Auditing a clinical supervision training programme

Nurses and service managers in a community trust were asked to evaluate a training course designed to help them implement the trust's clinical supervision policy. The audit identified several patterns of clinical supervision emerging within the trust. The author discusses the benefits of these to patients, staff and the organisation and draws some recommendations for nurses involved in implementing clinical supervision.

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KEY WORDS

- PROFESSIONAL DEVELOPMENT

These key words are based upon work undertaken by the RCN Library.

CLINICAL SUPERVISION serves a number of purposes. It should:

- Establish formal systems for practitioners to explore, discover and examine their practice in a safe and supportive environment
- Allow individuals to develop their thoughts and actions in a way that leads to enhanced care delivery to the patient or client group
- Enable practitioners to accept accountability for their own practice and development
- Contain the stresses of working in a demanding environment within the workplace.

When clinical supervision is effective, practitioners feel supported, valued and able to continue their work. The effective use of clinical supervision for all practitioners should contribute to the development of practice throughout the organisation.

Supervision, particularly when used in isolation, is often linked to negative perceptions of performance monitoring and discipline of staff by the manager (Butterworth 1992). However, clinical supervision is a vehicle that enables practitioners to develop skills and attitudes that enhance their care delivery, thus meeting their work and professional objectives. Systems of management appraisal and clinical supervision should run parallel to one another.

Appraisal is a management tool, and the manager has a key role in the
relationship. The clinical supervisor may or may not be the manager. The practitioner should take an active part in selecting the most appropriate clinical supervisor. This may be a peer, a manager or another professional colleague.

**BACKGROUND**

Northampton Community Healthcare Trust (NCHT) provides extensive community based healthcare services to the local population in a range of areas:

- Adult mental health (AMH)
- Elderly mentally ill services (EMI)
- Learning disability (LD)
- Health visiting (HV)
- Community nursing (CN)
- Palliative care (PC)
- Physical disability (PD)
- Community hospital services (CHS).

The trust employs a comprehensive nursing workforce of registered mental health, learning disability and general nurses; about 800 in total. The trust rose to the challenge of the target set out in the Department of Health's document, A Vision for the Future (1993) to support nurses in the development of their practice through the process of clinical supervision, according to a clear schedule:

**Autumn 1994** A task force of senior nurses and managers was set up to determine how the need would be met within the organisation. The task force decided to purchase a training package from a private company. This package included five three-day courses (two initial days with a follow-up day three months later) and training for three trust employees to continue the delivery of this course.

**March 1995** The training programme began.

**July 1995** The trust's nursing policy group ratified the clinical supervision nursing policy.

**September 1995** Following some practical difficulties the policy was distributed to all the care areas by early September.

**December 1995** An audit was carried out to establish how many nurses who had completed the three-day course had managed to adhere to the trust's clinical supervision policy. The audit explored nurses' perceptions of whether clinical supervision had improved the quality of care provided to patients and clients.

For the purpose of the audit the trust's clinical supervision policy was used as a measure of best practice.

**January 1996** By January 31, 1996 (25 per cent) nurses from across all service areas of the trust had attended at least the two-day part of the course, and 137 (17 per cent) had completed all three days.

**NURSE QUESTIONNAIRE**

In total 113 questionnaires were posted to nurses who had completed the three-day clinical supervision course by December 13 1995. Of these, 57 (50 per cent) were returned by January 31 1996.
Table 1 shows the distribution of questionnaires to each service area and the responses received.

Receiving clinical supervision Of the 57 responses received, 37 (65 per cent) indicated that they were receiving clinical supervision and 20 (35 per cent) said they were not. Figure 1 shows the clinical supervision status of practitioners according to their service area.

A definite pattern emerged. Six of the service areas appeared to have more practitioners receiving clinical supervision than not. However, the district nursing and health visiting services had more practitioners not receiving clinical supervision than receiving it. This reflects the feedback the facilitators received from course attendees during a number of follow-up training days throughout 1995.

Type of supervisor The trust's clinical supervision policy created a framework and flexibility for individual practitioners to adopt the type of clinical supervision which would meet their particular needs. Figure 2 shows the types of clinical supervision which practitioners selected.

The training facilitators were encouraged by these results, because one of the early concerns of course attendees was that managers would assume the role of clinical supervisor.

Forum for supervision The policy created an opportunity for practitioners to receive their clinical supervision in three different ways:

- Individual (one-to-one)
- Groups/teams
- Triads – one-to-one plus an independent facilitator.

Figure 3 shows the forums selected.

The facilitators were not surprised that most practitioners opted for individual or one-to-one clinical supervision. This method was referred to most in the training. It reflects the attendees' observations that it may be the easiest type of clinical supervision to set up because co-ordinating a meeting for two people is easier than for a larger number.

Supervisor's background The policy also allowed practitioners to receive their clinical supervision from supervisors who were from:

- Same profession, same service
- Same profession, different service
- Different profession, same service
- Different profession, different service.

Figure 4 shows the areas from which individuals selected their clinical supervisor and highlights that most selected clinical supervision from the same profession and service. This was disappointing, because clinical supervision has the potential to encourage interprofessional and multiprofessional networking which does not appear to have happened here.

Frequency The audit explored the frequency of clinical supervision. The trust policy indicated that it should take place at least once every six weeks. Figure 5 shows the mean number of clinical supervision sessions in relation to the type of clinical supervision. Practitioners who had set up managerial or non-managerial supervision were more likely to have had two clinical supervision sessions, which is in line with the policy. Those who were having peer supervision were likely to have had only one session in the previous three
months, which is the standard indicated in the policy. Only two out of 37 practitioners said that sessions in the last three months had been cancelled and not rearranged.

**Interruptions** The policy stated that all clinical supervision sessions should be uninterrupted. Figure 6 shows the number of interruptions experienced during sessions by type of supervision. Practitioners who were having managerial clinical supervision reported more interruptions than those who were receiving non-managerial or peer clinical supervision.

**Confidentiality** There was only one definite report of a breach in confidentiality and two others that suggested there may have been a breach. This may be indicative of the importance that practitioners attach to the process of clinical supervision.

**Patient/client benefits** Only 49 per cent of practitioners reported that their client or patient group had benefited from them receiving clinical supervision.

**Practitioners’ needs** Figure 7 shows practitioners’ perceptions, by service, that their needs had or had not been met in clinical supervision.

Only one practitioner stated that their needs were not met in clinical supervision.

**Benefits to practitioners** Practitioners stated that one of the major benefits of receiving clinical supervision was the relief and support that they had experienced. They also reported that supervision had:

- Developed their reflective practice skills
- Maintained standards of care
- Increased self-awareness and confidence
- Improved staff communications
- Improved continuity of care
- Enabled them to prioritise care.

Additional observations included:

- A number of people are setting up groups for clinical supervision
- Dissemination of a clinical supervision policy had enabled implementation
- It is valuable and will be extremely advantageous when practice is trust wide.

**Negative comments** Some negative comments received from course attendees were that:

- Sessions were used for management rather than clinical issues
- Time had not been identified for clinical supervision
- An identified facilitator for health visiting and district nursing would have been useful for implementation
- Imposed managerial clinical supervision is unhelpful
- Lack of time makes it difficult to implement
- A lack of practitioners who have completed the course makes it difficult to implement
- A number of individuals are finding it difficult to find a clinical supervisor
- Some practitioners said it was on hold until more practitioners have completed the course.
SERVICE MANAGERS' QUESTIONNAIRE
The service managers were sent a questionnaire to complete during the same audit period as the practitioners. The aim was to explore their perceptions of:

- The value of the course
- Implementation of clinical supervision in the service
- Their planned systems for monitoring clinical supervision
- The benefits of clinical supervision for patients and clients, employees and the trust.

Questionnaires were posted to the nine service managers and six had been returned by January 31 1996.

Adherence to policy The service managers were asked whether or not they thought the clinical supervision training enabled adherence to the trust’s clinical supervision policy. Four of the managers believed it did, one felt it did not and one was unable to say.

Positive feedback There were a number of positive comments about the quality of the training:

- Favourable feedback from course attendees
- Well structured
- Dynamic
- Motivating
- Good
- Satisfactory
- Quite successful implementation
- Adaptable to specific needs and clinical areas.

Negative feedback The difficulties that the service managers identified for implementing clinical supervision were:

- Not easy to apply to the community
- Lack of time and resources
- Limited numbers of staff had completed the course
- Large geographical work areas
- Lack of an individual in post to coach the implementation of clinical supervision.

Monitoring The service managers identified a number of methods to monitor the practice of clinical supervision, including:

- Retaining copies of the clinical supervision contracts (as per policy)
- Maintaining records of when clinical supervision had taken place
- Audit
- Staff communications, at staff meetings and during appraisal interviews (if in place) and meetings with senior nurses
- Care practice forums.

Benefits to patients/clients Two of the service managers commented that it was too early to say whether clinical supervision had resulted in any benefits. The other four suggested that the patients and clients would experience improved care planning and should receive improved standards of care.

Benefits for staff Perceived benefits for the staff were:
The development of reflective practice skills
Empowerment
Stress reduction
Increased confidence
Provision of a forum to discuss clinical issues and acquire professional support.

Benefits to the organisation Comments made suggested that it was too early to identify the additional benefits to the organisation.

Further comments A service manager suggested staff were so motivated and positive that by the end of 1996 all qualified staff would be receiving clinical supervision. However, the policy stated that practitioners should receive clinical supervision before giving it – service managers felt this might delay implementation.

DISCUSSION
The findings of the audit were rewarding. The policy appeared to have been adhered to and practitioners appeared to have made use of the flexibility that exists within the frameworks. One disappointment was the apparent lack of professional networking, as most practitioners have contracted their clinical supervision both within the same profession and the same service. However, practitioners have reported benefits to their patients, clients and themselves in terms of support and time for reflection.

Practitioners who have selected managerial and non-managerial clinical supervision have had twice as many sessions as those practitioners receiving peer clinical supervision. However, those receiving managerial clinical supervision had experienced more interruptions during their sessions than those receiving other types of clinical supervision.

Unfortunately, the health visiting and district nursing services appeared to experience more difficulties with the implementation of clinical supervision than the other service areas. Possible reasons for this include the lack of time, a large geographical area and the absence of a person to coach the implementation of clinical supervision. Feedback on the training courses inferred that the mental health and learning disability service areas had already begun to practise clinical supervision before the training and so had a head start on the other service areas.

There were favourable comments about the training course which, combined with the results of the audit, suggest that the training enables adherence to the trust policy.

Limitations The method of data collection restricted the information to quantitative data on practitioners' perceptions rather than accurate qualitative data. It failed to assess the clinical supervision position of those practitioners who have not undertaken the training, and the clinical supervision status of other professional staff groups employed by the trust.

Both the questionnaires in the audit asked for some information that was not relevant, and the design of some questions made the responses difficult to interpret and consequently invalid. Nevertheless, it does give some indication of the training and position of the practice of clinical supervision for nurses and health visitors within Northampton Community Healthcare Trust.

RECOMMENDATIONS
The health visiting and district nursing services have had 64 (30 per cent)...
practitioners attend the clinical supervision training. However, the responses received on this audit indicate that there may have been a poor implementation of clinical supervision into the practice areas. The users of those services will not receive the same benefits of clinical supervision as the users of other services in the trust experienced. The practitioners themselves will not have gained the same benefits as their colleagues from other service areas – if these practitioners are not receiving clinical supervision then they are not available to give it, which means that the trust’s resources have been used with limited return for service development.

**Identify lead person** The service areas need to identify a lead person to coach the implementation of clinical supervision into practice.

**Position statement** The service managers should release a position statement to all the practitioners working in the areas to inform them of expected outcomes following the completion of the course.

**Establish communications** To assist with the implementation of clinical supervision, communication systems should be established between the service managers and the facilitators of the training.

**Networking** There should be increased networking with the service areas where clinical supervision appears to have been implemented more successfully. The audit showed that there was limited professional and service networking within the process of clinical supervision. This is an important issue and would support the development of collaborative working.

Current organisational structures suggest that practitioners should remain loyal to their own service area. However, the trust’s senior managers should consider this issue when discussing the organisational structures. It can also be addressed when the clinical supervision policy is reviewed.

**Audit supervision in other professions** An audit should be carried out to establish the clinical supervision practices which occur within the other professions. This would inform the facilitators and the nursing staff of the potential networking and resources that may be available.

**Make time** Practitioners who contract clinical supervision with their manager need to ensure the sessions are uninterrupted as written in the policy. Both parties must understand the aims of the clinical supervision and avoid the blurring of boundaries between this relationship and that of management appraisal.

**Policy first** The training for clinical supervision began before the dissemination of the policy. It is strongly advised that in the future a policy is ratified before the training programme starts. Practitioners suggested that clinical supervision was much easier to implement following confirmation of the policy.

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**CURRENT POSITION**

The organisation was informed of the results of the audit and the feedback was positive. There has been progress, particularly in the community nursing and health visiting services. These groups of practitioners have reported systems of individual and group clinical supervision taking place. Their sessions tend to be with peers or non-managerial practitioners. The response suggests that the full scope of the trust policy is being used.

The training programme has continued with 50 per cent of the nursing workforce having participated. This highlights the importance of clinical supervision and the benefits it can provide when used effectively.
CONCLUSION
It is important to note that this organisation is comparatively young. The three units – mental health, learning disability and primary care (health visiting and district nursing) – that came together in 1995 to form the trust had not fully appreciated one another's roles. The structure of this training programme resulted in practitioners from all service areas of the organisation coming together to learn and develop. The opportunities that this has created are not necessarily quantifiable, but were recognised by facilitators and course attendees alike. Interprofessional training is a practice that will be encouraged whenever possible.

REFERENCES


Table 1. Number of questionnaires sent out and responses received from each service area

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<th>Service area</th>
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<th>Number of responses</th>
<th>Percentage of responses</th>
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<td>Palliative care</td>
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<td>Totals</td>
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Fig 1. Clinical supervision status of practitioner
Auditing a clinical supervision training programme

Fig 2. Types of clinical supervision selected

The total is higher than the number of practitioners receiving clinical supervision because some individuals had received more than one type of clinical supervision.

Fig 3. Forum for clinical supervision

Fig 4. Source of clinical supervisor
Fig 5. Mean number of clinical supervision sessions in the last three months

Fig 6. Number of interruptions by type of clinical supervision

Fig 7. Practitioners’ needs met in clinical supervision