

**Clinical supervisor's experiences of peer group clinical supervision during COVID-19: a mixed methods study**

DOODY, Owen, MARKEY, Kathleen, TURNER, James <<http://orcid.org/0000-0002-8360-1420>>, DONNELL, Claire O. and MURPHY, Louise

Available from Sheffield Hallam University Research Archive (SHURA) at:

<https://shura.shu.ac.uk/34150/>

---

This document is the Published Version [VoR]

**Citation:**

DOODY, Owen, MARKEY, Kathleen, TURNER, James, DONNELL, Claire O. and MURPHY, Louise (2024). Clinical supervisor's experiences of peer group clinical supervision during COVID-19: a mixed methods study. *BMC Nursing*, 23 (1): 612. [Article]

---

**Copyright and re-use policy**

See <http://shura.shu.ac.uk/information.html>

RESEARCH

Open Access



# Clinical supervisor's experiences of peer group clinical supervision during COVID-19: a mixed methods study

Owen Doody<sup>1\*</sup> , Kathleen Markey<sup>1</sup> , James Turner<sup>2</sup> , Claire O. Donnell<sup>1</sup>  and Louise Murphy<sup>1</sup> 

## Abstract

**Background** Providing positive and supportive environments for nurses and midwives working in ever-changing and complex healthcare services is paramount. Clinical supervision is one approach that nurtures and supports professional guidance, ethical practice, and personal development, which impacts positively on staff morale and standards of care delivery. In the context of this study, peer group clinical supervision provides allocated time to reflect and discuss care provided and facilitated by clinical supervisors who are at the same grade/level as the supervisees.

**Methods** To explore the clinical supervisor's experiences of peer group clinical supervision a mixed methods study design was utilised within Irish health services (midwifery, intellectual disability, general, mental health). The Manchester Clinical Supervision Scale was used to survey clinical supervisors ( $n = 36$ ) and semi-structured interviews ( $n = 10$ ) with clinical supervisors were conducted. Survey data were analysed through SPSS and interview data were analysed utilising content analysis. The qualitative and quantitative data's reporting rigour was guided by the CROSS and SRQR guidelines.

**Results** Participants generally had a positive encounter when providing clinical supervision. They highly appreciated the value of clinical supervision and expressed a considerable degree of contentment with the supervision they provided to supervisees. The advantages of peer group clinical supervision encompass aspects related to self (such as confidence, leadership, personal development, and resilience), service and organisation (including a positive working environment, employee retention, and safety), and patient care (involving critical thinking and evaluation, patient safety, adherence to quality standards, and elevated levels of care).

**Conclusion** There are many benefits of peer group clinical supervision at an individual, service, organisation, and patient level. Nevertheless, there is a need to address a lack of awareness and misconceptions surrounding clinical supervision to create an environment and culture conducive to realising its full potential. It is crucial that clinical supervision be accessible to nurses and midwives of all grades across all healthcare services, with national planning to address capacity and sustainability.

**Keywords** Clinical supervision, Peer group, Nursing

\*Correspondence:  
Owen Doody  
owen.doody@ul.ie

<sup>1</sup>Department of Nursing and Midwifery, Health Research Institute, University of Limerick, Limerick, Ireland  
<sup>2</sup>Department of Nursing and Midwifery, Sheffield Hallam University, Sheffield, UK



© The Author(s) 2024. **Open Access** This article is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License, which permits any non-commercial use, sharing, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if you modified the licensed material. You do not have permission under this licence to share adapted material derived from this article or parts of it. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc-nd/4.0/>.

## Background

Within a dynamic healthcare system, nurses and midwives face growing demands, underscoring the necessity for ongoing personal and professional development. This is essential to improve the effectiveness and efficiency of care delivery for patients, families, and societies. Despite the increased emphasis on increasing the quality and safety of healthcare services and delivery, there is evidence highlighting declining standards of nursing and midwifery care [1]. The recent focus on re-affirming and re-committing to core values guiding nursing and midwifery practice is encouraging such as compassion, care and commitment [2], competence, communication, and courage [3]. However, imposing value statements in isolation is unlikely to change behaviours and greater consideration needs to be given to ways in which compassion, care, and commitment are nurtured and ultimately applied in daily practice. Furthermore, concerns have been raised about global staff shortages [4], the evidence suggesting several contributing factors such as poor workforce planning [5], job dissatisfaction [6], and healthcare migration [7]. Without adequate resources and staffing, compromising standards of care and threats to patient safety will be imminent therefore the importance of developing effective strategies for retaining competent registered nurses and midwives is paramount in today's climate of increased staff shortages [4]. Clinical supervision serves as a means to facilitate these advancements and has been linked to heightened job satisfaction, enhanced staff retention, improved staff effectiveness, and effective clinical governance, by aiding in quality improvements, risk management, and heightened accountability [8].

Clinical supervision is a key component of professional practice and while the aim is largely known, there is no universally accepted definition of clinical supervision [8]. Clinical supervision is a structured process where clinicians are allowed protected time to reflect on their practice within a supportive environment and with the purpose of developing high-quality clinical care [9]. Recent literature published on clinical supervision [8–16] highlights the advantages and merits of clinical supervision. However, there are challenges also identified such as a lack of consensus regarding the meaning and goal, implementation issues, variations in approaches in its operationalisation, and an absence of research evidence on its effectiveness. Duration and experience in clinical supervision link to positive benefits [8], but there is little evidence of how clinical supervision altered individual behaviours and practices. This is reinforced by Kuhne et al., [15] who emphasise that satisfaction rather than effectiveness is more commonly examined. It is crucial to emphasise that reviews have pinpointed that clinical supervision lowers the risks of adverse patient outcomes

[9] and demonstrates enhancements in the execution of certain care processes. Peer group clinical supervision is a form of clinical supervision whereby two or more practitioners engage in a supervision or consultation process to improve their professional practice [17]. There is limited evidence regarding peer group clinical supervision and research on the experiences of peer clinical supervision and stakeholders is needed [13]. In Ireland, peer group clinical supervision has been recommended and guidelines have been developed [18]. In the Irish context, peer clinical supervision is where both clinical supervisees and clinical supervisors are peers at the same level/grade. However, greater evidence is required to inform future decisions on the implementation of peer group clinical supervision and the purpose of this study is to explore clinical supervisors' experiences of peer group clinical supervision. As the focus is on peer group supervisors and utilising mixed methods the experiences of the other stakeholders were investigated and reported separately.

## Method

### Design

A mixed methods approach was used (survey and semi-structured interviews) to capture clinical supervisor's experiences of clinical supervision. The study adhered to the Consensus-Based Checklist for Reporting of Survey Studies guidelines [19] (Supplementary File S1) and Standards for Reporting Qualitative Research guidelines [20] (Supplementary File S2).

### Participants

This study was conducted with participants who successfully completed a professionally credited award: clinical supervision module run by a university in Ireland (74 clinical supervisors across 5 programmes over 3 years). The specific selection criteria for participants were that they were registered nurses/midwives delivering peer group clinical supervision within the West region of Ireland. The specific exclusion criteria were as follows: (1) nurses and midwives who haven't finished the clinical supervision module at the University, (2) newly appointed peer group clinical supervisors who have yet to establish their groups and initiate the delivery of peer group clinical supervision.

### Measures and procedures

The Manchester Clinical Supervision Scale-26 was used to survey participants in February/March 2022 and measure the peer group clinical supervisors' overall experiences of facilitating peer group clinical supervision. The Manchester Clinical Supervision Scale-26 is a validated 26-item self-report questionnaire with a Likert-type (1–5) scale ranging from strongly disagree (1) to strongly

agree (5) [21]. The Manchester Clinical Supervision Scale-26 measures the efficiency of and satisfaction with supervision, to investigate the skills acquisition aspect of clinical supervision and its effect on the quality of clinical care [21]. The instrument consists of two main sections to measure three (normative, restorative, and formative) dimensions of clinical supervision utilising six sub-scales: (1) trust and rapport, (2) supervisor advice/support, (3) improved care/skills, (4) importance/value of clinical supervision, (5) finding time, (6) personal issues/reflections and a total score for the Manchester Clinical Supervision Scale-26 is also calculated. Section two consisted of the demographic section of the questionnaire and was tailored to include eight demographic questions concerning the supervisor's demographics, supervisee characteristics, and characteristics of clinical supervision sessions. There were also two open field questions on the Manchester Clinical Supervision Scale-26 (model of clinical supervision used and any other comments about experience of peer group clinical supervision). The main question about participants' experiences with peer clinical supervision was "What was your experience of peer clinical supervision?" This was gathered through individual semi-structured interviews lasting between 20 and 45 min, in March/April 2022 (Supplementary file 3).

### Ethical considerations

Health service institutional review boards of two University hospitals approved this study (Ref: 091/19 and Ref: C.A. 2199). Participants were recruited after receiving a full explanation of the study's purpose and procedure and all relevant information. Participants were aware of potential risks and benefits and could withdraw from the study, or the survey could be stopped at any time. Informed consent was recorded, and participant identities were protected by using a pseudonym to protect anonymity.

### Data analysis method

Survey data was analysed using the data analysis software package Statistical Package for the Social Sciences, version 26 (SPSS Inc., Chicago, IL, USA). Descriptive analysis was undertaken to summarise responses to all items and categorical variables (nominal and ordinal) were analysed using frequencies to detail the number and percentage of responses to each question. Scores on the Manchester Clinical Supervision Scale-26 were reverse scored for 9 items (Q1-Q6, Q8, Q20,21) and total scores for each of the six sub-scales were calculated by adding the scores for each item. Raw scores for the individual sub-scales varied in range from 0 to 20 and these raw scores were then converted to percentages which were used in addition to the raw scores for each sub-scale to describe and summarise the results of the Manchester Clinical Supervision

Scale-26. Cronbach's alpha coefficient was undertaken with the 26 questions included within the Manchester Clinical Supervision Scale-26 and more importantly with each of the dimensions in the Manchester Clinical Supervision Scale-26. The open-ended questions on the Manchester Clinical Supervision Scale-26 and interviews were analysed using content analysis guided by Colorafi and Evans [22] and categories were generated using their eight steps, (1) creating a coding framework, (2) adding codes and memos, (3) applying the first level of coding, (4) categorising codes and applying the second level of coding, (5) revising and redefining the codes, (6) adding memos, (7) visualising data and (8) representing the data.

### Research rigour

To ensure the validity and rigour of this study the researchers utilised the Manchester Clinical Supervision Scale-26 a recognised clinical supervision tool with good reliability and wide usage. Interviews were recorded, transcribed, and verified by four participants, data were collected until no new components appeared, data collection methods and analysis procedures were described, and the authors' biases were minimised throughout the research process. The Manchester Clinical Supervision Scale-26 instrument internal consistency reliability was assessed which was overall good ( $\alpha=0.878$ ) with individual subscale also good e.g., normative domain 0.765, restorative domain 0.864, and formative domain 0.900. Reporting rigour was demonstrated using the Consensus-Based Checklist for Reporting of Survey Studies guidelines [19] and Standards for Reporting Qualitative Research guidelines [20].

## Results

### Quantitative data

#### *Participant and clinical supervision characteristics*

Thirty-six of the fifty-two (69.2%) peer group clinical supervisors working across a particular region of Ireland responded to the Manchester Clinical Supervision Scale-26 survey online via Qualtrics. Table 1 identifies the demographics of the sample who were predominantly female (94.4%) with a mean age of 44.7 years (SD. 7.63).

Peer group clinical supervision session characteristics (Table 2) highlight over half of peer group clinical supervisors ( $n=20$ , 55.6%) had been delivering peer group clinical supervision for less than one year and were mainly delivered to female supervisees ( $n=28$ , 77.8%). Most peer group clinical supervision sessions took place monthly ( $n=32$ , 88.9%) for 31–60 min ( $n=27$ , 75%).

#### **Manchester Clinical Supervision Scale-26 results**

Participants generally viewed peer group clinical supervision as effective (Table 3), the total mean Manchester Clinical Supervision Scale-26 score among all peer group

**Table 1** Participant socio demographic characteristics ( $n = 36$ )

Participant characteristic	<i>n</i>	%
<b>Gender</b>		
Female	34	94.4
Male	2	5.6
<b>Age</b>		
Mean (SD) age in years	44.7 (7.63)	
<b>Professional Discipline</b>		
Nursing (General)	16	44.4
Nursing (Mental Health)	6	16.7
Nursing (Intellectual Disability)	5	13.9
Midwifery	4	11.1
Other -Paediatrics	1	2.8
Other – Public Health	2	5.5
Other – Nursing Education	1	2.8
Other - cANP	1	2.8
<b>Experience in Nursing/Midwifery</b>		
Less than 1 year	0	0
1–5 years	0	0
5–10 years	2	5.6
10–15 years	4	11.1
More than 15 years	30	83.3
<b>Current Role</b>		
Registered Staff Nurse	1	2.8
Registered Midwife	1	2.8
Advanced Nurse/Midwife Practitioner	3	8.3
Clinical Nurse/Midwife Specialist	7	19.4
Clinical Nurse/Midwife Manager 1	5	13.9
Clinical Nurse/Midwife Manager 2	8	22.2
Clinical Nurse/Midwife Manager 3	4	11.1
Assistant Director of Nursing	1	2.8
Other – Clinical Public Health Nurse	2	5.6
Other – Director CNME	1	2.8
Other – Director of Nursing	1	2.8
Other – Practice Development	1	2.8
<b>Current Area of Practice</b>		
Inpatient	13	36.1
Community	15	41.7
Both Inpatient and Community	4	11.1
Other – Acute Services but outpatient based	1	2.8
Other - Education	1	2.8
Other - ICU	1	2.8
Other - Liaison	1	2.8
<b>Length of Time in Current Role</b>		
Less than one year	3	8.3
1–2 years	9	25
3–5 years	6	16.7
More than 5 years	18	50
<b>Geographical Location for Work</b>		
Galway	9	25
Mayo	4	11.1
Roscommon	7	19.4
Limerick	13	36.1
Clare	2	5.6
North Tipperary	1	2.8

**Table 2** Characteristics of clinical supervision sessions ( $n = 36$ )

Supervisee characteristic	<i>n</i>	%
<b>Supervisee allocated or chosen</b>		
Allocated	23	63.9
Chosen	6	16.7
Other – Invited supervisees to attend clinical supervision	4	11.2
Other – Both allocated session and chosen by supervisee	1	2.8
<b>Supervisee junior or senior to supervisor</b>		
Junior	2	5.6
Senior	10	27.8
Same grade	16	44.4
Other – Different speciality/non-nursing	2	5.6
Other – External to organisation and grade unknown	6	16.6
<b>Supervisee Gender</b>		
Male	4	11.1
Female	28	77.8
Combination of male and female	4	11.1
<b>Supervisee Age</b>		
25–39 years	3	8.3
40–50 years	18	50
51–65 years	15	41.7
<b>Supervisee Professional Discipline</b>		
Nursing (General)	19	52.8
Nursing (Mental Health)	12	33.3
Nursing (Intellectual Disability)	2	5.6
Other – Public Health Nurses	2	5.6
Other – Nursing and Social Care	1	2.8

clinical supervisors was 76.47 (SD. 12.801) out of 104, Surpassing the clinical supervision threshold score of 73, which was established by the developers of the Manchester Clinical Supervision Scale-26 as the benchmark indicating proficient clinical supervision provision [21]. Of the three domains; normative, formative, and restorative, the restorative domain scored the highest (mean 28.56, SD. 6.67). The mean scores compare favourably to that of the Manchester Clinical Supervision Scale-26 benchmark data and suggest that the peer group clinical supervisors were satisfied with both the level of support, encouragement, and guidance they provided and the level of trust/rapport they had developed during the peer group clinical supervision sessions. 83.3% ( $n=30$ ) of peer group clinical supervisors reported being either very satisfied ( $n=12$ , 33.3%) or moderately satisfied ( $n=18$ , 50%) with the peer group clinical supervision they currently delivered. Within the peer group clinical supervisor's supervisee related issues ( $n=17$ , 47.2%), work environment-related issues ( $n=16$ , 44.4%), staff-related issues ( $n=15$ , 41.7%) were reported as the most frequent issues, with patient/client related issues being less frequent ( $n=8$ , 22.2%). The most identified model used to facilitate peer group clinical supervision was the Proctors model ( $n=8$ , 22.22%), which was followed by group ( $n=2$ , 5.55%), peer ( $n=2$ , 5.55%), and a combination of the seven-eyed model of clinical supervision and Proctors

**Table 3** Manchester Clinical Supervision Scale-26 total, domain, and sub scale scores for all supervisors ( $n=36$ ) – raw scores, percentages, and benchmarking

MCSS subscale scores and proctor domains	No. of Items	Possible ranges	Minimum, Maximum	Mean	Standard deviation (S.D.)	Percentage (%) mean out of 100
<b>Normative Domain</b>	9	0–36	(14, 34)	25.53	4.983	70.92%
Importance/value of clinical supervision	5	0–20	(11, 20)	17.42	2.089	87.08%
Finding time	4	0–16	(0, 16)	8.11	3.926	50.69%
<b>Restorative Domain</b>	10	0–40	(4, 39)	28.56	6.674	71.39%
Trust/rapport	5	0–20	(4, 19)	14.67	3.225	73.30%
Supervisor advice/support	5	0–20	(0, 20)	13.89	3.882	69.44%
<b>Formative Domain</b>	7	0–28	(0, 28)	22.39	5.266	79.96%
Improved care/skills	4	0–16	(0, 16)	12.58	3.065	78.64%
Reflection	3	0–12	(0, 12)	9.81	2.724	81.71%
<b>Total</b>	26	0–104	(36, 99)	76.47	12.801	73.53%

model ( $n=1$ , 2.77%) with some not sure what model they used ( $n=2$ , 5.553%) and 58.33% ( $n=21$ ) did not report what model they used.

#### Survey open-ended question

*'Please enter any additional comments, which are related to your current experience of delivering Peer Group Clinical Supervision.'* There were 22 response comments to this question, which represented 61.1% of the 36 survey respondents, which were analysed using content analysis guided by Colorafi & Evans [22]. Three categories were generated. These included: personal value/benefit of peer group clinical supervision, challenges with facilitating peer group clinical supervision, and new to peer group clinical supervision.

The first category 'personal value/benefit of peer group clinical supervision' highlighted positive experiences of both receiving and providing peer group clinical supervision. Peer group clinical supervisors reported that they enjoyed the sessions and found them both worthwhile and beneficial for both the group and them as peer group clinical supervisors in terms of creating a trusted supportive group environment and motivation to develop. Peer group clinical supervision was highlighted as very important for the peer group clinical supervisors working lives and they hoped that there would be more uptake from all staff. One peer group clinical supervisor expressed that external clinical supervision was a 'lifeline' to shaping their supervisory journey to date.

The second category 'challenges with facilitating peer group clinical supervision' identified time constraints, lack of buy-in/support from management, staff shortages, lack of commitment by supervisees, and COVID-19 pandemic restrictions and related sick leave, as potential barriers to facilitating peer group clinical supervision. COVID-19 was perceived to have a negative impact on peer group clinical supervision sessions due to staff shortages, which resulted in difficulties for supervisees attending the sessions during work time. Peer group clinical

supervisors felt that peer group clinical supervision was not supported by management and there was limited 'buy-in' at times. There was also a feeling expressed that peer group clinical supervision was in its infancy, as COVID-19 and its related restrictions impacted on this by either slowing down the process of commencing peer group clinical supervision in certain areas or having to move online. However, more recently improvements in managerial support and supervisee engagement with the peer group clinical supervision process are noted.

The final category 'new to peer group clinical supervision' highlighted that some peer group clinical supervisors were new to the process of providing peer group clinical supervision and some felt that this survey was not a true reflection of their experience of delivering peer group clinical supervision, as they were not fully established yet as clinical supervisors due to the impact of COVID-19. Peer group clinical supervisors identified that while they were new to providing peer group clinical supervision, they were enjoying it and that it was a learning curve for them.

#### Qualitative data

The qualitative phase explored peer group clinical supervisors' ( $n=10$ ) own experiences of preparation received and experiences of being a peer group clinical supervisor. Three themes were identified through data analysis, building the foundations, enacting engagement and actions, and realities (Table 4).

#### Building the foundations

This theme highlights the importance of prior knowledge, awareness, and training but also the recruitment process and education in preparing peer group clinical supervisors.

#### Knowledge and awareness

Participant's prior knowledge and awareness of peer group clinical supervision was mixed with some

**Table 4** Themes and subthemes

Themes	Subthemes
Building the foundations	Knowledge and awareness Recruitment Training and Education
Enacting engagement and actions	Forming the groups Getting a clear message out Setting the scene and grounding the group
Realities	Past experiences Delivering peer group clinical supervision Responding to COVID-19 Personal and professional development Future opportunities

reporting having little or no knowledge of clinical supervision.

*I'm 20 years plus trained as a nurse, and I had no awareness of clinical supervision beforehand, I really hadn't got a clue what all of this was about, so it was a very new concept to me (Bernie).*

Others were excited about peer group clinical supervision and while they could see the need they were aware that there may be limited awareness of the value and process of clinical supervision among peers.

*I find that there's great enthusiasm and passion for clinical supervision as it's a great support mechanism for staff in practice, however, there's a lack of awareness of clinical supervision (Jane).*

### Recruitment

Some participants highlighted that the recruitment process to become a peer group clinical supervisor was vague in some organisations with an unclear and non-transparent process evident where people were chosen by the organisation's management rather than self-selecting interested parties.

*It was just the way the training was put to the people, they were kind of nominated and told they were going and there was a lot of upset over that, so they ended up in some not going at all (Ailbhe).*

In addition, the recruitment process was seen as top loaded where senior grades of staff were chosen, and this limited staff nurse grade opportunities where there was a clear need for peer group clinical supervisors and support.

*We haven't got down to the ground level like you know we've done the directors, we've done the CNM3s the CNM2s we are at the CNM1s, so we*

*need to get down to the staff nurse level so the nurses at the direct frontline are left out and aren't receiving supervision because we don't have them trained (Bernie).*

### Training and education

Participants valued the training and education provided but there was a clear sense of 'imposter syndrome' for some peer group clinical supervisors starting out. Participants questioned their qualifications, training duration, and confidence to undertake the role of peer group clinical supervisor.

*Because it is group supervision and I know that you know they say that we are qualified to do supervision and you know we're now qualified clinical supervisors but I'm not sure that a three-month module qualifies you to be at the top of your game (Maria).*

Participants when engaged in the peer group clinical supervisor educational programme did find it beneficial and the true benefit was the actual re-engagement in education and published evidence along with the mix of nursing and midwifery practice areas.

*I found it very beneficial, I mean I hadn't been engaged in education here in a while, so it was great to be back in that field and you know with the literature that's big (Claire).*

### Enacting engagement and actions

This theme highlights the importance of forming the groups, getting a clear message out, setting the scene, and grounding the group.

#### Forming the groups

Recruitment for the group was of key importance to the peer group clinical supervisor and they all sent out a general invitation to form their group. Some supervisors used invitation letters or posters in addition to a general email and this was effective in recruiting supervisees.

*You're reaching out to people, I linked in with the ADoN and I put together a poster and circulated that I wasn't 'cherry picking, and I set up a meeting through Webex so people could get a sense of what it was if they were on the fence about it or unsure if it was for them (Karen).*

In forming the peer clinical supervision groups consideration needs to be given to the actual number

of supervisees and participants reported four to six supervisees as ideal but that number can alter due to attendance.

*The ideal is having five or six consistent people and that they all come on board and that you get the dynamics of the group and everything working (Claire).*

#### **Getting a clear message out**

Within the recruitment process, it was evident that there was a limited and often misguided understanding or perception of peer group clinical supervision.

*Greater awareness of what actually clinical supervision is, people misjudge it as a supervision where someone is appraising you, when in fact it is more of a support mechanism, I think peer support is the key element that needs to be brought out (Jane).*

Given the lack of clarity and understanding regarding peer group clinical supervision, the participants felt strongly that further clarity is needed and that the focus needs to be on the support it offers to self, practice, and the profession.

*Clinical supervision to me is clinical leadership (Jane).*

#### **Setting the scene and grounding the group**

In the initial phase of the group coming together the aspect of setting the scene and grounding the group was seen as important. A key aspect of this process was establishing the ground rules which not only set the boundaries and gave structure but also ensured the adoption of principles of trust, confidentiality, and safety.

*We start with the ground rules, they give us structure it's our contract setting out the commitment the expectation for us all, and the confidentiality as that's so important to the trust and safety and building the relationships (Brid).*

Awareness of group dynamics is important in this process along with awareness of the group members (supervisees) as to their role and expectations.

*I reiterate the role of each person in relation to confidentiality and the relationship that they would have with each other within the group and the group is very much aware that it is based on respect for each person's point of view people may have a fear of contributing to the group and setting the ground rules is important (Jane).*

To ground the group, peer group clinical supervisors saw the importance of being present and allowing oneself to be in the room. This was evident in the time allocated at the start of each session to allow 'grounding' to occur in the form of techniques such as a short meditation, relaxation, or deep breathing.

*At the start, I do a bit of relaxation and deep breathing, and I saw that with our own external supervisor how she settled us into place so very much about connecting with your body and you've arrived, then always come in with the contract in my first sentence, remember today you know we're in a confidential space, of course, you can take away information, but the only information you will take from today is your own information and then the respect aspect (Mary Rose).*

This settling in and grounding was seen as necessary for people to feel comfortable and engage in the peer group clinical supervision process where they could focus, be open, converse, and be aware of their role and the role of peer group clinical supervision.

*People have to be open, open about their practice and be willing to learn and this can only occur by sharing, clinical supervision gives us the space to do it in a space where we know we will be respected, and we can trust (Claire).*

#### **Realities**

This theme highlights the importance of the peer group clinical supervisors' past experiences, delivering peer group clinical supervision sessions, responding to COVID-19, personal and professional development, and future opportunities.

#### **Past experiences**

Past experiences of peer group clinical supervisors were not always positive and for one participant this related to the lack of ground rules or focus of the sessions and the fact it was facilitated by a non-nurse.

*In the past, I suppose I would have found it very frustrating as a participant because I just found that it was going round in circles, people moaning and you know it wasn't very solution focused so I came from my situation where I was very frustrated with clinical supervision, it was facilitated by somebody that was non-nursing then it wasn't very, there wasn't the ground rules, it was very loose (Caroline).*

However, many did not have prior experience of peer group clinical supervision. Nonetheless, through the education and preparation received, there was a sense of commitment to embrace the concept, practice, and philosophy.

*I did not really have any exposure or really much information on clinical supervision, but it has opened my eyes, and as one might say I am now a believer (Brid).*

### **Delivering peer group clinical supervision**

In delivering peer group clinical supervision, participants felt supervisees were wary, as they did not know what peer group clinical supervision was, and they had focused more on the word supervision which was misleading to them. Nonetheless, the process was challenging, and buy-in was questioned at an individual and managerial level.

*Buy-in wasn't great I think now of course people will blame the pandemic, but this all happened before the pandemic, there didn't seem to be you know, the same support from management that I would have expected so I kind of understood it in a way because then there wasn't the same real respect from the practitioners either (Mary Rose).*

From the peer group clinical supervisor's perspective, they were all novices in delivering/facilitating peer group clinical supervision sessions, and the support of the external clinical supervisors, and their own peer group clinical supervision sessions were invaluable along with a clinical supervision model.

*Having supervision myself was key and something that is vital and needed, we all need to look at our practice and how we work it's no good just facilitating others without being part of the process yourself but for me I would say the three principles of clinical supervision, you know the normative, formative and restorative, I keep hammering that home and bring that in regularly and revisit the contract and I have to do that often you know (Claire).*

All peer group clinical supervisors commented on the preparation for their peer group clinical supervision sessions and the importance of them having the right frame of mind and that often they needed to read over their course work and published evidence.

*I want everybody to have a shared voice and you know that if one person, there is something that*

*somebody feels very strongly and wants to talk about it that they e-mail in advance like we don't have a set agenda but that's agreed from the participant at the start (Caroline).*

To assist this, the peer group clinical supervisors noted the importance of their own peer group clinical supervision, the support of their peers, and external clinical supervisors. This preparation in an unpredictable situation can be difficult but drawing on one's experience and the experience within the group can assist in navigating beyond unexpected situations.

*I utilise the models of clinical supervision and this helps guide me, I am more of a facilitator of the group we are experts in our own area and our own role but you can only be an expert if you take the time to examine your practice and how you operate in your role (Brid).*

All clinical supervisors noted that the early sessions can be superficial, and the focus can be on other practice or management issues, but as time moves on and people become more engaged and involved it becomes easier as their understanding of supervision becomes clearer. In addition, there may be hesitancy and people may have difficulty opening up with certain people in the group and this is a reality that can put people off.

*Initially there was so much managerial bashing and I think through supervision, I began to kind of think, I need the pillars of supervision, the governance, bringing more knowledge and it shifted everything in the room, trying to marry it with all the tensions that people have (Mary Rose).*

For some clinical supervisors, there were expected and unexpected challenges for them as clinical supervisors in terms of the discussions veering off course and expectations of their own ability.

*The other big challenge is when they go off, how do you bring him back, you know when they veer off and you're expected to be a peer, but you have to try and recoil that you have to get the balance with that right (Mary Rose).*

While peer group clinical supervision is accepted and seen as a valuable process by the peer group clinical supervisors, facilitating peer group supervision with people known to you can be difficult and may affect the process.

*I'd love to supervise a group where I actually don't know the people, I don't know the dynamics within the group, and I'd love to see what it would be like in a group (Bernie).*

Of concern to clinical supervisors was the aspect of non-attendance and while there may be valid reasons such as COVID-19 the absence of a supervisee for several sessions can affect the group dynamics, especially if the supervisee has only engaged with early group sessions.

*One of the ones that couldn't attend because of COVID and whatever, but she's coming to the next one and I just feel there's a lot of issues in her area and I suppose I'm mindful that I don't want that sort of thing to seep in, so I suppose it's just for me just to keep reiterating the ground rules and the boundaries, that's something I just have to manage as a facilitator, but what if they don't attend how far will the group have progressed before she attends (Caroline).*

#### **Responding to COVID-19**

The advent of COVID-19 forced peer group clinical supervisors to find alternative means of providing peer group clinical supervision sessions which saw the move from face-to-face to online sessions. The online transition was seen as seamless for many established groups while others struggled to deliver sessions.

*With COVID we did online for us it was fine because we were already formed (Corina).*

While the transition may have been positive many clinical supervisors came across issues because they were using an online format that would not be present in the face-to-face session.

*We did have a session where somebody was in the main office and they have a really loud booming voice and they were saying stuff that was not appropriate to say outside of clinical supervision and I was like are you in the office can you lower it down a bit can you put your headphones on (Maria).*

However, two peer group clinical supervisors ceased or hastened the progress of rolling out peer group clinical supervision sessions mainly due to redeployment and staff availability.

*With COVID it just had to be canceled here, it's just the whole thing was canceled so it was very, very difficult for people (Mary Rose).*

It was clear from clinical supervisors that online sessions were appropriate but that they felt they were only appropriate for existing established groups that have had the opportunity to build relationships, develop trust, embed the ground rules, and create the space for open communication and once established a combined approach would be appropriate.

*Since we weren't as established as a group, not everybody knew each other it would be difficult to establish that so we would hold off/reschedule, obviously COVID is a major one but also I suppose if you have an established group now, and again, you could go to a remote one, but I felt like since we weren't established as a group it would be difficult to develop it in that way (Karen).*

Within practice COVID-19 took priority and other aspects such as peer group clinical supervision moved lower down on the priority list for managers but not for the clinical supervisors even where redeployment occurred.

*With COVID all the practical side, if one of the managers is dealing with an outbreak, they won't be attending clinical supervision, because that has to be prioritised, whereas we've prioritised clinical supervision (Maria).*

The valuing of peer group clinical supervision was seen as important by clinical supervisors, and they saw it as particularly needed during COVID-19 as staff were dealing with many personal and professional issues.

*During the height of COVID, we had to take a bit of a break for four months as things were so demanding at work for people but then I realised that clinical supervision was needed and started back up and they all wanted to come back (Brid).*

Having peer group clinical supervision during COVID-19 supported staff and enabled the group to form supportive relationships.

*COVID has impacted over the last two years in every shape and they needed the supervision and the opportunity to have a safe supportive space and it gelled the group I think as we all were there for each other (Claire).*

While COVID-19 posed many challenges it also afforded clinical supervisors and supervisees the opportunity for change and to consider alternative means of running peer group clinical supervision sessions. This change resulted

in online delivery and in reflecting on both forms of delivery (face-to-face and online) clinical supervisors saw the benefit in both. Face-to-face was seen as being needed to form the group and then the group could move online once the group was established with an occasional periodic face-to-face session to maintain motivation commitment and reinforce relationships and support.

*Online formats can be effective if the group is already established or the group has gone through the storming and forming phase and the ground rules have been set and trust built, then I don't see any problem with a blended online version of clinical supervision, and I think it will be effective (Jane).*

### **Personal and professional development**

Growth and development were evident from peer group clinical supervisors' experiences and this growth and development occurred at a personal, professional, and patient/client level. This development also produced an awakening and valuing of one's passion for self and their profession.

*I suppose clinical supervision is about development I can see a lot of development for me and my supervisees, you know personally and professionally, it's the support really, clinical supervision can reinvigorate it's very exciting and a great opportunity for nursing to support each other and in care provision (Claire).*

A key to the peer group clinical supervisor's development was the aspect of transferable skills and the confidence they gained in fulfilling their role.

*All of these skills that you learn are transferable and I am a better manager because of clinical supervision (Maria).*

The confidence and skills gained translated into the clinical supervisor's own practice as a clinical practitioner and clinical supervisor but they were also realistic in predicting the impact on others.

*I have empowered my staff, I empower them to use their voice and I give my supervisees a voice and hope they take that with them (Corina).*

Fundamental to the development process was the impact on care itself and while this cannot always be measured or identified, the clinical supervisors could see that care and support of the individual practitioner (supervisee) translated into better care for the patient/client.

*Care is only as good as the person delivering it and what they know, how they function and what energy and passion they have, and clinical supervision gives the person support to begin to understand their practice and how and why they do things in a certain way and when they do that they can begin to question and even change their way of doing something (Brid).*

### **Future opportunities**

Based on the clinical supervisor's experiences there was a clear need identified regarding valuing and embedded peer group clinical supervision within nursing/midwifery practice.

*There has to be an emphasis placed on supervision it needs to be part of the fabric of a service and valued by all in that service, we should be asking why is it not available if it's not there but there is some work first on promoting it and people knowing what it actually is and address the misconceptions (Claire).*

While such valuing and buy-in are important, it is not to say that all staff need to have peer group clinical supervision so as to allow for personal choice. In addition, to value peer group clinical supervision it needs to be evident across all staffing grades and one could question where the best starting point is.

*While we should not mandate that all staff do clinical supervision it should become embedded within practice more and I suppose really to become part of our custom and practice and be across all levels of staff (Brid).*

When peer group clinical supervision is embedded within practice then it should be custom and practice, where it is included in all staff orientations and is nationally driven.

*I suppose we need to be driving it forward at the coal face at induction, at orientation and any development for the future will have to be driven by the NMPDUs or nationally (Ailbhe).*

A formalised process needs to address the release of peer group clinical supervisors but also the necessity to consider the number of peer group clinical supervisors at a particular grade.

*The issue is release and the timeframe as they have a group but they also have their external supervision*

*so you have to really work out how much time you're talking about (Maria).*

Vital within the process of peer group clinical supervision is receiving peer group clinical supervision and peer support and this needs to underpin good peer group clinical supervision practice.

*Receiving peer group supervision helps me, there are times where I would doubt myself, it's good to have the other group that I can go to and put it out there to my own group and say, look at this, this is what we did, or this is what came up and this is how (Bernie).*

For future roll out to staff nurse/midwife grade resourcing needs to be considered as peer group clinical supervisors who were managers could see the impact of having several peer group clinical supervisors in their practice area may have on care delivery.

*Facilitating groups is an issue and needs to be looked at in terms of the bigger picture because while I might be able to do a second group the question is how I would be supported and released to do so (Maria).*

While there was ambiguity regarding peer group clinical supervision there was an awareness of other disciplines availing of peer group clinical supervision, raising questions about the equality of supports available for all disciplines.

*I always heard other disciplines like social workers would always have been very good saying I can't meet you I have supervision that day and I used to think my God what's this fabulous hour that these disciplines are getting and as a nursing staff it just wasn't there and available (Bernie).*

To address this equity issue and the aspect of low numbers of certain grades an interdisciplinary approach within nursing and midwifery could be used or a broader interdisciplinary approach across all healthcare professionals. An interdisciplinary or across-services approach was seen as potentially fruitful.

*I think the value of interprofessional or interdisciplinary learning is key it addresses problem-solving from different perspectives that mix within the group is important for cross-fertilisation and embedding the learning and developing the experience for each participant within the group (Jane).*

As we move beyond COVID-19 and into the future there is a need to actively promote peer group clinical supervision and this would clarify what peer group clinical supervision actually is, its uptake and stimulate interest.

*I'd say it's like promoting vaccinations if you could do a roadshow with people, I think that would be very beneficial, and to launch it, like you have a launch an official launch behind it (Mary Rose).*

## Discussion

The advantages of peer group clinical supervision highlighted in this study pertain to self-enhancement (confidence, leadership, personal development, resilience), organisational and service-related aspects (positive work environment, staff retention, safety), and professional patient care (critical thinking and evaluation, patient safety, adherence to quality standards, elevated care standards). These findings align with broader literature that acknowledges various areas, including self-confidence and facilitation [23], leadership [24], personal development [25], resilience [26], positive/supportive working environment [27], staff retention [28], sense of safety [29], critical thinking and evaluation [30], patient safety [31], quality standards [32] and increased standards of care [33].

In this study, peer group clinical supervision appeared to contribute to the alleviation of stress and anxiety. Participants recognised the significance of these sessions, where they could openly discuss and reflect on professional situations both emotionally and rationally. Central to these discussions was the creation of a safe, trustworthy, and collegial environment, aligning with evidence in the literature [34]. Clinical supervision provided a platform to share resources (information, knowledge, and skills) and address issues while offering mutual support [35]. The emergence of COVID-19 has stressed the significance of peer group clinical supervision and support for the nursing/midwifery workforce [36], highlighting the need to help nurses/midwives preserve their well-being and participate in collaborative problem-solving. COVID-19 impacted and disrupted clinical supervision frequency, duration and access [37]. What was evident during COVID-19 was the stress and need for support for staff and given the restorative or supportive functions of clinical supervision it is a mechanism of support. However, clinical supervisors need support themselves to be able to better meet the supervisee's needs [38].

The value of peer group clinical supervision in nurturing a conducive working environment cannot be overstated, as it indorses the understanding and adherence to workplace policies by empowering supervisees to understand the importance and rationale behind these

policies [39]. This becomes vital in a continuously changing healthcare landscape, where guidelines and policies may be subject to change, especially in response to situations such as COVID-19. In an era characterised by international workforce mobility and a shortage of healthcare professionals, a supportive and positive working environment through the provision of peer group clinical supervision can positively influence staff retention [40], enhance job satisfaction [41], and mitigate burnout [42]. A critical aspect of the peer group clinical supervision process concerns providing staff the opportunity to reflect, step back, problem-solve and generate solutions. This, in turn, ensures critical thinking and evaluation within clinical supervision, focusing on understanding the issues and context, and problem-solving to draw constructive lessons for the future [30]. Research has determined a link between clinical supervision and improvements in the quality and standards of care [31]. Therefore, peer group clinical supervision plays a critical role in enhancing patient safety by nurturing improved communication among staff, facilitating reflection, promoting greater self-awareness, promoting the exchange of ideas, problem-solving, and facilitating collective learning from shared experiences.

Starting a group arose as a foundational aspect emphasised in this study. The creation of the environment through establishing ground rules, building relationships, fostering trust, displaying respect, and upholding confidentiality was evident. Vital to this process is the recruitment of clinical supervisees and deciding the suitable group size, with a specific emphasis on addressing individuals' inclination to engage, their knowledge and understanding of peer group clinical supervision, and dissipating any lack of awareness or misconceptions regarding peer group supervision. Furthermore, the educational training of peer group clinical supervisors and the support from external clinical supervisors played a vital role in the rollout and formation of peer group clinical supervision. The evidence stresses the significance of an open and safe environment, wherein supervisees feel secure and trust their supervisor. In such an environment, they can effectively reflect on practice and related issues [41]. This study emphasises that the effectiveness of peer group supervision is more influenced by the process than the content. Clinical supervisors utilised the process to structure their sessions, fostering energy and interest to support their peers and cultivate new insights. For peer group clinical supervision to be effective, regularity is essential. Meetings should be scheduled in advance, allocate protected time, and take place in a private space [35]. While it is widely acknowledged that clinical supervisors need to be experts in their professional field to be credible, this study highlights that the crucial aspects of supervision lie in the quality of the relationship with the

supervisor. The clinical supervisor should be supportive, caring, open, collaborative, sensitive, flexible, helpful, non-judgmental, and focused on tacit knowledge, experiential learning, and providing real-time feedback.

Critical to the success of peer group clinical supervision is the endorsement and support from management, considering the organisational culture and attitudes towards the practice of clinical supervision as an essential factor [43]. This support and buy-in are necessary at both the management and individual levels [28]. The primary obstacles to effective supervision often revolve around a lack of time and heavy workloads [44]. Clinical supervisors frequently struggle to find time amidst busy environments, impacting the flexibility and quality of the sessions [45]. Time constraints also limit the opportunity for reflection within clinical supervision sessions, leaving supervisees feeling compelled to resolve issues on their own without adequate support [45]. Nevertheless, time-related challenges are not unexpected, prompting a crucial question about the value placed on clinical supervision and its integration into the culture and fabric of the organisation or profession to make it a customary practice. Learning from experiences like those during the COVID-19 pandemic has introduced alternative ways of working, and the use of technology (such as Zoom, Microsoft Teams, Skype) may serve as a means to address time, resource, and travel issues associated with clinical supervision.

Despite clinical supervision having a long international history, persistent misconceptions require attention. Some of these include not considering clinical supervision a priority [46], perceiving it as a luxury [41], deeming it self-indulgent [47], or viewing it as mere casual conversation during work hours [48]. A significant challenge lies in the lack of a shared understanding regarding the role and purpose of clinical supervision, with past perceptions associating it with surveillance and being monitored [48]. These negative connotations often result in a lack of engagement [41]. Without encouragement and recognition of the importance of clinical supervision from management or the organisation, it is unlikely to become embedded in the organisational culture, impeding its normalisation [39].

In this study, some peer group clinical supervisors expressed feelings of being impostors and believed they lacked the knowledge, skills, and training to effectively fulfil their roles. While a deficiency in skills and competence are possible obstacles to providing effective clinical supervision [49], the peer group clinical supervisors in this study did not report such issues. Instead, their concerns were more about questioning their ability to function in the role of a peer group clinical supervisor, especially after a brief training program. The literature acknowledges a lack of training where clinical supervisors

may feel unprepared and ill-equipped for their role [41]. To address these challenges, clinical supervisors need to be well-versed in professional guidelines and ethical standards, have clear roles, and understand the scope of practice and responsibilities associated with being a clinical supervisor [41].

The support provided by external clinical supervisors and the peer group clinical supervision sessions played a pivotal role in helping peer group clinical supervisors ease into their roles, gain experiential learning, and enhance their facilitation skills within a supportive structure. Educating clinical supervisors is an investment, but it should not be a one-time occurrence. Ongoing external clinical supervision for clinical supervisors [50] and continuous professional development [51] are crucial, as they contribute to the likelihood of clinical supervisors remaining in their roles. However, it is important to interpret the results of this study with caution due to the small sample size in the survey. Generalising the study results should be approached with care, particularly as the study was limited to two regions in Ireland. However, the addition of qualitative data in this mixed-methods study may have helped offset this limitation.

## Conclusion

This study highlights the numerous advantages of peer group clinical supervision at individual, service, organisational, and patient/client levels. Success hinges on addressing the initial lack of awareness and misconceptions about peer group clinical supervision by creating the right environment and establishing ground rules. To unlock the full potential of peer group clinical supervision, it is imperative to secure management and organisational support for staff release. More crucially, there is a need for valuing and integrating peer group clinical supervision into nursing and midwifery education and practice. Making peer group clinical supervision accessible to all grades of nurses and midwives across various healthcare services is essential, necessitating strategic planning to tackle capacity and sustainability challenges.

## Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s12912-024-02283-3>.

Supplementary Material 1

Supplementary Material 2

Supplementary Material 3

## Acknowledgements

The research team would like to thank all participants for their collaboration, the HSE steering group members and Carmel Hoey, NMPDU Director, HSE West Mid West, Dr Patrick Glackin, NMPD Area Director, HSE West, Annette Cuddy, Director, Centre of Nurse and Midwifery Education Mayo/Roscommon;

Ms Ruth Hoban, Assistant Director of Nursing and Midwifery (Prescribing), HSE West; Ms Annette Connolly, NMPD Officer, NMPDU HSE West Mid West.

## Author contributions

OD: Conceptualization, Methodology, Formal analysis, Investigation, Writing - Original Draft, Writing - Review & Editing, Project administration, Funding acquisition. COD: Methodology, Formal analysis, Investigation, Writing - Original Draft, Writing - Review & Editing, Funding acquisition. KM: Methodology, Formal analysis, Investigation, Writing - Original Draft, Writing - Review & Editing, Funding acquisition. JT: Methodology, Formal analysis, Writing - Original Draft, Writing - Review & Editing. LM: Methodology, Formal analysis, Investigation, Writing - Original Draft, Writing - Review & Editing, Funding acquisition.

## Funding

The authors declare that there are no sources of funding associated with this paper.

## Data availability

Data are available from the corresponding author upon request owing to privacy or ethical restrictions.

## Declarations

### Ethics approval and consent to participate

This study was approved by two health service institutional review boards University Hospital Limerick (Ref: 091/19) and Galway University Hospitals (Ref: C.A. 2199). The study was conducted in accordance with the principles of the Declaration of Helsinki and all study details were fully disclosed to participants, who were assured of the voluntary nature of participation and withdrawal. The study questionnaires were coded, and identities were not disclosed to guarantee participants' anonymity and all participants provided written informed consent before interviews.

### Consent for publication

No identifying images or other personal or clinical details of participants are presented in this paper that would compromise anonymity and all participants were aware and informed through the Participant Information Leaflet that the data collected may be reported through article and/or conference publications and this was reiterated during the qualitative data collection stage.

### Competing interests

The authors declare no competing interests.

Received: 4 January 2024 / Accepted: 22 August 2024

Published online: 02 September 2024

## References

- Zelenikova R, Gurkova E, Friganovic A, Uchmanowicz I, Jarosova D, Ziakova K, Plevova I, Papastavrou E. Unfinished nursing care in four central European countries. *J Nurs Manage*. 2020;28(8):1888–900. <https://doi.org/10.1111/jonm.12896>.
- Department of Health, Office of the Chief Nursing Officer. Position paper 1: values for nurses and midwives in Ireland. Dublin: The Stationery Office; 2016.
- Cummings J, Bennett V. Developing the culture of compassionate care: creating a new vision for nurses, midwives and care-givers. London: Department of Health; 2012.
- Both-Nwabuwe JM, Dijkstra MT, Klink A, Beersma B. Maldistribution or scarcity of nurses: the devil is in the detail. *J Nurs Manage*. 2018;26(2):86–93. <https://doi.org/10.1111/jonm.12531>.
- Squires A, Jylha V, Jun J, Ensio A, Kinnunen J. A scoping review of nursing workforce planning and forecasting research. *J Nurs Manage*. 2017;25:587–96. <https://doi.org/10.1111/jonm.12510>.
- Sasso L, Bagnasco A, Catania G, Zanini M, Aleo G, Watson R. Push and pull factors of nurses' intention to leave. *J Nurs Manage*. 2019;27:946–54. <https://doi.org/10.1111/jonm.12745>.
- Gea-Caballero V, Castro-Sánchez E, Díaz-Herrera MA, Sarabia-Cobo C, Juárez-Vela R, Zabaleta-Del Olmo E. Motivations, beliefs, and expectations of Spanish

- nurses planning migration for economic reasons: a cross-sectional, web-based survey. *J Nurs Scholarsh*. 2019;51(2):178–86. <https://doi.org/10.1111/jnu.12455>.
8. Cutcliffe J, Sloan G, Bashaw M. A systematic review of clinical supervision evaluation studies in nursing. *Int J Ment Health Nurs*. 2018;27:1344–63. <https://doi.org/10.1111/inm.12443>.
  9. Snowdon DA, Hau R, Leggat SG, Taylor NF. Does clinical supervision of health professionals improve patient safety? A systematic review and meta-analysis. *Int J Qual Health C*. 2016;28(4):447–55. <https://doi.org/10.1093/intqhc/mzw059>.
  10. Turner J, Hill A. Implementing clinical supervision (part 1): a review of the literature. *Ment Health Nurs*. 2011;31(3):8–12.
  11. Dilworth S, Higgins I, Parker V, Kelly B, Turner J. Finding a way forward: a literature review on the current debates around clinical supervision. *Contemp Nurse*. 2013;45(1):22–32. <https://doi.org/10.5172/conu.2013.45.1.22>.
  12. Buss N, Gonge H. Empirical studies of clinical supervision in psychiatric nursing: a systematic literature review and methodological critique. *Int J Ment Health Nurs*. 2009;18(4):250–64. <https://doi.org/10.1111/j.1447-0349.2009.00612.x>.
  13. Pollock A, Campbell P, Deery R, Fleming M, Rankin J, Sloan G, Cheyne H. A systematic review of evidence relating to clinical supervision for nurses, midwives and allied health professionals. *J Adv Nurs*. 2017;73(8):1825–37. <https://doi.org/10.1111/jan.13253>.
  14. Snowdon DA, Leggat SG, Taylor NF. Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience: a systematic review. *BMC Health Serv Res*. 2017;17(1):1–11. <https://doi.org/10.1186/s12913-017-2739-5>.
  15. Kühne F, Maas J, Wiesenthal S, Weck F. Empirical research in clinical supervision: a systematic review and suggestions for future studies. *BMC Psychol*. 2019;7(1):1–11. <https://doi.org/10.1186/s40359-019-0327-7>.
  16. Snowdon DA, Sargent M, Williams CM, Maloney S, Caspers K, Taylor NF. Effective clinical supervision of allied health professionals: a mixed methods study. *BMC Health Serv Res*. 2020;20(1):1–11. <https://doi.org/10.1186/s12913-019-4873-8>.
  17. Borders LD. Dyadic, triadic, and group models of peer supervision/consultation: what are their components, and is there evidence of their effectiveness? *Clin Psychol*. 2012;16(2):59–71.
  18. Health Service Executive. Guidance document on peer group clinical supervision. Mayo: Nursing and Midwifery Planning and Development Unit Health Service Executive West Mid West; 2023.
  19. Sharma A, Minh Duc NT, Lam Thang L, Nam T, Ng NH, Abbas SJ, Huy KS, Marušić NT, Paul A, Kwok CL, Karamouzian, M. A consensus-based checklist for reporting of survey studies (CROSS). *J Gen Intern Med*. 2021;36(10):3179–87. <https://doi.org/10.1007/s11606-021-06737-1>.
  20. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89:1245–51. <https://doi.org/10.1097/ACM.0000000000000388>.
  21. Winstanley J, White E. The MCSS-26©: revision of the Manchester Clinical Supervision Scale© using the Rasch Measurement Model. *J Nurs Meas*. 2011;193(2011):160–78. <https://doi.org/10.1891/1061-3749.19.3.160>.
  22. Colorafi KJ, Evans B. Qualitative descriptive methods in health science research. *HERD-Health Env Res*. 2016;9:16–25. <https://doi.org/10.1177/1937586715614171>.
  23. Agnew T, Vaught CC, Getz HG, Fortune J. Peer group clinical supervision program fosters confidence and professionalism. *Prof Sch Couns*. 2000;4(1):6–12.
  24. Mc Carthy V, Goodwin J, Saab MM, Kilty C, Meehan E, Connaire S, O'Donovan A. Nurses and midwives' experiences with peer-group clinical supervision intervention: a pilot study. *J Nurs Manage*. 2021;29:2523–33. <https://doi.org/10.1111/jonm.13404>.
  25. Rothwell C, Kehoe A, Farook SF, Illing J. Enablers and barriers to effective clinical supervision in the workplace: a rapid evidence review. *BMJ Open*. 2021;119:e052929. <https://doi.org/10.1136/bmjopen-2021-052929>.
  26. Francis A, Bulman C. In what ways might group clinical supervision affect the development of resilience in hospice nurses. *Int J Palliat Nurs*. 2019;25:387–96. <https://doi.org/10.12968/ijpn.2019.25.8.387>.
  27. Chircop Coleiro A, Creaner M, Timulak L. The good, the bad, and the less than ideal in clinical supervision: a qualitative meta-analysis of supervisee experiences. *Couns Psychol Quart*. 2023;36(2):189–210. <https://doi.org/10.1080/09515070.2021.2023098>.
  28. Stacey G, Cook G, Aubeeluck A, Stranks B, Long L, Krepa M, Lucre K. The implementation of resilience based clinical supervision to support transition to practice in newly qualified healthcare professionals. *Nurs Educ Today*. 2020;94:104564. <https://doi.org/10.1016/j.nedt.2020.104564>.
  29. Feerick A, Doyle L, Keogh B. Forensic mental health nurses' perceptions of clinical supervision: a qualitative descriptive study. *Issues Ment Health Nurs*. 2021;42:682–9. <https://doi.org/10.1080/01612840.2020.1843095>.
  30. Corey G, Haynes RH, Moulton P, Muratori M. Clinical supervision in the helping professions: a practical guide. Alexandria, VA: American Counseling Association; 2021.
  31. Sturman N, Parker M, Jorm C. Clinical supervision in general practice training: the interweaving of supervisor, trainee and patient entrustment with clinical oversight, patient safety and trainee learning. *Adv Health Sci Educ*. 2021;26:297–311. <https://doi.org/10.1007/s10459-020-09986-7>.
  32. Alfonsso S, Parling T, Spännargård Å, Andersson G, Lundgren T. The effects of clinical supervision on supervisees and patients in cognitive behavioral therapy: a systematic review. *Cogn Behav Therapy*. 2018;47(3):206–28. <https://doi.org/10.1080/16506073.2017.1369559>.
  33. Coelho M, Esteves I, Mota M, Pestana-Santos M, Santos MR, Pires R. Clinical supervision of the nurse in the community to promote quality of care provided by the caregiver: scoping review protocol. *Millennium J Educ Technol Health*. 2022;2:83–9. <https://doi.org/10.29352/mill0218.26656>.
  34. Toros K, Falch-Eriksen A. Structured peer group supervision: systematic case reflection for constructing new perspectives and solutions. *Int Soc Work*. 2022;65:1160–5. <https://doi.org/10.1177/0020872820969774>.
  35. Bifarin O, Stonehouse D. Clinical supervision: an important part of every nurse's practice. *Brit J Nurs*. 2017;26(6):331–5. <https://doi.org/10.12968/bjon.2017.26.6.331>.
  36. Turner J, Simbani N, Doody O, Wagstaff C, McCarthy-Grunwald S. Clinical supervision in difficult times and at all times. *Ment Health Nurs*. 2022;42(1):10–3.
  37. Martin P, Tian E, Kumar S, Lizarondo L. A rapid review of the impact of COVID-19 on clinical supervision practices of healthcare workers and students in healthcare settings. *J Adv Nurs*. 2022;78:3531–9. <https://doi.org/10.1111/jan.15360>.
  38. van Dam M, van Hamersvelt H, Schoonhoven L, Hoff RG, Cate OT, Marije P. Hennis. Clinical supervision under pressure: a qualitative study amongst health care professionals working on the ICU during COVID-19. *Med Edu Online*. 2023;28:1. <https://doi.org/10.1080/10872981.2023.2231614>.
  39. Martin P, Lizarondo L, Kumar S, Snowdon D. Impact of clinical supervision on healthcare organisational outcomes: a mixed methods systematic review. *PLoS ONE*. 2021;1611:e0260156. <https://doi.org/10.1371/journal.pone.0260156>.
  40. Hussein R, Salamonsen Y, Hu W, Everett B. Clinical supervision and ward orientation predict new graduate nurses' intention to work in critical care: findings from a prospective observational study. *Aust Crit Care*. 2019;325:397–402. <https://doi.org/10.1016/j.aucc.2018.09.003>.
  41. Love B, Sidebotham M, Fenwick J, Harvey S, Fairbrother G. Unscrambling what's in your head: a mixed method evaluation of clinical supervision for midwives. *Women Birth*. 2017;30:271–81. <https://doi.org/10.1016/j.wombi.2016.11.002>.
  42. Berry S, Robertson N. Burnout within forensic psychiatric nursing: its relationship with ward environment and effective clinical supervision? *J Psychiatr Ment Health Nurs*. 2019;26:7–8. <https://doi.org/10.1111/jpm.12538>.
  43. Markey K, Murphy L, O'Donnell C, Turner J, Doody O. Clinical supervision: a panacea for missed care. *J Nurs Manage*. 2020;28:2113–7. <https://doi.org/10.1111/jonm.13001>.
  44. Brody AA, Edelman L, Siegel EO, Foster V, Bailey DE Jr, Bryant AL, Bond SM. Evaluation of a peer mentoring program for early career gerontological nursing faculty and its potential for application to other fields in nursing and health sciences. *Nurs Outlook*. 2016;64(4):332–8. <https://doi.org/10.1016/j.outlook.2016.03.004>.
  45. Bulman C, Forde-Johnson C, Griffiths A, Hallworth S, Kerry A, Khan S, Mills K, Sharp P. The development of peer reflective supervision amongst nurse educator colleagues: an action research project. *Nurs Educ Today*. 2016;45:148–55. <https://doi.org/10.1016/j.nedt.2016.07.010>.
  46. Pack M. Unsticking the stuckness': a qualitative study of the clinical supervisory needs of early-career health social workers. *Brit J Soc Work*. 2015;45:1821–36. <https://doi.org/10.1093/bjsw/bcu069>.
  47. Bayliss J. Clinical supervision for palliative care. London: Quay Books; 2006.
  48. Kenny A, Allenby A. Implementing clinical supervision for Australian rural nurses. *Nurs Educ Pract*. 2013;13(3):165–9. <https://doi.org/10.1016/j.nepr.2012.08.009>.

49. MacLaren J, Stenhouse R, Ritchie D. Mental health nurses' experiences of managing work-related emotions through supervision. *J Adv Nurs*. 2016;72:2423–34. <https://doi.org/10.1111/jan.12995>.
50. Wilson HM, Davies JS, Weatherhead S. Trainee therapists' experiences of supervision during training: a meta-synthesis. *Clinl Psychol Psychother*. 2016;23:340–51. <https://doi.org/10.1002/cpp.1957>.
51. Noelker LS, Ejaz FK, Menne HL, Bagaka's JG. Factors affecting frontline workers' satisfaction with supervision. *J Aging Health*. 2009;21(1):85–101. <https://doi.org/10.1177/0898264308328641>.

### **Publisher's note**

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.