Intensive Care Society

The Professional Nurse Advocate:

Role Implementation in Critical Care

Endorsing Organisations

This document has the support and endorsement of the following organisations:

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Contents

Introduction

A Professional Nurse Advocate (PNA) is a nurse who has attended a clinical and professional leadership programme which aims to equip nurses with the skills and knowledge to deliver restorative clinical supervision to their colleagues and teams. The role began in maternity care and has recently been expanded to critical care. NHS England has produced a role description which can be found here, however there is variation in the core training and in the implementation of the role, which has led to risks around the psychological needs of staff. The RCN was commissioned by the NHS to work with stakeholders to create standards for PNA education and programme delivery and these standards are intended to offer education institutions a universal framework to align their programmes and to establish enhanced levels of quality assurance (these can be found here (1)).

The following are guidelines produced in by the Intensive Care Society and the Professional Nurse Advocate Community of Practice in consultation with UKCCNA, Psychologists in Intensive Care UK (PINC UK), the Neonatal Leads for Psychological Practice (NeoLeaP), the Association of Clinical Psychologists UK and the British Psychological Society. It provides guidance on the implementation of the role in critical care settings, how the role works with other services available, and the limitations of the role.

What is a PNA?

A PNA's primary role is to offer restorative clinical supervision. Within these sessions, the PNA offers clinical support: reflecting on patient care plans and good practice; wellbeing support: reflecting on personal and team impacts of the work; and learning support: enabling nurses to develop in their clinical practice. PNAs are also considered role models in the workplace, demonstrating leadership in advocating for good patient care, and demonstrating qualities that support good working conditions for staff including positive approaches to wellbeing and psychological safety.

Any trained critical care nurse may apply for PNA training; however, there is limited nationally funded places available. The selection criteria can be found in part two standard one of the RCN PNA education criteria. Good practice would be to select for pre-existing interpersonal skills and knowledge, and they should be an experienced critical care nurse likely to continue to remain working in critical care.

How are PNAs Trained?

PNA training is at level 7 study. The training provides those on the programme with skills to facilitate restorative supervision to their nursing colleagues, equips them to listen and to understand challenges and demands of colleagues, and to lead support and deliver quality improvement initiatives in response to this, utilising the advocating and educating for quality improvement model (A-EQUIP) of professional nursing leadership and clinical supervision. The model works for nurses in four ways:

- Advocating for the patient, the nurse and healthcare staff
- Providing clinical supervision using a restorative approach
- Enabling nurses to undertake personal action for quality improvement
- Promoting the education and development of nurses

What does the PNA offer?

The principal enabler of the role of the PNA is space to provide formalised, planned 1-1 and group restorative clinical supervision sessions. The PNA acts as a facilitator in these discussions. Restorative supervision should be a psychologically safe space to reflect and learn, where nurses feel safe to talk about their clinical practice and their experience of working in critical care. Restorative supervision may include space to provide the following:

- Discussion and reflection of clinical practice, professional issues and experiences at work, including any situation that may have been stressful at the time
- Reflection on career stage and development needs
- A space to guide new learning
- A space to guide and develop quality improvement ideas as appropriate
- A space for reflection on personally coping with the work in critical care environments

These can be provided 1-1 or as a group. Group sizes ideally consist of six to eight people. Effective supervision ratios depend on tasks, standards and responsibilities. These will vary for different nursing specialties and the appropriate ratio for deploying effective supervision can vary according to needs. The sessions are confidential, although any patient or staff safeguarding concerns are escalated. Notes are not taken during the session. The PNA may want to write their own reflective notes as an aide memoire, but these are not to contain any identifying material. The PNA may confidentially provide signposting if required to wellbeing resources, mental health professionals and occupational health.

Restorative supervision sessions are planned and offered formally rather than ad hoc to enable professional boundaries to be sufficiently in place. Some ad hoc conversations may occur in the context of work, but this is considered peer support rather than restorative clinical supervision and should therefore be followed up with an arranged formal restorative clinical supervision session. There are currently no clear guidelines as to how often each nurse should attend, but at least once a year and up to quarterly is considered minimum good practice. Sessions are usually for one hour. Sessions should be considered routine and pro-active to improve clinical practice, rather than a space to manage errors or incidents.

In addition, the PNA should be considered as a role model for good patient care and demonstrate visible leadership in the workplace. The PNA will liaise regularly with senior colleagues to help influence positive change on their unit. They also provide a role model of good self-care and professional boundaries within the work of a critical care unit. PNAs may have additional skills and other roles alongside their PNA roles. Their additional skills should be subject to the same standards of evidence, training and governance as any clinical skillset.

What are PNAs not trained to do:

The experience of engaging with restorative supervision has been reported to be beneficial for nurse's work-based wellbeing (2,3,4,5). Reflective practice in general is an important part of looking after staff at work. However, PNA training is not mental health training, and the role should not be confused with that of a mental health professional. It is imperative that PNAs not be asked to work outside of their scope of practice. If PNAs are asked to do so this poses potential risks to staff and patients.

- The PNA must not offer psychological interventions. These can only be provided by accredited Psychological Professionals, who may be employed directly within critical care in some settings, or may be accessed via occupational health or via the GP. Dual relationships, where PNAs are also continuing to work shifts clinically alongside their team need to be carefully considered. Caution must be applied if personal matters arise within the context of restorative supervision so that such discussions do not go beyond the context of supportive conversations.
- The PNA must not offer psychological debriefing after an incident at work i.e. bringing a group of staff together to discuss what happened and the impact of this in a group setting. These can only be offered by trained mental health professionals and only offered when it has been assessed that this is the appropriate course of action(6). All providers of intervention should be appropriately trained, and where relevant, hold accredited status for formal interventions. PNAs might offer some emotional support and space to reflect within the reflective clinical supervision, but they must not be asked to provide formal psychological debriefing of events in a 1-1 or group setting. Any reflection should be led by the nurse and should not be mandated. There should be a focus on how the nurse felt rather than any details. If there is sustained distress the PNA should signpost to professional psychological support. If a Practitioner Psychologist has not been funded in critical care for staff intervention, then signposting will be to Occupational Health/Employee Wellbeing/Wellbeing Hub services, or to the GP for mental health services.
- Provide formal wellbeing teaching. PNAs, through critical reflection, identify approaches to personal and professional growth in self and others to promote continuing development and education. Reflection of managing the impact of distressing and demanding situations at work will occur within restorative clinical supervision but the PNA should encourage reflection and sharing of experiences rather than taking an instructing role.

All nurses advocate for good practice and for their patients. However, the PNA role must not be confused with direct patient advocacy, or for the advocacy of family members in critical care. This is a differentiation between the PNA and the Professional Midwife Advocate, who is also trained to advocate directly for mother and baby.

PNA is usually a secondary function of a nurse's role. The role is not a replacement for nurse managers, formal accreditation and revalidation processes, practice education, quality, and safety roles. The PNA might have these roles independently of their PNA training, but these must not be an expectation of routine PNA practice. PNAs must be careful to clearly establish in their interactions with staff when they are working as a PNA and when they are working with a different professional hat.

What helps support the PNA in their role?

- Higher nursing management support and endorsement of the role to enable them in their roles. They should be provided with nursing line management to ensure the governance of their role, and support in the event of any clinical or staffing concerns arising in the context of restorative clinical supervision.
- PNAs time should be allocated and protected at minimum 15 hours per month (pro-rata) per PNA (7). These hours should ideally be shared across the weeks (e.g. 1 session/ 3.75 hours per week) to ensure that the PNA maintains a good work-life balance and consistency of availability to the team. Consideration for the ratio of PNAs to staff should be given, and the current aspirational ratio is 1 trained PNA for every 20 registered nurses employed in critical care2[i].
- A bookable private room that is free from distraction or being disturbed to provide the confidentiality required to offer restorative clinical supervision. Sessions could be offered online where agreed by both the PNA and staff member, although nurses should be enabled to attend sessions within their working hours.
- An understanding of confidentiality of staff, and clear local agreement of restorative clinical supervision being a confidential space, with a procedure in place in alignment with local Trust/ Health board safeguarding policy to ensure the management of risk to staff or patients.
- They must attend their own reflective practice, which may be provided by an accredited Practitioner Psychologist or another accredited psychological practitioner. This should be properly considered, funded, and arranged locally. Ideally, this should be arranged to occur for one hour for every 20 hours of active restorative supervision offered (e.g. if in one month the PNA spends 10 hours in active group or individual RCS sessions then they should have a booked personal supervision time every two months). The provider of the reflective practice must not be responsible for the line management or governance of PNAs. A local arrangement must be in place to raise concerns if needed.
- Continued professional development is imperative for PNAs. Practitioner Psychologists and other psychological practitioners are well placed to offer CPD in several areas, including but not limited to identifying and escalating risk and concerns, and appropriate mental health signposting.
- PNAs should participate in a community of practice to further their skills.

Understanding the Difference between Reflective Practice, Restorative Supervision and Clinical Supervision

Nursing supervision commonly draws from Proctor's (1986) (8) interactive framework of clinical supervision, which has three elements:

Restorative is the 'how' clinical supervision is undertaken, adopting a non-judgemental approach.

Formative is the 'why' we need it in practice, such as developing self-awareness through reflection and advancing our skills and knowledge through education and learning.

Normative is the 'what' we do in practice, so the managerial aspects that help us identify and follow processes that promote patient safety, underpinned by evidence-based expertise and critical reflection.

Reflective Practice is a process that involves evaluating and analysing our own experiences, actions, and decisions to gain new insights and improve our future performance. It does not have a governance or accountability structure however usual duty of care and safeguarding applies.

Restorative Supervision is recognised as an approach to support reflective practice through guided reflection, exploratory questioning and supportive challenge, enabling a focus on action planning and goal setting. Some of that action planning will include Quality Improvement. It does not have a governance or accountability structure, however, usual duty of care and safeguarding applies.

Clinical Supervision is a structured process that involves regular meetings between a supervisor and a worker, with the goal of providing support, guidance, and feedback on their work. It involves a governance structure, and it is a formal and mandatory part of practice.

How does the PNA role differentiate from other roles?

Although restorative supervision may have a positive impact upon nurses' experience of work and work-based wellbeing, the role should not be confused with a Practitioner Psychologist. A Practitioner Psychologist is a professional psychologist (Clinical, Counselling or Health) who has trained for a minimum of 6 years to doctorate level and is a specialist in psychological assessment, formulation and intervention. Practitioner Psychologists may offer Post Event Team Reflections, psychological interventions to staff, patients and relatives in critical care depending upon the local set up. They are well placed to offer supportive reflective spaces to PNAs so that they may reflect upon their practice and training to enhance their skills over time.

For more information on Practitioner Psychologists in critical care settings, please see the Intensive Care Society Guideline for Integrated Practitioner Psychologists in Intensive Care.

Peer Supporters are trained in a one-day course provided by the Intensive Care Society, for any professional in critical care. Peer Supporters offer informal and formal supportive conversations based on shared experiences at work. Although good ideas for improving practice may emerge from these conversations, QI is not the focus of this role. Restorative supervision is a more formalised approach, as described above. Some PNAs have chosen to dual train in Peer Support and may at times offer supportive conversations as a Peer Supporter.

Figure one, page 10, describes how the three roles fit together within the context of the Intensive Care Society strategy for Thriving at Work:

- Peer supporters offering formal and informal supportive conversations at work based on shared lived experience.
- PNAs offering restorative supervision to discuss clinical practice.
- Practitioner Psychologists offering formal psychological intervention and Post Event Team Reflection, but also able to support the PNA and Peer Supporters in their roles across all three levels through leadership, reflective practice and further training.

A useful video explaining more can be found here.

For staff: why should I attend Restorative Supervision?

Restorative supervision is a confidential space for you to talk about work. You may reflect on experiences you have had, or ones you might anticipate. You can talk with the PNA and others about challenges you face, and how you cope with the critical care environment. It may also be that you spot good ideas for improving practice and develop a QI project following these discussions. Talking about work in this way should be routine and proactive and can feel beneficial to share experiences. Restorative clinical supervision should not be emphasised as just a place for reacting when things have gone wrong, but more of a place for reflecting about how to provide good patient care and learning new ideas.

For Matrons/ Senior Nursing- why should I prioritise Restorative Supervision for my staff?

Restorative clinical supervision is not yet a routine part of nursing practice, however, reflective practice and clinical supervision are routine in other professions, and can be beneficial for improved patient outcomes, learning, innovation and staff engagement (9,10). It sends a message of care and interest to your teams. It also demonstrates psychological safety within your service, as you are encouraging your staff to be empowered, have a voice, and speak freely about developing practice. Research indicates it helps nurses to feel valued and empowered and offers opportunities for nurses to go on to further development (11,12). The opportunity to reflect on the work and feel safe to discuss work issues and case examples report increased staff engagement (13). It should not be a place for reacting when things have gone wrong, but a place for proactively considering and improving practice. It is therefore important to embed restorative supervision as part of routine practice.

Conclusion

The PNA role is a new role in critical care, and if supported well and implemented effectively it is to the benefit of both staff and patients. For further information on the role of the PNA and both how to access the programme or become one, please visit the NHS England webpages about PNAs here.

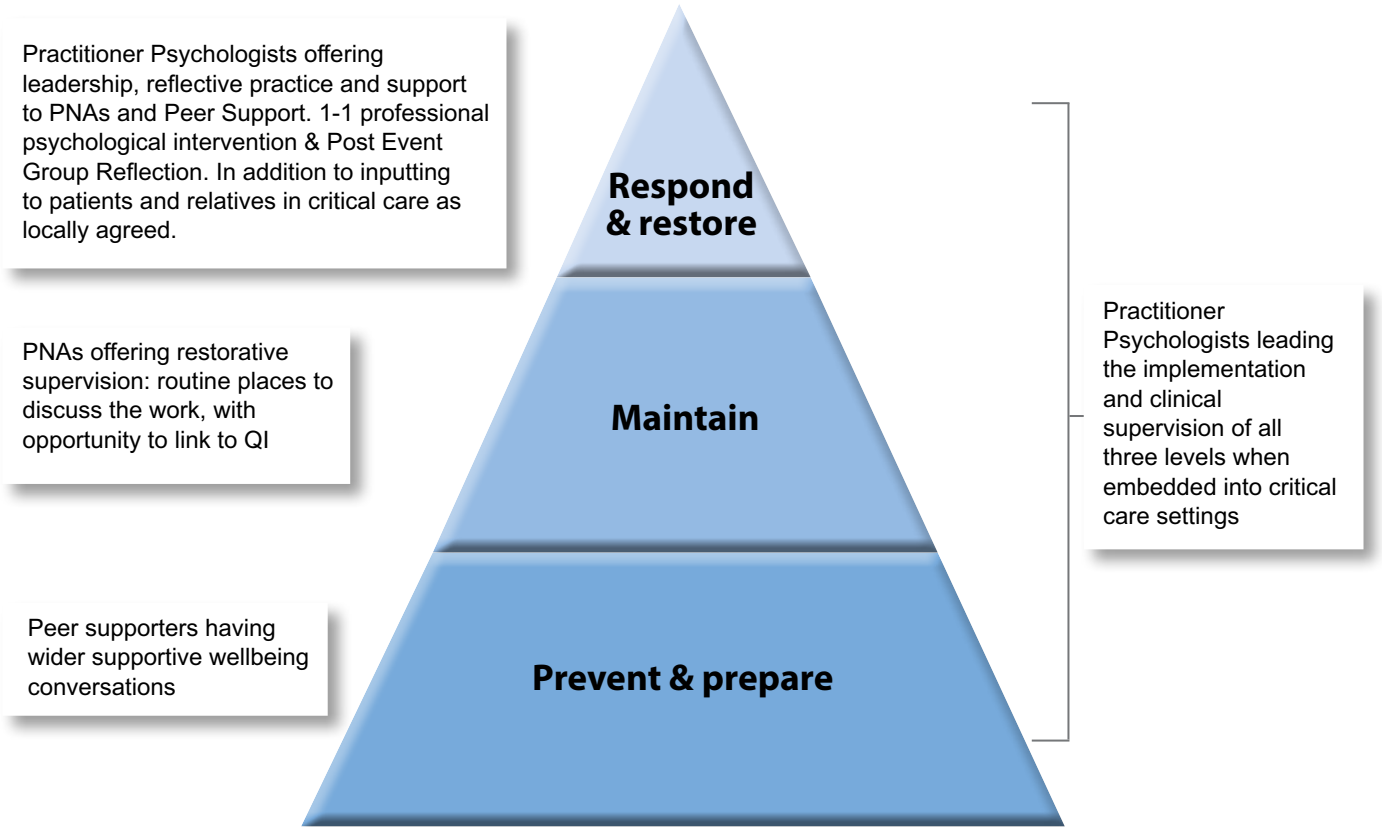

Figure one: ICS Thriving at Work Framework and where Peer Support, PNAs and Practitioner Psychologists may work together

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