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In this article...

- Why exposure to stressful situations can cause secondary traumatic stress
- How access to a professional nurse advocate can help nurses who are facing stressful situations
- Using restorative clinical supervision to support nurses in the delivery of care

Using restorative supervision to help nurses during the Covid-19 pandemic

COVID-19

ARE YOU OK

Key points

In 2020, during the first wave of the Covid-19 pandemic in the UK, some nursing staff showed signs of the effects of secondary traumatic stress

Secondary traumatic stress was having a negative impact on nurses' ability to deliver high-quality, compassionate care

The Advocating for Education and Quality ImProvement model is a useful tool to support nursing staff

The restorative supervisory aspect of the model can help nursing staff deal with high levels of anxiety and stress

The Advocating for Education and Quality ImProvement model can positively influence the quality of nurses' thoughts to cope with challenges in the workplace and gain personal resilience

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Abstract The Covid-19 pandemic has transformed how many health professionals deliver their clinical practice, causing them to experience increased levels of stress, anxiety and moral injuries. This article highlights how, by using the restorative element of the Advocating for Education and Quality ImProvement model, a professional nurse advocate helped nurses to gain resilience to work positively in difficult circumstances and cope with the anxieties they faced.

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When Covid-19 struck, nurses across the world found themselves nursing in the face of a global pandemic. This was a far cry from the anticipated celebration of the International Year of the Nurse and Midwife that year. This article discusses how I, while working as a professional nurse advocate at University Hospitals of North Midlands NHS Trust, delivered a model of restorative supervision to support nursing staff whose ward was converted from its usual clinical practice as a cardiology ward to a ward dedicated to treating people diagnosed with Covid-19.

When the pandemic hit, the landscape for the nursing team on Ward 221, a cardiology ward, changed overnight and the way of working required a different approach. Initially, the ward staff, while unnerved, were united in their commitment to care for a new type of patient group. Even though nursing patients with Covid-19 was far removed from their usual clinical remit, they worked cohesively and adapted to the complex challenges.

As the weeks progressed, the initial enthusiasm of the change of practice began to wane and the mood on the ward shifted from buoyant enthusiasm to quiet sadness and shock. Members of the team found themselves delivering end-of-life care for several patients on a daily basis and having to deliver bad news to distressed families over the telephone, while also dealing with challenging staffing levels. They were determined to carry on, but it was clear that the leaders were showing signs of being distressed and their resilience was diminishing.

Comments

In 2021, Tannenbaum et al stated that the Covid-19 pandemic created a set of circumstances, along with organisational and work–life stressors, that can have a negative impact on frontline patient care teams. Those stressors can fuel developing risk points that, if not avoided or acknowledged effectively, will likely result in poor teamwork and have a negative effect on patient safety and the quality of care.

Stability in the healthcare environment underpins the delivery of high-quality care for patients. The Covid-19 pandemic has had a significant impact on the work setting for nurses, as highlighted in the

literature. Maben and Bridges (2020) described new ways of working and accommodating new practices as potentially stressful for existing staff – and even more so for those members of a team who are new. Guedes dos Santos et al (2021), meanwhile, have also argued that Covid-19 has had a destructive influence on the working environment for healthcare staff. They have stated that, while the nature of healthcare work can be stressful under normal working circumstances, the pandemic has shifted the status of this workplace, leading to difficulties related to mental health, physical and mental exhaustion, feelings of helplessness and professional insecurity.

"If an appropriate intervention from the A-EQUIP model was not used in a timely manner, the ward team would be at risk of high levels of stress caused by exposure to distressing events over a prolonged period"

Working practices

The cardiology nursing team were in uncharted waters. The ward leaders no longer had a clear vision and purpose for the delivery of care, but found themselves in a scene of uncertainty and fear. Bennis and Nanus (1985) dubbed this shift of known boundaries into unfamiliar territory as the VUCA model, which comprises:

- **V**olatility – the nature and dynamics of change, and the nature and speed of change forces and change catalysts;
- **U**ncertainty – the lack of predictability, the prospects for surprise, and the sense of awareness and understanding of issues and events;
- **C**omplexity – the multiplex of forces, the confounding of issues, no cause-and-effect chain and confusion that surrounds organisation;
- **A**mbiguity – the haziness of reality, the potential for misreads and the mixed meanings of conditions; cause-and-effect confusion.

The ward team was experiencing a situation that resembled a VUCA world, underpinned by the Covid-19 situation. The new territory in which team members found themselves had the potential to have a negative impact on their wellbeing, resilience and ability to deliver safe, high-quality patient care.

Box 1. The four functions of the A-EQUIP model

- Formative – involves increasing knowledge education and skills development
- Normative – has a managerial focus on monitoring, evaluation and the quality-control aspects of professional practice
- Restorative – is concerned with the provision of the support that is needed to enhance health and wellbeing by means of restorative supervision
- Personal action for quality improvement

The VUCA model draws on leadership theories and each element of it enables leaders to gain an insight into general conditions and situations, and rationalise the underlying behaviour of groups and institutions, assessing why failures may occur. In recognition of this, the senior nurse leading the dedicated Covid-19 ward decided to engage with a professional nurse advocate to work with the ward staff to:

- Support them during the Covid-19 pandemic;
- Improve their resilience, both during the pandemic and beyond.

Support for staff

After the completion of a Master's module in NHS England's (2017) Advocating for Education and Quality ImProvement (A-EQUIP) model, I began to introduce the model into practice as a newly appointed professional nurse advocate. This was a new role to nursing, which had been introduced by the chief nursing officer (CNO) for England in 2021 to support nurses near the end of the third wave of Covid-19.

The A-EQUIP model was originally introduced to the midwifery profession in response to the findings of the Morecambe Bay inquiry (Kirkup, 2015) and legislative changes to the midwifery profession led to the removal of statutory supervision. This triggered the development of the A-EQUIP model for the profession, and the professional midwifery advocate role was introduced to deploy the model to the midwifery workforce (NHS England, 2017).

The philosophy of A-EQUIP was to provide a framework for midwives to embed continuous improvement, support and supervision into their practice to build their professional resilience and contribute to high-quality care. It involved the professional midwifery advocate using specific aspects of the model that best suited the needs of the midwife (Macdonald, 2019; Dunkley-Bent, 2017).

Given the positive impact the A-EQUIP model has had on the midwifery profession in terms of staff wellbeing, retention and professional resilience (NHS England, 2017), the model is equally pertinent to the nursing profession in terms of positively underpinning nursing practice and the delivery of care.

A-EQUIP is a four-function model with staff at the centre; it was inspired by Proctor's (1987) three-function model of clinical supervision and Hawkins and Shohet's (2012) adaptation of that model. A-EQUIP is described as having four broad functions, which are outlined in Box 1.

Secondary traumatic stress

When I reflected on the emotional stress the team members were experiencing, it was clear that, if an appropriate intervention from the A-EQUIP model was not used in a timely manner, the ward team would be at risk of high levels of stress caused by exposure to distressing events over a prolonged period; this would, ultimately, be harmful to their wellbeing.

It is well recognised that the stressful nature of some nursing work can put nurses at risk for secondary traumatic stress (Morrison and Joy, 2016) and compassion fatigue (Figley, 1995). A literature review by Beck (2011) showed that disturbing events can have a negative impact on nursing staff and decrease their ability to function safely at work; this, in turn, can lead to:

- Poor-quality work;
- Challenging interprofessional relationships;
- A high turnover of staff.

Reflecting on the potential negative consequences facing the ward due to the impact of Covid -19, I decided to apply the restorative function from the A-EQUIP model and focus on delivering support in the form of restorative supervision.

Restoring resilience

The restorative supervisory aspect of A-EQUIP is widely acknowledged to have a positive impact on staff (Pettit and Stephen, 2015). Rouse (2019) stated that the aim of those providing restorative clinical supervision is to help staff build their own resilience to diminish their stress and burnout; emphasis is placed on improving their wellbeing, which will support their ability to make appropriate clinical decisions in complex situations.

Macdonald (2019) described resilience as a "juggling" process, with nurses facing emotionally charged situations that require professional accountability at all times and mentions that the ultimate goal of restorative clinical supervision is to offer a safe environment to enable individuals to consider options and reflect constructively.

Wallbank (2013) also endorsed restorative resilience supervision; she commented that it would equip staff with the knowledge to cope with the demands made on them, stating that when consistently used, it is a robust evidence-based method to support staff. When healthcare staff attended restorative clinical supervision sessions, they demonstrated improved coping strategies and were found to have slightly increased levels of compassion satisfaction (Wallbank and Woods, 2012). This is the pleasure gained from work duties; it is a protective factor against individual stress and burnout and, as such, supports staff retention (Wallbank and Woods, 2012).

Actions for the team

Before delivering the sessions, I met with individuals and teams to introduce myself and my role, and explain the reasons behind the sessions and the format they would take. The dates were set out, staff were invited to attend and a room was made available in a safe and private place.

The sessions started in February 2021 and were delivered once a month over a period of six months, with breakout one-to-one sessions in between, if needed. I made sure the sessions were underpinned by the Solihull Approach (nd), which uses supportive concepts of containment and reciprocity. Containment could be used by nurses to:

- Express their emotions;
- Make sense of emotions in a calm manner;
- Form coping mechanisms (Wallbank and Woods, 2012).

The sessions were also supported by the appreciative inquiry (AI) model, which can be transformational for individuals and teams. Sharp and Dewar (2017) described AI as a developmental process; the approach aims to discover what gives life to a system, what energises people and what they most care about to produce both shared knowledge and motivation for action.

I planned to support staff to develop reflection action plans, if needed, to help them restore their capacity to think from within a safe, confidential and supportive relationship, with myself as their supervisor. Proctor (2004) endorsed this approach and stated that, if supervisees feel safe and supported, they are more open to supervision, which will lead to self-development strategies, including the building of positive, nurturing relationships.

When the sessions started, the group was told that the session would last for an hour, all discussions that took place during the session were confidential and, if an individual felt uncomfortable, they should feel safe to leave and we would check in with them after the session had ended.

Each individual supervision session was attended by up to five registered nurses, some of whom were in a senior clinical leadership position on the ward. Over the course of the six months, 10 members of staff regularly attended for restorative clinical supervision. The group included a band 7 ward manager, a band 6 deputy ward manager, band 6 clinical senior staff nurses and student nurses.

Informal evaluation

At the end of the six months, an informal evaluation was carried out by means of a snapshot survey. The sessions were evaluated positively and transformed the morale and resilience of the team, who remained together working on the ward. They are now in a position – and feel motivated – to further develop their nursing careers. More importantly, they know they can readily access restorative supervision to help them cope with any challenges that lie ahead.

The senior team and the rest of the ward staff on Ward 221 are now demonstrating enthusiasm and motivation for their work, which is reflected in the inhouse quality-accreditation achievements: the ward achieved Silver status and also received a Chief Executive Award in recognition of its staff's hard work during the second surge of Covid-19. In addition, team members have gained motivation to further their professional development in their clinical area or speciality, and five senior team members are undertaking further study in those areas or in leadership skills.

Box 2. **Staff comments on the sessions**

"I really enjoyed the sessions. It was great to share my feelings and experiences, as well as listening to others in a trusting and comfortable environment, which made me feel more confident to talk freely."

"My team [members] *now feel able to think through the situations they have dealt with and feel that they can definitely cope better as a team. If they face the same situation again, then they feel more confident to cope and know that they can have supervision again to support them."*

"A great chance to not just reflect, but [also to] *understand each other's needs and feelings. By having these sessions, it helps to understand we are not alone."*

"I would like to have more sessions on a regular basis as I felt they helped me to think through what I was feeling and thinking at the time, and how to work better."

"I felt listened to and it helped to hear that others felt the same way too."

"All staff said they would want further restorative supervision sessions, and that they felt better equipped to deal with anxieties, which would help them to support ward staff"

Feedback from nursing staff

Nursing team members who received restorative supervision were asked whether they would recommend it to their colleagues; all agreed that they would encourage their co-workers to access restorative supervision.

When asked whether they had benefited from attending the sessions, all said they had been able to think more clearly, and felt better able to cope with distressing thoughts and lead their team in a more positive and rational way. All staff said they would want more restorative supervision sessions and felt better equipped to deal with anxieties, which would help them to support the ward staff. Box 2 details some of the comments that were made by those who attended the sessions.

Conclusion

When I reflect on the knowledge I have gained in the delivery of restorative supervision as a part of the A-EQUIP model, I realised that there is a compelling argument to support nurses to develop resilience and help them cope with the work pressures they face.

In keeping with the CNO for England's strategy to expand the number of professional nurse advocates in practice (NHS England, 2021), the trajectory is to have one per setting at our hospital, which can only be beneficial for the nursing workforce.

By introducing restorative supervisory sessions to nursing practice, staff can benefit emotionally and physically from its supportive philosophy, which will enhance the quality of the care they deliver. I was a lone professional nurse advocate in my organisation but, soon, it seems certain that more individuals will be trained to deliver this service and expand it, which would serve the nursing population well. **NT**

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