JBI EVIDENCE IMPLEMENTATION

Enhancing the clinical supervision experience of staff members working within Primary and Community Care: a best practice implementation project

Abstract

Objectives: The project aimed to assess compliance with evidence-based criteria regarding the use of clinical supervision amongst district nurses and to improve knowledge and engagement in clinical supervision activities within the workplace.

Introduction: It is important to provide clinical support to all healthcare workers that provide opportunities to develop and be listened to in a supervised environment. Clinical supervision is seen as a key element to provide this support. It provides a professional working relationship between two or more members of staff where the reflection of practice and personal emotion can be discussed, which is outlined in many policies and guidelines.

Methods: A baseline audit was carried out using the JBI Practical Applications of Clinical Evidence System program involving 16 participants in one district nursing team in South Wales. The first step involved the development of the project and generating the evidence. Following this a baseline audit was conducted, educational training on clinical supervision was undertaken followed by clinical supervision sessions. A postimplementation re-audit was conducted following implementation.

Results: A total of 16 participants enrolled on the project. Receiving basic training and participating in clinical supervision was much higher than the baseline audit with both increasing to 100% compliance. Furthermore, 94% of participants were aware of clinical supervision activities and 88% knew of existing records on clinical supervision. The project results show a

large increase in compliance with all of the criterion.

Conclusions: Overall the implementation project achieved a improvement in evidence-based practice regarding clinical supervision in primary care.

Keywords: “clinical audit”; “clinical supervision”; “implementation”; “primary care”

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What is already known

- Clinical supervision is an important mechanism for healthcare professionals.
- Clinical supervision is underused in primary care amongst nurses.
- Clinical support and education are vital in developing resilience in healthcare.

What this paper adds

- Clinical supervision activities provide support and development for healthcare professionals within primary care.
- Educational sessions provide knowledge and acceptance of the importance of clinical supervision.
- Educational sessions increase the likelihood of clinical supervision activities taking place

Introduction

The nursing professional has changed dramatically over the years moving from a less prepared, less educated assistant in the 1950's, to a role with power, responsibility, and professionalism[1]. Nursing in itself is a profession that carries a high emotional cost in relation to its roles and responsibilities and therefore the idea that nurses need some sort of support is well established[2]. For healthcare organizations patient safety and the quality of care are priority[1], and one key factor relating to this is education and development of the nursing profession. There are a variety of forms that clinical support and education can come in, but all provide healthcare workers with opportunities to develop and be listened to in a supervised environment.

There is currently no precise definition for clinical supervision, most research emphasis that it is the support and guidance provided in an environment which is safe, it provides a place where staff can uncover their own personal emotions, reflect on practice, and receive feedback[9,19]. Clinical supervision is a support mechanism for nurses within practice. It emerged in the early 1990's with the introduction from the Department of Health (DH)[3] and was then adopted by the

health regulator in 2013 due to failings in standards of care[4-5]. In most healthcare services within the United Kingdom (UK), no training or qualifications are needed to become a clinical supervisor and even though clinical supervision is not mandatory for most UK nurses, the Nursing and Midwifery Council (NMC) in The Code[6] advises nurses to partake in professional development which includes supervision. Kadushin[7], who is one of the most influential writers on supervision asserts that there are three core functions of supervision: education, administration and support. This is in support of Proctors[8] seminal work which identified formative, restorative and normative functions. Clinical supervision is therefore seen as a professional working relationship that is ongoing between two or more staff members, these staff members can be of different levels of knowledge and expertise with the ultimate goal of support and sharing of knowledge. Developing resilience in nursing is vital in the current healthcare environment, as nurses need to be able to cope in rapidly changing environments and ensure quality of care is at its best. A lower level of resilience showed a higher association with exhaustion, professional efficacy and burnout [23].

Clinical supervision is one way of helping to achieve resilience, we already know that it has been associated with higher levels of patient safety within healthcare[9] but it has also been related to higher levels of job satisfaction which subsequently improves staff retention and wellbeing[9]. Successfully practicing clinical supervision can help reduce burnout, promote positive working environments, and aids the delivery of high-quality care[12-14].

Although undoubtedly clinical supervision provides educational development, adherence to quality assurance and practical and psychological support, its potential has yet to be fully understood in nursing practice[2]. A systematic review written in 2018[9] demonstrates the importance of clinical supervision, it identifyed an association between those healthcare professionals that were involved in clinical supervision and an increase in improvement in some care processes. However, there is still an absence of literature demonstrating its outcomes[10], and although there is a plethora of research that writes about the importance and benefits of clinical supervision, it remains underused[11]. Furthermore, there is limited research conducted on how best to organise and steer clinical supervision within practice, this alongside professional's

lack of awareness of effective clinical supervision adds to the confusion and lack of use of clinical supervision within healthcare[16]. Additionally, research has found an ongoing debate between the complex nature of clinical supervision and resistance from healthcare organizations in implementing clinical supervision[17,18]. Any attempt to research clinical supervision in healthcare has therefore been limited to this debate which has ultimately overlooked its role and benefits[17].

There has been little research conducted within primary care around the effectiveness and use of clinical supervision. One qualitative study carried out by Barriball et al[15] reported the benefits of it use within primary care, yet these benefits are only awarded if clinical supervision is regular, this proves to be difficult to accomplish across a primary care setting due to the variety of teams and staff members working within its setting. However, there are many models of clinical supervision that can be utilized to suit all staff and all organizations, therefore careful consideration can result in sustaining clinical supervision in all areas within primary care.

From the current literature sourced it shows a growing body of evidence that suggests clinical supervision is an important support mechanism within healthcare. This evidence implementation project will therefore explore this topic using the JBI Approach to Evidence Implementation[21] to explore current practices and promote the evidence-based information surrounding clinical supervision within primary care.

Objective(s)

The aim of this project is to improve compliance with evidence-based criteria regarding the use of clinical supervision among nurses within primary care.

The specific objectives are:

- To determine current concordance with evidence-based criteria regarding clinical supervision in primary and community care
- To identify barriers and facilitators in achieving concordance with clinical supervision within practice and to develop strategies to address these.

- To improve knowledge regarding best practice regarding the use of clinical supervision within the workplace among nurses within primary care.
- To improve concordance with clinical supervision alongside evidence-based criteria regarding clinical supervision.
- To improve outcomes regarding clinical supervision and primary care

Methods

This evidence implementation project used the JBI Evidence Implementation framework[21]. The JBI Implementation approach is grounded in the audit and feedback process along with a structured approach to the identification and management of barriers to compliance with recommended clinical practices. It consists of seven stages ranging from identification of a practice area for change to sustainability of that change.

This implementation project used the JBI Practical Appliance of Clinical Evidence System (JBI PACES) and Getting Research into Practice (GRiP) audit feedback tool. The first step involved communicating with a team for the project to take place in, once this was established a baseline audit was carried out which was informed by the best available evidence. Once completed the project team reviewed the results of the audit and discussed ways of improving these by designing implementation strategies. These strategies were then implemented in practice by the project team. Lastly a follow up audit was completed to assesses the effect of the implementation strategies.

Ethics

As this project is an implementation project, NHS Research Ethics Committee permissions are not required but local Health Board Research and Development regulations were adhered to throughout. The steps we took also ensured confidentiality, anonymity, right to withdraw and safe storage of data.

Phase 1: Stakeholder engagement (or team establishment) and baseline audit

The topic of this project is clinical supervision within primary care. The first part of the implementation project involved engaging stakeholders and identifying relevant team participants for the project, as outlined in table 1. The project team consisted of five members, including one primary care and public health lecture, one senior nurse, one team manager, and two team leaders, the senior nurse was approached by the project lead who then recruited the further members into the team . The primary care and public health lecturer led the project team, all members participated in both the development and the implementation of the project.

Table 1. Team members and their roles in the implementation project

Team members	**Roles**
Researcher, project lead	Project lead, project manager
Senior nurse	Project link to the health board within one primary care borough, project advisor
District nurse team manager	Project coordinator within clinical practice, clinical supervisor, audit data collection and clinical facilitator
District nurse team leader	Deliver clinical supervision, clinical facilitator
District nurse team leader	Deliver clinical supervision, clinical facilitator

The standards for the audit were obtained from available evidence that is reliable and robust and has been published within the last two years[22]. The audit criteria is shown in table 2 which was used to conduct the baseline audit, it demonstrations the standards of best practice including the sample of participants and the methods used to measure the compliance.

The audit was conducted in January 2020, the sample participants were made up of the registered nurses that worked within the district nursing team at the time of the project. The participants consisted of registered nurses only. The audit questionnaire was given to team members to complete by the project lead and team manager who would also be available to answer questions regarding the audit completion.

Table 2: Audit criteria, sample and methods used to measure percentage compliance with best practice

Audit Criteria	**Sample for audit 1 and 2**	**Method used to measure percentage compliance with best practice**
An organizational policy exists regarding clinical supervision	One district nursing team consisting of 16 nurses.	dichotomous audit questionnaire A 'yes' was scored if the participant knew of any existing policy on clinical supervision.
Nurses received at least one basic training on clinical supervision in their current work position within their current organization (on topics such as: what is clinical supervision, purposes, principles, and evaluation of clinical supervision, role and responsibilities of the supervisee and supervisor and confidentiality).	One district nursing team consisting of 16 nurses.	questionnaire A 'yes' was scored if the participants had received any training on clinical supervision under the same health board even if the participants received this when in another team or area.
Nurses are aware of all clinical supervision activities/programmes currently available within their organization	One district nursing team consisting of 16 nurses.	questionnaire A 'yes' was scored if the participants had any knowledge of activities within the same health board. A 'no' was scored if they knew of this training anywhere outside of the same health board.

Nurses were engaged in at least one clinical supervision activity (as supervisee or supervisor or both) in the last 12 months	One district nursing team consisting of 16 nurses.	questionnaire To score a 'yes' participants would have needed to have engaged in Clinical supervision under the same health board.
There are existing records on clinical supervision activities performed in the last 12 months	One district nursing team consisting of 16 nurses.	questionnaire If participants had engaged in clinical supervision a 'yes' could be scored here if this was recorded and documented.

Phase 2: Design and implementation of strategies to improve practice (GRiP)

The implementation project was carried out in one district nursing team in a locality based in a city centre in South Wales. It accounts for 302 patients across 4 General Practitioner offices. The sample size consisted of 16 registered nurses, this was established using convenience sampling and determined according to the number of nurses working in one district nursing team, participants included registered nurses only. Following the audit, the project team analyzed the baseline audit results and inputted them onto a software system called JBI PACES. The purpose of the baseline audit was to assess the use of clinical supervision in practice and identify any gaps, during the baseline audit the project lead spent time within the team setting and provided participants with the audit questions. Following the baseline audit the project team met virtually to discuss the results and used the GRiP process to discuss and identify the criteria needing to be implemented within the team to address the audit results. Interventions were planned to be developed and implemented within the district nursing team within four months of the baseline audit. However due to COVID-19 pandemic this process took longer than expected and the project was implemented nine months after the baseline audit in

October 2020. The strategies were developed through virtual meetings with the project team, educational sessions were developed by the team and taught to all participants. The team manager and team leaders where available to carry out individual or team clinical supervision sessions and recorded these on specific documentation that was implemented as part of the project. This process was iterative and progressed as the project evolved. Regular virtual meetings were set up for the project team to meet and discuss how the implementation was progressing. Strategies to reduce and overcome barriers were discussed during the meetings.

Phase 3: Follow-up audit post implementation of change strategy

A follow-up audit was carried out using the same evidence-based audit standards, sample size and participants within the same district nursing team, the methods used was the replication of the phase 1 audit. This was completed within five months after the last session of the implementation of education strategies in March 2021.

Analysis

Quantitative descriptive analysis was used to report on the data collected from both the pre audit and post audit. Audit questionnaires were dichotomous questions and were collected in and embedded in JBI-PACES. The comparisons between both audits will be reported on in the results section. Results data on changes in compliance was measured using descriptive statistics embedded in JBI-PACES in the form of percentage changes from baseline.

Results

Phase 1: Baseline audit

The baseline audit was conducted in January 2020, the baseline audit results highlighted a clear difference in the compliance in all criterions. The sample size consisted of 16 participants, all participants were female aged between 24 and 55 years, years of experience ranged from 2 months to 27 years. The compliance rates are as follows: Criteria 1 has the highest score of

38%, showing no knowledge of a specific policy related to clinical supervision in the workplace. Criterion 2 and 4 has the same compliance of 25%, both criterions talk about engagement in clinical supervision training. They both show low compliance to any education on clinical supervision and in receiving at least one clinical supervision session, thus showing a gap in practice and need for improvement. Criteria 3 had a similar percentage to both 2 and 4 (19%), showing a lack of knowledge of any activities associated with clinical supervision within practice. Lastly there was a 0% compliance rate reported for criteria 5 around existing records of clinical supervision, which coincides with the lack of sessions available on clinical supervision. The criteria can be found in figure 1 below.

Phase 2: Strategies for Getting Research into Practice (GRiP)

The project team analyzed the baseline audit results and identified the strategies needed by using the JBI GRiP program. The objectives of the project were to improve the outcomes of the use of clinical supervision within primary care. Providing educational sessions to the staff members in one district nursing team alone was supported by the project team and seen as the most feasible way to address the lack of use of clinical supervision within primary care, this would then be followed by conducting clinical supervision sessions within the team. Four educational sessions were conducted online throughout a period of a month and consisted of information on clinical supervision, its benefits and rationale within nursing, extra time was also incorporated into the sessions for questions and discussion around the topic. The methods used to assess this was a quantitative approach with the use of questionnaires to collect the data.

The implementation project needed to overcome many barriers during the project, the necessary strategies, and resources to overcome these are shown in table 3.

The first barrier encountered during the GRiP stage was communication. Communication issues between the project lead and the health board caused a delay in the commencement of the project. Communication was initially through email correspondence but due to the project aim not being understood by the health board telephone conversation where needed, thus the purpose, aim and project background was explained effectively and ultimately understood.

The second barrier was the COVID-19 pandemic, although a barrier at first the pandemic also proved to be an instigator for clinical supervision due to the support that was provided to the staff members. However, at the start of the project, the pandemic initially put a stop to the project due to limited staff, time and availability of teaching hours.

Lastly, the third barrier was the lack of availability of documentation on clinical supervision, there were no health board specific documentation available for the recording of clinical supervision sessions.

The strategies used to address some of these barriers involved the change in way the educational sessions were delivered to the participants, and the implementation and design of documentation that could be used to record clinical supervision sessions, please see table 3. The educational sessions were converted to online sessions that were conducted many times over a month to capture all participants, the project team also interacted with some of the sessions. To overcome the documentation barrier, the project lead designed a template that the project team evaluated and reviewed and initiated following its evaluation.

Table 3: Getting Research into Practice matrix

Barrier	**Strategy**	**Resources**	**Outcomes**
• communication issues in regard to the project and clinical supervision educational sessions	• Other ways of communication were discussed and agreed upon • Development of an agreed timeframe of communication with the project	• Formation of an agreed communication timeframe • Education sessions set in advance and staff members made aware of these sessions	• communication improved between the project team • staff were aware of what educational sessions were available and when • Compliance rate for criterion 3 improved from 19% to 94%

• difficulties to deliver educational face to face sessions due to COVID-19 pandemic	• Agreed on an extended timeline for the educational sessions • Development of online virtual educational sessions. • Sessions were run many times throughout a month in order to capture all participants.	• Formation of an agreed timeline • Development of a generic presentation that could be used to educate all staff • Virtual online meeting rooms set up and shared	• Participants preferred the online educational sessions as they could access the sessions from work or home • Completion of the educational session was completed within the extended timeframe • Attendance sheet was completed by the team manager • Compliance rate of criterion 2 increased from 25% to 100%
• Lack of Clinical supervision documentation	• Development of record sheet to document clinical supervision sessions	• Easy to read and completed documentation sheet highlighting the key points of the clinical supervision sessions and action plan to be addressed	• Project team highlighted the easy use of the documentation • Compliance rate of criterion 5 increased from 0% to 88%

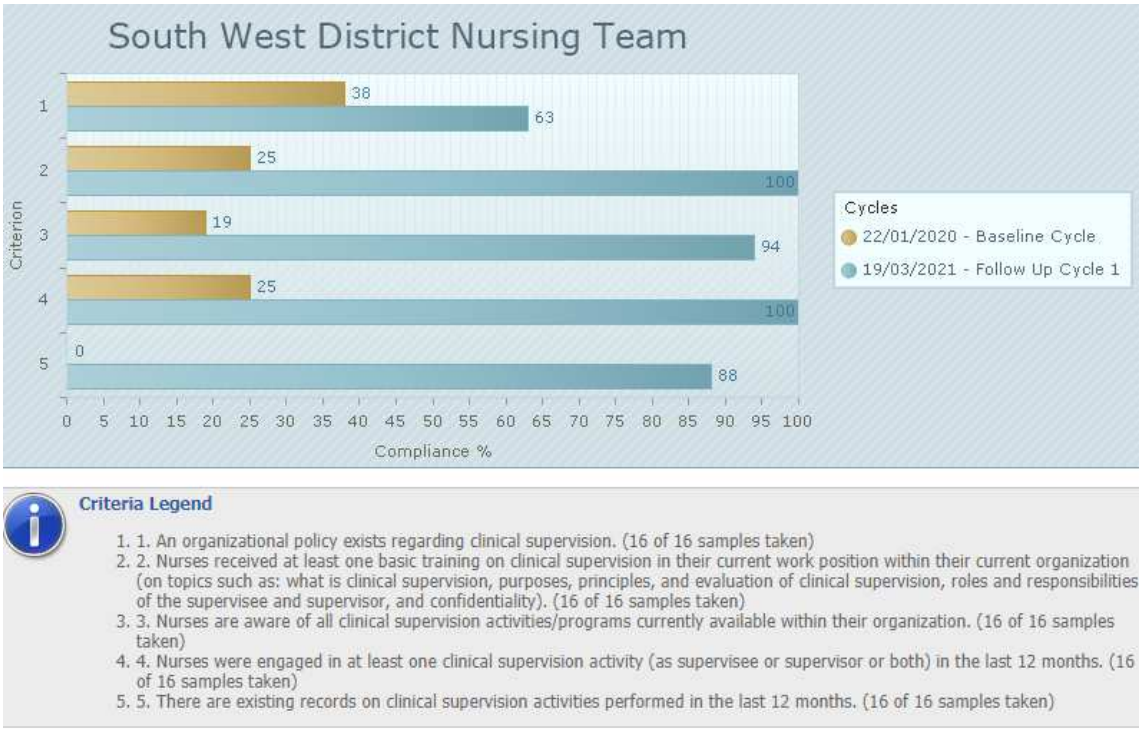
Phase 3: Follow-up audit

The baseline and follow-up audit compliance data are shown in figure 1. The follow up audit was conducted in March 2021. The sample size remained at 16 participants from the same district nursing team. From the results of the follow up audit this implementation project on clinical supervision has succeeded in the improvements in compliance with best practice for all of the audit criterions. JBI-PACES and GriP tools were used to identify all of the actions and resources used in the project.

There was a significant improvement in all criterions amongst the 16 particpants, this was especially seen in criterion 5 where the percentage rose from 0% to 88%. This showed an increased use of clinical records for documenting clinical supervision sessions. Criteria 2 and 4

also rose from 25% to 100%, again showing a significant improvement in nurses receiving both educational sessions on clinical supervision and attending sessions themselves in practice. Criteria 1 did not see as high an increase as the rest of the criterions, the percentage rose from 38% to 63% only seeing a 25% increase, however the implementation project had no influence over an organizational policy being that the project lead was based in a university outside of the health board. Lastly criteria 3 increased from 19% to 94% showing an increased knowledge in what activities are available to professional on clinical supervision.

Figure 1: Compliance (%) with best practice for audit criteria on clinical supervision at baseline and follow-up cycle



Discussion

Clinical supervision has been well established for many years within healthcare, it involves a supportive relationship between peers and supervisor and facilitates reflective learning[12].

However, there are many gaps between practice of clinical supervision and the evidence that underpins it, professionals are often unsure of the basics of what clinical supervision is and how they may implement this in practice[11]. In this study, the experience of nurse's knowledge and involvement in clinical supervision was analyzed, considering the overall benefit of clinical supervision the baseline audit established poor compliance to any type of exposure to clinical supervision in practice. In addition, during the baseline audit we found no existing records on clinical supervision activities performed in practice. The reason for this may be that there is a lack of clear guidance on how clinical supervision can be achieved.

The project team identified three barriers during the project and identified strategies to overcome these. The Covid-19 pandemic did slow the project down; however, it also aided in how participants viewed the importance of clinical supervision at times of hardship and stress in their work environment and therefore embraced the clinical supervision activities. This is supported by research conducted in this field of work where clinical supervision is seen to provide an environment which is safe and where staff can discuss emotions and reflect upon practice[9,19].

The educational sessions had to be redesigned to accommodate virtual online teaching, more sessions had to be run along the course of a month in order to reach all participants, yet the sessions were evaluated well, and compliance rate hit 100% in the follow up audit. Even though the project was run in the midst of a pandemic all participants managed to engage in at least one clinical supervision activity showing a 100% compliance in the follow up audit, this also shows the importance of clinical supervision in it entirety[9]. Despite the fact that published research reports the lack of awareness of effective clinical supervision, when professionals are educated of it benefits, compliance to sessions increase, therefore overcoming the ongoing debate between the complex nature of clinical supervision and resistance by organizations[17,18]. Although the project team identified no sufficient documentation available to record clinical supervision activity, this was overcome by designing a record sheet to fit this purpose and therefore seen the highest of rise in compliance in the follow-up audit from 0% to 88% compliance. There has been little research conducted on clinical supervision within primary care

alone due the complex nature of primary care in terms of variety of team, staff members and organizational structure, yet the reported outcomes of this implementation project and other research conducted in other organization structures within healthcare[12-15] show that clinical supervision can be incorporated into the work environment with use of education and managerial support.

The evidence base implementation project has narrowed the gap between the stigma around the complexity of clinical supervision and its benefits within primary care. It has shown that with careful planning and consideration clinical supervision can be incorporated within a team environment in primary care. Even though this change can be difficult to accommodate and proves to be challenging at times the project team would therefore like to deliver all training sessions online with a recorded educational session for staff to access at they free will and for all staff to have access to the training for future reference and for new staff joining the team, the project team would also like to incorporate an evaluation to the session for feedback to be received. The project team has recognized a limitation of the project that the implementation of clinical supervision across the wider section of primary care is an issue at a broader organizational level, yet it is hopeful that the results from this implementation project show that the wider expansion of clinical supervision in primary care can be achieved. Despite this limitation the project team felt that the implementation project was a success and improved the quality of nursing care, by supporting the wellbeing of staff members within a team. It has shown the importance of evidence-based implementation projects in regard to upskilling nursing staff of their knowledge and expertise and integrated the best available evidence into nursing practice.

Conclusion

It is important to carry out clinical support to all healthcare workers that provide opportunities to develop and be listened to in a supervised environment, clinical supervision is seen as a key element to deliver this support as it provides a professional working relationship between two or more members of staff where the reflection of practice and personal emotion can be discussed.

This implementation project has successfully addressed its aims and objectives of achieving concordance to clinical supervision sessions within primary care and the improvement of knowledge regarding best practice through education sessions on clinical supervision. The gap between clinical supervision and the sustainability of the benefits of clinical supervision within primary care has been narrowed and it is hopeful that the implementation project can help address the wider expansion of clinical supervision in primary care. In the future the strategies adopted to incorporate clinical supervision within primary care will be sustained with more best practice projects for the future.

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Conflict of interest

There is no direct conflict of interest to declare for this project. An indirect conflict of interest might be seen in the fact that Dr. Klugar is the director of the Czech Republic Centre for Evidence-Based Healthcare: a JBI Centre of Excellence, and Dr. Klugarová is deputy director of this centre.

Dr. Judith Carrier is director of Wales Centre for Evidence Based Care - A JBI Centre of Excellence.

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