Family Nursing & Home Care

Restorative Supervision Policy:

Clinical and Safeguarding

December 2022

Document Profile

Document Registration	Added following ratification
Type	Policy and procedure
Title	Restorative Supervision Policy: Safeguarding and Clinical
Authors	Dr Julie Luscombe (external) Jenny Querns, Safeguarding Lead Justine Bell, Head of Education and Development
Category clinical / corporate / education / Health & Safety / HR / Info Governance	Procedural document for clinical and safeguarding supervision
Description	Outlines the rationale and process for clinical staff to undertake safeguarding and clinical supervision in support of continued improved outcomes for the adults and children under FNHC care.
Approval Route	Organisational Governance Approval Group
Approved by	Organisational Governance Approval Group
Date approved	December 8 2022
Review date	January 2026
Document Status	This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Version control / changes made

Date	Version	Summary of changes made	Author
28.11.22	1	New policy superceding previous Supervision Policy and Safeguarding Restorative Supervision	Julie Luscombe Jenny Querns Justine Bell

Contents

1. INTRODUCTION

1.1 Rationale

Family Nursing & Home Care (FNHC) consists of a range of diverse teams and professionals all of whom are committed to providing high quality and safe care for the individuals and families who use our services. The implementation of a combined supervision model forms part of the clinical governance process to promote improved outcomes through the continued professional development, support and supervision of a highly competent, patient focused, experienced and resourceful staff group. This commitment is reflected in the strategic priorities outlined in the FNHC Impact Report (2021) which states that *"We will provide clinical and safeguarding supervision that is underpinned by best practice".*

The chosen model for the theoretical and practical framework for delivering supervision within FNHC is Restorative Resilience Supervision. The overarching framework encompasses Restorative Resilience Clinical Supervision (RRCS) and Safeguarding Restorative Supervision (SRS).

RRCS is a form of clinical supervision built on a strong evidence base that supports individuals or groups of professionals to process and develop their broad work experiences with a trained colleague through use of tools and frameworks that enable them to restore their capacity to think clearly, make rational decisions and maintain an effective relationship with their work. The focus is on the professional rather than the cases they are managing with the underpinning assumption that a supported professional is an effective professional.

SRS is an extension of the model which combines the restorative resilience aspect of clinical supervision with the 4 x 4 model of safeguarding supervision. Here the focus shifts to the client or cases the professional is managing. The process continues to involve a trained supervisor colleague facilitating a safe, analytical and supportive space for reflection on practice using evidence based tools and frameworks.
SRS focuses on the care provided by practitioners to children, young people and adults at risk, their carers and families with the overarching aim of enabling families to reduce risks and increase their safety.

Although the two approaches differ in focus and recording requirements they encompass the same core skills and tools. Therefore, the body of this policy refers to the generic philosophy, process, procedure and skills required to implement supervision. Detailed guidance and associated paperwork for each approach is presented in a separate toolkit (Appendices 1 & 2).

The Jersey Care Commission Standards for Home Care (JCC 2022) stipulate that organisations should "ensure that workers receive appropriate training, professional development, supervision and appraisal to enable them to provide care and treatment to care receivers to a safe and appropriate standard".

Whilst this standard could arguably be achieved by offering managerial supervision alone, FNHC have taken account of the evidence base that determines that patient outcomes and staff retention is improved when supervision approaches focus on structured facilitated processes that allow in depth reflection on practice.

This supports and maintains resilience plus develops the decision making, autonomy and problem-solving capacity of the professional. A staff group that feels supported in a culture of constructive challenge is more able to act on risk appropriately as well as improving the quality of the care or intervention they are delivering.

In addition, safeguarding children, young people and adults at risk of harm and abuse is a FNHC priority. FNHC have an established culture where safeguarding supervision is embedded in practice. High quality supervision is viewed as a "fundamental cornerstone" to best practice (Laming 2003, Safeguarding Partnership Board, 2022). Safeguarding supervision that has an added level of restoration provides balance to the process by supporting and enabling staff to use the critical thinking skills required for safe practice (Wonnacott and Wallbank, 2015).

1.2 Scope

The term 'staff' is used to describe all of those who care for patients/clients regardless of whether or not they have a professional health care qualification and who are on permanent or fixed term contracts or who have been seconded to FNHC from Health and Community Services.

The policy and process described does not replace the ongoing managerial supervision and case management that takes place as part of normal professional practice and consultation. The policy supplements the established approaches that are already required by some teams within FNHC (eg. MESCH, Baby Steps) and the trauma informed debriefing system.

1.3 Role and Responsibilities

Chief Executive Officer (CEO) and Board of Trustees

- Recognition of restorative supervision is an organisational priority in pursuit of the charitable strategic objectives with subsequent allocation of resources to achieve this

Director of Governance and Care

- Ensuring systems and processes are in place to allow staff access to supervision from appropriately trained supervisors as described in this policy
- Co-ordination of annual audit reports monitoring compliance and quality of experience plus interim governance reports as required
- Acting on findings from evaluation and audit reports

Safeguarding Lead and Head of Education

- Managing the register of supervisors for each approach
- Ensuring staff who require supervision have an allocated and suitably trained supervisor on appointment to FNHC
- Supporting the development and delivery of all levels of training to support this policy
- Ongoing support and training of supervisors and supervisees as required
- Monitoring and evaluation of reports focusing on uptake and quality of experience

- In accordance with the Safeguarding Partnership Board, complete an annual SRS audit reporting to Director of Governance and Care

Registered Managers and Team Leaders

- Ensuring their staff are fully aware of the policy and the expectation to incorporate supervision as a core element of professional practice
- Organising work plans and work structures to facilitate attendance to deliver or receive supervision sessions or attending designated relevant training
- Role modelling good practice in delivering supervision and accessing it
- Manage non-attendance during managerial supervision if required

Clinical supervisors and supervisees

- Supervisors and supervisees will have clearly defined responsibilities and associated competencies which are covered during the training. These are outlined in the toolkit for each approach (Appendices 1-3).

2. POLICY

The aim of this policy is to provide a robust evidence-based framework with associated guidance and toolkits to support a staff group to feel:

- Confident and supported in acting on and managing risk with vulnerable children or adults
- Able to communicate effectively across professions, resolve professional differences of opinion and escalate effectively as appropriate
- Confident in their critical reasoning, decision making and problem solving skills when faced with practice challenges and safeguarding concerns
- Able to constructively and safely challenge themselves and their colleagues through in depth structured reflection on practice

Meeting these aims will contribute to the continued delivery of high quality care and improved outcomes for all who receive FNHC services and will also contribute to the retention of the workforce.

2.1 Policy Principles

Restorative supervision approaches are aimed at benefitting the workforce and those who use the services. The restorative nature of sessions is essential to support the professional in their capacity to think, reflect and develop solution focused action plans for themselves and those in their care. In addition, it should encompass the following principles:

- The promotion of safe and evidence based care
- Be supervisee led not managerial led
- Facilitate personal and professional growth
- Include positive challenge
- Structured and facilitated to ensure time for reflection

3 PROCEDURE

Staff are expected to access both RRCS and SRS on a quarterly basis providing them with eight structured supervision sessions with an appropriately trained supervisor within a 12 month period. This is expected to be prioritised and diarised as an essential part of professional practice that supports improved patient outcomes. Meetings should be scheduled in a manner that considers each involved party and the commitments of their professional roles and their service areas.

All supervisors within FNHC will meet agreed criteria; either holding a managerial position or have been identified by a line manager as someone with the required skills and experience to fulfill the role. All supervisors are required to have received training on the Restorative Supervision approach before they can supervise colleagues. They will all receive a toolkit (Appendices 1 & 2) which will be supplemented by quarterly CPD sessions for peer support and dissemination of new evidence.

Those who are not supervising others will receive training on how to maximise the benefit of the sessions as a supervisee. New staff will be offered training on induction either as supervisor or supervisee depending on their role with an accompanying toolkit.

3.1 Supervision process

The process that underpins both RRCS and SRS is structured reflection facilitated by a trained supervisor using a range of evidence based tools depending on the needs of the supervisee and which approach is being accessed. However, the core skills for each approach are developed in the training package and include:

- Reflective practice
- Emotional containment
- Stress management
- Resilience training
- Action learning
- Coaching skills

The dominant form of supervision within FNHC will be individual. However, group supervision may occur if identified as a need; in which case an experienced facilitator will be made available. External supervision will be available for issues whereby no suitable supervisors can be found within the organisation. Multi-Agency Reflective Supervision (MARS) will be used where cases are stuck, there is drift or delay (MARS, SPB 2022).

3.2 Supervision working agreement

Understanding the responsibilities as a supervisor or supervisee is an important first step in establishing an effective supervisory relationship.
A working agreement for each supervision relationship should be formally documented outlining the supervisor and supervisee details, commencement date, review date, frequency and duration of supervision and a statement regarding the confidentiality agreement, all of which should be signed and dated with a copy kept by both parties. The template for the working agreements are contained in Appendices 1 & 2.

3.3 Confidentiality

For supervision to be effective the supervisee must feel safe and that any issues reflected upon within a session will be aired and shared in confidence. As with all health professionals there is a legal duty of care as per the appropriate regulatory body that may override confidentiality in exceptional circumstances such as:

- Concerns for the wellbeing of the supervisee.
- Concerns raised regarding safeguarding
- Where a training need is identified that requires action from a line manager
- Unsafe or unethical practice is revealed.
- Illegal activity is revealed

Regardless of circumstance, if either party deems confidentiality is required to be broken, organisational process will be followed. The supervisor/supervisee will agree the need to share information as necessary. Both parties should be aware of this at the close of the supervision session unless there is circumstance whereby either person wishes to discuss a concern without the other party being aware. Any conduct considered unprofessional by either party must be reported to the Director of Governance of Care.

Information and/or documentation that records or relates to confidential information shared during supervision may be accessed by third parties in some circumstances; for example if required by a search warrant, in disclosure requirements of a criminal case or under the Coroner's order.

3.4 Venue

The venue for supervision should be agreed in advance of the meeting. Every effort should be taken to find a confidential, safe environment where interruptions can be minimised.

3.5 Ceasing the supervision agreement

It is good practice to change supervisor after a period of time to benefit from alternative perspectives. It may also be possible that a supervision relationship is no longer productive for a variety of reasons and either or both parties may wish to disengage. Each working agreement should have a review date of one year when this discussion can take place. Confidentiality should be recognised and maintained after cessation. An alternative supervisor will be identified.

3.6 Procedure for cancelling meetings

As supervision should be diarised as a core element of professional practice, there has to be exceptional circumstances for either party to cancel a booked session. The party requiring to cancel must make every effort to speak in person to the other party at the earliest opportunity to rearrange an alternative date. The reason for cancellation will be discussed in the subsequent session. Although cancellations should be rare, if there is a pattern of cancellations, the supervisor can support the supervisee to address the reason for this. Support will also be made available to the supervisor if they are needing to cancel to manage this.

3.7 Supervision record notes

3.7.1 Restorative Resilience Clinical Supervision

For audit purposes, basic records as to time and date should be kept demonstrating that clinical supervision has taken place. The supervisor is responsible for informing the Education and Development department the dates they have delivered supervision to ensure Assure records are updated.

The supervisee should decide whether or not they wish to keep personal reflective notes as to the content and action plan. These can then be used for professional revalidation purposes. The responsibility for action and for storing those notes lies with the supervisee.

3.7.2 Safeguarding Restorative Supervision

Outside of safeguarding supervision sessions staff must share concerns as soon as possible with their line manager, safeguarding or operational lead and not wait for a quarterly supervision session. Consultative SRS is made available for cases which require bespoke safeguarding supervision. Any discussion that contributes to decision-making needs to be recorded using the Safeguarding Supervision Action Plan Template on EMIS.

Within supervision sessions, there should be an assessment of risk and an opportunity for restorative reflections. A record of supervision on EMIS should be documented using the Safeguarding Supervision Action Plan Templates with a review date dependent on risk to determine outcomes. A variety of evidence based tools to support the process are contained in Appendix 2.

The analysis of the case will be stored off record. The supervisee and supervisor will hold a copy of the supervision record to act as an aide memoire at the next supervision session.

All the 'off client' required documentation is located in Appendix 2, a copy of which should be kept by the supervisor and supervisee. This includes:

- Five point questionnaire
- Reflective framework
- Evidence based tools for use depending on relevance to case under discussion

Cases which stabilise or come to a natural end will close to supervision. Where there are professional differences of opinion or a case discussion requires escalation, the organisational and SPB process for Professional Difference/Escalation (SPB 2022) will be followed.

3.8 Training and support

3.8.1 Supervisors

The training of supervisors is a prerequisite to implementing restorative supervision. The training consists of one full day with an appropriately trained facilitator with a supporting video for the practicalities of each approach. Quarterly continuing professional development sessions will be offered to supervisors to provide new tools, update the evidence base and offer an opportunity for peer supervisor support.

3.8.2 Supervisees

Supervisees will receive a maximum of half day training consisting of an abbreviated version of the training for supervisors with a focus on benefits, policy, process, roles, responsibilities and making the most of supervision.

4 CONSULTATION PROCESS

Name	Title	Date
Rosemarie Finlay	Chief Executive Officer	Between 01.11.22 & 21.11.22
Tia Hall	Registered Managers District Nursing Service	As above
Michelle Cummings	Registered Manager Child and Family Services	As above
Terri O'Connor	Registered Manager Home Care Services	As above
Claire White	Director of Governance and Care	As above
Mo de Gruchy	Quality and Performance Development Nurse	As above
Elspeth Snowie	Head of Quality and Safety	As above

5 IMPLEMENTATION PLAN

Action	Responsible Person	Planned timeline
Policy ratification following consultation	Justine Bell and Jenny Querns	December 2022
Training for supervisors	Julie Luscombe, Justine Bell	February & April 2023
Training for supervisees	Julie Luscombe, Justine Bell	March & April 2023

6 MONITORING COMPLIANCE & EVALUATION

A 'real time' continuous audit will occur whereby an audit form must be completed by the supervisor/supervisee following all supervision sessions and entered onto ASSURE. This audit will demonstrate the level of engagement with supervision by staff who deliver clinical care to service users. The findings will be used to inform revision to the procedural document and identify areas for improvement.

The quality of the supervision experience will be measured separately at the end of each 12 month period following the ratification of this policy using an agreed evaluation framework (Appendix 4).

7 EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds (Appendix 5).

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

Always:

Putting patients first
Keeping people safe
Have courage and commitment to do the right thing
Be accountable, take responsibility and own your actions
Listen actively
Check for understanding when you communicate
Be respectful and treat people with dignity
Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times.

8 REFERENCES

Family Nursing and Home Care (2021) Start Well, Live Well, Age Well: Impact Report.

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Research in Practice for Adults (RIPFA) (2019) Embedding supervision https://www.researchinpractice.org.uk/adults/
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Wallbank S (2012) The Restorative Resilience Model of Supervision: A reader exploring resilience to workplace stress in health and social care professionals, Pavilion Publishing: UK

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APPENDIX 1

Restorative Resilience Clinical Supervision Toolkit

Supporting application to practice

To be used in conjunction with the Restorative Supervision Policy

1. Introduction

This toolkit is to be used as a companion to the Restorative Supervision Policy and restorative resilience supervision training. It is specifically for use for the Restorative Resilience Clinical Supervision approach (RRCS). Here you will find guidance for the process of facilitating supervision and tools you can use within your sessions to support your staff in developing a greater awareness of their practice.

Your aim as a *clinical* supervisor is to support your colleagues in developing their practice through focusing on the three functions of supervision: normative (standards/quality), formative (development) and supportive (restorative).

Please note that this is a controlled document and whilst it can be printed for personal use, new tools will be added as new information becomes available. The current version should always be accessed online.

2. The restorative resilience model of clinical supervision

RRCS is a form of clinical supervision built on a strong evidence base that supports individuals or groups of professionals to process their broad work experiences with a trained colleague through use of tools and frameworks that enable them to restore their capacity to think clearly, make rational decisions and maintain an effective relationship with their work. The focus is on the professional rather than the cases they are managing with the underpinning assumption that a supported professional is an effective professional.

Evidence shows that the thinking and psychological state of the supervisee will influence their needs during the session. Dr Sonya Wallbank developed the process model (zones) to describe the predominant states that supervisees tend to come into supervision with and matched the skills and tools that will support supervisees in finding the right approach to maximise the benefit of the session. These zones are covered in detail in the training programme.

For example, if someone is in the 'no' or 'why' zone as outlined in the training, and you try to use coaching techniques, you are unlikely to have a productive session. Instead, the skills of emotional containment and zones of influence are likely to be of more use. A reminder of the zones is presented below against the core skills.

The core skills within the approach include:

- Reflective Practice: for use in all zones
- Emotional Containment: ‘no zone’, ‘why zone’ (impacted productivity, high stress)
- Stress Management: ‘no zone’ ‘why zone’ (impacted productivity, high stress)
- Resilience Training: ‘why zone’ (feelings of overwhelm, productivity impacted)
- Action Learning: ‘I’ zone (wanting to learn and enhance practice, high productivity)
- Coaching skills: ‘we’ zone (high energy, creative and energetic, high productivity)

3. The Process

3.1 The Supervisory Relationship

The relationship between you and the supervisee is your most valuable tool for supervision. No matter how experienced the supervisor or how willing the supervisee if the relationship is not good, it is unlikely to be effective. Being clear on roles, responsibilities and contracting for the supervision experience will create a boundaried and effective partnership.

3.2 Roles and Responsibilities

The role of a clinical supervisor is a skilled and responsible one which involves supporting the quality of work carried out by your supervisee, helping them to explore their professional development needs and providing a safe place for exploration of their practice.
Your role is also to motivate and empower supervisees to take responsibility for being the other half of this partnership to ensure the experience is both meaningful and impactful. Specifically you are expected to:

- Agree a contract with your supervisee and agree a time to review
- Prepare for each session psychologically and practically to ensure you can fully engage with your supervisee
- Maintain boundaries, being clear about confidentiality limitations and creation of a safe space for exploration of practice, managing the agreed time
- Understand the functions of supervision and how the psychological state of a supervisee will influence how they approach supervision and choose an appropriate approach to use
- Use appropriate tools (reflective models, discussion springboards) to facilitate awareness in your supervisees
- Adhere to the reporting requirements outlined in the restorative supervision policy
- Signpost to appropriate practitioners or services if there are concerns about the health or performance of the practitioner in partnership with the supervisee and their line manager

3.3 Clinical supervision contract template

This agreement is between xxx (Supervisor) and xxx “Supervisee”. Both parties agree to the following:

We agree to meet quarterly for one hour at a pre agreed time and venue for a period of one year to:

- Reflect on identified practice issues (these may be clinical, professional or relational)
- Discuss current problems/concerns
- Explore areas for improvement or for replication of good practice
- Explore areas for learning and/or skills development
- Proactively work to find solutions and plan for further action

We are working within the restorative resilience clinical supervision model and will at times use tools to explore issues in more depth.

The content of the sessions will be kept confidential except when there are concerns about the safety or wellbeing of patients or a member of staff, concerns about professional practice or anything which may be deemed detrimental to the organisation in which case we will both agree an escalation process to the most appropriate person.

A record of attendance will be kept for monitoring and audit purposes. Minimal records will be kept by the supervisor. The supervisee is responsible for keeping any more detailed notes in support of their appraisal and/or portfolio.

The supervisor agrees to:

- Finding a suitable venue and ensuring it is free from distractions and interruptions
- Listen actively and use reflective models or other tools to support critical reflection on practice
- Offer supportive challenge and constructive feedback to help you improve practice when required

The supervisee agrees to:

- Come prepared with an issue from practice they would like to discuss
- Arrive on time, actively participate in problem solving and reflection on the issue
- Be open to feedback, change and consideration of alternative methods of practice
- Take any agreed action following the session

We both agree that regular supervision is a core part of professional practice and should be cancelled only in the case of illness or a crisis. If a session is cancelled, a new date must be agreed as soon as possible.

4 Signed.....
Signed.....
Agreed review date.....

4. Documentation templates

The following forms and templates are presented for supervisors:

- During the supervision session
- Following the supervision session

4.1 Suggested structure of a supervision session

A really simple structure works well to get a session started and keep it flowing. In truth, you cannot go far wrong if all you do is listen actively and encourage a reflective focus to your discussion. However, it can be helpful to think of a format for a clinical supervison session as a three step process.

Firstly, don't forget the basics in terms of 'checking in' with the supervisee. If they (or you) have had a particularly busy day so far, you might just need a couple of minutes to just acknowledge that and breathe!

Step 1:

- What is going on for you at the moment?
- What are you bringing today/would like to discuss today?

This step is in essence a mini contract because whatever the supervisee brings, you need to agree on the focus and the desired outcome. That might not be immediately obvious and you need to get a balance between letting the supervisee offload but also giving space for the opportunity to reflect and focus on what is actually going on. The key skill here is attentive, focused, active listening.

Step 2:

- How shall we divide the time today?
- The work! Use of reflection and/or tools to work through an issue

Step 3:

- What do you feel now about what we worked on today?
- What are you now taking away?
- What are your next steps?

The bulk of the session should ideally be taken up by step 2 but ensure you leave 10 minutes leading up to the end of the hour to ensure there is time to wrap up and agree actions before next time.

There is nothing more effective than a good conversation using active listening, open questions and problem solving. However, sometimes we may need to use different techniques to start off the process or to help the supervisee explore an issue in more depth.
These tools are for you to use as you see appropriate depending on the situation.

4.2 Emotional Touchpoints

A very simple tool to start a conversation if a supervisee is stuck for an issue to discuss is to use 'emotional touchpoints'. Ask your supervisee to think of a recent time in practice when they felt:

- Frustrated?
- Proud?
- Under prepared?
- Validated?

Use their answer to explore what was happening for them that made them feel that way. What was going on? What can they learn from this?

Alternatively, you could prepare some cards that name emotions and lay them out on a table. Ask the supervisee to pick one or more that most accurately reflects how they are currently feeling. Explore with them what is influencing this?

Some people find it easier to use pictures to link into emotions experienced to practice. Consider investing in a set of Evoke Cards or a set of postcards with different pictures on.

4.3 Steps to emotional containment

For use when a supervisee is presenting in the 'no' or 'why' zone of the process model.

Step 1: Check your own capacity to think
A fundamental aspect of being a supervisor is ensuring that you are feeling resilient yourself before a supervision session. You may be experiencing a moment of 'no' or 'why' zones as we all do but you must feel able to manage your own reactions to events and to think clearly. Ensure you have your own support system around you and attend your own supervision.

Step 2: Ensure that your physical environment supports containment
Consider where you are going to have the meeting/session. Is the venue at the right temperature, free from distractions or interruptions? These things may seem small but can heighten strong emotions if they are already present.

Step 3: Be aware of your own body language
This ensures you are able to manage your own communication without disrupting the flow of the session. You want to engage and be an active listener but you do need to be mindful of your reactions to what you are being told.

Step 4: Actively listen to the story and re-validate what you are hearing
It is so powerful to know you are being heard or what you are experiencing is being acknowledged. This is where your nursing communication skills come in. Using open ended questions, validating and supporting, reflecting back how they are feeling engages you in listening well and leads to the supervisee feeling valued and heard.

Step 5: Remember the importance of silence
When we describe something we find difficult or uncomfortable, we are often not able to tell a story in a logical or coherant way, especially if it upsets us. Give your supervisee space and time to process and hear what they are saying for themselves without feeling the need to fill every silence. That extra few seconds (even if it feels longer) often reveals information that

you could have talked over and lost. Silence can also work to enable your supervisee to process their responses to your questions. Think about how much speaking you do in a session. Although there is no hard and fast rule, remember that this is their supervision session and their experience should feature largely in it.

Step 6: Normalise
Let your supervisee know how often you hear about the difficulties of others (without breaking confidentiality) and reassure them that they are not alone. Professionals often need to present an exterior image of competence to show the world they have control. This means they often think they are the only person experiencing difficulties. Reflecting to them that it is a usual and normal reaction to their work can be very useful in breaking down barriers between you and helping them relax.

Step 7: Only ever offer small doses of advice, disclosure or solution
The role of supervisor can infer a sense of authority and being aware of that power balance is crucial if someone is to be an effective supervisor. Suspending your 'inner expert' and taking on the role of listener can be a difficult one to balance. Depending on the personality of your supervisee, they just look to you to be told what to do. However this is not the best form of learning. This does not mean you should never offer advice, guidance or examples of your experience, just think carefully about doing so and only offer small amounts.

Step 8: Stop
The boundaries of the session are crucial if it is going to be a containing experience. You will often find that you have had a productive session and are just about to end when the supervisee brings up something important. Sticking to your timed session ensures that you do not begin to explore something that the supervisee had not intended, even if you are curious to find out more. Explain that you will be able to explore this more in the next session.

4.4 Sample Reflective Model

There is no 'one size fits all' reflective model and there are many available so the choice you make will depend on your own personal preference, how your supervisee works and perhaps the issue they are bringing to discuss. When you choose a reflective model, you may need to consider:

- The needs of your supervisee
- The scenario they are bringing
- Their familiarity with the process
- Your own comfort and experience with the use of the model
- Adapting the questions so that they sound like YOU!

They all draw from experiential learning theory with the aim of identifying learning from practice and actions to take forward. Examples of reflective models you may want to explore include Gibbs experiential learning cycle , Driscoll (the ‘what’ model) and Johns Reflective Practitioner model based on Carper’s ways of knowing. You may be familiar with or decide to choose any of those. However, in this toolkit, we are presenting the model utilised within the clinical supervision training: Stephenson and Holm.

4.4. Stephenson and Holm reflective model

Holm and Stephenson suggest a series of prompt questions to ask yourself or your supervisee when you reflect on a situation. Not all questions will be appropriate in all situations, and you may feel the need to ask some questions more than once at different points in your session. Ask the supervisee to consider the following:

- What was my role in this situation?
- Did I feel comfortable or uncomfortable? Why?
- What actions did I take?
- How did I, and others, act? Was it appropriate?

- How could I have improved the situation for myself, the patient, colleagues or family?
- Did I expect anything different to happen? What and why? Has it changed my way of thinking in any way?
- What can I change in the future?
- Do I feel as if I have learnt anything new about myself?
- What knowledge from theory and research can I apply to this situation?
- Is there anything else I need to do/learn about to better manage this situation in the future?

4.5 Circle of Control

As humans we spend a lot of psychological energy worrying about things that are out of our control. The zone of influence tool is a powerful visual way of helping a supervisee who may be in the 'no' or 'why' zone in a situation where they may feel frustrated, disempowered or stuck. It can support them to understand:

- What they actually have control over
- What they could influence
- What they cannot directly influence and perhaps need to let concerns go or change how they react or think about them

You will have been given a handout on the training but in the absence of that, draw three circles on a piece of blank paper and adapt the dialogue below to your own style.

- Imagine this sheet of paper and three circles represents your work situation/frustrations.
- The inner circle is what you can directly control (the zone of control), the middle circle is what you cannot control but perhaps can influence and the outer circle is what you are unable to influence.
- Often we focus on the wrong thing. If we invest energy outside of our zone of power or on what we can't control, our zone of power will seem really small
- Ask them to fill in the blank circles with all the concerns they have and map them against what they can control, what they cannot control but could perhaps influence and what they have no control over.
- Then explore this with the supervisee. What could they do about this situation? Is there anything they can control or influence? If not, could they consider either putting it aside or changing how they respond to the situation?

4.3 Prioritising to support resilience

One of the most common themes discussed in clinical supervision is a feeling of overwhelm due to an ever increasing workload and competing priorities. It is true that time is a finite commodity but there are things we can do to focus and prioritise to allow more headspace to think clearly, rationally and make better decisions.

The prioritisation grid (Eisenhower grid) can help supervisees work out what is important and eliminate or delegate that which isn't or could be done better by someone else.
Ask your supervisee to brainstorm their 'to do' list onto the grid (example below but you can draw this).

Urgent and Important	Important but not urgent
Urgent but not important	Not important, not urgent

Ask them the following questions:

- Talk through which quadrant you are working in most often and explore why this is
- Focus on the top right hand box. These tend to be activities that are very important but keep getting knocked down the 'to do' list by the activities on the left of the grid.
- What happens if they do not spend time on the activities in the top right hand box? The answer is usually that they then become urgent and have knock on effects on the team, colleagues etc
- What can they do here to plan some time in on these activities to stop them becoming urgent?
- What on their grid could they delegate?
- What could they eliminate if it is neither urgent or important?
- How can they use time blocking in their diary and protect that to ensure priority work is completed?

5. Reflecting on your experience as a supervisor

Remember that being a supervisor is both a gift and a learning experience. Sometimes you will feel a session has gone really well and others you may reflect that perhaps you would like to do things a bit differently. Explore and find out what works best that suits your style whilst meeting the requirement of the policy.

You will be offered quarterly CPD sessions adding to your evidence base and toolbox whilst offering peer support. Please do attend these as they are there to support you.

FNHC thanks you for your commitment to your colleagues and to the continued pursuit of excellent quality care for all who use the services.

APPENDIX 2

Safeguarding Restorative Supervision Toolkit

Supporting application to practice

To be used in conjunction with the Restorative Supervision Policy

1. Introduction

This toolkit is specifically for use for the Safeguarding Restorative Supervision approach (SRS) and should be used as a companion to the Restorative Supervision Policy and restorative resilience supervision training. Here you will find guidance for:

- the process of facilitating the supervision
- required documentation templates
- tools you can use to support reflection, critical analysis and decision making within your sessions

This is not intended as a training tool for safeguarding. Practitioners should continue to utilise their training regarding safeguarding content and refer to the following documents as required:

https://safeguarding.je/wp-content/uploads/2020/01/Continuum-of-Need-Final-2020.pdf

https://safeguarding.je/making-safeguarding-personal/

Your aim as a *safeguarding* supervisor is to provide a supportive and analytical space for your colleagues who are caring for complex families with children, young people and vulnerable adults who may be at risk of neglect and significant harm. You will be using your professional judgement to decide which cases that you bring for SRS but they are likely to be those adults or children who present with complex needs, may be subject to child protection, have been identified as a child in need or children who are looked after.

Please note this is a controlled document and whilst it can be printed for personal use, new tools will be added as new information becomes available. The current version should always be accessed online.

2. The restorative resilience model of safeguarding supervision

SRS is an extension of the restorative resilience model of clinical supervision combining the restorative resilience aspect with the robust 4 x 4 model of safeguarding supervision. Here the focus shifts to the client or cases the professional is managing. However, the process continues to involve a trained supervisor colleague facilitating a safe space for reflection on practice using evidence based tools and frameworks to support decision making and development of that professional. The core skills within the approach include:

- Reflective Practice
- Emotional Containment
- Stress Management
- Resilience Training
- Action Learning
- Coaching skills

Tools to support work with supervisees using these skills can be found in the Restorative Resilience Clinical Supervision Toolkit (Appendix 1) and can be applied across RRCS and SRS. However, this toolkit contains tools and documentation you should utilise specifically for SRS.

3. The Process

a. The Supervisory Relationship

The relationship between you and the supervisee is your most valuable tool. Building trust and safety within the supervisory partnership are pre requisites for effective supervision. Being clear on roles, responsibilities and contracting for the supervision experience will create a boundaried and effective partnership.

3.2 Roles and Responsibilities

The role of a *safeguarding* supervisor is a skilled and responsible one which involves supporting and enabling staff to critically analyse their practice and decision making around identified cases, providing a safe space for reflection and restoration of wellbeing. Specifically, you are expected to:

- Maintain currency of knowledge of safeguarding and facilitation of supervision by attending relevant training and actively participating in your own supervision
- Agree a contract with your supervisee and agree a time to review (section 3.3)
- Prepare for each session psychologically and practically to ensure you can fully engage with your supervisee
- Maintain boundaries, being clear about confidentiality limitations and creation of a safe space for exploration of practice, escalation processes, managing the agreed time
- Review case records with the supervisee as part of the process and develop a system whereby cases are evaluated, escalated where necessary and follow FNHC process for sharing information appropriately and proportionately
- Use appropriate tools to facilitate accountability, empowerment and critical thinking in your supervisees and provide constructive feedback to support this
- Adhere to the reporting requirements outlined in the restorative supervision policy and this toolkit.
- Signpost to appropriate practitioners or services if there are concerns about the health or performance of the practitioner in partnership with the supervisee and their line manager

4.4 Safeguarding supervision template

This agreement is between xxx (Supervisor) and xxx “Supervisee”. Both parties agree to the following:

We agree to meet quarterly for one hour at a pre agreed time and venue for a period of one year to:

- Agree the agenda
- Review cases by discussion and review of records
- Use a creative and problem-solving approach to the work, appreciating the contributions of others involved
- Agree and monitor recorded action plans in relation to the individual at risk
- Identify developmental needs and action planning on how to meet them
- Provide a space for you to reflect on your experience or feelings about the work
- Review our supervision agreement after 12 months

We are working within the restorative safeguarding supervision model and will at times use tools to explore issues in more depth.

The content of the sessions will be kept confidential except when there are concerns about the safety or wellbeing of patients or a member of staff, concerns about professional practice

or anything which may be deemed detrimental to the organisation in which case we will both agree an escalation process to the most appropriate person.

A record of attendance will be kept for monitoring and audit purposes. Records will be maintained on the client's EMIS record and care plan as per policy requirements. The supervisee is responsible for keeping any more detailed notes in support of their appraisal and/or portfolio.

The supervisor agrees to:

- Finding a suitable venue and ensuring it is free from distractions and interruptions
- Listen actively and use relevant tools to support critical analysis and reflection on practice
- Offer supportive challenge and constructive feedback to help you improve practice when required
- Support escalation processes if required

The supervisee agrees to:

- Come prepared with a selected case from practice they would like to discuss having reviewed the client notes and completed a reflective framework
- Arrive on time, actively participate in problem solving and reflection on the issue
- Be open to feedback, change and consideration of alternative methods of practice
- Take any agreed action following the session including the responsibility for completing the appropriate documentation and recording for each session

We both agree that regular safeguarding supervision is a core part of professional practice and should be cancelled only in the case of illness or a crisis. If a session is cancelled, a new date must be agreed as soon as possible. If there are difficulties working together we will be honest and open with each other, maintain open communication and resolve difficulties in order for the supervision to be meaningful and impactful for both parties.

5 Signed.....
Signed.....
Agreed review date.....

4. Documentation templates

The following forms and templates are presented for supervisees and supervisors:

- In preparation for the supervision session
- During the supervision session
- Following the supervision session

a. Preparation for Supervision: responsibility of supervisee

In order to maximise the benefit of the session, it is expected that the supervisee will have reflected on the individual case they intend to bring to supervision. In this section, templates are presented to allow the supervisee a choice of how they prepare; supervisees can pick the one that most suits the case they wish to discuss. This thought and preparation will ensure meaningful use of the time within supervision.

4.1.1: Five key questions

Five key questions	
What is getting in the way of this child/young person or adults wellbeing (please capture the child and the adults voice, make this personal to the adult and child centred for the child)	
Do I have all of the information I need to help this child/young person or adult?	
What can I do now to help this child/young person or adult?	
What can my agency do to help this child/young person or adult?	
What additional help, if any, may be needed from others?	

4.1.2. Dependency Matrix: Strong to Weak View, Strong to Weak Evidence

What do I know?	**What is ambiguous?**
What do I assume?	**What is missing (what action is needed)?**

4.2: During the session: options for the supervisor

The following tools and templates should be used during the session guided by the supervisor as appropriate depending on the case brought for discussion and the needs of the supervisee.

4.2.1Risk Matrix

This must be estimated over a stated period or related to a given activity.

Level	Descriptor	Description
1	Rare	This will probably never happen/recur
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so
3	Possible	Will probably happen/recur but it is not a persisting issue
4	Likely	Might happen or recur occasionally
5	Certain	Will undoubtedly happen/recur, possibly frequently

Determining the Consequences of Harm

For example catastrophic means death or debilitating permanent injury and minor means requiring first aid.

Level	Descriptor	Description
1	Negligible	No/minor injuries, no time off work required, Informal complaint, rumours, low financial cost
2	Minor	First Aid Treatment, minor intervention, requiring time of work <3 days, verbal complaint, minor implications for patient safety if unresolved, breech of statutory legislation, local media coverage, Medium financial loss.
3	Moderate	Moderate injury requiring professional intervention, requiring time off work for 4-14 days, an event which impacts on a small no. of patients/staff, written complaint, low staff morale, single breech in statutory duty, local media coverage – long term reduction in public confidence.
4	Major	Major injury leading to long-term incapacity/disability, requiring time off work for >14 days, multiple complaints, unsafe staffing level or competence (>5 days), multiple breeches in statutory duty, National media coverage <3 days.
5	Catastrophic	Incident leading to death, multiple permenant injuries, inquest / ombudsman enquiry, prosecution, National media coverage >3 days.

A Simple Risk Level Estimator

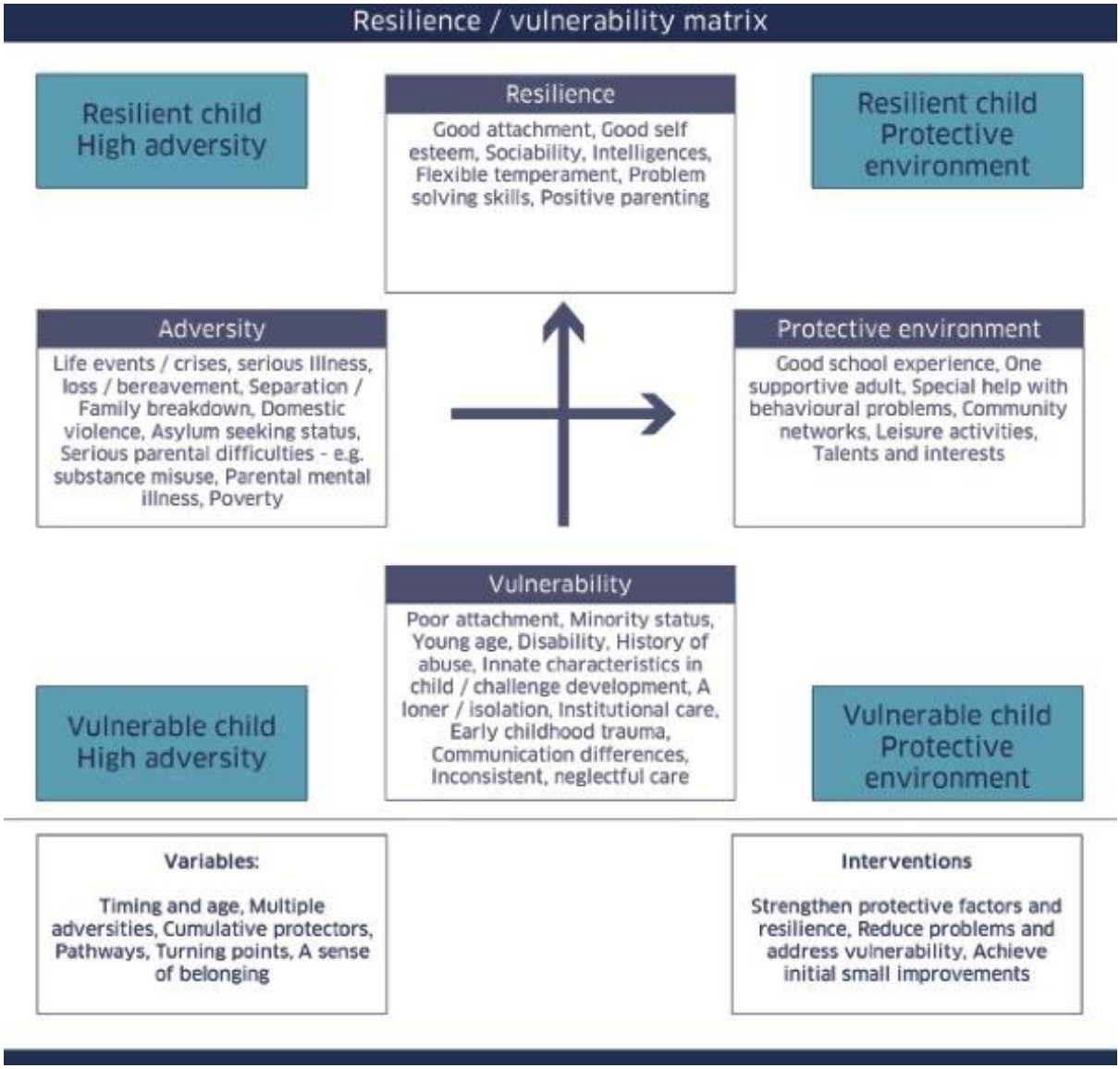
	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1–3	Low risk
4–6	Moderate risk
8–12	High risk
15–25	Extreme risk

4.2.1 Resilience/Vulnerability matrix

This matrix was developed to support practitioners to understand the interaction between the factors and gain some sense of the risk of impairment to the child's health and development and plan interventions. Resilience looks different for each age and stage of development although some factors are common despite age. Even though there are common and known factors for children, what is not known is how each area will interplay with the other to affect the individual child.



4.3 Following the session: agreeing joint responsibilities

4.3.1 Care Plan and Review Care Plan

An agreed plan of action should be completed after each session. As part of the supervisory agreement, supervisor and supervisee should agree who is going to complete it.

Action Required	By who	When	Review

4.3.2 Record of supervision – to be stored on ASSURE kept by supervisor and supervisee

It is imperative that a record is made of any supervision that has taken place for audit of supervisory contact pertaining to clients within FNHC care but also to protect both client and practitioner.

Name and Details of client (copy from EMIS)

Date of Supervision One to One/Group/Consultative (circle)

One to One or Consultative supervision:-

Supervisor

Supervisee

Group supervision Template

Session attendees Name	Signature	Designation

Appendix 3

Making the most of restorative supervision

A guide for supervisees

A guide to making the most of restorative supervision at FNHC

An introduction to restorative resilience supervision

1. Our commitment to you

FNHC is committed to providing high quality patient centred care for those individuals and families who require our services. This work is extremely rewarding, but as with any health care work, it can also sometimes be difficult and emotionally challenging. Evidence tells us that a supported workforce is key to ensuring patients receive safe, excellent and compassionate care.

Staff wellbeing matters to us. We recognise that you as a member of our clinical teams are our most important resource when bringing our vision of excellence in care to reality. We have put systems in place to ensure that all staff with a patient facing role have access to both restorative resilience clinical supervision and restorative safeguarding supervision. This will support you in carrying out your work to the best of your ability. We have identified it as mandatory to demonstrate how important this is to your practice. It is part of the patient intervention, not an additional extra.

This short guide will briefly outline some key points you need to know before you meet your clinical or safeguarding supervisor for the first time. It supplements the restorative supervision policy which you should read in full as it explains all the background and outlines the different roles and responsibilities across the organisation.

2. What is restorative resilience clinical supervision?

Restorative resilience clinical supervision is separate from the managerial or caseload supervision that you will have with your line manager or clinical lead. It is an opportunity for you to have regular structured time with a trained supervisor, perhaps from a different team, to talk in a confidential setting about your work. You will be expected to attend these sessions on a quarterly basis. The aim is to allow you the opportunity to:

- Honestly reflect on your practice and feel supported in your role
- Problem solve any practice challenges
- Develop new skills and knowledge within the new role
- Maintain and improve professional practice through a combination of support, coaching and constructive challenge where appropriate

3. What is restorative safeguarding supervision?

Restorative Safeguarding Supervision is an extension of the above approach. It combines the restorative resilience aspect of clinical supervision with the robust 4 x 4 model of safeguarding supervision. Here the focus shifts to the client or cases the professional is managing. However, the process continues to involve a trained supervisor colleague who may be your manager facilitating a safe space for reflection on practice using evidence based tools and frameworks. You will also be expected to attend these sessions on a quarterly basis.

4. Why do I need it?

Working in health care can pack an emotional punch. We all have vulnerabilities and we all have protective factors. Talking through our work with a trusted colleague allows us to keep these in balance. Our aim is always to deliver safe, excellent patient care and this is better delivered by staff who feel well supported and maintained. Restorative resilience supervision and restorative safeguarding supervision are there as a supportive mechanism for you and also a learning mechanism to help you identify what further skills or knowledge you might need. It supports you in your decision making and in turn this ensures good quality clinical care and effective, compassionate patient and family interactions.

5. What should I talk about?

Restorative resilience *clinical* supervision: The time is yours so you can talk about any aspect of your work that concerns you or even an episode of care that you feel pleased about. Some examples that you might consider include:

- Sometimes you are puzzled about in practice, perhaps curious about why things are done in a certain way and would like to explore this more.
- Perhaps you felt that you were unprepared for a situation and would like to think through what you would do differently next time.
- Might you have had an interaction with a patient or a family member that you feel could have gone better?
- Perhaps a particular patient or family impacted on you emotionally. Talking this through can clarify your thinking around this and give you support.

Your supervisor will have been trained to help you reflect on different situations and to help you unpick how you feel about this, how others involved might have felt and what

options might be tried in the future. Your supervisor is not there to offer advice but to give you a safe space to talk through your work and help you find your own solutions wherever possible. Any notes taken are yours to keep and should be used for your professional portfolio.

Restorative Safeguarding Supervision: Here you will be expected to have chosen an individual or a family that you are working with who presents with safeguarding concerns or challenges. Prior to coming to your session, you will need to complete a reflective template that asks you to consider what those concerns are, how you feel about them and how you have addressed them. Your supervisor will support you to identify what actions were taken, what the learning was and whether there is a requirement for further action. These notes will be recorded on the patient record.

6. Who will be my supervisor?

When you join FNHC, you will be allocated a clinical and safeguarding supervisor. They are not likely to be the same person. This person will contact you shortly after your induction period to arrange an initial meeting. They will discuss a working agreement with you when you will agree how often you will meet, the boundaries of confidentiality, who will be responsible for setting the date and booking a room. We have also encouraged supervisors to agree to review how things are working after 3-6 meetings. Both of you might want to change which is perfectly normal and actually encouraged as you can learn different things from different people.

7. How should I prepare for my sessions?

You will get as much out of your supervision sessions as you are prepared to put in. Some staff find it helpful to jot down notes in between meetings when something occurs to them that is bothering them or something interesting they want to explore. Some find it helpful to use reflective models to help them think through a situation before a session. If you are not familiar with reflective models, ask your supervisor who will be able to share some with you.

The most important thing to remember is that this time is precious and this time is yours. How you use it is up to you but you will gain more if you have identified something you would like to discuss and of course, please turn up on time as you are both likely to have other commitments both before and after the session.

8. What happens if I can't meet my supervisor?

FNHC has committed to making this happen. We have written the policy, agreed this can take place in working hours and provided the education but we need supervisors and supervisees to make this work. This may take careful and sometimes advanced planning to ensure you find times that are workable for both of you depending on the needs of your clinical areas and should be discussed at your first meeting. However, it should be diarised as an essential part of your practice and not cancelled unless there is an emergency.

As supervision is mandatory, we will be auditing who has or has not been attending the sessions and line managers are asked to check this is happening through appraisal processes.

9. Making the most of the opportunity

Finally, it is important to say that although restorative resilience clinical supervision and restorative safeguarding supervision is an integral part of the patient journey, we know that not all organisations manage to offer this. We are privileged to be able to do so within FNHC so we hope you make the most of this opportunity.

It has only been made possible by the willingness of your colleagues who have undergone extra training to become supervisors; their only motivation being that they believe in the process and they want to offer support to you as colleagues. By all working together on this, we can continue our journey towards excellence in patient care delivered by a committed, supported and resilient workforce.

Thank you for being part of the FNHC team.

Appendix 4

Evaluation Framework: outcomes based accountability

How much did we do? (groundwork)	How well did we do it?
• Policy development and ratification • Number of training sessions delivered • Number of supervisors trained • Number of supervisees trained • Inclusion of training and information in induction process • Number of CPD sessions delivered	• Training feedback • Number of supervisors active? • Minimum requirement of supervision achieved as per policy? • Accurate records of supervision
Is anyone better off?	**Methods to be used for evaluation**
• % sessions that took place in working hours • % supervisees who felt the sessions supported their resilience • % supervisees who felt sessions helped them develop their professional practice • % supervisees who felt that their confidentiality was respected • % supervisors who felt supported in their supervisor role • % supervisors who felt confident in their role	<u>Both approaches</u>: Survey feedback on supervision experience from supervisee and supervisor perspective after 12 months Exit interview feedback Records of uptake on minimum requirement <u>SRS</u> Annual audit of process Availability of care plans on EMIS Number of cases escalated