IN 2021, NHS England introduced the professional nurse advocate (PNA) role to deliver the Advocating and Educating for Quality Improvement (A-EQUIP) model of professional nursing leadership and clinical supervision (NHS England 2023a). A-EQUIP was originally developed in 2016 as an employer-led model of midwifery supervision supported by professional midwifery advocates (NHS England 2023b). Following its successful implementation in midwifery, A-EQUIP was extended to all areas of nursing practice to provide a clinical model of restorative supervision that equips PNA-trained nurses to listen to and understand the challenges experienced by colleagues and to lead quality improvement initiatives in response (NHS England 2023b).

Clinical supervision was introduced into UK nursing practice over 30 years ago, in response to recognition of nurses’ need for support and the need for continuous reflection on and development of their practice (Masamha et al 2022). Following the coronavirus disease 2019 (COVID-19) pandemic, the NHS Confederation (2021) identified the need for a reset to enable the NHS workforce to recover from the challenges brought about by the pandemic as well as longstanding workforce issues. Such workforce issues include high vacancy rates and concerns about working conditions, particularly in relation to the delivery of healthcare for older people (British Geriatrics Society 2023, Ocean and Meyer 2023). In its report, the NHS Confederation (2021) emphasised the need for restorative supervision to support staff’s health and well-being.

The restorative approach to clinical supervision within the A-EQUIP model, facilitated by the PNA, has been shown to have a positive effect on staff’s physical and psychological well-being.
emotional well-being, improve job satisfaction and improve patient experience (NHS England 2023b). This article aims to increase awareness of the role of the PNA and the A-EQUIP model and to assist nurses to better understand the relevance and value of restorative clinical supervision in relation to the care of older people.

Care of older people
Nurses in all areas of practice are likely to care for older people given that, in the UK, people aged 65 years and over are the largest group of users of health and social care services, account for over 40% of hospital admissions and occupy around 60% of hospital inpatient beds at any given time (British Geriatrics Society 2023). While not an inevitable part of ageing, frailty affects over half of adults in hospital or care homes, while more than one in ten people aged over 65 years in the community live with frailty (British Geriatrics Society 2023). People with frailty often have other long-term conditions, such as dementia, which can result in frequent hospital admissions and increasing social care support needs (Clegg et al 2013). This requires nurses to deliver care to an older population with diverse and complex needs.

In addition, nurses may have witnessed the effects of the COVID-19 pandemic on older people, such as increased loneliness, physical deconditioning and suboptimal mental and physical health (Brown et al 2021, Public Health England 2021); this, combined with their knowledge of the social and financial challenges experienced by some older people (Centre for Ageing Better 2022), can leave nurses with a sense of powerlessness (Tveiten 2021). Furthermore, nurses are delivering care to older people within the context of an ageing society and may not have chosen this nursing specialty or potentially even recognise it as such (Bowden et al 2021, United Nations 2021, Gendron 2022, Kagan 2022, Jeyasingam et al 2023), therefore they may not be invested in developing their specialist practice or undertake reflective practice in terms of working with this group.

Nurses are also experiencing workplace pressures, leaving them at risk of developing emotional exhaustion, burnout, anxiety and depression (West and Dawson 2012, Featherbe 2023). Emotional exhaustion has been found to have a detrimental effect on patient care (West and Dawson 2012). A study by Nestor et al (2021) that assessed the effects of COVID-19 on healthcare staff working in an older person’s care and palliative environment found that the burden was greatest for those providing prolonged, direct and intimate patient care.

Staff who feel unable to deliver person-centred care that is consistent with their values can be vulnerable to developing moral distress and dissatisfaction (Barney et al 2019). Kwame and Petrucka (2021) discussed how a task-based approach can prevent the delivery of person-centred care by acting as a barrier to effective nurse-patient communication and care quality. Such barriers can be more apparent within older people’s care settings, where effective communication can be challenging due to the effects of ageing (Jack et al 2019).

Restorative clinical supervision has been shown to reduce nurses’ levels of stress, anxiety, depression and burnout (Wallbank 2013, Whatley 2022). Therefore, providing nurses and other healthcare staff who work with older people in all settings with PNA-facilitated restorative clinical supervision could support their well-being, enhance their educational and professional development and promote quality improvement.

Professional nurse advocate role
Any Nursing and Midwifery Council (NMC) registered nurse working at band 5 or above in an NHS patient-facing clinical role who has studied to bachelor’s degree level can apply to train as a PNA. It is recommended that applicants first complete the Professional Clinical Nursing Leadership e-learning programme on the PNA role and A-EQUIP model (NHS England 2023b). PNA training (NHS England 2023c) is provided by accredited educational institutions or employer organisations and must meet the standards set by the Royal College of Nursing (RCN) (2023). NHS England (2023b) encourages trusts to commit to training at least one in 20 nurses to take on the PNA role by 2025. Within one year of the launch of the PNA role, around 5,000 nurses had undertaken the training (Devereux 2022).

Completion of the PNA training provides the nurse with a Master’s level clinical and professional leadership qualification and equips them with the skills and knowledge required to lead quality initiatives, contribute to a positive learning culture within their organisation and provide restorative clinical supervision (NHS England 2023c, RCN 2023). PNAs uphold the NMC (2018) professional standards of practice and behaviour and lead with emotional intelligence to provide a ‘safe space’ for colleagues in which to reflect on their practice and which supports them.

Key points
- Nurses in all areas of practice are likely to care for older people given that, in the UK, people aged 65 years and over are the largest group of users of health and social care services.
- Staff who feel unable to deliver person-centred care that is consistent with their values can be vulnerable to developing moral distress and dissatisfaction.
- The Advocating and Educating for Quality Improvement (A-EQUIP) model, facilitated by the professional nurse advocate (PNA), can have a positive effect on staff’s physical and emotional well-being.
- Restorative clinical supervision has been shown to reduce nurses’ levels of stress, anxiety, depression and burnout.
to feel a sense of belonging, contribution and autonomy (West et al 2020, NHS England 2023b).

Preliminary evaluation has found that those who have undertaken the PNA training have experienced increased feelings of empowerment, while nurses and organisations that have accessed PNA-facilitated restorative clinical supervision have reported positive experiences (RCN 2023). Emerging literature on the PNA role has discussed its potential to support nurses’ well-being in a wide range of healthcare settings, from the community to critical care (Critical Care Networks – National Nurse Leads 2018, Foster 2021, Muscat et al 2021, Carter 2022, Featherbe 2023, Jennison and Walker 2023, Miles 2023).

A-EQUIP model
NHS England (2023b) has provided national guidance on implementation of the A-EQUIP model, alongside a process map, checklists for the PNA role and case studies, and encourages NHS organisations to integrate the model within their standard contract service development and improvement plans; however, each organisation will have its own approach to implementation based on local needs. There is also a PNA and A-EQUIP community of practice on the FutureNHS (2023) virtual collaboration platform, which supports health and social care professionals to improve practice across organisations.

The A-EQUIP model aims to support a continuous quality improvement process by developing nurses’ personal and professional clinical leadership, enhancing the quality of patient care and preparing nurses for appraisal and professional revalidation. It is designed to benefit nurses and patients through (NHS England 2023b):

- Advocating for the patient, the nurse and healthcare staff.
- Providing clinical supervision using a restorative approach.
- Enabling nurses to undertake personal action for quality improvement.
- Promoting nurses’ education and development.

A-EQUIP is based on the three functions of Proctor’s (1987) model of clinical supervision – normative, formative and restorative – with the additional function of taking ‘personal action for quality improvement’ (NHS England 2023b) (Table 1).

Functions of the A-EQUIP model
The normative function promotes professional accountability and quality improvement by supporting nurses to become more effective in their practice, for example by undertaking quality initiatives to improve patient safety, while the formative function focuses on building knowledge and skills for professional development and self-reflection (NHS England 2023b). Both functions can support nurses working with older people to manage challenges such as recognising and caring for people with frailty and/or behavioural and psychological symptoms of dementia, and to enhance their practice in areas such as communication.

The restorative function, which focuses on the emotional needs of staff, promotes personal and professional reflection, and aims to provide strategies to mitigate workplace stress and help staff to feel supported and less isolated, increase their confidence and experience less stress, burnout and sickness absence (NHS England 2023b). The PNA training programme provides the PNA with knowledge of and skills in using various reflective approaches (RCN 2023) to enable them to provide individual and group restorative clinical supervision through coaching rather than ‘teaching’. PNA-facilitated restorative clinical supervision can provide nurses with the opportunity to take part in a confidential, solution-focused, one-to-one or group discussion to reflect on a specific issue or post-event debrief (NHS England 2017).

The ‘personal action for quality improvement’ function reinforces that contributing to continual quality improvement in care is part of everyone’s practice (RCN 2023).

Example of restorative clinical supervision in practice
The author of this article works as a specialty clinical educator at a large foundation trust in the north east of England. As part of her role she is involved in delivery of a trust-wide workforce development programme – Enhanced Care for Older People (EnCOP) (Frailty iCARE 2023) – developed by Northumbria University with support from the Ageing Well Network in response to local workforce needs post-COVID-19 and pre-existing workforce pressures (NHS England 2020, West et al 2020, NHS Confederation 2021). The EnCOP workforce development programme provides an evidence-based competency development framework for staff working with older people in essential, specialist and advanced roles (Frailty iCARE 2023).
During the trust’s pilot of the EnCOP programme, in 2020-22, it was identified that staff working in inpatient settings were unable to access protected time for professional development. To try to address this, the author designed additional workshops to support these staff to take time out of their clinical settings to engage in training and professional development in the care of older people. At that point the author was not a PNA, however the EnCOP workshops mirrored the A-EQUIP model of clinical supervision, with a particular focus on the restorative and personal action for quality improvement functions. The author trained as a PNA shortly after development of the workshops.

**Enhanced Care for Older People workshops**

The EnCOP workshops are delivered monthly by specialty clinical educators, including the author, from different sites around the geographically large trust to groups of between six and 20 nursing and allied health professional staff who work with older people. It is important to create a ‘safe space’ for those engaging in restorative clinical supervision (Kisfalvi and Oliver 2015), which addresses their ‘basic’ physiological and safety needs and ‘psychological’ needs for esteem and belongingness (Maslow 1987).

When this space is made available, staff feel able to define what is important to them and express challenging thoughts or feelings which, combined with development opportunities, supports a shared sense of purpose, sense of belonging and an inclusive culture (West et al 2020). To create this safe space, all participants are sent a welcome email with workshop times and a brief description of the content when they register. This is followed with a more detailed description of the workshop, a photograph of previous workshops and a link to the materials that will be used, such as PowerPoint presentations. In addition, at the start of each workshop a positive psychology activity is used to help participants feel welcome and to appreciate themselves and others. An example of such an activity is the At My Best Good Question Cards (atmybest.com/pages/good-question-cards), which are used in group sessions to help people appreciate and build on their strengths, successes and the positive people and circumstances in their lives.

The workshops aim to blend taught content with staff’s existing experience and knowledge on various topics, such as capacity, unconscious bias, polypharmacy, recognising and responding to frailty and communication, which aligns with the formative function of the A-EQUIP model. The ‘validation, express emotion, reassure, activity’ (VERA) framework is introduced to support staff to communicate effectively with people with dementia (Blackhall et al 2011).

The workshops are guided by acceptance and commitment therapy (ACT) principles (Harris 2019). ACT suggests the use of six interrelated processes (acceptance, cognitive defusion, present moment awareness, self as context, values and committed action) to enhance the person’s ability to connect fully and consciously with the present moment and to sustain or change behaviours that project their values (Barney et al 2019). A person’s values are a central aspect of ACT, which theorises that if an individual is unable to act in line with their core values this can cause them psychological distress (Barney et al 2019). ACT principles complement restorative clinical supervision by supporting staff to understand how their actions, for example not removing a mask when communicating with an older person due to infection control procedures or having to prioritise one patient’s needs over another’s, can disrupt their core values. Opportunities to reflect on such experiences and understand their effects on themselves, colleagues and patients can help to prevent feelings of powerlessness or despondency (Chenai 2021). Rolfe et al’s (2001) ‘What? So What? Now What?’ model is used to support peer reflection and debrief on such actions and on concepts such as ageism within healthcare systems and practice (Eost-Telling et al 2021, Gendron 2022).

During the workshops, staff anonymously record how they plan to use their learning in practice, using interactive presentation.

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### Table 1. Advocating and Educating for Quality Improvement model of professional nursing leadership and clinical supervision

<table>
<thead>
<tr>
<th>Function</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normative</td>
<td>Managerial aspects – concerning practice, learning and core mandatory training</td>
</tr>
<tr>
<td>Formative</td>
<td>Educational aspects – developing knowledge and skills in professional development and self-reflection</td>
</tr>
<tr>
<td>Restorative</td>
<td>Supportive aspects – including personal development, improving stress management and mitigating burnout</td>
</tr>
<tr>
<td>Personal action for quality improvement</td>
<td>Addresses the need for nurses to be familiar with and contribute to quality improvement to help improve patient care</td>
</tr>
</tbody>
</table>

(Adapted from Proctor 1987, NHS England 2023b)
Approach situations with a different outlook and how to dissolve certain situations

I will take a second and think more about how to put VERA into action and how best to communicate.

Help to identify why patients are distressed and best way to calm and distract them

When possible, slow down and listen

Be more compassionate

Be more mindful of environmental factors

Ensuring capacity is assessed. Use VERA. Review medication. Ensure I introduce myself and listen to

When applicable, potentially encourage patients to interact with each other to socialise and eliminate

Using different approaches for different people depending on their presentation and anxiety levels

Taking some time out when you can and getting to know patients to know what is important to them. Consider delirium when patient is more subdued

Also take time to recognise frailty

Isolation

Challenges of implementing the professional nurse advocate role and restorative clinical supervision

The PNA role and the A-EQUIP model provide an opportunity through restorative clinical supervision to develop a nursing workforce that is equipped to manage the unique challenges and to appreciate the rewards of caring for older people. However, Carter (2022) voiced concerns that the implementation of the PNA role within nursing has been slow, and that the A-EQUIP programme presumes that nurses are willing and able to commit their time to delivering restorative clinical supervision within their practice areas. The author’s discussions with staff working in older people’s settings reflect this concern. There is a paradox between recognising the need for restorative clinical supervision to address workforce issues, such as managing high patient workloads, and being hindered in its delivery by the same issues as well as the sense of guilt felt by some nurses at taking time away from direct patient care (Rouse 2019).

Masamha et al (2022) identified a number of what they termed ‘barriers to overcoming barriers’ to clinical supervision in nursing, including: alternative forums of support, such as handovers or debriefs, which some nurses preferred to use to reflect on their practice and receive support; a mistrust of the concept, where nurses perceived clinical supervision as a resource for reprimand; and time and cost, in terms of the conflict between recognition of the importance of investing time in clinical supervision and nurses perceiving they lacked time to participate. Masamha et al (2022) also emphasised that staff who were most likely to require clinical supervision were the least likely to receive it.

To begin to address such barriers requires an organisational culture that does not regard non-clinical work as low priority and in which self-care is role-modelled (Featherbe 2023, Smythe et al 2023). In addition, forums such as handovers or debriefs should be acknowledged as complementary sources of support for nurses and other healthcare staff. Finally, PNAs should be supported to develop a culture of effective supervision within their organisation (Smythe et al 2023).

Conclusion

Nurses in all areas of practice are likely to care for older people with diverse and increasingly complex needs. This can be challenging within the context of workforce pressures outside of their control which can leave them feeling unable to deliver the person-centred care that is consistent with their values.

Providing nurses and other healthcare staff with PNA-facilitated restorative clinical supervision supported by the A-EQUIP model could enhance their well-being and educational and professional development and promote quality improvement. To support effective implementation of restorative clinical supervision led by PNAs requires an organisational culture that does not regard non-clinical work as low priority and which role-models self-care.

Box 1. Examples of how workshop participants plan to use their learning to improve practice

'Approach situations with a different outlook and how to dissolve certain situations’

'Spend more time listening’

'Taking some time out when you can and getting to know patients to know what is important to them. When they start to get frustrated, trying to use the VERA* technique’

'When possible, slow down and listen’

'Using different approaches for different people depending on their presentation and anxiety levels’

'When applicable, potentially encourage patients to interact with each other to socialise and eliminate isolation’

'I will take a second and think more about how to put VERA into action and how best to communicate. Also take time to recognise frailty’

'Make more time to do more meaningful activities’

'Be more compassionate’

'Help to identify why patients are distressed and best way to calm and distract them’

'Ensuring capacity is assessed. Use VERA. Review medication. Ensure I introduce myself and listen to what’s important to the patient. Consider delirium when patient is more subdued’

'Be more mindful of environmental factors’

*VERA = validation, express emotion, reassure, activity framework