DISCUSSION PAPER **1**

Clinical Supervision

A Structured Approach to Best Practice

Clinical supervision in Ireland is discussed in terms of supporting continuing professional development and professional competence resulting in improved efficiency and effectiveness in the health service.

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of **Nursing** *and* **Midwifery**

An Chomhairle Náisiúnta d'Fhorbairt
Ghairmiúil an Altranais agus
an Chnáimhseachais

Introduction

The National Council for the Professional Development of Nursing and Midwifery (National Council) supports nurses and midwives in approaching their continuing professional development (CPD) needs. The National Council is pleased to present this discussion paper to inform, stimulate debate and discussion about the role of clinical supervision in supporting CPD in the interests of improving quality patient/client care. Definitions and potential benefits of clinical supervision are outlined. Clinical supervision in Ireland is discussed in terms of its expansion and use to support professional competence and thus efficiency and effectiveness in the health service. Examples of the use of clinical supervision from different perspectives in Ireland will be outlined in order to offer insight for services planning to introduce clinical supervision.

CPD is the 'systematic maintenance and broadening of knowledge and skills, and the development of personal qualities necessary for the execution of professional technical duties throughout the individuals working life' (National Council 2004). CPD can take many forms, for example attending short courses, audit of practice, project work, work-based learning and more recently clinical supervision. Clinical supervision should not be confused with the concept of 'supervised clinical practice'. Supervised clinical practice is a formal process in which nurses or midwives attain particular identified skills and competencies through mentorship, assessment and evaluation by a senior clinician. See Morrissey (2008), for a comprehensive discussion of structured support systems in an Irish nursing context, incorporating preceptorship, supervised clinical practice, peer support and clinical supervision.

Clinical supervision has emerged both internationally and in Ireland in nursing and midwifery as a means of using reflective practice and shared experiences to support CPD. It is increasingly being recommended as a means of supporting professional practice and multi-disciplinary working (Mental Health Commission 2006). Differing models, approaches and systems of clinical supervision are identified in the literature and in the Irish healthcare experience. The core element central to the process is that of reflection on practice. Any model can be adapted to suit the workplace environment. It is important that both the organisation and the individual nurse or midwife understands what clinical supervision involves and gives consideration to the intended outcomes. These outcomes can include:

- Improved service delivery though the use of evaluation systems
- New learning opportunities
- Improved staff retention
- Improved efficiency and effectiveness. (RCN 2007)

There is potential for clinical supervision to contribute to the development of a more articulate and skilled workforce which in turn can contribute positively to organisational objectives (White & Winstanley 2006, Hyrkas, et al 2006, UKCC 1996).

Defining clinical supervision

The literature provides a number of definitions for clinical supervision. Clinical supervision has been variously described as an educational process, a means of accomplishing organisational goals, or as a personally focussed competence development process (Jubb Shanley and Stevenson 2006). This ambiguity concerning the nature and goals of clinical supervision highlights the importance of clarification of definition and goals when approaching the introduction of clinical supervision.

> *'Given the context-driven meanings attributed to the term clinical supervision, the use of the term in any instance may require further clarification by the individual for the listener to understand the meaning'* (Jubb Shanley & Stevenson 2006 p. 587).

Jubb Shanley and Stevenson (2006) caution against accepting a 'taken for granted' meaning of clinical supervision, which may lead to the pursuit of conflicting goals and a diminution in the outcomes of the process.

The Royal College of Nursing Institute suggests this comprehensive definition:

> *'Clinical supervision is regular, protected time for facilitated, in-depth reflection of clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part she plays as an individual in the complexities of the events and the quality of her practice. This refection is facilitated by one or more experienced colleagues who have expertise in facilitation and frequent, 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 into management, research or education'* (RCN Institute 1997).

Cutcliffe et al (2001) argue that there is no one single way to carry out clinical supervision, they argue that this approach to definition could be seen as de-limiting. Rather than using a definition they suggest that agreeing parameters around what clinical supervision actually embraces is preferred. These parameters should indicate that clinical supervision is necessarily:

- Supportive and safe, because of clear, negotiated agreements by all parties with regard to the extent and limits of confidentiality
- Centred on developing best practice for service users
- Brave, because practitioners are encouraged to talk about the realities of their practice
- A chance to talk about difficult areas of work in an environment where the person attempts to understand
- An opportunity to ventilate emotion without fear of reprisals
- The opportunity to deal with material and issues that practitioners may have been carrying for many years (the chance to talk about issues which cannot easily be talked about elsewhere and which may have been previously unexplored)
- Not to be confused with or amalgamated with managerial supervision
- Not to be confused with or amalgamated with personal therapy/counselling
- Regular and protected time and offered equally to all practitioners
- Involves a committed relationship (from both parties)
- Separate and distinct from preceptorship or mentorship
- A challenging and facilitative relationship
- An invitation to be self-monitoring and self-accountable
- An opportunity to be reflective and becoming a reflective practitioner and
- An activity that continues throughout one's working life. (Cutcliffe et al 2001).

Underlying clinical supervision is the notion of a professional practitioner as someone who reflects on practice with the aim of expanding and deepening their practice over time (The Open University 1998).

Clinical supervision is often described in the context of which 'model' is being used; there is however a distinction between models of supervision such as; psychodynamic, educational, managerial, and models for the delivery of clinical supervision, such as; one-to-one, group and network (Butterworth & Faugier 1993, The Open University 1998). Proctor (undated) outlines three components of clinical supervision:

- **Formative educative function** which refers to the aspect of clinical supervision that relates to the professional development of the practitioner through reflection on practice and self awareness
- **Restorative supportive function** which through the development of a supportive relationship with the supervisor the practitioner deals with emotional issues arising from practice which can induce stress
- **Normative managerial function** which relates to the responsibility of the employer to put in place mechanisms for developing competence and supporting employees in the interest of clinical governance and risk management.

Proctor's three components therefore provide a framework which enables all three key components of clinical supervision to be integrated to provide balanced clinical supervision.

Whichever model is adopted, the key to effective clinical supervision is to recognise that it differs from the supervision of work activity and includes a wide range of activities and approaches that have a 'supervision' impact. This includes action learning, individual and team supervision, reflective learning groups, critical companionship, professional and peer supervision. Rather than assume a restrictive approach to the selection of a model, those planning to partake or initiate supervision are urged to recognise the diversity of approaches available (NIPEC 2006a). Therefore, the model of supervision which is chosen should be contextualised to the care setting and the level of expertise available.

Evidence of the benefits of clinical supervision

Research into clinical supervision has tended to focus on process and staff related benefits. A large seminal study on clinical supervision was conducted by Butterworth et al (1997). This study was known as the Clinical Supervision Evaluation Project (CSEP) and found an overwhelmingly positive response to clinical supervision from nurses who welcomed 'the structured opportunity to talk meaningfully to a trusted colleague about their circumstances at work'. Those who received clinical supervision suffered less psychological distress arising from their work and in areas where clinical supervision was not offered, there were measurable detrimental effects on the workforce. Davey et al (2006) affirmed that investment in good quality clinical supervision for all nurses can be a key strategy in retention of staff. A randomized controlled trial of clinical nurse specialists suggested that those who attended clinical supervision following training in communication skills were more likely to transfer those skills into practice (Heaven et al 2006).

A comparative study examining the effects of clinical supervision on qualified nurses, while identifying no significant differences in levels of burnout between supervised and unsupervised nurses, revealed that supervised nurses reported a more listening and supportive management, coping better at work and feeling that they had better access to support (Teasdale et al 2001). It is suggested that systematic clinical supervision combined with supervised nursing care plans, constitute a support strategy that improves nurses' creativity, and the organizational climate (Berg & Hallberg 1999).

In 2006 the Northern Ireland Practice and Education Council undertook a review to examine the guidance on clinical supervision in the Health and Personal Social Services (HPSS) (NIPEC 2006b). The report made recommendations about establishing an action plan for ensuring that clinical supervision systems were established in Northern Ireland. The Chief Nursing Officer of Northern Ireland considered the issue sufficiently important for it to be considered within the Department of Health and Social Service and Public Safety, Quality and Standards for Health and Social Care.

While the evidence appears to suggest that clinical supervision has positive outcomes for staff, there is limited research evidence to substantiate any claims in relation to patient outcomes. A study that examined the cost effectiveness of clinical supervision looked at the costs (nurse time and cost of supervisor) and benefits (knowledge, patient satisfaction, complaints, litigation and sick leave) and concluded that clinical supervision was cost effective as the number of sick days decreased and the number of patients treated increased thus improving productivity (Hyrkas et al 2001).

A quasi-experimental study that looked at patient outcomes in a mental health setting found that the severity of positive symptoms of patients suffering from schizophrenia decreased significantly more in a cohort being treated by students who were in engaged in clinical supervision compared with to a group treated by students not engaged in clinical supervision (Bradshaw et al 2007).

Research from the United States has demonstrated significant favourable correlations between educational levels of nurses and patient mortality rates (Aiken et al 2003). Butterworth el at (2008) suggest that if clinical supervision is viewed in the context of a holistic definition of education it is likely that if tested similar positive associations might be revealed. With accountability and governance being high on the policy agenda in health care, the introduction of systems like clinical supervision to support professional competence will contribute to an overall strategy to achieve safe, quality patient care. However, more systematic evaluation of the outcomes for service delivery is required (Winstanley & Whyte 2003).

Clinical Supervision in Ireland

There has been a sustained growth in the practice of clinical supervision in Ireland over the last number of years. An increasing number of organisations have sought to introduce clinical supervision. The National Council through its continuing education funding process has supported the piloting and evaluation of 14 clinical supervision programmes. A review of these offers some insight into the level of interest and activity for clinical supervision in Ireland (see table 1). The programmes incorporate a wide variety of activities that centre on some form of facilitated reflection on practice fulfilling the essence of clinical supervision.

There is a perception that clinical supervision is solely practiced in mental health services and not used widely in other health care settings. In the absence of systematic research into the area, the programmes funded by the National Council would appear to challenge this perception. Some nurses working in specialist counselling and psychotherapy roles are required to avail of clinical supervision as a requirement of their membership of professional bodies such as the Irish Association of Counselling Psychotherapists (IACP)[1]. This may or may not be funded by the employers and is usually organised by the individual. However, while clinical supervision is increasingly being introduced in some mental health settings in Ireland, it is very much at an 'embryonic' stage (Morrissey 2008).

Table 1: Clinical supervision (CS) programmes funded by the National Council

TITLE AND YEAR OF PROJECT	SERVICE	SUMMARY	OUTCOME
2008 CS training for community mental health nurses/ clinical nurse specialists	Cluain Mhuire Community Mental Health Service	A three day training programme to introduce a solution focussed approach to CS	Ongoing
2007 Achieving Clinical Effectiveness and Clinical Governance through CS	All health service providers and prison service Western Region	This programme provided information and skills for nurses and midwives on CS with a view to introducing a programme of clinical supervision across all services	Ongoing

1 The IACP require applicants for membership to provide evidence of clinical supervision, set requirements for clinical supervisors, publish a code of ethics and practice for supervisors and set standards relating to how clinical supervision is conducted (IACP 2008a, IACP 2008b, IACP 2008c and IACP 2008d).

TITLE AND YEAR OF PROJECT	SERVICE	SUMMARY	OUTCOME
2007 CS programme for newly qualified nurses-Adult Mental Health	Dublin West/South West, Kildare/West Wicklow Mental Health Services	A clinical facilitator was appointed to develop, introduce and evaluate a programme that would introduce the concept of and develop the skills of newly qualified and newly appointed overseas nurses in relation to CS. The intention is to introduce CS as a support to development of clinical practice	Ongoing
2006 An introduction to CS for nurse managers	Nurse managers in Midland region	This programme aimed to provide an introduction to CS with a view to the establishment of CS in the services	Ongoing
2006 Professional CS	Acute Hospitals Network and Public Health Nurses, Mid-Western Region	This programme aimed to equip 92 nurses and midwives with the skills to provide and engage in CS A separate programme was provided for supervisors and supervisees	Ongoing. To date those trained as supervisors are engaged in providing CS for staff. Policies in relation to the implementation of CS have been devised
2005 CS for Clinical Nurse Managers (CNM)	Cork Mental Health Services	Skills training for CNMs in clinical supervision was developed	17 CNMs have been trained in the provision of CS
2005 CS for Palliative Care Nurses	North West Hospice, Sligo	This programme aimed to select and implement a model of CS in the service. Four supervisors were trained to provide CS for staff	Ongoing
2005 CS for palliative home care nurses	Our Lady's Hospice, Harold's Cross	This programme established a model of group CS within the palliative home care nursing team	The pilot was positively evaluated by staff. CS is to be introduced on a permanent basis
2005 Introduction of CS in Forensic Nursing	Forensic nursing service, Central Mental Hospital, Dundrum	This programme aimed to introduce CS to the service through the training of 20 staff in CS with a view to implementing clinical supervision for nursing staff	Ongoing
2005 A pilot project to introduce CS for nurses in primary care	Eastern region nurses working in community/primary care settings	This project aimed to introduce and train nurses to provide CS	Ongoing
2003 A clinical support CS programme	Mental Health Nurses North Western Region	This programme trained 'trainers' in the facilitation of CS with a view to the introduction of a model of CS for nurses working the mental health services	CS is now available to staff in the region

TITLE AND YEAR OF PROJECT	SERVICE	SUMMARY	OUTCOME
2002 CS Public Health Nurses Project	Public Health Nursing Service-South Eastern Region	This project involved the selection of an appropriate model of CS through a review of service structure and review of models of CS. Training was provided for 80 PHNs	Ongoing
2002 Developing skills of CS	Mental Health Nurses Southern Region	This programme provided skills training for mental health nurses in CS	The education programme was positively evaluated and plans were made to introduce CS
2002 CS in practice module	Dublin City University and partner mental health services	This programme developed a workshop to introduce the concept of CS to nurses and a module to prepare nurses as clinical supervisors	A module was developed and delivered

It is evident from the nature of the programmes that there is much interest in clinical supervision as a means of supporting clinical practice across a wide variety of clinical settings. It is also apparent that the understanding of clinical supervision differs and that different models are being adopted and adapted to suit the workplace environment. Almost exclusively the programmes have been set up to introduce the concept of clinical supervision and to initiate a framework for the introduction of clinical supervision. This indicates the early stage of the integration of clinical supervision as a component of CPD in the Irish nursing and midwifery context.

Implementing Clinical Supervision: Organisational and Individual Issues

There are many key issues involved in successfully implementing clinical supervision into the workplace. Some are organisational issues and some relate to the individual. The organisation should support the concept of formalised reflection on practice; a recent review of contemporary literature on clinical supervision concluded that the evidence suggests that organisational culture is an important determinant of implementation (Butterworth et al 2008).

The introduction of CS needs to be planned with consideration being given to:

- Selection of a model that will fit with the organisation and meet the needs of participants and organisational goals
- Resources required
- Recruitment, selection and training of supervisors
- Preparation of staff to engage in clinical supervision
- Development of policies to govern the management of clinical supervision in the organisation particularly in relation to staff rights, participation, consent, confidentiality and documentation
- Monitoring and evaluation of the quality, success and outcomes of clinical supervision.

This has implications for risk management policy, resource allocation and human resource policies. The essential enabling factors required for successfully introducing clinical supervision are:

- A trusting relationship between the supervisor and supervisee
- A contract and ground rules
- A commitment to meet regularly
- A place to meet where there is no distraction
- Management commitment to provide time and funding for the process
- Opportunities for supervisors to be supervised
- Identified qualities and criteria to be fulfilled by supervisors
- Provision of training for supervisors and funding for this training
- Consideration of whether or not the supervisor is a nurse (or midwife)
- Consideration of whether the supervision is organised within groups or on a one-to-one basis
- Mechanisms for selecting supervisors, evaluating the supervisory relationship and reviewing progress .

(RCN Institute 1997).

The importance of providing appropriate education and training for clinical supervision facilitators is referred to throughout the literature. Whilst there is no widespread formal method or programme for the training and education of clinical supervision facilitators, a number of programmes have been developed in Ireland. The National Council has funded the development of a module on clinical supervision in Dublin City University. This programme developed a workshop to introduce the concept of clinical supervision to nurses and a module to prepare nurses as clinical supervisors. Some universities also offer post-graduate facilitation in learning modules.

Taking into account the enabling factors discussed above and the issues that organisations need to address prior to introducing clinical supervision the next section outlines three different approaches to introducing clinical supervision. These three approaches differ due to the particular circumstances of each organisation.

- The first case study outlines why the service introduced clinical supervision on a one to one basis
- The second case study demonstrates how clinical supervision was introduced for a group of nurses
- The third case study is provided from two perspectives. The first is from the Nursing and Midwifery Planning and Development Unit perspective who aimed to introduce clinical supervision regionally (3a). The second is a description of how one of those services managed the introduction of clinical supervision from the perspective of the Director of Nursing (3b).

Case Study 1

Introducing clinical supervision into an Adult Mental Health Mental Service

It was as result of a needs analysis that clinical supervision was introduced into an adult mental health service in the Eastern Region. An evaluation of the experiences of the rostered placement year for student psychiatric nurses identified that they needed support in their new roles as staff nurses in the service. As the workforce comprises a majority of newly qualified and internationally recruited nurses, it was decided to introduce clinical supervision as a means of supporting staff new to the service or new to the staff nurse role.

Funding from the National Council meant that they could develop the expertise. Subsequently the project, which was led by the Nursing Practice Development Co-Ordinator (NPDC), was planned and implemented in conjunction with a lecturer from the partner university.

Demystifying clinical supervision

"The first step was to de-mystify clinical supervision for staff, identify misconceptions they may have had and allay their fears." (NPDC)

This involved information sessions open to all staff and publicity flyers being made available in all parts of the service. Training, in the form of a three day workshop, was then provided for staff who wished to become clinical supervisors. While the supervisors were mostly Clinical Nurse Managers or Clinical Nurse Specialists, it was emphasized in the project that supervision could not be provided by a staff nurse's line manager, as the nature of the relationships are incompatible.

The training programme included content on:

- Defining clinical supervision and its purpose
- Individual learning styles in the context of clinical supervision
- Contracting for clinical supervision
- Conceptual models of clinical supervision and the supervisory relationship
- Moving from the role of clinician to clinical supervisor
- Assisting supervisees to be supervised
- Methods, goals and interventions in group and individual clinical supervision
- Transference and countertransference in clinical supervision
- Organisations and contextual factors in clinical supervision
- Professional and ethical issues in clinical supervision
- Evaluation of process and outcome in clinical supervision.

The training programme, which achieved An Bord Altranais Category 1 approval, was strongly influenced by Proctor and Heron's Models of CS and was attended by 15 potential clinical supervisors.

Positive evaluation

"Staff who had worked abroad with clinical supervision became champions for it." (NPDC).

An evaluation of the training programme revealed overwhelmingly positive views from participants. The participants unanimously stated

that participating in the workshop had contributed to their personal growth with comments that they were looking forward to their role as clinical supervisors. The main concern staff had in relation to participation related to the maintenance of records, with issues of confidentiality being particularly important. Following on from this information training guidelines and policies were developed to govern and support the provision of CS in the organization. These included:

- A supervision contract
- Documentation for recording of CS sessions
- Role responsibilities for supervisors and supervisees
- Confidentiality and professional responsibilities.

Two staff in each of the services were granted protected time to act as co-ordinators to manage the roll out of the project, taking responsibility for provision of space, time etc. Participation in clinical supervision is voluntary for staff but is strongly recommended and the core management in both services agreed to provide protected time for staff to participate. Facilitated peer supervision by the external supervisor was provided for the supervisors to support them in their role.

Lessons learned

According to the NPDC, uptake of clinical supervision was initially slow, this may in part be due to timing (the training programme ended at the beginning of peak holiday time) and the fact that for many staff this is their first encounter that they have had with clinical supervision and maybe need more time to adapt to the concept. However the first few steps have been positive and more training is planned which may stimulate uptake. This coordinated staged approach to the implementation of clinical supervision in an organization is a template for other services wishing to address issues of staff support and development.

Case Study 2

Introducing clinical supervision for clinical nurses specialists

The National Council funded a small organisation to introduce clinical supervision for their Clinical Nurse Specialists. The aim of the programme was to introduce CS in order to identify solutions to problems, improve practice and increase the understanding of professional issues. The specific aims were to:

- To reduce the nurses feelings of stress and promote coping strategies
- To provide an opportunity to debrief following difficult cases
- To audit clinical decision making
- To provide an opportunity of learning
- To enable the development of professional skills
- To help enhance standards of care, efficiency and knowledge
- To ultimately benefit clients, the practitioner, nursing and the organisation
- To address the nurses perceived lack of support
- To assist the nurses to adjust to their evolving role.

Group clinical supervision

The model of clinical supervision utilised was 'group clinical supervision'. This model was chosen to meet the needs of the twenty-one nurses that were involved in a cost effective manner. In order to maintain and improve team dynamics and to achieve a manageable group size, supervision was delivered to three teams. The sessions were held in a dedicated 'off site' room and a sign was put up on the door to avoid interruptions. Each team meet on a pre-organised and agreed date on a monthly basis. The two hour time slot for each session was protected by members of the other teams who fielded phone calls and enquires on behalf of their colleagues.

Prior to the commencement of the clinical supervision session the facilitator met the three teams to explore what the participants' expectations were and what they hoped to achieve from the programme. At this meeting a contract was agreed around issues of confidentiality and attendance. Any anxieties or concerns about the programme were also aired.

As part of the preparation for this programme participants were asked to fill out a questionnaire to ascertain what they wanted to achieve. Some of the comments included:

'"Hopefully to recognise my skills as a competent specialist nurse. To find professional support and to recognise areas that need improvement. To reflect on my practice and as a result to enhance it."

"Would hope that clinical supervision will provide a framework which will allow us to review our practice, in particular reviewing difficult cases in a safe non-threatening manner."

"A more structured way for dealing with problems or difficult situations within my working day. Sorting out problems by working

with the team. Relief of the high levels of stress in my working environment."

As the project progressed, the participants completed questionnaires at three stages:

- Pre clinical supervision (above)
- Intermediate evaluation – after four months
- Final evaluation – after ten months.

The final evaluation adopted two approaches; it asked for the participants' impressions and it then compared sick leave prior to, and after the project. The results, while not statistically significant because of the small numbers involved, are noteworthy. Figure 1 outlines this.

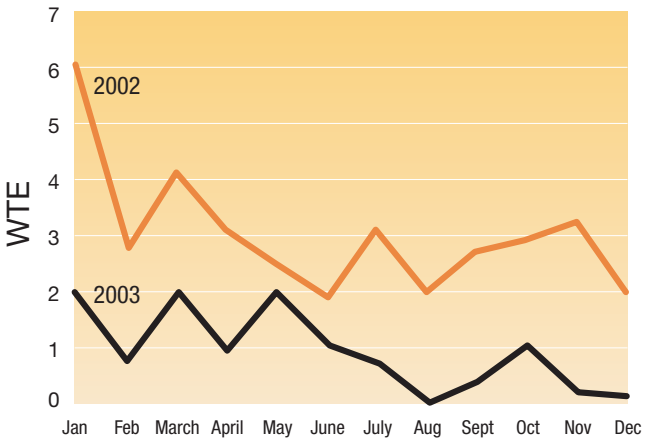

Figure 1: Sick leave comparison between pre - and post - clinical supervision

The overall return rate of the final questionnaires was 74%. In response to being asked 'what have you achieved' some of the participants responded:

"It has given me a safer place to reflect on my practice. I have also gained more insight into how my colleagues feel about their work."

"A huge benefit to my practice, I now deal with situations in a better way."

"A mechanism for thoughtful reflection on my work and myself within my work, both during sessions and beyond."

In response to being asked 'have you felt any benefit from participating in clinical supervision', some of the participants responded:

"Insight into my practice, personal needs, coping mechanisms, space to reflect, freedom to acknowledge limitations, space to reflect my feelings, fears and acknowledge successes."

In response to being asked whether participating in clinical supervision has been detrimental in any way, some participants responded:

"It has been a very positive experience personally and as a team member."

Overall the clinical supervision programme was deemed to have positive outcomes on the nurses who participated and on the organisation. At the time of writing the organisation is continuing to offer clinical supervision to all staff and other areas have adopted the model.

Case Study 3a

Introducing clinical supervision – The Nursing and Midwifery Planning and Development Unit Perspective

The next section outlines how clinical supervision was introduced in Ireland across different services using a different model to those outlined above. In order help clarify the processes involved in introducing clinical supervision this section takes a question and answer approach. The lead for the introduction came from the Nursing and Midwifery Planning and Development Unit (NMPDU). The key person for establishing and integrating clinical supervision was the Director of Nursing/Midwifery. The first section outlines how and why the NPMDU approached the initiative and the second section outlines how the service introduced it.

Why did you want introduce it?

- As part of my role as Professional Development Officer in the NMPDU, I felt that clinical supervision (or action learning) is essential for personal professional development. It is also part of good governance, whereby practitioners are enabled to critically reflect on their practice with the help of a skilled supervisor.

How did you go about planning its introduction?

- In 2004, I met with directors of public health nursing, directors of midwifery, directors of nursing in acute care, and directors of nursing in the voluntary services and explained the concepts of clinical supervision. I outlined my proposal to run an experiential

programme that would involve a learning contact whereby nurses and midwives who participated in a supervisor training programme would be expected to provide supervision to three members of staff. I also explained the time commitment involved and the expected benefits of introducing clinical supervision into their service.

- A session was provided for Directors by the external facilitator to help them decide if they wished to implement professional supervision.

Can you describe the processes involved?

- The Directors of Nursing/Midwifery agreement to implement clinical supervision was confirmed.
- A training programme for participants was delivered by a recognized expert. This consisted of five days for supervisors, which was shortened when awareness of the concepts of supervision became embedded, and one day for supervisees.
- During the programme, participants developed the ground rules and framework.
- Ground rules were negotiated between the supervisor and the supervisee at the start of the process.
- Sessions took place every 4-6 weeks for 50 minutes per session between supervisor and supervisee.
- The location was agreed by both parties.
- Both supervisor and supervisee contributed to the agenda for the CS session. The supervisee and supervisor prepared by reflecting on how they wanted to use the time, what issues to raise and from this the agenda was set.
- Interventions/processes used included agenda setting, listening, summarising, clarifying, open questions, support, challenging, prioritising, generating options, choosing among options, evaluation of action and learning from reflecting on practice and giving feedback.
- An agreed process for confidentiality was established and the signed record is held in a secure and confidential manner by the supervisor.
- Recording of the meeting took place when participants were still in session. A document was prepared for this. It included, names of both parties, positions, date, time, agenda of supervisor and supervisee, follow-on items from last supervision, summary of discussion, decisions made, responsibility and finally the date for the next supervision meeting.

What policies did you need to put in place?

- Each service agreed their own policy for supervision.

How did you select supervisors?

- We started with assistant directors of nursing/midwifery, then moved onto the directors of nursing/midwifery.
- Each supervisor subsequently drew up transparent criteria for selecting three supervisees for a period of time, mostly one year.

Following this, supervision was offered to other staff members. All supervisors felt that having more than three supervisees would not be possible due to time constraints.

How did you prepare supervisors?

- The five day programme explored the background, reasons for, functions and blocks to supervision. The programme was experiential and participants were given the opportunity to practice providing and receiving supervision, developing the intervention skills and observation of supervision. The five days were delivered in two parts: Part one consisted of three consecutive days and Part two took place six weeks later over two consecutive days.
- Participants developed a policy and framework to guide supervision in their own area.

How did you communicate with staff?

- As professional supervision was new to this culture, a one day programme for all supervisees was provided to coincide with the supervision. Supervisors also provided information and clarification to supervisees. The aim of the preparation and communication was to dispel any negative associations with the word supervision and to promote the awareness of the use of supervision as a space for reflection, learning and development.

What model was selected and why?

- As it was new to participants, it was felt that one to one supervision would be most appropriate.
- The philosophy that underpinned the model was support, learning and accountability, the rationale for this was because support has been shown in research to be very important for empowerment, problem solving and job satisfaction.
- Learning to ensure that learning from experience and study days was assimilated by the practitioner and development through reflection on practice.
- Accountability to ensure practitioners have a safe place to explore concerns, get help and also for the line manager to be aware of staff development needs to ensure safe care.

How successful was the introduction?

- Each supervisee provided supervision for three participants. Supervisees were very satisfied with the structure and process.
- Supervisors found the process worthwhile as well as challenging.
- The embargo on recruitment and increasing workloads has meant that further training programmes could not be delivered.

And how were the outcomes measured?

- Focus group interviews with supervisors.
- Questionnaires with supervisees comments included: *"complements case analysis, acknowledgement, more direct communication, has led to development in person and in practice, provides safety net, chance to explore issues, feel valued."*

What were the main obstacles?

- The major difficulty was the time constraint.

What would you do differently?

- I think the most important thing starting out is to clarify the time commitment involved. The level of responsibility, authority and accountability for supervision has to be agreed at the outset to avoid misunderstandings.
- The one thing we would do differently is provide information of both action learning and supervision to senior nurse and midwife managers at the beginning.

Any other comments?

- Commitment to and appreciation of work-based learning is vital for sustainability.

Case Study 3b

Introducing clinical supervision – Director of Nursing/Midwifery Perspective

Why did you want introduce it?

The need for it arose out of discussion around professional development of staff and valuing staff at our Nursing and Midwifery Strategy meetings. I was aware of the importance of accountability for practice for my staff and for myself using the scope of practice framework. I saw it as a means of offering support to my staff working in the clinical setting, and saw it as a conduit to support their professional development. It also would afford me the opportunity to remain connected to live clinical issues as they arose and to empower staff to deal with these issues.

How did you go about planning its introduction?

I undertook training in professional supervision (7 days) which was organized and facilitated by the NMPDU and was funded by the National Council. This training was facilitated by an expert who had a lot of experience in this area and had published a book on the topic. Training was offered to Clinical Nurse/Midwife Managers 1, 2, and 3's and they in turn supervised others as well as being supervised.

What policies did you need to put in place?

We put in place a Professional Supervision Policy and an Operational Procedure for Professional Supervision.

How did you select supervisors?

We encouraged staff to self select and strongly encouraged newly appointed staff to avail of the training, which they did.

How did you prepare supervisors?

They attended a one day training session with the expert in clinical supervision, this was the same person throughout the process.

How did you communicate with staff?

We produced an information leaflet and poster through the hospital's Nursing and Midwifery Strategy Group. I also kept it on the agenda for the Clinical Nurse/Midwife Managers meetings that are held every two weeks. Finally I developed a power point presentation on the key aspects of professional supervision and circulated it to all departments.

What model was selected and why?

One to one supervision was chosen as it was perceived to be more intimate and was thought not to be as potentially threatening as group supervision could have been for some. One to one supervision focused on the balance of functions of Supervision: Accountability, Support and Learning.

How successful was the introduction?

The supervisor and supervisee evaluation was overwhelmingly positive. As staff self selected this had the benefit of working with the willing rather that somebody feeling they had been forced to participate. Supervisees looked for meetings as they were really getting something positive from it.

How were the outcomes measured?

- By recording changes in clinical practice.
- By keeping a record of meetings on an agreed template which can be audited.
- Direct feedback from supervisees re. issues resolved in supervision and
- The superviser and the supervisee evaluation were used to measure efficacy.

Any difficulties?

Finding the time.

What would you do differently?

We would ensure that a commitment was sought prior to training for supervision that the trainee would take on a supervisee.

We would invite the expert trainer to participate as an observer in one of the clinical supervision sessions to ensure that all of the lessons had been learnt.

Any other comments?

The positive feedback from those who are part of supervision out weighs the indifference of those who didn't. Prior to commencing the supervision we agreed a few key ground rules which were adhered to, these included:

- Both supervisor and supervisee had to contribute to the agenda for the session
- Agree not to misuse the session and turn it into a talking shop or dumping ground
- Agree to being on time and keeping to the agreed time
- A summary of each meeting was agreed
- No interruptions/no phone.
- Quiet location
- Cancel only when absolutely necessary.

Resources to Support the Introduction of Clinical Supervision

Guidelines for Portfolio Development for Nurses and Midwives (2006) (2nd Edition) National Council for the Professional Development of Nursing and Midwifery

This document provides useful guidance on developing your professional portfolio, including sample record sheets for clinical supervision.

Professional Supervision Myths, Culture and Structure, by Eileen O'Neill, RMS Publications, Tipperary.

This Irish publication offers an overview of issues in professional supervision together with practical advice on how to go about it with case histories.

Clinical Supervision in Mental Health Nursing, Chapter by Jean Morrissey in Morrissey J., Keogh B. and Doyle L. (2008) Psychiatric /Mental Health Nursing An Irish Perspective. Gill and Mac Millan, Dublin.

This chapter offers an overview of key issues relating to clinical supervision with a specific focus on mental health nursing and importantly, does so in an Irish context.

See the web site of the Irish Association for Counselling and Psychotherapy (IACP)

http://www.irish-counselling.ie/ for information on their requirements for clinical supervisors and code of ethics and practice for the conduct of clinical supervision

The Manchester Clinical Supervision Scale (Winstanley 2000)

This internationally validated research instrument was developed from the findings of the Clinical Supervision Evaluation Project and provides a means of evaluating the effectiveness of clinical supervision from the perspective of the supervisee.

Also see references on pages 13 and 14.

Conclusion

Clinical supervision has emerged internationally and in Ireland in the nursing and midwifery workplace as a method of using reflective practice and shared experiences as part of CPD. Differing models and systems of clinical supervision are abundant and there are a variety of models and approaches to undertaking clinical supervision. It is evident that clinical supervision is used in different ways and to varying extents in Ireland. There is evidence demonstrating that the uptake of clinical supervision has positive impacts not just on the retention and absenteeism rates of nurses but that it also has a positive effect on the quality of patient care. This discussion paper has discussed the different definitions of clinical supervision, the different models that have been used and it has highlighted the role of the National Council in supporting clinical supervision development. It is hoped that this paper will encourage services to review their portfolio of CPD provision and consider whether clinical supervision would be an appropriate and beneficial tool to support nursing and midwifery practice.

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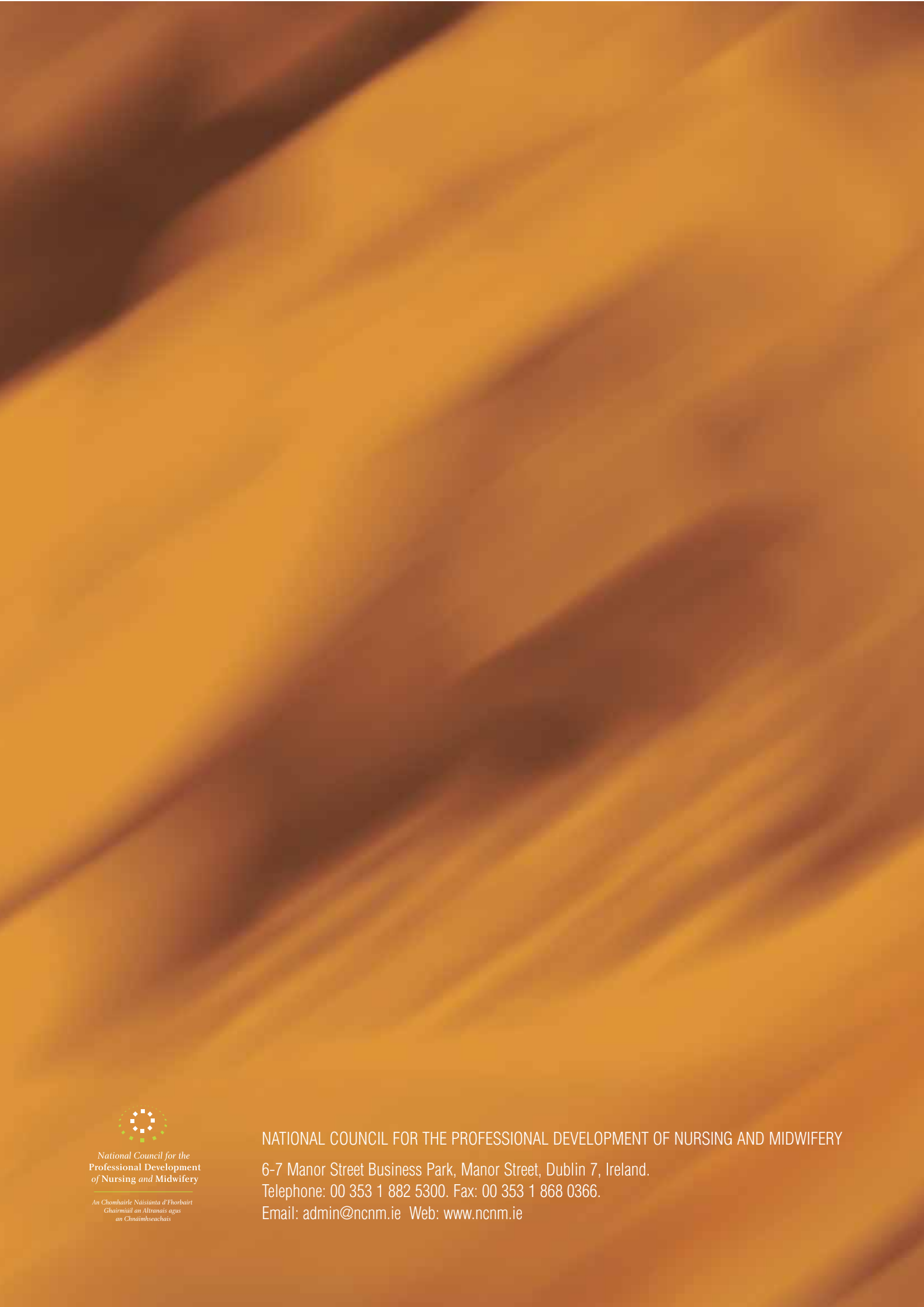

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An Chomhairle Náisiúnta d'Fhorbairt Ghairmiúil an Altranais agus an Chnáimhseachais

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