Practitioner views on safeguarding supervision

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Abstract

This study explores the views of community nurses and their perceptions of safeguarding supervision. Thirty-seven front-line nurses from a Community NHS Foundation Trust completed an on-line survey tool ‘Qualtrics’. Ethics approval was granted from both the trust, Health Research Authority and the University. Results from this small scale study suggest that the model of safeguarding supervision was not important in the process, the preferred mode was a combination of one to one and group. The factors perceived as most important were feeling safe/safe environment, experienced practitioner and critical reflection. The ‘qualities’ of the supervisor deemed most important was prior training in supervision skills, leadership skills were not deemed as important. Most felt that the supervisor should be from the same professional background.

Key Words: safeguarding supervision, front line nurses, model and mode of supervision, qualities of the supervisor.

Introduction

This paper is a follow up to the literature review carried out by Guindi et al (2019) which highlighted the lack of empirical evidence on safeguarding supervision from the perspective of front-line nursing practitioners in the community working with children. Safeguarding supervision has been in practice for over ten years amongst community practitioners namely health visitors, school nurses, Looked after Children (LAC) and family nurses. The first paper on this subject area was written by Green-Lister and Crisp in 2005. However, since then there has only been a handful of papers written on this subject namely; Hall, 2007; White 2008; Botham, 2013; Hackett, 2013; Jarrett and Barlow, 2014; Rooke, 2015; Smikle, 2017; Warren, 2018 and Little, Baker and Jinks, 2018.

There is recognition that supervision practice must be evaluated from the point of outcomes on its effectiveness in safeguarding children (Karpetis, 2019). The findings from this small-scale study will look at safeguarding supervision in the context of front line community practitioners. It will explore and build on the suggested factors identified in the literature review by Guindi et al, (2019) about what practitioners find helpful and unhelpful in the process.

Safeguarding practice is continually evolving following the lessons learnt when things go wrong in practice resulting in the death of a child. High profile cases driven by the media has put pressure on the government to act and respond by carrying out inquiries and making recommendations to prevent further deaths (Laming, 2003. Laming 2009).

Professor Eileen Munro's first review into child protection spoke about the importance of a systems approach and the need to be child focussed in the work of safeguarding children (Munro, 2010). This child-focused approach was supported by the Office for Standards in Education, Children's Services and Skills (Ofsted) in their thematic review report titled 'The voice of the child: learning lessons from serious case reviews' (Ofsted, 2011).

Ofsted (2011: 15) suggested that 'there was a difference between hearing the voice of the child and the actions that followed'. In that this was not always followed in practice. 'Professional supervision is a core mechanism for helping social workers to critically reflect on the understanding they are forming with a family' (Munro, 2011a: 53). This interim report was followed by Munro's third and final report (Munro, 2011b). In her final report, Munro shifts her thinking in recognising that GPs and Health Visitors (HVs) are well placed to identify problems early.

Nurses' responsibility for Supervision

More than twenty-five years ago the United Kingdom Central Council (now known as the Nursing and Midwifery Council) bought out guidelines on supervision (UKCC 1996). The UK regulator, the Care Quality Commission (2015) speak about roles and responsibilities in safeguarding children and adults. Everyone has a responsibility to safeguard children (HM Government, 2018). Nurses should have access to safeguarding supervision in order to stay professionally up to date with practices and recognise children who are at risk of abuse or neglect (RCN, 2019).

Study Aim/Purpose

This study will explore the views of community nurses in order to get their perspective on safeguarding supervision and examine some of the suggested factors found in the literature pertaining to community nurses; (Green-Lister and Crisp, 2005, Hall, 2007; White 2008; Botham, 2013; Hackett, 2013; Jarrett and Barlow, 2014; Rooke, 2015; Smikle, 2017; Warren, 2018 and Little, Baker and Jinks, 2018).

Research Questions

This study has selected three questions centred around factors which are of interest to the author. A fourth question explores the other factors found in the literature review carried out by Guindi et al, (2019).

1. What are the views of community nurses (health visitors, school nurses, family nurses and nurses working with children in care) towards the application of a safeguarding supervision model?

2. How do community nurses perceive mode (one to one, group, peer, or combination) of safeguarding supervision within the process?
3. What are the thoughts of community nurses on whether a safeguarding supervisor should have specific ‘qualities’ such as leadership skills/supervision training prior to taking up the role of supervisor?
4. What other factors do community nurses feel are helpful/unhelpful in safeguarding supervision?

The above questions have been chosen as these were possible factors that were deemed helpful/unhelpful in safeguarding supervision carried out by Guindi et al, (2019) and the author would like to explore them further.

Method/ethical approval

Strategy and design

An on-line survey was designed to gather both qualitative and quantitative information consisting of 14 questions. The first three questions consisted of gaining consent, identifying role, and length qualified. The remaining questions were designed around the themes identified in the authors literature review (Guindi et al, 2019). The author asked specific qualitative questions around model, mode and qualities of the supervisor in order to answer the research questions. This generated meaning behind the numerical data.

Data was gathered through a secure on-line project management system known as Qualtrics. All respondents were assigned a number and referred to only in this way. Entry into the system was password-protected and only known to the author.

Data was accessed from the researcher’s laptop, which was also password protected.

Ethics

Permissions to carry out the research was gained from the trust facilitated through the research and development team, with a letter of access granted. Approval was gained from the Health Research Authority (HRA) along with the university.

Population

The survey was started by 47 respondents. However, only 37 health visitors, school nurses, family nurses, nurses who look after children, and the nurses from the pilot were kept. The rationale behind the 10 being discarded was that they either did not complete the survey or they did not meet the criteria for inclusion (administrators and nursery nurses). The inclusion criteria consisted of those nurses working directly with children under 18 years in a home visiting capacity. It excluded adult nurses working with families, sexual health nurses, learning disability/mental health nurses. Most of the sample consisted of health visitors (*n* = 25, i.e. 67.6%), there were fewer school nurses (*n* = 5, i.e. 13.5%), looked after children nurses (*n* = 3, i.e. 8.1%), family nurses(*n* = 2, i.e. 5.4%%), and pilot health visitors (*n* = 2, i.e. 5.4%). Experience in practice ranged from newly qualified up to forty-one years, with the average of M = 14.11 years (SD = 11.915).

Procedures

The workforce were informed that the research was being conducted via a community bulletin and team meetings. The on-line survey was planned to remain open for one month. However, after two weeks the response rate was poor with only 30 employees having responded. Two follow-up email reminders were sent, and the questionnaire was extended an additional week, which resulted in another 17 responses.

Results

Models of safeguarding supervision

Respondents were asked to score their familiarity of a safeguarding supervision model out of 100%. Figure 1 shows that respondents were most familiar with the Signs of Safety (SOS) model of supervision (29, i.e. 78.4%), the reflective model (26, i.e. 70.3%), and the Family Partnership Model (FPM) (18, i.e. 48.4%). There were 11 respondents familiar with the resilience model (29.7%), seven familiar with the restorative supervision model (18.9%), six familiar with the Brealey model (16.2%), five with the 4x4x4 model of integrated supervision (13.5%), and four familiar with the Peskin model (10.8%).

When asked to expand on their answer, 25 respondents gave additional information with 13 giving a rationale for choosing their preferred model for supervision. These were primarily working knowledge of the model and it being aligned with social care.

Modes of safeguarding supervision

Respondents were asked about their preferred mode of supervision. 35 out of the 37 replied. Figure 2 demonstrates that primarily the respondents preferred a combination of one-to-one supervision, group supervision, and peer supervision (15, i.e. 40.5%). One in three opted for one-to-one supervision (12, i.e. 32.4%), and one in five opted for group supervision (7, i.e. 18.9%). None of respondents opted for peer supervision, three respondents (8.1%) did not reveal their preference as they were newly qualified and had not yet received supervision. The mean was 2.49 with a standard deviation 1.36. The findings were not significant.

Twenty-seven respondents expanded on this answer which included both advantages and disadvantages of each mode. A combination of both one-to-one and group supervision was given as the most effective way to safeguard children.

Qualities of the Supervisor

Professional background of supervisor

34 out of 37 responded to this question. 24 respondents (64.9%) reported that it was important to them to have a safeguarding supervisor who comes from the same profession as them. However, five respondents (13.5%) were unsure, another five (13.5%) indicated that this was not important. Three (8.1%) did not disclose this information.

When asked to expand on their answer, 24 responded. Of these, 19 wanted someone who understood their role but did not specify whether this had the same meaning as having someone from the same profession. Two spoke in general terms with no clear rationale for their decisions in wanting someone from the same profession. Two respondents would be happy with someone from another profession being their supervisor.

Training and credibility of the safeguarding supervisor

34 respondents (89.2%) who answered this question, 26 (78.8%) thought that a safeguarding supervisor should have a qualification in safeguarding supervision before undertaking their role. Twenty respondents expanded on this question when asked. These included views regarding having perceived confidence and creditability in the supervisor gained through this specific training and knowledge.

Out of 32 respondents, 21 did not think that a safeguarding supervisor needs to have undertaken a leadership course prior to acting as a supervisor.

Other factors important to the supervision process

Table 1 illustrates that the most important factor in safeguarding supervision on a scale of 0 to 100% of importance was feeling safe/safe environment followed by an experienced practitioner and being allowed the time and space to critically reflect on one's own practice. The least important factors was the ability to apply theory in

practice and the model of supervision used. Eight respondents (21.6%) did not disclose this information.

Discussion

This community trust uses the Signs of Safety (SoS) model delivered through a combination of both 1:1 and group supervision. The findings reflect that this trust is most familiar with the SoS model, as this was the model that they worked with and was aligned with Social Care. However, model of supervision was ranked lowest in importance out of all the factors. The second most familiar was the reflective model. Reflection in nursing is well embedded in practice and has been recognised within clinical supervision since 1995 when the United Kingdom Central Council (UKCC), now known as the Nursing and Midwifery Council (NMC), published definitive guidelines for nurses and health visitors (UKCC, 1996).

The literature review conducted by Guindi, et al, (2019) suggested that practitioners wanted a national model to be introduced and perceived this as beneficial for auditing purposes. This was called for by both Hall (2007) and Rowse (2009). Botham (2013) echoes this in her literature review when she names the absence of an accepted ‘model’ as a theme. Botham (2013: 30) states, ‘analysis of the literature indicates there is no definitive definition or working model for safeguarding children supervision for health visiting professionals and school nurses’. Therefore, it is difficult to measure how effective safeguarding supervision is as there is no model that is recommended, recognised, or accepted for practice on the national level (Hall, 2008). Wallbank (2015: 45) also calls for a nationally recognised safeguarding supervision model, which she feels ‘would be welcomed by practitioners and safeguarding boards alike’. However, based on the findings in this survey the model

of safeguarding supervision is of little consequence when it comes to the effectiveness of safeguarding supervision.

Mode of Safeguarding Supervision

Most front-line practitioners (40.5%) preferred a combination of supervision modes. This may suggest that one-to-one, group, or peer supervision are not enough to meet the needs of practitioners within the trust. It is important to acknowledge that respondents found both modes to have benefits. This was reflected in some of the responses. Both one-to-one and group supervision can meet the needs of supervisees in different ways.

These views were also reflected in the literature review and wider research (Guindi et al, 2019). Rooke (2015: 43) found that there were advantages to receiving both types of supervision within the visiting health practice: 'Individual clinical or restorative supervision reported to be more informal and useful for dealing with the emotional elements of the role, whereas, child protection group supervision reported to be beneficial for accountability, outcomes and actions'.

One-to-one safeguarding supervision was the respondents' second most-preferred mode of supervision (32.4%). The advantages of one-to-one supervision were evident in the responses given. 'One-to-one is required in complex cases (Respondent 4). 'One-to-one gives me protected time' (Respondent 14). Others argue that one-to-one supervision is problematic as it may not hold people accountable (Butterworth & Fougier, 1992). Davis and Cockayne (2005: 20) suggest that 'it carries a risk of collusion and provides a weak means of addressing poor practice'. This suggests that a group setting may be better for holding members

accountable. One-to-one supervision can provide consistency, predictability, and regularity and is likely to facilitate the development of a positive relationship. Group supervision was rated lowest in the survey responses (18.9%), although there were some perceived advantages. Tripartite supervision was also valued and used within the FPM facilitating learning. This is supported by others, but it does depend on the skill, commitment, and attendance, and it can be more valuable than one-to-one supervision (Bond & Holland, 2010).

The literature review conducted by Guindi et al, (2019) suggests that there were both helpful and unhelpful factors in safeguarding supervision. There were also factors that facilitated the supervisory relationship. The author wanted to see if these were reflected in the sample population. The top three highest ranking factors were feeling safe/safe environment, experienced practitioner, and critical reflection.

It is uncertain what practitioners mean by the term 'experienced practitioner' this needs further exploration to define. The concept of an experienced practitioner was first addressed by Green-Lister and Crisp (2005) when they suggested the need for more formal, systematic supervision for all nurses. An experienced practitioner was thought of as more important for health visitors in front-line practice. According to Green-Lister and Crisp (2005: 67) 'there were particular concerns from HVs that supervision should be provided by someone with expertise in child protection'. The concept of an expert practitioner was again raised by Hall (2007: 30). Her findings showed that practitioners wanted 'an expert practitioner who could listen to their concerns and provide feedback both positive and negative'..

Botham (2013: 30) links experienced practitioner to feeling safe: 'Supervisees need to feel safe to be able to function properly, preferably with an experienced colleague

who will challenge them and aid their decision making'. This may suggest that a less experienced supervising practitioner may not have the confidence or knowledge to challenge their supervisees. There does appear to be a link between experienced practitioners and ensuring safe and effective practice. Rooke (2015: 44) suggested that 'gaining regular feedback on casework and debriefing sessions with an experienced practitioner, was reported to be of benefit to the delivery of safe and effective practice'.

The concept of being critical in practice was first raised by Green-Lister and Crisp (2005: 68) They stated, 'The ability to critically analyse and discuss ones' own practice requires trusting relationships between participants'. This finding was also supported by Botham (2013). Jarrett and Barlow (2014: 35) found that family nurses are 'encouraged to be challenged and reflect on their practice, and as a result of increasing awareness were able to examine and re-evaluate the clinical decision that they made'.

Implications and recommendations

This study was a relatively small-scale study with only 37 respondents. The findings cannot be generalised to the entire population of front-line practitioners as the findings only covered a single Community NHS Foundation Trust.

- Model of supervision does not appear to be of importance to practitioners, but critical reflection is important for learning.
- The preferred mode of supervision suggests a combination of both one to one and group but needs further evidence.
- Qualities of a supervisor still needs further exploration, but additional training in supervision skills is deemed important.

- Experienced practitioner was a key factor in safeguarding supervision; it would be of value to explore this concept further.
- Providing a safe environment/feeling safe was important in supervision; how is this achieved, and does its absence have an impact on the child remains unknown.

Conclusion

Direction from previous government reports and independent inquiries such as the Munro Reports (2010, 2011a and 2011b) and Ofsted (2011) suggest that supervision should be child focussed in order to hear the 'voice of the child'. The question now needs to be asked as to how to achieve this through supervision? There was some suggestion in this study that the SoS model is best placed to hear the 'voice of the child'. But model of supervision applied was ranked the least important factor.

The results from study do not bring any insights into whether any one factor is more important than any other when it comes to hearing the child's perspective within safeguarding supervision, and this is where the focus needs to lie if we are to understand the impact of safeguarding supervision in protecting children from harm.

The study was carried out within a single trust only but seems to suggest that there are factors deemed more important in supervision for practitioners, such as being supervised by an experienced practitioner, feeling safe/safe environment, and being allowed the time to critically reflect on their practice.

However, there are still several issues that need to be explored further regarding the model, mode, and regularity of safeguarding supervision received to explore whether they result in better outcomes for children.

It is still unclear whether having a recognised qualification in safeguarding supervision skills makes any difference in achieving positive outcomes for children. But leadership training was not thought to be necessary for the role of supervisor.