

Clinical Supervision for Palliative Care

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Introduction

Palliative care is arguably the most stressful area of nursing and care work, as well as being one of the most rewarding. It is an enormous privilege to share the final part of anyone's life journey – a journey that can too often feel lonely – and helping to ease that loneliness as part of a palliative care team is fulfilling and valuable. It is work that requires a high level of practical skill, which can help the dying person to feel more comfortable and confident. But practical skills, valuable though they are, are not enough. Palliative care demands from its practitioners an equally high level of compassion and resilience. Offering this combination of practical comfort and deeply felt concerned support is hugely demanding. Palliative care is a relatively new area of expertise and is growing rapidly, yet in its initial inspiration (and it *was* and *is* inspirational) and in its growth, little consideration has been given to the wants and needs of those who provide the care. Although there is an increasing and welcome realisation that more help is needed for those close to the dying person (those people who we might term 'informal carers' – the relatives and friends) there has been rather less thought given to the wants and needs of the professional carer. Some research has shown that the challenge of providing care at such a profound level can result in the use of 'burn out' and 'distancing' as coping strategies, and it has shown that neither is very desirable. This book is an attempt to suggest a strategy for professional help which will also enhance patient and client care.

Clinical supervision has been researched, promoted, and proven as a very effective strategy for constantly developing skills, for maintaining and raising standards, for encouraging personal and professional development, and for building team ethos. This book therefore explores clinical supervision and the qualities, skills, models and ethics needed to ensure success.

Clinical Supervision for Palliative Care is written as a workbook. You will find pauses for reflection and it is recommended that you keep paper and pen to hand to write down your answers to questions. Good palliative care is based on good communication – so you are asked to interact with the text. The book was researched with a range of professionals working in the field, and with some of those receiving their care. Their experiences are relayed verbatim and with their permission. You will find their words in shaded boxes throughout this book. I am greatly indebted to these people for their time, their frankness and their encouragement – they clearly felt, as I do, that practitioners both need and deserve all the support they can get. I hope that the book will encourage implementation of clinical supervision across the widening field of palliative care – not only because it will support and

sustain practitioners (who are not always good at looking after themselves!) But because it will also fulfil the ultimate goal of all of us – the best possible care of dying people, helping them to the death that they want, and easing their suffering and that of those closest to them.

What is clinical supervision?

Defining the concept

This book begins with a conundrum. What is clinical supervision? Indeed, is it possible to define it exactly? So many definitions seem to exist that it is worth looking at a few of them so that we may come to some sort of consensus that will guide or ‘ground’ us as we work through the ensuing chapters. But first, try to work out your personal definition:

 **Your thoughts**

How would you define supervision?
How would you define clinical supervision?

A dictionary definition will usually tell us that supervision is something like ‘directing or watching with authority, the work, proceedings or progress’ of something or someone. It is this sense of ‘with authority’ which has led to some quite serious misapprehensions about supervision in general and about clinical supervision in particular. This misapprehension is summed up by Feltham and Dryden (1994) in this way:

Unfortunately the term supervision still carries connotations of managerial oversight and control, mistrust and coercion...

It is indeed unfortunate that the term can conjure up often unpleasant images of an overseer of some sort, with no reference to what ‘vision’ (an important half of the whole word) might imply. ‘Vision’ has much more positive connotations; it implies imaginative ways of looking at things, perhaps a degree of foresight, and maybe even a degree of wisdom. If we accept this definition, then supervision should have these qualities in abundance.

How does your definition of supervision compare so far?

The word 'clinical' adds a further dimension and tends perhaps to medicalise the concept of supervision. Within the nursing/health care professions, practitioners have been urged to attend not only to the physical needs of the people in their care, but also to their 'social, emotional and psychological requirements' (Butterworth and Faugier, 1992). These closer interpersonal exchanges, which are increasingly advocated, bring health care closer to social work, where supervision has long been a norm, and to counselling, where it is mandatory. In both social work and counselling, the term 'supervision' on its own is more usual, but (especially in counselling) the term 'clinical' often precedes it, and this reminds us that clinical supervision is not confined to a health care or medical sphere. As palliative care is often teamwork (it may involve counsellors and social workers) this is important.

So, what are we talking about? What *is* clinical supervision?

Here are some definitions. As you read each one, take time to record how far you agree or disagree with each writer's views – and remember that your own definition has value too.

1. Client-work supervision is a formal process that provides a practitioner with the discipline and support of an experienced colleague in the careful and confidential oversight of the practitioner's work with clients. The supervision relationship is a mutual one and is not in any way hierarchical, nor must it be confused with formal management (COSCA, 1996).
2. Clinical supervision is a practice-focused professional relationship, involving a practitioner reflecting on practice guided by a skilled supervisor (Bishop, 2001).
3. Supervision is a working alliance between a worker or workers, in which the workers can reflect on themselves in their working situation by giving an account of their work, and receiving feedback and, where appropriate, guidance (Proctor, 1988; Inskipp and Proctor, 1989).
4. Supervision is a formal and mutually agreed arrangement; the task is to work together to ensure and develop the efficacy of the supervisee's practice (BACP, 1996).
5. Clinical supervision is an integral, formalised, yet flexible element of professional practice, utilising a range of strategies aimed at facilitating support and development for practitioners whilst also safeguarding standards and upholding 'best practice' in a non-threatening manner (Bishop, 2001).

 **Your thoughts**

Which definitions of clinical supervision do you agree with?

Which definitions of clinical supervision do you disagree with?

Whether you agree or disagree with these definitions, or with part(s) of them, some points seem to stand out particularly clearly. Let's look at some of these points in order:

1. **Clinical supervision is non-hierarchical** although in work terms a supervisor may be higher up the career ladder than a supervisee, when they meet for clinical supervision they meet as equals. This is why, in general terms, it is not recommended that a supervisee's line manager becomes his or her supervisor. One reason for this is that the supervisee might be reluctant to discuss uncertainties with the very person who will conduct an appraisal and who might have some influence over promotion prospects. If you think of yourself as a supervisee or a potential supervisee you can perhaps understand the difficulties posed by hierarchy, however much you might like and respect your line manager. The situation may be especially difficult for voluntary helpers, who may be managed by a professional, and it can be equally difficult for the supervisor of the volunteers! Try to list some other difficulties you can envisage with hierarchy:
2. **Clinical supervision is about work** in this sense it is less about the practitioners themselves and more about their interactions with clients and patients. This is not to say that clinical supervision is not supportive – it is – but it does highlight the fact that it is very different from personal counselling or therapy.
3. **Clinical supervision encourages reflective practice** in the busy world of nursing and care (or of teaching or any other work involving interaction with people), it is too often difficult to find time to reflect on practice and process. Yet research by professional bodies shows it is very clear that reflection raises standards (as well as providing a range of other benefits which we will look at in a later chapter). Reflective practice is a term that has become very popular in nursing, counselling, and care circles. It seems to be used as a term of general approval – reflective practice is A Good Thing – yet too often there is

insufficient time allocated for practitioners to carry out such reflection. A supervisee interviewed on this matter expressed this paradox to me: 'you're supposed to reflect on your practice, but if you try to, you're seen as self-indulgent or something.' A well implemented system of clinical supervision should aim to remedy this paradox.

4. **Clinical supervision depends upon some sort agreement between the partners in the 'working alliance** this may be anything from a fairly formal contract or agreement, to a more loosely agreed arrangement to meet regularly to focus on the supervisee's work. There is, however, a clear indication that there should be some sort of mutually agreed arrangement to meet regularly. If clinical supervision is haphazard or *ad hoc* it is unlikely to provide the kind of structured reflection which seems so universally approved of.

Bishop's definition (Bishop, 2001) sums up these points, whilst adding that Clinical Supervision is non-threatening, which brings us back to the early part of this chapter where we mentioned that the term can have quite threatening overtones for some people.

If clinical supervision is seen as authoritarian or as disciplinary, it hardly seems likely that it will promote the type of reflective practice so desirable in care work! To ensure the non-threatening nature of supervision requires skill on the part of the supervisor, as well as a willingness on the part of the supervisee to enter into the 'working alliance'.

Look again at the personal definitions you attempted earlier. Would you like to alter or amend them in any way? If so, how? Why? Why not?

 **Your thoughts**

What amendments, if any, would you make to your personal definitions?

If you review the definitions quoted previously, does there seem to you to be anything missing?

 **Your thoughts**

What 'concept' is missing from the quoted definitions?