Nottinghamshire Hospice
adding life to days

POLICY/PROCEDURE INFORMATION (Policy no CS011)	
Subject	**Clinical Supervision Policy and Procedure** (This policy is subject to periodic review and will be amended according to service development needs).
Applicable to	This policy applies to all health professionals and clinical staff who work for or provide care on behalf of Nottinghamshire Hospice.
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Lead responsible for Policy **Policy written by**	Director of Care Services Director of Care Services
Policy reviewed by	Kate Martin, Jo Polkey and Ann Rowe (Trustee) – March 2021
Notified to (when)	Quality and Safety Board – April 2021
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CQC Standard if applicable	Supporting information and guidance: Supporting effective clinical supervision 20130625 800734 v1 00
Links to other Hospice Policies	Learning, Training and Development Policy HR0006 Clinical Governance Policy CS005
Links to external policies	http://www.cqc.org.uk/ http://www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf http://www.cot.co.uk/sites/default/files/publications/public/Code-of-Ethics2010.pdf http://www.cot.co.uk/organisation-and-management-ot-services/briefing-55-managementbriefing-supervision http://www.hpc-uk.org/assets/documents/10001314CPD_and_your_registration.pdf
Summary	This policy aims to provide a clear understanding of clinical supervisory processes at Nottinghamshire Hospice that focus on the personal and professional development of care staff. It also provides a framework for the reporting of supervisory activity undertaken at the Hospice which can form part of the

	quality assurance and reporting for governance purposes.
This policy replaces	

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1. INTRODUCTION

The concept of clinical supervision was identified in 'A Vision for the Future' (Department of Health 1993). The value and benefits of clinical supervision have repeatedly been highlighted in successive national guidance, for example, The NHS Plan 2000.

More recently (July 2013) the Care Quality Commission has published a Supporting Information & Guidance document entitled: Supporting effective clinical supervision. This follows the Francis and Winterbourne View reports and 'sets out what effective clinical supervision should look like and has application to registered providers, registered managers and staff across ALL care sectors and settings'.

Nottinghamshire Hospice recognises that our staff work in emotionally charged environments, caring for people approaching end of life and supporting their families. The complexities in the nature of the different levels of interaction with people at such a distressing time requires skill and judgement. An appropriate provision of support to reflect the challenges faced by staff is imperative if they are to continue to offer care of the highest quality and protect patients when they are at their most vulnerable. There are several types of supervision – three most commonly referred to are: clinical, management and professional. The terms used sometimes overlap.

- **Clinical supervision** provides an opportunity for staff to reflect on and review their practice, discuss individual cases in depth, change or modify their practice and identify training and continuing development needs.

- **Managerial supervision** is carried out by a supervisor with authority and accountability for the supervisee.

- **Professional supervision** is often interchangeable with clinical supervision. This is often carried out by another member of the same profession or group. Where it is a statutory requirement for some health professionals to undergo supervision e.g., midwives, counsellors, it should not be confused with clinical supervision.

There are many definitions and models relating to clinical supervision. The following definition from the **Nursing and Midwifery Council** (2006) reflects healthcare settings.

"A formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations" (NMC 2006. p6)

The **Care Quality Commission** states that "The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional response to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice."

The **Royal College of Nursing** states "[Clinical supervision is] the term used to describe a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex clinical situations. It is central to the process of learning and to the expansion of the scope of practice and should be seen as a means of encouraging self-assessment and analytic and reflective skills."

Coaching and mentoring are also recognised as effective and supportive ways to develop both personally and professionally. Coaching and mentoring can be defined as "learning relationships which help people to take charge of their own development, to release their potential and to achieve results which they value" (Connor & Pokora, 2007).

For the purpose of this document the term supervisor refers to the professionals facilitating clinical supervision and supervisee refers to those attending clinical supervision.

2. RELATED POLICIES AND GUIDANCE

- CQC (2013) "Supporting information and guidance: Supporting effective clinical supervision"
- Chartered Society of Physiotherapy. (2005)" A Guide to Implementing Clinical Supervision"
- Connor M, Pokora J (2007) "Coaching and Mentoring at Work" Maidenhead. Open University Press
- Nursing and Midwifery Council- NMC, (2018) "Standards for competence for registered nurses"
- Nursing and Midwifery Council – NMC (2018) "The Code"
- Nursing and Midwifery Council – NMC (2018) "The New NMC Code – Professional Staff, Quality Services"
- https://www.england.nhs.uk/wp-content/uploads/2017/04/a-equip-midwifery-supervision-model.pdf

3. AIM OF THE POLICY

This policy aims to provide a clear understanding of supervisory processes at Nottinghamshire Hospice that focus on the personal and professional development of all clinical staff. It also provides a framework for the reporting of supervisory activity undertaken at the Hospice which can form part of the quality assurance and reporting for governance purposes.

The **Care Quality Commission** advises: "Clinical supervision should be valued within the context of the culture of the organisation, which is crucial in setting the tone, values and behaviours expected of individuals. It should sit alongside good practices in recruitment, induction and training to ensure that staff have the right skills, attitudes and support to provide high quality services."

"Importantly, clinical supervision has been linked to good clinical governance, by helping to support quality improvement, managing risks, and by increasing accountability."

4. SCOPE OF THE POLICY

The policy is aimed at all health professionals and clinical support staff including volunteers at Nottinghamshire Hospice.

This policy has been developed to provide a framework around which the practice of Clinical Supervision can be enhanced within Nottinghamshire Hospice. The aim of the framework is that it will support a variety of models of clinical supervision that can be developed in accordance with local circumstances and staff development needs.

Clinical supervision does not seek to replace managerial supervision. The role of the line manager in providing supervision for their staff is an important part of ensuring effective performance is maintained. Clinical supervision is an additional means of support and development to that line of management. All clinical staff working for Nottinghamshire Hospice will have managerial supervision by their line manager. (Policy no HR0006 Learning, Training & Development. Policy and Procedures)

5. POLICY PRINCIPLE

All healthcare professionals and clinical staff who have direct patient contact will have access to clinical supervision. This includes both professionally registered and non-registered staff.

Nottinghamshire Hospice will provide all staff with enough time to carry out/attend clinical supervision sessions and as such will be paid additional hours should they not be able to undertake sessions within their usual working hours due to hospice work commitments.

It is the joint responsibility of individuals and their line managers to ensure that they receive access to clinical supervision at the required frequency.

6. ROLES AND RESPONSBILITIES

6.1 Registered Manager

The Registered Manager is responsible for having suitable arrangements in place to ensure that people employed for the purposes of carrying out the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people who use services safely and to an appropriate standard. An effective system of clinical supervision is one way of ensuring this and as such the Registered Manager will be monitoring the quality of the supervision offered through audit, evaluation and peer support

The **Nursing and Midwifery Council** identified the possible benefits of receiving effective clinical supervision as: "Improved capacity to identify solutions to problems, increased understanding of professional issues, improved standards of patientcare, opportunities to further develop skills and knowledge and enhanced understanding of own practice."

6.2 Line Managers

Line managers are responsible for recognising the benefits that clinical supervision provides and ensuring their staff are aware of clinical supervision opportunities. In some instances, staff may receive clinical supervision via another employer, if verified and this should be clearly documented within the management supervision. Clinical supervision at the Hospice should still be encouraged and it's important that all staff attend at least one Clinical Supervision session at the Hospice annually to ensure the challenging nature of hospice work is fully recognised and acknowledged.

- Provide time for clinical supervision and monitor attendance.
- Provide ongoing managerial supervision for all their staff.

6.3 All Care Staff

In a busy working life it can be very difficult to find the time and energy required to engage in clinical supervision. In a culture where we put the needs of others before our own it takes courage to acknowledge our own needs. *Participating in clinical supervision is a measure of the value we place on ourselves as individuals.*

The **Care Quality Commission** guidance suggests

"It can help staff to manage the personal and professional demands created by the nature of their work. This is particularly important for those who work with people who have complex and challenging needs – clinical supervision provides an environment in which they can explore their own personal and emotional reactions to their work. It can allow the member of staff to reflect on and challenge their own practice in a safe and confidential environment. They can also receive feedback on their skills that is separate from managerial considerations."

It has been argued that effective clinical supervision and the possibility for learning, development and support it provides can be protective against work related stresses.

It is therefore mandatory for all staff to:

- Actively engage in clinical supervision activities in accordance with the requirements from their professional body and the Hospice.
- Ensure that they participate in clinical supervision to meet their personal and professional development needs.
- Be proactive in agreeing the direction of their supervision and identification of area of practice that needs to be explored in a supervisory session.
- Maintain a record of learning from supervision/coaching in their personal/professional portfolio.

6.4 Supervisors

Clinical Supervisors will have undertaken relevant training and be allocated sufficient time to competently provide clinical supervision for their quota of staff.

Clinical Supervisors will provide all staff with a biography, detailing their clinical and supervisory experience so that staff are able to choose which supervisor they conduct their sessions with.

"Having a supervisor who was not the individual's line manager was also key to achieve a successful supervisor/supervisee relationship" (Cutcliffe and Hyrkas, 2006).

It is therefore imperative that the Supervisors are not the line manager of the person they are providing clinical supervision to. They must also:

- Provide an environment in which supervisee feels safe and is encouraged to explore potentially difficult situations, behaviours and attitudes.
- Ensure that they focus on the developmental needs of the supervisee and maintain a non-judgmental approach.
- Utilise appropriate skills to ensure that supervision sessions are effective and purposeful.

- Agree with supervisee at the outset regarding any communication that will take place with the supervisee’s line manager.

- Maintain supervision records and complete a record of supervisory activity and return this to the line manager.

7. STANDARDS AND PRACTICE

Good clinical supervision relies on trust and therefore (within some limits, see below) a supervisee has a right to expect the content of the session to remain confidential. At the start of every session a contract/ground rules and the content will be agreed between the supervisor and supervisee.

If concerns are identified in the course of clinical supervision about a staff member’s conduct, competence or physical or mental health, the supervisor may need to disclose information from a supervision session to an appropriate person, such as the staff member’s line manager. This should be clearly set out in any supervision contract.

“Clinical supervision has been identified as able to increase nurses’ sensitivity towards themselves and the families they care for” (Jones, 2006)

“Where nurses attend clinical supervision they have an increased level of satisfaction with their psychosocial work environment through increased job satisfaction and wellbeing” (Begat and Serverisson, 2006)

Clinical Supervision therefore should involve a supervisor and a group of supervisees reflecting on and critically evaluating clinical practice with a view to supporting best practice and improving performance. It should be planned and systematic and conducted within agreed boundaries with the purpose of developing skills and narrowing the gap between theory and practice.

8. FORMAT, FREQUENCY AND MODEL OF CLINICAL SUPERVISON

8.1 Format of Clinical Supervision

This policy recognises the following scenarios as acceptable for use in the hospice. Clinical supervision can be undertaken as an individual practitioner or with a group of practitioners.

- **One to one -** with a supervisor from the same or different clinical setting or profession

- **Group supervision -** where a group of staff receive supervision together from the same supervisor

- **Informal supervision -** Whilst this policy focuses on the provision of clinical supervision in a formal setting, it is acknowledged that some staff participate in informal discussion of experiences with colleagues outside of the work setting. This can provide a valuable learning experience; however, the Hospice encourages staff to engage in formal supervision processes to ensure that the activity remains a meaningful and constructive process for the supervisee and to demonstrate how this activity has contributed towards personal and professional

development with maximum benefit for patient care. Episodes of informal supervision will not be recorded as clinical supervision at the hospice.

Group and/or individual clinical supervision will be supported depending on local requirements. Clinical supervision should be face-to-face, however where this is not possible (in the light of Covid-19 pandemic) flexible methods of supervision will also be made available e.g., telephone calls, Zoom etc.

Where individual sessions are required, they may last up to 50 minutes. Group sessions will accommodate a maximum of 5 people and last up to 90 minutes.

8.2 Frequency of Clinical Supervision

There are currently no statutory requirements or national guidance about clinical supervision provision in health care settings. Whilst clinical supervision is regarded as an essential component of safe and effective professional practice by a range of professional bodies, in health care it is recommended that provision is developed and governed at local level.

The Care Quality Commission states: "Clinical supervision should take place regularly. The frequency and duration should be adequate to ensure safe and competent care for people who use services. The most appropriate supervision arrangements for a member of staff are determined by a number of factors including their experience, the type of work they carry out and their individual needs."

As a rule, staff who hold a professional qualification i.e. Registered Nurses require more frequent clinical supervision in order to help maintain their registration and deal with the more complex workload.

To ensure that all staff receive the appropriate amount of Clinical Supervision to their role, Nottinghamshire Hospice has drawn up the following guide.

4 - 8 shifts per month = part time

8 -16 shifts per month = full time

8.2.1 Registered nurse's clinical supervision requirements

- working only for NH full time – every 8 weeks = 6 sessions/year
- working only for NH part-time – every 12 weeks = 4 sessions/year
- employed elsewhere and receiving (verified) clinical supervision = 2 sessions/year at the hospice

8.2.2 S/HCA's clinical supervision requirements through NH

- working only for NH full time – every 12 weeks = 4 sessions/year
- working for NH part-time – every 16 weeks = 3 sessions/year
- employed elsewhere and receiving (verified) clinical supervision = 2 sessions/year at the hospice

8.3 Model of Supervision

There are several different models that can be utilised in Clinical Supervision and facilitators are encouraged to develop their own style, using models and frameworks to support the process of reflection within the sessions they facilitate. Proctor's framework (Proctor 2011) is well recognised and will be adopted for group Clinical Supervision sessions. This encompasses three main areas of focus as follows -

- **Normative** – reviewing, maintaining and developing standards of care in relation to safety, ethics and quality practice.
- **Formative** – developing professional knowledge and skills and embrace the concept of reflection to apply theory to practice.
- **Restorative** – the supportive element focusing on self-awareness and self-development.

9. TRAINING

Due to the nature of the work we undertake the hospice has chosen to invest in training supervisors in the 'Restorative Resilience Model of Supervision' as it has an emphasis beyond the content of the work being done by the health professional and aims to build their resilience and autonomy. The model has been shown to reduce burnout in health visitors by 43% and stress by 62%, with an increase in 'compassion satisfaction' (Wallbank and Woods 2012). It has now been largely adopted by NHS England.

All Clinical Supervision supervisors will have received specialist training and have a good understanding of Clinical Supervision so they can fulfil their role in a competent way and be alert and observant in recognising signs of the following -

- **Compassion satisfaction** – the pleasure that one derives from being an effective caregiver.
- **Burnout** – feelings of hopelessness, difficulties in dealing with work or carrying out the work effectively.
- **Compassion fatigue** – psychopathological symptoms associated with secondary exposure to stressful events.

Specialising in providing care for those experiencing death, grief, and bereavement has been recognised as a trigger for compassion fatigue.

10. CONFIDENTIALITY

The supervision process is confidential between the supervisor and supervisee. Any discussion of the content of a supervision session should not be discussed outside of the session without the agreement of all parties.

However, should a situation arise where maintaining confidentiality would put patients or others at risk of harm, the supervisor is required to take appropriate action e.g. illegal activity, bad practice, and unprofessional conduct.

11. DOCUMENTATION AND REPORTING

In order to audit and evaluate the process of clinical supervision it is necessary to record some basic information relating to the process in terms of frequency and duration of meetings and basic themes discussed.

Before starting supervision with an individual or group the supervisor must explain what records will be maintained and used in reports to demonstrate the level of supervision attended. These reports do not include the individual names of supervisee. Nor will they contain any of the content of the supervision discussion. This will include a contract for group sessions (see Appendix 1)

Supervisors are required to keep written records of all supervisory activity. As a minimum, the supervisor must record the following details for every formal session; the date, time, place, names of attendees, topics discussed and any learning / actions that

resulted from the clinical supervision activity. They will also forward a copy of this record to their manager (see Appendix 1).

Supervisees are encouraged to keep records as they form a useful reference for future sessions, a reminder of action agreed, help in individual revalidation processes and support the evaluation of the process for the Hospice's ongoing quality improvement activity (see Appendix 2).

Managers will ensure that a record of attendance at supervision is maintained, for reporting to the Care Quality Commission and Commissioners when requested. This record will also be useful to support individual clinical staff with evidencing their continuing professional development for revalidation.

Supervisees are also reminded that any reference to patients should be anonymous.

12. IMPLEMENTATION AND EVALUATION

- The policy will be ratified in accordance with the hospice procedure through the appropriate governance group and reviewed annually.
- The policy will be available for all staff on the N:drive or on the Hospice website.
- Managers need to ensure relevant new policies and procedures are highlighted to their teams through relevant channels.

Evaluating clinical supervision is an inclusive process that seeks feedback from staff about practical aspects such as timing of sessions and about experiential aspects such as how helpful they have found sessions. This will be carried out informally at the end of every session but also in a more formal approach utilising the Professional Quality of Life Scale (ProQOL) twice a year. See Appendix 3.

Evaluating the themes discussed helps to identify potential areas for development and support within the teams. This allows managers to respond to the stresses and difficulties staff are experiencing in their work. Supervisors will meet every 3 months to share relevant data and plan training and development.

The whole Clinical Supervision process will be reviewed regularly by the Supervisors, the Palliative Care Lead and the Director of Care as it may need to be adjusted over time to accommodate more or less participants, to fit around emerging regular commitments or for other reasons unique to our organisation and teams.

13. FURTHER READING

1 Proctor, B (2011) Group Supervision a Guide to Creative Practice (2nd Edition). London: Sage

2 Wallbank, S and Woods, G (2012) A healthier visiting workforce: findings from Restorative Supervision programme. Community Practitioner, vol 85, no 11, p20-23

3 Care Quality Commission (2013) Supporting Information and Guidance: Supporting Effective Clinical Supervision. London: Care Quality Commission

4 Hospice UK (2015) Resilience – A framework for supporting hospice staff to flourish in stressful times

5 Helen and Douglas House (2015) A Clinical Supervision Toolkit

Appendix 1

Supervision Attendance Record and Contract

SUPERVISION ATTENDANCE RECORD

Date of session	
Name of supervisor	
Address of venue	
Name of those attending	
Print name	Sign

CLINICAL SUPERVISION CONTRACT

- Supervision will take place every eight to twelve weeks.
- Supervision sessions will last between 50 – 90 minutes depending on the number of supervisees.
- Mutual confidentiality within the boundaries of professional practice. Agree how concerns can be shared and escalated with line manager.
- Attend the sessions, if need to cancel ensure plenty of notice where possible
- Punctuality – be on time, start on time, finish on time (supervisor to monitor)
- Mutually agreeable comfortable, quiet place without disturbance or distraction
- Discussion with supervisee about what they hope to achieve from supervision
- Review of supervision after session four
- Supervisor to have a plan to support session ie. questions to support initial sessions and relationship building
- Mobile phones on silent

Please provide a list or summary the topics discussed e.g., pain management, difficult patient   Please note, this information will be used for quality monitoring and details of discussion should not be shared.
Please list any learning / actions taken   Please note this information will be used for quality assurance

Appendix 2

EXAMPLE OF REFLECTIVE ACCOUNT

<table>
<tr><td colspan="2">Reflective Account</td></tr>
<tr><td colspan="2">This form or the NMC reflective accounts record log are designed to help you think about and reflect on any learning that you have identified during your clinical supervision. This reflection can be used as evidence for your own development or as part of your Revalidation if you are a nurse.</td></tr>
<tr><td>Supervisor’s name</td><td></td></tr>
<tr><td>Supervisor’s job role & workplace</td><td></td></tr>
<tr><td>Date of clinical supervision</td><td></td></tr>
<tr><td colspan="2">What is the nature of the learning you have identified?</td></tr>
<tr><td colspan="2">What did you learn your clinical supervision session?</td></tr>
<tr><td colspan="2">How did you change or improve your work as a result?</td></tr>
<tr><td colspan="2">How is this relevant to your code? Select a theme: prioritise people - practice effectively - preserve safety - promote professionalism and trust.</td></tr>
<tr><td colspan="2">Sign</td></tr>
<tr><td colspan="2">Date</td></tr>
</table>

Appendix 3

ProQOL Version 5

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

When you care for people you have direct contact with their lives. As you may have found, your compassion for those you care for can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a carer. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things (in the last 30 days).

1 = Never 2 = Rarely 3 = Sometimes 4 = Often 5 = Very Often

1. I am happy.
2. I am preoccupied with more than one person I care for.
3. I get satisfaction from being able to care for people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I care for.
7. I find it difficult to separate my personal life from my life as a carer.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I care for.
9. I think that I might have been affected by the traumatic stress of those I care for.
10. I feel trapped by my job as a carer.
11. Because of my helping, I have felt "on edge" about various things.
12. I like my work as a carer.
13. I feel depressed because of the traumatic experiences of the people I care for.
14. I feel as though I am experiencing the trauma of someone I have cared for.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with training and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a carer.
20. I have happy thoughts and feelings about those I care for and how I could help them.
21. I feel overwhelmed because my workload seems endless.

22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I care for.

24. I am proud of what I can do to help.

25. As a result of my helping, I have intrusive, frightening thoughts.

26. I feel "bogged down" by the system.

27. I have thoughts that I am a "success" as a carer.

28. I can't recall important parts of my work with trauma victims.

29. I am a very caring person.

30. I am happy that I chose to do this work.