Clinical supervision using the 4S model 1: considering the structure and setting it up

Despite recommendations, many nurses do not receive regular clinical supervision but with careful planning it is possible to create a successful comprehensive scheme

INTRODUCTION

An older nurse commented recently: “In the old days, supervision for nurses used to be terrifying. Even not so long ago I remember going in with trepidation and coming out in tears – and that was a pretty common occurrence for many of us.” No wonder it has been so difficult to establish regular clinical supervision practice for health service staff in recent times.

The literature itself is little help. While there are many useful pieces of work, almost all of them focus on the practice or usefulness of supervision rather than its practical integration into an organisation.

Not everyone goes without as several disciplines in the NHS must, and do, have regular supervision. Counsellors and psychotherapists; psychologists; art, music and drama therapists; play therapists; child protection workers and midwives (Nursing and Midwifery Council, 2008a) all have mandatory supervision. However, many disciplines, including nursing, have not yet incorporated it into everyday practice. Many nurses do not have regular, protected access to confidential conversations about the everyday challenges of their work. This would give them space and time to consider how they deal with increasing the quality of care with limited resources, and with ethical and moral issues such as delivering bad news or supporting distressed patients and families.

Specific, evidence based benefits of clinical supervision include more rounded and responsible staff who use, develop and reflect on every element of their capacity, thereby working more confidently and effectively. In addition, feeling committed, cared for by management, and constantly learning and supporting each other (Senge et al, 1994) has implications for improving morale and staff retention and reducing burnout and sickness levels (Hyraas et al, 2006). The standard Department of Health documents establishing national policy continue to advocate the use of good staff support as part of clinical governance, as do all professional bodies, including the NMC. The NMC (2008b) strongly and specifically advocates regular clinical supervision for all registrants; the DH (2006) specified continuous good governance and staff support: “Healthcare organisations [should] ensure that staff concerned with all aspects of the provision of healthcare…participate in further professional and occupational development commensurate with their work throughout their working lives.” Neglecting or abandoning the idea of clinical supervision is, therefore, not an option. However, it is not a job for individual clinicians. If a system of supervision is to be successful, the whole trust must take on the task.

MAKING IT HAPPEN: THE 4S SCHEME

If a trust has made a clear decision to integrate clinical supervision into its clinical governance, it is possible to create a robust scheme in which all those who work with patients access supervision, either one to one or in small groups. This can, and should, be collaborative and encouraging, even enjoyable – something that staff are eager to attend and find helpful in their work.

The 4S scheme (Waskett, 2009a; 2009b) uses four essential ‘S’ elements to establish a robust and useful scheme:

° Structure;
° Skills;
° Support;
° Sustainability.

This is a systemic approach in which all elements interlock and are an essential part of the overall scheme. This article addresses structure; the three other elements are discussed in subsequent articles.

STRUCTURE

Large complex bureaucratic organisations like NHS trusts can be difficult places in which to introduce new initiatives. They are in a state of endless change and introducing yet another can be daunting; everyone always feels under pressure. One danger is that employees may feel isolated and alienated. Good supportive supervision is one way to remedy this.

Often, clinical supervision is “fudged” and slipped in under a heading of management supervision, appraisals, one to one meetings with team leaders, or even team meetings. These are essential elements of working life, but they are not clinical supervision. This distinction is so important that, to make it clear, at least one large organisation with its own excellent supervision scheme calls it “non-management supervision” (Hill, 2005).

In the past, many trusts wrote policies on supervision and some staff may have been

Practice Points

Nurse leaders/managers planning to implement a supervision scheme should follow this advice:

° Don’t rush; think it through together first.
° Start with the basic systemic framework and policy.
° Do it in order: structure, skills, support, sustainability.
° Plan for long term practice, not a short term “project”.

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trained as clinical supervisors. However, anecdotal evidence indicates that such staff may or may not be able to maintain supervision practice; their training can be costly and may seldom be used. Hawkins and Shohet (2003) described exactly this experience as trainers. In these instances, while supervisors may have been trained, their employing organisation has not been helped to do the necessary structural work that enables them to use their new skills effectively. If organisations can start from scratch, it is wise to start by considering the structure and processes necessary to enable a supervision scheme to flourish. Box 1 details useful questions for nurse managers.

**STARTING FROM SCRATCH**

Among those identified to lead and guide the establishment of the supervision scheme should be someone senior and high profile, whose backing will be visible and influential across the organisation. Senge et al (1994) recommended starting at the top when making this kind of systemic change. Without this, the scheme is likely to fail. A small group of managers with the authority to make things happen can then take on the role of planning and preparing for the scheme, writing or reviewing policy and other necessary paperwork, and agreeing processes. It is important to do this before supervisors begin training, as the training can then be tailored to take account of the local policy and protocols developed. The following decisions affect how the training is tailored to the organisation (Table 1) (part 2 of this series outlines the later stages involving training, starting the scheme and evaluation). The sections below outline some of the choices, decisions and actions the lead group makes at this stage.

**Small group or individual supervision?**

One to one work is flexible and closely tailored to individuals. The confidentiality of the relationship allows supervisees to explore personal issues. In groups, much time is saved as up to eight people share a two hour supervision slot. Not everyone has to present every time (which may or may not be an advantage) and people learn from, and support, each other. However, there may be confidentiality issues, and thought should be given to how much group members interact outside the supervision group. The group setting may inhibit certain relevant issues being aired. Finally, practitioners or the trust may have strong personal preferences for one or other type of supervision.

**How many supervisors need to be trained and available?**

We can make some basic assumptions:
- Supervision sessions (group or individual) occur every eight weeks;
- Groups comprise up to eight people;
- When fully trained and up to speed, each supervisor can be given protected time to supervise three groups or five individuals every eight weeks;
- One hour of one to one or two hours of group supervision requires around 1.5 hours or 2.5 hours respectively of supervisor time, including time allowed for preparation, paperwork and travel.

If individual supervision is the model of choice, typically 17% of the eligible workforce needs to be trained. If group supervision is specified, then only about 4% needs to be trained. This is a powerful economic argument for group work.

**Should supervision be mandatory or optional?**

If so, for whom would it be mandatory? All staff? All clinicians? It is only possible to make non-managerial supervision mandatory if there are enough trained supervisors to offer the service to all staff. A great deal of awareness raising would need to be carried out, and a decision made as to who would police and enforce the ruling.

One variation, recently put into operation by Salford Community Health, the provider arm of Salford NHS, involves making joint training courses for potential supervisors and supervisees compulsory for all clinical staff. As participants finished their courses they were expected to start carrying out regular supervision, so there was a growing body of staff using supervision while new trainees were joining courses behind them. Monitoring is high priority in this method.

Salford’s scheme is non-hierarchical and multidisciplinary – an excellent model. The key to doing this type of supervision well is having the collaborative language skills to help supervisees (or groups) develop and expand the quality of their work, as well as having a firm grasp of the ethical and boundary issues involved. In this approach, supervision is not about offering solutions or giving advice, but about eliciting the strengths, decision making and expertise of supervisees.
Marketing an optional scheme

If possible, marketing expertise should be used to target the scheme at potential supervisees. One or more of the lead group could be invited to team meetings to explain the new type of supervision. There must be an appreciation of any current supervision, as long as supervisors and supervisees think it works and is useful. Newsletters and bulletins can carry short and encouraging messages and the senior, influential person’s name should be used. Middle managers must be engaged, so they can make it possible for their staff to attend sessions.

How many supervisees?

The number of individual supervisees and/or groups each supervisor is expected to have should be specified in the policy so that supervisors do not feel obliged to take on more than they can manage. Supervisors should always be in control of their workload (with their managers’ permission) and should be able to refuse requests if necessary. Although policy may specify up to five individual supervisees or three groups (or a mix) in any one eight week period, newly trained supervisors may not feel confident taking more than one individual or group at the start; this can be increased as they gain experience.

Frequency of supervision sessions

This depends on resources. It is wise to book dates well in advance. Managers should know when team members will be at supervision and for how long, so they can plan service provision. Supervision sessions should only ever be interrupted if there is an emergency.

Protected time for supervisors

Supervisees need one hour per session if they are working one to one with their supervisor, certainly for at least the first year. With time and practice, this may be cut without compromising the effectiveness of supervision. Sharry (2007) and Norman (2003) suggested how groups of up to eight can be effective in a two hour slot by using certain techniques and structures.

Protected time for supervisors

For a supervisor to supervise one group and one individual, the trust’s annual time outlay is 38.5 hours (Table 2). However, this does not take account of sickness/annual leave and other delays, and assumes a 52 week year. Also, as supervisors gain experience they will be able to take on more individuals/groups without needing extra supervision and support themselves. They may also be able to cut one to one timing as they and their supervisees gain experience. Groups can be taught how to self supervise using specific techniques, perhaps with “arms length” support from a supervisor.

Nevertheless, supervision is not a task to be minimised, skipped or fit round other duties. It is a skilled and demanding role that should be taken seriously and written into job descriptions. Depending on the value allocated to supporting staff, some trusts may choose to write job descriptions in which substantial hours are allocated to supervision duties.

Monitoring and evaluating the scheme

Supportive supervision is a costly investment in staff, so must be monitored and evaluated.

The lead group will need to consider this as part of the scheme’s framework. As this is a confidential activity, no material discussed can be made public; however, questions of who takes part in supervision, and when, are legitimate. A sign in sheet for each session can be collected so that, at the end of a certain period of time, it is clear how many staff use supervision and how often.

Evaluation is also necessary; the main issue at this point for the lead group is to decide whether they wish to record some baseline data for comparison later (also discussed in part 3).

Write policy, contract, monitoring sheets and any other documentation

Having made the previous decisions, writing the documentation is fairly simple. Ratifying the policy could be delayed until the scheme is up and running, which would enable any practical amendments to be made later.

CONCLUSION

Given this thorough grounding and preparation, the supervision scheme will have a good start. Within a year or so it will no longer be a “scheme” but a widely used, natural and invaluable part of professional practice.

Part 2, to be published in next week’s issue, discusses in house training for supervisors.

TABLE 2. TIME COST OF SUPERVISION – SUGGESTED TIMINGS

<table>
<thead>
<tr>
<th>Process</th>
<th>Frequency</th>
<th>Time allowed per session for supervisor</th>
<th>Total protected time required for supervisor per year</th>
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<tbody>
<tr>
<td>Supervision of one individual</td>
<td>1 x 1 hour session every 8 weeks</td>
<td>1.5 hours (including 0.5 hours for preparation, paperwork and travel)</td>
<td>9.75 hours per supervisor</td>
</tr>
<tr>
<td>Supervision of one group</td>
<td>1 x 2 hour meeting every 8 weeks</td>
<td>2.5 hours (including 0.5 hours for preparation, paperwork and travel)</td>
<td>16.25 hours per group</td>
</tr>
<tr>
<td>Supervisor’s supervision (essential)</td>
<td>1 session every 8 weeks in either a 1:1 or group of supervisors</td>
<td>1 hour (remains the same however many supervisees/groups)</td>
<td>6.5 hours</td>
</tr>
<tr>
<td>Supervisor skills maintenance/continuing professional development by ongoing training/support (essential)</td>
<td>3 hours twice a year</td>
<td>3 hours twice a year (remains the same however many supervisees/groups)</td>
<td>6 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total: 38.5 hours per year</td>
</tr>
</tbody>
</table>

REFERENCES

Nursing and Midwifery Council (2008b) Clinical Supervision for Registered Nurses. London: NMC. tinyurl.com/nmc-supervision
Waskett C (2009b) Clinical Supervision Resources. tinyurl.com/clinical-super