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Clinical Supervision:

developing, implementing and evaluating practice standards in Acute & Community Mental Health

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INTRODUCTION

Supervision:

Guidelines for the implementation of clinical supervision were developed within this service and implemented from April 1996. As stated within the guidelines: 'Supervision is viewed as a structured, on-going and objective process in which a more experienced peer or more senior person maintains a negotiated contractual relationship with the individual nurse, assisting him/her to focus and reflect upon his/her professional role and clinical practice, thereby facilitating professional development. In order for supervision to be effective, it should be well-structured, uninterrupted and regular, each session being based upon a clear agenda agreed between supervisor and supervisee.'

These guidelines represented a practice-based response to the Report of the Mental Health Nursing Review Team (DOH, 1994), which recommended that '...clinical supervision is established as an integral part of practice up to and including the level of advanced practitioner for mental health nurses' (recommendation 11).

Model of Supervision:

The guidelines describe a model for the basis of supervision, based upon three distinct and inter-related models of clinical supervision (Hawkins & Shohet, 1990):

- Educative (or 'formative') to develop the skills, understanding and abilities of the supervisee by means of reflection and exploration
- Supportive (or 'restorative') to acknowledge the actual or potential psychological effects upon the supervisee of interactions with patients / clients; to deal with stresses and difficulties that the supervisee experiences within nurse - client relationships
- Managerial (or 'normative') to provide for quality control, enhancing problem-solving and awareness, providing feedback about clinical performance, and preparing for and/or reviewing the management of the clinical environment

Standards for Supervision:

Various standards are described within the guidelines, covering the roles of the

supervisor and supervisee, the arrangements for providing supervision and the maintenance of written records of supervision. These standards may be explicitly stated, as shown in Table 1.

Table 1

No.	**STANDARD STATEMENT**
1	The supervisor supervises the supervisee in an objective and professional manner in relation to his/her clinical performance, approach and attitude to his/her work, and his/her ability to work as a member of the nursing and multi-disciplinary team.
2	The supervisee attends regular, pre-arranged supervision sessions, adopting an open and reflective approach towards constructive comment and criticism about his/her own clinical practice.
3	The supervisee brings all relevant records to the session so that the quality of care-planning, evaluation and record-keeping can be assessed.
4	The supervisee receives supervision via one or more modes of: individual supervision, peer supervision and group supervision.
5	Both supervisor and supervisee arrange a mutually-convenient time and venue for each supervision session, held within normal working hours wherever possible.
6	The frequency of supervision sessions is dependent upon the needs of the supervisee, in accordance with the following guidance:- maximum frequency: 2 hours per week; minimum frequency: 1 hour every two-months.
7	Both supervisor and supervisee have an agreed and clear written contract or mandate for the supervision relationship.
8	Both supervisor and supervisee have an agreed draft agenda for the next session at the end of each supervision session, such being revised as necessary at the beginning of the subsequent session.
9	Both supervisor and supervisee are responsible for ensuring that a record of clinical supervision is maintained, each signing the record at the end of each session, using the standard record-form.
10	Both supervisor and supervisee retain an up-to-date copy of the supervision record, although it is accepted that these records are the property of the Trust.

Although the guidelines suggest that the supervisor will normally be the supervisee's line-manager, for supervisees who specialise in a particular therapeutic approach, it is suggested that s/he should be encouraged to seek supervision from a similarly orientated and more experienced practitioner - known as the 'consultant' (Wilkin, 1992), viewed as an adjunct to the supervision which is provided by his/her line-manager (the supervisor), rather than an alternative.

Implementation of Clinical Supervision:
In April 1996, the agreed guidelines for the provision of clinical supervision were implemented for all nursing personnel working within the Acute & Community Mental Health Service.

A programme of supervision workshops were facilitated by the Skills Development Service, primarily for supervisors, prior to the implementation of the agreed guidelines. Moreover, further workshops were offered by the educational facilitator, for both supervisors and supervisees, following the implementation of the guidelines.

An evaluation of the implementation of clinical supervision was conducted during November & December 1996 via a survey-based audit, from which a few additional standards were proposed. These standards may be explicitly stated, as shown in Table 2.

Table 2

No.	STANDARD STATEMENT
11	Each nurse receives regular formal clinical supervision of his / her practice.
12	The supervisor provides clinical supervision for up to a maximum of five clinical staff.
13	Each supervision session is based upon a managerial – educational – supportive model of supervision, the content of which is driven by the needs of the supervisee.
14	The supervisee is permitted some flexibility in the choice of a supervisor, option for additional specialist supervision (consultancy) and mode of supervision (individual / peer / group): the former requires the supervisee to provide a clear rationale for selecting a supervisor other than his/her line-manager.
15	The supervisee reports satisfaction with, and positive outcomes from, engaging within the supervision process.

More recently, the initial evaluation of the implementation of the guidelines was followed up with a re-audit during January & February 1998, undertaken with the aim of assessing the extent to which the standards (Nos. 1 – 15) were being met.

METHOD

A questionnaire was developed as the principle audit tool for surveying nursing staff with regard to the provision, arrangements, content and outcomes of clinical supervision. The questionnaire, which incorporated fixed response, rated and open comment items, was developed during October 1996 and was subject to only minor modifications for the re-audit in 1998.

The questionnaire was forwarded to all nursing staff (both qualified & unqualified staff) working within the Acute & Community Mental Health Service, covering three acute in-patient wards, a day-hospital and five community mental health nursing teams. Staff working on one of the Trust's elderly assessment in-patient wards were also included in the sample due to the fact that they were also managed by the same Clinical Manager.

Sufficient copies of the questionnaire were forwarded to the managers of each care-setting during each audit period. A cover letter was attached to each questionnaire outlining the reasons for the audit, requesting completion and giving details for return. A statement regarding anonymity and confidentiality was incorporated.

FINDINGS

Whilst a short summary of the main findings of the 1998 re-audit are presented in the following section of this report, some direct comparisons with the baseline audit findings (Butler, 1997) are presented.

FINDINGS OF RE-AUDIT: Jan. & Feb. 1998

Baseline audit (1996): 39 / 89 questionnaires were returned (= 44% return).
Re-audit (1998): 50 / 90 questionnaires were returned (= 56% return), although 10/50 (20%) respondents unfortunately provided only partial responses. This was the result of incomplete copying of the questionnaire by ward staff-members, despite the previous distribution of sufficient copies of the complete questionnaire via Ward-managers and Lead CMHNs.

About the respondents:

26 (= 52%) respondents were male nurses, 24 (= 48%) were female.
Of the respondents, 29 (= 58%) were working on in-patient areas, 3 (= 6%) in day-care settings and the remaining 18 (= 36%) in community settings.
In addition to being supervised, 16 (= 32%) respondents were supervising other staff. Of these, 10 were G/H-grade nurses (inc. 6 Lead CMHNs), 5 were F-grade nurses and one was a D-grade nurse.
Of the 50 respondents, 49 were receiving some form of clinical supervision. Only one (a recently employed E-grade) respondent had <u>not</u> received any supervision and was not aware of any plans for it's introduction.
Of 39 supervisees responding, 13 (= 33%) were being supervised by a Lead CMHN, 12 (= 31%) by a ward-manager, 3 (= 8%) by a charge-nurse, and 11 (= 28%) by their line-manager.

About the content of sessions (*Chart 1*):
Each of the 39 supervisees responding to this item indicated one or more areas which best described the content of clinical supervision sessions.

As shown on the chart, clinical supervision sessions incorporate a variety of content areas, although tend to be primarily managerial and educational (reflection on clinical case-work; educational support & professional development) in content, with supportive content (strengths & weaknesses; personal problems; transference & inter-personal issues) being the least reported aspect. This was most striking for the Lead CMHNs / H-grade (N = 6), who indicated only 2/27 responses relating to the supportive areas of clinical supervision, with 20/27 responses relating to the managerial aspect. In / day-patient nurses and the CMHNs were most likely to report more supportive and educational content areas relative to the managerial aspect, as shown within Table 3 .

The above findings show only an overall trend in the content areas reported and should not be used for making absolute comparisons as the number of potential response categories for each of the three content types were not equal: supportive (4 categories); managerial (7); educational (3).

However, comparison with the baseline audit findings (Butler, 1997) do show a general increase in supportive and educational content of supervision sessions relative to managerial content for all three professional groups, as shown by comparing Table 3 with Table 4.

Table 3: Total responses (N = 39) of content type for professional group (1998)

	LCMHNs	**CMHNs**	**In/Day**	**Totals**
Supportive	2 (7%)	8 (12%)	25 (22%)	35 (17%)
Managerial	20 (74%)	36 (52%)	54 (47%)	110 (52%)
Educational	5 (19%)	25 (36%)	35 (31%)	65 (31%)
Totals (all areas)	27	69	114	210

Table 4: Total responses (N = 36) of content type for professional group (1996)

	LCMHNs	**CMHNs**	**In/Day**	**Totals**
Supportive	0 (0%)	4 (8%)	21 (20%)	25 (15%)
Managerial	16 (94%)	25 (56%)	56 (54%)	97 (58%)
Educational	1 (6%)	16 (36%)	27 (26%)	44 (27%)
Totals (all areas)	17	45	104	166

Chart 1: Content of Supervision

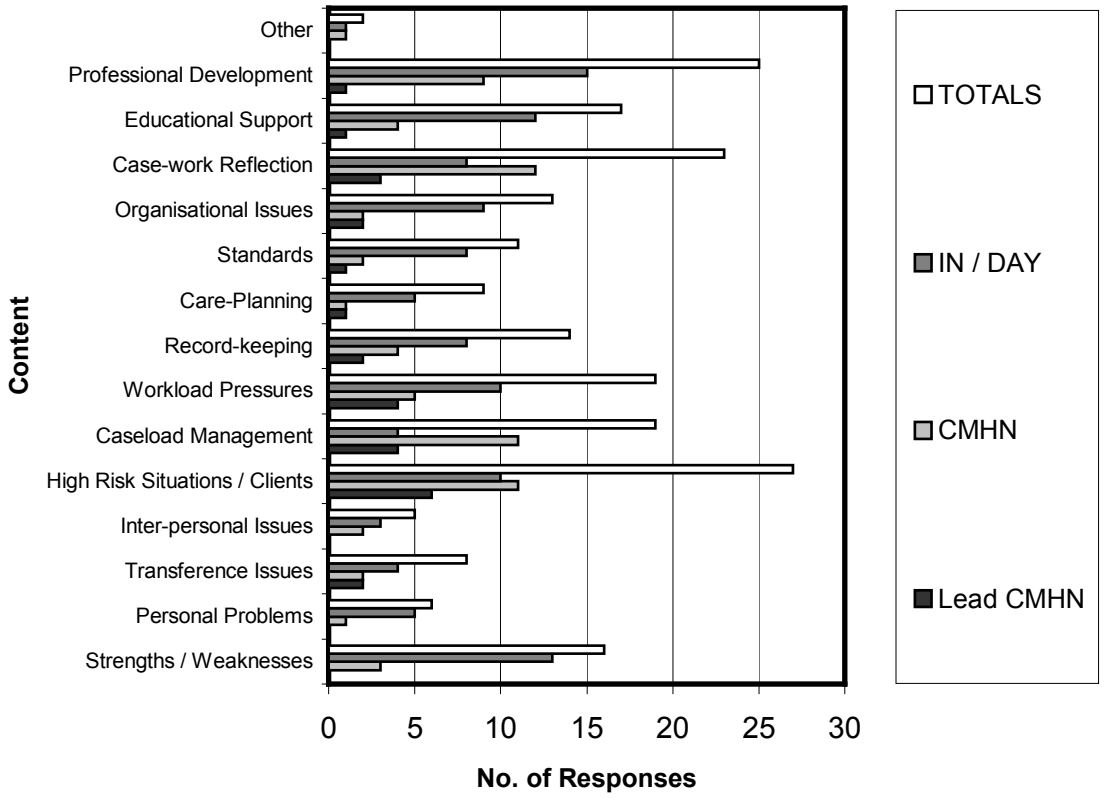
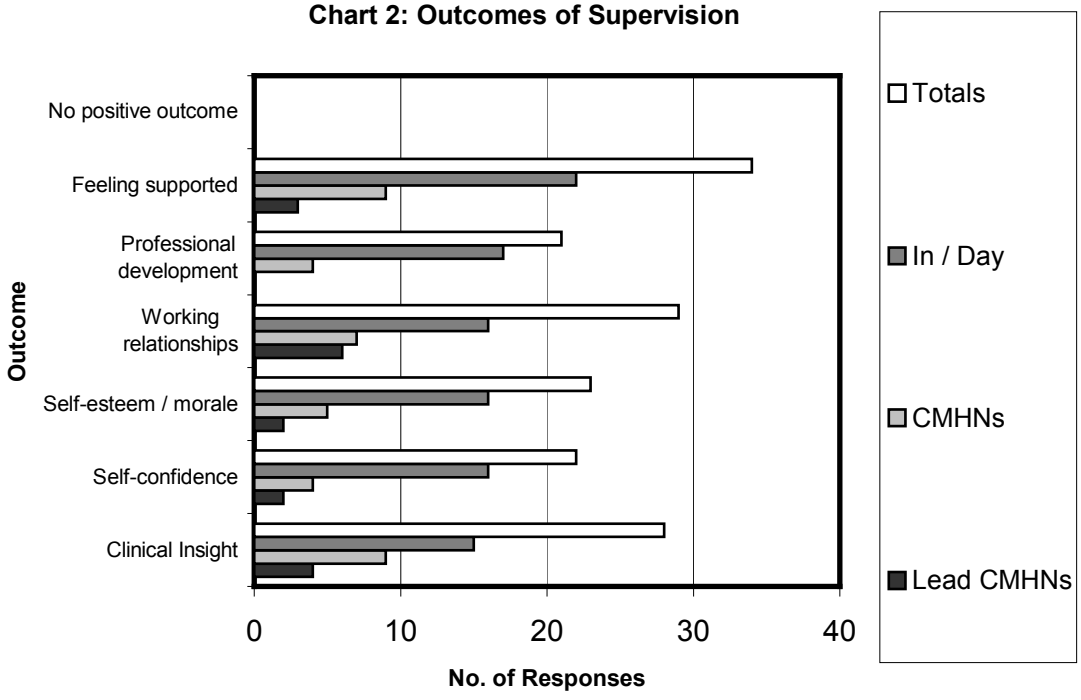


Chart 2: Outcomes of Supervision



Evaluation / outcomes of clinical supervision:

Of the 38 supervisees responding, 37 (= 97%) supervisees agreed that clinical supervision offers them a safe environment for exploring practice-related issues.

Outcomes of clinical supervision (*Chart 2*):
Of the 46 supervisees responding, all indicated one or more positive outcomes of clinical supervision to date, as shown in Chart 2.
In comparison to the baseline audit findings of 1996 (Butler, 1997), none of the respondents reported 'no positive outcomes' as compared with 3/36 (= 8%) in 1996.

Other direct comparisons are note-worthy, as shown in Table 5. As shown, feeling supported (74%), stronger working relationships (63%) and gaining additional clinical insight (61%) were the most commonly reported outcomes. These areas were the most commonly reported outcomes for all three professional groups. As shown, increasing numbers of supervisees reported more positive outcomes as compared with the baseline audit.

Table 5

	1996 Audit (N=36)	**1998 Audit (N=46)**	**Relative Change (%)**
Additional clinical insight	18 (50%)	28 (61%)	+ 11%
Increased self-confidence	10 (28%)	22 (48%)	+ 20%
Enhanced self-esteem / morale	7 (19%)	23 (50%)	+ 31%
Stronger working relationships	13 (36%)	29 (63%)	+ 27%
Clearer direction for professional development	18 (50%)	21 (46%)	- 4%
Feeling supported	25 (69%)	34 (74%)	+ 5%
TOTAL (all positive outcomes)	91 (2.5 outcomes per respondent)	157 (3.4 outcomes perrespondent)	

CONCLUSIONS / RECOMMENDATIONS

The following comments are made in view of the findings of this survey-based re-audit and should be considered during the ensuing action-planning phase. In forming recommendations, audit findings are compared against the ***fifteen practice standards,*** which were identified earlier.

- Only 1/50 (= 2%) respondents had either not received any clinical supervision to date or had only had one session compared with 12% of respondents in the baseline audit. This sole respondent was a relatively new employee. It is thus clear that the guidelines are now being implemented for all nursing staff within the acute / community mental health service. ***Standard 11 = 98%***

- Only 1/12 (= 8%) responding supervisors reported supervising more than five staff. ***Standard 12 = 92%***

- The majority of supervisees (82.5%) are receiving clinical supervision at least monthly compared with 67% of respondents in the baseline audit. It is recommended that regular sessions are established for all nursing staff, although the frequency of sessions will depend upon individual need. In addition, supplementary supervision was arranged in six cases, primarily for specialist therapeutic approaches. ***Standard 6 = 82.5%***

- Only 47% of supervisees reported that clinical supervision was based upon an explicit written contract as compared with 48.6% of respondents in the baseline audit. Establishing a contract may lead to greater clarity about the process of clinical supervision between supervisor and supervisee. It is recommended that an explicit contract is established with all supervisees, although some supervisors have requested training input on drafting and agreeing written contracts. Whilst an outline contract is available for sharing ideas, this should only be used as a guide and template rather than as a pre-set contract which is not then subjected to mutual agreement. ***Standard 7 = 47%***

- The vast majority of respondents reported that supervision sessions occurred at a mutually convenient time (= 98%) and venue (= 100%) within normal working hours (= 96%). ***Standard 5 = 96%***

- The guidelines suggest the adoption of a managerial-educational-supportive model of supervision (***Standard 13***). Although clinical supervision for some continues to be primarily managerial in nature, there is an overall trend in the relative increase of supportive and educational components for all nursing groups as compared with the baseline audit findings. It may prove more beneficial and acceptable to attend more to the equally important and required supportive aspects of the model. It should also be emphasised that the model of clinical supervision is intended to be supervisee-driven i.e. the supervisee bringing issues / material into supervision, rather than supervisor-led (***Standard 13***).

- All except one respondent confirmed record-keeping for supervision sessions. Whilst two examples of recording forms are currently in use, these may need to be changed or modified to suit both the model of clinical supervision which is adopted and the individual needs of the supervisee. One example of a current recording form does include a section for the supervisee to consider and record his/her agenda (***Standard 8***) prior to the supervision session (OPDC, 1994). ***Standard 9 = 97.4%***

- General dissatisfaction with group supervision has continued to be expressed by Lead CMHNs, and in particular: insufficient time available for the size of the group; insufficient commitment by group-members; content tends to be primarily managerial; feedback is often unhelpful and thus the group experience can be uncomfortable. Perhaps more fundamental to this process is the absence of a written contract. However, since the baseline audit, several Lead CMHNs have reported receiving individual supervision sessions as a complementary component to group sessions. It continues to be recognised that individuals will have differing preferences for the mode of clinical supervision (***Standards 4 & 14***) e.g. some staff who receive individual supervision feel that they would benefit from peer group supervision. There are now some reported examples where the supervisees' choice of the mode of supervision has been met e.g. the establishment of a peer group in place of individual supervision. Given the due consideration of practical arrangements for ensuring supervision, a degree of flexibility and choice in meeting individual preferences can only be encouraged.

- Various areas for improvement were identified, and in particular: the need to ensure that supervision is based upon a mutually agreed contract; that sessions are well structured; that there is prompt follow-up of actions which directly result from supervision sessions; and, that sessions are scheduled onto ward rotas to reduce the frequency of cancelled sessions which result from unpredictable ward situations.

- It is most encouraging that, without exception, all supervisees reported gaining one or more positive outcomes from clinical supervision, and even when certain areas of dissatisfaction were identified. ***Standard 15 = 100%***

- Further training was requested by 13/38 (34%) of the respondents, with various suggestions of training issues being made: regular training updates; skills training, focussing upon supervisor skills in particular; and, training input in meeting individual needs which are identified as an outcome of supervision.

Clinical Supervision is viewed as of benefit to both the supervisee and the Trust. It offers the opportunity to present, discuss and reflect upon clinical practice, to become aware of areas of strength and weakness, and to promote strategies which assist both personal and professional progression. The Trust is likely to benefit from the indirect improvement of the overall quality of care to patients and from the positive impact upon the skill and motivation of staff.

To further illustrate the potential benefits of clinical supervision to the individual as a supportive and educational process which concentrates upon aspects of clinical case-work, the example shown in Fig. 1 is given, as prepared for and discussed within a recent educational workshop on the application of cognitive-behaviour therapy with difficult clients.

It is strongly suggested that the audit findings and recommendations of this report are discussed within mental health unit staff-meetings and within the respective CMHN Teams, agreeing and implementing an explicit action-plan for further qualitative improvement in the implementation of clinical supervision.

All respondents who participated within this audit are gratefully acknowledged.

FIG. 1 EXAMPLE: *a 'clinical' application of supervision*

experience of client sessions:
client avoids / resists / rejects / is flattering / therapist dislikes client

therapist cognitions:
he's not trying
she won't let me help her
I can't seem to deal with this
our lack of progress reflects badly on me
why should I bother to help this scumbag
she'll only drop out any way
why bother - nothing will sink in - nothing will change

therapist feelings:
sadness / despair / futility / frustration / anger / fear / attraction / hopelessness / suspiciousness / discouragement

therapist actions / issues explored in supervision:
expectations / obstacles / limits / level of disclosure
impact on therapeutic process
problems viewed as windows on important dysfunctional beliefs of client & therapist
opportunities to use cognitive-behavioural strategies on self

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