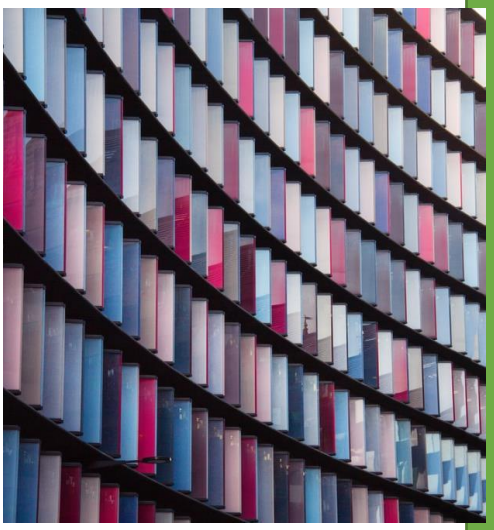

Evaluation of the Implementation of Peer Group Clinical Supervision for Registered Nurses and Registered Midwives - HSE West Mid West

June - 2023

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To cite this report: Doody, O., O Donnell, C., Murphy, L., Turner, J. and Markey, K. (2023) *Evaluation of the Implementation of Peer Group Clinical Supervision for Registered Nurses and Registered Midwives: HSE West Mid West*. Limerick: University of Limerick and the Nursing and Midwifery Planning and Development Unit, HSE West Mid West.

ISBN: 9781911620464

Acknowledgements

The authors wish to thank the Nursing and Midwifery Planning and Development Unit (NMPDU) in the Health Service Executive (HSE) West Mid West who commissioned this evaluation. Our sincere thanks to Ms Mary Frances O'Reilly, former NMPDU Director, HSE West Mid West, Ms Carmel Hoey, NMPDU Director, HSE West Mid West and Dr Patrick Glackin, NMPD Area Director, HSE West for their vision, leadership and commitment to the introduction and implementation of peer group clinical supervision for nurses and midwives in this area. In addition, we would like to acknowledge the two Nursing and Midwifery Peer Group Clinical Supervision Steering Groups for their advice, guidance and valued support throughout the evaluation. To our collaborator and external advisor on clinical supervision, Dr James Turner we express our thanks for supporting the evaluation at each stage. The evaluation team wish to express our appreciation to all the participants who contributed to this evaluation. We wish to acknowledge and extend our gratitude to all the peer group clinical supervisors who participated in this evaluation and who support the personal and professional development of their peers in the HSE West Mid West. Special thanks to the project leads involved in the introduction and implementation of peer group clinical supervision in HSE West Mid West: Ms 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; Ms Mary B. Rice, former NMPD Officer, NMPDU HSE West Mid West and Ms Lorraine Dunne, Clerical Officer, NMPDU, HSE West Mid West.

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Abbreviations

ADoN	Assistant Director of Nursing
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CHO	Community Healthcare Organisation
CNME	Centre of Nursing and Midwifery Education
CPD	Continuous Professional Development
CS	Clinical Supervision
DoH	Department of Health
EBCD	Experience Based Co-Design
HSE	Health Service Executive
MCSS-26	Manchester Clinical Supervision Scale – 26 items
MeSH	Medical Subject Headings
NMBI	Nursing and Midwifery Board of Ireland
NMPDU	Nursing and Midwifery Planning and Development Unit
UoG	University of Galway
ONMSD	Office of the Nursing and Midwifery Service Director
SPSS	Statistical Package for the Social Sciences
UL	University of Limerick

Executive Summary

The Irish healthcare system faces many challenges; therefore, nurses and midwives need on-going support in providing evidence based, safe, high quality and accessible care. Within a rapidly evolving healthcare system, there are increasing demands on nurses and midwives, highlighting the need for continuous personal and professional development that will enhance effective and efficient care delivery for patients, families and societies. Clinical supervision is advocated as a way to enable support and learning for individual practitioners to develop their knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex clinical situations (Turner and Hill 2011a, b; Pollock et al. 2017; Kuhne et al. 2019). Clinical supervision provides professional support through regular protected time for discussions and facilitated reflection, enabling opportunities for individuals to think about their practice and question the effectiveness of their care, thus empowering them to make improvements (Cutcliffe et al. 2018). The Nursing and Midwifery Planning and Development Unit (NMPDU) HSE West Mid West introduced peer group clinical supervision in 2018 and following its implementation commissioned this evaluation. The evaluation sought key stakeholders' experiences and views.

The project consisted of four phases

- Phase 1 – Focus groups were held with both peer group clinical supervision steering groups (n=2) to gain insight into the governance and oversight of this initiative.
- Phase 2 – Individual tele-interviews were held with external clinical supervisors.
- Phase 3 – Online survey of new peer group clinical supervisors utilising the Manchester Clinical Supervision Scale-26 (MCSS-26) questionnaire.
- Phase 4 – Individual tele-interviews with new peer group clinical supervisors.

Key recommendations

At an organisational level, there is a need to have a clear understanding of what peer group clinical supervision is, its form and purpose and this would encompass:

- Clearly define and identify the aim and intention of peer group clinical supervision across all services and staff grades within an organisation.

- The inclusion of peer group clinical supervision in job specifications to demonstrate the value peer group clinical supervision has as a method to develop, recruit and retain staff.

- Organisational policies to reflect the importance of peer group clinical supervision by incorporating:

    - An agreed standard of what regular peer group clinical supervision is with a commitment of a minimum of one hour per month.

    - Clearly defined roles and objectives for peer group clinical supervision.

    - The allocation of protected time for all concerned to ensure that peer group clinical supervision is embedded into the culture and fabric of the organisation.

Critical to the success of peer group clinical supervision is the criteria and support extended to clinical supervisors. For consideration:

- The Health Service Executive (HSE) criteria to become a peer group clinical supervisor should be explicit.

- There should be clear guidance and expectations for peer group clinical supervisors e.g., awareness of and being up to date on relevant policies, procedures and guidelines; maintenance of up-to-date records of peer group clinical supervision sessions, confidentiality, being supportive and being a credible expert.

- Ongoing external clinical supervision and continuous professional development (CPD) for peer group clinical supervisors is required.

- Organisations should incorporate mechanisms to support ongoing review and feedback from peer group clinical supervisors and supervisees.

- Guidance regarding the preferred method of delivery of peer group clinical supervision e.g., face-to-face, online or a combination of both.

- Implementation of the initiative should be standardised and equitable across services and all nursing and midwifery grades with support from management and HSE with inbuilt evaluation measures.

- Provision of a private space for peer group clinical supervision sessions to occur.

- Addressing issues such as travel and protected time to attend peer group clinical supervision.

- Group size of four to six members is manageable and appropriate.

- Capturing the benefits of peer group clinical supervision on aspects such as job satisfaction, being listened to, increased social support, stress relief, peer support, improved relationship with patients/service users, improved confidence and competence in practice, increased professional knowledge, improved communication skills and reflective practice.

The processes within peer group clinical supervision sessions should:

- Develop an agreement of shared understanding of peer group clinical supervision and expectations between the peer group clinical supervisor and supervisees and establish the environment through setting ground rules, building the relationship and trust, having respect and upholding confidentiality.

- Facilitate regular and constructive feedback and provide reflective time within peer group clinical supervision sessions.

- Agree a standardised process for recording and documenting as required.

- Ensure flexibility as this is required to accommodate different work patterns.

Chapter 1 - Introduction

1.1 Background and Policy Context

Providing quality healthcare that is safe, person-centred, effective and efficient, are core priorities for global healthcare services and professionals working within these services. Healthcare services are evolving at a rapid pace in response to growing evidence underpinning practice, changing demographics of patient population and the evolving nature of service needs. This is compounded by changing healthcare environments, global nursing and midwifery shortages, reduced resources (Jangland et al. 2018; Zhao et al. 2020) and reduced staff morale (Burke et al. 2014; Sasso et al. 2019). Care provision in such environments proves challenging for nurses and midwives and supports are warranted to help frontline staff and management through implementing strategies such as clinical supervision. This assists in maintaining quality care delivery and in supporting personal and professional staff development (Proctor, 1986). Markey et al. (2020) further propose clinical supervision as a solution focused approach that supports nurses and midwives in busy healthcare environments by providing a safe space to critically examine their behaviours and practices whilst also supporting quality patient care outcomes. This is reflected in national policy, and regional documents such as the HSE North-East Nursing and Midwifery Peer Group Clinical Supervision Strategic Plan 2017-2020 (HSE, 2017) and the Guidance Document on Peer Group Clinical Supervision (NMPDU HSE West Mid West, 2019).

In recognising and valuing the contribution of clinical supervision to improving and maintaining quality, safe care of patient/service users; the NMPDU HSE West Mid West established two nursing and midwifery peer group clinical supervision steering groups (hereafter referred to as peer group clinical supervision steering groups) (West and Mid West) in May 2018. The purpose of the peer group clinical supervision steering groups was to provide strategic oversight and governance of the introduction, implementation and evaluation of peer group clinical supervision for nursing and midwifery throughout HSE West (Galway, Mayo and Roscommon) and HSE Mid West (Limerick, Clare, North Tipperary). To date, approximately 100 nurses and midwives across all clinical areas and grades have been supported to become peer group clinical supervisors. To support this, a guidance document on peer group clinical supervision was developed (NMPDU HSE West Mid West, 2019). Peer group clinical supervision offers support to all levels of nursing

and midwifery staff and management and can benefit quality of care for patients/service users (HSE, 2015).

1.2 Aim of the Evaluation

The overall aim of this evaluation was to evaluate the implementation of peer group clinical supervision for nurses and midwives working in HSE West Mid West. To achieve this, the commissioning brief was agreed with UL researchers and NMPDU HSE West Mid West and four phases were specified to inform the evaluation and meets its objectives.

1. Facilitate and analyse focus groups with both steering group committees.

2. Facilitate and analyse individual interviews with external clinical supervisors.

3. Collect and analyse data from a validated online questionnaire (MCSS-26) to identify new peer group clinical supervisors' perceptions of clinical supervision.

4. Facilitate and analyse individual interviews with new peer group clinical supervisors.

1.3 Definition of Clinical Supervision

The Office of the Nursing and Midwifery Service Director (ONMSD) HSE (2019, p.2) defines clinical supervision as 'a professional relationship between a supervisor and supervisee, where the supervisor facilitates the practitioner in reflecting critically upon their practice'. By offering learning opportunities, support, professional guidance and oversight of the clinical supervisee's work, clinical supervision promotes high standards of ethical practice and ensures the welfare of service users and staff alike. According to Bond and Holland (2010), peer group clinical supervision is a form of group supervision where 'peer colleagues within the same discipline meet, led by a supervisor who may be more experienced in the same field as the supervisees and has group facilitation skills'.

1.4 Outline of the Report

Chapter One: Presents the background and context of clinical supervision, outlines the aim of the evaluation and defines clinical supervision/peer group clinical supervision.

Chapter Two: Presents a narrative literature review on clinical supervision.

Chapter Three: Presents the methods adopted for this evaluation.

Chapter Four: Presents an overview and contextualisation of the findings.

Chapter Five: Presents the recommendations and conclusions of the evaluation.

1.5 Chapter Summary

Providing safe quality care is a global priority and this is difficult in a rapidly changing healthcare environment. Key to meeting this goal is healthcare staff who feel valued and supported to work in healthcare delivery, ensuring a motivated workforce. Providing care can be challenging for nurses and midwives and supports such as peer group clinical supervision are necessary in maintaining quality care delivery and in supporting personal and professional staff development. Clinical supervision offers support, guidance and provides a safe space for nurses and midwives to critically examine their behaviours and practices. In recognition of the value and contribution of peer group clinical supervision to improving and maintaining quality, safe care of patients and service users; the NMPDU HSE West Mid West introduced peer group clinical supervision for nurses and midwives. This report presents an evaluation of the implementation and presents findings from both steering group committee members, external clinical supervisors, new peer group clinical supervisors and contextualises these findings to make recommendations for the future.

Chapter 2 - Narrative Literature Review

2.1 Introduction

This chapter presents a summary of the findings of a narrative literature review on clinical supervision, offering a comprehensive overview and broad perspective of a wide range of published literature on the topic. As there have been numerous recent literature reviews published on clinical supervision this review adopted an 'interpretive narrative overview' approach (Greenhaigh et al. 2018) and synthesis of the findings are presented under six themes.

2.2 Literature Reviews on Clinical Supervision

There have been several literature reviews published on clinical supervision (Buss and Gonge, 2009; Turner and Hill, 2011a; Dilworth et al. 2013; Snowdon et al. 2016; Pollock et al. 2017; Snowdon et al. 2017; Cutcliffe et al, 2018; Kuhne et al. 2019). On synthesising these reviews, the benefits and value of clinical supervision is widely reported. However, a lack of consensus on the definition and purpose of clinical supervision, challenges with its implementation, wide variations of approaches on how it is operationalised, and a dearth of empirical evidence on its effectiveness were also identified. Cutcliffe et al. (2018) found that the length of experience of clinical supervision correlates with positive benefits, but there is less of a focus on how clinical supervision changed individual behaviours and practices. Similarly, Kuhne et al. (2019) found that satisfaction with, as opposed to effectiveness of clinical supervision are most frequently investigated. However, other reviews identify that clinical supervision reduced risks of adverse patient outcomes (Snowdon et al. 2016) and shows improvements in performance of some processes of care (Snowdon et al. 2017).

2.3 Purpose and Function of Clinical Supervision

Although there is no universal agreement on the definition of clinical supervision, there is broad agreement over its function and purpose, which can be summarised as the 'facilitation of professional support and learning enabling safe practice of healthcare professionals' (Pollock et al. 2017, p.1826). Clinical supervision supports 'professional conversations' amongst healthcare professionals (Lyth, 2000; Office of the Nursing and Midwifery Service Director, 2015) and

generally has three core functions: formative (educational and learning), normative (standards of care and accountability), and restorative (supportive) (Proctor, 1986). Although these functions are often presented as separate functions, they intersect and overlap in practice (Brunero and Lamont, 2012). However, there are those that argue that the evaluation function of clinical supervision is equally important but receives less attention (Milne, 2007). The diverse interpretations of clinical supervision highlight the need to articulate an agreed definition of its purpose.

Clinical supervision can support nurses and midwives in improving standards of care and encourages professionals to think about and reflect on their behaviours and practices, as a means of improving the quality of care provided (Bifarin and Stonehouse, 2017). At the heart of clinical supervision is learning and enhancement of practice as it has patient safety, staff development and support, and professional well-being as core to its purpose (Dilworth et al. 2013; Tomlinson, 2015). Clinical supervision is a professional conversation encouraging reflective learning, highlighting that reflection is core to effective clinical supervision. Understanding the professional self is a marker of skilled practice (Dewane, 2006). Therefore, clinical supervision provides opportunities for nurses and midwives to critically review and transform their beliefs, values and behaviours, through empowering professionals to negotiate learning and development requirements (Esfahani et al. 2017; Key et al. 2019).

2.4 Clinical Supervision Frameworks and Models

Pollock et al. (2017) identify the diverse variations in approaches of how clinical supervision is operationalised. Of the numerous clinical supervision frameworks and models reported in the literature, each one has its own merits, therefore making it difficult for one model to meet everyone's needs. Examples of models include Proctor's Model of Supervision (1986), Tandem Model by Milne (2009) and the Cyclical Model (Page and Wosket, 2015). Proctor's Model of Supervision (1986) was further developed by Inskipp and Proctor (2001) focusing on the tasks of restorative, formative and normative. These tasks bring attention to support, learning and accountability for the clinical supervisee. Page and Wosket (2015) offer a sequenced framework based on five areas including contract, focus, space, bridge and review. The Tandem Model (Milne, 2009) highlights the importance of seeking a baseline of learning needs for the clinical

supervisee and planning thereafter to support their development. Regardless of the models or frameworks being utilised, clinical supervision needs to be professionally led and learner centred, where the clinical supervisee controls the outcome of clinical supervision, so it is meaningful and effective (Kilminster et al. 2007; Tomlinson 2015).

2.5 Operationalising Clinical Supervision

Approaches to clinical supervision can vary per discipline and geography (Turner and Hill, 2011a) and can be provided through individual, group, or peer clinical supervision (Bifarin and Stonehouse, 2017). The structure of clinical supervision is changing in the 21st century with options of facilitation via face-to-face or electronic means (Kuhne et al. 2019). Peer supervision is where clinical supervisees discuss their clinical practice with their peers, with no formal clinical supervisor, whilst peer group clinical supervision is where peers come together to explore their practice, which is facilitated by a clinical supervisor (Taylor, 2013). Pollock et al. (2017) identified that group clinical supervision was the most common and individual clinical supervision the least reported method of clinical supervision identified in their systematic review. It is important to assess the culture of an organisation before the implementation of clinical supervision (Driscoll, 2000; Brunero and Lamont, 2012). Improving access to, and the experience of clinical supervision can be achieved through planning its implementation, delivery and monitoring (McCarron et al. 2017). Exploring both positive and negative outcomes of clinical supervision and its implementation processes are also necessary (Kuhne et al. 2019).

There are wide disparities within the literature as to who takes on the role of clinical supervisor, with varying levels of training, preparation and experiences for their role reported (Pollock et al. 2017). A clinical supervisor should be somebody that supports, prompts and guides clinical supervisees to critically reflect on their practice and examine ways of improving it (Lillyman, 2007). It should not be seen within the context of a management relationship that can become overshadowed by management agendas, appraisal and performance (Brunero and Lamont, 2012; Cutcliffe et al. 2018). The complexity of the supervisory and managerial relationship should not be underestimated. A clinical supervisor has a supportive role, providing a scaffolding of support, but also holding a monitoring function to supporting standards of care. The need for preparation and training for clinical supervisees and clinical supervisors is acknowledged (Hall, 2018; Key et

al. 2019) and clinical supervisors require excellent facilitation, listening and reflection skills (Van Ooijen, 2013; Bifarin and Stonehouse, 2017). These skills should be based on experience, adequate education, training and preparation (Tomlinson, 2015).

2.6 Benefits of Clinical Supervision

Clinical supervision is recognised as a method of enhancing quality care and has gained momentum in some areas of nursing and midwifery practice (Parlour and Slater, 2014). Clinical supervisees who engage in clinical supervision value it as a supportive mechanism (Dawson et al. 2013; Evans and Macroft, 2015), see it as a professional development activity (Snowdon et al. 2017) and are generally positive towards its effects (Malin, 2000; Maplethorpe et al. 2014). Clinical supervision nurtures resilience and enables the expansion of one's scope of practice through self-assessment and development of enhanced analytical and reflective skills (Hyrkas and Paunonen-Ilmonen, 2000). There is growing evidence to suggest clinical supervision supports effectiveness of care (Cutcliffe et al. 2018), improves patient safety (Tomlinson, 2015; Snowdon et al. 2016; Esfahani et al. 2017) and improves performance of some processes of care (Snowdon et al. 2017). It is also associated with higher levels of job satisfaction, improved staff retention, effectiveness and good clinical governance, by helping to support quality improvements, managing risks and increasing accountability (O'Connell et al. 2013; Cutcliffe et al. 2018). Clinical supervision has been found to reduce staff stress and burnout (Wallbank and Hatton, 2011) and promotes greater coping mechanisms when working in complex environments (Gonge and Buus, 2011). Nurses and midwives feel valued and supported when clinical supervision is arranged for them (Pollock et al. 2017; Hall, 2018), which can lead to enhancements of the capability and capacity for providing quality and safe patient care. Clinical supervision provides individuals with opportunities to think about and review their practice, identify education and training needs and question the effectiveness of their care, thus empowering them to make improvements. The principles of clinical supervision also facilitate the development of leadership skills (Blishen, 2016), which is a core requisite in today's contemporary healthcare environment.

Francis and Bulman (2019) highlight how clinical supervision supports the development of resilience and confidence in nurses and midwives working in increasingly complex healthcare settings. Clinical supervision has a supportive function (Proctor, 1986), which enables nurses and

midwives to raise emotional concerns about their practice and helps them build their confidence. Failure to explore these emotions in a supportive environment can result in stress, fatigue and burnout (Dhaini et al. 2017; White et al. 2019). In addition, clinical supervision is a forum for learning and enhancing practice (Dilworth et al. 2013). Clinical supervision provides opportunities for nurses and midwives to critically examine clinical practice within a safe environment (Blishen, 2016) and supports positive professional socialisation (Bifarin and Stonehouse, 2017). Through clinical supervision individual practitioners develop their knowledge and competence and assume responsibility for their own practice (McCarron et al. 2017; Bifarin and Stonehouse, 2017; Key et al. 2019).

2.7 Challenges and Pitfalls with Clinical Supervision

Although most of the literature reviewed report on the positive effects of clinical supervision, questions are raised regarding the effects of clinical supervision on improving patient care (Snowdon et al. 2017) and its general helpfulness in dealing with challenges in daily practice (Carney, 2005; Edwards et al. 2005; Kuhne et al. 2019). Commonly reported challenges with clinical supervision that also require further consideration include uncertainty over its purpose and getting buy-in from all stakeholders (Bifarin and Stonehouse, 2017; McCarron et al. 2017; Cutcliffe et al. 2018). Availability of suitably trained clinical supervisors (Brunero and Lamont, 2012; McCarron et al. 2017; Cutcliffe, 2018; Kuhne et al. 2019) and challenges with releasing staff (Bifarin and Stonehouse 2017) are also reported in the literature. Despite its function and value, clinical supervision remains underused in many areas (McCarron et al. 2017; Key et al. 2019). The lack of consensus regarding its definition and a deficiency of evidence informing frameworks guiding clinical supervision delivery are contributing factors to its underuse (Pollock et al. 2017; Snowdon et al. 2017; Kuhne et al. 2019). Therefore, careful planning, implementation and evaluation of clinical supervision as an intervention is warranted to truly understand ways of overcoming the challenges with its operationalisation (McCarron et al. 2017).

Clearly clinical supervision requires support from managers to facilitate release of staff, to have a strategic way of providing skilled and adequately trained clinical supervisors and a clear vision of its purpose and function. However, raising awareness amongst staff as to the philosophy, purpose and function of clinical supervision is critical to its success as participation should be voluntary

(Brunero and Lamont, 2012; Pollock et al. 2017; McCarron et al. 2017). Clinical supervisees should manage the agenda during clinical supervision sessions and if they are fearful of being exposed or do not 'buy-in' to its philosophy, they can guard their contributions during discussions, which results in sustaining practices, attitudes and behaviours by engaging in 'safe talk' (Duncan-Grant, 2003). These functions, roles and perspectives relate to one another, and need to be considered to create a forum for critical reflection that is deemed 'safe' for the supervisee to discuss their issues freely without the fear of censure (Pack, 2012). There is a need to appreciate the value of clinical supervision, plan for the appropriate education and training for its implementation and commit to providing meaningful and effective clinical supervision for the nursing and midwifery team. Although some argue that clinical supervision should be a mandatory professional requirement (Tomlinson, 2015), taking a 'top down' approach to its implementation may result in resistance, lack of ownership and commitment to its operationalisation and successful implementation. Dilworth et al. (2013) identify the need for genuine support and ownership from managers for clinical supervision to be effective.

2.8 Chapter Summary

Clinical supervision is a process of professional support and learning, through regular protected time for discussions and facilitated reflection. The wealth of evidence highlighting the benefits and effectiveness of clinical supervision is compelling, but it remains underutilised in many areas of nursing and midwifery practice. Greater attention is needed regarding its implementation and the enablers and barriers to its successful implementation. Although there is a wealth of published literature on clinical supervision, there is a lack of quality empirical studies evaluating its effectiveness (Pollock et al. 2017; Cutcliffe et al. 2018; Kuhne et al. 2019). In particular, the need for further research on the facilitators and barriers of clinical supervision is recommended (Pollock et al. 2017).

Chapter 3 - Methods

3.1 Introduction

This chapter presents an overview of the methods used within the evaluation, which comprised of three different methods; focus group interviews, surveys and one-to-one interviews. Each stakeholder group were included as data from different contexts allowing the 'true' status to emerge, increasing the evaluation rigour (Tashakkori and Teddie, 2010).

3.2 Design

The acceptance that a one-size-fits-all to knowledge development does not exist, allows us to move beyond purist approaches while still preserving the integrity of knowledge creation. This view is important especially in nursing and midwifery, which operates, assists and cares for complex human beings and situations who have different perceptions (Bahramnezhad et al. 2015). Therefore, it is essential to consider the suitability of a method or methods that meet the objectives of this evaluation (Kaushnik and Walsh, 2019). The combination of qualitative and quantitative methods permits a more comprehensive approach that is based on the complexity and context of nursing and midwifery practice (Shaw et al. 2010). Within this evaluation a qualitative element was incorporated which included focus groups and semi-structured interviews underpinned by qualitative descriptive design (Bradshaw et al, 2017). Also, within this evaluation a quantitative element was chosen as it is a formal, objective, systematic process (Curtis and Drennan, 2013; Gerrish and Lathlean 2015). The quantitative approach used in this evaluation was a questionnaire underpinned by the principles of survey research (Story and Tait, 2019). Of note was the advent of the COVID-19 pandemic, which resulted in postponement and methodological changes within this evaluation in-line with social distancing public health guidelines and thereby face-to-face events were replaced with telecommunication methods.

3.3 Research Site

The research site included Hospital Groups and Community Health Organisations (CHOs) (acute and primary care) in HSE West Mid West incorporating the counties Galway, Mayo, Roscommon, Limerick, Clare and North Tipperary.

3.4 Sample

The sample size consisted of external clinical supervisors (n=5), peer group clinical supervision steering group members (n=24), new peer group clinical supervisors (n=74) (nurses and midwives who successfully completed the Professional Credit Award: Clinical Supervision: Supporting Continuing Professional Development module provided by University of Galway (UoG)) across 5 programmes over 3 years.

3.4.1 Inclusion Criteria

Criteria for inclusion were:

- Registered nurses/midwives delivering peer group clinical supervision within the HSE West Mid West area.
- External clinical supervisors who delivered external clinical supervision to the new peer group clinical supervisors.
- Peer group clinical supervision steering group members in HSE West Mid West area.

3.4.2 Exclusion Criteria

Criteria for exclusion were:

- Registered nurses/midwives who had not completed the UoG clinical supervision module/training.
- New peer group clinical supervisors who had not yet set up their groups and were not delivering peer group clinical supervision.

3.5 Recruitment

The HSE West Mid West peer group clinical supervision steering group project officer leads acted as gatekeepers for the distribution of information to potential participants. A recruitment 'pack' was emailed to all potential participants which included an invitation letter, information sheet, a link to the survey and email address to express an interest in participating in tele-interviews.

3.6 Data Collection

Phase 1 utilised focus group interviews with the HSE West Mid West peer group clinical supervision Steering Group members.

Phase 2 and phase 4 utilised semi-structured tele-interviews with the external clinical supervisors and the new peer group clinical supervisors.

Phase 3 used a survey approach via an online self-reporting questionnaire on Qualtrics to collect data on demographics and clinical supervision from the peer group clinical supervisors using the Manchester Clinical Supervision Scale-26 (MCSS-26) (Winstanley and White, 2011). The MCSS-26 is a validated 26-item self-reporting questionnaire with a Likert-type (1-5) scale ranging from strongly disagree [1] to strongly agree [5] (Winstanley and White 2011). The instrument measures the three dimensions of clinical supervision (formative, restorative, and normative) utilising six sub-scales:

1) Trust and rapport,
2) Clinical 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 MCSS-26 is also calculated.

3.7 Data Analysis

Phase 1 data was analysed using Doody et al. (2013) inductive content analysis framework. This involved six steps: 1) Generating rich data, 2) Familiarising oneself with the data, 3) Writing memos, 4) Indexing, 5) Formation of themes, and 6) Mapping and interpretation. Phases 2 and 4 data were analysed using thematic content analysis which involved searching through data to identify any recurrent patterns (Nowell et al. 2017). Burnard's (2011) thematic content analysis was selected as the most appropriate framework, as it is a content sensitive method which offers flexibility in terms of research design and creates a focused engagement rather than detachment (Sandelowski, 2011). Phase 3 data was analysed using data analysis software package Statistical Package for the Social Sciences (SPSS), IBM version 26 (SPSS Inc., Chicago, Il, USA). To examine internal consistency Cronbach's alpha coefficient were calculated (Pallant, 2020). Colorafi and Evans (2016) content analysis framework guided the analysis of the open-ended questions.

3.8 Integration

Findings from each phase were integrated in a "Contextualising of the Findings" chapter to represent the findings from the four phases. This process was supported by the involvement of the HSE West Mid West peer group clinical supervision steering group members who had the opportunity to validate, refine or suggest interpretations or misinterpretations and consider findings in the terms of relevance to practice, education management and policy.

3.9 Ethical Considerations

Measures to ensure the rights and dignity of participants were upheld and in place throughout this evaluation. The framework utilised to promote ethical soundness within the evaluation incorporates Research Ethics Committee approval and the ethical principles of; respect for persons/autonomy, beneficence and non-maleficence, justice, veracity, fidelity, and confidentiality (Nursing and Midwifery Board of Ireland - NMBI, 2015). Two health service institutional review boards (Saolta University Health Care Group, University Hospital Limerick) approved this study. Full disclosure ensured participants received all relevant information outlining the evaluation, as well as likely risks and benefits. Thereby, participants had the right to self-determination and could withdraw at any time without consequence (NMBI, 2015). This was reinforced by the researchers being honest with participants informing them of potential risks and benefits in addition to their right to decide to participate (or not) without coercion as well as their right to withdraw from the research (Moule et al. 2017). Prior to completing the online survey and tele-interviews a consent form was read and consent ticked and/or recorded and for the focus group interviews all participants completed a written consent form. Participants had the right to anonymity and the right to assume that data collected remained confidential. A pseudonym was assigned to each participant's transcript to protect anonymity.

3.10 Chapter Summary

This chapter presented an overview of the methods utilised in this evaluation. It details the mixed method approach adopted, incorporating both qualitative and quantitative designs across the four phases of the evaluation.

Chapter 4 - Findings Overview and Contextualisation

4.1 Introduction

This chapter presents a synopsis of the findings of each phase of the evaluation highlighting the themes or key findings which will be integrated within the chapter. Phase 1 involved two focus group interviews with the peer group clinical supervision steering group members (n=19) 79% response, phase 2 involved semi-structured tele-interviews with the external clinical supervisors (n=5) 100% response, phase 3 surveyed new peer group clinical supervisors (n=36) 48.6% response and phase 4 involved semi-structured tele-interviews with peer group clinical supervisors (n=10) 13.5% response.

4.2 Findings - Focus Group Interviews - Steering Groups

Three themes were identified through data analysis: getting buy in, organisational readiness, and personal and professional development.

Theme 1 - Getting Buy In, represented:

- Buy in from staff,
- Organisational commitment,
- Visibility in undergraduate curricula.

Theme 2 - Organisational Readiness, represented:

- A collaborative approach,
- Building capacity and demystifying clinical supervision,
- Increasing awareness.

Theme 3 - Personal and Professional Development, represented:

- Supporting staff,
- Building resilience,
- Increasing patient safety.

4.3 Findings - Interviews - External Clinical Supervisors

External clinical supervisors viewed themselves as an active part of the peer group clinical supervision process, helping to grow and build its successful implementation. External clinical supervisors and organisational support for new peer group clinical supervisors are a key component in delivering a strong sustainable service. Two themes were identified through data analysis: organisational structures and facilitation of clinical supervision.

1) Organisational Structures, represented:

- Buy-in from management,
- Time and financial factors,
- Benefits of peer group clinical supervision

2) Facilitation of Clinical Supervision, represented:

- A nurturing environment,
- Building trust,
- Being prepared
- The need for sustainability.

4.4 Findings - Survey - Peer Group Clinical Supervisors

New peer group clinical supervisors were surveyed (N=36), the total mean MCSS-26 score across all peer group clinical supervisors was 76.47 (S.D. 12.801) out of 104, higher than the clinical supervision threshold score of 73 identified as the indicative threshold for efficient clinical supervision provision (Winstanley and White, 2011). The restorative domain scored highest followed by the formative and normative domains.

- Restorative domain (mean 28.56, S.D. 6.67),
- Formative domain (mean 22.39, S.D. 5.26),
- Normative domain (mean 17.42, S.D. 2.089).

4.5 Findings Interviews – New Peer Group Clinical Supervisors

Three themes were identified through data analysis.

Theme 1 - Building the Foundations, represented:

- Knowledge and awareness,
- Recruitment,
- Training and education.

Theme 2 - Enacting Engagement and Actions, represented:

- Forming the group,
- Getting a clear message out,
- Setting the scene, grounding the group.

Theme 3 - Realities, represented:

- Past experiences,
- Delivering peer group clinical supervision,
- Responding to COVID-19,
- Personal and professional development,
- Future opportunities.

4.6 Contextualising the Findings

The findings of each phase of this evaluation integrate well with each other and highlight the clear benefits and support offered by the introduction and implementation of peer group clinical supervision in the HSE West Mid West. Through the integration and co-design aspect of the project, it is evident that there are several touchpoints, which relate to: benefits, establishing and facilitating groups, support and commitment, culture, strategy, sustainability and on-going review. These touchpoints are discussed below, drawing on and supported by the clinical supervision literature from nursing and midwifery and wider health and social care evidence.

4.7 Benefits

The benefits of peer group clinical supervision identified within this evaluation related to self (confidence, leadership, personal development, resilience), service and organisation (positive working environment, retention, safety) and professional patient care (critical thinking and evaluation, patient safety, quality standards, increased standards of care). These findings are reinforced by the wider literature which identifies several areas such as: self-confidence and facilitation (Agnew et al. 2020; Harvey et al. 2020; Saab et el. 2021), leadership (Markey et al.

2020; Mc Carthy et al. 2021), personal development (Snowdon et al. 2020a; Rothwell et al 2021), resilience (Francis and Bulman, 2019; Markey et al. 2020), positive/supportive working environment (Falender, 2018; Samson et al. 2019; Chircop et al. 2022), staff retention (Driscoll et al. 2019; Martin et al 2019; Stacey et al. 2020), sense of safety (Pepper, 2018; Feerick et al. 2021), critical thinking and evaluation (Bearman et al. 2018; Corey et al 2021; King et al 2020), patient safety (Alfonsson et al. 2018; Snowdon et al. 2020b; Sturman et al. 2021), quality standards (Alfonsson et al. 2018; Ali et al. 2018) and increased standards of care (Yuswanto et al. 2018; Coelho et al. 2022).

Clinical supervision has resulted in improvement in confidence (Westervelt et al. 2018) and leadership skills (Mackay et al. 2018; Corey et al. 2021) as clinical supervision has been seen to empower leadership, promote an innovative climate and promote self-development (O Shea et al. 2019; McCarthy et al. 2021). Having clinical supervision can promote resilience by reducing stress and anxiety (Gonge and Buus, 2016, Francis and Bulman, 2019) and this seems to relate to the fact that clinical supervision provides a method for sharing skills, knowledge and resources, in a safe and supportive environment (Bifarin and Stonehouse, 2017). Within this evaluation peer group clinical supervision appeared to help reduce stress and anxiety, as participants identified that it enabled them to focus on personal and professional development and created opportunities to discuss and reflect on professional situations both emotionally and rationally. Key to this process was that discussions took place in a safe and collegial environment and this is supported in the literature where research has highlighted that clinical supervision reduced anxiety and stress (Brink et al. 2012; Toros and Falch-Eriksen, 2021). Having clinical supervision provided the opportunity to share resources (information, knowledge and skills), discuss their issues and support one another (Bifarin and Stonehouse, 2017; Driscoll et al. 2019). The advent of the COVID-19 pandemic further emphasised the need for peer group clinical supervision and support for our nursing/midwifery workforce (Turner et al. 2022) as there is a need to assist them to maintain their wellbeing and problem-solving ability.

Evident within this evaluation and the literature is how effective peer group clinical supervision enables a better working environment. This is important as a supportive working environment can enhance the engagement and uptake of workplace policies because clinical supervisees understand the importance and reason for the policies (Martin et al. 2021). This is vital as the healthcare

environment is ever changing and guidelines/policies can be in a state of flux for example in response to COVID-19 or other situations. In addition, from a working relationship and a nurse - patient relationship perspective, clinical supervision can enhance cultural awareness (Ivers et al. 2017). Peer group clinical supervision helps improve the working environment through promoting teamwork, relationships and support, which all support professional development (Jølstad et al. 2017). In supporting a positive working environment clinical supervision can impact on staff retention (Hussein et al. 2019), have a positive effect on job satisfaction (Love et al. 2017) and reduces burnout (Berry and Robertson, 2019). For this to occur there needs to be a safe, trusting and confidential relationship and environment created (Rodwell et al. 2017; Beavis et al. 2021).

Fundamental within the peer group clinical supervision process was affording staff the opportunity to take time out and reflect, problem solve and generate solutions. Critical thinking and evaluation are embedded within clinical supervision as the focus of the group discussion is on understanding the issue and context and problem solving to learn for the future (Pollock et al. 2017; Corey et al. 2021). Research has made links with clinical supervision and an increase in quality and standards of care (Snowdon et al. 2017; Sturman et al. 2021). Thus, peer group clinical supervision plays a vital role in patient safety as this process tends to improve communication amongst staff, facilitate reflection, greater self-awareness, sharing ideas, problem solving and learning from others.

4.8 Establishing and Facilitating Groups

Having established a group was fundamental to the peer group clinical supervisors learning and development as evidenced in this evaluation. This was evident in how the peer group clinical supervisors established their groups, the environment, ground rules and built relationships, trust, respect and confidentiality. Underpinning this process was the recruitment of peer group clinical supervisees and appropriate group size but most of all addressing people's willingness to engage, knowledge of peer group clinical supervision and addressing the lack of awareness or misconceptions of what peer group clinical supervision represents. In addition, the education preparation through the UoG peer group clinical supervision module (Clinical Supervision: Supporting Continuing Professional Development) and the support of external clinical supervisors were essential to the implementation of peer group clinical supervision in the area.

As identified above the evidence highlights that having an open and safe environment, where peer group clinical supervisees feel comfortable with and trust their clinical supervisor is vital so they

can reflect on practice and practice issues (Love et al. 2017; Snowdon et al. 2017). This safe environment is important in enabling clinical supervisees to understand and identify their own emotional experiences and learn from experience and take this learning back to their clinical practice (Mohammadi et al. 2019). Participants in this evaluation identified there is a balance to be struck between discussing professional and personal issues based on the needs of the individual (Wilson et al. 2016). It was evident that their peer group clinical supervision sessions were determined more by process, rather than content and that they utilised the process to frame their sessions in the early stages while they settled into their role as peer group clinical supervisors. However, there was an energy and interest to support peer group clinical supervisees and develop new insights and as the peer group clinical supervisors became more comfortable, they were more at ease with professional and personal issues.

Participants of the evaluation acknowledge being able to develop and build a positive relationship based on trust with clinical supervisees is important (Love et al. 2017). However, this is facilitated by having the opportunity to be able to explore one another's belief and value system in a neutral space, away from the workplace, providing support to manage emotions and feelings in an open and reflexive manner (MacLaren et al. 2016; MacLaren, 2018). Thus, this process takes time and is not a given from the start and for peer group clinical supervision to be effective it needs to occur regularly (at least monthly). Meetings need to be arranged in advance, have protected time and be conducted in a private space (Bifarin and Stonehouse, 2017). This is essential as in reality the peer group clinical supervisor and clinical supervisee learn together and develop a shared understanding of practice issues (Wilson et al. 2016). To aid this learning and development self-disclosure by peer group clinical supervisors is perceived as positive, specifically regarding their own experiences, knowledge and values. This assists in normalising clinical supervisees experiences, encouraging them to share their perspectives (MacLaren, 2018).

It is generally accepted that for a clinical supervisor to be credible they need to be an expert in their professional field and understand work-related issues so as to be better placed to support the clinical supervision process (Wilson et al. 2016; Love et al. 2017) and have familiarity and experience of the cultural and organisational context. Wilson et al. (2016) highlight that the most important aspect of clinical supervision was the quality of the relationship with the clinical supervisor, which needed to be supportive, caring, open, collaborative, sensitive, flexible, helpful

and non-judgemental. Evidence suggests that being flexible such as, having peer group clinical supervision at different times of the day to accommodate shift patterns is valued (Bulman et al. 2016; Wilson et al. 2016; Brown et al. 2018). However, within this evaluation, the aspect of the low number of different grades of staff arose and a collaborative approach across services or nursing and midwifery disciplines could be considered. For example, Assistant Directors of Nursing from a CHO could form a peer group clinical supervision group of the same grade with a different discipline/service as a group may not be possible in one centre/hospital.

It is widely recognised that receiving regular and constructive feedback and spending time to reflect on practice is an important part of the peer group clinical supervision process. To be effective, feedback must be timely, of high quality and delivered in a supportive manner (Hardavella et al. 2017). Within this evaluation, peer group clinical supervision was valued and mainly focused on tacit knowledge, experiential learning, and real-time feedback. Through providing feedback, facilitating group discussion and dialogue there are opportunities to discuss clinical situations, provide individual affirmation from the peer group clinical supervisor and supervisees but more importantly facilitate a change in attitudes and behaviour in relation to care delivery and teamwork. Assisting staff development through enabling peer group clinical supervisee preparedness for practice through receiving feedback on how they handled a situation and identifying what they could do differently in the future is beneficial. To reinforce this aspect there is a clear need for clinical supervisors to be able to provide feedback, while also remaining open to receiving feedback themselves (Wilson et al. 2016).

4.9 Support and Commitment

Management support and buy-in is essential for the success of peer group clinical supervision and considering organisational culture and attitude toward clinical supervisory practice is an important factor (Strickler et al. 2018; Colthart et al. 2018; Markey et al 2020; Stacey et al. 2020). Participants within this evaluation all highlighted that there needs to be managerial support and buy-in for peer group clinical supervision to be successful, where clinical supervision is supported at both a management and individual staff level. A lack of time and heavy workloads were found to be the main barriers to effective clinical supervision (Brody et al. 2016; Lalani et al. 2018). The literature highlights that, clinical supervisors are often unable to find time for clinical supervision due to busy environments, which ultimately restricted the clinical supervisor's flexibility and

quality of the session (Bulman et al. 2016; McBride et al. 2017). Furthermore, when time is pressurised, it has been reported that there is often a lack of opportunity for reflection within clinical supervision sessions, leaving clinical supervisees feeling they must figure things out themselves without adequate support (Bulman et al. 2016; Wilson et al. 2016). It was anticipated that the challenges of time and resources would arise, however the real question for participants in this evaluation was the value placed on clinical supervision and how it was embedded in the culture/fabric of the organisation/profession. Participants in this evaluation felt that as peer group clinical supervision becomes valued and embedded it would become custom and practice thus one would find time for peer group clinical supervision and engage with the process. From an organisational perspective consideration must be given to the adoption of peer group clinical supervision across all grades and for organisational policies to reflect the importance of peer group clinical supervision by incorporating a minimum timeframe for clinical supervision to be allocated, create clearly defined roles and objectives, and by allocating funding and support for clinical supervision (Elfering et al. 2017). In addition, technology needs to be provided and supported (e.g., Zoom, Microsoft Teams, Skype) to overcome distance barriers. Based on the participants experience during COVID-19 of delivering peer group clinical supervision they felt a hybrid approach to peer group clinical supervision is appropriate. However, to establish the ground rules, relationships, trust, respect and confidentiality participants in this evaluation felt the initial four to six sessions should be face-to-face and then once a quarter with the remaining online.

While clinical supervision has a long international history and is well established, this is not necessarily the case in Ireland, as participants in this evaluation identified that misconceptions about peer group clinical supervision exist. Given these misconceptions it is important to be aware of and combat past perceptions/attitudes to and of peer group clinical supervision, such as clinical supervision not seen as a priority (Nancarrow et al. 2014; Pack, 2015), perceived to be a luxury (Love et al. 2017), self-indulgent (Bayliss, 2006) or just chatting during work hours (Kenny and Allenby, 2013). There is a lack of a common understanding about the role and purpose of clinical supervision as it is perceived to equate to surveillance and being watched (Kenny and Allenby, 2013; Nancarrow et al. 2014; Wilson et al. 2016) and such negative associations with the term led to a lack of engagement (Love et al. 2017). Participants in this evaluation highlighted that addressing these misconceptions at all levels of the organisation is important especially from an organisational management and leadership perspective so that peer group clinical supervision will

be valued, supported and resourced appropriately. This is the first step in ensuring clinical supervision in busy environments is not neglected or deferred to accommodate the latest crisis (Love et al. 2017; Snowdon et al. 2017). Followed by consideration being given to a wider implementation plan of peer group clinical supervision for nurses and midwives, to include peer group clinical supervision awareness sessions for clinical supervisees and organisational leaders; to inform potential clinical supervisors, clinical supervisees and managers about the supportive nature of the model and addresses the restructuring of workforce models to create the time and space needed for nurses and midwives to engage (Love et al. 2017). Participants in this evaluation were clear that if the management or organisation do not encourage and recognise the importance of peer group clinical supervision, then it is unlikely that it will become embedded in the organisation, thereby hindering clinical supervision from becoming the norm (Martin et al. 2021; Saab et al. 2021).

Within this evaluation, some peer group clinical supervisors described a sense of being an imposter, perceiving they lacked the knowledge, skill and training to be an effective peer group clinical supervisor. While a lack of skill and competence are barriers to providing effective clinical supervision (da Silva Pinheiro et al. 2014; MacLaren et al. 2016), the peer group clinical supervisors in this evaluation did not report these and it was more that they questioned their ability to function as a peer group clinical supervisor after a short training programme. The lack of training is recognised in the literature where clinical supervisors feel unprepared and unable to fulfil the role of clinical supervisor (da Silva Pinheiro et al. 2014; Wilson et al. 2016; Love et al. 2017). To address such issues peer group clinical supervisors, need to be familiar with professional guidelines and ethical standards, have role clarity and understand the clinical supervisor's scope of practice and responsibilities (Love et al. 2017). Therefore, there is a need for clearer guidelines and expectations for clinical supervisors (Gonge and Buus, 2011). However, within this evaluation the support through the provision of a Level 9 education module, support from external clinical supervisors and the peer group clinical supervision session were crucial to enabling the peer group clinical supervisor to relax into their role. This enabled them to learn through experience, develop their skills of peer group clinical supervision facilitation and for the few overcome their anxiety and sense of being an imposter.

4.10 Culture

Within this evaluation the participants did not draw reference to any cultural issues which may indicate the monocultural aspect of the implementation and engagement with peer group clinical supervision. It may well be that cultural diversity may not be truly evident until more nurses/midwives engage with peer group clinical supervision. Nonetheless, while culture was not evident peer group clinical supervisors did acknowledge the uniqueness of each person and understand that every person has a distinct self-identity, apart from the culture that shaped them. As the initiative broadens peer group clinical supervisors will need to be aware of their own biases, as no one is culturally neutral, and working with colleagues from different cultural backgrounds is considered a core clinical supervision skill. Furthermore, both peer group clinical supervisors and clinical supervisees will be working with clients/patients and colleagues from different cultural backgrounds and consideration needs to be given to culturally competent clinical supervision (Tsui et al. 2014; Lee, 2018; Jones et al. 2019). Such an approach includes seeing different cultures as an asset, builds social justice competence, values diversity, demonstrates humility and enables insights into diverse and marginalised groups of staff and clients/patients (Fickling et al. 2019; Jones and Branco, 2020). Cultural awareness can improve communication, reflection, sharing ideas and problem solving (Ivers et al. 2017).

4.11 Strategy

Within this evaluation and the literature, the evidence highlights that the quality of the peer group clinical supervisor and clinical supervisee relationship is key to success (Love et al. 2017) and where feasible, peer group clinical supervisees should choose their clinical supervisor. Generally, the selection is based on the needs of the clinical supervisee. However, consideration could be given to matching based on key characteristics such as values, cultural understanding, gender and age (Nancarrow et al. 2014). In addition, it is recognised that greater session frequency, with regular progress reviews, is related to positive outcomes (Kenny and Allenby, 2013; Kuhne et al. 2019; Bradley and Becker, 2021). Clinical supervisory relationships develop over time and need to be sustained over time. Within this evaluation it was identified that nurse/midwife managers played a key role in facilitating peer group clinical supervision through the provision of protected time and providing an appropriate environment and space for it to take place (Koivu et al. 2012). At an organisational level clinical supervision should be included in the job descriptions of nurses

and midwives (Koivu et al. 2011) and consideration should be given to ensure equal access to supervision, particularly for those who work night shifts (Gonge and Buus, 2011).

While there has been a strategy to educate peer group clinical supervisors and this has been a welcome investment, it cannot be a one-off investment. Such a strategy needs to extend to ongoing external clinical supervision (Wilson et al. 2016) and continuing professional development (Noelker et al. 2009) for clinical supervisors. Such investment means that peer group clinical supervisors are more likely to stay in their role and develop and continue to improve their facilitation skills. Such training could focus on the qualities identified by Bogo and McKnight (2006) as involving clinical supervisors who: (a) are available, (b) are knowledgeable about tasks and skills and can relate these techniques to theory, (c) hold practice perspectives and expectations about service delivery similar to the supervisee's, (d) provide support and encourage professional growth, (e) delegate (shared responsibility) to clinical supervisees to fulfil their tasks and responsibilities, (f) serve as a professional role model, and (g) communicate in a mutual and interactive supervisory style. As identified earlier a key aspect relating to the successful implementation was self-selection which affords interested parties to engage and commit to peer group clinical supervision and this strategy could continue and support the 'buy in'.

4.12 Sustainability

Based on the findings of this evaluation, peer group clinical supervision should be regular and at a minimum for one hour once a month which was deemed sustainable into the future. There is little evidence as to the ideal frequency and duration of clinical supervision sessions (Gonge and Buus, 2016), but to ensure sufficient support and avoid ongoing concerns there was evidence that clinical supervision should occur at least monthly (Dilworth et al. 2013) and for at least one hour (Saxby et al. 2015). However, fortnightly (McMahon and Errity, 2014) and weekly (O'Connor, 2012; Taylor, 2013) have been reported but would be resource intensive and most likely unsustainable across the professions of nursing and midwifery. What is most likely to affect sustainability is familiarity with the purpose and format of clinical supervision (Driscoll et al. 2019), providing time to discuss and reflect on issues (Wallbank, 2010; Dawson et al. 2012), receiving feedback (Brink et al. 2012; Martin et al. 2015) and the benefits of clinical supervision delivered in a group (Taylor, 2013). Peer group clinical supervision groups need to be relatively

small to allow all members to contribute to group rules, safety, participation and ownership. Based on this evaluation four to six members per group was identified as manageable and appropriate.

Support for and release of staff to travel and attend peer group clinical supervision is a clear demand on services and while the evidence in this evaluation does highlight issues with time, the true issue seems to be valuing and embedding peer group clinical supervision in nursing and midwifery practice. However, given the demand on nurse and midwives time alternative mechanisms of delivery are warranted. For example, it was evident during the COVID-19 pandemic that converting to online meetings was very successful. Therefore, the delivery of peer group clinical supervision in an online format is appropriate for established groups. In situations where they commence online, greater time is needed to develop the ground rules, build trust and develop the relationships, and occasional face-to-face sessions is recommended, particularly at the outset. The use of online platforms in the delivery of clinical supervision has been growing and with COVID-19 it became a necessity, and its usefulness has been highlighted (Anderson et al. 2022; Bender and Werries, 2022).

Fundamental to sustaining peer group clinical supervision was the support provided to clinical supervisors through their own external clinical supervision sessions which were facilitated by an external clinical supervisor. The external clinical supervisors enabled the new peer group clinical supervisors by offering fresh insights and solutions (O'Connor, 2012). This process was identified as essential in this evaluation and a means of support and sustaining the peer group clinical supervisor themselves to sustain their group as they often questioned themselves as facilitators and experts. Such support highlights the aspect of being clear about the purpose of peer group clinical supervision sessions and meeting individual's needs and in doing so reinforcing sustainability.

4.13 Ongoing Review

Peer group clinical supervisors and clinical supervisees need to ensure peer group clinical supervision sessions are specific to the needs of each individual and their profession, meet the demands of a range of settings, and to consider experience, ability, and expertise of everyone. Priority areas within peer group clinical supervision sessions may include clinical practice, skills development, career development, or confidence building, and thus peer group clinical supervision should be person-centred placing the clinical supervisee at the centre (Gardner et al. 2018). Ongoing review and feedback should be inbuilt into the peer group clinical supervision process to

ensure the purpose and function of clinical supervision is being met for all involved (Pesqueira et al. 2021; Tugendrajch et al. 2021). In addition, any ongoing review needs also to consider if peer group clinical supervision is sufficient on its own and if an alternative should be provided for those who do not voluntarily self-select and sign up for peer group clinical supervision. This is important considering that Love et al. (2017) identified that a mix of one-to-one and group clinical supervision sessions produced higher scores on performance and satisfaction than just one type of clinical supervision on its own.

4.14 Chapter Summary

Overall, through this evaluation many benefits of peer group clinical supervision are highlighted for the individual, service, organisation and patient/service user. The key to success starts with addressing the lack of awareness and misconceptions about peer group clinical supervision and when establishing sessions having the right environment and setting the ground rules. For peer group clinical supervision to reach its full potential there needs to be management and organisational support for the release of staff but more importantly the valuing and embedding of peer group clinical supervision within nursing and midwifery practice. The ongoing support for peer group clinical supervision needs to be prioritised with external clinical supervision and continuing education opportunities available to peer group clinical supervisors. Nevertheless, most importantly an organisational and national strategic plan for peer group clinical supervision is needed to prioritise peer group clinical supervision, make it accessible to all grades of nurses and midwives and address capacity, recruitment, retention and sustainability issues in Ireland.

Chapter 5 – Conclusions and Recommendations

5.1 Introduction

This chapter provides a summary of the outcomes and conclusions of the evaluation of the implementation of peer group clinical supervision for nurses and midwives in HSE West Mid West in Ireland. Recommendations are made based on the evaluation, and are applicable to the ongoing implementation, delivery and support of peer group clinical supervision.

5.2 Conclusions

A key factor in peer group clinical supervision is the relationship between the peer group clinical supervisor and supervisee, which is based on trust, the clinical supervisor being credible and an expert in the field. Benefits of peer group clinical supervision are evident such as reducing stress and anxiety, improving job satisfaction, creating a more supportive work environment, improved teamwork, all of which in turn can lead to improved patient/client care. There is little evidence on the ideal length and frequency of peer group clinical supervision to be effective but what is evident is that regular sessions providing constructive and timely feedback is most beneficial. There were also several barriers to effective peer group clinical supervision identified, such as a lack of time and high workload which impacted on the level of support, quality and flexibility of peer group clinical supervision delivered. Furthermore, peer group clinical supervision is not always perceived as a priority by managers, the organisation or peer group clinical supervisees which affects uptake and engagement. This lack of priority may be linked to a lack of understanding and clarity on what peer group clinical supervision is, its purpose and what it involves.

Several key factors that should be considered in supporting the roll out of peer group clinical supervision such as building a good, quality relationship between the peer group clinical supervisor and supervisee. The provision of protected time for peer group clinical supervision, on-going support for both peer group clinical supervisors and supervisees through ongoing CPD and updates were all identified as relevant in sustaining delivery. Peer group clinical supervisors and supervisees need to be aware of and engage with the HSE guidance documents which guides the structure of peer group clinical supervision where clear boundaries, tasks, ground rules, good record keeping, and review exists. Furthermore, consideration needs to be given to the use of technology in supporting peer group clinical supervision and the structure such an approach would

involve such as online only, alternative sessions or a hybrid model as the use of technology can be useful in addressing time, resources and travel issues.

5.3 Recommendations

Based on this evaluation there are several recommendations addressing the support and delivery of peer group clinical supervision for the future.

At an organisational level, there is a need to have a clear understanding of what peer group clinical supervision is, its form and purpose and this would encompass:

- Clearly define and identify the aim and intention of peer group clinical supervision across all services and staff grades within an organisation.

- The inclusion of peer group clinical supervision in job specifications to demonstrate the value peer group clinical supervision has as a method to develop, recruit and retain staff.

- Organisational policies to reflect the importance of peer group clinical supervision by incorporating:

    - An agreed standard of what regular peer group clinical supervision is with a commitment of a minimum of one hour per month.

    - Clearly defined roles and objectives for peer group clinical supervision.

    - The allocation of protected time for all concerned to ensure that peer group clinical supervision is embedded into the culture of the organisation.

Critical to the success of peer group clinical supervision is the criteria and support extended to clinical supervisors. For consideration:

- The HSE criteria to become a peer group clinical supervisor should be explicit.

- There should be clear guidance and expectations for peer group clinical supervisors e.g., awareness of and being up to date on relevant policies, procedures and guidelines; maintenance of up-to-date records of peer group clinical supervision sessions, confidentiality; being supportive and being a credible expert.

- Ongoing external clinical supervision and continuous professional development (CPD) for peer group clinical supervisors is required.

- Organisations should incorporate mechanisms to support ongoing review and feedback from peer group clinical supervisors and supervisees.

- Guidance regarding the preferred method of delivery of peer group clinical supervision e.g., face-to-face, online or a combination of both.

- Implementation of the initiative should be standardised and equitable across all services and all nursing and midwifery grades with support from management and HSE with inbuilt evaluation measures.

- Provision of a private space for peer group clinical supervision sessions to occur.

- Addressing issues such as travel and time to attend peer group clinical supervision.

- Group size of four to six members is manageable and appropriate.

- Capturing the benefits of peer group clinical supervision on aspects such as job satisfaction, being listened to, increased social support, stress relief, peer support, improved relationship with patients/service users, improved confidence and competence in practice, increased professional knowledge, improved communication skills and reflective practice.

The processes within peer group clinical supervision sessions should:

- Develop an agreement of shared understanding of peer group clinical supervision and expectations between peer group clinical supervisor and supervisee and establish the environment through setting ground rules, building the relationship and trust, having respect and upholding confidentiality.

- Facilitate regular and constructive feedback and provide reflective time within peer group clinical supervision sessions.

- Agree a standardised process for recording and documentation of peer group clinical supervision sessions as required.

- Ensure flexibility as this is required to accommodate different work patterns.

5.4 Chapter Summary

This evaluation draws on the experiences of the peer group clinical supervision steering groups, external clinical supervisors and new peer group clinical supervisors. While the evaluation gives us insight into the experiences of these participants it is worthwhile to highlight that the experiences of peer group clinical supervisees was not captured in this evaluation due to time constraints, availability, response and service demands due to the COVID-19 pandemic. Overall, this evaluation is positive and highlights:

- Peer group clinical supervision is based on mutual trust and respect.
- There needs to be a shared understanding of the purpose of peer group clinical supervision among all parties (HSE, organisations, managers, peer group clinical supervisors and clinical supervisees).
- An agreed contract is in place setting out the form, purpose, expectations, frequency and duration of peer group clinical supervision.
- Peer group clinical supervision focuses on providing support through the sharing/enhancing of knowledge and skills to support personal and professional development and improving service delivery.
- Ongoing CPD and updates are provided for clinical supervisors.
- Flexibility and equity in access to peer group clinical supervision needs to be considered.

- Peer group clinical supervision needs to be available to all grades.

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