion, yet a valid, testable schedule of benefits has not been produced. Indeed the largest study conducted in the UK to date (Butterworth *et al.* 1997) utilised standardized 'off the shelf' scales, which whilst well established were not designed specifically for the purpose to which they were put. For instance, the General Health Questionnaire (GHQ-28), which is a psychiatric screening tool, and the Minnesota Job Satisfaction Scale, an American questionnaire based upon a theory of motivation was first published in 1959 (Herzberg *et al.* 1959).

For the present study an instrument was developed based on Proctor's three function interactive model (Proctor 1988a). This enabled the collection of biographical and attitudinal data. A five point Likert scale examined reported benefits and attitudes toward clinical supervision. This instrument produces an overall reported benefits score but also permits discrimination of reported benefits for each of the three dimensions 'formative', 'normative' and 'restorative'.

The instrument was developed through 11 semi-structured interviews with registered nurses who had been active participants within clinical supervision relationships for between 6 months and 3 years. Interviews were conducted over a 3 month period by one of five registered nurses (including RMN, RNMH and RGN) who were members of a clinical supervision implementation group. Additional data were subsequently collected from ten of the interviewees' supervisory partners through interview or, where interviews were not possible, a questionnaire which replicated the semi-structured interview schedule was administered.

The authors conducted a content analysis of this data, identifying 114 distinct statements that were thematically grouped. On completion the statements and emergent themes were presented back to the interviewers for validation (Eby 1993). These statements were then subdivided into 'reported benefits' and attitudinal disposition'. The reported benefits were further sub-divided to reflect the formative, normative and restorative dimensions. The reported benefits and attitudinal statements were collapsed and reduced in number, then developed into questionnaire items. The reported benefits section contained 21 items, seven for each of the dimensions (although this was not apparent to the research participants). The attitudinal section contained 13 items (not reported in this paper).

The resulting instrument was piloted for ambiguity, clarity and overall comfort with 70 registered nurses. The response rate was 50%. Analysis of responses produced changes to wording, layout and data management techniques.

Sample

The registered nursing workforce of a large NHS Community Trust in England ($n = 662$) was invited to participate in the study. Each received a personally addressed letter and a copy of the questionnaire. Participation was voluntary and anonymity was assured. Responses were free-posted to the University of Bradford.

Results

Two hundred and one questionnaires were returned within the deadline, a response rate equivalent to 30·4% of the registered nursing workforce. Of these, 161 nurses reported current, active engagement in clinical supervision, the majority of which were 'one to one' relationships. Figure 1 illustrates the respondent profile by workplace/post.

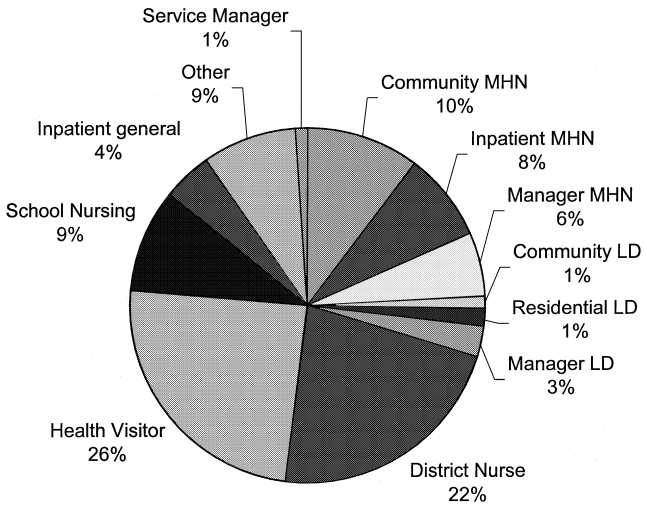

Figure 1 Respondent profile by post.

Organisation of clinical supervision

The length of professional experience since first registration ranged from 1 month to 40 years, with a mean of 18 years and 4 months. The mean length of experience of clinical supervision varied significantly across clinical directorates, from 30·7 months for learning disabilities nurses, to 28·1 months for mental health nurses to just 13·1 months for community staff. The use of formal, written contracts was reported by 47·8%, a further 37·7% reported using a verbal contract whilst the remaining 14·5% reported using neither.

On the selection of supervisors for one to one supervision (the preferred organizational system for 75·1% of the respondents), 63% of respondents selected supervisors from outside of their immediate clinical environment, 28·4% selected them from within their own team, the remaining 8·6% selected their supervisor from outside the Trust. Forty-eight per cent of supervisors were nurses on a higher clinical grade than the supervisee, 46% were the same grade and the remaining 6% were a lower grade.

Benefits of clinical supervision

Each of Proctor's three functions were expressed in seven questionnaire items enabling the calculation of a mean overall benefit value and a mean value for each of the three dimensions. In Table 1 each of the 21 benefit statements is labelled F, N or R to indicate the function it relates to,

Table 1 Benefits of clinical supervision (CS), in ascending rank order by mean

Abridged benefits statement	F/N/R	Valid n	Mean	Median	Mode	SD
Mainly a time to off-load feelings	R	158	2·7	2	2	1·14
CS relieves pressure of work	R	158	2·86	2	2	1·04
I can give an example of a change to my practice as a result of clinical supervision	N	158	3·33	3	4	0·82
CS has helped me become more creative at work	F	158	3·35	4	4	1
I have been helped to identify my development needs through CS	F	158	3·39	4	4	1·01
CS reduces my work related stress	R	158	3·41	4	4	1·12
Through CS I have learned new ways to approach practice	F	158	3·45	4	4	0·96
CS has improved my nursing practice	N	158	3·5	4	4	0·95
CS helps my self confidence	R	158	3·54	4	4	0·99
CS has helped me to challenge existing practice	N	158	3·58	4	4	0·94
CS helps me to feel less isolated in my practice	R	158	3·76	4	4	0·97
I am more able to talk about tricky practice issues in CS than in other settings	N	158	3·76	4	4	1·1
CS has helped me to cope with difficult situations	R	158	3·78	4	4	0·91
CS has helped me feel practice is of an acceptable standard	N	158	3·84	4	4	0·79
CS has made me more aware of my own behaviour	F	158	3·87	4	4	0·79
CS makes me feel more supported in my practice	R	158	3·89	4	4	0·86
CS has increased my self awareness	F	158	3·93	4	4	0·78
CS helps me to develop new ideas on how to tackle work related problems	F	158	3·94	4	4	0·8
CS has helped me think through situations more critically	F	158	3·97	4	4	0·67
I receive useful advice in CS	N	158	3·97	4	4	0·81
CS has helped me look more objectively at my work	N	158	4·07	4	4	0·66

Table 2 Total scores for each of the three functions

Sum of scores	N	Minimum	Maximum	Mean	SD
Formative benefits	158	14	35	25·91	3·99
Normative benefits	158	14	35	26·04	3·90
Restorative benefits	158	13	34	23·94	4·27

benefits are shown in ascending rank order (by mean) with mode and standard deviation values.

The two statements with the lowest scores relate to pressure of work and 'off-loading' of feelings. Respondents disagree that these are tangible benefits of clinical supervision in their experience. However, at the other extreme, critical appraisal of practice, ideas on how to change practice and increased objectivity are apparent, suggesting that perceived benefits are, indeed, work related. In all, 19 of the 21 benefit statements tend towards the positive with modes of 4.

A total of 14 items have mean values of 3·5 or higher. A second level of analysis on the total scores for each of the three functions was conducted. This is shown in Table 2.

Clearly, the mean benefits for each of the three dimensions are very similar, indicating that benefits are perceived in each of the three functions with normative benefits being most highly rated and formative the least, albeit by a small margin. This supports Proctor's three function interactive model and challenges the commonplace notion of clinical supervision as being primarily a mechanism for simply off loading occupational stress.

Length of participation and benefits

H1 Reported benefits do not increase with greater length of participation in Clinical supervision.

Analysis. Spearmans rho (a non-parametric measure of correlation) was used to establish the relationship between time spent in Clinical supervision (in months) and reported benefits.

Result. $N = 149$, $P = 0{\cdot}026$ (two-tailed), the null hypothesis is not supported. Reported benefits increase with greater length of participation in clinical supervision.

Length of service and benefits

H2 There will be no relationship between length of service since first registration and reported benefits.

Analysis. Spearmans rho was used to establish the relationship between length of professional experience since first registration and reported benefits (overall and each of the three dimensions formative, normative and restorative). A two-tailed test was used in each case.

Results

(a) Length of service and overall reported benefits: $N = 153$, $P = 0{\cdot}047$, the null hypothesis is rejected;
(b) length of service and restorative benefits: $N = 153$, $P = 0{\cdot}06$, the null hypothesis is rejected;
(c) length of service and formative benefits: $N = 153$, $P = 0{\cdot}044$, the null hypothesis is rejected;
(d) length of service and normative benefits: $N = 153$, $P = 0{\cdot}291$ (not significant, the null hypothesis is supported).

The negative scores in the correlation coefficient (not shown) indicate that in the first three cases the reports of perceived benefits *decrease* with length of service. By contrast, normative benefits show a weak, positive correlation with length of service. These results suggest that more experienced practitioners experience less formative and restorative benefits from clinical supervision, although they continue to benefit from normative influences.

Contract use and benefits

H3 Nurses who use formal, written contracts do not report significantly greater benefits than those who use a verbal contract or those who report no contract use.

Analysis. A Kruskall Wallis Test was used to establish if there were significant differences in reported benefits between the group who used a written contract ($n = 66$), those who used a verbal contract ($n = 51$) and those who reported using no contract at all ($n = 19$). A two-tailed test was used.

Results

(a) Contract use and overall reported benefits: $n = 136$, $P = 0{\cdot}767$, the null hypothesis is supported;
(b) contract use and restorative benefits: $n = 136$, $P = 0{\cdot}329$, the null hypothesis is supported;
(c) contract use and formative benefits: $n = 136$, $P = 0{\cdot}344$, the null hypothesis is supported;
(d) contract use and normative benefits: $n = 136$, $P = 0{\cdot}145$, the null hypothesis is supported.

Nurses using a written contract do not report significantly greater benefit from their clinical supervision than nurses who use a verbal contract or those who report no contract use.

DISCUSSION OF FINDINGS

The descriptive statistics provide some context to the results that follow. The supervisor characteristics are noteworthy as the majority are selected from outside of the supervisees own clinical area, and just over half are on a higher clinical grade than the supervisee. This suggests a willingness amongst a significant proportion of the sample to develop clinical supervision relationships with nurses who are not peers in terms of proximity or seniority, perhaps motivated by a desire for objectivity and to avoid the pit-fall of 'consensus collusion', as Butterworth *et al.* (1996) warned.

The benefits reported from participation in clinical supervision indicate positive experiences of clinical supervision in each of Proctor's three dimensions, supporting claims to its real world application in individual relationships and larger evaluations of clinical supervision. This finding supports the suggestion that nurses may receive benefit in each of these aspects (Butterworth *et al.* 1996) and challenges suggestions that nurses are unprepared for, or unaware of the inherent conflicts (Yegdich & Cushing 1998) within 'dual role relationships' (Kitchener 1988). The findings reported here suggest that nurses may seek to avoid dual role conflicts through the selection of supervisors from outside their immediate clinical environment or outside the Trust. Just 28·4% of nurses in this study selected supervisors from within their area.

Inferential data analysis produced a number of interesting results. The length of experience in clinical supervision is positively correlated with reported benefits, possibly an indication that skills in using clinical supervision develop over time and/or that application of new learning to clinical practice is not immediate.

An inverse relationship between length of service and reported benefits in the formative and restorative dimensions was apparent (although these benefits were still reported). However, there was no relative decline in perceived benefit over time against the normative dimension. Hence clinical supervision is likely to meet different needs for nurses at different points in their careers, a point that should be considered by supervisors who may overvalue the restorative dimension and intrude on supervisees' personal boundaries (Morcom & Hughes 1996).

Interestingly, contract use did not lead to increased reported benefits. This finding challenges a fundamental structure within clinical supervision and indeed the authors' training practices (Bowles & Young 1998) in which the contract is regarded as a way to safeguard boundaries and articulate goals for professional development. It may indicate that the written contracts currently in use provide inadequate support or guidance to clinical supervision relationships, as they may not contain clear goal statements or may not support periodic evaluation of achievements within clinical supervision. Conversely, verbal contracts may provide these factors in equal and sufficient part. Clearly these questions deserve closer investigation.

Limitations of this study

Potential limitations in the design of this study include:

1 The interviewers were members of a group that had articulated an organizational strategy for clinical supervision. This may have limited their objectivity and contributed to social desirability phenomena amongst the interviewees involved in the instrument development.
2 Interviews were not tape-recorded, written notes were the only data source for content analysis.
3 Interviewees had all been exposed to clinical supervision training that may have shaped the content of their interview responses.
4 The differentiation of reported benefits into the three functions (formative, normative and restorative) was challenging as they are not all mutually exclusive and a degree of overlap is inevitable. Hence differential analysis of these dimensions should be considered in this context.
5 The response rate, while reasonable for a postal survey, is likely to be subject to sample bias, i.e. it is likely to be a disproportional representation of a committed or enthusiastic sub-group of the larger workforce.

CONCLUSIONS

This study has identified some of the potential benefits of clinical supervision and the extent to which practising nurses are already experiencing these benefits in a wide variety of clinical settings.

The development of an instrument specifically for this study contributed to face validity and permitted focused analysis through statistical measures. It is hoped the schedule of benefits reported here may contribute to an emerging taxonomy of outcomes of clinical supervision that may be tested in increasingly robust studies.

The use of Proctor's three function interactive model facilitated the design stages of the study providing both a structure for evaluation and the primary focus of that evaluation. Its relevance as the most preferred theoretical framework was supported by the findings, which indicated that clinical supervision relationships reflected each of the three functions with no single function dominating the other two. The results indicate willingness amongst participants to examine and change practice. This supports suggestions that clinical supervision has a role within quality management and clinical governance strategies of NHS Trusts.

A number of limitations have been identified. A repeat study is planned for the end of 1999, possibly in a number of Trusts, which will take account of these issues. In addition, analysis of 'attitudinal disposition' and qualitative data will be reported at a later date, with cross-references to the issues reported here.

It is suggested that the use of formal contracts between supervisory partners merits further study, perhaps with reference to the maintenance of boundaries and goal setting/achievement.

Acknowledgement

Grateful thanks to Vicky Selway for managing our correspondence and data.

References

Bowles N. & Young C. (1998) Clinical supervision: partnerships for sound practice. *Nursing Times (Learning Curve Supplement)* **2**(10), 7–10.

Butterworth T. (1994) Preparing to take on clinical supervision. *Nursing Standard* **8**(52), 32–34.

Butterworth T. & Bishop V. (1995) Identifying the characteristics of optimum practice: findings from a survey of practice experts in nursing, midwifery and health visiting. *Journal of Advanced Nursing* **22**(1), 24–32.

Butterworth T., Bishop V. & Carson J. (1996) First steps towards evaluating clinical supervision in nursing and health visiting: Theory, policy and practice development. A review. *Journal of Clinical Nursing* **5**(2), 127–132.

Butterworth T., White E., Jeacock J., Clements A. & Bishop V. (1997) *It is Good to Talk.* University of Manchester, School of Nursing, Midwifery and Health Visiting, Manchester.

Cutcliffe J.R. & Proctor B. (1998) An alternative training approach to clinical supervision: 2. *British Journal of Nursing* **7**(6), 345–350.

Department of Health (1994) *Working in Partnership: A Collaborative Approach to Care. Report of the Mental Health Nursing Review Team.* HMSO, London.

Eby M. (1993) Validation: Choosing a test to fit the design. *Nursing Research* **1**(2), 26–43.

Farrington A. (1998) Clinical supervision: issues for mental health nursing. *Mental Health Nursing* **18**(1), 19–21.

Fowler J. (1996) What do you do after saying Hello? *British Journal of Nursing* **5**(6), 382–385.

Herzberg F., Mausner B. & Synderman B. (1959) *The Motivation to Work.* Wiley, New York.

Jones A. (1998) Getting going with clinical supervision: an introductory seminar. *Journal of Advanced Nursing* **27**(3), 560–566.

Kitchener K.S. (1988) Dual role relationship, what makes them problematic? *Journal of Counselling and Development* **67**, 217–221.

Marrow C.E., Macauley D.M. & Crumbie A. (1997) Promoting reflective practice through structured clinical supervision. *Journal of Nursing Management* **5**(2), 77–82.

Morcom C. & Hughes R. (1996) How can clinical supervision become a real vision for the future? *Journal of Psychiatric and Mental Health Nursing* **3**(2), 117–124.

NHS Management Executive (1993) *Vision for the Future.* NHSME, London.

Nicklin P. (1997) A practice centred model of clinical supervision. *Nursing Times* **93**(46), 52–54.

Proctor B. (1988a) Supervision: A co-operative exercise in accountability. In Marken M. & Payne M. (eds.) *Enabling and Ensuring: Supervision in Practice* 2nd edn. Leicester, National Youth Bureau and Council for Education and Training in Youth and Community Work, pp. 21–34.

Proctor B. (1988b) *Supervision: A Working Alliance.* Videotape Training Manual. Alexia, St. Leonards, East Sussex.

United Kingdom Central Council for Nurses, Midwives and Health Visitors (1995) Clinical *Supervision for Nursing and Health Visiting*, Registrars Letter 4/95, 24 January 1995. UKCC, London.

United Kingdom Central Council for Nurses, Midwives and Health Visitors (1996) *Position Statement on Clinical Supervision.* UKCC, London.

Yegdich T. & Cushing A. (1998) An historical perspective on clinical supervision in nursing. *Australian and New Zealand Journal of Mental Health Nursing* **7**(1), 3–24.

Wolsey P.L. & Leach L. (1997) Clinical supervision: A hornet's nest? *Nursing Times* **93**(44), 24–27.