Report on the Evaluation of the Implementation of Peer Group Clinical Supervision for Nurses in the HSE South (Cork and Kerry)

University College Cork, November 2020

Working together in a focused, supportive reflexive environment to enhance lifelong professional learning

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Nursing & Midwifery Planning & Development Unit Cork and Kerry

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Foreword

The publication of this *Report on the Evaluation of the Implementation of Peer Group Clinical Supervision for Nurses in the HSE South (Cork and Kerry*) represents an important milestone in the professional and personal development of nurses and midwives in clinical practice. This report provides robust evidence on the positive impact of Clinical Supervision on the nurses and midwives who attended Peer Group Clinical Supervision (PGCS) and adds to existing evidence that supports Clinical Supervision as a means of peer support for all nurses and midwives. The report also highlights the logistical challenges associated with its implementation; however, it is evident that the perceived benefits for nurses who attended the PGCS sessions far outweigh these challenges.

In collaboration with Directors of Nursing, Directors of Midwifery and Area Directors Mental Health Services, the Nursing and Midwifery Planning and Development Unit (NMPDU) HSE South, Cork & Kerry recognised the potential for Clinical Supervision to support and develop nurses and midwives in clinical practice. The NMPDU convened a steering group of representatives from nursing and midwifery services, advanced practice, Centres of Nursing and Midwifery Education (CNME), Office of the Nursing and Midwifery Services Directorate (ONMSD) and Higher Education Institutions (HEI) to oversee the development, implementation and evaluation of the PGCS Pilot Project 2018-2019.

The publication of this report will act as a guide to inform future implementation of PGCS and the NMPDU's intention and commitment to progress the implementation and sustainability of PGCS into the future.

The World Health Organization has designated 2020 the International Year of the Nurse and Midwife and the year has proved to be an unprecedented challenge for all nurses and midwives due to the global pandemic. Nurses and midwives' resilience has been tested to extraordinary levels and nurses and midwives have, as always, responded in an expert and professional manner. The need for supported reflection and problem solving has never been more significant and it is hoped that the PGCS framework will be utilised in services and organisations for staff, organisational and ultimately patient/service user benefits.

I would like to express my sincere thanks to the Steering Group members and to acknowledge their support, expertise, and dedication throughout the project. I would also like to thank the Directors of Nursing, Directors of Midwifery and Area Directors Mental Health Services who commissioned this work.

I would also like to acknowledge the expert team of researchers in University College Cork who facilitated this research in a very collaborative and professional manner.

Finally, and most importantly, I would like to acknowledge the contribution of the nurses and midwives, line managers and supervisors who participated and engaged in this research in such an open minded manner, without whom this project and research could not have taken place.

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List of Abbreviations

ADoN/M	Assistant Directors of Nursing/Midwifery
CN/MM	Clinical Nurse/Midwife Managers
CNME	Centre for Nursing and Midwifery Education
DoN/M	Director of Nursing/Midwifery
HEI	Higher Education Institute
HSE	Health Service Executive
M	Line Managers
MCSS-26 ©	Manchester Clinical Supervision Scale ©
N	Nurse Supervisees
NMBI	Nursing and Midwifery Board of Ireland
NMPDU	Nursing and Midwifery Planning and Development Unit
ONMSD	Office of the Nursing and Midwifery Services Directorate
PGCS	Peer Group Clinical Supervision
S	Supervisors
SD	Standard Deviation
SOF	Survey of Organisational Functioning

Executive Summary

Peer Group Clinical Supervision (PGCS) is a form of Clinical Supervision whereby two or more practitioners engage in a supervision or consultation process to improve their professional practice. It is a process of supporting healthcare professionals to develop their practice through regular discussion with experienced and knowledgeable colleagues. In response to the increasing demands for quality and safe healthcare outcomes, the Nursing and Midwifery Planning and Development Unit (NMPDU) for Cork and Kerry recognised the potential for Clinical Supervision to support nurses in clinical practice. In September 2018, the NMPDU embarked on a pilot project to evaluate the effectiveness of a supervisor-led PGCS programme, a form of group Clinical Supervision, for nurses in the region.

The overall aim of this commissioned report is to report the findings of a mixed-methods research evaluation of PGCS for nurses in Cork and Kerry. There is limited empirical evidence regarding the impact of PGCS on nurses and midwives (Borders, 2012) and as such, two studies (one qualitative and one quantitative) were designed to measure specific outcomes, including nurse supervisees' overall experiences of participating in PGCS, as well as differences in their understanding of Clinical Supervision and their perceptions of organisational functioning before and after engaging in PGCS. The perceptions of clinical supervisors and senior line managers and their experiences of the PGCS process were also captured through the qualitative arm of the research[1].

The NMPDU supports nurses and midwives in Ireland to undertake post-registration education and ensure continuing professional development. In response to requests from services, the NMPDU recognised the potential for Clinical Supervision to support nurses in clinical practice. The NMPDU convened a steering group (Appendix 1) of representatives from nursing and midwifery services, advanced practice, CNMEs, ONMSD and HEI to oversee the development and implementation of this project.

PGCS was offered to all nursing and midwifery services in Cork and Kerry and 10 groups of staff across 9 sites agreed to participate in this pilot project. Monthly one-hour PGCS sessions were facilitated between September 2018 and August 2019. Each PGCS group comprised of four to six nurses. Protected time within the working day was allocated for most PGCS sessions which were held in private and quiet venues. PGCS discussions revolved around: (1) enhancing the quality of work practices; (2) exploring decision-making processes and their impact on patients; (3) seeking and receiving information; (4) expressing and exploring issues arising through work practices; (5) being challenged in a supportive manner; and (6) receiving support and feedback.

Each peer group consisted of staff of the same or similar grade, with four to six participants in each group. In total, 57 nurses, across the nine sites, commenced the PGCS project. Prior to the commencement of the project, nurse supervisees were informed verbally that the outcomes of the project were being evaluated using research methods. They were informed that they were not obliged to partake in either of the research studies and that this would not affect their participation in the PGCS sessions.

The qualitative study utilised focus groups and individual interviews. All PGCS session supervisees, as well as supervisees' line managers and the supervisors who facilitated the PGCS sessions, were eligible to participate, with separate focus group/individual interviews held for each of these three groups. There was a total of 27 participants in this study (18 PGCS nurse supervisees, five line managers, and four clinical supervisors).

The quantitative study used a pre-post design and all nurse supervisees who attended the PGCS sessions were eligible to participate by completing two questionnaires – the first prior to the commencement of the first PGCS session and the second following the completion of the final PGCS session (12 months later). A total of 51 supervisees participated in the quantitative study.

[1] The term, 'nurse supervisees', is used throughout this report to describe nurses who availed of PGCS. 'Line managers' were those who supported supervisees in availing of PGCS, and 'supervisors' were those who facilitated the PGCS sessions.

The perceived benefits of PGCS, challenges faced, and recommendations for future PGCS programmes were explored with the three groups of participants (supervisees, managers and supervisors). Overall, there were multiple perceived benefits for staff that attended the sessions, including increase in confidence, improvements in morale, reduction in stress, and overall feelings of empowerment. The PGCS sessions represented a 'safe place' that facilitated shared decision-making and problem-solving, where supervisees could share and learn from each other. There were particular benefits for lone workers.

For the organisations and patients, the perceived benefits were indirect and considered to be long-term rather than short-term. They included improved staff productivity and more calming working environments, which were mainly attributed to improved staff morale. Overall, supervisees felt that they were able to be more mindful and present with patients and their families following participation in PGCS.

Overall, there were multiple perceived benefits for staff that attended the sessions, including increases in confidence, improvements in morale, reductions in stress, and overall feelings of empowerment.

The main challenges associated with the PGCS sessions centred on staffing, specifically difficulties releasing staff from their clinical roles to attend the sessions, and the lack of cover for the sessions. The issue of time was frequently raised, with some supervisees and their managers describing difficulties finding protected time to attend the sessions. This was a particular issue for supervisees who were not based at the sites where the sessions took place, who had to factor in travel time, as well as the session time. Other challenges included difficulties managing workloads and prioritising PGCS sessions over competing demands, booking venues, difficulties ensuring good group dynamics and supervisees' initial worries about confidentiality being maintained within the PGCS groups.

The main challenges associated with the PGCS sessions centred on staffing, specifically difficulties releasing staff from their clinical roles to attend the sessions, and the lack of cover for the sessions. The issue of time was frequently raised.

Managers agreed that the issue of protected time and cover must be considered, with some suggesting that staff participate in the sessions on their day off unless additional resources were made available to assist them with arranging staff cover. Managers also felt that more tangible outcomes should be measured, and that more consideration should be given to the benefits that PGCS offers organisations and service users. The feasibility of this will be discussed in Section 4.

Findings of the quantitative study supported those of the qualitative study, with overall scores on the Manchester Clinical Supervision Scale indicating efficacious Clinical Supervision provision. Overall, PGCS was rated highly by supervisees, with higher than average scores on all items of the scale. However, finding time to attend PGCS sessions was highlighted as an issue. Regarding supervisees' perceptions of organisational functioning, as measured by the Survey of Organisational Functioning, changes between pre- and post- responses for matched questionnaires revealed a significant increase in adaptability but a decrease in cohesion, as well as non-significant increases to communication and growth, and a decrease to stress between the two data time points.

The recommendations in this report are primarily based on the findings of the qualitative and quantitative studies, while also drawing upon existing literature. They are presented under five categories: (1) Awareness; (2) Staffing and Scheduling; (3) Clinical Supervisors; (4) Supervisees; (5) Evaluation.

Recommendations

Awareness

1. PGCS should be embedded into the culture of the organisation and its benefits in terms of stress reduction, calmer working environments, staff morale and staff retention should be made explicit.
2. Promote and increase awareness of PGCS among nursing and midwifery staff at all levels and grades. Provide clarity around the meaning of 'Clinical Supervision' and promote its direct benefits for staff, and indirect benefits for organisations and patients.
3. Education is needed for senior nurse managers, such as Directors of Nursing and Midwifery and Assistant Directors of Nursing and Midwifery, on the nature, format, and benefits of PGCS. Consideration should be given to providing this education online, for example through the Health Service Executive's HSELanD, acknowledging that a similar programme already exists entitled Professional Supervision for Health and Social Care Professionals.

Staffing and Scheduling

4. Staff should have protected time to attend PGCS sessions. Provision to cover staff workload and responsibilities is needed while they attend the PGCS sessions in line with local service provision.
5. Carefully consider the location of PGCS sessions to reduce travel time, particularly for those that work in the community. Consider rotating venues for community-based staff. Consideration should be given to finding a suitable online platform for PGCS session.
6. Consider the length of PGCS sessions and allocate time in each session for supervisees to settle in, become acquainted, and acclimatise to the group. It may be appropriate to increase each session from 60 to 75 minutes.

Clinical Supervisors

7. Supervisors must take a lead role in the PGCS groups, clearly articulating boundaries and group rules. In the first session, supervisors need to reiterate the purpose of PGCS and clarify any misconceptions about the process.
8. For this pilot project, supervisors had qualifications in counselling and Clinical Supervision. However, for the sustainability of PGCS and to facilitate its availability to all nursing and midwifery staff, there is a need to build internal capacity and train clinical supervisors.
9. When building internal capacity, it is recommended that this is delivered through the Centres of Nurse Education, using an adapted version of the national programme designed for mental health nurses.
10. Supervisors should be trained and guided in the use of a Clinical Supervision Framework. Proctor's (2008) Model is recommended by The Office of the Nursing and Midwifery Services Directorate (ONMSD) due to its applicability to nursing and midwifery practice.
11. It is strongly recommended that Clinical Supervision is provided by internally trained clinical supervisors to ensure sustainability.

Supervisees

12. Supervisees should participate in PGCS on a voluntary basis only and should not be mandated by line management.

13. Staff from all levels and grades should be offered the opportunity to participate in PGCS. However, in line with the ethos of PGCS, groups should consist of peers that work at the same (level) grade as each other.

14. Group sizes should be kept small (4-6 supervisees per group).

15. Before the commencement of PGCS sessions, there is a need to ensure supervisees are clear on the expectations of the group, including maintaining confidentiality, one of the most important considerations, as well as the content and focus of discussions.

Evaluation

16. Evaluate the outcomes of PGCS using tangible and measurable means, while acknowledging that indirect benefits to organisations and patients are difficult to measure and may be best ascertained through qualitative research.

Section 1 Introduction

1.1 Background to This Project

The NMPDU for Cork and Kerry Supports nursing and midwifery services to provide a safe, quality service that improves patient care in line with local service needs and national HSE policy. In response to the increasing demands for quality and safe healthcare outcomes, the NMPDU recognised the potential for Clinical Supervision to support nurses in clinical practice. As such, in September 2018, the NMPDU embarked on a 12-month pilot project to implement and evaluate PGCS for nurses in Cork and Kerry. This project was informed by the implementation of a similar project in HSE Dublin North-East in 2017.

The NMPDU supports nurses and midwives in Ireland to undertake post-registration education and ensure continuing professional development. In response to requests from services, the NMPDU recognised the potential for Clinical Supervision to support nurses in clinical practice. The NMPDU convened a steering group of representatives from nursing and midwifery services, advanced practice, CNMEs, ONMSD, and HEI to oversee the development and implementation of this project.

1.2 Clinical Supervision

In recent years, Clinical Supervision has become widely acknowledged as a beneficial aspect of modern, effective health care delivery. Both internationally and across health disciplines, it is accepted that Clinical Supervision has two main aims; (1) to foster supervisees' professional development and competence, and (2) to ensure client welfare through monitoring the quality of professional service (Bernard & Goodyear, 2014). It is a process of professional support and learning in which nurses and midwives are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues (Fowler, 2011). Butterworth and Faugier (1997) describe Clinical Supervision as a major force in improving clinical standards and enhancing the quality of care. Supervision promotes personal and professional development through fostering a supportive relationship and working alliance and is increasingly being recommended as a means of supporting professional practice.

Clinical Supervision is a process of professional support and learning in which nurses and midwives are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues (Fowler 2011).

Within contemporary literature, there is limited evidence regarding the direct benefits of practitioner supervision for service users (Bradshaw et al., 2007; Callahan et al., 2009; Milne et al., 2008; Rousmaniere et al., 2016). However, there is evidence that practitioners experience many professional benefits from attending supervision, including improved practice knowledge and skill, enhanced self-efficacy and self-awareness, and strengthened relationships with service users (Watkins, 2011; Wheeler & Richards, 2007). Clinical Supervision fits well within the clinical governance framework, and there is potential for it to contribute to the development of a more articulate and skilled workforce, which in turn can contribute positively to organisational objectives.

Effective Clinical Supervision is believed to have a key role in enabling health professionals working across different disciplines including nursing and midwifery, to practice effectively and independently in a complex health system, ultimately enhancing the safety and quality of patient care. At its best, Clinical Supervision can be fundamental in safeguarding standards, developing professional expertise, and improving the delivery of quality care. This is evident throughout the National Supervision Guidance document, which was published by the HSE in 2015 (HSE, 2015). This guidance document supports the process of Clinical Supervision to strengthen the quality of care and staff engagement, with the goal of improving and maintaining safe, quality,

effective and efficient care for services users (HSE, 2015). Outlined in this document is the Irish public health service policy objective that: "all health and social care professionals should participate in regular, high quality, consistent and effective supervision" (HSE, 2015; p.5).

1.2.1 Definitions of Clinical Supervision

There are a variety of definitions of Clinical Supervision, all of which acknowledge the integral role Clinical Supervision plays in maintaining the safety and quality of patient care. The current project was guided by the following two definitions:

- Clinical Supervision is defined as a structured process for: "*regular, protected time for facilitated, in-depth reflection of clinical practice. It aims to enable the supervisee to achieve, sustain, and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part he/she plays as an individual in the complexities of the events and the quality of her* practice" (Bond & Holland, 2010; p.15).
- The Care Quality Commission states that "*The purpose of Clinical Supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice* (Care Quality Commission, 2013; p.4).

1.2.2 Models of Clinical Supervision

There are different models of Clinical Supervision, reflecting the different work context and the professional training needs and expectations of staff. There is no one model of Clinical Supervision that will suit all settings (Milne et al., 2008). In the Clinical Supervision Framework for Nurses working in Mental Health Services developed by the ONMSD in 2015, Proctor's (2008) Model was identified as the model of choice (ONMSD, 2015). Therefore, the current project was also guided by Proctor's (2008) Model of Supervision.

1.2.2.1 Proctor's Model of Supervision

This model outlines three functions of Clinical Supervision (Proctor, 2008):

1. Formative (educative/development of skills) function:

This function refers to the aspect of Clinical Supervision that relates to the professional development of the practitioner. The formative function of supervision outlines the developing of skills and understanding the abilities of the supervisee through an in-depth reflection of their work. This function supports experiential learning.

2. Restorative (supporting personal well-being) function:

This function refers to the development of a supportive relationship with the supervisor which in turn supports the practitioner in dealing with the emotional impact arising from practice. Within this supportive relationship, the practitioner should be able to share concerns and difficulties regarding their clinical nursing and midwifery practice.

3. Normative (managerial/organisational responsibility) function

The normative function highlights the importance of professional and organisational standards and the need for competence and accountability. It supports the practitioner to develop skills and competencies, allowing practice to be challenged in a safe environment. This function assists the practitioner to meet the clinical governance and risk management agenda.

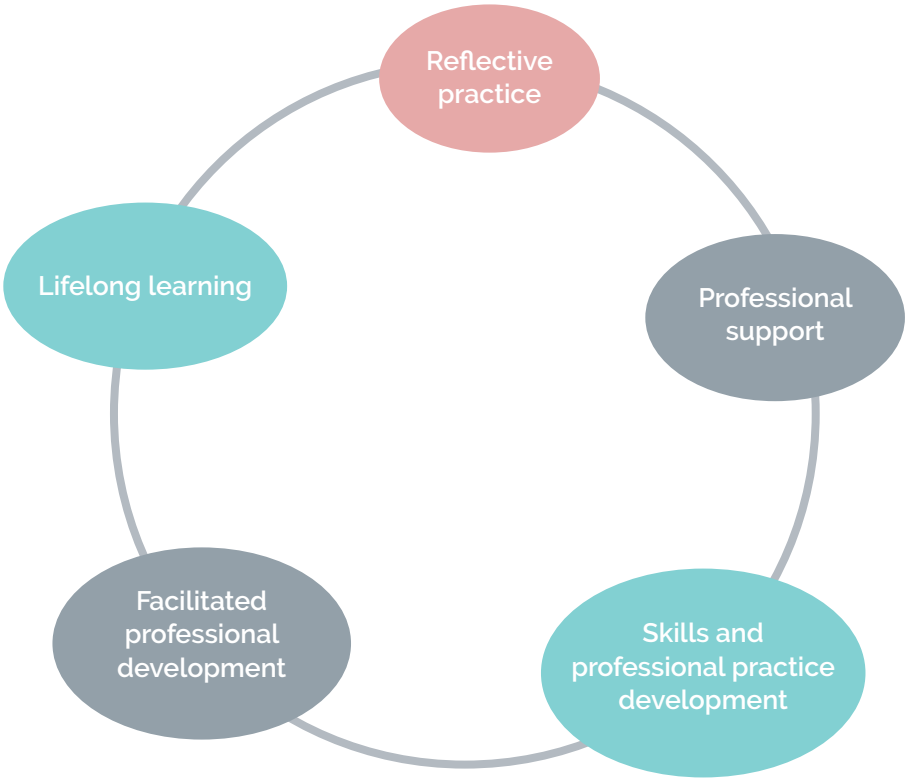
1.2.3 The Importance of Clinical Supervision

Clinical Supervision is an important process in supporting nurses and midwives within organisations with elements of clinical governance including:

- Quality improvement
- Risk identification and management
- Systems of accountability and responsibility

It provides a structured approach to deeper reflection on clinical practice which can lead to improvements in practice and service user care and contribute to clinical risk management (Royal College of Nursing, 2003). The core elements of clinical supervision identified by the NMPDU are outlined in **Figure 1.1.**

Figure 1.1 Core elements of Clinical Supervision (NMPDU 2018)



1.2.4 Peer Group Clinical Supervision

Clinical Supervision can be conducted in different formats such as one to one, with a team or within a group of peers. PGCS is a form of group supervision and is not usually led by a supervisor. However, for the purpose of this pilot project, it was agreed that developing supervisor led PGCS was the most appropriate structure within the HSE South, taking cognisance of the limited availability of experienced internal Clinical Supervisors. This decision was made by the PGCS Steering Group which included representation from the nursing and midwifery services within Cork and Kerry.

1.3 The Peer Group Clinical Supervision Framework

A framework for the delivery of PGCS was developed by the NMPDU, in conjunction with key stakeholders who formed a steering group in advance of the introduction of PGCS. This framework is underpinned by evidence that supports nurses and midwives in further developing their competence in clinical practice within their scope of practice as outlined by the Nursing and Midwifery Board of Ireland (NMBI, 2015).

The overarching aim of the PGCS framework was to provide guidance to nursing and midwifery services and inform the development of PGCS in the HSE South (Cork and Kerry) **(Appendix 2)**. This framework aimed to support staff to enhance and maintain the delivery of quality, safe patient care (NMPDU (Cork and Kerry), 2018). The goal of the PGCS framework is to optimise patient care and outcomes by enabling lifelong learning through reflection for nurses and midwives. The outcome of the framework is the contribution to improved patient care in line with national CS outcomes.

- Enabling the opportunity to gain information and insights and promote reflective practice.
- Encouraging professional and personal growth.
- Valuing and enabling the development of professional knowledge in practice.
- Supporting the development of clinical skills and professional practice in response to service user needs.
- Improving standards and the quality of nursing care.
- Supporting and empowering nurses to work effectively.
- Facilitating a process of support from the emotional and personal stress involved in nursing.

1.4 Implementation of This Project

1.4.1 Core Principles

During the implementation phase of this project, certain core principles were agreed upon. These principles are outlined in **Table 1.1.**

Table 1.1 Core principles of the current project

Frequency	PGCS should take place every month.
Duration	PGCS should take one hour. It should be facilitated by protected time within the working day.
Group size	PGCS groups comprise of 4-6 staff of the same or similar grade.
Venue	PGCS should take place at a work-based location free from distraction or interruption. Where this is not possible, consideration should be given to providing a quiet space which offers privacy and distance from the day to day activities.
Commitment	The process of supervision occurs within a trusting relationship established between supervisor and supervisees. All contribute to the relationship and have responsibilities within the supervision process. All supervisors will be required to attend for supervision of their PGCS work.

1.4.2 Content of Sessions

Clinical Supervision is provided to facilitate effective professional practice. Therefore, it was agreed from the outset that the content of PGCS sessions must centre on the work of individual members of staff.

A PGCS session should have elements that include:

- Monitoring and enhancing the quality of work practices
- Exploring decision making processes and their impact on patients
- Seeking and receiving information
- Expressing and exploring issues arising through work practices
- Being challenged in a supportive manner
- Receiving support and feedback
- Ensuring confidentiality is maintained at all times

1.4.3 Project Sites

For this pilot project, PGCS was offered to 10 groups of staff across 9 sites in Cork and Kerry, over a 12-month period. Each peer group consisted of staff of the same grade, with 4-6 participants in each group **(Table 1.2).**

Table 1.2 Description of the groups and supervisees

Service area	Groups (n=10)	Supervisees* (n=57)
Acute Care (General Nursing)	5	29
Intellectual Disability Nursing	2	12
Public Health Nursing	2	11
Mental Health Nursing	1	5

* 57 commenced the programme; 5 did not complete the full 12-month programme due to maternity leave and sick leave and one person joined a group after the project had commenced. Attendance rates at each of the PGCS sessions ranged from 50-87% at the various sites throughout the 12-month period.

1.4.4 Supervisors

Three external supervisors and one internal supervisor, all of which were psychotherapists and supervisors accredited by the Irish Association for Counselling and Psychotherapy, facilitated the PGCS groups. All supervisors had master's level qualification. Two of the external supervisors were retired nurses, the third external supervisor did not have a nursing background. The internal supervisor held a Clinical Nurse Specialist (CNS) position in the mental health services.

1.5 Evaluation of This Project

To evaluate the effectiveness of this pilot project, a mixed-methods study was commissioned by the NMPDU and undertaken by staff at the School of Nursing and Midwifery, University College Cork, following a tendering process. The findings are presented in sections 2 and 3 of this report.

1.5.1 Research Aim

To complete a mixed-methods research evaluation of PGCS for nurses in HSE South Cork and Kerry.

1.5.2 Research Objectives

1. To measure and examine differences in participants' understanding of Clinical Supervision before and after engaging in PGCS.
2. To measure and examine differences in participants' perceptions of organisational functioning before and after PGCS.
3. To explore nurses' overall experiences of participating in PGCS.
4. To explore clinical supervisors' experiences of delivering PGCS to nurses.
5. To explore senior managers perceptions of the benefits of PGCS for the supervisee and the organisation.

Section 2 Qualitative Evaluation

2.1 Aims and Objectives

This qualitative evaluation aimed to explore the experiences of PGCS in Cork and Kerry nursing services from the perspective of supervisees who availed of PGCS, line managers who supported supervisees in availing of PGCS, and supervisors who facilitated PGCS sessions. Data from each participant group are summarised in **Appendix 3.**

2.2 Methods

2.2.1 Design

This was a qualitative descriptive study, which aimed to explore the phenomenon of interest in its natural state without adhering to prior views of this phenomenon (Guba & Lincoln, 1994). Moreover, qualitative description helps researchers obtain candid and unadorned responses to questions that are of interest to researchers, practitioners, and policymakers (Sandelowski, 2000).

2.2.2 Participants

Non-probability purposive sampling was used to recruit a heterogenous sample of participants. Participants eligible for this study were: (i) supervisees who availed of PGCS, (ii) line managers who supported supervisees in availing of PGCS, and (iii) supervisors who facilitated PGCS sessions.

2.2.3 Data Collection

Ethical approval for this study was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals (Approval number ECM 4 (n) 13/08/19).

Participants were advised verbally prior to commencement of peer group Clinical Supervision, that the pilot project was being evaluated through research and that they had the right to refuse to partake in the research. They were also informed that their refusal to participate would in no way affect their participation in PGCS or their employment.

Participants were provided with a written information leaflet providing further details on the study and the nature of their potential participation. Prior to commencement of data collection, all participants were again provided with details of the research, including the written consent form**.** Consent forms were stored separately from data transcripts in a locked cabinet of the lead investigators office in UCC.

Data were kept confidential and identifiers were omitted at transcription. Electronic transcripts of the interviews were stored on the lead investigators password protected office computer at UCC and will be destroyed within the timeline indicated by the University (stored for a minimum of 10 years).

Data were collected between October and November 2019 using individual interviews and focus groups. The combination of individual interviews and focus groups is known to enrich qualitative data (Lambert & Loiselle, 2008). These approaches were also well suited for participants who had clinical commitments which meant they could not attend the set focus group dates.

All interviews were audio-recorded and transcribed verbatim by professional transcription services. Interviews were conducted by researchers who had no prior relationship with the participants. Participants were asked to provide written informed consent and to fill a brief socio-demographic questionnaire**.**

Focus groups revolved around participants' experiences of PGCS, particularly the perceived benefits of PGCS, the challenges experienced during PGCS, and recommendations for the future of PGCS.

2.2.4 Data Analysis

A combination of inductive and deductive content analyses was used in the present study (Elo & Kyngäs, 2008). First, data from each participant group (i.e. supervisees, line managers, and supervisors) were analysed separately. Transcripts were read and reread for content and direct quotes from participants were reduced to codes. Similar codes were gathered using a coding sheet and were collapsed into sub-categories which were later grouped under categories. Similar categories were then assigned to themes which were predetermined based on the focus group questions and the PGCS framework. Data source triangulation was later performed to explore convergence, complementarity, and dissonance between results (Carter et al., 2014).

2.3 Results

2.3.1 Sample Characteristics

There was a total of 27 participants in the qualitative study. Of those, eighteen were nurse supervisees (referred to as N in this section), five were line managers (referred to as M in this section), and four were supervisors (referred to as S in this section). All participants were female. For group N, years of experience ranged between 12 and 40 years (M=26.6, SD=8). All were from a nursing background with some holding dual qualifications, and the majority held a Clinical Nurse Manager 2 (CNM2) post (n=12). Years in current post ranged between 1 and 22 years (M=7.4, SD=7.1). Almost half of the supervisees were Higher/Postgraduate Diploma holders (n=8).

All line managers (n=5) were from a nursing background. The majority (n=3) were bachelor's degree holders and worked as Assistant Directors of Nursing (ADoNs). Line managers' years of experience ranged between 20 and 40 years (M=29, SD=6.4) and years in current post ranged from 2 to 10 years (M=7, SD=3.3).

All four supervisors were master's degree holders and had 13 to 39 years work experience (M=24.8, SD=9.3), they required a minimum of three years' experience as a clinical supervisor to be eligible to facilitate the PGCS sessions. The full sample characteristics are presented in **Table 2.1.**

Table 2.1 Characteristics of participants in the qualitative study (n=27)

Characteristics	Supervisees (n=18)	Managers (n=5)	Supervisors (n=4)
Gender			
Female	18	5	4
Years of experience			
Range	12-40	20-40	13-39
Mean(SD)	26.6(8)	29(6.4)	24.8(9.3)
Highest level of education			
Certificate	1	0	0
Diploma	2	0	0
Bachelor's	5	3	0
Postgraduate diploma	8	1	0
Master's	2	1	4
Professional background			
Nursing	16	4	
Nursing and Midwifery (dual)	2	1	
Current role			
Staff Nurse	3	0	
Clinical Nurse Manager 1	3	0	
Clinical Nurse Manager 2	12	0	
Clinical Nurse Manager 3	0	1	
Assistant Director of Nursing	0	3	
Director of Nursing	0	1	
Years in current role			
Range	1-22	2-10	
Mean(SD)	7.4(7.1)	7(3.3)	
Clinical area			
Acute Care (General Nursing)	12	3	
Public Health	3	2	
Intellectual Disability	3	0	

SD, standard deviation

Three themes were identified from the interviews: (1) PGCS benefits and gains (personal gains, direct benefits for practice, indirect benefits for patients and the organisation, and positive supervisor characteristics); (2) challenges to PGCS (lack of 'buy-in' and familiarity with the process, disruptions caused by workload and staffing, logistical challenges, and fear of losing momentum); and (3) enhancements for future PGCS (flexible work arrangements, content and logistical improvements, and enhancing awareness and reach).

2.3.2 Peer Group Clinical Supervision Benefits and Gains

PGCS was perceived as beneficial to self and practice and indirectly to the organisation and patients.

2.3.2.1 Personal gains

Overall, supervisees reported becoming calm; mindful; empowered; confident; better communicators; and more self-aware because of PGCS:

"…We had some brilliant brainwaves during it [PGCS] and one of the things we came up with is that we like declutter….so I decluttered my office because we'd have a load of…stuff…and I put up lovely pictures…even if I only get into my office for five minutes during the day, it's just a lovely calm peaceful place…" (N5-9).

Some supervisees recalled the role of PGCS in helping them become better communicators and reducing stress:

"It [PGCS] definitely cut down on the stress side of things and like we are stressed out all the time because you're trying to beat the clock all of the time from once you come in until you go home…we definitely have better communication skills as a result of what we learned" (N2-4).

All supervisors deemed PGCS to be a positive opportunity for supervisees to build their confidence in a *"very healthy"* and *"non-sterile environment"*:

"…People came and they offloaded what was happening currently in their day-to-day or in their week and it was like helping them to work through that…support and building up people with confidence in themselves and being able to manage and to take time to look at what's happening for themselves" (S1).

2.3.2.2 Direct benefits for practice

PGCS resulted in improvements in connectivity, through the enhancement of team cohesion and unity. Improvements were also noted in management duties, such as the ability to make decisions, promote change, and delegate tasks. Furthermore, participants reported that they felt empowered and less isolated in their roles. Lone workers reported that PGCS helped decrease feelings of isolation and improve their sense of unity:

"It [PGCS] united us very much…the isolation feeling went within our work. It gave us more backup…we were all working in isolation on our own and now it is a lot easier to pick up the phone and ring one another…towards the end, I felt we were all speaking from the one voice…you feel you're not on your own" (N2-4).

"…I'd bring it back to the lone worker because that is the biggest issue we would have, or our staff would have. I guess if they [supervisees] feel supported, then they're not as fearful going into the same scenario or going back into the same house…" (M2).

For supervisees, PGCS *"helped define roles and boundaries"* (N2-4) and enabled them to ***"see the wood from the trees…decide and prioritise and defer and delegate other duties and jobs that [they] necessarily don't have to be doing all the time" (N5-9).***

Increased *"sharing"* of experiences was frequently mentioned as a benefit from PGCS. This included sharing of information, learning, problem-solving, decision-making, understanding, and workload:

"If you have a problem, everyone else has the same type of problem, but some people would deal with it in different ways and learning how an approach that I might take to a problem, somebody else could take a totally different approach and if they're willing to share that with you…" (N1).

This was iterated by supervisors and line managers who believed that supervisees' ability to share and hear the experiences of others helped them realise that they were not alone in their struggles:

> ***"…If you know that everybody's feeling exactly the same at each shift, it's not just you, it sort of changes the dynamic" (M3-5).***

2.3.2.3 Indirect benefits for patients and the organisation

PGCS benefits for patients were perceived as indirect and long-term since patients would benefit from less stressed and more productive staff. Supervisees believed that ***"if you're feeling a bit better yourself, it's automatically going to help whoever you're looking after" (N1***). Similarly, line managers mentioned that ***"a satisfied nurse is a satisfied patient…" (M3-5).*** Furthermore, listening to peers during PGCS session enabled supervisees to ***"deal with family members and different family dynamics" (N13-16).***

While they perceived that PGCS was beneficial to patients, supervisees believed that the benefit ***"would be indirect, rather than direct because the service user will always get the best care anyway" (N17,18).*** Similarly, some managers did not see ***"anything tangible but expect it [PGCS] would have had a certain level of impact on clients" (M3-5).***

Participants noted improved staff morale, increased productivity, and becoming better role models for their colleagues. PGCS was also perceived by most supervisees to potentially reduce sick leave with many believing that the organisation would benefit from more confident, autonomous, and empowered staff:

> ***"Ultimately, the organisation benefits because they have more autonomous and more confident managers and maybe, like morale does get low and some days, you feel 'oh my God, this is so hard.' Whereas if you feel supported and if you know listen, we'll get through this. There are other people going through the same experiences. I think that the organisation will benefit in knowing that" (N17,18).***

Line managers perceived PGCS benefits to the organisation as ***"something that will be seen as has a benefit in time" (M1):***

> ***"I mean the CNMs [Clinical Nurse Managers] have reported to us that they felt it beneficial, they felt supported, they felt they had a forum where they could discuss amongst themselves" (M3-5).***

2.3.2.4 Positive supervisor characteristics

Supervisees spoke highly of supervisors and described them as calm, empathetic, and positive. It was also noted that the structured approach adopted by supervisors was beneficial in keeping supervisees on track. Because supervisors were nurturing and sensitive to individual needs, they were able to find answers to some of the problems that supervisees had faced:

> ***"We had a wonderful facilitator. She made life very easy for us and brought us along and we didn't even know we were being brought along…she was very experienced…she brought a lot of her own experience into the room in dealing with people…she gave everybody time…reached out to everybody every single day…and you could see she had such mighty skills. She really facilitated. She did her job" (N2-4).***

Of the four supervisors, three were from a nursing background; however, this was not perceived as a barrier by the supervisees:

> ***"We had trust in our facilitator…which I suppose put us at ease that we were able to speak freely. You see, the fact that she was a professional and outside of the hospital, we kind of trusted her not to be judging us or coming back with information. She had no reason to feed back to management…I still see the value of [us] meeting as a group, but [I] certainly think it wouldn't be as beneficial without the structure of the independent facilitator" (N5-9).***

Supervisees often referred to supervisors as ***"facilitators."*** In fact, the word 'supervision' caused confusion among supervisees and was not favoured by supervisors:

> ***"The word 'supervision.' It felt for me, my experience with the group was more like a support group…they found that [supervision] a little bit threatening…they felt was I kind of going to be looking at their practice" (S1).***

> ***"They [supervisees] think of performance management or something…they think, 'Oh God, I'm being supervised. I'm being watched here now'…I mean it's a nice term, but now when I heard it first, I really thought it would involve some formal supervision" (N1).***

2.3.3 Challenges to Peer Group Clinical Supervision

While experiences were predominantly positive, various challenges to PGCS were reported including lack of 'buy-in' and familiarity with the process; disruptions caused by workload and staffing; logistical challenges; and fear of losing momentum.

2.3.3.1 Lack of 'buy-in' and familiarity with the process

Unfamiliarity with PGCS resulted in initial apprehension and confidentiality concerns:

> ***"…I was afraid that we might be inhibited by each other and afraid to open up a bit maybe because of knowing people so well…I found it hard at the beginning to let my guard down…it took me a while to get comfortable, but once I did, I really did feel comfortable" (N17,18).***

Supervisees' lack of awareness of the purpose behind PGCS was also identified by supervisors as a challenge:

> ***"…They [supervisees] knew a little bit about supervision and had been given information about supervision, but that was very basic…some of them didn't really have any understanding, a deep understanding of supervision" (S1).***

Line managers felt that their role was only to facilitate their nurses to attend PGCS. One manager stated knowing ***"nothing about the Clinical Supervision process. [she] just facilitated it" and believed that "there was a huge secrecy" (M1). Other line managers referred to PGCS as a "secret society" (M3-5)***. One line manager added:

> ***"I didn't know what happened in the meetings, but I did get informal feedback that two of the nurses arriving out of this meeting, they seemed to use it as a place to air their concerns…now, that would be enough for me to stop supervision forever" (M2).***

Line managers' suspicions were felt by several supervisees who were expecting more ***"buy-in" (N1)*** from their line managers:

> ***"There's probably been a little bit of suspicion because we've been a little bit organised for our management meetings, I do think that there probably has been a little bit of suspicion from [line managers], 'What are you up to?' or 'What are you at?'" (N5-9)***.

2.3.3.2 Disruptions caused by workload and staffing

Despite having a protected hour for most PGCS sessions, supervisees found it hard to find cover to attend PGCS, with balancing competing demands causing difficulty and having to ***"pick up the pieces" (N10-12)*** after PGCS sessions:

> ***"Compliance was difficult because of the demands of [the] job and even though [the group] had it 'diaried'…life and work would clash, even with the diary sometimes…I think it is hard to kind of come down***

from the hype of running, running, running and suddenly being expected to stop and you know there's 22 jobs waiting for you when you go out in an hour or whatever" (N1).

Prioritising work over PGCS was also a challenge for nurses whose role was ***"unpredictable"*** (N13-16). Similarly, line managers reported difficulties supporting nurses to attend PGCS sessions due to lack resources:

"I've very transient staff, so then to be training them all up on supervision…and then they're gone… that is very challenging…I had one group. I couldn't facilitate a second group…because I don't have the resources to free them up. I would certainly not run it during summer holidays…there was one meeting I couldn't support the staff. I had no one for protected time because everyone was on annual leave…" (M2).

Supervisors believed that supervisees were ***"pulled by management…pulled by staff…pulled by patients" (S2)*** and that ***"staff weren't always replaced when they were coming off a ward and that put them under pressure…"*** (S3,4). Despite agreeing to have an extra member join the group beforehand, supervisees also shared an example of a participant who joined one of the groups at a late stage, which caused disruptions within their group:

"There was a change in our group…one person left and that took us a while then to kind of get back into that…so, we didn't know that it would have to go through a system basically for another person to join or it would have to go through…she was kind of put in the role. I could see that she was kind of told she had to do it…" (N13-16).

2.3.3.3 Logistical challenges

The logistics of running PGCS sessions in terms of process, location, and duration were challenging to participants. One supervisee stated that at times, one person was ***"stronger and talking more,"*** and that ***"some people were quieter than other personalities" (N1).*** Others found it hard to keep conversations focused and to focus on the positives rather than the negatives.

PGCS duration, the time it took supervisees to ***"settle,"*** and travel to and from PGCS session were identified as major challenges:

"[PGCS] was a bit too short…you'd be rushing so much to get there, sometimes it would take a little while to ground yourself…" (N2-4).

"[We] were really getting to the root of the problem, the hour was up…the time went really fast" (N5-9).

Supervisees who worked in rural areas and the community had to factor in travel time:

"Within the geographical [location], that it actually takes more than the hour. You know, it takes us three hours really by the time we're altogether and that…over the road and if you were behind a low loader [big truck] or something like that, you were going to be late" (N2-4).

Time constraints were also identified as stressors by line managers and supervisors:

"…If you think six people in a group is six hours, but it's more than six hours actually because it's six direct hours of supervision, but they have to get to the place and get back, so it's probably more like 12 hours…" (M2).

"They [supervisees] had to come straight back out of it [PGCS] and go back onto the ward…so there wasn't a lot of time to integrate and put them together again…it was really, really challenging for the facilitator to manage that…it's like if there was a feeling of being catapulted in to do something and then leave and then it would take me about half an hour afterwards to de stress myself" (S2).

Some line managers struggled to ensure the right mix of people in PGCS groups, with some supervisees refusing to participate in PGCS due to ***"concerns about confidentiality" (M3-5).*** One line manager said that she would be ***"very careful as to the type of people [she would] put in the room" (M1).***

In terms of PGCS delivery, supervisors were either neutral or shared negative feedback regarding the PGCS Framework. One supervisor described the framework as ***"good…basic enough for the level we're at" (S1)***. Others argued that their supervision work was not solely led by the framework and at times the work was guided by the need of the group in a given session. Supervisors preferred to be led by ***"whatever came up at the time or whatever shape things went into in the actual group" (S3,4).***

2.3.3.4 Fear of losing momentum

For some supervisees, completing PGCS triggered a sense of loss and a fear that the impact of PGCS becomes ***"diluted"*** with time and wished that PGCS was ***"a little bit longer":***

> ***"…I think there was a willingness from our line manager, but it's just staffing issues, the practicalities…we do understand that practically, it is difficult for them, but at the same time, it's very important for us too…I don't know if our manager has ever done Clinical Supervision, so she may not realise the support that it is" (N2-4).***

> ***"We would like to continue it [PGCS] and now we're trying to do it ourselves, but if it isn't made available to us, I think it will be a shame and I think it'll be a huge loss…fear going forward to maintain that structure and that commitment to it [PGCS]…afraid that it [impact of PGCS] would be diluted" (N5-9)***.

2.3.4 Enhancements for Future Peer Group Clinician Supervision

Overall, participants suggested that PGCS continues, with some stating that PGCS ought to ***"be seen as a core part of everybody's job because it is the ultimate experience" (N2-4).*** Participants stressed the importance of flexible work arrangements to accommodate PGCS, improving PGCS content and logistics, and enhancing PGCS awareness and reach.

2.3.4.1 Flexible work arrangements

Overlapping shifts, protected time, staff cover, and supervision on days off were some of the recommendations made to overcome workplace challenges:

> ***"Put outside people's duty time or extra time that they were paid to come in…get people to come in an hour earlier. I know it is extra duty and give it back to them another time, but I suppose all departments are kind of just short-staffed even as is…or if people had half-days, that hour, that it was either given back or paid extra at another time…It's just even if somebody could take over while you're away from your desk…but sometimes they can't because you're the only one…" (N10-12).***

All line managers felt strongly that further consideration should be given to scheduling. One line manager suggested that staff ***"could try and schedule where possible to do this [PGCS] on their day off" (M1).*** She added:

> ***"…I think people have to take ownership for themselves when they sign up to these courses [PGCS] to say that ok, well, you will be expected to commit to an hour a month for the next 12 months. Are you willing to sort out your rota to make sure that you're actually on a day off as opposed to a day on? Because it is becoming increasingly more difficult to facilitate releasing people off the floor" (M1).***

2.3.4.2 Content and logistical improvements

These related to the location, duration, delivery, and content of future PGCS sessions. To reduce travel time, participants recommended making PGCS available in ***"more localised areas" (N1)*** and suggested that PGCS for frontline workers should be ***"done much closer to people's worksites" (N17,18)***. Some recommended reducing the duration of PGCS to *"only 30 minutes"* (N1) and to take a break over the summer, while the majority believed that ***"an hour is very short"*** and that ***"an hour and a half would actually have been a better timeframe…" (N5-9)***. This was reiterated by one supervisor:

> ***"I don't know if they'd [supervisees] get off for an hour and a half. I think being there for an hour, but perhaps maybe an hour and 15 minutes. If you could have 15 minutes for people coming and going so that you'd actually have an hour session" (S1).***

Supervisees recommended that ***"it was important that the sessions went regularly" (N13-16)*** and, to keep momentum, they suggested ***"monthly follow-up sessions" (N17,18).*** In terms of content and delivery, participants recommended a ***"little bit of mindfulness or meditation" (N10-12).*** Smaller groups were also favoured ***"because it kept [them] focused and it gave everybody a chance to participate…" (N5-9)***. Supervisees recommended that funders should be ***"a bit selective, who they train up to become facilitators" (N1)*** with a preference for ***"having an outside facilitator" (N5-9).*** This was also favoured by one external supervisor who believed that an ***"external supervisor, not an internal one, is far superior" (S2).*** She added:

> ***"…They [supervisees] wouldn't be able to trust somebody from inside…because they're all connected…everybody's connected and knows everybody's business…they could really trust the confidentiality and my objectivity from the offsite and they found that hugely beneficial, that I wasn't caught up in the workplace small politics" (S2).***

2.3.4.3 Enhancing awareness and reach of PGCS

Supervisors stressed the importance of creating a *"culture that supervision is really beneficial and important"* (S2) and believed that PGCS awareness and preparation were needed beforehand. This was iterated by supervisees:

> ***"Looking at buy-in before from people that might be willing…before you start anything in here, the first thing I'd do is call a meeting of all the people that it would involve, particularly all the nursing and care staff, whoever, the managers or whoever, and just get people's views on it and see how they feel about it" (N1).***

Supervisors also highlighted the importance of staff attending only when they choose to, and not being mandated by line managers. They also suggested that supervisees' expectations from PGCS should be explored and that supervisees ought to meet their supervisors beforehand:

> ***"The space needed a bit more preparation…maybe one of the ways is to have an open workshop on supervision…explaining to people what it's all about and then after that, let them opt into it if that's something they feel they'd be interested in…where people are informed about what they're coming to, and that would ensure then that when you started the group, that everyone in the group was on the same page in terms of what their expectations might be" (S3,4).***

Supervisors believed that support from line managers was vital, with one supervisor suggesting that *"a maintenance agreement for the staff doing the work"* (S2). Another potential means of optimising this was to include line managers in PGCS groups:

> ***"…It would be also beneficial then if this was a project for CNM2s [Clinical Nurse Manager 2] and CNM1s, that CNM3s and teams got the benefit of supervision. You would see it trickling down much better…said all the different layers, you know, all the different levels of management do it…I think that will create a culture of change" (S2).***

To counteract the potentially negative connotation of *"supervision,"* supervisors suggested that the title of the programme be re-considered to include *"peer support."*

Most supervisees held managerial positions. They recommended involving staff nurses, midwives, and other disciplines in PGCS:

> ***"Maybe if there was kind of a mixed group…like say someone from different hospitals because we found that sometimes the same issues were coming up month on month. And I wonder if it was a different mix from different hospitals and that, would it be more beneficial because we just felt oh, here we go again the same thing, the same person, the same issues being brought up…I would think that would be more beneficial if they were from other areas besides our own as well because like you say, we have the same issues here with the same people…It'd probably be of bigger benefit really to people, to staff nurses, I would presume, nearly even just because their issues might be more patient-focused" (N10-12).***

Similarly, the mixing of junior and senior staff to enhance group learning and support was recommended by supervisors:

> ***"What I've learned from just my group was that a good mix of staff, a lot of learning goes on…. So, maybe let them have the same type of experience, but to vary it. Junior staff learn a lot from more senior staff and vice versa. There's new learning as well… different backgrounds, different years of experience…" (S3,4)***

Section 3 Quantitative Evaluation

3.1 Aims and Objectives

The overall aim of this study was to evaluate the pilot implementation of PGCS for nurses in Cork and Kerry services. The specific objectives were to:

1. Measure and examine differences in supervisees' understanding of Clinical Supervision before and after engaging in PGCS.
2. Measure and examine differences in supervisees' perceptions of organisational functioning before and after engaging in PGCS.

3.2 Methodology

3.2.1 Design

A pre-post study design was used. A pre-post study measures the occurrence of an outcome before and after some type of intervention is implemented (Thiese, 2014). In this case, the intervention in question was participation in the PGCS sessions, and the various outcomes related to supervisees' perspectives of the effectiveness of PGCS.

3.2.2 Participants

All nurse supervisees who attended the PGCS sessions were eligible to participate in this study. This did not include line managers and supervisors who facilitated PGCS sessions.

3.2.3 Procedures

Prior to the commencement of the PGCS pilot project, supervisees were informed verbally that the outcomes of the project were being evaluated using research methods. They were informed that they were not obliged to partake in the research study and that this would not affect their participation in the PGCS sessions. All supervisees were provided with a written information leaflet that provided further details of the study. Participation in the research study involved completing a questionnaire before the commencement of the PGCS project (pre-test) and after completing the project (post-test).

Once consent was obtained, the project lead distributed the questionnaires to supervisees who agreed to participate in the research study. Data were kept confidential, and no identifying information appeared on the questionnaires. In order to ensure anonymity but to enable pre-test and post-test data to be matched, participants were asked to complete a unique code using the first letter of their mother's and father's names and the last 3 digits of their mobile number. They were advised of their right to withdraw from the study. This specifically related to them consenting to participate in the study and completing the pre-test questionnaire but not being obliged to complete the post-test questionnaire 12 months later. They were also advised that because questionnaires were anonymous (i.e. no names just code number entered), it would be very difficult to remove their questionnaire data once it had been submitted to the research team.

3.2.4 Ethics

Ethical approval was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals (Reference Number: ECM 4 (m) 03/07/18).

3.2.5 Data Collection

The questionnaires were purposefully designed. The pre-Clinical Supervision questionnaire included a number of demographic questions, including supervisees' sex; age; level of education; current role; current area of practice; length of experience in nursing/midwifery; length of time in current role; and whether or not they had prior experience of Clinical Supervision. Supervisees' understanding of Clinical Supervision was measured using four open-ended questions, and their perceptions of how their organisation functions were measured using selected items from a standardised tool, the Survey of Organisational Functioning (SOF) (Texas Christian University Institute of Behavioural Research, 2008). Nineteen sub-scales, comprising a total of 107 items, from the SOF were included in the pre- and post- questionnaire packages **(Table 3.1).**

Table 3.1 The Survey of Organisational Functioning - Description of sub-scales

Sub-scale	Number of items	Interpretation
1. Program Needs	8	Two measures of 'Motivation for Change'
2. Pressures for Change	7	
3. Staffing	6	Four measures of 'Resources'
4. Training	4	
5. Computer Access	7	
6. e-Communications	4	
7. Growth	5	Four measures of 'Staff Attributes'
8. Efficacy	5	
9. Influence	6	
10. Adaptability	4	
11. Mission	5	Six measures of 'Organisational Climate'
12. Cohesion	6	
13. Autonomy	5	
14. Communication	5	
15. Stress	4	
16. Change	5	
17. Burnout	6	Three measures of 'Job Attitudes'
18. Satisfaction	6	
19. Director Leadership	9	

The post-Clinical Supervision questionnaire collected data on supervisees' perceptions of the benefits and facilitators of Clinical Supervision using three open-ended questions. Their perceptions of organisational functioning were measured again using the SOF, and their overall experiences of participating in the PGCS pilot project were measured using the 26-item version of the Manchester Clinical Supervision Scale © (MCSS-26©) (Winstanley & White, 2011). The MCSS-26© is a validated measure of the effectiveness of Clinical Supervision, and contains 6 sub-scales with a total of 26 items **(Table 3.2).**[2]

[2] The MCSS-26© was not developed as a 'pre-post' research instrument and is only suitable for use after a respondent has gone through the clinical supervision process (White & Winstanley 2019). Therefore, the MCSS-26© items were included in the post-clinical supervision questionnaire package only.

Table 3.2 The 26-item Manchester Clinical Supervision Scale - Description of Sub-Scales (White & Winstanley, 2019)

Sub-scale	Number of items	Interpretation	Range of raw scores
Importance/ Value of Clinical Supervision	5	A measure of the importance of receiving CS and whether the CS process is valued or necessary to improve quality of care	0-20
Finding Time	4	A measure of the time available for the supervisee to attend CS sessions	0-16
Trust/Rapport	5	A measure of the level of the trust/rapport with the supervisor during the CS sessions	0-20
Supervisor Advice/ Support	5	A measure of the extent to which the supervisee feels supported by the supervisor and a measure of the level of advice and guidance received	0-20
Improved Care/ Skills	4	A measure of the extent to which the supervisee feels that CS has affected their delivery of care and improvement in skills	0-16
Reflection	3	A measure of how supported the supervisee feels with reflecting on complex clinical experiences	1-12

3.2.6 Data Analysis

All statistical analyses were performed using SPSS version 26. Age was categorised (21-30; 31-40; 41-50; 51-60; >60 years). For analysis, the length of time in the current job was dichotomised as follows: ≤5 years; >5 years.

3.2.6.1 The Survey of Organisational Functioning (SOF)

Scores were reversed for 12 items, and total scores for each sub-scale were calculated by adding together the scores for each set of items, dividing the sum by the number of items included, and multiplying by 10 in order to rescale the final scores. As a result, total scores for each sub-scale ranged from 10 to 50. To test for differences between pre- and post- survey responses, paired samples t-tests were performed. Independent samples t-tests were performed to test for differences between the responses of participants that had been in their current role for >5 years and those that had been in their current role for ≤5 years.

3.2.6.2 The 26-item Manchester Clinical Supervision Scale (MCSS-26 ©)

Scores were reversed for 9 items, and total scores for each sub-scale were calculated by adding together the scores for each item. As a result, the range of raw scores for each sub-scale differed **(Table 3.2).** The raw scores were converted to percentages by dividing the raw scores by the maximum values and multiplying by 100. Descriptive statistics were used to summarise both, the raw scores and the percentage values for each sub-scale.

3.3 Results

3.3.1 Sample Characteristics

A total of 51 supervisees agreed to participate in the quantitative study and completed pre-test questionnaires **(Table 3.3).** The majority (n=48; 94%) were female and aged between 31 and 60 years (n=47; 92%). Most had a bachelor's degree (or equivalent) or a master's level qualification in nursing (n=36; 71%), and almost all had more than 5 years of nursing and/or midwifery experience. At the time of attending the PGCS sessions, most supervisees were working in a clinical nurse/midwife manager role (n=42; 82%). Over one-half were working in general acute nursing settings (n=26; 51%), and 49% (n=25) of participants had been in their current role for more than 5 years.

Table 3.3 Sample characteristics (n=51)

Characteristics	n	(%)
Sex		
Female	48	(94.1)
Male	3	(5.9)
Age		
21-30 years	3	(5.9)
31-40 years	16	(31.3)
41-50 years	17	(33.3)
51-60 years	14	(27.4)
>60 years	1	(2)
Level of education		
Apprenticeship nurse training	7	(13.7)
Diploma in nursing/midwifery	8	(15.7)
Degree or equivalent	31	(59.6)
Masters	5	(9.8)
Experience in nursing		
4-5 years	1	(2)
Over 5 years	50	(98)
Current role		
Staff nurse/midwife	4	(7.8)
Clinical nurse/midwife manager	42	(82.3)
Clinical nurse/midwife specialist	4	(7.8)
Advanced nurse/midwife practitioner	1	(2)
Current area of practice		
General acute nursing	26	(51.0)
General community nursing	10	(19.6)
Midwifery	1	(2)
Mental health nursing	5	(9.8)
Intellectual disability nursing	9	(17.6)
Length of time in current job		
Under 6 months	4	(7.8)
6-11 months	6	(11.8)
1-3 years	13	(25.5)
4-5 years	3	(5.9)
Over 5 years	25	(49)

Note: 51 supervisees completed a pre-test questionnaire, and a total of 47 supervisees completed a post-test questionnaire. However, only 36 pre-post questionnaires could be matched. Therefore, data from only 36 supervisees was used in the pre and post analysis. Data from 47 supervisees were used in the analysis that required post-questionnaire data only (MCSS-26©). As a result, the collected data is presented under three headings: pre-PGCS; pre- and post- PGCS; post-PGCS.

3.3.2 Pre-Peer Group Clinical Supervision Data

3.3.2.1 Understanwding of, and reasons for engagement with, Clinical Supervision prior to participating in the project

Four open-ended questions that were included in the pre-Clinical Supervision questionnaire captured data on supervisees' understanding and reasons for participating in Clinical Supervision prior to involvement in the PGCS project. As 51 supervisees completed this part of the questionnaire, which was not being matched with post-test data, all responses are reflected in the analysis.

Understanding of Clinical Supervision

Almost all participants (n=49, 98%) understood Clinical Supervision as one or more of the following: a means of giving support to colleagues; a means of getting support from colleagues; a means of reflecting on their practice; sharing learning through discussion of issues; or developing professional knowledge.

Reasons for participating in peer group Clinical Supervision

A number of participants (n=13, 26%) identified isolation in their role/area of work or being new to a team/ new to a role as a reason for participating in peer group Clinical Supervision. Others (n=29, 58%) reported the sharing of information, development of practice, learning from and liaising with others and reducing stress as their reason for participating in peer group Clinical Supervision. Eight participants reported being involved because their line manager selected them, or they wanted to help others or to get 'time off the floor' (n=8, 16%).

Concerns about participating in peer group Clinical Supervision

Over half of participants (n=26, 52%) reported that they had no concerns about taking part in group Clinical Supervision. For other participants, two major concerns were reported: maintaining confidentiality (n=9, 18%) and not having the time to commit to supervision (n=9, 18%). Participants who expressed concerns about confidentiality were worried that they would feel *"judged by fellow group members"*. Concerns about time were related to the apprehension about not being able to commit to supervision, but some participants viewed supervision as an addition to their workload: *"Current workload very demanding, having anything extra to do on top of this may add extra stress."*

Hopes for what will result from participating in peer group Clinical Supervision

The main expectation held by participants was that engagement in Clinical Supervision would help to improve their practice (n=35, 70%). One participant commented that through developing *"better self and professional awareness,"* they could become "*a better manager and caregiver.*" Other participants (n=15, 30%) sought support from their peers, highlighting the importance of *"greater bonding and understanding, ability to support and be supported."* Four participants (8%) voiced concerns about occupational stress and hoped that Clinical Supervision would result in experiencing *"less stress"* at work. A small number of participants (n=3, 6%) felt their role was ill-defined, or that they felt invalidated in their role; one participant hoped that engagement in Clinical Supervision would result in "*greater understanding of [their] role.*" One participant expressed that they had no expectations for the process, and that they were only engaging in Clinical Supervision in order *"to appease management."*

3.3.3 Pre- and Post-Peer Group Clinical Supervision Data (Survey of Organisational Functioning)

3.3.3.1 Staff perceptions of organisational functioning

Staff perceptions of organisational functioning were measured pre- and post- participation in the Peer Group Clinical Supervision pilot project using nineteen sub-scales of the SOF. A total of 36 supervisees completed both pre- and post- questionnaires that could be matched, and their data were used in this analysis.

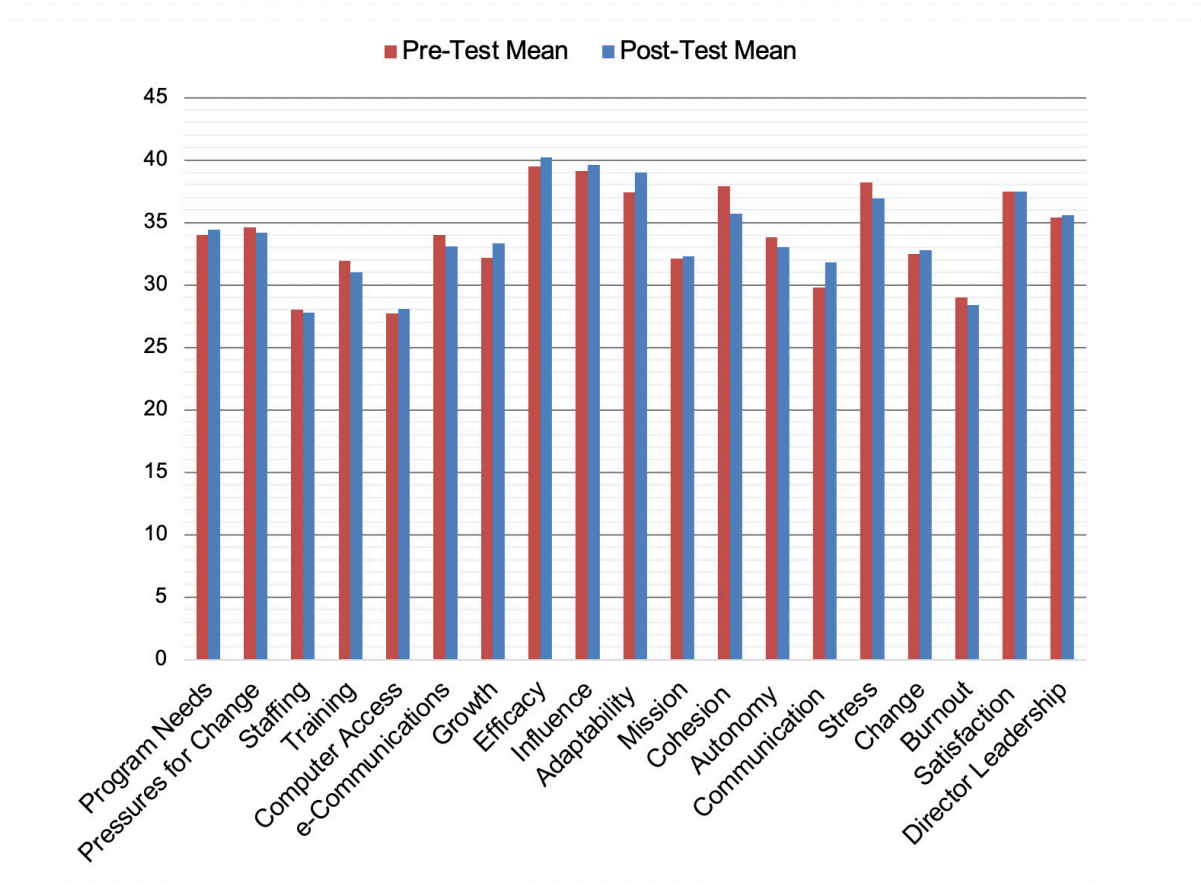
Due to the relatively small sample size, there were very few changes that reached statistical significance. Changes between pre- and post- responses for matched questionnaires revealed a significant increase in adaptability (mean difference 1.6) but a decrease in cohesion (mean difference -2.3). Non-significant increases to communication (mean difference 2.1) and growth (mean difference 1.1) and a decrease to stress (mean difference -1.3) were also seen between the two data time points **(Table 3.4** and **Figure 3.1).**

Table 3.4 Survey of Organisational Functioning - Differences in Responses Pre- and Post - Participation in PGCS

Item name	No. paired responses	Pre-survey mean (SD)		Post-survey mean (SD)		Mean difference	Significance	
							t	*p*
Motivation for change								
1. Programme Needs	30	34	(7.9)	34.4	(7.8)	0.4	0.289	0.774
2. Pressures for Change	30	34.6	(5.8)	34.2	(6.6)	-0.4	-0.302	0.765
Resources								
3. Staffing	35	28.0	(7.5)	27.8	(7.0)	-0.2	-0.210	0.835
4. Training	34	31.9	(9.4)	31.0	(8.5)	-0.9	-0.653	0.518
5. Computer Access	34	27.7	(5.4)	28.1	(5.6)	0.4	0.441	0.662
6. e-Communications	34	34.0	(9.4)	33.1	(7.7)	-0.9	-0.816	0.420
Staff attributes								
7. Growth	34	32.2	(9.8)	33.3	(8.4)	1.1	0.984	0.332
8. Efficacy	35	39.5	(4.9)	40.2	(4.9)	0.7	0.887	0.381
9. Influence	33	39.1	(5.8)	39.6	(5.2)	0.5	0.665	0.511
10. Adaptability	34	37.4	(5.7)	39.0	(5.2)	1.6	2.069	0.046 *
Organisational climate								
11. Mission	33	32.1	(6.9)	32.3	(6.8)	0.2	0.237	0.811
12. Cohesion	33	37.9	(7.1)	35.7	(7.5)	-2.3	-2.148	0.039 *
13. Autonomy	32	33.8	(6.7)	33.0	(5.9)	-0.8	-0.791	0.435
14. Communication	34	29.8	(7.4)	31.8	(7.4)	2.1	1.856	0.072
15. Stress	34	38.2	(8.3)	36.9	(8.5)	-1.3	-1.116	0.272
16. Change	34	32.5	(7.5)	32.8	(6.3)	0.3	0.421	0.676
Job attitudes								
17. Burnout	33	29.0	(7.7)	28.4	(7.2)	-0.6	-0.744	0.462
18. Satisfaction	34	37.5	(6.9)	37.5	(6.5)	0	0	1.0
19. Director Leadership	35	35.4	(10.9)	35.6	(9.8)	0.2	0.105	0.917

SD, standard deviation.
t-statistic and p-value from paired sample t-tests. *p<0.05: statistically significant

Figure 3.1 Pre-Post Responses to the Survey of Organisational Functioning



Differences in staff perceptions of organisational functioning based on the length of time in their current role

Due to the relatively small sample size, differences in the mean scores of supervisees that had been in their current role for more than 5 years and those that had been in their current role for 5 years or less did not reach statistical significance **(Table 3.5).**

However, there were some notable differences between the two groups of supervisees, with mean differences of at least 1 point on the following items:

- **Computer access:** Supervisees that had been in their current role for 5 years or less were less likely to have reported an increase in 'computer access' in their post-Clinical Supervision questionnaire (mean difference of -0.3 compared to 0.9).
- **Efficacy:** Supervisees that had been in their current role for 5 years or less were more likely to have reported an increase in 'efficacy' in their post-Clinical Supervision questionnaire (mean difference of 1.8 compared to -0.2).
- **Influence:** Supervisees that had been in their current role for 5 years or less were more likely to have reported an increase in 'Influence' in their post-Clinical Supervision questionnaire (mean difference of 1.4 compared to -0.2).

- **Cohesion:** Supervisees that had been in their current role for 5 years or less were more likely to have reported a reduction in 'cohesion' in their post-Clinical Supervision questionnaire (mean difference of -3.5 compared to -1.1).
- **Stress:** Supervisees that had been in their current role for 5 years or less were more likely to have reported a reduction in 'stress' in their post-Clinical Supervision questionnaire (mean difference of -3.5 compared to 0.4).
- **Change:** Supervisees that had been in their current role for 5 years or less were more likely to have reported an increase in 'change' in their post-Clinical Supervision questionnaire (mean difference of 1.1 compared to -0.2)
- **Burnout:** Supervisees that had been in their current role for 5 years or less were less likely to have reported a decrease in 'burnout' in their post-Clinical Supervision questionnaire (mean difference of 0.6 compared to -1.7).
- **Satisfaction:** Supervisees that had been in their current role for 5 years or less were less likely to have reported an increase in 'satisfaction' in their post-Clinical Supervision questionnaire (mean difference of -0.7 compared to 0.5).

Table 3.5 Survey of Organisational Functioning - mean differences between pre- and post-questionnaire scores. Comparing supervisees that had been in their current role for 5 years or more to those that had been in their current role for less than five years.

Item	≤5 years in current role	> 5 years in current role	Significance
	Mean difference between pre- and post- scores	Mean difference between pre- and post-scores	*p*-value
Motivation for change			
1. Programme Needs	0.4	0.5	0.985
2. Pressures for Change	0.7	-1.4	0.416
Resources			
3. Staffing	-0.7	0.3	0.594
4. Training	-0.5	-1.2	0.806
5. Computer Access	**-0.3**	**0.9**	**0.464**
6. e-Communications	-1.3	-0.5	0.717
Staff attributes			
7. Growth	0.9	1.2	0.919
8. Efficacy	**1.8**	**-0.2**	**0.211**
9. Influence	**1.4**	**-0.2**	**0.304**
10. Adaptability	1.8	1.4	0.811
Organisational climate			
11. Mission	-0.6	1.1	0.419
12. Cohesion	**-3.5**	**-1.1**	**0.251**
13. Autonomy	-0.9	-0.7	0.914
14. Communication	2.4	1.8	0.789
15. Stress	**-3.5**	**0.4**	**0.104**
16. Change	**1.1**	**-0.2**	**0.458**
Job attitudes			
17. Burnout	**0.6**	**-1.7**	**0.215**
18. Satisfaction	**-0.7**	**0.5**	**0.534**
19. Director Leadership	-0.3	0.6	0.761

p-value from independent samples t-test.

3.3.4 Post - Peer Group Clinical Supervision Data

3.3.4.1 Perceptions of Clinical Supervision after participating in the project

Three open-ended questions that were included in the post-Clinical Supervision questionnaire captured data on supervisees' perceptions of Clinical Supervision after participating in the PGCS project. A total of 47 supervisees provided responses to these three questions, and their responses are summarised below.

3.3.4.2 What Clinical Supervision means to supervisees

After participating in the project, all supervisees reported Clinical Supervision sessions to represent a space to meet with their colleagues and peers in order to engage in discussion and reflect on any issues and concerns that they may have in their workplace settings. Many saw it as a *"safe place,"* and as an opportunity to learn from their colleagues' experiences while also sharing their own experiences. Importantly, it was considered to be a confidential space. It was also seen as a space to reflect on one's own practice. Keywords that frequently arose in supervisees' responses to this question were: *"support"* (n=15; 32%); *"reflect"* (n=11; 23%); *"sharing"* (n=8; 17%); *"learning"* (n=7; 15%); *"safe"* (n=7; 15%); and *"confidential"* (n=6; 13%).

3.3.4.3 Benefits of peer group Clinical Supervision

The main perceived benefit of Clinical Supervision was that it offered staff dedicated and protected time to share their clinical experiences, problems, and vulnerabilities with colleagues, to talk things through, and to problem-solve. In particular, participants valued the opportunity to work as a group to solve problems, rather than in isolation. For many, participation in Clinical Supervision lessened feelings of isolation, and seven supervisees (15%) commented that it made them realise that that they were often not alone in their experiences and that everyone is *"in the same boat."* Three participants commented specifically that participation made them better understand the limitations of their role.

PGCS also offered supervisees the opportunity to get to know colleagues and peers, including those that may work in different departments, with one attendee commenting that Clinical Supervision "*allowed me to get to know and spend time with my peers…gave deeper understanding of our colleagues pressures and stresses"* and another stating that it helped in *"developing a good working relationship with colleagues from different departments within the hospital."*

3.3.4.4 Factors that facilitated and inhibited participation in Peer Group Clinical Supervision

The word *"time"* appeared in 20 (43%) of the responses to the question about factors that facilitated and inhibited participation in Clinical Supervision. The provision of protected time and an acceptance of this by line managers was identified as one of the most important facilitators of attendance at Clinical Supervision sessions. However, the time required to travel to and from the sessions was an issue for those that worked outside of the settings in which the sessions took place was an issue and a factor that made participation in the sessions difficult for some supervisees. Other factors that were perceived to inhibit participation were heavy workloads and competing demands, and difficulties *"coming off the floor,"* with one attendee commenting that there are *"plenty of jobs to be done instead."* Having an experienced facilitator was mentioned by 10 supervisees (21%) as being an important factor in the success of the sessions, with a number specifically recommending that if possible, the facilitator should have a non-nursing background. Other factors that were perceived to facilitate participation in the sessions were having rooms booked and dates planned out well in advance and having small group sizes.

3.3.4.5 Supervisees' perceptions of the effectiveness of Clinical Supervision

The MCSS-26 © was used as a measure of the effectiveness of the Peer Group Clinical Supervision pilot project. These data were collected in the post-Clinical Supervision questionnaire which was completed by a total of 47 supervisees.

Overall, the total mean score on the MCSS-26 © for all supervisees was 79.8 out of 103 which was well above the overall score of 73.0 which the developers identified as being the indicative threshold for efficacious Clinical Supervision provision **(Table 3.6).**

Overall, Clinical Supervision was rated highly by supervisees, with the item labelled 'importance/value of Clinical Supervision' obtaining a mean score of 16.9 out of 20. Supervisees reported high levels of trust/ rapport with their supervisors during the Clinical Supervision sessions (16.1 out of 20), and the mean scores indicated that in general, they felt supported and were satisfied with the advice and guidance received from their Clinical Supervision supervisors (14.9 out of 20). In addition, supervisees' responses indicated that they felt that Clinical Supervision has improved their skills (12.9 out of 16) and supported them in reflecting on complex clinical experiences (10.5 out of 12) **(Table 3.6).** For all these items, the mean scores obtained in this sample were higher than the MCSS-26© benchmark data **(Table 3.7).**

The item labelled 'Finding Time' obtained the lowest mean score (9 out of 16). This item is a measure of the time available for the supervisee to attend Clinical Supervision sessions and highlights how participants may have sometimes struggled to find the time to prioritise attendance at Clinical Supervision over their clinical roles.

Table 3.6 Manchester Clinical Supervision Scale - Raw Scores

MCSS© 26 factor	Number of valid responses	(Minimum, Maximum)	Mean	Standard Deviation (SD)
Importance/ value of Clinical Supervision	44	(10, 20)	16.9	2.8
Finding time	43	(0, 16)	9.0	3.9
Trust/Rapport	44	(9, 20)	16.1	2.9
Supervisor advice / support	45	(6, 20)	14.9	(3.4)
Improved care/skills	45	(4, 16)	12.9	(2.9)
Reflection	45	(6, 12)	10.5	(1.6)
Total score	**39**	**(48, 103)**	**79.8**	**(12.6)**

Table 3.7 Manchester Clinical Supervision Scale - Benchmarking the raw scores with the MCSS-26© User Manual Data

MCSS© 26 factor	Current Study Mean	Benchmark data from MCSS-26© User Manual Mean
Importance/ value of Clinical Supervision	16.9	15.8
Finding time	9	8.6
Trust/Rapport	16.1	15.7
Supervisor advice / support	14.9	14.1
Improved care/skills	12.9	12.2
Reflection	10.5	10

Section 4 Discussion and Recommendations

4.1 Discussion

Internationally, the benefits of Clinical Supervision for healthcare staff are being increasingly recognised, and include improved practice knowledge and skills, enhanced self-efficacy and self-awareness, and strengthened relationships with patients and service users (Cross et al., 2010; Watkins, 2011; Wheeler & Richards, 2007). However, there is some debate in the literature about what Clinical Supervision entails, the challenges that exist in measuring its effectiveness, and the difficulties that arise when attempting to implement it in practice (Dilworth et al., 2013).

While evidence exists to support the use of Clinical Supervision in nursing practice, there are limited studies of the effectiveness of PGCS. As such, the aim of this pilot study was to apply quantitative and qualitative research methodologies to evaluate the implementation of a PGCS programme for nurses in an Irish context. As recommendations emerge and guidelines are developed in order to make Clinical Supervision available to nurses and midwives working across the Irish health services, it is imperative to evaluate the impact of PGCS from multiple perspectives. In doing so, we can build an evidence base to inform future decisions around the implementation of Clinical Supervision in clinical practice in Ireland.

Overall findings from this research indicated that the three groups of participants (nurse supervisees, supervisors, and line managers) held positive views about the PGCS process, with the positive benefits for supervisees particularly evident. The process of PGCS helped supervisees reflect on their work, their professional role, and their interaction with colleagues. It also afforded a level of support for nurses who reported the need for PGCS such as lone workers. Similar gains from Clinical Supervision are well documented in the literature (Cutcliffe et al., 2018, O'Shea et al., 2019).

However, across the groups of participants, there were some challenges associated with PGCS, as well as some evidence of misunderstandings of what Clinical Supervision constituted, and some unrealistic expectations about what participating in PGCS could achieve. For example, there was strong consensus among all participants that the process of participating in PGCS had visible benefits for those staff members that attended the sessions but for line managers in particular, it was deemed important to be able to measure direct benefits to patients and organisations. This lack of obvious measurable benefits for organisations and patients is a common critique of Clinical Supervision (Dilworth et al., 2013). However, it is extremely difficult to identify and quantify such benefits as much longer follow-up periods (longer than 12 months, for example) would be required to allow supervisees the time to integrate any new skills or approaches to care gained from attending regular PGCS sessions. In addition, criticism of the lack of obvious benefits for patients and organisations are often secondary to unrealistic expectations and confusion around the role of Clinical Supervision (Dilworth et al., 2013).

A lack of time and competing demands are frequently noted in the literature to be barriers to the implementation of PGCS in clinical practice, and these were two frequently occurring themes in both the qualitative and quantitative studies outlined in this report. 'Finding time' was the lowest scoring item on the MCSS-26©, highlighting how participants sometimes struggled to find the time to prioritise attendance at Clinical Supervision over their clinical roles. In general, PGCS supervisees felt strongly that they should have protected time to attend PGCS during their working hours, whereas some line managers suggested that people should attend on their day off in order to overcome difficulties that they experienced in trying to arrange staff cover. Some of these conflicting perspectives may arise from a lack of awareness of the role and structure of PGCS. Dilworth et al. (2013) argue that an expectation for nurses to attend in their own time actually creates a "moral dilemma," and that support from line management, in terms of negotiating rosters and arranging cover, is necessary to allow dedicated time within work hours to avail of Clinical Supervision. If any PGCS programme

is to be successful, it is imperative that supervisees are granted sufficient protected time during their working day to participate. For nurses that work out in the community, the time required to travel to and from PGCS sessions should be considered. Organisations that agree to facilitating protected time for participating in PGCS need to ensure that it is honoured. In addition, it is important that the workload of supervisees does not simply accumulate while they are attending PGCS and individuals should not be penalised for attending sessions by having to 'make up for lost time.'

There were also differing opinions on timing and frequency of PGCS sessions. For example, some PGCS supervisees felt that they would have benefited from each session being longer than one hour, while others felt that sessions could have been of a shorter duration. Supervisors also expressed a view that sessions should be longer in length to allow supervisees to *"settle in."* While there is a scarcity of evidence regarding the ideal length and frequency of effective supervision (Rothwell et al., 2019), relevant guidance states that the length of group Clinical Supervision sessions should be 90 minutes (ONMSD, 2015). Furthermore, there is some evidence in the literature that in order to be most effective, Clinical Supervision should be held at least monthly and for at least one hour (Edwards et al., 2005).Our findings concur and suggest that adding time to the allocated hour may allow supervisees to reach PGCS venues on time, disengage from the therapeutic work, and focus on PGCS.

There were few significant changes between participants' responses to the SOF pre- and post- participation in PGCS. This may have been attributable to the relatively small sample size, or it may in fact reflect an inability of PGCS to change staff perceptions of many aspects of organisational functioning. Items of the SOF for which there was some evidence of positive changes between the two time points included adaptability, communication, growth, and stress, which was a positive finding and supported by many of the findings from the qualitative study. Of note, there was a significant decrease in mean scores for the item 'cohesion', which acts as a measure of participants' perceptions of how well staff get on, mutually respect each other, and work together as a team. Further exploration of this finding may be merited.

It was evident that supervisors were not explicitly using Proctor's (2008) Model as a framework to guide their PGCS sessions. This model is recommended by the Office of the Nursing and Midwifery Services Director (ONMSD, 2015; O'Shea et al., 2019). If PGCS is to become embedded into nursing and midwifery practice in Ireland, then it is imperative that a guiding framework is used to ensure consistency and build internal capacity within the organisation. As such, supervisors need to be provided with information on how to use this model in practice. Indeed, O'Shea et al (2019) highlight the need for clinical supervisors to be provided with training on theoretical models and how to implement them.

Difficulties implementing PGCS into routine clinical practice are well-documented in the research literature and are often related to staffing levels. This issue was consistently raised in studies outlined in this report (Rothwell et al., 2019). In order to address this issue, many of the logistical issues related to PGCS need to be resolved at a local level, and while all organisations should adhere to the PGCS framework and the recommendations, which are both outlined in this report, there will be times that local factors, such as local service provision needs, will need to be taken into account when attempting to implement a PGCS programme for nursing and midwifery staff. While taking cognisance of the findings, the longer-term aim of building internal capacity of internal supervisors within the organisation needs to be considered. These findings are echoed in an evidence review by Rothwell et al. (2019) who reported that having supervisors who are expert in the field adds to their credibility, while highlighting the detrimental effects of no or poor supervision.

Study findings highlight the central role of nursing management in PGCS, as evident from interviews with line managers who expressed their frustration from the perceived secrecy surrounding PGCS. Some line managers also expressed their lack of involvement in the PGCS process and the lack of measurable clinical outcomes as a result. Of note, the central component of Clinical Supervision is reflection on practice (National Council for the Professional Development of Nursing and Midwifery, 2008), which further stresses the need for *a priori* awareness of the nature, purpose, and expectations from PGCS.

Brunero and Lamont (2011) evaluated the implementation of Clinical Supervision in Australia and reported that senior nursing management was involved in planning and implementing PGCS from the outset; yet, a lack of support from senior nurses prevailed (Brunero & Lamont, 2011). Current study findings concur with this, highlighting the centrality of nursing management to future success of such initiatives. In mental health nursing, for example, nursing management is responsible for ensuring flexibility for staff to access Clinical Supervision (ONMSD, 2015). In doing so, an evidence base can be built to inform future decisions on the implementation of PGCS, including building internal capacity in practice.

When implemented appropriately, a programme of PGCS can provide a 'safe place' for nurses and midwives to engage in regular discussion with their colleagues and peers and represents one way of meeting their continuous professional development needs. The findings and recommendations of this report are in line with the National Guidance for Supervision for Health and Social Healthcare Professionals, published by the HSE (2015), as well as published guidance on Clinical Supervision for Nurses working in Mental Health Services (ONMSD, 2015; O'Shea et al., 2019), and provide an evidence base upon which the roll-out of PGCS to nurses and midwives nationally can be based.

Findings from the two studies outlined in this report add to the existing evidence that supports Clinical Supervision as a means of providing peer support and stress relief for nurses. This pilot study identified several challenges associated with implementing a programme of PGCS into clinical practice; however, it is evident that the perceived benefits for nurses who attended the PGCS sessions far outweigh these challenges. Many of the challenges stem from a lack of awareness and confusion about the role, structure, and function of PGCS and unrealistic expectations about its outcomes. These challenges can be overcome with appropriate awareness campaigns and training for nursing staff, line managers, and supervisors, as appropriate.

4.1.1 Limitations

There were some unavoidable limitations to this piece of research. Due to the nature of the recruitment methodology used and participants 'opting in' to participate in the interviews or focus groups and/or to complete the pre and post surveys, it is possible that there were systematic differences between participants and non-participants. For example, those who selected to participate in the research studies may have had more favourable views of the PGCS process in comparison to those that did not participate.

In order to keep participants' responses to the pre- and post-questionnaires anonymous, rather than including their names, participants were asked to enter a unique code at the start of each questionnaire which would enable their responses to the pre- and post-questionnaires to be matched. Unfortunately, it became apparent that some codes were entered incorrectly in the post-questionnaires, which meant that some participants' questionnaires could not be matched. This resulted in a total number of matched pre- and post-questionnaires that was lower than expected. Overall, larger sample sizes are favourable in quantitative research if statistically significant differences are to be observed. Due to the relatively small number of participants that completed matched questionnaires, very few differences that could be deemed statistically significant were observed. Regardless of this, the quantitative data collected gave us a good insight into the effectiveness of this PGCS pilot project and the data were supported by many of the qualitative findings. Of note, sample sizes as small as 20 participants are often considered as acceptable in pilot studies (Johanson & Brooks, 2010).

4.2 Recommendations

It is acknowledged that effective PGCS delivery is not without challenges. The space for PGCS needs to be primed and the provision of protected time is key to maximise the impact of PGCS. The fear of losing momentum and the worry that the positive impact of PGCS becomes diluted over time ought to be addressed between supervisees and line managers. For organisations as well as individuals to achieve benefits of PGCS, services need to commit to appropriate preparation in advance of participating in PGCS, this includes the training of internal supervisors to build capacity and ensure sustainability of PGCS in nursing and midwifery. Building internal capacity for PGCS is currently being progressed by the Centres of Nursing and Midwifery Education, who have developed a four-day NMBI accredited education programme, for delivery to eligible health service applicants. The development of internal supervisors is inherent to the fundamental cultural change required within the organisation to foster an understanding of and demand for PGCS and is vital for its ultimate sustainability.

A total of 16 recommendations to guide decisions around the future provision of PGCS for nurses and midwives in Ireland are presented here, under five headings: (1) Awareness; (2) Staffing and Scheduling; (3) Clinical Supervisors; (4) Supervisees; and (5) Evaluation. These recommendations have been informed by the findings of the qualitative and quantitative studies, which are outlined in Sections 2 and 3 of this report. Where there was evidence of differing perspectives and opinions on certain issues (e.g. the frequency and timing of PGCS sessions), the available literature was drawn upon to finalise the recommendation.

4.2.1 Awareness

1. PGCS should be embedded into the culture of the organisation and its benefits in terms of stress reduction, calmer working environments, staff morale and staff retention should be made explicit.
2. Promote and increase awareness of PGCS among nursing and midwifery staff at all levels and grades. Provide clarity around the meaning of 'Clinical Supervision' and promote its direct benefits for staff, and indirect benefits for organisations and patients.
3. Education is needed for senior nurse managers, such as Directors of Nursing and Midwifery and Assistant Directors of Nursing and Midwifery, on the nature, format, and benefits of PGCS. Consideration should be given to providing this education online, for example through the Health Service Executive's HSELanD, acknowledging that a similar programme already exists entitled Professional Supervision for Health and Social Care Professionals.

4.2.2 Staffing and Scheduling

4. Staff should have protected time to attend PGCS sessions. Provision to cover staff workload and responsibilities is needed while they attend the PGCS sessions in line with local service provision.
5. Carefully consider the location of PGCS sessions to reduce travel time, particularly for those that work in the community. Consider rotating venues for community-based staff. Consideration should be given to finding a suitable online platform for PGCS session.
6. Consider the length of PGCS sessions and allocate time in each session for supervisees to settle in, become acquainted, and acclimatise to the group. It may be appropriate to increase each session from 60 to 75 minutes.

4.2.3 Clinical Supervisors

7. Supervisors must take a lead role in the PGCS groups, clearly articulating boundaries and group rules. In the first session, supervisors need to reiterate the purpose of PGCS and clarify any misconceptions about the process.
8. For this pilot project, supervisors had qualifications in counselling and Clinical Supervision. However, for the sustainability of PGCS and to facilitate its availability to all nursing and midwifery staff, there is a need to build internal capacity and train clinical supervisors.
9. When building internal capacity, it is recommended that this is delivered through the Centres of Nurse Education, using an adapted version of the national programme designed for mental health nurses.
10. Supervisors should be trained and guided in the use of a Clinical Supervision Framework. Proctor's (2008) Model is recommended by The Office of the Nursing and Midwifery Services Directorate (ONMSD) due to its applicability to nursing and midwifery practice.
11. It is strongly recommended that Clinical Supervision is provided by internally trained clinical supervisors to ensure sustainability.

4.2.4 Supervisees

12. Supervisees should participate in PGCS on a voluntary basis only and should not be mandated by line management.
13. Staff from all levels and grades should be offered the opportunity to participate in PGCS. However, in line with the ethos of PGCS, groups should consist of peers that work at the same (level) grade as each other.
14. Group sizes should be kept small (4-6 supervisees per group).
15. Before the commencement of PGCS sessions, there is a need to ensure supervisees are clear on the expectations of the group, including maintaining confidentiality, one of the most important considerations, as well as the content and focus of discussions.

4.2.5 Evaluation

16. Evaluate the outcomes of PGCS using tangible and measurable means, while acknowledging that indirect benefits to organisations and patients are difficult to measure and may be best ascertained through qualitative research.

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Appendices

Appendix 1	Membership of the PGCS Steering Group 2018-2020
Appendix 2	PGCS Framework: Principles and Implementation Process
Appendix 3	Qualitative Study – Summary of Findings

Appendix 1

Membership of the PGCS Steering Group 2018-2020

Dr James O'Mahony	Lecturer, School of Nursing and Midwifery, University College Cork; PGCS Steering Group Chair
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Anne Walsh	Director, Nursing and Midwifery Planning and Development Unit HSE South (Cork and Kerry)
Olive Long	Director of Midwifery, Cork University Maternity Hospital, Cork
Bernie O'Sullivan	Director of Nursing, Cope Foundation, Cork (Retired from Steering Group in May 2019)
Anna Broderick	Director of Nursing, Cope Foundation, Cork (Replacing Bernie O'Sullivan from June 2019)
Patricia Moloney	Director of Nursing, Mallow General Hospital, Cork
Ann Moran	Nurse Practice Development Co-ordinator, Cork University Hospital, Cork
Sinead Boyce	Registered Advanced Nurse Practitioner, (Psychotherapy), Cork Kerry Adult Mental Health Services
Marianne O'Connor	Assistant Director of Nursing, South Infirmary Victoria University Hospital, Cork
Cathy O'Sullivan	Nurse Practice Development Co-ordinator, Kerry Mental Health Services, Kerry
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Sharon Walsh	Assistant Director of Nursing, Adult Mental Health Services, Cork
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Jennie Synnott	Interim Area Director of Nursing, Child and Adolescent Mental Health Services, Cork

Appendix 2

PGCS Framework: Principles and Implementation Process

Principle 1

Peer Group Clinical Supervision is available to all nurses and midwives to optimise patient care and outcomes

Health Professional	• Supervisees are responsible for, and committed to, participating in Peer Group Clinical Supervision and on-going professional development • Clinical Supervisors are committed to ensuring they facilitate effective Peer Group Clinical Supervision
Health Service	• The service provides access to Peer Group Clinical Supervision at a level appropriate to the supervisees experience and needs • Services provide a strong and measurable commitment to their staff accessing peer group Clinical Supervision

Principle 2:

Peer Group Clinical Supervision supports best practice and consistent delivery of patient care

Health Professional	• Health professionals involved in the process of Peer Group Clinical Supervision have a shared understanding of the purpose of Clinical Supervision and their roles and responsibilities • Supervisees and Clinical Supervisors are responsible for maintaining their own appropriate records of Peer Group Clinical Supervision sessions
Health Service	• Organisational processes and resources are in place outlining the purpose of Peer Group Clinical Supervision • Organisational governance arrangements are in place to support Peer Group Clinical Supervision

Principle 3

Peer Group Clinical Supervision is high quality and effective in addressing the needs of nurses and midwives

Health Professional	• Peer Group Clinical Supervisors access education and training addressing the core knowledge and skills required to facilitate effective Peer Group Clinical Supervision • Approaches to Peer Group Clinical Supervision are tailored to meet the needs of the supervisees
Health Service	• Peer Group Clinical Supervision education programme and policy are supervisee-centred and based on a shared understanding of expected Peer Group Clinical Supervision standards • Services support nurses and midwives to undertake training and encourage them to build on their skills of Peer Group Clinical Supervision facilitation

Principle 4

Peer Group Clinical Supervision contributes to continuous professional learning and practice improvement

Health Professional	• Peer Group Clinical Supervision is recognised as an essential component of the nurses and midwives' role and is incorporated into their professional development plan • Supervisees and Supervisor ensure a professional working agreement is in place and a working relationship is developed to promote a safe learning environment
Health Service	• Services support learning and development in a safe and supportive work environment • Structured, transparent processes are in place in relation to issues related to patient safety and risk identification and to inform appropriate service line manager

Principle 5

Peer Group Clinical Supervision supports high quality care through data collection and monitoring for continuous improvement

Health Professional	• Collecting and reviewing information from Peer Group Clinical Supervision is an essential component of nurses and midwives' role, to support reflection on their Clinical Supervision activity
Health Service	• Services collect data on the programmes of Peer Group Clinical Supervision for evaluation and benchmarking of outcomes

Implementation

It is the responsibility of the Director of Nursing/Midwifery to implement the Peer Group Clinical Supervision Framework at service level. It is recommended that information sessions on the Framework are provided to nurses and midwives prior to implementation.

Guideline for Implementation Process
Frequency: Peer Group Clinical Supervision should be provided monthly.
Duration: Peer Group Clinical Supervision sessions should be scheduled for one hour.
Participants: Peer Group Clinical Supervision groups should comprise of 4-6 staff of the same or similar grade.
Where: Peer Group Clinical Supervision should take place at a work-based location free from distraction or interruption. This is facilitated protected time within the working day.
Commitment: The process of supervision occurs within a trusting relationship established between supervisor and supervisees, all contribute to the relationship and have responsibilities within the supervision process.
Who supervises: Peer Group Clinical Supervision should be provided by a trained supervisor, with at least 5 years postgraduate clinical experience, who participates in their own regular supervision and is committed to continuous professional development.
Recording: Written records of Peer Group Clinical Supervision will be maintained by the supervisor. Records are kept in accordance with the HSE (2013) Record Retention Policy. Supervisees may also choose to keep their own records in the form of a reflective journal.
Boundaries: Both supervisor and supervisee are expected to adhere to the Peer Group Clinical Supervision agreement as agreed at the outset of supervision agreement.
Agreement: The Peer Group Clinical Supervision agreement should be discussed and agreed by both supervisor and supervisees at the first meeting. The agreement should be signed by all parties. The agreement is open to review by all parties as required.
Confidentiality: All professional and clinical issues discussed are confidential and are not for discussion outside of the Peer Group Clinical Supervision session. The exceptions to this will be outlined in the Peer Group Clinical Supervision Agreement and may include circumstances where matters disclosed are of such a nature that they require disclosure to a third party. **Challenge:** Supervisor and supervisees should be open to giving and receiving constructive feedback. **Review:** The Peer Group Clinical Supervision Agreement will be reviewed at least twice a year or more frequently if requested with the aim of ensuring a focus on purpose and direction of supervision.
Evaluation: Evaluation of the Peer Group Clinical Supervision process will take place annually at a minimum by services utilising an evaluation tool.

Appendix 3 Qualitative study – Summary of Findings

Themes, categories, and sub-categories from interviews with supervisees (n=18)

Themes	Categories	Sub-categories
PGCS benefits	Personal gains	• Becoming calmer at work • Decluttering desk and mind • Empowerment • Improved communication • Increased confidence • Increased self-awareness • Personal wellbeing • Protected space • Respect for others • Stress reduction • Support with personal problems • Time to reflect/mindfulness
	Sharing	• Clinical problems • Experiences • Information • Learning • Problems and problem-solving • Understanding • Workload
	Benefits for practice	• Connectivity, teamwork, and team building • Better staff management • Decide, prioritise, defer, delegate • Empower staff • Group cohesion • Improved productivity • Improved role clarity • Sense of unity • Managing change • Open discussions • Peer support and learning • Reduced isolation in role • Reflecting on practice
	Benefits for organisation	• Cohesion amongst staff • Collective voice to address organisational issues • Contagious calm • Encouraged by management to avail of PGS • Improved staff morale • Increased productivity • Less sick leave • No benefit to the organisation • Proactive rather than reactive approach

	Benefits to patients	• Staff wellbeing and stress reduction • Improved standard of care • More free time to spend with patients • More mindful and present with patients • Indirect benefits due to improved staff morale • Dealing with family members made easier
	Favourable supervisor characteristics	• Calm, empathetic, positive supervisor • Experienced facilitator using own experience • External facilitator was beneficial • Facilitator gave advice • Facilitator gave everyone time to talk individually • Facilitator is open to questions • Found answers to problems themselves • Inclusive environment • Independent facilitator • Kept participants on track • Structured facilitator • Trusted facilitator
Challenges experienced during PGCS	Initial uncertainties and concerns	• Evolving process/time needed to adjust • Initial apprehension • Initial concerns about confidentiality • Initial uncertainty and suspicion • Lack of clarity about membership rules
	Competing responsibilities	• Work awaiting after PGCS • Workload not being covered • Hard to prioritise PGCS over work • Hard to organise PGCS • Time away from work • Travel to attend PGCS
	PGCS process and flow	• Ensuring that everyone gets to speak • Keeping conversations focused • Hard to discuss positives/focusing on negatives • Gaps between sessions disrupting flow • Changes in group membership was problematic • Not enough time given for PGCS/ 1 hour not enough
	Completion of PGCS	• Inability to maintain protected time post PGCS • Sense of loss • Fear of PGCS becoming diluted with time
	Line managers' understanding of PGCS	• Lack of understanding of the importance of PGCS • Forcing one participant into PGCS

Recommendations for the future of PGCS	Wider reach	• Involve other groups (staff nurses/midwives and other disciplines) • Ensuring 'buy-in' • Mix staff from different areas
	Supervisor characteristics	• Facilitator to take active role (e.g. offer feedback) • Need for 'strong' facilitators • Careful selection of those being trained to facilitate PGCS • Recommend external facilitator
	Work arrangements	• Overlap shifts to free up staff to attend • Protected time • Cover for workload while absent • PGCS to be made available in more sites to reduce travel time
	Duration of PGCS	• Reduce PGCS to 30 minutes • Recommend more time/ PGCS sessions • Recommend 6 months and not 12 months
	PGCS content and logistics	• Clarity around rules relating to group membership • Include mindfulness/meditation • Increase understanding of PGCS • Keep group size small (as is) • Sessions need to be more regular

Themes, categories, and sub-categories from interviews with line managers (n=5)

Themes	Categories	Sub-categories
PGCS benefits	Benefits for staff	• Increased staff confidence • Particular benefits for lone workers • Improved staff morale • A safe place to share concerns • Shared decision-making • Shared problem-solving
	Organisational benefits	• Indirect benefits due to improved staff morale • Improved working environments • Increased productivity • Senior staff leading by example • Long-term rather than short-term benefits
	Benefits for patients	• Indirect benefits due to improved staff confidence and morale • Long-term rather than short-term benefits
Challenges experienced during PGCS	Secrecy	• Lack of awareness about what was involved in the PGCS sessions
	Staffing levels	• Difficulties releasing staff from their clinical roles • Difficulties arranging staff cover • Lack of resources • Lack of protected time for CS • Difficulties scheduling staff time off
	Space	• Difficulties booking regular venues • Other things taking precedence
	Staff turnover	• Transient staff • Training staff up on CS and then they leave the job • Difficult to keep it up and offer CS for all new staff
	Managing discussions	• Difficulties managing the content of CS discussions • Unrealistic staff expectations
	Selecting appropriate groups	• Difficulties ensuring the right mix of people in the groups • Ensuring confidentiality • Staff not wanting to participate in the CS process with their own colleagues
Recommendations for the future of PGCS	Outcomes	• More tangible, measurable outcomes required
	Logistics	• More consideration given to the logistical issues, including space and location of CS sessions • Should be continued
	Work arrangements	• Consideration given to staff scheduling, and the difficulties in releasing staff from clinical duties when there is no cover • Staff participate on their day off

Themes, categories, and sub-categories from interviews with supervisors (n=4)

Themes	Categories	Sub-categories
PGCS benefits	Positive experiences	• PGCS an interesting experience for supervisors • Senior supervisees better able to benefit from sessions owing to reduced clinical pressures • Location (place of work) facilitator • Sense that people benefitted from process • Prior acquaintance within group a facilitator to trust/ group dynamics • Current intervention a positive start for a basic level
Challenges experienced during PGCS	Awareness and understanding of PGCS	• Name 'Clinical Supervision' problematic • Supervisees being swapped in/out by line managers who thought this appropriate • Understanding amongst supervisees of the model of Clinical Supervision limited prior to attendance • Understanding of PGCS limited amongst senior colleagues, those assisting with the delivery of the interventions (e.g. Nurse Managers)
	Time required to optimise the intervention	• Took time to settle in • Time for group members to become acquainted • Time to acclimate after start/before end of sessions • Time of group was shortened by clinical needs • Rushing to and from PGCS could leave supervisees potentially psychologically 'vulnerable'
	Organisational factors	• Noticeable issue with group supervisees being asked/ told to attend • Supervisees not receiving assistance with their clinical workload before being released from clinical work • Work location not ideal (only 1 Supervisor said this)
	Impact on the supervisor	• Sense that only 'superficial' psychological work/ processes occurred • Costs relating to travel, parking etc • Time away from their own work • Additional time taken on this evaluation • Challenge to convert group thinking from negative to solution-focused approaches
Clinical Supervision framework	Neutral	• Useful as a sensitising influenced • Psychological process as evolving one, not to be directed by a framework
	Negative aspects	• Supervisors rather to be less prescriptive in practice • Prefer to practice as they are trained, be more integrative • Preferred to be led by the group requirements/dynamics
	PGCS organisation	• Greater consideration for protected time for supervisees • Break needed in the 12-month delivery (break in summer) • Additional time would be ideal, e.g. 75 minutes

Recommendations	PGCS awareness	• Needs to be a more accepting culture amongst managers • More groundwork should be undertaken to ensure everyone is primed pre PGCS • Supervisees should be there in a voluntary capacity only • Training/workshops for HSE managers on PGCS • Suggestion that managers also could attend to become aware • Importance of an objective, impartial (external/ non HSE) facilitator • Time to meet facilitator in person beforehand • Diversify the groups to contain staff of different levels • Concerns about future provision of this model, if not delivered by trained counsellors/therapists

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University College Cork, November 2020

Working together in a focused, supportive reflexive environment to enhance lifelong professional learning

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Foreword

The publication of this *Report on the Evaluation of the Implementation of Peer Group Clinical Supervision for Nurses in the HSE South (Cork and Kerry*) represents an important milestone in the professional and personal development of nurses and midwives in clinical practice. This report provides robust evidence on the positive impact of Clinical Supervision on the nurses and midwives who attended Peer Group Clinical Supervision (PGCS) and adds to existing evidence that supports Clinical Supervision as a means of peer support for all nurses and midwives. The report also highlights the logistical challenges associated with its implementation; however, it is evident that the perceived benefits for nurses who attended the PGCS sessions far outweigh these challenges.

In collaboration with Directors of Nursing, Directors of Midwifery and Area Directors Mental Health Services, the Nursing and Midwifery Planning and Development Unit (NMPDU) HSE South, Cork & Kerry recognised the potential for Clinical Supervision to support and develop nurses and midwives in clinical practice. The NMPDU convened a steering group of representatives from nursing and midwifery services, advanced practice, Centres of Nursing and Midwifery Education (CNME), Office of the Nursing and Midwifery Services Directorate (ONMSD) and Higher Education Institutions (HEI) to oversee the development, implementation and evaluation of the PGCS Pilot Project 2018-2019.

The publication of this report will act as a guide to inform future implementation of PGCS and the NMPDU's intention and commitment to progress the implementation and sustainability of PGCS into the future.

The World Health Organization has designated 2020 the International Year of the Nurse and Midwife and the year has proved to be an unprecedented challenge for all nurses and midwives due to the global pandemic. Nurses and midwives' resilience has been tested to extraordinary levels and nurses and midwives have, as always, responded in an expert and professional manner. The need for supported reflection and problem solving has never been more significant and it is hoped that the PGCS framework will be utilised in services and organisations for staff, organisational and ultimately patient/service user benefits.

I would like to express my sincere thanks to the Steering Group members and to acknowledge their support, expertise, and dedication throughout the project. I would also like to thank the Directors of Nursing, Directors of Midwifery and Area Directors Mental Health Services who commissioned this work.

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List of Abbreviations

ADoN/M	Assistant Directors of Nursing/Midwifery
CN/MM	Clinical Nurse/Midwife Managers
CNME	Centre for Nursing and Midwifery Education
DoN/M	Director of Nursing/Midwifery
HEI	Higher Education Institute
HSE	Health Service Executive
M	Line Managers
MCSS-26 ©	Manchester Clinical Supervision Scale ©
N	Nurse Supervisees
NMBI	Nursing and Midwifery Board of Ireland
NMPDU	Nursing and Midwifery Planning and Development Unit
ONMSD	Office of the Nursing and Midwifery Services Directorate
PGCS	Peer Group Clinical Supervision
S	Supervisors
SD	Standard Deviation
SOF	Survey of Organisational Functioning

Executive Summary

Peer Group Clinical Supervision (PGCS) is a form of Clinical Supervision whereby two or more practitioners engage in a supervision or consultation process to improve their professional practice. It is a process of supporting healthcare professionals to develop their practice through regular discussion with experienced and knowledgeable colleagues. In response to the increasing demands for quality and safe healthcare outcomes, the Nursing and Midwifery Planning and Development Unit (NMPDU) for Cork and Kerry recognised the potential for Clinical Supervision to support nurses in clinical practice. In September 2018, the NMPDU embarked on a pilot project to evaluate the effectiveness of a supervisor-led PGCS programme, a form of group Clinical Supervision, for nurses in the region.

The overall aim of this commissioned report is to report the findings of a mixed-methods research evaluation of PGCS for nurses in Cork and Kerry. There is limited empirical evidence regarding the impact of PGCS on nurses and midwives (Borders, 2012) and as such, two studies (one qualitative and one quantitative) were designed to measure specific outcomes, including nurse supervisees' overall experiences of participating in PGCS, as well as differences in their understanding of Clinical Supervision and their perceptions of organisational functioning before and after engaging in PGCS. The perceptions of clinical supervisors and senior line managers and their experiences of the PGCS process were also captured through the qualitative arm of the research[1].

The NMPDU supports nurses and midwives in Ireland to undertake post-registration education and ensure continuing professional development. In response to requests from services, the NMPDU recognised the potential for Clinical Supervision to support nurses in clinical practice. The NMPDU convened a steering group (Appendix 1) of representatives from nursing and midwifery services, advanced practice, CNMEs, ONMSD and HEI to oversee the development and implementation of this project.

PGCS was offered to all nursing and midwifery services in Cork and Kerry and 10 groups of staff across 9 sites agreed to participate in this pilot project. Monthly one-hour PGCS sessions were facilitated between September 2018 and August 2019. Each PGCS group comprised of four to six nurses. Protected time within the working day was allocated for most PGCS sessions which were held in private and quiet venues. PGCS discussions revolved around: (1) enhancing the quality of work practices; (2) exploring decision-making processes and their impact on patients; (3) seeking and receiving information; (4) expressing and exploring issues arising through work practices; (5) being challenged in a supportive manner; and (6) receiving support and feedback.

Each peer group consisted of staff of the same or similar grade, with four to six participants in each group. In total, 57 nurses, across the nine sites, commenced the PGCS project. Prior to the commencement of the project, nurse supervisees were informed verbally that the outcomes of the project were being evaluated using research methods. They were informed that they were not obliged to partake in either of the research studies and that this would not affect their participation in the PGCS sessions.

The qualitative study utilised focus groups and individual interviews. All PGCS session supervisees, as well as supervisees' line managers and the supervisors who facilitated the PGCS sessions, were eligible to participate, with separate focus group/individual interviews held for each of these three groups. There was a total of 27 participants in this study (18 PGCS nurse supervisees, five line managers, and four clinical supervisors).

The quantitative study used a pre-post design and all nurse supervisees who attended the PGCS sessions were eligible to participate by completing two questionnaires – the first prior to the commencement of the first PGCS session and the second following the completion of the final PGCS session (12 months later). A total of 51 supervisees participated in the quantitative study.

[1] The term, 'nurse supervisees', is used throughout this report to describe nurses who availed of PGCS. 'Line managers' were those who supported supervisees in availing of PGCS, and 'supervisors' were those who facilitated the PGCS sessions.

The perceived benefits of PGCS, challenges faced, and recommendations for future PGCS programmes were explored with the three groups of participants (supervisees, managers and supervisors). Overall, there were multiple perceived benefits for staff that attended the sessions, including increase in confidence, improvements in morale, reduction in stress, and overall feelings of empowerment. The PGCS sessions represented a 'safe place' that facilitated shared decision-making and problem-solving, where supervisees could share and learn from each other. There were particular benefits for lone workers.

For the organisations and patients, the perceived benefits were indirect and considered to be long-term rather than short-term. They included improved staff productivity and more calming working environments, which were mainly attributed to improved staff morale. Overall, supervisees felt that they were able to be more mindful and present with patients and their families following participation in PGCS.

Overall, there were multiple perceived benefits for staff that attended the sessions, including increases in confidence, improvements in morale, reductions in stress, and overall feelings of empowerment.

The main challenges associated with the PGCS sessions centred on staffing, specifically difficulties releasing staff from their clinical roles to attend the sessions, and the lack of cover for the sessions. The issue of time was frequently raised, with some supervisees and their managers describing difficulties finding protected time to attend the sessions. This was a particular issue for supervisees who were not based at the sites where the sessions took place, who had to factor in travel time, as well as the session time. Other challenges included difficulties managing workloads and prioritising PGCS sessions over competing demands, booking venues, difficulties ensuring good group dynamics and supervisees' initial worries about confidentiality being maintained within the PGCS groups.

The main challenges associated with the PGCS sessions centred on staffing, specifically difficulties releasing staff from their clinical roles to attend the sessions, and the lack of cover for the sessions. The issue of time was frequently raised.

Managers agreed that the issue of protected time and cover must be considered, with some suggesting that staff participate in the sessions on their day off unless additional resources were made available to assist them with arranging staff cover. Managers also felt that more tangible outcomes should be measured, and that more consideration should be given to the benefits that PGCS offers organisations and service users. The feasibility of this will be discussed in Section 4.

Findings of the quantitative study supported those of the qualitative study, with overall scores on the Manchester Clinical Supervision Scale indicating efficacious Clinical Supervision provision. Overall, PGCS was rated highly by supervisees, with higher than average scores on all items of the scale. However, finding time to attend PGCS sessions was highlighted as an issue. Regarding supervisees' perceptions of organisational functioning, as measured by the Survey of Organisational Functioning, changes between pre- and post- responses for matched questionnaires revealed a significant increase in adaptability but a decrease in cohesion, as well as non-significant increases to communication and growth, and a decrease to stress between the two data time points.

The recommendations in this report are primarily based on the findings of the qualitative and quantitative studies, while also drawing upon existing literature. They are presented under five categories: (1) Awareness; (2) Staffing and Scheduling; (3) Clinical Supervisors; (4) Supervisees; (5) Evaluation.

Recommendations

Awareness

1. PGCS should be embedded into the culture of the organisation and its benefits in terms of stress reduction, calmer working environments, staff morale and staff retention should be made explicit.
2. Promote and increase awareness of PGCS among nursing and midwifery staff at all levels and grades. Provide clarity around the meaning of 'Clinical Supervision' and promote its direct benefits for staff, and indirect benefits for organisations and patients.
3. Education is needed for senior nurse managers, such as Directors of Nursing and Midwifery and Assistant Directors of Nursing and Midwifery, on the nature, format, and benefits of PGCS. Consideration should be given to providing this education online, for example through the Health Service Executive's HSELanD, acknowledging that a similar programme already exists entitled Professional Supervision for Health and Social Care Professionals.

Staffing and Scheduling

4. Staff should have protected time to attend PGCS sessions. Provision to cover staff workload and responsibilities is needed while they attend the PGCS sessions in line with local service provision.
5. Carefully consider the location of PGCS sessions to reduce travel time, particularly for those that work in the community. Consider rotating venues for community-based staff. Consideration should be given to finding a suitable online platform for PGCS session.
6. Consider the length of PGCS sessions and allocate time in each session for supervisees to settle in, become acquainted, and acclimatise to the group. It may be appropriate to increase each session from 60 to 75 minutes.

Clinical Supervisors

7. Supervisors must take a lead role in the PGCS groups, clearly articulating boundaries and group rules. In the first session, supervisors need to reiterate the purpose of PGCS and clarify any misconceptions about the process.
8. For this pilot project, supervisors had qualifications in counselling and Clinical Supervision. However, for the sustainability of PGCS and to facilitate its availability to all nursing and midwifery staff, there is a need to build internal capacity and train clinical supervisors.
9. When building internal capacity, it is recommended that this is delivered through the Centres of Nurse Education, using an adapted version of the national programme designed for mental health nurses.
10. Supervisors should be trained and guided in the use of a Clinical Supervision Framework. Proctor's (2008) Model is recommended by The Office of the Nursing and Midwifery Services Directorate (ONMSD) due to its applicability to nursing and midwifery practice.
11. It is strongly recommended that Clinical Supervision is provided by internally trained clinical supervisors to ensure sustainability.

Supervisees

12. Supervisees should participate in PGCS on a voluntary basis only and should not be mandated by line management.

13. Staff from all levels and grades should be offered the opportunity to participate in PGCS. However, in line with the ethos of PGCS, groups should consist of peers that work at the same (level) grade as each other.

14. Group sizes should be kept small (4-6 supervisees per group).

15. Before the commencement of PGCS sessions, there is a need to ensure supervisees are clear on the expectations of the group, including maintaining confidentiality, one of the most important considerations, as well as the content and focus of discussions.

Evaluation

16. Evaluate the outcomes of PGCS using tangible and measurable means, while acknowledging that indirect benefits to organisations and patients are difficult to measure and may be best ascertained through qualitative research.

Section 1 Introduction

1.1 Background to This Project

The NMPDU for Cork and Kerry Supports nursing and midwifery services to provide a safe, quality service that improves patient care in line with local service needs and national HSE policy. In response to the increasing demands for quality and safe healthcare outcomes, the NMPDU recognised the potential for Clinical Supervision to support nurses in clinical practice. As such, in September 2018, the NMPDU embarked on a 12-month pilot project to implement and evaluate PGCS for nurses in Cork and Kerry. This project was informed by the implementation of a similar project in HSE Dublin North-East in 2017.

The NMPDU supports nurses and midwives in Ireland to undertake post-registration education and ensure continuing professional development. In response to requests from services, the NMPDU recognised the potential for Clinical Supervision to support nurses in clinical practice. The NMPDU convened a steering group of representatives from nursing and midwifery services, advanced practice, CNMEs, ONMSD, and HEI to oversee the development and implementation of this project.

1.2 Clinical Supervision

In recent years, Clinical Supervision has become widely acknowledged as a beneficial aspect of modern, effective health care delivery. Both internationally and across health disciplines, it is accepted that Clinical Supervision has two main aims; (1) to foster supervisees' professional development and competence, and (2) to ensure client welfare through monitoring the quality of professional service (Bernard & Goodyear, 2014). It is a process of professional support and learning in which nurses and midwives are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues (Fowler, 2011). Butterworth and Faugier (1997) describe Clinical Supervision as a major force in improving clinical standards and enhancing the quality of care. Supervision promotes personal and professional development through fostering a supportive relationship and working alliance and is increasingly being recommended as a means of supporting professional practice.

Clinical Supervision is a process of professional support and learning in which nurses and midwives are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues (Fowler 2011).

Within contemporary literature, there is limited evidence regarding the direct benefits of practitioner supervision for service users (Bradshaw et al., 2007; Callahan et al., 2009; Milne et al., 2008; Rousmaniere et al., 2016). However, there is evidence that practitioners experience many professional benefits from attending supervision, including improved practice knowledge and skill, enhanced self-efficacy and self-awareness, and strengthened relationships with service users (Watkins, 2011; Wheeler & Richards, 2007). Clinical Supervision fits well within the clinical governance framework, and there is potential for it to contribute to the development of a more articulate and skilled workforce, which in turn can contribute positively to organisational objectives.

Effective Clinical Supervision is believed to have a key role in enabling health professionals working across different disciplines including nursing and midwifery, to practice effectively and independently in a complex health system, ultimately enhancing the safety and quality of patient care. At its best, Clinical Supervision can be fundamental in safeguarding standards, developing professional expertise, and improving the delivery of quality care. This is evident throughout the National Supervision Guidance document, which was published by the HSE in 2015 (HSE, 2015). This guidance document supports the process of Clinical Supervision to strengthen the quality of care and staff engagement, with the goal of improving and maintaining safe, quality,

effective and efficient care for services users (HSE, 2015). Outlined in this document is the Irish public health service policy objective that: "all health and social care professionals should participate in regular, high quality, consistent and effective supervision" (HSE, 2015; p.5).

1.2.1 Definitions of Clinical Supervision

There are a variety of definitions of Clinical Supervision, all of which acknowledge the integral role Clinical Supervision plays in maintaining the safety and quality of patient care. The current project was guided by the following two definitions:

- Clinical Supervision is defined as a structured process for: "*regular, protected time for facilitated, in-depth reflection of clinical practice. It aims to enable the supervisee to achieve, sustain, and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part he/she plays as an individual in the complexities of the events and the quality of her* practice" (Bond & Holland, 2010; p.15).
- The Care Quality Commission states that "*The purpose of Clinical Supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice* (Care Quality Commission, 2013; p.4).

1.2.2 Models of Clinical Supervision

There are different models of Clinical Supervision, reflecting the different work context and the professional training needs and expectations of staff. There is no one model of Clinical Supervision that will suit all settings (Milne et al., 2008). In the Clinical Supervision Framework for Nurses working in Mental Health Services developed by the ONMSD in 2015, Proctor's (2008) Model was identified as the model of choice (ONMSD, 2015). Therefore, the current project was also guided by Proctor's (2008) Model of Supervision.

1.2.2.1 Proctor's Model of Supervision

This model outlines three functions of Clinical Supervision (Proctor, 2008):

1. Formative (educative/development of skills) function:

This function refers to the aspect of Clinical Supervision that relates to the professional development of the practitioner. The formative function of supervision outlines the developing of skills and understanding the abilities of the supervisee through an in-depth reflection of their work. This function supports experiential learning.

2. Restorative (supporting personal well-being) function:

This function refers to the development of a supportive relationship with the supervisor which in turn supports the practitioner in dealing with the emotional impact arising from practice. Within this supportive relationship, the practitioner should be able to share concerns and difficulties regarding their clinical nursing and midwifery practice.

3. Normative (managerial/organisational responsibility) function

The normative function highlights the importance of professional and organisational standards and the need for competence and accountability. It supports the practitioner to develop skills and competencies, allowing practice to be challenged in a safe environment. This function assists the practitioner to meet the clinical governance and risk management agenda.

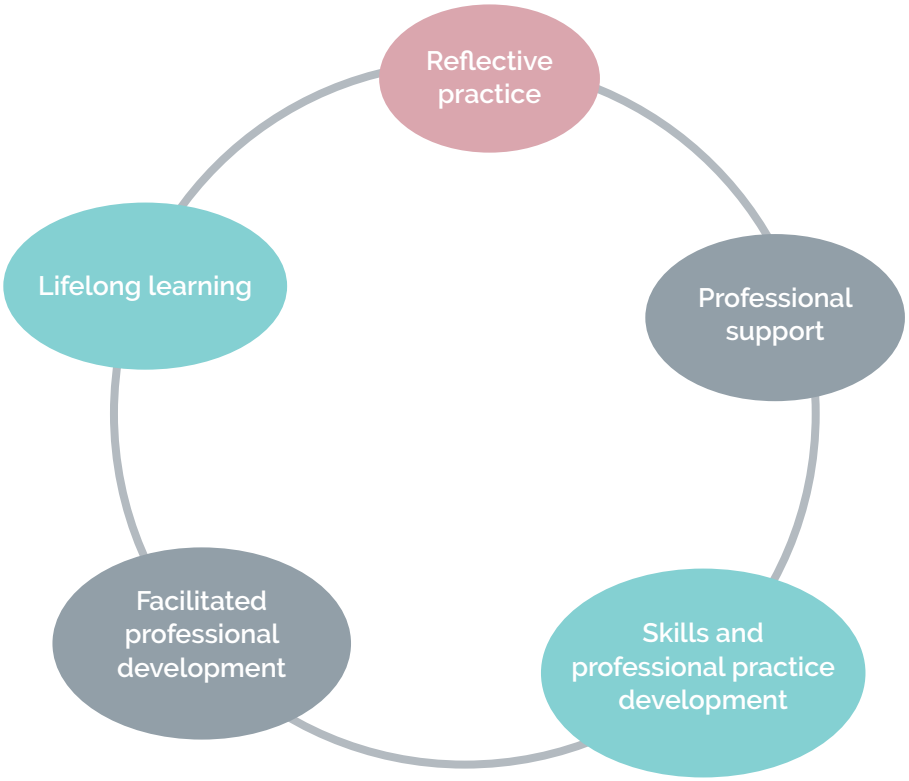
1.2.3 The Importance of Clinical Supervision

Clinical Supervision is an important process in supporting nurses and midwives within organisations with elements of clinical governance including:

- Quality improvement
- Risk identification and management
- Systems of accountability and responsibility

It provides a structured approach to deeper reflection on clinical practice which can lead to improvements in practice and service user care and contribute to clinical risk management (Royal College of Nursing, 2003). The core elements of clinical supervision identified by the NMPDU are outlined in **Figure 1.1.**

Figure 1.1 Core elements of Clinical Supervision (NMPDU 2018)



1.2.4 Peer Group Clinical Supervision

Clinical Supervision can be conducted in different formats such as one to one, with a team or within a group of peers. PGCS is a form of group supervision and is not usually led by a supervisor. However, for the purpose of this pilot project, it was agreed that developing supervisor led PGCS was the most appropriate structure within the HSE South, taking cognisance of the limited availability of experienced internal Clinical Supervisors. This decision was made by the PGCS Steering Group which included representation from the nursing and midwifery services within Cork and Kerry.

1.3 The Peer Group Clinical Supervision Framework

A framework for the delivery of PGCS was developed by the NMPDU, in conjunction with key stakeholders who formed a steering group in advance of the introduction of PGCS. This framework is underpinned by evidence that supports nurses and midwives in further developing their competence in clinical practice within their scope of practice as outlined by the Nursing and Midwifery Board of Ireland (NMBI, 2015).

The overarching aim of the PGCS framework was to provide guidance to nursing and midwifery services and inform the development of PGCS in the HSE South (Cork and Kerry) **(Appendix 2)**. This framework aimed to support staff to enhance and maintain the delivery of quality, safe patient care (NMPDU (Cork and Kerry), 2018). The goal of the PGCS framework is to optimise patient care and outcomes by enabling lifelong learning through reflection for nurses and midwives. The outcome of the framework is the contribution to improved patient care in line with national CS outcomes.

- Enabling the opportunity to gain information and insights and promote reflective practice.
- Encouraging professional and personal growth.
- Valuing and enabling the development of professional knowledge in practice.
- Supporting the development of clinical skills and professional practice in response to service user needs.
- Improving standards and the quality of nursing care.
- Supporting and empowering nurses to work effectively.
- Facilitating a process of support from the emotional and personal stress involved in nursing.

1.4 Implementation of This Project

1.4.1 Core Principles

During the implementation phase of this project, certain core principles were agreed upon. These principles are outlined in **Table 1.1.**

Table 1.1 Core principles of the current project

Frequency	PGCS should take place every month.
Duration	PGCS should take one hour. It should be facilitated by protected time within the working day.
Group size	PGCS groups comprise of 4-6 staff of the same or similar grade.
Venue	PGCS should take place at a work-based location free from distraction or interruption. Where this is not possible, consideration should be given to providing a quiet space which offers privacy and distance from the day to day activities.
Commitment	The process of supervision occurs within a trusting relationship established between supervisor and supervisees. All contribute to the relationship and have responsibilities within the supervision process. All supervisors will be required to attend for supervision of their PGCS work.

1.4.2 Content of Sessions

Clinical Supervision is provided to facilitate effective professional practice. Therefore, it was agreed from the outset that the content of PGCS sessions must centre on the work of individual members of staff.

A PGCS session should have elements that include:

- Monitoring and enhancing the quality of work practices
- Exploring decision making processes and their impact on patients
- Seeking and receiving information
- Expressing and exploring issues arising through work practices
- Being challenged in a supportive manner
- Receiving support and feedback
- Ensuring confidentiality is maintained at all times

1.4.3 Project Sites

For this pilot project, PGCS was offered to 10 groups of staff across 9 sites in Cork and Kerry, over a 12-month period. Each peer group consisted of staff of the same grade, with 4-6 participants in each group **(Table 1.2).**

Table 1.2 Description of the groups and supervisees

Service area	Groups (n=10)	Supervisees* (n=57)
Acute Care (General Nursing)	5	29
Intellectual Disability Nursing	2	12
Public Health Nursing	2	11
Mental Health Nursing	1	5

* 57 commenced the programme; 5 did not complete the full 12-month programme due to maternity leave and sick leave and one person joined a group after the project had commenced. Attendance rates at each of the PGCS sessions ranged from 50-87% at the various sites throughout the 12-month period.

1.4.4 Supervisors

Three external supervisors and one internal supervisor, all of which were psychotherapists and supervisors accredited by the Irish Association for Counselling and Psychotherapy, facilitated the PGCS groups. All supervisors had master's level qualification. Two of the external supervisors were retired nurses, the third external supervisor did not have a nursing background. The internal supervisor held a Clinical Nurse Specialist (CNS) position in the mental health services.

1.5 Evaluation of This Project

To evaluate the effectiveness of this pilot project, a mixed-methods study was commissioned by the NMPDU and undertaken by staff at the School of Nursing and Midwifery, University College Cork, following a tendering process. The findings are presented in sections 2 and 3 of this report.

1.5.1 Research Aim

To complete a mixed-methods research evaluation of PGCS for nurses in HSE South Cork and Kerry.

1.5.2 Research Objectives

1. To measure and examine differences in participants' understanding of Clinical Supervision before and after engaging in PGCS.
2. To measure and examine differences in participants' perceptions of organisational functioning before and after PGCS.
3. To explore nurses' overall experiences of participating in PGCS.
4. To explore clinical supervisors' experiences of delivering PGCS to nurses.
5. To explore senior managers perceptions of the benefits of PGCS for the supervisee and the organisation.

Section 2 Qualitative Evaluation

2.1 Aims and Objectives

This qualitative evaluation aimed to explore the experiences of PGCS in Cork and Kerry nursing services from the perspective of supervisees who availed of PGCS, line managers who supported supervisees in availing of PGCS, and supervisors who facilitated PGCS sessions. Data from each participant group are summarised in **Appendix 3.**

2.2 Methods

2.2.1 Design

This was a qualitative descriptive study, which aimed to explore the phenomenon of interest in its natural state without adhering to prior views of this phenomenon (Guba & Lincoln, 1994). Moreover, qualitative description helps researchers obtain candid and unadorned responses to questions that are of interest to researchers, practitioners, and policymakers (Sandelowski, 2000).

2.2.2 Participants

Non-probability purposive sampling was used to recruit a heterogenous sample of participants. Participants eligible for this study were: (i) supervisees who availed of PGCS, (ii) line managers who supported supervisees in availing of PGCS, and (iii) supervisors who facilitated PGCS sessions.

2.2.3 Data Collection

Ethical approval for this study was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals (Approval number ECM 4 (n) 13/08/19).

Participants were advised verbally prior to commencement of peer group Clinical Supervision, that the pilot project was being evaluated through research and that they had the right to refuse to partake in the research. They were also informed that their refusal to participate would in no way affect their participation in PGCS or their employment.

Participants were provided with a written information leaflet providing further details on the study and the nature of their potential participation. Prior to commencement of data collection, all participants were again provided with details of the research, including the written consent form**.** Consent forms were stored separately from data transcripts in a locked cabinet of the lead investigators office in UCC.

Data were kept confidential and identifiers were omitted at transcription. Electronic transcripts of the interviews were stored on the lead investigators password protected office computer at UCC and will be destroyed within the timeline indicated by the University (stored for a minimum of 10 years).

Data were collected between October and November 2019 using individual interviews and focus groups. The combination of individual interviews and focus groups is known to enrich qualitative data (Lambert & Loiselle, 2008). These approaches were also well suited for participants who had clinical commitments which meant they could not attend the set focus group dates.

All interviews were audio-recorded and transcribed verbatim by professional transcription services. Interviews were conducted by researchers who had no prior relationship with the participants. Participants were asked to provide written informed consent and to fill a brief socio-demographic questionnaire**.**

Focus groups revolved around participants' experiences of PGCS, particularly the perceived benefits of PGCS, the challenges experienced during PGCS, and recommendations for the future of PGCS.

2.2.4 Data Analysis

A combination of inductive and deductive content analyses was used in the present study (Elo & Kyngäs, 2008). First, data from each participant group (i.e. supervisees, line managers, and supervisors) were analysed separately. Transcripts were read and reread for content and direct quotes from participants were reduced to codes. Similar codes were gathered using a coding sheet and were collapsed into sub-categories which were later grouped under categories. Similar categories were then assigned to themes which were predetermined based on the focus group questions and the PGCS framework. Data source triangulation was later performed to explore convergence, complementarity, and dissonance between results (Carter et al., 2014).

2.3 Results

2.3.1 Sample Characteristics

There was a total of 27 participants in the qualitative study. Of those, eighteen were nurse supervisees (referred to as N in this section), five were line managers (referred to as M in this section), and four were supervisors (referred to as S in this section). All participants were female. For group N, years of experience ranged between 12 and 40 years (M=26.6, SD=8). All were from a nursing background with some holding dual qualifications, and the majority held a Clinical Nurse Manager 2 (CNM2) post (n=12). Years in current post ranged between 1 and 22 years (M=7.4, SD=7.1). Almost half of the supervisees were Higher/Postgraduate Diploma holders (n=8).

All line managers (n=5) were from a nursing background. The majority (n=3) were bachelor's degree holders and worked as Assistant Directors of Nursing (ADoNs). Line managers' years of experience ranged between 20 and 40 years (M=29, SD=6.4) and years in current post ranged from 2 to 10 years (M=7, SD=3.3).

All four supervisors were master's degree holders and had 13 to 39 years work experience (M=24.8, SD=9.3), they required a minimum of three years' experience as a clinical supervisor to be eligible to facilitate the PGCS sessions. The full sample characteristics are presented in **Table 2.1.**

Table 2.1 Characteristics of participants in the qualitative study (n=27)

Characteristics	Supervisees (n=18)	Managers (n=5)	Supervisors (n=4)
Gender			
Female	18	5	4
Years of experience			
Range	12-40	20-40	13-39
Mean(SD)	26.6(8)	29(6.4)	24.8(9.3)
Highest level of education			
Certificate	1	0	0
Diploma	2	0	0
Bachelor's	5	3	0
Postgraduate diploma	8	1	0
Master's	2	1	4
Professional background			
Nursing	16	4	
Nursing and Midwifery (dual)	2	1	
Current role			
Staff Nurse	3	0	
Clinical Nurse Manager 1	3	0	
Clinical Nurse Manager 2	12	0	
Clinical Nurse Manager 3	0	1	
Assistant Director of Nursing	0	3	
Director of Nursing	0	1	
Years in current role			
Range	1-22	2-10	
Mean(SD)	7.4(7.1)	7(3.3)	
Clinical area			
Acute Care (General Nursing)	12	3	
Public Health	3	2	
Intellectual Disability	3	0	

SD, standard deviation

Three themes were identified from the interviews: (1) PGCS benefits and gains (personal gains, direct benefits for practice, indirect benefits for patients and the organisation, and positive supervisor characteristics); (2) challenges to PGCS (lack of 'buy-in' and familiarity with the process, disruptions caused by workload and staffing, logistical challenges, and fear of losing momentum); and (3) enhancements for future PGCS (flexible work arrangements, content and logistical improvements, and enhancing awareness and reach).

2.3.2 Peer Group Clinical Supervision Benefits and Gains

PGCS was perceived as beneficial to self and practice and indirectly to the organisation and patients.

2.3.2.1 Personal gains

Overall, supervisees reported becoming calm; mindful; empowered; confident; better communicators; and more self-aware because of PGCS:

"…We had some brilliant brainwaves during it [PGCS] and one of the things we came up with is that we like declutter….so I decluttered my office because we'd have a load of…stuff…and I put up lovely pictures…even if I only get into my office for five minutes during the day, it's just a lovely calm peaceful place…" (N5-9).

Some supervisees recalled the role of PGCS in helping them become better communicators and reducing stress:

"It [PGCS] definitely cut down on the stress side of things and like we are stressed out all the time because you're trying to beat the clock all of the time from once you come in until you go home…we definitely have better communication skills as a result of what we learned" (N2-4).

All supervisors deemed PGCS to be a positive opportunity for supervisees to build their confidence in a *"very healthy"* and *"non-sterile environment"*:

"…People came and they offloaded what was happening currently in their day-to-day or in their week and it was like helping them to work through that…support and building up people with confidence in themselves and being able to manage and to take time to look at what's happening for themselves" (S1).

2.3.2.2 Direct benefits for practice

PGCS resulted in improvements in connectivity, through the enhancement of team cohesion and unity. Improvements were also noted in management duties, such as the ability to make decisions, promote change, and delegate tasks. Furthermore, participants reported that they felt empowered and less isolated in their roles. Lone workers reported that PGCS helped decrease feelings of isolation and improve their sense of unity:

"It [PGCS] united us very much…the isolation feeling went within our work. It gave us more backup…we were all working in isolation on our own and now it is a lot easier to pick up the phone and ring one another…towards the end, I felt we were all speaking from the one voice…you feel you're not on your own" (N2-4).

"…I'd bring it back to the lone worker because that is the biggest issue we would have, or our staff would have. I guess if they [supervisees] feel supported, then they're not as fearful going into the same scenario or going back into the same house…" (M2).

For supervisees, PGCS *"helped define roles and boundaries"* (N2-4) and enabled them to ***"see the wood from the trees…decide and prioritise and defer and delegate other duties and jobs that [they] necessarily don't have to be doing all the time" (N5-9).***

Increased *"sharing"* of experiences was frequently mentioned as a benefit from PGCS. This included sharing of information, learning, problem-solving, decision-making, understanding, and workload:

"If you have a problem, everyone else has the same type of problem, but some people would deal with it in different ways and learning how an approach that I might take to a problem, somebody else could take a totally different approach and if they're willing to share that with you…" (N1).

This was iterated by supervisors and line managers who believed that supervisees' ability to share and hear the experiences of others helped them realise that they were not alone in their struggles:

> ***"…If you know that everybody's feeling exactly the same at each shift, it's not just you, it sort of changes the dynamic" (M3-5).***

2.3.2.3 Indirect benefits for patients and the organisation

PGCS benefits for patients were perceived as indirect and long-term since patients would benefit from less stressed and more productive staff. Supervisees believed that ***"if you're feeling a bit better yourself, it's automatically going to help whoever you're looking after" (N1***). Similarly, line managers mentioned that ***"a satisfied nurse is a satisfied patient…" (M3-5).*** Furthermore, listening to peers during PGCS session enabled supervisees to ***"deal with family members and different family dynamics" (N13-16).***

While they perceived that PGCS was beneficial to patients, supervisees believed that the benefit ***"would be indirect, rather than direct because the service user will always get the best care anyway" (N17,18).*** Similarly, some managers did not see ***"anything tangible but expect it [PGCS] would have had a certain level of impact on clients" (M3-5).***

Participants noted improved staff morale, increased productivity, and becoming better role models for their colleagues. PGCS was also perceived by most supervisees to potentially reduce sick leave with many believing that the organisation would benefit from more confident, autonomous, and empowered staff:

> ***"Ultimately, the organisation benefits because they have more autonomous and more confident managers and maybe, like morale does get low and some days, you feel 'oh my God, this is so hard.' Whereas if you feel supported and if you know listen, we'll get through this. There are other people going through the same experiences. I think that the organisation will benefit in knowing that" (N17,18).***

Line managers perceived PGCS benefits to the organisation as ***"something that will be seen as has a benefit in time" (M1):***

> ***"I mean the CNMs [Clinical Nurse Managers] have reported to us that they felt it beneficial, they felt supported, they felt they had a forum where they could discuss amongst themselves" (M3-5).***

2.3.2.4 Positive supervisor characteristics

Supervisees spoke highly of supervisors and described them as calm, empathetic, and positive. It was also noted that the structured approach adopted by supervisors was beneficial in keeping supervisees on track. Because supervisors were nurturing and sensitive to individual needs, they were able to find answers to some of the problems that supervisees had faced:

> ***"We had a wonderful facilitator. She made life very easy for us and brought us along and we didn't even know we were being brought along…she was very experienced…she brought a lot of her own experience into the room in dealing with people…she gave everybody time…reached out to everybody every single day…and you could see she had such mighty skills. She really facilitated. She did her job" (N2-4).***

Of the four supervisors, three were from a nursing background; however, this was not perceived as a barrier by the supervisees:

> ***"We had trust in our facilitator…which I suppose put us at ease that we were able to speak freely. You see, the fact that she was a professional and outside of the hospital, we kind of trusted her not to be judging us or coming back with information. She had no reason to feed back to management…I still see the value of [us] meeting as a group, but [I] certainly think it wouldn't be as beneficial without the structure of the independent facilitator" (N5-9).***

Supervisees often referred to supervisors as ***"facilitators."*** In fact, the word 'supervision' caused confusion among supervisees and was not favoured by supervisors:

> ***"The word 'supervision.' It felt for me, my experience with the group was more like a support group…they found that [supervision] a little bit threatening…they felt was I kind of going to be looking at their practice" (S1).***

> ***"They [supervisees] think of performance management or something…they think, 'Oh God, I'm being supervised. I'm being watched here now'…I mean it's a nice term, but now when I heard it first, I really thought it would involve some formal supervision" (N1).***

2.3.3 Challenges to Peer Group Clinical Supervision

While experiences were predominantly positive, various challenges to PGCS were reported including lack of 'buy-in' and familiarity with the process; disruptions caused by workload and staffing; logistical challenges; and fear of losing momentum.

2.3.3.1 Lack of 'buy-in' and familiarity with the process

Unfamiliarity with PGCS resulted in initial apprehension and confidentiality concerns:

> ***"…I was afraid that we might be inhibited by each other and afraid to open up a bit maybe because of knowing people so well…I found it hard at the beginning to let my guard down…it took me a while to get comfortable, but once I did, I really did feel comfortable" (N17,18).***

Supervisees' lack of awareness of the purpose behind PGCS was also identified by supervisors as a challenge:

> ***"…They [supervisees] knew a little bit about supervision and had been given information about supervision, but that was very basic…some of them didn't really have any understanding, a deep understanding of supervision" (S1).***

Line managers felt that their role was only to facilitate their nurses to attend PGCS. One manager stated knowing ***"nothing about the Clinical Supervision process. [she] just facilitated it" and believed that "there was a huge secrecy" (M1). Other line managers referred to PGCS as a "secret society" (M3-5)***. One line manager added:

> ***"I didn't know what happened in the meetings, but I did get informal feedback that two of the nurses arriving out of this meeting, they seemed to use it as a place to air their concerns…now, that would be enough for me to stop supervision forever" (M2).***

Line managers' suspicions were felt by several supervisees who were expecting more ***"buy-in" (N1)*** from their line managers:

> ***"There's probably been a little bit of suspicion because we've been a little bit organised for our management meetings, I do think that there probably has been a little bit of suspicion from [line managers], 'What are you up to?' or 'What are you at?'" (N5-9)***.

2.3.3.2 Disruptions caused by workload and staffing

Despite having a protected hour for most PGCS sessions, supervisees found it hard to find cover to attend PGCS, with balancing competing demands causing difficulty and having to ***"pick up the pieces" (N10-12)*** after PGCS sessions:

> ***"Compliance was difficult because of the demands of [the] job and even though [the group] had it 'diaried'…life and work would clash, even with the diary sometimes…I think it is hard to kind of come down***

from the hype of running, running, running and suddenly being expected to stop and you know there's 22 jobs waiting for you when you go out in an hour or whatever" (N1).

Prioritising work over PGCS was also a challenge for nurses whose role was ***"unpredictable"*** (N13-16). Similarly, line managers reported difficulties supporting nurses to attend PGCS sessions due to lack resources:

"I've very transient staff, so then to be training them all up on supervision…and then they're gone… that is very challenging…I had one group. I couldn't facilitate a second group…because I don't have the resources to free them up. I would certainly not run it during summer holidays…there was one meeting I couldn't support the staff. I had no one for protected time because everyone was on annual leave…" (M2).

Supervisors believed that supervisees were ***"pulled by management…pulled by staff…pulled by patients" (S2)*** and that ***"staff weren't always replaced when they were coming off a ward and that put them under pressure…"*** (S3,4). Despite agreeing to have an extra member join the group beforehand, supervisees also shared an example of a participant who joined one of the groups at a late stage, which caused disruptions within their group:

"There was a change in our group…one person left and that took us a while then to kind of get back into that…so, we didn't know that it would have to go through a system basically for another person to join or it would have to go through…she was kind of put in the role. I could see that she was kind of told she had to do it…" (N13-16).

2.3.3.3 Logistical challenges

The logistics of running PGCS sessions in terms of process, location, and duration were challenging to participants. One supervisee stated that at times, one person was ***"stronger and talking more,"*** and that ***"some people were quieter than other personalities" (N1).*** Others found it hard to keep conversations focused and to focus on the positives rather than the negatives.

PGCS duration, the time it took supervisees to ***"settle,"*** and travel to and from PGCS session were identified as major challenges:

"[PGCS] was a bit too short…you'd be rushing so much to get there, sometimes it would take a little while to ground yourself…" (N2-4).

"[We] were really getting to the root of the problem, the hour was up…the time went really fast" (N5-9).

Supervisees who worked in rural areas and the community had to factor in travel time:

"Within the geographical [location], that it actually takes more than the hour. You know, it takes us three hours really by the time we're altogether and that…over the road and if you were behind a low loader [big truck] or something like that, you were going to be late" (N2-4).

Time constraints were also identified as stressors by line managers and supervisors:

"…If you think six people in a group is six hours, but it's more than six hours actually because it's six direct hours of supervision, but they have to get to the place and get back, so it's probably more like 12 hours…" (M2).

"They [supervisees] had to come straight back out of it [PGCS] and go back onto the ward…so there wasn't a lot of time to integrate and put them together again…it was really, really challenging for the facilitator to manage that…it's like if there was a feeling of being catapulted in to do something and then leave and then it would take me about half an hour afterwards to de stress myself" (S2).

Some line managers struggled to ensure the right mix of people in PGCS groups, with some supervisees refusing to participate in PGCS due to ***"concerns about confidentiality" (M3-5).*** One line manager said that she would be ***"very careful as to the type of people [she would] put in the room" (M1).***

In terms of PGCS delivery, supervisors were either neutral or shared negative feedback regarding the PGCS Framework. One supervisor described the framework as ***"good…basic enough for the level we're at" (S1)***. Others argued that their supervision work was not solely led by the framework and at times the work was guided by the need of the group in a given session. Supervisors preferred to be led by ***"whatever came up at the time or whatever shape things went into in the actual group" (S3,4).***

2.3.3.4 Fear of losing momentum

For some supervisees, completing PGCS triggered a sense of loss and a fear that the impact of PGCS becomes ***"diluted"*** with time and wished that PGCS was ***"a little bit longer":***

> ***"…I think there was a willingness from our line manager, but it's just staffing issues, the practicalities…we do understand that practically, it is difficult for them, but at the same time, it's very important for us too…I don't know if our manager has ever done Clinical Supervision, so she may not realise the support that it is" (N2-4).***

> ***"We would like to continue it [PGCS] and now we're trying to do it ourselves, but if it isn't made available to us, I think it will be a shame and I think it'll be a huge loss…fear going forward to maintain that structure and that commitment to it [PGCS]…afraid that it [impact of PGCS] would be diluted" (N5-9)***.

2.3.4 Enhancements for Future Peer Group Clinician Supervision

Overall, participants suggested that PGCS continues, with some stating that PGCS ought to ***"be seen as a core part of everybody's job because it is the ultimate experience" (N2-4).*** Participants stressed the importance of flexible work arrangements to accommodate PGCS, improving PGCS content and logistics, and enhancing PGCS awareness and reach.

2.3.4.1 Flexible work arrangements

Overlapping shifts, protected time, staff cover, and supervision on days off were some of the recommendations made to overcome workplace challenges:

> ***"Put outside people's duty time or extra time that they were paid to come in…get people to come in an hour earlier. I know it is extra duty and give it back to them another time, but I suppose all departments are kind of just short-staffed even as is…or if people had half-days, that hour, that it was either given back or paid extra at another time…It's just even if somebody could take over while you're away from your desk…but sometimes they can't because you're the only one…" (N10-12).***

All line managers felt strongly that further consideration should be given to scheduling. One line manager suggested that staff ***"could try and schedule where possible to do this [PGCS] on their day off" (M1).*** She added:

> ***"…I think people have to take ownership for themselves when they sign up to these courses [PGCS] to say that ok, well, you will be expected to commit to an hour a month for the next 12 months. Are you willing to sort out your rota to make sure that you're actually on a day off as opposed to a day on? Because it is becoming increasingly more difficult to facilitate releasing people off the floor" (M1).***

2.3.4.2 Content and logistical improvements

These related to the location, duration, delivery, and content of future PGCS sessions. To reduce travel time, participants recommended making PGCS available in ***"more localised areas" (N1)*** and suggested that PGCS for frontline workers should be ***"done much closer to people's worksites" (N17,18)***. Some recommended reducing the duration of PGCS to *"only 30 minutes"* (N1) and to take a break over the summer, while the majority believed that ***"an hour is very short"*** and that ***"an hour and a half would actually have been a better timeframe…" (N5-9)***. This was reiterated by one supervisor:

> ***"I don't know if they'd [supervisees] get off for an hour and a half. I think being there for an hour, but perhaps maybe an hour and 15 minutes. If you could have 15 minutes for people coming and going so that you'd actually have an hour session" (S1).***

Supervisees recommended that ***"it was important that the sessions went regularly" (N13-16)*** and, to keep momentum, they suggested ***"monthly follow-up sessions" (N17,18).*** In terms of content and delivery, participants recommended a ***"little bit of mindfulness or meditation" (N10-12).*** Smaller groups were also favoured ***"because it kept [them] focused and it gave everybody a chance to participate…" (N5-9)***. Supervisees recommended that funders should be ***"a bit selective, who they train up to become facilitators" (N1)*** with a preference for ***"having an outside facilitator" (N5-9).*** This was also favoured by one external supervisor who believed that an ***"external supervisor, not an internal one, is far superior" (S2).*** She added:

> ***"…They [supervisees] wouldn't be able to trust somebody from inside…because they're all connected…everybody's connected and knows everybody's business…they could really trust the confidentiality and my objectivity from the offsite and they found that hugely beneficial, that I wasn't caught up in the workplace small politics" (S2).***

2.3.4.3 Enhancing awareness and reach of PGCS

Supervisors stressed the importance of creating a *"culture that supervision is really beneficial and important"* (S2) and believed that PGCS awareness and preparation were needed beforehand. This was iterated by supervisees:

> ***"Looking at buy-in before from people that might be willing…before you start anything in here, the first thing I'd do is call a meeting of all the people that it would involve, particularly all the nursing and care staff, whoever, the managers or whoever, and just get people's views on it and see how they feel about it" (N1).***

Supervisors also highlighted the importance of staff attending only when they choose to, and not being mandated by line managers. They also suggested that supervisees' expectations from PGCS should be explored and that supervisees ought to meet their supervisors beforehand:

> ***"The space needed a bit more preparation…maybe one of the ways is to have an open workshop on supervision…explaining to people what it's all about and then after that, let them opt into it if that's something they feel they'd be interested in…where people are informed about what they're coming to, and that would ensure then that when you started the group, that everyone in the group was on the same page in terms of what their expectations might be" (S3,4).***

Supervisors believed that support from line managers was vital, with one supervisor suggesting that *"a maintenance agreement for the staff doing the work"* (S2). Another potential means of optimising this was to include line managers in PGCS groups:

> ***"…It would be also beneficial then if this was a project for CNM2s [Clinical Nurse Manager 2] and CNM1s, that CNM3s and teams got the benefit of supervision. You would see it trickling down much better…said all the different layers, you know, all the different levels of management do it…I think that will create a culture of change" (S2).***

To counteract the potentially negative connotation of *"supervision,"* supervisors suggested that the title of the programme be re-considered to include *"peer support."*

Most supervisees held managerial positions. They recommended involving staff nurses, midwives, and other disciplines in PGCS:

"Maybe if there was kind of a mixed group…like say someone from different hospitals because we found that sometimes the same issues were coming up month on month. And I wonder if it was a different mix from different hospitals and that, would it be more beneficial because we just felt oh, here we go again the same thing, the same person, the same issues being brought up…I would think that would be more beneficial if they were from other areas besides our own as well because like you say, we have the same issues here with the same people…It'd probably be of bigger benefit really to people, to staff nurses, I would presume, nearly even just because their issues might be more patient-focused" (N10-12).

Similarly, the mixing of junior and senior staff to enhance group learning and support was recommended by supervisors:

"What I've learned from just my group was that a good mix of staff, a lot of learning goes on…. So, maybe let them have the same type of experience, but to vary it. Junior staff learn a lot from more senior staff and vice versa. There's new learning as well… different backgrounds, different years of experience…" (S3,4)

Section 3 Quantitative Evaluation

3.1 Aims and Objectives

The overall aim of this study was to evaluate the pilot implementation of PGCS for nurses in Cork and Kerry services. The specific objectives were to:

1. Measure and examine differences in supervisees' understanding of Clinical Supervision before and after engaging in PGCS.
2. Measure and examine differences in supervisees' perceptions of organisational functioning before and after engaging in PGCS.

3.2 Methodology

3.2.1 Design

A pre-post study design was used. A pre-post study measures the occurrence of an outcome before and after some type of intervention is implemented (Thiese, 2014). In this case, the intervention in question was participation in the PGCS sessions, and the various outcomes related to supervisees' perspectives of the effectiveness of PGCS.

3.2.2 Participants

All nurse supervisees who attended the PGCS sessions were eligible to participate in this study. This did not include line managers and supervisors who facilitated PGCS sessions.

3.2.3 Procedures

Prior to the commencement of the PGCS pilot project, supervisees were informed verbally that the outcomes of the project were being evaluated using research methods. They were informed that they were not obliged to partake in the research study and that this would not affect their participation in the PGCS sessions. All supervisees were provided with a written information leaflet that provided further details of the study. Participation in the research study involved completing a questionnaire before the commencement of the PGCS project (pre-test) and after completing the project (post-test).

Once consent was obtained, the project lead distributed the questionnaires to supervisees who agreed to participate in the research study. Data were kept confidential, and no identifying information appeared on the questionnaires. In order to ensure anonymity but to enable pre-test and post-test data to be matched, participants were asked to complete a unique code using the first letter of their mother's and father's names and the last 3 digits of their mobile number. They were advised of their right to withdraw from the study. This specifically related to them consenting to participate in the study and completing the pre-test questionnaire but not being obliged to complete the post-test questionnaire 12 months later. They were also advised that because questionnaires were anonymous (i.e. no names just code number entered), it would be very difficult to remove their questionnaire data once it had been submitted to the research team.

3.2.4 Ethics

Ethical approval was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals (Reference Number: ECM 4 (m) 03/07/18).

3.2.5 Data Collection

The questionnaires were purposefully designed. The pre-Clinical Supervision questionnaire included a number of demographic questions, including supervisees' sex; age; level of education; current role; current area of practice; length of experience in nursing/midwifery; length of time in current role; and whether or not they had prior experience of Clinical Supervision. Supervisees' understanding of Clinical Supervision was measured using four open-ended questions, and their perceptions of how their organisation functions were measured using selected items from a standardised tool, the Survey of Organisational Functioning (SOF) (Texas Christian University Institute of Behavioural Research, 2008). Nineteen sub-scales, comprising a total of 107 items, from the SOF were included in the pre- and post- questionnaire packages **(Table 3.1).**

Table 3.1 The Survey of Organisational Functioning - Description of sub-scales

Sub-scale	Number of items	Interpretation
1. Program Needs	8	Two measures of 'Motivation for Change'
2. Pressures for Change	7	
3. Staffing	6	Four measures of 'Resources'
4. Training	4	
5. Computer Access	7	
6. e-Communications	4	
7. Growth	5	Four measures of 'Staff Attributes'
8. Efficacy	5	
9. Influence	6	
10. Adaptability	4	
11. Mission	5	Six measures of 'Organisational Climate'
12. Cohesion	6	
13. Autonomy	5	
14. Communication	5	
15. Stress	4	
16. Change	5	
17. Burnout	6	Three measures of 'Job Attitudes'
18. Satisfaction	6	
19. Director Leadership	9	

The post-Clinical Supervision questionnaire collected data on supervisees' perceptions of the benefits and facilitators of Clinical Supervision using three open-ended questions. Their perceptions of organisational functioning were measured again using the SOF, and their overall experiences of participating in the PGCS pilot project were measured using the 26-item version of the Manchester Clinical Supervision Scale © (MCSS-26©) (Winstanley & White, 2011). The MCSS-26© is a validated measure of the effectiveness of Clinical Supervision, and contains 6 sub-scales with a total of 26 items **(Table 3.2).**[2]

[2] The MCSS-26© was not developed as a 'pre-post' research instrument and is only suitable for use after a respondent has gone through the clinical supervision process (White & Winstanley 2019). Therefore, the MCSS-26© items were included in the post-clinical supervision questionnaire package only.

Table 3.2 The 26-item Manchester Clinical Supervision Scale - Description of Sub-Scales (White & Winstanley, 2019)

Sub-scale	Number of items	Interpretation	Range of raw scores
Importance/ Value of Clinical Supervision	5	A measure of the importance of receiving CS and whether the CS process is valued or necessary to improve quality of care	0-20
Finding Time	4	A measure of the time available for the supervisee to attend CS sessions	0-16
Trust/Rapport	5	A measure of the level of the trust/rapport with the supervisor during the CS sessions	0-20
Supervisor Advice/ Support	5	A measure of the extent to which the supervisee feels supported by the supervisor and a measure of the level of advice and guidance received	0-20
Improved Care/ Skills	4	A measure of the extent to which the supervisee feels that CS has affected their delivery of care and improvement in skills	0-16
Reflection	3	A measure of how supported the supervisee feels with reflecting on complex clinical experiences	1-12

3.2.6 Data Analysis

All statistical analyses were performed using SPSS version 26. Age was categorised (21-30; 31-40; 41-50; 51-60; >60 years). For analysis, the length of time in the current job was dichotomised as follows: ≤5 years; >5 years.

3.2.6.1 The Survey of Organisational Functioning (SOF)

Scores were reversed for 12 items, and total scores for each sub-scale were calculated by adding together the scores for each set of items, dividing the sum by the number of items included, and multiplying by 10 in order to rescale the final scores. As a result, total scores for each sub-scale ranged from 10 to 50. To test for differences between pre- and post- survey responses, paired samples t-tests were performed. Independent samples t-tests were performed to test for differences between the responses of participants that had been in their current role for >5 years and those that had been in their current role for ≤5 years.

3.2.6.2 The 26-item Manchester Clinical Supervision Scale (MCSS-26 ©)

Scores were reversed for 9 items, and total scores for each sub-scale were calculated by adding together the scores for each item. As a result, the range of raw scores for each sub-scale differed **(Table 3.2).** The raw scores were converted to percentages by dividing the raw scores by the maximum values and multiplying by 100. Descriptive statistics were used to summarise both, the raw scores and the percentage values for each sub-scale.

3.3 Results

3.3.1 Sample Characteristics

A total of 51 supervisees agreed to participate in the quantitative study and completed pre-test questionnaires **(Table 3.3).** The majority (n=48; 94%) were female and aged between 31 and 60 years (n=47; 92%). Most had a bachelor's degree (or equivalent) or a master's level qualification in nursing (n=36; 71%), and almost all had more than 5 years of nursing and/or midwifery experience. At the time of attending the PGCS sessions, most supervisees were working in a clinical nurse/midwife manager role (n=42; 82%). Over one-half were working in general acute nursing settings (n=26; 51%), and 49% (n=25) of participants had been in their current role for more than 5 years.

Table 3.3 Sample characteristics (n=51)

Characteristics	n	(%)
Sex		
Female	48	(94.1)
Male	3	(5.9)
Age		
21-30 years	3	(5.9)
31-40 years	16	(31.3)
41-50 years	17	(33.3)
51-60 years	14	(27.4)
>60 years	1	(2)
Level of education		
Apprenticeship nurse training	7	(13.7)
Diploma in nursing/midwifery	8	(15.7)
Degree or equivalent	31	(59.6)
Masters	5	(9.8)
Experience in nursing		
4-5 years	1	(2)
Over 5 years	50	(98)
Current role		
Staff nurse/midwife	4	(7.8)
Clinical nurse/midwife manager	42	(82.3)
Clinical nurse/midwife specialist	4	(7.8)
Advanced nurse/midwife practitioner	1	(2)
Current area of practice		
General acute nursing	26	(51.0)
General community nursing	10	(19.6)
Midwifery	1	(2)
Mental health nursing	5	(9.8)
Intellectual disability nursing	9	(17.6)
Length of time in current job		
Under 6 months	4	(7.8)
6-11 months	6	(11.8)
1-3 years	13	(25.5)
4-5 years	3	(5.9)
Over 5 years	25	(49)

Note: 51 supervisees completed a pre-test questionnaire, and a total of 47 supervisees completed a post-test questionnaire. However, only 36 pre-post questionnaires could be matched. Therefore, data from only 36 supervisees was used in the pre and post analysis. Data from 47 supervisees were used in the analysis that required post-questionnaire data only (MCSS-26©). As a result, the collected data is presented under three headings: pre-PGCS; pre- and post- PGCS; post-PGCS.

3.3.2 Pre-Peer Group Clinical Supervision Data

3.3.2.1 Understanwding of, and reasons for engagement with, Clinical Supervision prior to participating in the project

Four open-ended questions that were included in the pre-Clinical Supervision questionnaire captured data on supervisees' understanding and reasons for participating in Clinical Supervision prior to involvement in the PGCS project. As 51 supervisees completed this part of the questionnaire, which was not being matched with post-test data, all responses are reflected in the analysis.

Understanding of Clinical Supervision

Almost all participants (n=49, 98%) understood Clinical Supervision as one or more of the following: a means of giving support to colleagues; a means of getting support from colleagues; a means of reflecting on their practice; sharing learning through discussion of issues; or developing professional knowledge.

Reasons for participating in peer group Clinical Supervision

A number of participants (n=13, 26%) identified isolation in their role/area of work or being new to a team/ new to a role as a reason for participating in peer group Clinical Supervision. Others (n=29, 58%) reported the sharing of information, development of practice, learning from and liaising with others and reducing stress as their reason for participating in peer group Clinical Supervision. Eight participants reported being involved because their line manager selected them, or they wanted to help others or to get 'time off the floor' (n=8, 16%).

Concerns about participating in peer group Clinical Supervision

Over half of participants (n=26, 52%) reported that they had no concerns about taking part in group Clinical Supervision. For other participants, two major concerns were reported: maintaining confidentiality (n=9, 18%) and not having the time to commit to supervision (n=9, 18%). Participants who expressed concerns about confidentiality were worried that they would feel *"judged by fellow group members"*. Concerns about time were related to the apprehension about not being able to commit to supervision, but some participants viewed supervision as an addition to their workload: *"Current workload very demanding, having anything extra to do on top of this may add extra stress."*

Hopes for what will result from participating in peer group Clinical Supervision

The main expectation held by participants was that engagement in Clinical Supervision would help to improve their practice (n=35, 70%). One participant commented that through developing *"better self and professional awareness,"* they could become "*a better manager and caregiver.*" Other participants (n=15, 30%) sought support from their peers, highlighting the importance of *"greater bonding and understanding, ability to support and be supported."* Four participants (8%) voiced concerns about occupational stress and hoped that Clinical Supervision would result in experiencing *"less stress"* at work. A small number of participants (n=3, 6%) felt their role was ill-defined, or that they felt invalidated in their role; one participant hoped that engagement in Clinical Supervision would result in "*greater understanding of [their] role.*" One participant expressed that they had no expectations for the process, and that they were only engaging in Clinical Supervision in order *"to appease management."*

3.3.3 Pre- and Post-Peer Group Clinical Supervision Data (Survey of Organisational Functioning)

3.3.3.1 Staff perceptions of organisational functioning

Staff perceptions of organisational functioning were measured pre- and post- participation in the Peer Group Clinical Supervision pilot project using nineteen sub-scales of the SOF. A total of 36 supervisees completed both pre- and post- questionnaires that could be matched, and their data were used in this analysis.

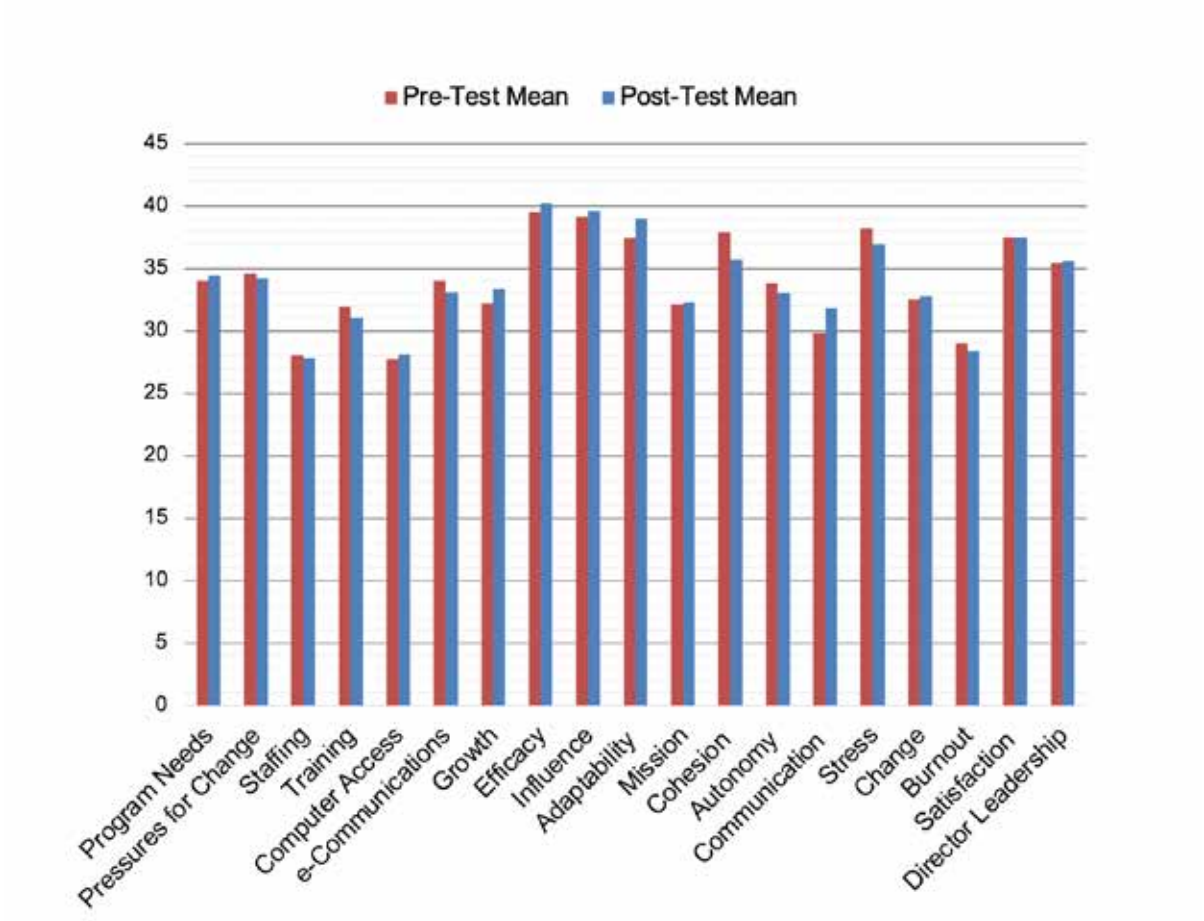
Due to the relatively small sample size, there were very few changes that reached statistical significance. Changes between pre- and post- responses for matched questionnaires revealed a significant increase in adaptability (mean difference 1.6) but a decrease in cohesion (mean difference -2.3). Non-significant increases to communication (mean difference 2.1) and growth (mean difference 1.1) and a decrease to stress (mean difference -1.3) were also seen between the two data time points **(Table 3.4** and **Figure 3.1).**

Table 3.4 Survey of Organisational Functioning - Differences in Responses Pre- and Post - Participation in PGCS

Item name	No. paired responses	Pre-survey mean (SD)		Post-survey mean (SD)		Mean difference	Significance	
							t	*p*
Motivation for change								
1. Programme Needs	30	34	(7.9)	34.4	(7.8)	0.4	0.289	0.774
2. Pressures for Change	30	34.6	(5.8)	34.2	(6.6)	-0.4	-0.302	0.765
Resources								
3. Staffing	35	28.0	(7.5)	27.8	(7.0)	-0.2	-0.210	0.835
4. Training	34	31.9	(9.4)	31.0	(8.5)	-0.9	-0.653	0.518
5. Computer Access	34	27.7	(5.4)	28.1	(5.6)	0.4	0.441	0.662
6. e-Communications	34	34.0	(9.4)	33.1	(7.7)	-0.9	-0.816	0.420
Staff attributes								
7. Growth	34	32.2	(9.8)	33.3	(8.4)	1.1	0.984	0.332
8. Efficacy	35	39.5	(4.9)	40.2	(4.9)	0.7	0.887	0.381
9. Influence	33	39.1	(5.8)	39.6	(5.2)	0.5	0.665	0.511
10. Adaptability	34	37.4	(5.7)	39.0	(5.2)	1.6	2.069	0.046 *
Organisational climate								
11. Mission	33	32.1	(6.9)	32.3	(6.8)	0.2	0.237	0.811
12. Cohesion	33	37.9	(7.1)	35.7	(7.5)	-2.3	-2.148	0.039 *
13. Autonomy	32	33.8	(6.7)	33.0	(5.9)	-0.8	-0.791	0.435
14. Communication	34	29.8	(7.4)	31.8	(7.4)	2.1	1.856	0.072
15. Stress	34	38.2	(8.3)	36.9	(8.5)	-1.3	-1.116	0.272
16. Change	34	32.5	(7.5)	32.8	(6.3)	0.3	0.421	0.676
Job attitudes								
17. Burnout	33	29.0	(7.7)	28.4	(7.2)	-0.6	-0.744	0.462
18. Satisfaction	34	37.5	(6.9)	37.5	(6.5)	0	0	1.0
19. Director Leadership	35	35.4	(10.9)	35.6	(9.8)	0.2	0.105	0.917

SD, standard deviation.
t-statistic and p-value from paired sample t-tests. *p<0.05: statistically significant

Figure 3.1 Pre-Post Responses to the Survey of Organisational Functioning



Differences in staff perceptions of organisational functioning based on the length of time in their current role

Due to the relatively small sample size, differences in the mean scores of supervisees that had been in their current role for more than 5 years and those that had been in their current role for 5 years or less did not reach statistical significance **(Table 3.5).**

However, there were some notable differences between the two groups of supervisees, with mean differences of at least 1 point on the following items:

- **Computer access:** Supervisees that had been in their current role for 5 years or less were less likely to have reported an increase in 'computer access' in their post-Clinical Supervision questionnaire (mean difference of -0.3 compared to 0.9).
- **Efficacy:** Supervisees that had been in their current role for 5 years or less were more likely to have reported an increase in 'efficacy' in their post-Clinical Supervision questionnaire (mean difference of 1.8 compared to -0.2).
- **Influence:** Supervisees that had been in their current role for 5 years or less were more likely to have reported an increase in 'Influence' in their post-Clinical Supervision questionnaire (mean difference of 1.4 compared to -0.2).

- **Cohesion:** Supervisees that had been in their current role for 5 years or less were more likely to have reported a reduction in 'cohesion' in their post-Clinical Supervision questionnaire (mean difference of -3.5 compared to -1.1).
- **Stress:** Supervisees that had been in their current role for 5 years or less were more likely to have reported a reduction in 'stress' in their post-Clinical Supervision questionnaire (mean difference of -3.5 compared to 0.4).
- **Change:** Supervisees that had been in their current role for 5 years or less were more likely to have reported an increase in 'change' in their post-Clinical Supervision questionnaire (mean difference of 1.1 compared to -0.2)
- **Burnout:** Supervisees that had been in their current role for 5 years or less were less likely to have reported a decrease in 'burnout' in their post-Clinical Supervision questionnaire (mean difference of 0.6 compared to -1.7).
- **Satisfaction:** Supervisees that had been in their current role for 5 years or less were less likely to have reported an increase in 'satisfaction' in their post-Clinical Supervision questionnaire (mean difference of -0.7 compared to 0.5).

Table 3.5 Survey of Organisational Functioning - mean differences between pre- and post-questionnaire scores. Comparing supervisees that had been in their current role for 5 years or more to those that had been in their current role for less than five years.

Item	≤5 years in current role	> 5 years in current role	Significance
	Mean difference between pre- and post- scores	Mean difference between pre- and post-scores	*p*-value
Motivation for change			
1. Programme Needs	0.4	0.5	0.985
2. Pressures for Change	0.7	-1.4	0.416
Resources			
3. Staffing	-0.7	0.3	0.594
4. Training	-0.5	-1.2	0.806
5. Computer Access	**-0.3**	**0.9**	**0.464**
6. e-Communications	-1.3	-0.5	0.717
Staff attributes			
7. Growth	0.9	1.2	0.919
8. Efficacy	**1.8**	**-0.2**	**0.211**
9. Influence	**1.4**	**-0.2**	**0.304**
10. Adaptability	1.8	1.4	0.811
Organisational climate			
11. Mission	-0.6	1.1	0.419
12. Cohesion	**-3.5**	**-1.1**	**0.251**
13. Autonomy	-0.9	-0.7	0.914
14. Communication	2.4	1.8	0.789
15. Stress	**-3.5**	**0.4**	**0.104**
16. Change	**1.1**	**-0.2**	**0.458**
Job attitudes			
17. Burnout	**0.6**	**-1.7**	**0.215**
18. Satisfaction	**-0.7**	**0.5**	**0.534**
19. Director Leadership	-0.3	0.6	0.761

p-value from independent samples t-test.

3.3.4 Post - Peer Group Clinical Supervision Data

3.3.4.1 Perceptions of Clinical Supervision after participating in the project

Three open-ended questions that were included in the post-Clinical Supervision questionnaire captured data on supervisees' perceptions of Clinical Supervision after participating in the PGCS project. A total of 47 supervisees provided responses to these three questions, and their responses are summarised below.

3.3.4.2 What Clinical Supervision means to supervisees

After participating in the project, all supervisees reported Clinical Supervision sessions to represent a space to meet with their colleagues and peers in order to engage in discussion and reflect on any issues and concerns that they may have in their workplace settings. Many saw it as a *"safe place,"* and as an opportunity to learn from their colleagues' experiences while also sharing their own experiences. Importantly, it was considered to be a confidential space. It was also seen as a space to reflect on one's own practice. Keywords that frequently arose in supervisees' responses to this question were: *"support"* (n=15; 32%); *"reflect"* (n=11; 23%); *"sharing"* (n=8; 17%); *"learning"* (n=7; 15%); *"safe"* (n=7; 15%); and *"confidential"* (n=6; 13%).

3.3.4.3 Benefits of peer group Clinical Supervision

The main perceived benefit of Clinical Supervision was that it offered staff dedicated and protected time to share their clinical experiences, problems, and vulnerabilities with colleagues, to talk things through, and to problem-solve. In particular, participants valued the opportunity to work as a group to solve problems, rather than in isolation. For many, participation in Clinical Supervision lessened feelings of isolation, and seven supervisees (15%) commented that it made them realise that that they were often not alone in their experiences and that everyone is *"in the same boat."* Three participants commented specifically that participation made them better understand the limitations of their role.

PGCS also offered supervisees the opportunity to get to know colleagues and peers, including those that may work in different departments, with one attendee commenting that Clinical Supervision "*allowed me to get to know and spend time with my peers…gave deeper understanding of our colleagues pressures and stresses"* and another stating that it helped in *"developing a good working relationship with colleagues from different departments within the hospital."*

3.3.4.4 Factors that facilitated and inhibited participation in Peer Group Clinical Supervision

The word *"time"* appeared in 20 (43%) of the responses to the question about factors that facilitated and inhibited participation in Clinical Supervision. The provision of protected time and an acceptance of this by line managers was identified as one of the most important facilitators of attendance at Clinical Supervision sessions. However, the time required to travel to and from the sessions was an issue for those that worked outside of the settings in which the sessions took place was an issue and a factor that made participation in the sessions difficult for some supervisees. Other factors that were perceived to inhibit participation were heavy workloads and competing demands, and difficulties *"coming off the floor,"* with one attendee commenting that there are *"plenty of jobs to be done instead."* Having an experienced facilitator was mentioned by 10 supervisees (21%) as being an important factor in the success of the sessions, with a number specifically recommending that if possible, the facilitator should have a non-nursing background. Other factors that were perceived to facilitate participation in the sessions were having rooms booked and dates planned out well in advance and having small group sizes.

3.3.4.5 Supervisees' perceptions of the effectiveness of Clinical Supervision

The MCSS-26 © was used as a measure of the effectiveness of the Peer Group Clinical Supervision pilot project. These data were collected in the post-Clinical Supervision questionnaire which was completed by a total of 47 supervisees.

Overall, the total mean score on the MCSS-26 © for all supervisees was 79.8 out of 103 which was well above the overall score of 73.0 which the developers identified as being the indicative threshold for efficacious Clinical Supervision provision **(Table 3.6).**

Overall, Clinical Supervision was rated highly by supervisees, with the item labelled 'importance/value of Clinical Supervision' obtaining a mean score of 16.9 out of 20. Supervisees reported high levels of trust/ rapport with their supervisors during the Clinical Supervision sessions (16.1 out of 20), and the mean scores indicated that in general, they felt supported and were satisfied with the advice and guidance received from their Clinical Supervision supervisors (14.9 out of 20). In addition, supervisees' responses indicated that they felt that Clinical Supervision has improved their skills (12.9 out of 16) and supported them in reflecting on complex clinical experiences (10.5 out of 12) **(Table 3.6).** For all these items, the mean scores obtained in this sample were higher than the MCSS-26© benchmark data **(Table 3.7).**

The item labelled 'Finding Time' obtained the lowest mean score (9 out of 16). This item is a measure of the time available for the supervisee to attend Clinical Supervision sessions and highlights how participants may have sometimes struggled to find the time to prioritise attendance at Clinical Supervision over their clinical roles.

Table 3.6 Manchester Clinical Supervision Scale - Raw Scores

MCSS© 26 factor	Number of valid responses	(Minimum, Maximum)	Mean	Standard Deviation (SD)
Importance/ value of Clinical Supervision	44	(10, 20)	16.9	2.8
Finding time	43	(0, 16)	9.0	3.9
Trust/Rapport	44	(9, 20)	16.1	2.9
Supervisor advice / support	45	(6, 20)	14.9	(3.4)
Improved care/skills	45	(4, 16)	12.9	(2.9)
Reflection	45	(6, 12)	10.5	(1.6)
Total score	**39**	**(48, 103)**	**79.8**	**(12.6)**

Table 3.7 Manchester Clinical Supervision Scale - Benchmarking the raw scores with the MCSS-26© User Manual Data

MCSS© 26 factor	Current Study Mean	Benchmark data from MCSS-26© User Manual Mean
Importance/ value of Clinical Supervision	16.9	15.8
Finding time	9	8.6
Trust/Rapport	16.1	15.7
Supervisor advice / support	14.9	14.1
Improved care/skills	12.9	12.2
Reflection	10.5	10

Section 4 Discussion and Recommendations

4.1 Discussion

Internationally, the benefits of Clinical Supervision for healthcare staff are being increasingly recognised, and include improved practice knowledge and skills, enhanced self-efficacy and self-awareness, and strengthened relationships with patients and service users (Cross et al., 2010; Watkins, 2011; Wheeler & Richards, 2007). However, there is some debate in the literature about what Clinical Supervision entails, the challenges that exist in measuring its effectiveness, and the difficulties that arise when attempting to implement it in practice (Dilworth et al., 2013).

While evidence exists to support the use of Clinical Supervision in nursing practice, there are limited studies of the effectiveness of PGCS. As such, the aim of this pilot study was to apply quantitative and qualitative research methodologies to evaluate the implementation of a PGCS programme for nurses in an Irish context. As recommendations emerge and guidelines are developed in order to make Clinical Supervision available to nurses and midwives working across the Irish health services, it is imperative to evaluate the impact of PGCS from multiple perspectives. In doing so, we can build an evidence base to inform future decisions around the implementation of Clinical Supervision in clinical practice in Ireland.

Overall findings from this research indicated that the three groups of participants (nurse supervisees, supervisors, and line managers) held positive views about the PGCS process, with the positive benefits for supervisees particularly evident. The process of PGCS helped supervisees reflect on their work, their professional role, and their interaction with colleagues. It also afforded a level of support for nurses who reported the need for PGCS such as lone workers. Similar gains from Clinical Supervision are well documented in the literature (Cutcliffe et al., 2018, O'Shea et al., 2019).

However, across the groups of participants, there were some challenges associated with PGCS, as well as some evidence of misunderstandings of what Clinical Supervision constituted, and some unrealistic expectations about what participating in PGCS could achieve. For example, there was strong consensus among all participants that the process of participating in PGCS had visible benefits for those staff members that attended the sessions but for line managers in particular, it was deemed important to be able to measure direct benefits to patients and organisations. This lack of obvious measurable benefits for organisations and patients is a common critique of Clinical Supervision (Dilworth et al., 2013). However, it is extremely difficult to identify and quantify such benefits as much longer follow-up periods (longer than 12 months, for example) would be required to allow supervisees the time to integrate any new skills or approaches to care gained from attending regular PGCS sessions. In addition, criticism of the lack of obvious benefits for patients and organisations are often secondary to unrealistic expectations and confusion around the role of Clinical Supervision (Dilworth et al., 2013).

A lack of time and competing demands are frequently noted in the literature to be barriers to the implementation of PGCS in clinical practice, and these were two frequently occurring themes in both the qualitative and quantitative studies outlined in this report. 'Finding time' was the lowest scoring item on the MCSS-26©, highlighting how participants sometimes struggled to find the time to prioritise attendance at Clinical Supervision over their clinical roles. In general, PGCS supervisees felt strongly that they should have protected time to attend PGCS during their working hours, whereas some line managers suggested that people should attend on their day off in order to overcome difficulties that they experienced in trying to arrange staff cover. Some of these conflicting perspectives may arise from a lack of awareness of the role and structure of PGCS. Dilworth et al. (2013) argue that an expectation for nurses to attend in their own time actually creates a "moral dilemma," and that support from line management, in terms of negotiating rosters and arranging cover, is necessary to allow dedicated time within work hours to avail of Clinical Supervision. If any PGCS programme

is to be successful, it is imperative that supervisees are granted sufficient protected time during their working day to participate. For nurses that work out in the community, the time required to travel to and from PGCS sessions should be considered. Organisations that agree to facilitating protected time for participating in PGCS need to ensure that it is honoured. In addition, it is important that the workload of supervisees does not simply accumulate while they are attending PGCS and individuals should not be penalised for attending sessions by having to 'make up for lost time.'

There were also differing opinions on timing and frequency of PGCS sessions. For example, some PGCS supervisees felt that they would have benefited from each session being longer than one hour, while others felt that sessions could have been of a shorter duration. Supervisors also expressed a view that sessions should be longer in length to allow supervisees to *"settle in."* While there is a scarcity of evidence regarding the ideal length and frequency of effective supervision (Rothwell et al., 2019), relevant guidance states that the length of group Clinical Supervision sessions should be 90 minutes (ONMSD, 2015). Furthermore, there is some evidence in the literature that in order to be most effective, Clinical Supervision should be held at least monthly and for at least one hour (Edwards et al., 2005).Our findings concur and suggest that adding time to the allocated hour may allow supervisees to reach PGCS venues on time, disengage from the therapeutic work, and focus on PGCS.

There were few significant changes between participants' responses to the SOF pre- and post- participation in PGCS. This may have been attributable to the relatively small sample size, or it may in fact reflect an inability of PGCS to change staff perceptions of many aspects of organisational functioning. Items of the SOF for which there was some evidence of positive changes between the two time points included adaptability, communication, growth, and stress, which was a positive finding and supported by many of the findings from the qualitative study. Of note, there was a significant decrease in mean scores for the item 'cohesion', which acts as a measure of participants' perceptions of how well staff get on, mutually respect each other, and work together as a team. Further exploration of this finding may be merited.

It was evident that supervisors were not explicitly using Proctor's (2008) Model as a framework to guide their PGCS sessions. This model is recommended by the Office of the Nursing and Midwifery Services Director (ONMSD, 2015; O'Shea et al., 2019). If PGCS is to become embedded into nursing and midwifery practice in Ireland, then it is imperative that a guiding framework is used to ensure consistency and build internal capacity within the organisation. As such, supervisors need to be provided with information on how to use this model in practice. Indeed, O'Shea et al (2019) highlight the need for clinical supervisors to be provided with training on theoretical models and how to implement them.

Difficulties implementing PGCS into routine clinical practice are well-documented in the research literature and are often related to staffing levels. This issue was consistently raised in studies outlined in this report (Rothwell et al., 2019). In order to address this issue, many of the logistical issues related to PGCS need to be resolved at a local level, and while all organisations should adhere to the PGCS framework and the recommendations, which are both outlined in this report, there will be times that local factors, such as local service provision needs, will need to be taken into account when attempting to implement a PGCS programme for nursing and midwifery staff. While taking cognisance of the findings, the longer-term aim of building internal capacity of internal supervisors within the organisation needs to be considered. These findings are echoed in an evidence review by Rothwell et al. (2019) who reported that having supervisors who are expert in the field adds to their credibility, while highlighting the detrimental effects of no or poor supervision.

Study findings highlight the central role of nursing management in PGCS, as evident from interviews with line managers who expressed their frustration from the perceived secrecy surrounding PGCS. Some line managers also expressed their lack of involvement in the PGCS process and the lack of measurable clinical outcomes as a result. Of note, the central component of Clinical Supervision is reflection on practice (National Council for the Professional Development of Nursing and Midwifery, 2008), which further stresses the need for *a priori* awareness of the nature, purpose, and expectations from PGCS.

Brunero and Lamont (2011) evaluated the implementation of Clinical Supervision in Australia and reported that senior nursing management was involved in planning and implementing PGCS from the outset; yet, a lack of support from senior nurses prevailed (Brunero & Lamont, 2011). Current study findings concur with this, highlighting the centrality of nursing management to future success of such initiatives. In mental health nursing, for example, nursing management is responsible for ensuring flexibility for staff to access Clinical Supervision (ONMSD, 2015). In doing so, an evidence base can be built to inform future decisions on the implementation of PGCS, including building internal capacity in practice.

When implemented appropriately, a programme of PGCS can provide a 'safe place' for nurses and midwives to engage in regular discussion with their colleagues and peers and represents one way of meeting their continuous professional development needs. The findings and recommendations of this report are in line with the National Guidance for Supervision for Health and Social Healthcare Professionals, published by the HSE (2015), as well as published guidance on Clinical Supervision for Nurses working in Mental Health Services (ONMSD, 2015; O'Shea et al., 2019), and provide an evidence base upon which the roll-out of PGCS to nurses and midwives nationally can be based.

Findings from the two studies outlined in this report add to the existing evidence that supports Clinical Supervision as a means of providing peer support and stress relief for nurses. This pilot study identified several challenges associated with implementing a programme of PGCS into clinical practice; however, it is evident that the perceived benefits for nurses who attended the PGCS sessions far outweigh these challenges. Many of the challenges stem from a lack of awareness and confusion about the role, structure, and function of PGCS and unrealistic expectations about its outcomes. These challenges can be overcome with appropriate awareness campaigns and training for nursing staff, line managers, and supervisors, as appropriate.

4.1.1 Limitations

There were some unavoidable limitations to this piece of research. Due to the nature of the recruitment methodology used and participants 'opting in' to participate in the interviews or focus groups and/or to complete the pre and post surveys, it is possible that there were systematic differences between participants and non-participants. For example, those who selected to participate in the research studies may have had more favourable views of the PGCS process in comparison to those that did not participate.

In order to keep participants' responses to the pre- and post-questionnaires anonymous, rather than including their names, participants were asked to enter a unique code at the start of each questionnaire which would enable their responses to the pre- and post-questionnaires to be matched. Unfortunately, it became apparent that some codes were entered incorrectly in the post-questionnaires, which meant that some participants' questionnaires could not be matched. This resulted in a total number of matched pre- and post-questionnaires that was lower than expected. Overall, larger sample sizes are favourable in quantitative research if statistically significant differences are to be observed. Due to the relatively small number of participants that completed matched questionnaires, very few differences that could be deemed statistically significant were observed. Regardless of this, the quantitative data collected gave us a good insight into the effectiveness of this PGCS pilot project and the data were supported by many of the qualitative findings. Of note, sample sizes as small as 20 participants are often considered as acceptable in pilot studies (Johanson & Brooks, 2010).

4.2 Recommendations

It is acknowledged that effective PGCS delivery is not without challenges. The space for PGCS needs to be primed and the provision of protected time is key to maximise the impact of PGCS. The fear of losing momentum and the worry that the positive impact of PGCS becomes diluted over time ought to be addressed between supervisees and line managers. For organisations as well as individuals to achieve benefits of PGCS, services need to commit to appropriate preparation in advance of participating in PGCS, this includes the training of internal supervisors to build capacity and ensure sustainability of PGCS in nursing and midwifery. Building internal capacity for PGCS is currently being progressed by the Centres of Nursing and Midwifery Education, who have developed a four-day NMBI accredited education programme, for delivery to eligible health service applicants. The development of internal supervisors is inherent to the fundamental cultural change required within the organisation to foster an understanding of and demand for PGCS and is vital for its ultimate sustainability.

A total of 16 recommendations to guide decisions around the future provision of PGCS for nurses and midwives in Ireland are presented here, under five headings: (1) Awareness; (2) Staffing and Scheduling; (3) Clinical Supervisors; (4) Supervisees; and (5) Evaluation. These recommendations have been informed by the findings of the qualitative and quantitative studies, which are outlined in Sections 2 and 3 of this report. Where there was evidence of differing perspectives and opinions on certain issues (e.g. the frequency and timing of PGCS sessions), the available literature was drawn upon to finalise the recommendation.

4.2.1 Awareness

1. PGCS should be embedded into the culture of the organisation and its benefits in terms of stress reduction, calmer working environments, staff morale and staff retention should be made explicit.
2. Promote and increase awareness of PGCS among nursing and midwifery staff at all levels and grades. Provide clarity around the meaning of 'Clinical Supervision' and promote its direct benefits for staff, and indirect benefits for organisations and patients.
3. Education is needed for senior nurse managers, such as Directors of Nursing and Midwifery and Assistant Directors of Nursing and Midwifery, on the nature, format, and benefits of PGCS. Consideration should be given to providing this education online, for example through the Health Service Executive's HSELanD, acknowledging that a similar programme already exists entitled Professional Supervision for Health and Social Care Professionals.

4.2.2 Staffing and Scheduling

4. Staff should have protected time to attend PGCS sessions. Provision to cover staff workload and responsibilities is needed while they attend the PGCS sessions in line with local service provision.
5. Carefully consider the location of PGCS sessions to reduce travel time, particularly for those that work in the community. Consider rotating venues for community-based staff. Consideration should be given to finding a suitable online platform for PGCS session.
6. Consider the length of PGCS sessions and allocate time in each session for supervisees to settle in, become acquainted, and acclimatise to the group. It may be appropriate to increase each session from 60 to 75 minutes.

4.2.3 Clinical Supervisors

7. Supervisors must take a lead role in the PGCS groups, clearly articulating boundaries and group rules. In the first session, supervisors need to reiterate the purpose of PGCS and clarify any misconceptions about the process.

8. For this pilot project, supervisors had qualifications in counselling and Clinical Supervision. However, for the sustainability of PGCS and to facilitate its availability to all nursing and midwifery staff, there is a need to build internal capacity and train clinical supervisors.

9. When building internal capacity, it is recommended that this is delivered through the Centres of Nurse Education, using an adapted version of the national programme designed for mental health nurses.

10. Supervisors should be trained and guided in the use of a Clinical Supervision Framework. Proctor's (2008) Model is recommended by The Office of the Nursing and Midwifery Services Directorate (ONMSD) due to its applicability to nursing and midwifery practice.

11. It is strongly recommended that Clinical Supervision is provided by internally trained clinical supervisors to ensure sustainability.

4.2.4 Supervisees

12. Supervisees should participate in PGCS on a voluntary basis only and should not be mandated by line management.

13. Staff from all levels and grades should be offered the opportunity to participate in PGCS. However, in line with the ethos of PGCS, groups should consist of peers that work at the same (level) grade as each other.

14. Group sizes should be kept small (4-6 supervisees per group).

15. Before the commencement of PGCS sessions, there is a need to ensure supervisees are clear on the expectations of the group, including maintaining confidentiality, one of the most important considerations, as well as the content and focus of discussions.

4.2.5 Evaluation

16. Evaluate the outcomes of PGCS using tangible and measurable means, while acknowledging that indirect benefits to organisations and patients are difficult to measure and may be best ascertained through qualitative research.

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Appendices

Appendix 1 Membership of the PGCS Steering Group 2018-2020

Appendix 2 PGCS Framework: Principles and Implementation Process

Appendix 3 Qualitative Study – Summary of Findings

Appendix 1

Membership of the PGCS Steering Group 2018-2020

Dr James O'Mahony	Lecturer, School of Nursing and Midwifery, University College Cork; PGCS Steering Group Chair
Kerry McAuliffe	Director of Nursing, University Hospital Kerry, Tralee, Co. Kerry; PGCS Steering Group Co-Chair
Carmel Buckley	Area Director, Nursing and Midwifery Planning and Development, HSE South, Office of the Nursing and Midwifery Services Directorate
Sinéad Connaire	Nursing and Midwifery Planning and Development Officer, PGCS Project Lead, Nursing and Midwifery Planning and Development Unit, Cork and Kerry, HSE South
Dr Aine Horgan	Senior Lecturer, School of Nursing and Midwifery, and ENGAGE Interdisciplinary Clinical Mental Health Research Network, University College Cork
Joanna McCarthy	Interim Director of Public Health Nursing, Public Health Nursing Services, West Cork
Anne Walsh	Director, Nursing and Midwifery Planning and Development Unit HSE South (Cork and Kerry)
Olive Long	Director of Midwifery, Cork University Maternity Hospital, Cork
Bernie O'Sullivan	Director of Nursing, Cope Foundation, Cork (Retired from Steering Group in May 2019)
Anna Broderick	Director of Nursing, Cope Foundation, Cork (Replacing Bernie O'Sullivan from June 2019)
Patricia Moloney	Director of Nursing, Mallow General Hospital, Cork
Ann Moran	Nurse Practice Development Co-ordinator, Cork University Hospital, Cork
Sinead Boyce	Registered Advanced Nurse Practitioner, (Psychotherapy), Cork Kerry Adult Mental Health Services
Marianne O'Connor	Assistant Director of Nursing, South Infirmary Victoria University Hospital, Cork
Cathy O'Sullivan	Nurse Practice Development Co-ordinator, Kerry Mental Health Services, Kerry
Margaret Hern	Assistant Director of Public Health Nursing, North Cork Public Health Nursing Services, Cork
Bernadette O'Riordan	Clinical Nurse Specialist, Diabetes Prevention, West Cork Community Services, Cork
Sharon Walsh	Assistant Director of Nursing, Adult Mental Health Services, Cork
Dr Elizabeth Heffernan	Director of Nursing & Midwifery Education, Kerry Centre of Nursing and Midwifery Education, Kerry
Jennie Synnott	Interim Area Director of Nursing, Child and Adolescent Mental Health Services, Cork

Appendix 2

PGCS Framework: Principles and Implementation Process

Principle 1

Peer Group Clinical Supervision is available to all nurses and midwives to optimise patient care and outcomes

Health Professional	• Supervisees are responsible for, and committed to, participating in Peer Group Clinical Supervision and on-going professional development • Clinical Supervisors are committed to ensuring they facilitate effective Peer Group Clinical Supervision
Health Service	• The service provides access to Peer Group Clinical Supervision at a level appropriate to the supervisees experience and needs • Services provide a strong and measurable commitment to their staff accessing peer group Clinical Supervision

Principle 2:

Peer Group Clinical Supervision supports best practice and consistent delivery of patient care

Health Professional	• Health professionals involved in the process of Peer Group Clinical Supervision have a shared understanding of the purpose of Clinical Supervision and their roles and responsibilities • Supervisees and Clinical Supervisors are responsible for maintaining their own appropriate records of Peer Group Clinical Supervision sessions
Health Service	• Organisational processes and resources are in place outlining the purpose of Peer Group Clinical Supervision • Organisational governance arrangements are in place to support Peer Group Clinical Supervision

Principle 3

Peer Group Clinical Supervision is high quality and effective in addressing the needs of nurses and midwives

Health Professional	• Peer Group Clinical Supervisors access education and training addressing the core knowledge and skills required to facilitate effective Peer Group Clinical Supervision • Approaches to Peer Group Clinical Supervision are tailored to meet the needs of the supervisees
Health Service	• Peer Group Clinical Supervision education programme and policy are supervisee-centred and based on a shared understanding of expected Peer Group Clinical Supervision standards • Services support nurses and midwives to undertake training and encourage them to build on their skills of Peer Group Clinical Supervision facilitation

Principle 4

Peer Group Clinical Supervision contributes to continuous professional learning and practice improvement

Health Professional	• Peer Group Clinical Supervision is recognised as an essential component of the nurses and midwives' role and is incorporated into their professional development plan • Supervisees and Supervisor ensure a professional working agreement is in place and a working relationship is developed to promote a safe learning environment
Health Service	• Services support learning and development in a safe and supportive work environment • Structured, transparent processes are in place in relation to issues related to patient safety and risk identification and to inform appropriate service line manager

Principle 5

Peer Group Clinical Supervision supports high quality care through data collection and monitoring for continuous improvement

Health Professional	• Collecting and reviewing information from Peer Group Clinical Supervision is an essential component of nurses and midwives' role, to support reflection on their Clinical Supervision activity
Health Service	• Services collect data on the programmes of Peer Group Clinical Supervision for evaluation and benchmarking of outcomes

Implementation

It is the responsibility of the Director of Nursing/Midwifery to implement the Peer Group Clinical Supervision Framework at service level. It is recommended that information sessions on the Framework are provided to nurses and midwives prior to implementation.

Guideline for Implementation Process
Frequency: Peer Group Clinical Supervision should be provided monthly.
Duration: Peer Group Clinical Supervision sessions should be scheduled for one hour.
Participants: Peer Group Clinical Supervision groups should comprise of 4-6 staff of the same or similar grade.
Where: Peer Group Clinical Supervision should take place at a work-based location free from distraction or interruption. This is facilitated protected time within the working day.
Commitment: The process of supervision occurs within a trusting relationship established between supervisor and supervisees, all contribute to the relationship and have responsibilities within the supervision process.
Who supervises: Peer Group Clinical Supervision should be provided by a trained supervisor, with at least 5 years postgraduate clinical experience, who participates in their own regular supervision and is committed to continuous professional development.
Recording: Written records of Peer Group Clinical Supervision will be maintained by the supervisor. Records are kept in accordance with the HSE (2013) Record Retention Policy. Supervisees may also choose to keep their own records in the form of a reflective journal.
Boundaries: Both supervisor and supervisee are expected to adhere to the Peer Group Clinical Supervision agreement as agreed at the outset of supervision agreement.
Agreement: The Peer Group Clinical Supervision agreement should be discussed and agreed by both supervisor and supervisees at the first meeting. The agreement should be signed by all parties. The agreement is open to review by all parties as required.
Confidentiality: All professional and clinical issues discussed are confidential and are not for discussion outside of the Peer Group Clinical Supervision session. The exceptions to this will be outlined in the Peer Group Clinical Supervision Agreement and may include circumstances where matters disclosed are of such a nature that they require disclosure to a third party. **Challenge:** Supervisor and supervisees should be open to giving and receiving constructive feedback. **Review:** The Peer Group Clinical Supervision Agreement will be reviewed at least twice a year or more frequently if requested with the aim of ensuring a focus on purpose and direction of supervision.
Evaluation: Evaluation of the Peer Group Clinical Supervision process will take place annually at a minimum by services utilising an evaluation tool.

Appendix 3 Qualitative study – Summary of Findings

Themes, categories, and sub-categories from interviews with supervisees (n=18)

Themes	Categories	Sub-categories
PGCS benefits	**Personal gains**	• Becoming calmer at work • Decluttering desk and mind • Empowerment • Improved communication • Increased confidence • Increased self-awareness • Personal wellbeing • Protected space • Respect for others • Stress reduction • Support with personal problems • Time to reflect/mindfulness
	Sharing	• Clinical problems • Experiences • Information • Learning • Problems and problem-solving • Understanding • Workload
	Benefits for practice	• Connectivity, teamwork, and team building • Better staff management • Decide, prioritise, defer, delegate • Empower staff • Group cohesion • Improved productivity • Improved role clarity • Sense of unity • Managing change • Open discussions • Peer support and learning • Reduced isolation in role • Reflecting on practice
	Benefits for organisation	• Cohesion amongst staff • Collective voice to address organisational issues • Contagious calm • Encouraged by management to avail of PGS • Improved staff morale • Increased productivity • Less sick leave • No benefit to the organisation • Proactive rather than reactive approach

	Benefits to patients	• Staff wellbeing and stress reduction • Improved standard of care • More free time to spend with patients • More mindful and present with patients • Indirect benefits due to improved staff morale • Dealing with family members made easier
	Favourable supervisor characteristics	• Calm, empathetic, positive supervisor • Experienced facilitator using own experience • External facilitator was beneficial • Facilitator gave advice • Facilitator gave everyone time to talk individually • Facilitator is open to questions • Found answers to problems themselves • Inclusive environment • Independent facilitator • Kept participants on track • Structured facilitator • Trusted facilitator
Challenges experienced during PGCS	Initial uncertainties and concerns	• Evolving process/time needed to adjust • Initial apprehension • Initial concerns about confidentiality • Initial uncertainty and suspicion • Lack of clarity about membership rules
	Competing responsibilities	• Work awaiting after PGCS • Workload not being covered • Hard to prioritise PGCS over work • Hard to organise PGCS • Time away from work • Travel to attend PGCS
	PGCS process and flow	• Ensuring that everyone gets to speak • Keeping conversations focused • Hard to discuss positives/focusing on negatives • Gaps between sessions disrupting flow • Changes in group membership was problematic • Not enough time given for PGCS/ 1 hour not enough
	Completion of PGCS	• Inability to maintain protected time post PGCS • Sense of loss • Fear of PGCS becoming diluted with time
	Line managers' understanding of PGCS	• Lack of understanding of the importance of PGCS • Forcing one participant into PGCS

Recommendations for the future of PGCS	Wider reach	• Involve other groups (staff nurses/midwives and other disciplines) • Ensuring 'buy-in' • Mix staff from different areas
	Supervisor characteristics	• Facilitator to take active role (e.g. offer feedback) • Need for 'strong' facilitators • Careful selection of those being trained to facilitate PGCS • Recommend external facilitator
	Work arrangements	• Overlap shifts to free up staff to attend • Protected time • Cover for workload while absent • PGCS to be made available in more sites to reduce travel time
	Duration of PGCS	• Reduce PGCS to 30 minutes • Recommend more time/ PGCS sessions • Recommend 6 months and not 12 months
	PGCS content and logistics	• Clarity around rules relating to group membership • Include mindfulness/meditation • Increase understanding of PGCS • Keep group size small (as is) • Sessions need to be more regular

Themes, categories, and sub-categories from interviews with line managers (n=5)

Themes	Categories	Sub-categories
PGCS benefits	Benefits for staff	• Increased staff confidence • Particular benefits for lone workers • Improved staff morale • A safe place to share concerns • Shared decision-making • Shared problem-solving
	Organisational benefits	• Indirect benefits due to improved staff morale • Improved working environments • Increased productivity • Senior staff leading by example • Long-term rather than short-term benefits
	Benefits for patients	• Indirect benefits due to improved staff confidence and morale • Long-term rather than short-term benefits
Challenges experienced during PGCS	Secrecy	• Lack of awareness about what was involved in the PGCS sessions
	Staffing levels	• Difficulties releasing staff from their clinical roles • Difficulties arranging staff cover • Lack of resources • Lack of protected time for CS • Difficulties scheduling staff time off
	Space	• Difficulties booking regular venues • Other things taking precedence
	Staff turnover	• Transient staff • Training staff up on CS and then they leave the job • Difficult to keep it up and offer CS for all new staff
	Managing discussions	• Difficulties managing the content of CS discussions • Unrealistic staff expectations
	Selecting appropriate groups	• Difficulties ensuring the right mix of people in the groups • Ensuring confidentiality • Staff not wanting to participate in the CS process with their own colleagues
Recommendations for the future of PGCS	Outcomes	• More tangible, measurable outcomes required
	Logistics	• More consideration given to the logistical issues, including space and location of CS sessions • Should be continued
	Work arrangements	• Consideration given to staff scheduling, and the difficulties in releasing staff from clinical duties when there is no cover • Staff participate on their day off

Themes, categories, and sub-categories from interviews with supervisors (n=4)

Themes	Categories	Sub-categories
PGCS benefits	Positive experiences	• PGCS an interesting experience for supervisors • Senior supervisees better able to benefit from sessions owing to reduced clinical pressures • Location (place of work) facilitator • Sense that people benefitted from process • Prior acquaintance within group a facilitator to trust/ group dynamics • Current intervention a positive start for a basic level
Challenges experienced during PGCS	Awareness and understanding of PGCS	• Name 'Clinical Supervision' problematic • Supervisees being swapped in/out by line managers who thought this appropriate • Understanding amongst supervisees of the model of Clinical Supervision limited prior to attendance • Understanding of PGCS limited amongst senior colleagues, those assisting with the delivery of the interventions (e.g. Nurse Managers)
	Time required to optimise the intervention	• Took time to settle in • Time for group members to become acquainted • Time to acclimate after start/before end of sessions • Time of group was shortened by clinical needs • Rushing to and from PGCS could leave supervisees potentially psychologically 'vulnerable'
	Organisational factors	• Noticeable issue with group supervisees being asked/ told to attend • Supervisees not receiving assistance with their clinical workload before being released from clinical work • Work location not ideal (only 1 Supervisor said this)
	Impact on the supervisor	• Sense that only 'superficial' psychological work/ processes occurred • Costs relating to travel, parking etc • Time away from their own work • Additional time taken on this evaluation • Challenge to convert group thinking from negative to solution-focused approaches
Clinical Supervision framework	Neutral	• Useful as a sensitising influenced • Psychological process as evolving one, not to be directed by a framework
	Negative aspects	• Supervisors rather to be less prescriptive in practice • Prefer to practice as they are trained, be more integrative • Preferred to be led by the group requirements/dynamics
	PGCS organisation	• Greater consideration for protected time for supervisees • Break needed in the 12-month delivery (break in summer) • Additional time would be ideal, e.g. 75 minutes

Recommendations	PGCS awareness	• Needs to be a more accepting culture amongst managers • More groundwork should be undertaken to ensure everyone is primed pre PGCS • Supervisees should be there in a voluntary capacity only • Training/workshops for HSE managers on PGCS • Suggestion that managers also could attend to become aware • Importance of an objective, impartial (external/ non HSE) facilitator • Time to meet facilitator in person beforehand • Diversify the groups to contain staff of different levels • Concerns about future provision of this model, if not delivered by trained counsellors/therapists

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