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Clinical supervision for the 21st Century sexual health nurse-is it fit for purpose?

Glasgow City HSCP Health and Social Care Partnership

SANDYFORD caring about sexual, reproductive and emotional health

NHS Greater Glasgow and Clyde

NHS Lothian

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Background: the experience of the sexual health nurse

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- Short, intense interactions
- Patient experiences of violence, shame, stigma, anxiety
- Increase in technical skills and responsibilities
- Focus on clinical supervision at national policy level
- Existing evidence on CS based on elderly care, mental health, ward based nursing

Aim of project

To develop an effective format for undertaking clinical supervision with sexual health nurses

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Methods

2 stage mixed methods sequential design

1. Online survey of all sexual health nurses in mainland Scotland (n=205)

2. Individual interviews with nurses and doctors working in Scottish NHS sexual health services

Definition of clinical supervision

“facilitation of support and learning for health care practitioners enabling safe, competent practice and the provision of support to individual professionals who may be working in stressful situations”

Pollock et al (2017)

Survey participants n=109 sexual health nurses (53%)

Characteristics	
Age	25-66 (median 48)
AfC band	
Band 5	14 (13%)
Band 6	70 (64%)
Band 7	22 (20%)
Band 8	3 (3%)
Experience in sexual health	0-35 years (median 11)
Receiving clinical supervision	**Yes** 61 (56%) **No** 47 (43%)
Line managed by supervisor	**Yes** 14 (13%) **No** 47 (43%)

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Manchester Clinical Supervision Scale: n=39/61 (64%) receiving CS

7 demographic and organisational factors:

- Age
- Agenda for change banding
- Length of sessions
- Time between sessions
- Whether supervisor chosen/allocated
- Design of sessions
- Location of clinical supervision

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7 demographic and organisational factors:

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- Length of sessions > an hour compared to ≤ an hour (p=0.049)
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- Length of sessions > an hour compared to ≤ an hour (p=0.049)
- Time between sessions ≥ monthly compared to ≤ 3 monthly (p=0.044)
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- Whether supervisor chosen/allocated
- Design of sessions individual +/- group vs group alone (p=0.002)
- Location of clinical supervision

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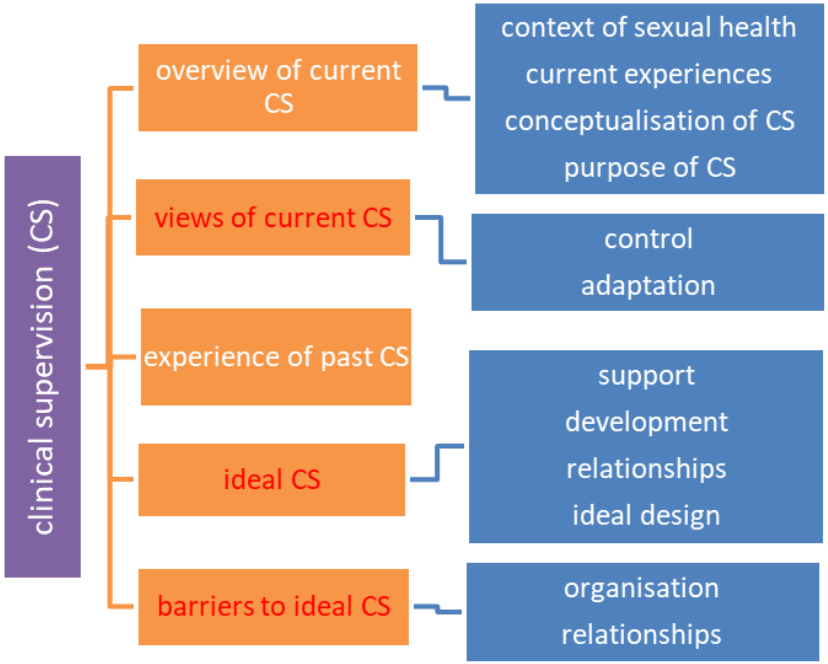
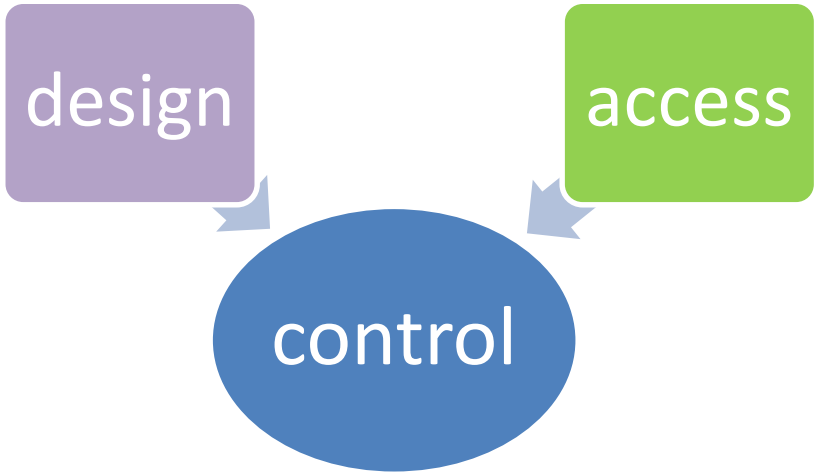
Interview participants

	Doctors n=6	Nurses n=11
Age range	21-40	31-60
Gender not stated		
Length of time in sexual health (years)	0-10	0->21
Health boards	2 (large)	6 (small, medium, large)
Type of CS	1-1 educational supervisor Clinical supervisors	1-1 1-1 and group Group with 1-1 option Group only
Supervised by	Senior doctors	Nurses –including line managers Counsellors Psychologists Peers

Interview results



Current clinical supervision



- Doctors-less control over design, more control over access to supervisor
- All doctors/most nurses derived some benefit from CS
- Nurses-most who were satisfied chose design of CS or supervisor
- Adaptations very common-proximal work relationships used

Control: access

So obviously I’ve got an educational supervisor, who is great, and who I can meet with fairly easily, or can speak to on the phone. So I could discuss clinical, you know, non-clinical but still related to work things with them

doctor#2

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Control: access

So unfortunately because it's clinical supervision it's not tailored to an individual, it's tailored to a time, I'm not getting very much supervision at the moment because if it's on a day that I'm not here or I don't work, I miss it.

nurse#2

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Ideal clinical supervision

Emotional support

Development

Relationship with supervisor

Ideal design

- Clarity of purpose
- Consistency of delivery
- Considerable but not exclusive support for groups
- Central role of trust and safety within groups
- Half of nurses wanted one to one option

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Ideal clinical supervision-consistency of delivery

But sometimes you don't want to be knocking on someone's door, you just want to say “Well, this is a time when we can discuss this.”

nurse #2

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Barriers to ideal clinical supervision

Organisational

- Resources (time)
- Ethos of organisation
- Managing urgent v regular clinical supervision

Relationships

- Quality of supervision
- Personal barriers relating to groups

Barriers to ideal supervision: relationships

because actually that's not just a task, there's an art to that, there's a skill around watching conversations, checking people are safe… That actually isn't just about task, task, task, task, it's about someone having the right qualities to kind of have an eye to that. And want to do it

nurse#6

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What this study adds

First study to address clinical supervision within context of sexual health nursing

Key findings emphasise

- The importance of control over design of CS
- Centrality of the relationship with the supervisor
- Balancing urgent need with regularity
- Inclusion of one to one option

Area of concern: only 56% respondents had CS even with wide definition

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Acknowledgements

- NHS sexual health nurses and doctors
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Going forward

- How to provide effective clinical supervision for sexual health nurses in a resource poor environment
- Evaluation of intervention- measures of effectiveness
- Other groups eg health care support workers

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Mean scores for Manchester Clinical Supervision Scale n=39

	Mean	S/D	Median	Mean as % of total score	Total possible score
Importance /value	15.1	3.2	15	75.5	20
Finding time	8.9	3.0	9.0	55.6	16
NORMATIVE	24	5.2	25	66.7	36
Trust/rapport	15.1	3.6	15	75.5	20
Supervisor advice/support	12.3	4.7	13	61.5	20
RESTORATIVE	27.5	7.5	29	68.8	40
Improved care/skills	10.4	3.9	11	65	16
Reflection	8.5	2.7	9.0	70.8	12
FORMATIVE	18.9	6.2	21	67.5	28
TOTAL MCSS	70.4	16.6	74	67.7	104

Supervision	N =39	MCSS Mean scores (standard deviation)							
		norm	p=	restor	p=	form	p=	total	p=
Length of sessions									
≤ 1 hour	19	22.3 (5.0)	**0.049**	27.7 (6.5)	0.860	19.2 (5.6)	0.763	69.2 (13.6)	0.680
> 1hour	20	25.6 (5.0)		27.3 (8.5)		18.6 (6.8)		71.5 (19.3)	
Time between sessions									
≤ 1 month	7	27.4 (4.3)	0.119	32 (8.4)	**0.044**	22.4 (5.5)	0.156	82.1 (15.2)	**0.044**
2-3 months	15	24 (5.7)		29 (5.7)		19.3 (5.5)		72 (14)	
> 3months	17	23 (4.8)		24 (7.6)		17.1 (6.7)		64 (17)	
Allocation of supervisor									
Allocated	34	24.4 (5.0)	0.358	27.3 (7.9)	0.545	18.8 (6.6)	0.590	70.4(17 .5)	0.951
Chosen	4	21.8 (7.3)		29.8 (3.8)		19.5 (1.0)		72 (11)	
Other	1 *								
Configuration of sessions									
Group	30	23 (5.0)	**0.027**	25.4(7.1)	**0.001**	17.6 (6.5)	**<0.001**	66 (15.9)	**0.002**
Individual + both	9	27.3 (4.7)		34.3 (4.2)		23.1 (2.3)		84.8 (9.1)	
Age									
Age ≤ 46	17	23.6 (5.4)	0.672	28.2 (7.2)	0.609	19.5 (5.9)	0.618	71.2 (16.2)	0.776
Age ≥47	22	24.3 (5.2)		26.9 (7.9)		18.5 (6.5)		69.7 (17.3)	
Agenda for change banding									
Band 5	6	27.8 (4.1)	**0.020**	32.5 (7.7)	0.208	22.8 (4.1)	0.206	83.2 (15.2)	0.086
Band 6	27	22.5 (4.7)		26.6 (7.6)		17.9 (6.3)		67.0 (15.7)	
Band 7 +	6	27 (5.9)		26.3 (5.8)		19.5 (6.7)		72.8 (17.9)	
Location of sessions									
Workplace	39	*not included in t-tests							
Outside	0								
Both	0								

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Manchester Clinical Supervision Scale domains and subscales (Proctor 1986)

formative	• Improved care/skills • reflection
normative	• Importance /value • Finding time
restorative	• Trust/rapport • Supervisor advice/support

Strengths and weaknesses

Strengths

- Interviewing doctors illuminated experiences of nurses
- Mixed methods- interviews gave depth to quantitative findings

Weaknesses

- No gender
- Staff grade doctors may have been closer to nurses in experience
- Multiple understandings of what clinical supervision is
- Only 39 completed MCSS scale
- Possible reluctance to take part- fear of disclosure?

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Overview of current CS

Circumstances of work

Sexual assault/child protection/+results/distress

vs

Routine “nobody’s going to die here”(nurse#5)

Context of sexual health

you have to very quickly develop a rapport with someone that's never met you until… to give you their deepest, darkest secrets that they've not even really admitted to themself - never mind anyone else. And then you examine them and then treat them and then get them out the door.

nurse#7

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Aim of project

To develop an effective format for undertaking clinical supervision with sexual health nurses

Outcomes

1. Key factors determining effective CS for sexual health nurses
2. An understanding of CS as experienced by sexual health nurses and doctors
3. Development of a pilot CS intervention for sexual health nurses

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adaptations

if I raised an issue, what I'm expecting others to say to me and what I'm expecting them to say to me, to help me with. I think it definitely has helped with that side of things. So even though obviously I've got the contract, it's a kind of… that's the norm.

nurse#8

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