



Department of

**Health, Social Services
and Public Safety**

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CLINICAL SUPERVISION FOR MENTAL HEALTH NURSES IN NORTHERN IRELAND: BEST PRACTICE GUIDELINES

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ACKNOWLEDGEMENTS

These guidelines have been completed with the help of numerous individuals supported by their respective organisations. The contribution and support of HSS Trusts throughout Northern Ireland has been important in advancing the development of guidelines for clinical supervision in mental health nursing practice. Particular thanks also goes to Mrs Pat Cullen, Chair of the Project Group, members of the group and Chairs of sub-groups. In addition, special thanks are extended to Mr Francis Rice, DHSSPS, whose expert advice and support was invaluable to producing the guidelines.

FOREWORD

Clinical supervision is an essential component in ensuring the provision of safe and accountable practice. Its importance is underlined by the introduction of Clinical and Social Care Governance, and I believe its implementation is fundamental to developing safe and effective practice.

This document sets out the benefits of clinical supervision for mental health nurses. The guidance represents the work completed by a regional project group led by the Nursing and Midwifery Advisory Group at the DHSSPS. It is intended to encourage all practising mental health nurses to engage in the clinical supervision process as well as assist managers to understand and support the implementation of clinical supervision. As stated in the guidelines, clinical supervision is at this time not a mandatory process. However, I would ask that the actions contained in this document are viewed with commitment and fully implemented throughout mental health nursing. The guidance outlines the responsibilities of education establishments charged with providing nurse training and education. The education and training components are integral to the effective implementation of clinical supervision. Education establishments will be assisted by the Northern Ireland Practice and Education Council (NIPEC) to ensure effective design and delivery of this training.

Finally, I wish to thank all those involved in developing the guidelines. I recognise the commitment given to developing this document. I am confident that through its proper implementation, nursing practice will continue to be developed and enhanced and care for people will be delivered at a high level.

Judith Hill (Miss)
Chief Nursing Officer

1.0 INTRODUCTION

Mental Health Nursing, like other areas of nursing and other Health and Social Care professionals is working in a constantly challenging and changing environment.

The need to support nurses in uncertain times, increase morale and decrease conflict, resolve personal or inter-personal difficulties, ensure less strain and burnout and encourage self-awareness and self-expression has arisen in a changed nursing context of valuing relationships with patients within the restructured health services and Health Service restructure (Yegdich, 1999). According to Butterworth and Faugier, (1992) clinical supervision is central to promoting personal and professional development, reducing stress and burnout and improving clinical standards and enhancing the quality of care for patients.

Clinical supervision offers a framework that encourages review and reflection in practice. If properly implemented, clinical supervision will be the greatest driver in taking forward excellence in care (Driscoll, 2000). Clinical supervision must have commitment from all levels in the organisation - from practitioner through to Chief Executive. It requires time, funding, manpower and training. As recognised by many nursing experts who have written widely on the subject, clinical supervision, in the near future needs to be embedded in pre-registration nurse education and facilitated in clinical practice where the continuum of clinical supervision really begins. In this way, clinical supervision will be expected, as a continuum of lifelong learning (Bishop, 1998a; Butterworth, 1998; DOH, 1999; UKCC, 1996; Driscoll, 2000).

2.0 THE CONTEXT

A number of factors have influenced the need for clinical supervision in nursing practice. The following list summarises the principle factors that significantly relate to the need for clinical supervision to be developed in mental health nursing.

- i. The changing patterns in health and social care delivery i.e. the shift to community based care for mentally ill people.
- ii. The changing patterns of illness i.e. patients with complex illness and multiple diagnoses now being admitted for assessment and treatment.
- iii. The introduction of clinical and social care governance (CSCG), placing the responsibility for the quality of care jointly on organisations and on individuals within organisations (Butterworth and Woods, 1999).
- iv. The publication of the Department of Health's Clothier Report (1994) - commonly referred to as the 'Allitt inquiry'.
- v. The increased emphasis on effectively managing risk, including clinical risk management.
- vi. Changes in professional regulation and the need to maintain registration through self-regulation activities.

3.0 BACKGROUND

In April 2002, a regional project group was established by the Nursing and Midwifery Advisory Group (NMAG) to undertake the development of guidelines for implementing clinical supervision in mental health nursing.

The project was undertaken as a result of requests from mental health managers and practitioners to introduce a co-ordinated approach to implementing clinical supervision throughout relevant HSS Trusts in Northern Ireland. Concerns were raised about the difficulties practitioners and managers encountered in attempting to agree a definition of clinical supervision that could be applied in all areas where mental health nurses practice, the problems with putting in place arrangements for implementing clinical supervision and finding an agreed approach to training supervisors and supervisees.

Nominations to a Regional Project Group were sought from all HSS Trusts providing mental health services, the two universities in the province, two in-service consortia responsible for providing in-service education in mental health and the prison health care service.

Management, mental health nursing practice, practice development and all generic and specialist mental health services across hospital and community were represented within the membership of the group. The membership of the Project Group is listed at Annex 1.

4.0 AIM AND OBJECTIVES

4.1 Aim of the Project

The aim of the project is to explore ways to make clinical supervision available to all mental health nurses in a manner designed to enable them to evaluate and improve their contribution to patient and client care.

4.2 Project Group Objectives

The Project Group established eight main Objectives:

- To complete a review of the literature and policy guidance, and in particular that which applies specifically to mental health nurses;
- To complete a baseline assessment of current practice of clinical supervision in order to inform the way forward (service providers);
- To agree a definition of clinical supervision that is relevant to all mental health nurses;
- To determine an appropriate model(s)/framework(s) which will support the effective implementation of clinical supervision;
- Examine ways to implement clinical supervision for nurses working in a diverse range of care areas;
- Develop an action plan which will guide the implementation of clinical supervision including training for supervisors and supervisees;
- Outline the important factors to be considered in effectively communicating a strategy for best practice;
- Detail arrangements for auditing/evaluating the implementation and operationalisation of clinical supervision including the training arrangements.

In order to progress the objectives established for the project group, subgroups were formed with membership designed to reflect a cross-section of service provision and specialist interests.

Recommendations

1. Clinical supervision should be a statutory requirement.
2. These guidelines should be endorsed by Chief Executives of Trusts and fully implemented.
3. Heads of Education Establishments should endorse the education and training components.

5.0 SURVEY OF CURRENT CLINICAL SUPERVISION PRACTICE

Nurse Directors in Health and Social Services Trusts providing mental health services, the two Universities and In-Service nurse education providers were asked to provide relevant information, guidance, policy and protocols developed by their organisation relating to clinical supervision. The following information was requested:

- An overview of what is happening with clinical supervision in mental health within individual organisations;
- Details of each organisations policy on clinical supervision including any specific mental health policy/guidance/protocol documents;
- Details on operational arrangements in place for carrying out clinical supervision, including information on the model/models used and how supervision is carried out, for example individually, group or both;
- Details of training for supervisors and supervisees including the name of the training provider;
- Information on the resource commitment required or anticipated for implementing clinical supervision;
- Details of any difficulties encountered in the implementation of clinical supervision;
- Details of any formal reviews of clinical supervision policies and protocols.

5.1 Analysis of Current Clinical Supervision Practice in Mental Health Nursing

Responses to the baseline survey were received from twelve Trusts. The two Universities and two in-service education providers responded to education and training related questions.

5.2 An Overview of the Current Position with Implementing Clinical Supervision

An analysis of the survey responses indicated that all of the Trusts have made efforts to implement clinical supervision over time and across the range of areas where mental health nurses practice. However in almost all Trusts implementation has not been achieved to a degree that would facilitate the effective use of clinical supervision. Some success is reported in areas where specialist mental health orientated practitioners work. The following are important key findings:

- Less than 25% of the responding Trusts had succeeded in implementing clinical supervision for nurses providing inpatient care;
- Two Trusts had successfully put in place developmental orientated supervision and support for community psychiatric nurses. However some Trusts described clinical supervision as encompassing managerial supervision and performance appraisal;
- Many nurses and managers assumed clinical supervision to be part of managerial supervision and/or performance appraisal processes and feel that it is not possible to separate these;
- Clinical supervision is very well established and positively accepted in areas where nurses are practising as specialist practitioners. For these nurses, clinical supervision has commonly been introduced during their specialist training;
- Over 50% of responding Trusts indicated that clinical supervision is provided by the supervisees respective line manager and involves caseload review i.e. size of caseload, analysis of caseloads i.e. clinics attended, treatments etc and training requirements;

- Over 50% of responding Trusts reported that clinical supervision is provided at team assessment meetings which are usually led by the consultant psychiatrist;
- 75% of the Trusts responding advised that in general mental health services, clinical supervision is not established and plans are not well developed to work towards an implementation process.

5.3 Details of policies/procedures/guidelines and protocols

- Four of the twelve responding Trusts provided some form of policy guidelines;
- None of the responding Trusts were operating clearly defined policy or guidelines on the practice of supervision for mental health nurses. Those Trusts with related policy tended to focus on the concepts associated with clinical supervision and not on the actual implementation process.

5.4 Operational arrangements for implementing Clinical Supervision

- None of the respondents indicated the use of a preferred model. Some suggestions on possible models that could be considered were noted, however, no progress had been made at Trust level with implementing a preferred model;
- In areas where clinical supervision is implemented i.e. specialist practice, it appears that a combination of individual and group supervision is operationalised.

5.5 Current Training and Education Arrangements

Trusts are currently accessing training in clinical supervision provided by two of the three in-service consortia. Current training programmes for supervisors, supervisees and managers in their respective training perspectives are delivered over a two-day period.

5.5.1 Training for Supervisees

Both consortia provide awareness training for supervisees with the following objectives:

- To provide an awareness of essential features of clinical supervision;
- To discuss the concepts and benefits of reflective practice;
- To explore ways supervisees can prepare for clinical supervision;
- To discuss strategies to maximise the clinical supervision process.

5.5.2 Training for Supervisors

This training is aimed at facilitating supervisors to increase their knowledge and skills to enable them to be effective clinical supervisors. The following key areas are included:

- Identification of core issues relating to clinical supervision;
- An appreciation of the essential features of communication;
- Work in group situations to experience aspects of clinical supervision;
- Examination of the concepts of the clinical supervision relationship.

5.5.3 Training for Managers

Training for managers is aimed at facilitating managers to explore their role in supporting practitioners to implement clinical supervision. The following objectives were identified:

- To gain an appreciation of essential features of clinical supervision;
- To explore conditions in the workplace for the effective implementation of clinical supervision;
- To reflect on the manager's role in supporting staff to develop clinical supervision strategies.

5.6 Resource Commitment

- All responding Trusts emphasised the need for adequate financial resource to be made available and ringfenced for the proper implementation of clinical supervision. Without this commitment Trusts clearly believe that clinical supervision cannot be implemented;
- Trusts identified implications for recurring and non-recurring costs. Recurring costs are mainly concerned with staff cover during release associated with the giving and receiving of clinical supervision. Non-recurring costs are associated with initial training provision and the time required to release staff for training;
- Lack of resources was clearly highlighted as the main reason for clinical supervision not being in place;
- At times of staffing crisis, clinical supervision sessions arranged are usually cancelled;
- Trusts estimated that each practitioner should have between 1½ - 2hrs protected time each month for clinical supervision;
- Sufficient cover must be available during the nurse's absence i.e. a replacement must be available when necessary.

5.7 Difficulties encountered in implementing Clinical Supervision

- All responding Trusts are experiencing problems with implementing clinical supervision;
- The absence of regional guidelines on the development and implementation of clinical supervision was identified as a difficulty;
- All Trusts identified as problematic, anxieties within the generic mental health nursing population with regard to engagement in clinical supervision. These difficulties do not appear to exist amongst specialist practitioners, or nurses working in specialist services such as addictions and child and adolescent services;
- Problems with recruitment, retention and sustaining current staffing levels were identified as barriers to successfully implementing clinical supervision;
- Difficulties were being encountered with regard to differentiating between clinical supervision, preceptorship, management supervision, professional supervision and performance appraisal.

5.8 Formal Reviews Completed

None of the responding Trusts had formally reviewed or evaluated the impact of their policies/protocols/guidelines relating to clinical supervision.

6.0 DEFINING CLINICAL SUPERVISION IN MENTAL HEALTH NURSING

The project group emphasised the importance of agreeing a clear definition of what is meant by the term clinical supervision in the context of mental health nursing. The group believe that there are key principles that differentiate clinical supervision from other forms of supervision and appraisal. For the purpose of agreeing a comprehensive definition, sub-groups carried out an extensive review of published definitions. Arising from their deliberations the following principle based definition was determined that can readily be applied across the range of care areas where mental health nurses may work.

6.1 Clinical Supervision in mental health nursing:

- is a supervisee led formal process where protected time is facilitated for professional support and learning;
- enables practitioners to develop knowledge, competence and skills required to provide best care for patients/clients;
- is an ongoing activity bringing practitioners (supervisees) and skilled knowledgeable supervisors together in a supportive environment;
- is a lifelong commitment for and by practitioners extending throughout their professional career;
- facilitates ongoing reflective practice;
- is aimed at advancing clinical autonomy and self-esteem leading to personal and professional development.

Recommendation

1. The definition should be agreed and accepted by all practising mental health nurses and managers. The definition must be visible in all operational guidelines, policies and procedures pertaining to clinical supervision.

6.2 Protected Time

While not expressly included in the definition, organisations must commit to facilitating supervisees and supervisors to have 'time out' to engage meaningfully in clinical supervision sessions. In most cases, experience indicates that this amounts to a maximum of two hours per month per person. Whilst acknowledging the potential resource implications that this may impose on organisations, it is a small price to pay given that the investment will facilitate and develop practitioners who will be in a position to provide safe, modern, evidence based quality care for patients/clients. In addition, it is clear that practitioners who are facilitated to avail of clinical supervision will feel valued and have clear commitment to patients/clients and their employing organisation.

Without this commitment to protected time, the project group believe that clinical supervision cannot be properly implemented.

Recommendation

1. Organisations should commit to facilitating protected time for supervisees and supervisors. This will require both committed finance and cover for practitioners during their involvement in clinical supervision activities.

7.0 THE BENEFITS OF CLINICAL SUPERVISION

There are a number of benefits of clinical supervision for both managers and practitioners. All benefits must be considered in the context of providing better care for patients i.e. the recipients of nursing interventions. Yvonne Moores, then Chief Nursing Officer (CNO) for England (in Dudley & Butterworth, 1994) described clinical supervision as 'fundamental to safeguarding standards, the development of professional expertise and the delivery of quality care'. Kelly et al (2001) highlight a number of benefits for Community Psychiatric Nurses (CPN's) engaged in the clinical supervision process. This study of CPN's confirmed that 'supervision relieves isolation, leads to personal development and provides for greater confidence'. These findings confirmed Brooker's and White's (1997) study where similar benefits of clinical supervision were highlighted, including additional clinical insight, increased confidence and stronger working relationships. Bishop (1994) as well as highlighting the benefits for practitioners, their colleagues in multi-disciplinary teams and for managers suggests ultimately that clinical supervision improves the quality of care of patients by:

- Maintaining and safeguarding standards of care;
- Valuing the development of professional and practice knowledge;
- Ensuring the optimal delivery of quality care.

Driscoll (2000) commenting on Bishop's work refers to these as primary aims which need to be taken account of in any model of clinical supervision. He asserts that clinical supervision sessions should always focus on 'practice concerns', as the issues explained in clinical supervision will always be from within the domain of clinical nursing.

The project group, in reviewing the extensive literature on clinical supervision endorse and recommend the cited benefits as compelling reason for the implementation of clinical supervision for practitioners in mental health nursing. The group agreed that the following benefits, outlined from the relevant literature, best describe the principal benefits for practitioners and managers. Furthermore, these benefits accruing from the practice of clinical supervision, all impact directly on the quality of patient and client care. This is fundamental to the establishment of and maintenance of best practice in mental health nursing.

7.1 Benefits for Practitioners

The principal benefits for practitioners can be summarised as follows:

- Practitioners feel valued and self-esteem is increased. In addition, practitioners experience an increase in professional confidence and competence particularly in situations where other professionals seek their professional opinion;
- Clinical supervision encourages safe autonomous practice that reflects individual person centred care. It increases job satisfaction and reduces the pre-occupation on an 'unfair' blame culture. Openness is also encouraged through the process;
- Engaging in clinical supervision enhances personal and professional development and assists practitioners in meeting PREP requirements. Overall supervision encourages continuous professional and personal development and a commitment to lifelong learning;
- Clinical supervision encourages positive challenging of practice in a safe, supportive environment where individual practitioners can freely examine weaknesses. Furthermore, practitioners feel empowered and facilitated to take responsibility for their professional actions and decisions. It also offers direction by what can be termed as a 'critical friend'.

7.2 Benefits for Managers

In order for clinical supervision to be effective and fully integrated into practice, a committed management approach is essential. Therefore, the project group highlight benefits for managers rather than organisations. At the outset, the group recognised the difficulties for managers in supporting a process that is by design not primarily managerial and one that may therefore be perceived as conflicting with the existing managerial processes. As well, managers are accountable for ensuring that safe, evidence-based care is provided for patients/users by practitioners who have up to date knowledge, skill and experience.

If however, clinical supervision is viewed in the context of facilitating the development of practitioners and through practice development advancing a confident, evidence orientated and knowledgeable practitioner then the advantages to managers striving to deliver a quality service to patients and clients are obvious and any apparent challenge to the manager role within the clinical supervision relationship irrelevant. The challenge for managers is to ensure that practitioners are facilitated to participate in clinical supervision so that the potential of advancing the personal and professional development of staff and through that strategy the quality of patient and client care.

The necessary robust operational policies include the contracting arrangements between supervisor and supervisee that clearly include guidance on the role and responsibilities of the manager and the types of situations that must be communicated to them. Agreeing such important baseline principles at the outset is crucial to the effectiveness of the process of clinical supervision.

The project group consider the following benefits to be important for managers:

- Clinical supervision enables managers to satisfy themselves that the Nursing and Midwifery Council (NMC), Code of professional conduct, guidelines and standards are considered on an ongoing basis by practitioners and thus adhered to in every respect. It supports the principles of clinical and social care governance;
- Engagement in clinical supervision facilitates improvements in practice, leads to increased safe care delivery that results in reduced complaints and possible litigation. It also is a key safeguard for managers who clearly support practitioners to review and continually reassess their professional actions and possible inactions;
- It improves morale and encourages motivation. By supporting the process, practitioners acknowledge that managers are placing importance on their need to have protected time to review clinical practice and re-evaluate their professional and personal development;
- Clinical supervision also provides opportunities to manage conflict and to examine resolution strategies. In addition, it greatly assists managers to meet statutory quality requirements, and assists in ensuring accountability and regulatory functions are not ignored.

Recommendations

1. Managers should ensure that practitioners are facilitated to participate in clinical supervision.
2. Managers should ensure that robust operational policies are put in place in their organisations.
3. Operational policies should include the contracting arrangements between supervisor and supervisee, the role and responsibilities of managers and types of situations to be communicated to them.

8.0 COSTING CLINICAL SUPERVISION

There are significant costs involved in setting up and providing clinical supervision. It has been estimated that the cost for a medium sized HSS Trust to provide one hour of supervision a month to each nurse would cost in the region of £125,000 (Nicklin, 1997). Nicklin suggests that if the cost resulted in reduced sickness levels, improved clinical effectiveness and quality of care, a reduction in complaints and clinical errors, and increased staff morale, clinical supervision would pay for itself.

In particular, time is an important resource for clinical supervision. Time needs to be found within the working day if supervision is to be properly implemented (Lyth, 2000).

Recommendations

1. Organisations should provide time within the working day for clinical supervision to be carried out effectively.
2. Organisations should provide appropriate funding for clinical supervision.

9.0 CHOOSING A SUITABLE MODEL OF CLINICAL SUPERVISION

There are countless clinical supervision models described in the literature and many are relevant to mental health nursing practice.

The project group, in considering various models concluded that this guidelines paper should not prescribe a specific model. Rather the guidance should outline a set of concepts or principle statements that may be applied across a broad range of potential applications of clinical supervision including, group, multi-disciplinary or specialist practitioners.

In this regard, the clinical supervision process must:

- Ensure that the primary focus is on clinical practice and benefits patients/clients care;
- Promote safe practice;
- Be supervisee led and not directed by managers;
- Adopt a flexible approach in applying the process;
- Facilitate personal and professional growth;
- Be capable of being applied in a variety of mental health care settings;
- Ensure time for reflection and practise review - not monitoring;
- Support positive challenging;
- Be easily understood;
- Facilitate the development of patient/client focused practice and nurse education.

10.0 THE PURPOSE OF CLINICAL SUPERVISION

The purpose of a clinical supervision session can be described under three headings:

1. Clinical discussion - exploring interventions and the supervisee's knowledge and skills.
2. Emotional support - attempting to assist in dealing with the stress inherent in mental health nursing.
3. Professional development - exploring with the supervisee their knowledge base and development of skills.

11.0 GROUND RULES FOR CLINICAL SUPERVISION

In setting up clinical supervision, it is essential that the boundaries of the supervisory relationship are established through the explicit drawing up of the ground rules via a mutually negotiated contract (Rolfe et al, 2001).

Basic ground rules should be discussed, agreed and be clearly visible in a supervision contract which both the supervisor and supervisee should sign at the initial session.

The following factors need to be considered in drawing up a contract.

- Linking and communicating with managers.
- The frequency, duration and venue for the sessions.
- Commitment from both parties to make themselves available for agreed sessions.
- The need for punctuality.
- Commitment from the supervisee to prepare an agenda for each session.
- Agreement on the understanding of confidentiality and recording of the sessions.
- Arrangements for re-negotiating the supervision format at any time - e.g. changing from group to individual.
- Agreements to ensure that the supervisee understands that the sessions will be both challenging and supportive.
- Arrangements for reviewing the contract.
- Supervisor and supervisee must agree to show respect and loyalty to the supervision sessions.
- In the event of either being dissatisfied with the process, it should be agreed that issues are, in the first instance addressed within the supervision relationship.

Recommendation

1. The recommended ground rules listed should be agreed at the outset by the supervisor and supervisee and included in a contract. Both the supervisor and the supervisee should sign the contract at the initial supervision session.

12.0 METHODS OF RECORDING AND DOCUMENTING CLINICAL SUPERVISION

12.1 Confidentiality and Clinical Supervision:

The Legal Perspective

The current position on confidentiality by the UKCC (NMC), (1996) is that if an employer includes in the contract of employment a requirement that the employee undertakes clinical supervision, then the documentation is the property of the employer. However, if an employer merely encourages an employee to participate in clinical supervision, then any records made are 'probably' the property of the employer (Driscoll, 2000).

Whatever the position, confidentiality must be addressed in a sensitive manner in operational policies developed by organisations. Otherwise, there may be a risk that supervisors and supervisees will be tempted not to keep records (Bond & Holland, 1998). The regional group sought advice from the DHSS&PS legal department in relation to confidentiality. The legal advice reiterated the advice already given by the UKCC in 1996, and is as follows:-

'If clinical supervision is to become part of the practitioners normal employment duties i.e. clinical supervision is included in employment contracts, then any notes compiled during supervision sessions cannot be regarded as confidential as far as the employer is concerned'.

The notes are the property of the employer and may only be disclosed with the employers consent on production of a court order or subpoena. If an employing authority wishes to agree that records relating to clinical supervision are confidential to the supervisor and supervisee, then this must be clearly stated in the organisations policy document, detailing the position and authority of the person who has given this agreement. The document should be signed and dated by this person.

If clinical supervision is to facilitate real staff development, then clearly it will require considerable trust on the part of both parties (Macintosh & Ashman, 1999). This presents a considerable challenge to organisations, supervisees and supervisors. Clinical supervision is a complex innovation that seeks to explore nursing practice in a way that will only work in a climate of openness and trust; this climate cannot be taken for granted (Bassett, 1999).

12.2 Record Keeping

The project group fully support the need to make and retain a written record of each supervision session.

Documentation is simply a description of what happened during the session and subsequent reflections and actions (Driscoll, 2000). Keeping records is an important safeguard because they can be presented at the next session as an accurate account of what went on during the previous session.

Records are intended to promote safe practice as well as safe supervisory practice.

An ongoing record is developmental for both supervisor and supervisee and can form the basis for further reflection to maintain professional registration.

Records can provide evidence for auditing and reviewing the effectiveness of clinical supervision and can also provide evidence on the practitioner's part that they are participating in the clinical and social care governance process.

12.3 Recording Clinical Supervision Sessions

The supervisor and supervisee should make written records. Keeping written notes of the supervision sessions is essential to completing robust audit and evaluation of the effectiveness of clinical supervision.

Written records should not be viewed in a suspicious or negative way. They are an essential part of the supervisory process and clearly show that practitioners are engaging in a process that enables them to provide safe and effective care for patients/clients.

Records can be in the form of brief notes that can be supported by the use of reflective journals held by the supervisee. Reflective journals are useful in compiling personal professional portfolios.

Generally, written records should include:

- time and date of the session;
- name of clinical supervisor and supervisee;
- outline of agenda for discussion;
- outcomes and action plan;
- date and time of next session.

A sample recording pro-forma is provided at Annex 2.

Recommendations

1. Organisations should state their position in relation to confidentiality in their operational policy on clinical supervision. The policy should detail the position and authority of the person in the organisation who has agreed the confidentiality statement.
2. Supervisors and supervisees should keep written records of the supervision session.

13.0 SUPERVISORS AND SUPERVISEES

13.1 Who are the Supervisors?

Many writers have detailed the fundamental features of the role of the supervisor (Fitzgerald, 2000; Johns & Mc Cormick, 1998; Faugier & Butterworth, 1994; Faugier, 1992). These writers refer to the supervisor having a willingness to facilitate learning in others whilst being open to learning about themselves. It is thought to be essential that supervisors have a willingness to undertake self-assessment and they should not only have training in clinical supervision but should also be in a supervision relationship on their own behalf (Kohner, 1994). This is crucial, according to Rolfe et al (2001), if the supervisor is going to role model one of the fundamental purposes of supervision to their supervisee, i.e. to look at the intention behind the intervention.

The project group agreed that to effectively implement the concepts and principles outlined in this best practice document, it was necessary for clinical supervision of mental health nurses to be carried out by practising mental health nurses. However, the group recognise that most mental health nurses practice in multi-professional environments and therefore that it may be important for mental health nurses to consult with practitioners from another discipline for expertise and professional guidance that is not readily available within the nursing profession. It is important that in such cases the arrangements are acceptable to the clinical nurse supervisor and that structures are in place for tripartite communication, if necessary.

In this regard, the project group proposes that:

- Supervisors are all practising mental health nurses who will have completed recognised training as described in this guidance document at Section 14.0;
- Supervisors must have sound clinical skills, a strong knowledge base and be a practising clinical nurse or nurse therapist;

- Supervisors should demonstrate a clear commitment to the role of the clinical supervisor and possess care qualities such as being available to carry out reflective supervision, reliability, supportiveness and commitment;
- Supervisors should have the capacity to inspire supervisees to reflect on and evaluate their clinical and therapeutic work.

13.2 Who are the Supervisees?

Much of the literature on clinical supervision tends to focus on the developmental needs of the clinical supervisor, sometimes at the expense of the supervisee (Sams, 1997). However, as Bond & Holland (1998) point out supervisees are not passive players in the clinical supervision process but are central to its success

The project group gave careful consideration to agreeing who should receive clinical supervision - should it be all trained mental health nurses and nursing assistants, nurses providing direct clinical care or should nurses involved in an indirect way also receive clinical supervision?

After careful consideration of the agreed description of clinical supervision, it was agreed that clinical supervision should be available to all first and second level mental health nurses who are practising clinicians carrying out direct therapeutic work with patients/clients.

It was also agreed that other forms of supervision and support differentiated in these guidelines should be considered for support staff and other nursing staff not charged with delivering clinical and therapeutic care i.e. managers, practice development nurses etc.

Recommendations

1. Supervisors should be practising mental health nurses. For nurses working in multi-professional environments, it is important that they consult with practitioners from disciplines with expertise and professional guidance not available within the nursing profession.
2. Supervisors should complete recognised training as described in this document.
3. Supervisees should be classified as all practising 1st and 2nd level mental health nurses, providing direct therapeutic care for patients.

14.0 TRAINING FOR SUPERVISEES, SUPERVISORS AND MANAGERS

In reviewing the literature regarding training needs, it is clear that there are three distinct groups of people requiring training. These are supervisees, supervisors and managers.

Bishop (1998b) carried out a survey to explore the level of implementation of clinical supervision within Trusts in England and Scotland. Whilst the majority of the respondents were engaged in some form of clinical supervision, this was not without its difficulties. It is therefore crucial that all levels of staff within an organisation, including managers, have access to adequate information and education regarding the purpose of supervision, so that informed decisions can be taken in order to mobilise the necessary resources (Farrington, 1995; Kohner, 1994).

Scanlon (1998) notes that 'given the sophistication of clinical supervision, advanced education is advocated'. The need for adequate training is also highlighted by Gilmore (1999) who claims that without appropriate training, the benefits of clinical supervision cannot be realised.

Kelly et al (2001) note in their study of CPNS, that 63.9% (n=61) of supervisors surveyed felt that appropriate training was needed. The authors of this study suggest that the identified training deficits in supervision skills raises questions regarding the degree to which these skills are being taught on CPN qualifying and continuing education programmes. Moreover, they note that such limitations must influence how efficiently clinical

supervision is currently being practised and the availability of skilled supervisors in the field to carry out clinical supervision effectively. Limitations of this nature must affect the degree to which problem solving, improving practice and increasing understanding of professional issues can be achieved through the medium of the clinical supervision currently in operation (Kelly, et al., 2001).

The project group in examining training requirements gave much consideration to who should provide the training. The group agree that it would be inappropriate to be prescriptive about preferred training providers. However, the group was unanimous in recommending that the application and implementation components of clinical supervision should be provided by practitioners who are skilled in clinical supervision. They should be practising and actively engaged in clinical supervision.

However, the project group also acknowledge that there are components of the training that could be delivered by trainers not actively engaged in clinical supervision. Examples of these areas include: the background to clinical supervision, core skills of supervisors and supervisees and recording and documentation. These practical applications will be directed by this document which recommends a framework for delivering the training programmes.

14.1 Supervisee Training

Butterworth et al (1997), Fyffe (1997) and Sams (1997) highlight the need for supervisees to receive preparation, which aims at enabling them to participate and gain maximum benefit from clinical supervision.

The overall aim of training for supervisees is to ensure that they have a clear understanding of what clinical supervision is about and to experience engagement in the clinical supervision process through role-play. Furthermore, supervisee training should be focused on the skills required to participate effectively in the process. There should be particular emphasis on the importance of reflection linked to practice Rolfe, et al (2001).

14.2 Supervisor Training

Supervisor training is identified as crucial to the success of clinical supervision (Johns, 1996; Bulmer, 1997; Fyffe, 1997; Roden, 1997).

The primary aim of training supervisors is to ensure that they are able to practice their core skills. As with supervisee training, role-play should be included in training programmes. It is important that following training, supervisors continue to meet as a group, to ensure ongoing information sharing and to provide a support mechanism for members.

Training programmes for supervisors should include:

- responsibilities of the supervisor;
- confidentiality, recording and contracting;
- examination of the challenges, barriers and pitfalls.

It is important that training programmes achieve a balance between challenging myths and beliefs and supporting supervisors to develop the necessary skills and expertise.

14.3 Manager Training

The UKCC (NMC) 1996, states that links between clinical supervision and management are important. Development and establishment of clinical supervision should therefore involve managers. This should include the involvement of managers in training.

Managers require a generic awareness of clinical supervision. By this the project group means that they must be aware of the benefits of clinical supervision, the links to clinical and social care governance, the roles of the

supervisors, the commitment required to facilitate proper clinical supervision and the content of this guidance document.

Recommendation

- Supervisors, supervisees and managers should complete appropriate training based on the recommendations in this document.

14.4 Duration of Training Programmes

The project group recommend three levels of training as described below.

LEVEL OF TRAINING	FOR WHOM	OUTCOMES	DURATION
1. Awareness Training <ul style="list-style-type: none"> Introduction to Best Practice Guidance Defining clinical supervision Benefits of clinical supervision Implementing clinical supervision 	<ul style="list-style-type: none"> Chief Executives Directors of Nursing Nurse Managers Practitioners 	<i>Participants will:</i> 1(a) evaluate how clinical supervision can enhance individual and organisational working and promote safe patient and client care. 1(b) consider how clinical supervision can be supported and resourced to enable effective clinical supervision to be successful in busy clinical practice.	1 Day
2. Supervisee Training <ul style="list-style-type: none"> Skills including role play Emphasis on recording, confidentiality All of the above (awareness training) 	All first and second level nurses (including supervisors who are receiving clinical supervision)	<i>Participants will:</i> 2(a) critically analyse how clinical supervision can impact on and improve their own professional practice. 2(b) examine the principles of clinical supervision with regard to the role of the supervisee 2(c) engage in a clinical supervision process which values trust, confidentiality, goal-setting and achievement	3 Days
3. Supervisor Training <ul style="list-style-type: none"> Skills of the supervisor Carrying out clinical supervision Role play 	Clinical Supervisors	<i>Participants will:</i> 3(a) discuss the development of an effective supervisor-supervisee relationship in a non-threatening, supportive environment. 3(b) examine the roles and responsibilities of supervisors and supervisees during clinical supervision. 3(c) explore the skills supervisors require to facilitate clinical supervision 3(d) discuss the employers' Clinical Supervision protocols; (to include the role and responsibilities of managers and situations which must be communicated to them).	3 Days

In adopting the above framework, opportunities for staff to receive recognition for the training, should be afforded academic accreditation.

Recommendation

- The proposed training framework should be adopted by provider organisations and Heads of Education.

15.0 EVALUATING AND AUDITING THE IMPLEMENTATION OF CLINICAL SUPERVISION

The UKCC (NMC) 1996 accepts that there is currently a lack of information on the benefits and outcomes of having clinical supervision in practice. Employers have invested in clinical supervision largely on the assumption that it will be advantageous in clinical practice and will therefore need to be convinced that further investment is warranted (Driscoll, 2000). Driscoll also suggests that it is necessary to supply evidence for the effectiveness of clinical supervision in practice in order to strengthen the case for employing organisations to fully support the initiative by incorporating it into annual business plans. Butterworth et al (1997) in a government-sponsored multi-site evaluation of clinical supervision, offers empirical evidence that clinical supervision and mentorship schemes protect as well as support clinical staff in practice, but recommends that staff must be given adequate time and preparation to adapt to the additional roles and responsibilities.

The project group recommend that HSS Trusts should put in place arrangements for evaluating and monitoring the impact of clinical supervision. The DHSS&PS will monitor the implementation of this guidance on clinical supervision, and will keep it under review.

The following areas are considered to be important in respect of the evaluation and monitoring the implementation and impact of clinical supervision:

- evidence of a robust operational policy,
- plans for implementing clinical supervision,
- development of a system for recording sessions,
- agreement on a contract and the ground rules,
- training plan outlining training for supervisors, supervisees and managers,
- development of a panel of supervisors.

It would also be useful for supervisors and supervisees to agree a mechanism for collecting data and information that would inform any subsequent evaluation of the process. This could be achieved through the development of a standardised evaluation form that could be completed at the end of clinical supervision sessions.

The project group recommend that as well as gathering statistical and numerical data, it is important to build upon this with the collection of qualitative information on the practice of clinical supervision. Qualitative feedback from supervisors, supervisees and managers should be seen as having an important contribution to make to the evaluation of the process of clinical supervision.

Ultimately, consideration should be given to the means of assessing the impact of clinical supervision on the quality of care delivery systems and on direct patient/client care. While these are challenging issues, there is merit in advancing research in these areas.

Recommendations

1. Organisations should put in place formal arrangements for evaluating and auditing the benefits of clinical supervision.
2. The DHSS&PS should put in place arrangements for monitoring the implementation of these guidelines, as well as ongoing review of the guidance document.
3. Consideration should be given to undertaking research on the impact of clinical supervision on the delivery of care.

16.0 CONCLUSIONS

Clinical supervision is an important issue for the mental health nursing profession as it continues to develop and refine nursing practice within a changing Health and Personal Social Services (HPSS).

These guidelines represent the outcome of the work completed by the regional project group. The guidelines are intended to assist service providers in developing local policies and procedures that will support the full implementation of clinical supervision for all practising mental health nurses. They are also designed to positively encourage all practising mental health nurses to engage in the clinical supervision process, and to recognise the contribution it makes to the safe, effective delivery of care as well as the many benefits that accrue for professional development and enhancement of individual clinical skills and expertise. The group recognise that clinical supervision is currently neither a statutory requirement nor a mandatory process. However, the project group strongly support the belief that it should be a statutory requirement and acknowledge the position of the Nursing and Midwifery Council (NMC) in relation to this. Against this background, the project group would ask that these guidelines are endorsed by Chief Executives of Trusts and fully implemented. Equally, heads of education establishments should endorse the education and training components of the guidance.

The project group believe that the implementation of the recommendations outlined in this guidance document will facilitate practising nurses to explore the boundaries of practice in a safe and clinical effective way. The guidelines support the principles underpinning the clinical and social care governance agenda. These principle ensure accountability, assure the public that standards are met, that adverse events are rapidly detected, openly investigated and lessons learnt, that good practice is rapidly disseminated and that processes are in place to ensure continuous improvement in clinical care.

The project group concludes that an important element linked to Clinical Supervision is the investment in Continuing Professional Development (CPD). Mental health nurses must engage in lifelong learning that demonstrates improvements in the quality of care delivered to patients and clients.

17.0 SUMMARY OF RECOMMENDATIONS

1.0 Aims and Objectives

- Clinical supervision should be a statutory requirement;
- These guidelines should be endorsed by Chief Executives of Trusts and fully implemented;
- Heads of Education Establishments should endorse the education and training components.

2.0 Defining Clinical Supervision in Mental Health Nursing

- The definition should be agreed and accepted by all practising mental health nurses and managers. The definition must be visible in all operational guidelines, policies and procedures pertaining to clinical supervision.

3.0 The Benefits of Clinical Supervision

- Managers should ensure that practitioners are facilitated to participate in clinical supervision;
- Managers should ensure that robust operational policies are put in place in their organisations;
- Operational policies should include the contracting arrangements between supervisor and supervisee, the role and responsibilities of managers and types of situations to be communicated to them.

4.0 Costing Clinical Supervision

- Organisations should provide time within the working day for clinical supervision to be carried out effectively;
- Organisations should provide appropriate funding for clinical supervision.

5.0 Ground Rules for Clinical Supervision

- The recommended ground rules listed should be agreed at the outset by the supervisor and supervisee and included in a contract. Both the supervisor and the supervisee should sign the contract at the initial supervision session.

6.0 Methods of Recording and Documenting Clinical Supervision

- Organisations should state their position in relation to confidentiality in their operational policy on clinical supervision. The policy should detail the position and authority of the person in the organisation who has agreed the confidentiality statement;
- Supervisors and supervisees should keep written records of the supervision session.

7.0 Supervisors and Supervisees

- Supervisors should be practising mental health nurses. For nurses working in multi-professional environments, it is important that they consult with practitioners from disciplines with expertise and professional guidance not available within the nursing profession;
- Supervisors should complete recognised training as described in this document;
- Supervisees should be classified as all practising 1st and 2nd level mental health nurses, providing direct therapeutic care for patients.

8.0 Training for Supervisees, Supervisors and Managers

- Supervisors, supervisees and managers should complete appropriate training based on the recommendations in this document;
- The proposed training framework should be adopted by provider organisations and heads of education.

9.0 Evaluating and Auditing the Implementation of Clinical Supervision

- Organisations should put in place formal arrangements for evaluating and auditing the benefits of clinical supervision;
- The DHSS&PS should put in place arrangements for monitoring the implementation of these guidelines, as well as ongoing review of the guidance document;
- Consideration should be given to researching the impact of clinical supervision on the delivery of care.

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SAMPLE

CLINICAL SUPERVISION RECORD

DATE

TIME

NAME OF SUPERVISEE OR GROUP NAMES

NAME OF SUPERVISOR -GRADE/POSITION

SUPERVISION SESSION NUMBER

REFLECTION ON PREVIOUS SESSION:

ISSUES DISCUSSED AT THIS SESSION:

ISSUES FOR ACTION/FOLLOW UP:

DATE & TIME OF NEXT SESSION

SIGNED (SUPERVISEE)

DATE

SIGNED (SUPERVISOR)

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September 2004

Ref: 167/2004