Supervision in Nursing in Northern Ireland – A Review of Current Processes

1.0 Background

1.1. In 2007 it was recognised through evidence in practice and a range of regional critical incident inquiries[1][2][3] that the implementation and maintenance of robust nursing supervision processes for safe and effective care delivery should be supported.

1.2. Supervision processes had also been acknowledged as a method of improving organisational recruitment and retention of nursing staff and had an established association with job satisfaction, increased autonomy and reduced absenteeism[4].

1.3. *The Review of Clinical Supervision for Nursing in the HPSS 2006*[5] carried out by the Northern Ireland Practice and Education Council (NIPEC) on behalf of the Department of Health and Social Services and Public Safety (DHSSPS), reported on the extent and nature of supervision activity across the eighteen Trusts in Northern Ireland. The final report recommended action in order to enhance and promote professional supervision for nursing in Trusts throughout Northern Ireland (NI).

1.4. The report included a new adopted definition, encompassing the many activities which are understood to have a supervision impact:

> *'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety'.*[6]

1.5. Subsequent to this review, the Chief Nursing Officer (CNO) for Northern Ireland (NI) published *Standards for Supervision for Nursing*[7] detailing two regional standards for supervision, asking NIPEC to facilitate a regional initiative with the five Health and Social Care (HSC) Trusts to support the implementation for HSC organisations.

CNO Standards

1.6. The Supervision Regional Forum was afforded the opportunity to revise the standards subsequent to the work of the project. The revised standard statements were:

Standard Statement 1

Supervision will contribute to the delivery of safe and effective care when practitioners have access to appropriate systems that facilitate the development of knowledge and competence through a culture of learning by reflection.

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[1] Lewis, RJ, Cole, D, Williamson, A (2003). *Review of Health and Social Services in the case of David and Samuel Briggs*. Belfast, DHSSPS.

[2] Regional Quality Improvement Authority (2005). *Review of the lessons arising from the death of the Late Janine Murtagh*, Belfast, RQIA.

[3] McCleery Inquiry Panel (2006). *Executive summary and recommendations from the report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board.* Belfast, DHSSPS.

[4] Hyrkäs, K., Appelqvist-Schmidlechner, K. and Haataja, R. (2006). Efficacy of clinical supervision: Influence on job satisfaction, burnout and quality of care. *Journal of Advanced Nursing*. 55(4), 521-535.

[5] The Review of Clinical Supervision for Nursing in the HPSS 2006 NIPEC available from www.nipec.n-i.nhs.uk

[6] Northern Ireland Practice and Education Council (2007). The Review of Clinical Supervision for Nursing in the HPSS 2006 on Behalf of the DHSSPS. Belfast, NIPEC.

[7] Chief Nursing Officer for Northern Ireland (2007). *Standards for Supervision for Nursing*. Belfast, DHSSPS.

Standard Statement 2

An organisational framework supporting effective leadership and performance management will ensure that supervision will become an effective tool to improve the safety and quality of care.

1.7. The CNO at that time indicated in a letter to the HSC Trusts in July 2007 that it was his intention to monitor the implementation and maintenance of supervision processes against the Standard Statements via an annual report to the DHSSPS by each Trust Executive Director of Nursing. The first Trust reports were submitted April 2009.

1.8. The outcomes of the implementation project were: a regional policy and procedure document, a frequently asked questions leaflet, standardised record keeping resources including contracts for supervisors and supervisees, and a regional approach to the preparation of supervisors and supervisees.

1.9. Subsequent to implementation it was deemed helpful that NIPEC should undertake an evaluation of the effectiveness of supervision from the perspective of the registrants. This was to include multiple choice style questions on the processes, frequency and preparation for supervision and qualitative information in relation to the impact that supervision was having on the quality of care delivery – from the perspective of the nurses who engaged with evaluation processes.

1.10. The use of the perspective of registrants had been highlighted as helpful from a short literature review conducted in 2009. Bégat and Severinsson found that nurses undertaking supervision were supported to identify and refuse to take on responsibility outside of their competence. In such situations, there was a proactive willingness to learn yet a reduction in the anxiety nurses experienced when they were asked to engage in what was termed 'unethical care'[8]. It was proposed that evaluation from the perspective of the supervisor or supervisee was required to justify the resources implicated in sustaining a supervision system within an organisation[9].

1.11. In addition, the importance of supervisor training and careful selection of individuals to supervise was emphasised, studies revealing several characteristics which were common to those supervisors deemed effective by the supervisees[10].

1.12. NIPEC published a hard copy questionnaire in 2010 to test questions, refining and converting to an online format in 2011. Since then NIPEC has evaluated the process of supervision including perceived impact on practice each year, delivering final confidential reports to each HSC Trust by year end. The results of the questionnaire are usually incorporated in the Trust annual report to CNO.

1.13. NIPEC was been commissioned by the CNO to develop an encompassing model framework for midwifery supervision in NI, in readiness of the legislative changes to the Nursing and Midwifery Order 2001 (section 60). The model will seek to provide professional accountability assurances to the Chief Nursing Officer, Executive Directors of Nursing and other stakeholders in NI. In addition the new model must also provide accountability assurances to the public.

[8] Bégat, I. and Severinsson, E. (2001). Nurses' reflections on episodes occurring during their provision of care – an interview study. *International Journal of Nursing Studies*. 38, 71-77.

[9] Dudley, M. and Butterworth, T. (1994). The costs and some benefits of clinical supervision: an initial exploration. *The International Journal of Psychiatric Nursing Research.* 1, 34-40.

[10] Cutcliffe, J. and Proctor, B. (1998). An alternative training approach to clinical supervision: Part one. *British Journal of Nursing*. 7, 280-285.

1.14. This commission includes the review of existing processes for supervision in nursing to position the region in a state of readiness for revalidation, aligning with messages emanating from the work the Task and Finish group for Midwifery Supervision in NI.

2.0 Purpose

2.1 The purpose of this paper is to set out distinct themes arising from a review of nursing supervision in Northern Ireland.

2.2 The review encompassed:

1. A time limited review of current supervision processes in NI against the CNO standards across the five HSC Trusts in relation to:
    a. Enablers to supervision across care settings and fields of practice
    b. Barriers to supervision across care settings and fields of practice
    c. Use of developed resources (2008/9) for supervision including the organisational policy and procedure document
    d. Recording and monitoring arrangements for each HSC Trust
    e. Arrangements to support supervision for nurses within autonomous advanced and specialist practice roles
    f. Organisational support mechanisms provided to supervisors
2. A review of recent literature to discover evidence of:
    a. Definitions of supervision
    b. Standards for supervision e.g. optimal numbers of supervisors : supervisees; optimal number of annual sessions
    c. Approaches and variety of models / methods of completing supervision.
    d. Learning and development for the preparation of supervisors and supervisees.

3.0 Methodology

3.1 A desk top electronic exercise was taken forward across the five HSC trusts and independent and voluntary organisations that had engaged with the project Sub-Group. A pro forma with relevant questions was devised to answer items 1 c – f; 'Blog Boards' were placed in team environments across HSC and Independent and voluntary settings to ask nurses to contribute to questions relating to 1 a – c & e.

3.2 A literature search was conducted via CINAHL using the search term 'nursing supervision', limiting returns to 2001 – 2016 and full text articles. A total of 20 documents were reviewed as relevant.

4.0 Findings

4.1 From the desk top review it was evident that all HSC Trusts were using a refreshed version of the policy and procedural document produced as a result of the CNO Standards project in 2008.

4.2 Monitoring arrangements were in place in each Trust. Most organisations had a central database for collecting compliance figures, however some element of the process was usually paper based. Processes for bank staff were not clear in some organisations.

4.3 Across the region between 65 – 76% of nursing staff received 2 sessions of supervision annually, meeting the CNO standard, percentages being higher for one session annually.

4.4 Resources to support supervisees and supervisors included records templates, Frequently Asked Questions leaflets, and monitoring arrangements.

4.5 One organisation had recently carried out a review of the number of supervisors and noted that in some directorates struggling to be compliant with the CNO standards, there was a deficiency of supervisors, which was now being addressed. In some organisations support was offered to disparate specialist staff via nominated 8a nursing staff who would offer supervision to lone workers or those not managed directly by a nurse. It was also noted that some staff – as much as 10% - were completing supervision in their own time.

4.6 Learning and development to prepare supervisors was generally carried out by the Clinical Education Centre, with some support offered within individual organisations to develop supervisors once they had completed the formal segment of learning and development.

4.7 The independent and voluntary sector organisation participating noted a UK wide policy for supervision in nursing with monitoring mechanisms in place to meet Regulation and Quality Improvement Authority requirements.

4.8 Data collated from the 'blog boards' demonstrated evidence of the following themes:

- Confusion around the purpose of supervision almost equal in the number of responses that demonstrated understanding relating to the revised purpose definition from 2007.
- Understanding of the role of supervisee
- Understanding of the role of supervisor – with a small number of responses demonstrating a lack of understanding
- Enablers: safe secure environment; protected time to prepare and engage in supervision; trusting, respectful relationships; a framework to guide the process; experienced and competent supervisors; access to appropriate resources; honesty; named supervisor; staff valuing the process.
- Barriers: workload; lack of protected time; inexperienced supervisors; lack of trust; storage of records; lack of engagement; staff not valuing the process; frequent staff transfers; confusion between performance management and professional supervision; action plans not being followed up or evaluated.
- The term 'supervision' was not valued – suggestion to change the term to 'reflection in nursing' or 'reflective practice'.

4.9 The literature review whilst triangulating the responses of NI nurses, did not provide new evidence that might assist in the construction of a framework to support supervision.

4.10 The commitment of employing organisations was deemed a pre-requisite, recognising the importance of careful preparation of supervisors[11] and strong organisational leadership[12]. It was also suggested that the approach to supervision may vary due the range of nursing roles that exist, however common principles should be recognised in each approach:

- **Restorative** - whereby the practitioner can share concerns/difficulties
- **Normative** - whereby a practitioner with greater experience is able to provide another practitioner with feedback
- **Formative** - whereby the practitioner is able to develop his/her practice under the guidance of a more experienced person.

4.11 The commitment of individual practitioners was acknowledged as a crucial element of success of supervision – in particular being open to honest feedback and the potential for growth[13].

4.12 Organisations that recognise supervision as a tool that drives quality and places importance on the process will often succeed at fully implementing supervision in nursing[14]. This includes a mandate for protecting time[15] and identifying the numbers of nursing staff requiring supervision and preparation of the appropriate number of supervisors to engage effectively in the process.

4.13 Records management was an area for identifying clearly what expectations existed in terms of principles for keeping records, ownership, action planning and evaluation/ follow-up of action plans[16]. A balance was required, however, to avoid making the process overly bureaucratic – something that was deemed unhelpful.

4.14 As previously mentioned, the literature did not advocate one distinct model in terms of efficacy[17]. Principles for supervision practice were the focus, for example the requirement to:

- Define what supervision is and means in practice[18]
- Define numbers of supervisees: supervisors for one-to-one and group supervision[19]
- Define learning and development outcomes for preparation of supervisors[20]
- Name/ identify supervisors in practice environments[21] - linked to the importance of trust and establishing a relationship to reflect honestly[2223]

[11] Fowler, J. (2013) Clinical Supervision from staff nurse to nurse consultant Part 1: What is clinical supervision? *British Journal of Nursing* Vol. 22 (13).
[12] Fowler, J. (2013) Clinical Supervision from staff nurse to nurse consultant Part 4: Clinical Supervision. *British Journal of Nursing* Vol. 22 (14).
[13] Ibid.
[14] Fowler, J. (2013). Clinical Supervision from staff nurse to nurse consultant Part 6: Implementation at a strategic level. *British Journal of Nursing.* Vol. 22 (18).
[15] Fowler, J. (2013). Clinical Supervision from staff nurse to nurse consultant Part 10: Prioritising and making time. *British Journal of Nursing.* Vol. 22 (22).
[16] Fowler, J. (2013). Clinical Supervision from staff nurse to nurse consultant Part 8: Confidentiality and records. *British Journal of Nursing.* Vol. 22 (19).
[17] Fowler, J. (2013). Clinical Supervision from staff nurse to nurse consultant Part 9: Models of implementation. *British Journal of Nursing.* Vol. 22 (21).
[18] Davis, C. and Burke, L. (2012). The effectiveness of clinical supervision for a group of ward managers in a district general hospital: an evaluative study. *Journal of Nursing Management*. Vol 20. Pp 782 – 793.
[19] Ibid.
[20] Cutcliffe, J.R. and Sloan, G. (2014). *Towards a Consensus of a Competency Framework for Clinical Supervision in Nursing: Knowledge, Attitudes and Skills in the Clinical Supervisor*. London, Routledge.

- Define and support an infrastructure in each organisation[24]
- Define the process and provide resources to assist[25][26]

5.0 Conclusion

5.1 It is of some reassurance that the data received from staff delivering direct patient/ client care and services, and other colleagues who responded to the blog boards, correlated with the findings of the literature review.

5.2 From this time-limited review of supervision in nursing in Northern Ireland, some distinct recommendations have been agreed by the Project Sub Group. They are that future work to develop a framework for nursing and midwifery should consider defining:

1. What supervision is and means in practice
2. The importance of trust and establishing a relationship to facilitate honest reflection
3. A clear process
4. Numbers of supervisees: supervisors for one-to-one and group supervision
5. Identifying named supervisors in practice environments
6. Learning and development outcomes for preparation of supervisors
7. A supportive infrastructure in each organisation with an organisational lead
8. Resources to assist, including outlines of different approaches to supervision, guidance on keeping records and templates for recording
9. Rebranding or renaming of the framework.

5.3 This paper was prepared by Angela Reed, Senior Professional Officer, NIPEC with the assistance of Elinor Welch, Person Centred Practice Lead Nurse, SEHSCT.

[21] Ibid, at n 18.
[22] Brunero, S. (2011). The process, logistics and challenges of implementing clinical supervision in a generalist tertiary referral hospital. Scandinavian Journal of Caring Studies. Vol. 26. Pp 186 – 193.
[23] Bifarin, O. and Stonehouse, D. (2017). Clinical Supervision: an important part of every nurse's practice. *British Journal of Nursing.* Vol. 26 (6).
[24] Ibid, at n 15.
[25] Ibid, at n 16.
[26] Ibid, at n 11.