

ENHANCING WELLBEING IN INFLAMMATORY BOWEL DISEASE SPECIALIST NURSES: MAKING A CASE FOR REGULAR CLINICAL SUPERVISION – A SMALL PILOT STUDY

Abstract

Background

Increasing demands on Inflammatory Bowel Disease Clinical Nurse Specialists (IBD-CNSs) can create overwhelming workloads, leading to stress and burnout.

Aim

To assess the potential for cognitive behavioural therapy (CBT)-based clinical supervision to enhance IBD-CNS wellbeing.

Design

Using exploratory qualitative research we interviewed IBD-CNSs who had participated in CBT-based clinical supervision sessions delivered previously in one UK hospital by a psychotherapist. Interviews were audio-recorded, then transcribed and anonymised by an independent transcriptionist. Data were analysed thematically.

Findings

Four nurses participated. Four themes emerged: *'Surprise benefits'*, *'Learning from others'*, *'Thinking differently to change self and practice'* and *'Features of clinical supervision sessions.'* Participants found group CBT-based supervision helpful for thinking differently about work-related challenges; all wanted to continue but were concerned about accommodating clinical supervision in already-busy schedules.

Conclusions

Regular CBT-based clinical supervision has the potential to enhance wellbeing of IBD-CNSs. Further research with more participants can confirm these preliminary findings.

Keywords: burnout, clinical nurse specialist, clinical supervision, stress, wellbeing

Key points

- Inflammatory bowel disease clinical nurse specialists experience high levels of stress that is detrimental to their wellbeing and can lead to burnout
- Clinical supervision has been shown to be beneficial for other clinical care specialists
- Cognitive behavioural therapy -based clinical supervision offers a promising approach to supporting the wellbeing of IBD clinical nurse specialists
- Further work is needed to build on the promising findings of this small pilot study

BACKGROUND

Inflammatory Bowel Disease (IBD), is an umbrella term for a group of chronic, incurable conditions which includes Crohn's Disease and ulcerative colitis. Commonly diagnosed during adolescence and early adulthood, these have a relapsing-remitting pattern, and unpredictable symptoms of fatigue, pain and urgency. Management is primarily medical, often using a vast array of complex powerful medications which can cause iatrogenic effects. Surgery may be needed to resect unsalvageable diseased bowel, or provide temporary relief from intractable symptoms, for example via a temporary ileostomy (Adamina et al. 2019; Magro et al. 2015). Patients have a long-term relationship with their disease, and with 'their' IBD nurse specialist. Increasingly, nurses are entering an inflammatory bowel disease clinical nurse specialist (IBD-CNS) role soon after qualifying (Leary and Mason 2018), and lone working, the demand for support from patients via email and telephone helplines, as well as oversight of own caseload, biologic drug infusion clinics, MDT meetings and patient advocacy can quickly lead to work-related distress, burnout and attrition (Leary and Mason 2018). Stansfield (2019) comments that this complex and demanding caseload is unsustainable, both for service provision, and for nurses themselves. Addressing the wellbeing of these IBD-CNSs is one essential aspect of ensuring future services are sustainable.

Wellbeing of the clinical workforce is a current focus for the NHS (NHS Employers 2018). Clinical supervision is an effective mechanism for supporting wellbeing; it enables reflective practice, provides support and encouragement, and develops self-confidence and self-esteem (Bifaran and Stonehouse 2017). Clinical supervision has also been associated with reductions in staff burnout (Edwards et al. 2006), increased job satisfaction (Hyrkäs et al. 2006), and the improved mental health of nurses (Ohlson and Arvidsson 2005). Over twenty years ago, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC: now Nursing and Midwifery Council (NMC) stated that 'every practitioner should have access to clinical supervision' (Cowe and Wilkes 1998). There is evidence of access to and benefits of clinical supervision amongst nurses in a range of clinical settings (Cutcliffe et al. 2018), but to our knowledge, clinical supervision may rarely be provided routinely to IBD-CNSs in the UK. As the first stage of a long-term plan to initiate routine clinical supervision for all IBD-CNSs across the UK, the authors conducted a small-scale pilot study to test the feasibility and acceptability of cognitive behavioural therapy-based clinical supervision amongst the IBD-CNS team at one central London hospital.

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) is an established psychological model and approach involving talking therapy. The CBT approach invites people to consider changing their negative automatic thoughts for more balanced thinking and perspectives, whilst also adjusting typical responses and behaviours that lead to unhelpful outcomes (Beck 1964). The CBT psychological approach is based on the concept that our thoughts, emotions, behaviours

and physiological responses are all interconnected [Fig.1]. The CBT approach posits that helping people explore and learn how to change the way they think and behave will improve functioning levels.

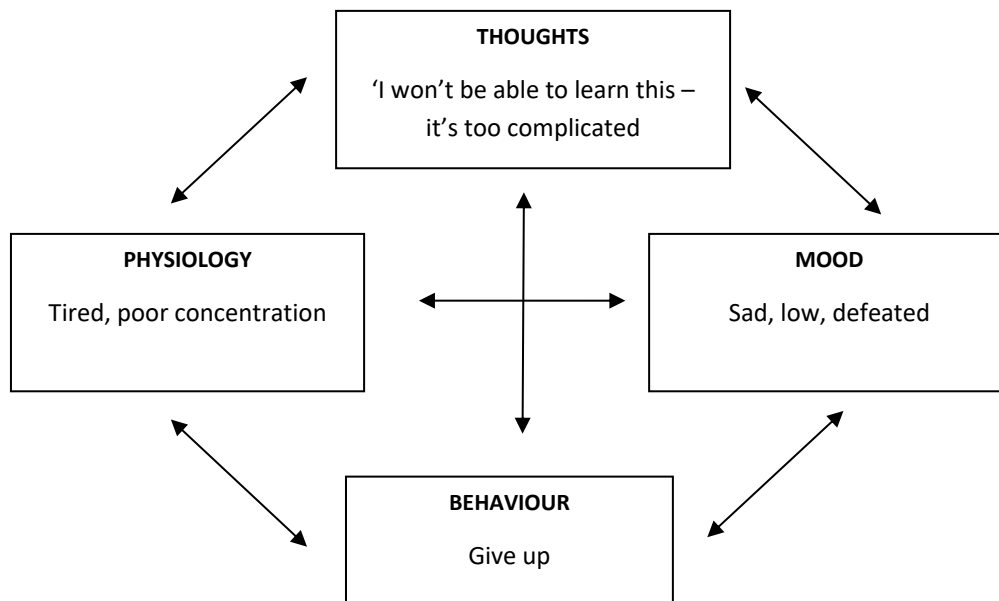


Figure 1. The relationship between thoughts, mood, behaviour and physiology. Adapted from Greenberger and Padesky (1995)

Cognitive behavioural therapy can assist with a variety of different problems, including anxiety, depression, panic, phobias (including agoraphobia and social phobia), stress, bulimia, obsessive compulsive disorder, post-traumatic stress disorder, bipolar disorder and psychosis. The approach is also helpful for people presenting with anger, low self-esteem and physical health problems such as pain or fatigue. Recommended by NICE guidelines for depression and all the anxiety disorders (NICE 2004a, 2004b, 2005a, 2005b, 2006, 2009a, 2009b, 2011), CBT treatment always commences with establishing the person's goals for treatment, followed by providing psychoeducation to help empower them whilst adhering to their preferred treatment focus. Interventions are disorder-specific, and able to be adapted according to the bespoke needs of the individual. Typical CBT Interventions for depression may involve establishing a routine, behavioural activation by activity scheduling, thought record diaries and the collection of positive data logs. When treating an anxiety disorder such as panic, interventions such as discussion techniques and behavioural experiments are used to help clients identify panic-related thoughts and images, alongside helping them learn appropriate responses to their symptoms by reducing avoidance strategies in which identifying and eliminating safety behaviours act to maintain their anxiety.

This process occurs through actively interrupting familiar negative automatic thoughts (NATS)

and promoting the ability to view a situation from a new perspective, away from those previously encoded unhealthy patterns of thinking. What emerges in changed behaviours, are changes in responses from others with whom they come into contact. Ultimately, taking this approach is believed to develop a healthier, more balanced outlook together with a better understanding of the individual's own ability to manage future reactions and responses.

CBT as an effective model for clinical supervision

Clinical supervision has been defined as '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 safety of care in complex situations' (Department of Health 1993, 3).

A key component of clinical supervision is that it provides a reflective space in which to explore a difficulty being experienced that may otherwise remain unaddressed. A common scenario in busy clinical settings, these unaddressed issues can potentially lead to employees feeling overwhelmed, frustrated, incompetent and burnt out. The CBT model may be an effective clinical supervision model as the principle approach of this model has been designed to equip both the clinician and the recipient respectively (Temple and Bowers 1998). The CBT approach apportions time by way of an agenda and structures the sessions according to the difficulty being presented. Using Socratic questioning to explore the difficulty rather than providing a solution, the individual learns the skill of critically questioning their negative responses to that difficulty and is eventually able to apply that same skill in other areas of their practice.

For IBD-CNS', a CBT approach to clinical supervision may be beneficial because of the nature of the relationship between IBD-CNS' and patients, and the long-term consequences of chronic illness that those patients are experiencing, which may include reduced physical and social functioning, poor quality of life, anxiety and depression, and reduced survival. These presentations can lead to an increased demand on IBD-CNS services, as patients turn to these specialists for support. A CBT approach may be an effective clinical supervision model for healthcare professionals caring for the chronic population, assisting nurses to explore and target patients' cognitions and behaviours whilst also addressing their own.

DESIGN AND METHOD

The study adopted an exploratory qualitative approach (Stebbins 2001) to explore participants' experiences of a clinical supervision initiative, delivered once weekly for six consecutive weeks by (blinded for review).

The supervision sessions were not part of this project, but had been arranged by the service

lead, providing opportunity for this follow-up project. The research question was: What is the experience and perceived usefulness of cognitive behavioural therapy-based clinical supervision for IBD Clinical Nurse specialists?

Recruitment and sample size

All members of the IBD-CNS team were invited to participate. The invitation email and electronic copy of the study information sheet were circulated to the team by the clinical lead (blinded for review). Those interested in taking part responded directly to the independent researcher (blinded for review) who arranged the interview venue, date and times with each respondent individually. As a pilot study, the sample size was not critical since the purpose was to gain perspectives about clinical supervision in order to inform a future, larger project.

Inclusion and exclusion criteria

Nurses were eligible if they worked at the target hospital as a member of the IBD-CNS team, had been qualified and in post for any amount of time, with any work pattern (full-time, part-time), and had attended at least two of the six previous CBT-based clinical supervision sessions. There were no exclusion criteria.

Ethical considerations

Consultation with the Health Research Authority's online decision-making tool and the Research and Development Department at the Trust confirmed that this project was considered service evaluation and so HRA ethics approval was not required. Ethics approval was therefore provided by the University of Greenwich.

Written informed consent was collected immediately prior to each interview. This was a small team and impossible to maintain complete anonymity, yet confidentiality was imperative. Interviews were therefore conducted by (blinded for review) who had no prior relationship with the participants, and whilst other members of the clinical team may have known who had been interviewed, no detail of what had been shared by whom was revealed by the interviewer. The audio files were transcribed by an independent research fellow at the University of Greenwich, and then proofread and anonymised by (blinded for review) before sharing with (blinded for review) for analysis. The risk of being identified despite anonymisation due to publication of the study by other IBD-CNSs across the professional network was discussed with each participant by (blinded for review) prior to the interview taking place. All acknowledged this risk and agreed to their data being used for publication.

Data collection

Semi-structured interviews took place in a nearby third-party venue close to but separate from the hospital where all participants worked. Participants were initially asked to *'Tell me*

about your experience of the clinical supervision sessions'. Follow-up questions included asking participants to identify what they liked least and best about clinical supervision, its impact on their practice, and the potential interest in regular clinical supervision. Interviews were recorded on a digital voice recorder.

Data analysis

Following proofreading by (blinded for review) to ensure anonymity, transcripts were shared across the team and a simple thematic analysis, based on the analytical hierarchy of Spencer et al. (2003) was conducted by each team member individually, before final themes were agreed. Briefly, the process requires the researchers to independently read through each transcript, identifying initial 'things of interest' in each transcript; then reading across all transcripts again and noting common 'things of interest' that are beginning to emerge. Once these have been identified, the team meets to discuss their findings and collaborate on shaping and organising these things of interest into themes and sub-themes. Conducting analysis in this way means that each researcher completes an individual review of the data, but the final themes are a consensus agreement between all researchers, thus minimising bias and enhancing trustworthiness of the findings.

FINDINGS and DISCUSSION

Six IBD-CNSs were invited to the study; four took part (all female; qualified 3-10 years, in specialist role 2 – 8 years). Interviews lasted between 11 and 23 minutes. Four core themes emerged from the data: '*Surprise benefits*', '*Learning from others*', '*Thinking differently to change self and practice*' and '*Features of clinical supervision sessions*'. Each theme is outlined below; verbatim quotes are not linked to a participant identifier due to the small sample size but all participants are represented.

Surprise benefits reflects the consensus view of participants that clinical supervision was a valuable and worthwhile experience, which sometimes went against expectations:

I was a bit like hmmm am I going to be wasting my time? I didn't even know what [clinical supervision] meant or what we were supposed to be doing in those supervision meetings ... But I went to them and I completely changed my mind from the beginning. I thought I wasn't going to say anything but I was probably one of the team that talked more about everything

Participants found it valuable to be able to bring bothersome issues from clinical practice to the sessions, and receive beneficial input which helped them find a way of coping with that issue:

I find [the sessions] made you reflect on your views on certain situations so if you had a

particular patient that you find difficult, you were able to bring it to that setting and be challenged ... not challenged on your views ... but be made to see things from different points of view so ... why is the patient acting like that and why am I acting the way I am towards that patient?

Overall, the sessions were considered 'worth finding time for' and all participants wanted these to continue on a regular basis.

Learning from others reveals the supportive way in which participants, regardless of seniority and experience, could learn from their colleagues in what they described as 'a safe professional environment':

I'm still learning but [colleagues] are sharing, we are sharing each other's ideas so it helps as well because if I don't know that thing then at least somebody [can suggest] 'you have to do this like that'

There was recognition that this shared learning could benefit practice, as well as the individual:

'Colleagues have different opinions in the world and if you talk about whatever is happening, other people can help you ... It doesn't have to be [anything] special but they have other opinions, other ways of seeing things'

Importantly, participants recognised that having an external unbiased facilitator enabled them to focus professionally on the issues at hand:

'You need someone that's able to facilitate the session in order to make sure that the right outcomes come from the session or else it could just become some kind of gossiping or bitching session'

Group dynamics were also revealed. Not all participants could attend all sessions, and it was noticed that this was reflected in the 'feel' of the session. Too few people could stifle discussion and limit the benefits to participants, especially if there was interpersonal 'history' between them. Staff also bring existing issues between themselves into supervision which can be played out in the session. Whilst the group sessions were appreciated, some suggested there might be occasions where a one-to-one supervision would be more beneficial:

'What if you have a problem or a situation or something, [if you're] not okay with one of the members of staff that is actually in the [group] clinical supervision which is happening at the moment?'

These interpersonal challenges, especially in small groups, could affect the willingness of staff with less professional confidence to air their experiences and concerns about clinical issues.

Thinking differently to change self and practice addresses the impact that clinical supervision had on participants. For some, there was immediate change in the way they thought about stressful situations:

'I think I definitely pause a bit more to think about the patient's perspective and you maybe think well why am I frustrated at that situation? It just makes you kind of reflect a bit more on situations. And I think I still do that'

Others described definite decisions to make a practical change to their way of working:

'You sometimes don't realise how patients [can] drain you. How many emails they send you and how many times they call you and you think it's normal but then you say to someone else and they say well maybe you shouldn't answer, maybe you need to wait until the end of the day to answer the email and things like that, that I never think that's possible to do. If I receive an email, I would reply straight away and then you get another one from the same person and it's nonstop. So, and I think I'm not doing that anymore'

Others felt that whilst clinical supervision was helpful, they would need to be engaged with it for longer, to bring about the behavioural changes which would be beneficial long-term:

'[Supervision was] not so much about the actual situation itself. It was taking yourself away from that situation and [thinking about] how you personally and emotionally deal with that ... in time I guess, the idea is that you learn to do that for yourself in lots of situations'

Extrapolating beyond the immediate clinical setting in this way suggests that CBT-focused clinical supervision can have benefits far beyond the patient / practitioner relationship, into other relationships with colleagues, and the outside world.

The final theme '**Features of clinical supervision sessions**' addresses the practical aspects which participants found beneficial. All agreed that having an independent skilled facilitator, who had no clinical experience in the field of IBD, was valuable:

'[The facilitator] was very good. I liked her and I liked her approach ... she was so impartial in the fact that she has no experience of what we do. No knowledge of that area particularly. She, she was able to kind of relate it to her own clinical practise sometimes and give advice sometimes about things – 'this is how you could respond'

The facilitator's status also afforded a sense of emotional safety to participants;

[The sessions] allowed you to rethink situations in a safe environment with somebody that wasn't part of the team or even part of IBD

This last statement may suggest that the close-knit nature of the world of IBD clinical and research work may present barriers to admitting personal vulnerabilities relating to IBD nursing, and that this may be more effectively enabled by a third party facilitator. Participants were agreed that the presence of an external facilitator also meant that the sessions remained focussed on relevant clinical issues.

All participants wanted the sessions to continue, though recognised the potential challenges in finding time within their busy schedule to attend. Discussion included having supervision included in job plans so that it became a requirement rather than an 'added extra', and offering hourly sessions at least fortnightly, but ideally weekly. Group sessions were considered more valuable overall, although the potential for individual sessions - particularly to address issues of team dynamics – was also discussed.

DISCUSSION

The findings from this small study suggest that, in keeping with other areas of nursing specialism, clinical supervision has the potential to improve staff wellbeing and patient care (Hyrkäs 2005; Snowden et al. 2017;). Whilst most of the evidence for effectiveness of clinical supervision as a support mechanism for staff comes from mental health nursing (for example, Lakeman and Glasgow 2009; Maclaren et al. 2016), its role is beginning to be appreciated in other settings, including community and hospice services (Abbott et al. 2018; Chilvers and Ramsey 2009). Although the UK Government identified the need for and value of clinical supervision in 1993, it still may not be routinely available to all advanced practice / specialist nurses across the UK despite an increasingly demanding workload.

NHS Lanarkshire (2010) report several variations in clinical supervision practice across the UK, including inconsistencies in provision within areas and professions, use of different models, difficulties allocating time for supervision activity, and confusion as to the focus and purpose of supervision. Similar issues are indicated in this small study; the delivery, structure and function of the sessions need to be clearly set out and agreed – participants in this study commented on the difficulties of committing time to attend, despite finding it beneficial when they could. Some also had troublesome professional relationships with colleagues but did not feel this was the right forum to address those issues.

Despite these difficulties, the participants in this small study found benefit in clinical supervision, some already making positive changes to their approach to workload and patient-derived stressors. Regular sessions may promote and maintain enhanced wellbeing, although further research to evaluate the effectiveness of clinical supervision for nurses and

allied health care professionals is needed (Dawson et al. 2013).

LIMITATIONS

This is a very small pilot study representing the experience of one particular clinical IBD-CNS team in a single UK hospital. The experiences of other teams in different hospitals may vary, and service provision issues may affect the capacity to support clinical supervision in other settings. Exploratory qualitative studies such as this are not intended to be replicable, nor the findings generalisable; rather, this type of study is used to promote thinking about a particular topic and provide some starting evidence to support future research work.

CONCLUSION AND NEXT STEPS

This small pilot study suggests there is potential to address work-related stress for IBD-CNSs through regular clinical supervision and thus simultaneously enhance staff wellbeing, communication between colleagues and – potentially - patient care. We now plan to conduct an in-depth qualitative study with senior IBD-CNSs who have recently left or are considering leaving the NHS due to stress and / or burnout, to generate robust evidence on the impact of this specialist role on wellbeing. The findings, together with those from this small pilot study, will support an application for funding to deliver a larger clinical supervision study across the IBD nurse network in the UK.

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