

An integrated approach to introducing and maintaining supervision: the 4S model

The 4S model of supervision – structure, skills, support and sustainability – is intended to help professionals reach excellence in their practice

AUTHOR Carole Waskett, PGDip, BSc, Cert Supervision in Counselling and Therapeutic Relationships, Cert Solution-Focused Practice, is clinical supervision and professional support facilitator at Bolton PCT and private consultancy and training practitioner at Northwest Solutions.

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Although strongly recommended as a matter of clinical governance for nurses and other health service professionals, supervision is not universally and robustly in place. This article outlines the 4S model – structure, skills, support and sustainability. This first puts in place a managerial structure, then teaches a solution-focused approach and skills to volunteer supervisors, as well as ensuring support and sustainability.

INTRODUCTION

Clinical supervision is rather like the Cheshire cat in *Alice in Wonderland*; it smiles broadly from on high, but fades in and out of view. Some departments, services or teams use supervision regularly. Others mean to – or once meant to – but somehow the practice has dwindled or faded.

The literature is extensive and tends to focus on the supervisory pair or group, and the practice, evaluation or research into supervision itself (Hyrkas et al, 2006; Teasdale et al, 2001; Driscoll, 2000; Jones, 1999; Bond and Holland, 1998; Butterworth and Faugier, 1992). This article takes a more systemic, four-stage view of embedding a supervision scheme into a trust or organisation.

All NHS clinicians should practise supervision. The NMC (2008) advice sheet on supervision stated: ‘Clinical supervision should be available to registered nurses throughout

their careers so they can constantly evaluate and improve their contribution to the care of people’. Other professional bodies, such as the Royal College of Speech and Language Therapists (2009) and the Society of Radiographers (2003), have made similar statements.

Hill (2005) reported on a successful scheme offering supervision to the whole range of allied health professionals (AHPs) and healthcare scientists in Birmingham, and stated: ‘Clinical supervision is key to AHP professional practice.’ Hawkins and Shohet (2003) described a model favoured by university courses, aimed at all in the helping professions.

The practice is mandatory among counsellors, psychotherapists, psychologists, and art, drama and music therapists, among others. It is common – although not universal – in mental health services, and among occupational therapists.

Experience suggests that regular supervision is more of an intention than a reality, often for good reasons (Robinson, 2005).

There are no clear guidelines to promote confidence in clinical supervision among hard-pressed managers, nor are there universally accepted definitions.

Many managers and clinicians have vague and uncertain views of clinical supervision. Sweeney et al (2001) stated: ‘Although there is no lack of theoretical writing... the theories themselves have provided little guidance for ongoing research and practice. This has resulted in confusion...’

There is confusion with line management, clinical teaching, preceptorship, mentorship, policing, coaching and counselling. Some

PRACTICE POINTS

- Embedding supervision in an organisation needs preparation, planning, ongoing management and evaluation.
- Structure, skills, support and sustainability are all essential to a robust and lasting scheme.
- Supervision should be simple, disciplined and routine.
- The goal of supervision is to support and facilitate supervisees’ increasing growth towards excellence.

think it is a method of managing poor performance for a short period of time. I would argue that it is none of these things.

All clinicians should have regular line management and access to clinical advice from a more senior practitioner. These are different from supportive supervision (Table 1). A broad, simple definition of supervision might be:

‘An off-line, career-long relationship (or serial relationships) offered to all staff at any level, in which the supervisee can talk regularly with another person/group, in confidence, about personal

learning, development and progress as a professional practitioner. The aim of both supervisee and supervisor is to facilitate and encourage the supervisee’s ongoing growth towards excellence in the practice of their profession.’

So the challenge is to introduce a supervision scheme that is streamlined and practical, collaborative and effective, and in which there is a comprehensible, robust structure that staff find easy to use and keep using.

There are very few schemes that take the whole system into account and these are inclined to be rigorous but cumbersome (RCN Institute, 2000).

Most importantly, any scheme should help both supervisors and supervisees to work more efficiently, feel more energised and learn together with joy from their working experiences and resourcefulness. It should ultimately benefit patients by helping clinicians to be more in touch with their own confidence, compassion and pride in their work.

Anecdotal evidence suggests that efforts to establish supervision in many trusts have

begun – and all too often ended – with training supervisors. These staff members, overworked and unsupported, have usually failed to deliver over time through no fault of their own.

However well trained, a supervisor or group of supervisors cannot work against a culture unused to the concept, without managerial support, structure and resources. Supervision schemes are most likely to succeed where they are planned and steps are taken in succession.

The 4S model has four stages – structure, skills, support and sustainability.

STRUCTURE

Management commitment is needed first, to lay down a clear, comprehensible structure that will support supervisors and supervisees.

The group leading on supervision should have the power to make decisions and the authority to make things happen. Their role is not to train as supervisors, unless they wish to, but to act as facilitators and guardians so that the scheme can grow and flourish.

They will need to agree on the definition of supervision and why they have decided on it. Once they have agreed, they can use their joint resourcefulness to implement their decisions.

Choices and dilemmas

● Optional or mandatory

Optional may be better for several reasons. Willing supervisees are easier to work with for newly trained supervisors; good supervision will show its worth and create demand, enabling slow organic growth; it saves resources to train a smaller group of supervisors and not overload them to begin with; and multidisciplinary supervision is more possible in an optional system. If a mandatory scheme is envisaged, enough

trained supervisors will have to be provided and policing will have to be considered. In this case, it would be wise to spend ample time raising awareness of the scheme before it begins.

● Group, one to one or both

Unless staff have a preference, it is often better to offer a choice. This can always be reviewed. New supervisors will find it easier to work with one person. Groups have a different structure and can be run as

peer groups after a short period of training with a supervisor (Sharry, 2007; Nicholl, 2005).

● Timing of sessions

One-hour sessions are enough for one-to-one work and two hours for a group of up to eight – certainly no longer for either – at intervals of 6–8 weeks. Monthly is better but time pressures mean compromise is necessary.

● Working across disciplines

There are many advantages to working across disciplines, including objectivity and the avoidance of friends and close colleagues. It is not necessary to have superior clinical knowledge or even seniority to be an effective supervisor. The relationship needs to be completely professional and reliable without any power gradient.

● Resource allocation

This will depend on work pressures and travelling times, as well as on room availability. Supervision should be a career-long activity so resources will need to be built into budgets for the duration. It is better to allocate minimal resources and stick to decisions than to offer broad largesse that soon disappears.

BOX 1. STRUCTURE

- Managers need to take control and offer structure and support for a supervision scheme.
- Structure, skills, support and sustainability should all be addressed in planning.
- Do not rush – allow time to set the scheme up robustly.
- Evaluation of the whole scheme is essential.

● Evaluation

Consideration needs to be given to outcomes required and how they can be measured. Staff morale, sickness levels and retention may be important elements. Audit departments can be helpful here. Consider taking baseline measurements before the scheme and two years later. The Manchester Clinical Supervision Scale (Osman Consulting, 2009) might be used.

● Policies, protocols and contracts

These should be produced before the next stage. Trusts and departments can learn from each other, sharing knowledge and template paperwork.

● Managing logistics

Supervision relationships tend to work better if the supervisee has chosen the supervisor (Cerinus, 2005). An effective method can be to set up a database of supervisors, with a short paragraph about each one. Prospective supervisees access this and contact the supervisor of their choice to ask for a trial period of supervision. There should be a limit to each supervisor's caseload, and they should feel free to decline. It should be specified how many one-to-ones and/or group sessions a supervisor should undertake over a year.

CLINICAL SUPERVISION SKILLS

Volunteers interested in practising as supervisors are invited to a two-day course on supervision skills.

A solution-focused approach is simple, collaborative and respectful while being easily understood by health service staff (Waskett, 2006). This model, while mainly used for counselling and psychotherapy supervision (Macdonald, 2007; O'Connell and Jones, 1997; Thomas, 1996) can be adapted very well to supportive supervision for health professionals.

Although simple, the approach needs discipline, self-awareness and lots of practice. Supervisors learn to be respectfully curious and realise they do not have to know any answers. This can be difficult for NHS staff who have been trained to problem solve. The solution-focused approach is not a problem-solving model, but a solution-building one – a subtle difference that takes time to understand.

On the other hand, most health service staff start from a good position as their training has

TABLE 1. SOME TASKS IN MANAGING, TEACHING AND SUPPORTING PROFESSIONALS

Line management/team leadership	Clinical advice/teaching	Supervision
Leading the team/service	Demonstrating procedures	Listening non-judgementally
Everyday management of the team	Suggesting reading material	Debriefing
Coaching and supporting team members	Giving information	Asking respectful questions about work
Performance management	Acting as a role model	Recognising and appreciating supervisees' strengths and resources
Appraisal	Creating learning opportunities in one-to-one informal or formal training	Helping to establish supervisees' direction/progress towards excellence
Not confidential (as default position)	Not confidential	Confidential (as default position)
	Assessing	Enabling reflection on thinking/feelings/actions
	Marking	Facilitating forward movement in career

Practice in depth

KEYWORDS CLINICAL SUPERVISION STRUCTURE | EDUCATION | SUPERVISION

given them people skills, understanding around confidentiality issues and common sense, which stand them in good stead.

The potential supervisor learns communication skills to enable the supervisee to identify their strengths and resources, look at how they want to use these to progress in their work, and use practical steps towards this goal. This approach has added value in that participants comment on its transferability to use with patients and in other situations (Macdonald, 2007; Burns, 2005). Supervisors also learn to manage the dual role of looking out for the well-being of patients, clients or families that supervisees may discuss in supervision, in addition to supervisees' well-being and progress.

Understanding boundaries

Supervisors need a sound understanding of boundary issues. These include confidentiality and many grey areas. It is also important to look at record-keeping, accountability and the relationships between supervisor, supervisee and line manager.

Participants leave the course with a clear idea of what they will be doing next. They are encouraged to read more around the model, enjoy their new learning, and relax into their roles as partners who are very much learning by doing. It is fine to make lots of mistakes. Transparency with partners is built into this model of work, with both learning together.

SUPPORT

Supervision is not an exercise in dull bureaucracy. It is hard work, demanding concentration and attention. It can be exciting, inspiring and even frightening.

Being a supervisor is a position of serious responsibility and obligation to the supervisee, their patients and their organisations. Balancing these fairly, positively and non-judgementally, while of help to the supervisee, asks much of these newly trained people.

After initial training, supervisors have fragile, largely unpractised skills but they learn rapidly as they begin to work with supervisees.

The temptation will be to let self-discipline slip, to chat and eventually become didactic. It

BOX 2. PRACTICE

- The purpose of supervision is to assist supervisees to work as effectively as possible.
- Supervisors should have a power-free relationship with supervisees.
- The solution-focused model of supervision is simple yet disciplined and respectful.
- Supervision for all clinicians should be career long, not just for emergencies.

is extremely seductive for new supervisors to help supervisees by telling instead of asking.

Supervisors need ongoing support to develop skills, learn from each other, troubleshoot, have a place to explore aspirations and uncertainties, and find inspiration. There are several ways to do this. Typically, supervisors will meet as a group regularly, perhaps quarterly. Supervisors must have their own ongoing supervision. The partners must agree that discussions involving supervisees must remain confidential unless both agree on formal action.

SUSTAINABILITY

The working group will be planning for sustainability from the beginning to ensure there is detail on what managers will need to do to keep the scheme moving through the years and inevitable changes ahead.

Some essential elements are:

- Ongoing resource investment (tapering down over time);
- Someone whose job is to monitor, manage and evaluate the scheme;
- Ongoing courses and support groups for supervisors, perhaps run by experienced supervisors;
- Routine expectations from managers that new staff will link up with a supervisor, and will be questioned about supervision in appraisal interviews. The use of supervision skills (by both supervisor or supervisee) should be mapped onto the Knowledge and Skills Framework;
- A regularly updated, ratified policy;
- Regular evaluation to show the return on investment and indicate improvements;
- Local elements.

CONCLUSION

This model takes time to introduce and establish. Initially, it demands commitment, investment, training and hard work.

However, once the scheme is running, it becomes routine. Using a clear structure backed by senior management, solution-focused skills training, and ongoing practice and support, the 4S is a simple yet effective and sustainable model of supervision. ●

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