Case Supervision Policy
for
Health Visitors, Public Health Nurses, School Nurses and Children's Nurses

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Contents

NHS SHETLAND DOCUMENT DEVELOPMENT COVERSHEET*

Name of document	**Case Supervision Policy for Health Visitors, Public Health Nurses, School Nurses and Paediatric Nurses**	
Registration Reference Number	**CSPOL008**	**New ☐ Review ☑**
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Executive Lead	Kate Kenmure	

Proposed groups to present document to:				
Child Health Team			ANMAC	
Joint Governance Group			Clinical Care and Professional Governance Committee	
Date	**Version**	**Group**	**Reason**	**Outcome**
16/02/2016	1	CHT	PO	PRO
04/04/2016	1	ANMAC	PO	PRO
03/05/2016	1	Joint Governance Group	C/S	PRO
17/05/2016	1	CCPGC	For final approval	Approved

Examples of reasons for presenting to the group	**Examples of outcomes following meeting**
• Professional input required re: content (PI)	• Significant changes to content required – refer to Executive Lead for guidance (SC)
• Professional opinion on content (PO)	• To amend content & re-submit to group (AC&R)
• General comments/suggestions (C/S)	• For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
• For information only (FIO)	• Recommend proceeding to next stage (PRO)

*To be attached to the document under development/review and presented to the group
Please record details of any changes made to the document on the back of this form

DATE	CHANGES MADE TO DOCUMENT

This Document must be read in conjunction with NHS Shetland Clinical Supervision Policy

1. Purpose

This document replaces the previous policy which is due for review. This refreshed policy must still be read in conjunction with NHS Shetland's Clinical Supervision Policy.

2. Introduction

The Nursing and Midwifery Council (NMC) requires that Nurses, Midwives and Allied Health Professionals (NMAHPs) undertake Reflective Practice and/ or Clinical Supervision to support continuing professional development (CPD) and the renewal of their professional registration (NMC 2014). Increasingly both Reflective Practice and Clinical Supervision are recognised as supportive approaches for Nurses and Health Visitors to enhance the delivery of NHS Scotland's Quality Ambitions of safe, effective and person-centred care (Scottish Government 2010).

Reflective Practice and Clinical Supervision are seen as approaches to enable nurses to reflect on aspects or events within their practice; to examine what happened, what was good or bad about the experience, what else could have been done and what could be changed or improved in practice as a result of this learning (NES 2014a).

Potential benefits of participating in Reflective Practice or Clinical Supervision:

- Improved team communication
- Opportunity for staff voices to heard and valued
- Finding solutions through effective team work
- Enhanced person-centred experience for patients and staff
- Contribution to CPD evidence for KSF and NMC Revalidation

3. Supervision

Supervision is a term used widely across health and social services and may describe quite different activities ranging from personal development through to management of staff, as well as case and clinical supervision. It can be performed individually or in groups and can be informal or formal. It can also focus on processes or outcomes and involve peers, students and line managers (Carpenter et al 2012). It is essential that staff understand the different functions and types of supervision available to them and this policy covers case supervision as distinct from other forms of supervision identified above. Case supervision therefore aims, to ensure that practitioners within the Child Health Team (CHT) are provided with an opportunity to reflect on practice and supported to provide the best possible response to children who are experiencing abuse or neglect or are vulnerable in any other way.

4. Definitions

Case supervision is the review of identified vulnerable children within an individual practitioner's caseload. It is undertaken at regular timetabled intervals, normally every 4-6 weeks. It includes supervisee presentations of clients at different stages of their care pathway and/or who have particular clinical characteristics. It is structured to enable efficient support and effective decision making by practitioners and their supervisor. The first priority of case supervision is to enhance and safeguard the delivery of effective care for the client. However, although case supervision also strives to optimize outcomes for clients, there is little evidence that any model of supervision has had any significant impact on outcomes for children and families. What case supervision does do is emphasize learning from clinical work with a view to promote professional development (Carpenter et al 2012). This, hopefully, promotes more confidence in practitioners. Case supervision is not about performance management and ensuring that organizational procedures have been followed as this is dealt with under Capability Procedures.

5. Background

Numerous serious case reviews have highlighted the need for effective case supervision to ensure safe, confident and competent practitioners. Research has also demonstrated that, by allowing practitioners the opportunity to reflect on their work in a positive, supportive environment, case supervision helps with the successful and consistent integration of processes into practice (Coventry LSBC 2013; Beach and Oates 2014).

NHS Shetland health professionals have had access to clinical supervision for some time and a need for more structured case supervision was recommended in the HMIE Report of 2009. This type of supervision includes a management responsibility to ensure safe practice.

6. Roles and Responsibilities

The roles and responsibilities of both the supervisee and supervisor are:

6.1 Supervisee

(i) be proactive in the selection of cases that will enhance their knowledge and skills

(ii) to arrange and participate in supervision sessions on a 4-6 weekly basis for one hour with their supervisor

(iii) prepare for the session by identifying any issues for discussion and exploration

(iv) implement any agreed actions and recommendations from supervision sessions

(v) give and receive constructive feedback

(vi) be active in pursuit of own professional development

(vii) maintain an appropriate record of supervision within the case records

6.2 Supervisor

(i) Promote an open, supportive and respectful working relationship

(ii) Ensure confidentiality except where the supervisee demonstrates poor or dangerous practice. This must be investigated under the NHS Shetland Capability Procedures with reference to the NMC code (2015).

(iii) Give constructive feedback sensitive to their level of training and expertise

(iv) Ensure environment is free from disturbance, quiet and private and that confidentiality is maintained unless an issue requires attention outside the supervision relationship such as safeguarding or unsafe practice.

7. PREVENT *Playing Our Part: Implementing the Prevent Strategy*

The Counter-Terrorism and Security Act 2015 places a duty on the NHS, to have, "*due regard to the need to prevent people from being drawn into terrorism*", this also applies to the Police, Local Authorities and Further and Higher Education. CONTEST is the UK Government's counter-terrorism strategy of which The *Prevent* Strategy, is one strand. ***Prevent:*** **to stop people becoming terrorists or supporting violent extremism.**

We as NHS staff have valuable experience in protecting vulnerable people, and this places Health Boards in a key supportive position. All staff need a general awareness of *Prevent* and to feel ready to deal with concerns when they arise. Vigilance and early intervention, together with an understanding within the NHS of the risks and threats, is paramount.

Mitigation – Local Protocol

To mitigate the risks posed to NHS staff:

Staff training:

7.1 Ensure that all staff have access to training and information and an awareness of Prevent concerns through inclusion in induction/mandatory refresher/access to on-line resources – web-link?

7.2 All staff should know how to raise a concern:

- Discuss in the first instance with line manager,
- Line manager's action will depend upon concern raised but will want out **check** out the concern and **share** appropriately.
- Sources of advice are NHS Shetland: wendy.hatrick@nhs.net, Public Health Specialist and janice.irvine@nhs.net, Advanced Practitioner (Protection)

7.3 Ensure front-line staff have access to suitable training and should know how to raise a professional concern in relation to a young person:

- Discuss a Prevent related concern with line manager/Child's named person or within case supervision session.
- Use Getting It Right For Every Child (GIRFEC) interagency screening meeting or make a child protection referral to the duty social worker

- Following an interagency discussion a plan will be formulated to assist chid or young person and their family

Venues Premises and Publicity

7.4 Ensuring that NHS owned facilities/buildings are not used for meetings/activities or for issuing propaganda that support radicalisation. In agreeing the use of Board facilities for meetings:

- Staff should understand the nature of the meeting and be alert to possible issues of a radical nature or behaviours likely to raise a concern.

7.5 Board sanctioned publicity via social media or web pages do not provide a platform for extremists/dissemination of extremist views

Policies and Procedures

7.6 Policy and Procedures which relate to Board business relevant to Prevent concerns will be updated to include this information relevant to the individual policy/procedure and practice, for example Child and Adult Protection procedures.

7.7 Any events / incidents and risks about PREVENT concerns should be recorded using the Board's risk register and adverse events procedure using DATIX.

We are all responsible for ensuring existing arrangements for protecting vulnerable adults and children, and use of NHS buildings and facilities, are adapted as necessary so that *Prevent* is mainstreamed and embedded into frontline healthcare services.

8. Cases suitable for discussion

Cases taken to supervision by members of the CHT are chosen by the supervisee but would normally have been allocated “Additional” HPI (SG 2011).

8.1 supervision sessions will follow a structured format in which the supervisee will bring the records of cases to be discussed to the session.

8.2 Both the supervisor and supervisee will record a brief synopsis of the discussion and store this at the rear of the child’s records.

8.3 An evaluation form including specific concerns, a critical analysis of the management of the case and an action plan for future use, will be completed and retained by the supervisee (Appendix i).

8.4 A record of supervision sessions will be completed and retained by the supervisor (Appendix ii).

8.5 If during a supervision session, it becomes evident that serious misconduct has arisen, the supervisor will end the session and report her concerns to the Child and Family Health Manager. The supervisor will also notify the supervisee’s line manager informing them of the concerns and allowing them to take appropriate action. In line with HR policy, the outcome of any investigation will be shared with the supervisee.

9. Audit

Audit of supervision processes (Appendix iii) will be held at least on an annual basis and the results communicated to the Family Health Manager.

References and Bibliography

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Appendix i

Evaluation of Case Supervision

To be completed and retained by Supervisee

Date of supervision session:

Synopsis of case review including CHI numbers:

Expressed concerns (including action I have taken):

Critical evaluation of involvement (what I have learned):

Future Actions (what I would do differently including identifying learning needs):

Signature of Supervisee and date:

Record of Supervision Sessions Appendix **ii**

(To be completed and retained by Supervisor)

Date	Case Discussed	Future Actions	Date of Next Supervision

Case Supervision Audit **Appendix iii**

To ensure that a high quality of case supervision takes place within NHS Shetland, we would appreciate it if you could answer the following questions. Please tick the most appropriate box for each question. All questionnaires are confidential and anonymous.

General

Q1 Grade

□ HCSW □ Band 5 □ Band 6 □ Band 7

Q2 Have you read the Case Supervision Policy?

□ Yes □No (please go to Q4)

Q3 a) Did you find the Case Supervision Policy easy to read?

□Yes □ No

b) Do you understand the content of Case Supervision Policy?

□ Yes □ No

c) Does the Case Supervision Policy contain all the information you need?

□ Yes □ No

d) Do you find the Case Supervision Policy helpful?

□ Yes □ No

Sessions

Q4 How often are your case supervision sessions usually held? Every___ weeks

Q5 On the whole, are you satisfied with how often your supervision sessions are held?

□ No, held too often □ Yes, right amount □ no, not held often enough

Q6 Which of the environmental aspects are usually adhered to during your supervision session?

□ Free from disturbance □ Quiet □ Private

Q7 Do you think your case supervision sessions are confidential?

□ Yes □ No

Q8 Do you make a record of your supervision session?

□ Yes □ No

Q9 As a supervisee, do you feel able to give honest feedback to your supervisor?

□ Yes □ No

Quality

Q10 How beneficial do you find your supervision session?

□ Very beneficial □ Beneficial □ Slightly beneficial □ Not beneficial

Q11 Does the supervision cover the following areas? *(Please tick all that apply)*

□ Support □ Professional responsibilities □ Career developments

□ Reflection on clinical practice □ Regular feedback

Q12 If you have any other comments regarding case supervision, please write them below:

Please send your completed questionnaire to:

Clare Stiles, Team Leader, Child Health, Gilbert Bain Hospital.