GUIDELINES FOR IMPLEMENTATION OF CLINICAL SUPERVISION IN PSYCHIATRIC NURSING

Background:

The AIRC decision of September 2000 with regard to psychiatric nurses supported the development of a package of professional development initiatives to be implemented over the 3- year life of the agreement. This included the implementation of clinical supervision and support positions. A representative working party of stakeholders convened by the Centre for Psychiatric Nursing Research and Practice (CPNRP) developed and agreed these guidelines for implementation of clinical supervision within approved mental health services.

Introduction:

Clinical supervision in this document refers to discipline specific supervision for psychiatric nurses working in specialist public mental health services in Victoria. It is recognised that there are a number of clinical supervision models available that aim to enhance clinical care, promote standards of psychiatric nursing practice and support the professional development of psychiatric nurses. The implementation of clinical supervision within approved mental health services requires due consideration of relevant issues. A Resource document to accompany these guidelines will be available.

Clinical supervision is a formal process of professional support and learning which enables individual practitioners to develop knowledge competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations (Department of Health 1992 cited in Sloan 1996 p42). Other definitions, which reflect models of practice, attempt to summarize the essence of clinical supervision – a number of these will be found in the Resource document.

Purpose:

These guidelines aim to:

- Provide an agreed set of principles to inform the development of local policies and procedures within approved mental health services.
- Articulate the issues that require consideration in the implementation of clinical supervision.
- Be adaptable to different service systems and resource availability.

Policy Context:

Additional to the AIRC decision previously referred to in these guidelines, various agencies and professional bodies e.g. Australian & New Zealand College of Mental

Health Nurses also recommend a process of clinical supervision for mental health clinical staff.

DHS guidelines for mental health service provision in Crisis Assessment and Treatment Services and Mobile Support and Treatment Services view clinical supervision both as a process for ensuring a quality service and as a tool for staff development. In the DHS 'Mobile Support and Treatment Services: Guidelines for Service Provision (1995)' document, the service manager is given the responsibility for "establishing supervision structures, maintaining supervision standards and linking workers to supervisors" (pp.35)
The Commonwealth through the National Mental Health Education and Training Advisory Group also recommends the practice of clinical supervision. In the draft document National Practice Standards for the Mental Health Workforce (vers.3). Practice Standard 12 refers to supervision in both the Rationale and in the Skills component of that standard.

Standard 5 in the Standards of Practice for Mental Health Nursing in Australia (ANZMHN 1995) states under the knowledge attributes for that standard that the (nurse is) "familiar with clinical supervision in supporting nursing practice and professional growth" (p17).

Models and Scope of Clinical Supervision:

Clinical Supervision should not be confused with Management Supervision, although it is recognized that the two can go hand in hand in certain discipline areas (e.g. Social Work). It is important to stress that Clinical Supervision does not replace Management Supervision, so that if the two are separated out, as is sometimes seen as desirable, Management Supervision (which can include clinical skills/intervention appraisal) is not obviated.

Notwithstanding this important distinction, it is noted that Clinical Supervision can encompass a number of areas of clinical practice. However, as Psychiatric/Mental health nursing is primarily concerned with interactive processes and strategies, the supervision often concentrates on communication styles and techniques. Psychiatric/Mental health nurses are involved in counselling and education, behavioural and physical interventions. The success of each of these strategies requires a basis in sound communication practices. It is the development of these sound practices that forms the substance of Clinical Supervision and helps to distinguish Clinical Supervision from Mentorship, Preceptorship, Peer Support and Debriefing.

Broadly, there are directive and non-directive, individual, group and peer approaches to Clinical Supervision. The practice of clinical supervision can be informed by a variety of theoretical underpinnings: psychoanalytic, cognitive, behavioural, intellectual/reflective. Clinical Supervision does not, however, equate with therapy, but is a process of clinical skills development. The skills for psychiatric nurses are at least informed by the question of boundaries and a distinguishing of their individual needs (e.g. psychological, physical, values based) from those of the consumer/client.

When determining a model/approach there are a number of factors to consider: the experience and knowledge of the supervisee; the supervisor's own preference or style of working; the particular needs of the supervisee at a particular time; the particular context in which the supervisee works. Importantly, a supervisee should contract with a supervisor or supervisory group around the parameters of the supervision process. For example, if the supervision includes the giving of clinical advice or direction then professional and legal ramifications for all involved would need to be considered. If supervision were to be conducted in this way then it might in fact be a form of clinical management and properly belong under clinical management or performance appraisal structures. On the other hand, there are forms of Clinical Supervision that don't fall into this category as the focus is on future outcomes of skills application rather than on an evaluation of past or present practices.

Key Principles for the implementation of clinical supervision

- AMHS' should consider a model that enables incremental implementation of clinical supervision as it is envisaged that most organisations will not be able to sustain making Clinical Supervision immediately available because of the large numbers of staff that are likely to wish to participate and the need to have trained and experienced clinical supervisors available.

- AMHS' should develop their own comprehensive locally agreed procedures and practices in relation to clinical supervision that address the issues raised in these guidelines.

- Participation by nurses and managers in the development of local procedures and practices is essential to ensure supervisors and supervisees are fully aware of the purpose and benefits of supervision. The involvement of nurses in the development and implementation of clinical supervision aids trust in the resultant system and avoids the perception of management imposition.

- Ground rules should be agreed so that nurses and supervisors approach clinical supervision openly, confidently and with mutual awareness of what is involved. This includes stating how issues are raised, discussed or recorded and how confidentiality is dealt with.

- The ratio of supervisees to supervisor, how supervisors are chosen or changed and details of what model of supervision is used should be included.

- Preparation of supervisors is critical to the successful implementation of clinical supervision. 'In house' or external education programs may be used for this purpose.

- Staff wishing to participate in clinical supervision should have access to information sessions where the organisation's model for clinical supervision and its associated policies and procedures are discussed.

- Evaluation of clinical supervision is needed to assess how it influences care, practice standards and the service. Evaluation systems should be determined locally. Indicators of benefit could include safer practice; reduced untoward incidents and complaints; better targeting of educational and professional development; better assessment of client opinion; increased compliance with post-registration education requirements; reduced stress among staff; improved confidence; greater awareness of accountability; better risk management and awareness of effective evidence-based practice.

- Participation in clinical supervision is of a voluntary nature.

Working Party membership:

- Allan Townsend, Australian Nursing Federation
- Barbara Keeble-Devlin, RPN6/7Senior Nurses representative
- Bee Mitchell-Dawson, Mental Health Branch, DHS
- Daniel Nicholls, Academic Nurses Forum
- Dianne Hawthorn, Health & Community Services Union
- Felicity Humble, RPN4/5 Clinical Educators/Consultants representative
- Julie Hercelinskyj, Australian & New Zealand College of Mental Health Nurses (Vic)
- Kerrie Hancox, Centre for Psychiatric Nursing Research and Practice
- Penny Cash, Nurses Board Victoria
- Tess Priddy, RPN4/5 Clinical Educators/Consultants representative