Collegian 28 (2021) 359–368

Contents lists available at ScienceDirect

Collegian

journal homepage: www.elsevier.com/locate/colegn

Peer group clinical supervision: Qualitative perspectives from nurse supervisees, managers, and supervisors

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ARTICLE INFO

Article history:
Received 22 July 2020
Revised 12 November 2020
Accepted 13 November 2020

Keywords:
Clinical supervision
Health services
Midwifery
Nursing
Peer group clinical supervision
Qualitative research

ABSTRACT

Background: Clinical supervision helps promote practitioners' personal and professional development through fostering a supportive relationship and working alliance. Peer group clinical supervision is a form of clinical supervision whereby two or more nurses engage in a supervision process to improve their professional practice and provide quality care.

Aim: To explore the experiences of supervision from the perspectives of nurse supervisees, their direct line managers, and clinical supervisors.

Methods: A qualitative descriptive pragmatic design was used. Individual interviews and focus groups were conducted with 27 participants. Data were analysed using deductive content analysis.

Findings: Three main categories were identified: Perceived benefits of peer group clinical supervision, challenges faced during peer group clinical supervision, and enhancements for future peer group clinical supervision sessions. Stress reduction, problem solving, managing change, and improved prioritisation were amongst the benefits gained from clinical supervision. Challenges included competing work demands, staffing issues, and the duration, location, and process of supervision. Participants recommended adding time to the allocated supervision hour, raising awareness of peer group clinical supervision in advance, and training expert supervisors.

Discussion: The space for peer group clinical supervision needs to be primed beforehand through providing and ensuring protected time, the availability of experienced supervisors, and raising key stakeholders' awareness of what supervision entails. Stress caused by competing work demands and the fear of losing momentum need to be considered by services in advance.

Conclusion: Findings support the planning, delivery, and evaluation of future peer group clinical supervision sessions, while addressing challenges identified by study participants.

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https://doi.org/10.1016/j.colegn.2020.11.004
1322-7696/

Summary of relevance
Problem or issue
There is limited evidence regarding the nature, structure, and impact of peer group clinical supervision on various stakeholders.
What is already known
Peer group clinical supervision enables nurses and midwives to practise effectively in a complex health system, ultimately enhancing the quality of patient care.
What this paper adds
Direct benefits to self and practice and indirect benefits to patients and healthcare organisations were identified. Overcoming cultural barriers such as lack of familiarity with peer group clinical supervision and its process can be addressed by raising awareness of clinical supervision in advance and training expert supervisors.

1. Introduction

Clinical supervision is a key component of good professional practice for healthcare professionals (Gonge & Buus, 2015; Pollock et al., 2017). While the aim and objectives are largely known, there is no universally accepted definition of clinical supervision (Cutcliffe, Sloan, & Bashaw, 2018). (Bond and Holland, 2011) described clinical supervision as a structured process where clinicians are allowed protected time to reflect on their practice within a supportive environment with the purpose of achieving, sustaining, and resourcefully developing high-quality clinical care. Similarly, Fowler (2011) defined clinical supervision as a process of professional support and learning in which practitioners are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues.

Clinical supervision is believed to promote nurses' and midwives' personal and professional development through fostering a supportive relationship and working alliance (Bernard & Goodyear, 2014). Moreover, clinical supervision is thought to play a key role in enabling nurses and midwives to practise effectively and independently in a complex healthcare system, ultimately enhancing the safety and quality of patient care (Bernard & Goodyear, 2014; Golia & McGovern, 2015).

2. Literature review

Clinical supervision is a beneficial aspect of modern and effective healthcare delivery (Pollock et al., 2017). Although the benefits of clinical supervision for healthcare staff are being increasingly recognised, 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 clinical practice (Dilworth, Higgins, Parker, Kelly, & Turner, 2013). Pollock et al. (2017) conducted a systematic review of evidence on the use of clinical supervision for nurses and found that there was a lack of empirical evidence on the nature and format of clinical supervision. This was believed to be confounded by a predominant lack of structured formats and frameworks to guide the supervision process. A more recent review also found limited evidence regarding the ideal length and frequency of clinical supervision (Rothwell, Kehoe, Farook, & Illing, 2019). Moreover, evidence relating to the direct benefits of clinical supervision for clients is lacking (Pollock et al., 2017; Rousmaniere, Swift, Babins-Wagner, Whipple, & Berzins, 2016). However, there is evidence that practitioners experience many professional benefits from attending clinical supervision, including improved practice knowledge and skills; enhanced confidence, self-efficacy, and self-awareness; and strengthened relationships with patients and their families (Cross, Moore, & Ockerby, 2010; Golia & McGovern, 2015).

Peer group clinical supervision (PGCS) is a form of clinical supervision whereby two or more practitioners engage in a supervision or consultation process in order to improve their professional practice (Bogo & McKnight, 2006; Borders, 2012). In their literature review, Golia and McGovern (2015) identified three types of PGCS: Facilitated PGCS, planned PGCS, and ad hoc PGCS. Facilitated PGCS serves as an opportunity for meaningful peer engagement under the direction of a trained supervisor. Planned PGCS involves establishing regular meetings for supervisees to discuss clinical issues without necessarily having a facilitator and ad hoc PGCS involves unplanned and spontaneous engagement activities that take place either in a dyad or in a group context (Golia & McGovern, 2015).

There is limited empirical evidence regarding the impact of PGCS on nurses (Borders, 2012; Cross et al., 2010; Golia & McGovern, 2015). Research on the perceived barriers and enablers to clinical supervision from the perspectives of key stakeholders is needed (Pollock et al., 2017). PGCS is being increasingly recommended as a means of supporting professional practice in the Irish context (Office of the Nursing and Midwifery Services Director 2015). 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 (Nursing and Midwifery Planning and Development Unit (Cork/Kerry) 2018; O'Shea, Kavanagh, Roche, Roberts, & Connaire, 2019). In doing so, an evidence base can be built to inform future decisions on the implementation of PGCS, including building internal capacity in practice.

This qualitative study explored the experiences of PGCS from the perspectives of nurses who attended PGCS, line managers who supported nurses in attending PGCS, and supervisors who facilitated PGCS sessions. In particular, this study aimed to answer the following question: What are nurse supervisees', line managers', and supervisors' perceived (i) benefits of PGCS, (ii) challenges faced during PGCS, and, if challenges are identified, (iii) recommended strategies to address challenges to PGCS?

3. Methods

3.1. Peer group clinical supervision process

Proctor's (2008) Model of Supervision outlines the role of formative, restorative, and normative functions in clinical supervision (Fig. 1). Based on this model, a PGCS Framework was developed to underpin PGCS sessions. This framework includes five principles focused on (i) making PGCS available to all nurses and midwives; (ii) supporting best practice and patient care; (iii) addressing the needs of nurses and midwives; (iv) fostering continuous professional learning and practice development; and (v) supporting high quality patient care ((Nursing and Midwifery Planning and Development Unit Health Service Executive North East 2017); Nursing and Midwifery Planning and Development Unit (Cork/Kerry) 2018).

The Nursing and Midwifery Planning and Development Unit (NMPDU) supports nurses and midwives in Ireland to undertake postregistration education and ensure continuing professional development. In response to requests from services, the NMPDU recognised the potential for PGCS to help nurses and midwives in their clinical practice. Therefore, a steering group of representatives from nursing and midwifery services, advanced practice, centres of nursing and midwifery education, and higher education institutions in Ireland was convened to oversee the development and implementation of this project. While PGCS was developed by nurs-

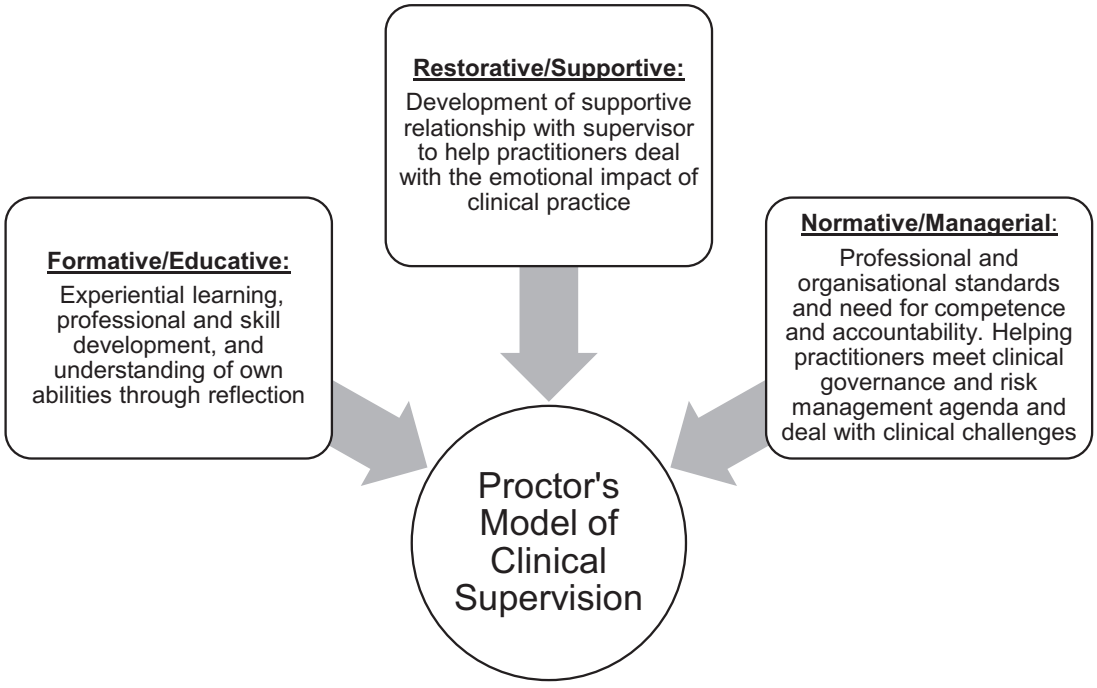

Fig. 1. Proctor's model of clinical supervision (Proctor, 2008).

ing and midwifery bodies, only nurses participated in PGCS, with some holding dual nursing and midwifery qualifications.

A facilitated or supervisor-led PGCS model was used. This structured model affords supervisees the opportunity to share their experiences with their colleagues and receive feedback from experienced clinical supervisors as well as their peers. This was believed to enhance the quality of work and increase teamwork and team cohesion (Nursing and Midwifery Planning and Development Unit (Cork/Kerry) 2018). PGCS was offered to 10 groups of nursing staff across nine sites in Irish counties Cork and Kerry. Monthly PGCS sessions were facilitated over 12 months (September 2018 to August 2019) and every session was scheduled for 1 hour. Each PGCS group was composed of four to six nurses who worked in the same organisation, were from the same or similar grade, and who were nominated by their line managers to partake in PGCS. Nurses worked in various clinical settings including acute care (general nursing), public health, mental health, and intellectual disability services.

A formal agreement was signed by both supervisors and nurse supervisees beforehand with reference to practicalities such as the working alliance, learning goals, ethical and legal considerations, formative and summative feedback, and the evaluation process (Nursing and Midwifery Planning and Development Unit (Cork/Kerry) 2018). Protected time in the form of 1 hour in a working day was allocated for each PGCS session which took place in private and quiet work-based locations. Facilitated PGCS discussions revolved around: (i) Enhancing the quality of work practices; (ii) exploring decision-making processes and their impact on patients; (iii) seeking and receiving information; (iv) expressing and exploring issues arising through work practices; (v) being challenged in a supportive manner; and (vi) receiving support and feedback. Written records of PGCS were maintained by the supervisors. Supervisees were encouraged to keep their own records in the form of a reflective journal (Nursing and Midwifery Planning and Development Unit (Cork/Kerry) 2018).

3.2. Study design

A qualitative descriptive pragmatic design was used (Patton, 2015), indicating that "the essential criteria for making design decisions are practical, contextually responsive, and consequential" (Datta, 1997; p.34). In qualitative pragmatic studies, a research question relating to a real-world situation is first identified, leading to research enquiry which seeks to better understand and ultimately answer the research question. Findings from pragmatic studies often have implications for policy, new initiatives, or social change (Duram, 2010; Kaushik & Walsh, 2019).

As a research paradigm, pragmatism proposes that researchers should use the methodological approach that works best to answer a particular research question (Tashakkori, Teddlie, & Teddlie, 1998). Therefore, qualitative description which draws from the general tenets of the naturalistic enquiry was chosen to describe the phenomenon (i.e., PGCS) from the perspective of individuals who have experienced it (i.e., supervisees, line managers, and supervisors) without adhering to pre-existing theoretical or epistemological perspectives (Sandelowski, 2000). Moreover, qualitative description helps obtain authentic and candid responses to inquiries relevant to researchers, practitioners, and policy makers. Examples of such inquiries include: "What are the concerns of people about an event? What are people's responses toward an event?" (Sandelowski, 2000; p.337). This line of enquiry is appropriate to answer the research question of the present study.

This study is reported according to the Standards for Reporting Qualitative Research (SRQR) checklist. This is known to maintain an audit trail and reduce reporting bias in qualitative research (O'Brien, Harris, Beckman, Reed, & Cook, 2014).

3.3. Participants

Participants were recruited using purposive sampling. Before the commencement of PGCS, supervisees were informed verbally

Table 1
Number of individual interviews and focus groups conducted per participant group.

Participant group	Number of participants	Number of individual interviews	Number of focus groups	Numbers of participants per focus group
Supervisees	18	1	5	3–5
Managers	5	2	1	3
Supervisors	4	2	1	2

by the funding organisation that outcomes from their engagement in PGCS were going to be evaluated independently. Following completion of PGCS, eligible individuals were invited to participate in the study via e-mail with two reminders. Participants were assured that their participation was voluntary and that they could withdraw from the study without any negative repercussions on their employment.

PGCS was offered to 57 nurses divided over 10 groups. Each group availed of 12 PGCS sessions over a 12-month period. Of those, five did not complete PGCS due to maternity and sick leave and one nurse joined a group after the project commenced. Therefore, nurses (n = 53) working in acute care (general nursing), public health, mental health, and intellectual disability services completed PGCS and were invited to participate in the current study along with their direct line managers (n = 10). PGCS supervisors (n = 4) had dedicated time to lead and deliver PGCS sessions for the 10 nursing groups. Those with clinical commitments were afforded the time to deliver PGCS over the 12-month period. Overall, 18 nurses, five line managers, and the four clinical supervisors participated in this study.

3.4. Data collection

Ethical approval was granted by the Clinical Research Ethics Committee at the host university. Data were collected between October and November 2019 using individual interviews and focus groups. Combining both data collection approaches helped enrich qualitative data (Lambert & Loiselle, 2008), and was suitable for participants who had clinical commitments and those who did not wish to discuss their experiences with members of their PGCS group. Participants were also afforded the option of participating in telephone interviews due to their busy work schedules and geographical location. The number of individual interviews and focus groups conducted per participant group are presented in Table 1.

Participants were provided with an information leaflet and were required to provide written informed consent. Data were handled and stored according to the host university's Data Protection Policy. All interviews were audio-recorded and conducted by experienced researchers who were not known to participants. Participants completed a brief socio-demographic questionnaire before the interviews. A semistructured interview guide with open-ended probes initially developed by Landers et al. (2020) to evaluate the impact of a compassionate care leadership programme was adapted to the context of the current study. Discussions revolved around three key areas: (i) Perceived benefits of PGCS to self, practice, organisation, and patients; (ii) challenges faced during PGCS; and (iii) recommendations for future PGCS sessions.

3.5. Data analysis

Interviews were transcribed verbatim and identifiers were omitted at transcription. Data were analysed using deductive content analysis (Elo & Kyngäs, 2008). This involved coding the data according to predetermined main categories (i.e., perceived benefits of PGCS, challenges faced during PGCS, and enhancements for future PGCS sessions) which were primarily guided by the research question and the semistructured interview guide. An analysis matrix was created with three columns. The first column contained the question/context where the particular excerpt was mentioned, the second column contained the main categories, the third column contained the generic categories, the fourth column contained the code, and the fifth column contained participant excerpts. A sample analysis matrix is presented in Table 2.

Data from each participant group (i.e., supervisees, line managers, and supervisors) were coded by five researchers independently, and were cross-checked for accuracy by the lead researcher. Data source triangulation was then performed. This involved collating codes from the three participant groups under the predetermined main categories, and exploring convergence, complementarity, and dissonance between the results (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014).

3.6. Trustworthiness

Trustworthiness in qualitative research is assessed in terms of research credibility, dependability, conformability, transferability, and authenticity (Elo et al., 2014; Lincoln & Guba, 1985). In the present study, dependability and conformability were improved by having the primary researcher cross-check the coding process, and by maintaining a dialogue between the researchers throughout data collection and analysis (Elo et al., 2014; Graneheim & Lundman, 2004). Conformability was enhanced further by maintaining an audit trail (Saldaña, 2009) and ensuring that all study elements have been reported (O'Brien et al., 2014).

Transferability and credibility were enhanced through conducting data source triangulation, whereby expert researchers collated codes from the three participant groups under the predetermined main categories, and explored convergence, complementarity, and dissonance between the results. Transferability and credibility were also enhanced by selecting a heterogeneous sample of participants from three different groups (i.e., supervisees, line managers, and supervisors) and from various health services within a wide geographical area. The thick description of the data collection process and sample characteristics also helped enhance transferability and credibility. Credibility was improved further by describing participants' experiences of PGCS using their own words (Cope, 2014). Finally, authenticity was sought by having experienced and independent researchers conduct the interviews and analyse data (Whittemore, Chase, & Mandle, 2001), as well as using icebreakers such as social conversations in order to build rapport with participants before the interviews (Holloway & Galvin, 2016).

4. Results

4.1. Participant characteristics

All 27 participants were female. Nurse supervisees' years of experience ranged between 12 and 40 years. All were from a nursing background and the majority (n = 12) held a "Clinical Nurse

Table 2
Sample data analysis matrix.

Context	Main category	Generic category	Codes	Excerpts
What benefits have you gained from this process?	Peer group clinical supervision benefits and gains	Personal gains	Reduced stress	"It 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" (N2–4).
			Increased group and self-awareness	"More self-awareness and then a group awareness that we were all really having the same issues and kind of struggling in the dark on our own with them, whereas we saw that we were all having the same ones" (N5–9).
			Support from colleagues and time to vent	"Just the support really that they gave me the time and I was allowed vent. That's what I felt anyway, the main thing was the support from my colleagues really" (N10–12).

Table 3
Characteristics of participating supervisees, managers, and supervisors (n = 27).

	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 and Midwifery (dual)	16	4	
	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 mean (SD)	1–22	2–10	
	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.

Manager 2″ post (i.e., senior nurse manager in charge of a full ward). Years in current post ranged between 1 and 22 years. Almost half of the supervisees were higher/postgraduate diploma holders (n = 8). Line managers' years of experience and years in current role ranged from 20 to 40 years and 2 to 10 years, respectively. Most line managers (n = 3) were Assistant Directors of Nursing and bachelor's degree holders. Of note, holding a Level 8 qualification such as a bachelor's degree is one of the essential requirements for the post of Assistant Director of Nursing/Midwifery in the Irish healthcare system. Higher qualifications are desirable but not mandatory (Health Service Executive, 2020; Quality and Qualifications Ireland, 2020). All four supervisors were master's degree holders and had 13 to 39 years work experience. The full participant characteristics are presented in Table 3.

Three main categories were identified from the interviews: (i) Perceived benefits of PGCS; (ii) challenges faced during PGCS; and (iii) enhancements for future PGCS sessions. Main categories, generic categories, and detailed participant excerpts are presented in Table 4. In the findings, nurse supervisees were referred to as "N," line Managers as "M," and supervisors as "S."

4.2. Main category 1: Perceived benefits of peer group clinical supervision

PGCS was believed to have several direct benefits for supervisees both on a personal level and on their clinical practice. Patients and healthcare organisations, however, were perceived to benefit indirectly from supervisees' engagement in PGCS. Benefits reaped from PGCS were primarily attributed to having experienced and organised supervisors lead and facilitate all PGCS sessions.

On a personal level, supervisees reported becoming more calm, mindful, confident, and self-aware as a result of their participation in PGCS. Some supervisees recalled the role of PGCS in helping "cut down on the stress side of things" and enabling them to "have

Table 4
Main categories, generic categories, and sample excerpts from participants.

Main categories	Generic categories	Sample excerpts
Perceived benefits of peer group clinical supervision	Personal gains	"…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).
	Direct benefits for practice	"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).
	Indirect benefits for patients and the organisation	"If you're feeling a bit better yourself, it's automatically going to help whoever you're looking after or caring for or whatever the situation is. I do think they obviously feel an offshoot or benefit" (N1). "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).
	Positive supervisor characteristics	"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).
Challenges faced during peer group clinical supervision	Lack of 'buy-in' and familiarity with the process	"…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). "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).
	Disruptions caused by workload and staffing	"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).
	Logistical challenges	"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). "...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 [supervisees] have to get to the place and get back, so it's probably more like 12 hours…" (M2).
	Fear of losing momentum	"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).
Enhancements for future peer group clinician supervision sessions	Flexible work arrangements	"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).
	Content and logistical improvements	"…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).
	Enhancing awareness and reach	"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).

better communication skills as a result" (N2–4). Similarly, all four supervisors deemed PGCS to be a positive opportunity for supervisees to build their confidence in a "very healthy" and "nonsterile environment" (S1).

From a clinical perspective, PGCS was perceived to enhance cohesion and unity amongst members of the same PGCS group. Most supervisees held managerial positions; therefore, practice improvements related primarily to supervisees' management duties, such as the increase in their ability to make clinical decisions and promote change in the workplace. PGCS also helped supervisees "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). Empowerment was identified as another key benefit from PGCS, particularly amongst lone workers who initially reported feeling isolated in their roles either because they worked in geographically dispersed regions (e.g., public health nurses) or were based in rural areas. The role of PGCS in enhancing "sharing" amongst supervisees was another key discussion point in all the interviews. This related to the sharing of information, learning, problem-solving, decision-making, understanding, and workload between the one PGCS group:

"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 they're willing to share that with you…" (N1).

Some supervisees believed that PGCS helped them become more mindful and present with their patients and equipped them with the means to better deal with family members. These benefits, however, were perceived to be indirect rather than direct "because the service user will always get the best care anyway" (N17,18). Similarly, line managers reported "not seeing anything tangible" (M3–5) in terms of improvements in patient care but stated that patients would benefit from less stressed and satisfied nurses.

PGCS benefits for the organisation were also perceived as indirect and as "something that will be seen in time" (M1). Most supervisees reported that the organisation would benefit from more confident, autonomous, calm, and empowered staff, with some believing that PGCS would potentially help reduce sick leave.

Several supervisees believed that the above benefits would not have been possible without having supervisors facilitate PGCS sessions. Terms like "calm," "empathetic," "experienced," "positive," "nurturing," "sensitive to individual needs," and "able to find answers to problem raised during PGCS sessions" were used by supervisees to describe their supervisors. Moreover, supervisors' structured approach to leading PGCS sessions was perceived as beneficial in keeping supervisees on track.

4.3. Main category 2: Challenges faced during peer group clinical supervision

While experiences of PGCS were predominantly positive with a number of benefits as a result, various challenges were iterated by study participants. These pertained primarily to the lack of a priori preparation and familiarity with the PGCS process, and the resulting lack of endorsement of PGCS by some line managers. Other challenges related to the stress caused by competing work demands; the logistic of attending PGCS sessions such as the PGCS process, duration, and travel time; and the fear of losing momentum following completion of PGCS.

Supervisors felt that the lack of prior preparation and familiarity with the PGCS process caused initial apprehension and confidentiality concerns amongst supervisees who "found it hard at the beginning to let [their] guard down" (N17,18). Supervisees often referred to supervisors as "facilitators." Indeed, terms like "supervisor" and "supervision" caused initial confusion amongst supervisees who felt that their practice was going to be "scrutinised" (N1) during PGCS sessions. This was echoed by supervisors who believed that supervisees felt threatened by the word "supervisor" and "felt that the [supervisor] was going to be looking at their practice" (S1). Some line managers also seemed unfamiliar with PGCS, stating that they knew "nothing about the clinical supervision process, [they] just facilitated it" (M1). As a result, they felt that "there was a huge secrecy" (M1) surrounding PGCS, with some line managers referring to PGCS as a "secret society" (M3–5). Indeed, line managers' suspicions and lack of familiarity with PGCS were sensed by supervisees, who used terms like "lack of buy-in" (N1) to designate their line managers' lack of endorsement of PGCS.

Supervisees' competing work demands also served as key challenges over the duration of PGCS. Such challenges pertained to difficulties securing cover for supervisees to attend PGCS sessions; difficulties agreeing on supervision dates and times that suit all PGCS group members; spending several hours away from work on a workday; and having to "pick up the pieces" (N10–12) upon their return to work. Likewise, line managers reported difficulties rostering and supporting their nurses to attend PGCS sessions due to the lack resources and understaffing. Supervisors also acknowledged the stress caused by supervisees' competing work demands, with one supervisor stating that it felt like supervisees were being "pulled by management…pulled by staff…pulled by patients" (S2). This was believed to impede supervisees' full engagement in the PGCS process.

The logistics of running PGCS sessions in terms of participation, delivery, location, and duration was challenging to participants. One line manager said that she would be "very careful as to the type of people [she] would put in the room [PGCS session]" (M1), yet line managers struggled to ensure the right mix of people in PGCS groups, primarily due to understaffing. This may have resulted in having a person who was "stronger and talking more," having "some people who were quieter than other personalities" (N1), difficulties keeping conversations focused, and difficulties focussing on the positives rather than the negatives. In terms of PGCS delivery, supervisors gave mixed feedback regarding the PGCS Framework. One supervisor described the framework as "good…basic enough for the level we're at" (S1), while others argued that their supervision work was guided by the need of the group in a given session rather than the PGCS Framework per se.

Protected time in the form of 1 hour was granted to all supervisees in order to attend PGCS sessions on a workday. However, supervisees who worked in rural clinical environments or within wide geographical areas (e.g., public health nurses) had to factor in the time it took them to travel to and from PGCS venues. As a result, it took some supervisees 3 hours from the time they left work to attend PGCS to the time they went back to work following PGCS. This was also perceived as a major stressor for supervisors:

"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 destress myself" (S2).

Monthly PGCS sessions ran over 12 months. Most supervisees wished that PGCS was "a little bit longer" (N2–4) and expressed feelings of loss and fear that the impact of PGCS becomes "diluted" with time. Therefore, some supervisees requested to uphold the protected hour following completion of PGCS to maintain momentum. However, their request was denied by their line managers due to the high workload and understaffing.

4.4. Main category 3: Enhancements for future peer group clinician supervision sessions

Generally, participants suggested that PGCS should continue. However, in order to sustain PGCS and integrate it "as a core part of everybody's job" (N2–4), participants stressed the importance of having flexible work arrangements, enhancing the logistics of PGCS delivery, raising awareness of PGCS beforehand, and involving heterogenous and mixed cohorts of nurses and other healthcare professionals in the supervision process.

Overlapping shifts, respecting the protected time (i.e., 1 hour) allocated for supervisees to attend PGCS, ensuring staff cover, and conducting PGCS session on supervisees' days off were amongst the recommendations made in order to overcome workplace-related challenges. All line managers felt that further consideration should be given to scheduling, with one line manager suggesting that staff "have to take ownership for themselves when they sign up to these courses [PGCS]" and "could try and schedule where possible to do this [PGCS] on their day off" (M1).

Participants believed that the location, duration, delivery, and content of future PGCS sessions ought to be considered amongst

subsequent cohorts. For instance, supervisees recommended that PGCS is made available in "more localised areas" (N1) and suggested that PGCS sessions for frontline workers, staff working in geographically dispersed regions, and staff in rural areas ought to be delivered "much closer to people's worksites" (N17,18). Some supervisees recommended reducing the duration of PGCS to "only 30 minutes" (N1) and to take a break over the summer. However, most supervisees and supervisors believed that "an hour is very short" and that "an hour and a half would actually have been a better timeframe…" for each PGCS session (N5–9).

Some supervisees recommended "monthly follow-up sessions" (N17,18) in order to keep the momentum going following the completion of PGCS. In terms of content and delivery enhancements, supervisees recommended a "little bit of mindfulness or meditation" (N10–12). Supervisees suggested that small group PGCS continues "because it kept [them] focused and it gave everybody a chance to participate…" (N5–9). Supervisees recommended that PGCS funders should be "a bit selective, who they train up to become facilitators" (N1) with a preference for "having an outside facilitator" (N5–9).

Supervisees and 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. Supervisors stated that "the space [for PGCS] needed a bit more preparation" through exploring supervisees' expectations from PGCS and having supervisees meet their supervisors beforehand. Moreover, supervisors believed that support from line managers was vital, with one supervisor recommending a formal "maintenance agreement for the staff doing the work [PGCS]" (S2), and another suggesting including line managers in future PGCS groups. To counteract the potentially negative connotation of "supervision," supervisors suggested that the title of the programme be reconsidered to include "peer support." Supervisors also highlighted the importance of staff attending only when they choose to, and not being mandated by their line managers.

Supervisee groups were relatively homogenous, whereby the 18 supervisees who participated in the present study were female, 15 held managerial posts, and 12 worked in acute care. Therefore, it was recommended that involving staff from all levels including nurses, midwives, and other healthcare disciplines in PGCS would be beneficial. Moreover, since "junior staff learned a lot from more senior staff and vice versa" (S3,4), the mixing of junior and senior staff to enhance group learning and support was recommended by the supervisors and supervisees.

5. Discussion

This study explored supervisees', line managers', and supervisors' experiences of PGCS. Findings highlight several positive aspects of PGCS, including personal benefits such as stress reduction and problem solving, as well as benefits for clinical practice, such as managing change and improved prioritisation and delegation. Indirect benefits to patients and the organisation were also iterated, through having nurses who were less stressed and well equipped to manage challenging clinical situations.

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 in rural areas. Similar gains from clinical supervision are well documented in the international literature (Cross et al., 2010; Cutcliffe et al., 2018; Golia & McGovern, 2015; O'Shea et al., 2019). For instance, a qualitative study reported that supervision helped increase participants' confidence and reduce their stress levels (Golia & McGovern, 2015), and a systematic review of 28 studies found that clinical supervision increased nurses' sense of wellbeing (Cutcliffe et al., 2018).

Benefits for patients were perceived as indirect, not tangible, and difficult to measure in the short term. These mostly related to being cared for by nurses who felt less stressed as a result of their engagement in PGCS. Indeed, evidence relating to improved quality of care provided by supervisees is rare (Bradshaw, Butterworth, & Mairs, 2007; Pollock et al., 2017), and a number of studies were unable to identify direct benefits of clinical supervision to patients (White & Winstanley, 2010; Watkins, 2011).

Despite the numerous benefits, several challenges to PGCS were identified, including competing work demands, staffing issues impacting attendance, and logistical challenges. Most participants supported monthly sessions and some suggested that within the year, a break of one month over the summer period is warranted. For many supervisees and supervisors, the time allocated for participation and facilitation (i.e., 1 hour per session) was insufficient and constrained by clinical commitments. 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 (Office of the Nursing and Midwifery Services Director 2015). 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.

Supervisees, while voicing challenges, identified ways to overcome those and maintain their participation. This is encouraging considering that deliberate nonparticipation in group supervision is common (Gonge & Buus, 2015). Overall, supervisors and supervisees highlighted the importance of overcoming cultural barriers such as a lack of familiarity with and understanding of PGCS and its process, both by supervisees and their line managers. Terms like "buy-in" give an indication of the lack of endorsement of PGCS by upper management and highlight the awareness-raising efforts required to successfully implement PGCS. Such findings align with those of Dilworth et al. (2013) who argued that opposition to clinical supervision is engendered by an implicit culture within healthcare organisations that are resistant to change, allowing barriers such as time, staffing, and budgets to propagate. Similarly, lack of support from line management and unfamiliarity with clinical supervision might cause ambiguity around the purpose of clinical supervision and may impede resulting changes in clinical practice. This was iterated by current study participants and reflected in the wider literature (Cutcliffe et al., 2018).

To overcome such barriers, participants stressed the importance of informing future cohorts about PGCS in advance using, for example, information sessions with varying levels of staff and managers. 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, 2012) 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. 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 (Office of the Nursing and Midwifery Services Director 2015). Of note, while mental health nurses took part in PGCS, none participated in the current study.

Another key recommendation from participants relates to training future supervisors. Overall, participants called for qualified and experienced supervisors who were not colleagues or peers within their organisation, with some favouring supervisors from a non-nursing background. 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.

6. Implications

Overall, study findings support the planning, delivery, and evaluation of future PGCS sessions. This would inadvertently impact positively on organisations and patients as expressed by participants. While the purpose of PGCS is not to yield tangible and measurable clinical outcomes per se, future research ought to elicit patients' experiences of nurses undertaking PGCS and explore practice changes resulting from PGCS, where and when applicable.

In terms of PGCS delivery, there is a continual need for experienced clinical supervisors capable of supporting nurses and midwives during supervision. This can be achieved, for example, through building internal capacity for PGCS. Future clinical supervisors must adopt a facilitative and supportive approach towards supervisees (Care Quality Commission, 2013) and possess skills such as questioning, active listening, focusing, and summarising (Van Ooijen, 2013). Supervisors are also expected to participate in their own clinical supervision (O'Shea et al., 2019).

Health service management should ensure that line managers and staff are aware of the nature and practices of PGCS. This would highlight the importance of this initiative further and help clarify expectations from PGCS. Processes of PGCS and how it is implemented in clinical practice should be reviewed by the relevant bodies to ensure it is not deprioritised and its effect is not diluted over time, a concern expressed by a number of supervisees. This could be achieved; though, having a clear supervision policy and having senior managers monitor the quality and frequency of clinical supervision (Bifarin & Stonehouse, 2017; Zutshi, McDonnell, & Leay, 2007).

Current study findings point to ambivalence around the use of frameworks for clinical supervision, particularly amongst supervisors, though the use of theoretical frameworks, such as Proctor's (2008) Model of Supervision, appears to be a core element of clinical supervision (Brunero & Lamont, 2012; Pollock et al., 2017). This is a potential area for future research.

7. Limitations

Despite enhancing rigour and trustworthiness, some limitations were inevitable. For instance, no midwives participated in PGCS and no mental health nurses participated in the current study. Therefore, participant characteristics might not be comparable to those of the target population. Moreover, only participants who were interested in participating were interviewed, which increases the risk of self-selection bias and hinders the transferability of findings to the remaining cohort of supervisees.

8. Conclusion

This study identified several benefits for PGCS such as increased confidence, self-awareness, and empowerment. Supervisees also reported reduced feelings of isolation and increased sharing of problems and workloads. The benefits to patients and the organisation, however, were believed to be indirect and not measurable in the short term. PGCS was not without challenges. These related to the lack of a priori preparation and familiarity with PGCS and the resulting lack of endorsement or "buy-in" by some line managers. Other challenges related to supervisees' competing work demands, the logistic of attending PGCS sessions, and the fear of losing momentum following completion of PGCS. These challenges can be addressed by providing protected time for supervisees to benefit from PGCS, raising staff's awareness of what supervision entails, clarifying supervisees and line managers' expectations from PGCS, and resolving logistical challenges.

Author contributions

Mohamad M. Saab: Conceptualisation, methodology, formal analysis, investigation, writing- original draft, writing - review and editing, visualisation, project administration; *Caroline Kilty*: Formal analysis, investigation, writing - original draft, writing - review and editing; *Elaine Meehan*: Formal analysis, investigation, writing - review and editing; *John Goodwin*: Formal analysis, investigation, writing - review and editing; *Sinéad Connaire*: Conceptualisation, writing - review and editing; *Carmel Buckley*: Conceptualisation, writing - review and editing; *Anne Walsh*: Conceptualisation, writing - review and editing; *James O'Mahony*: Conceptualisation, writing - review and editing; *Vera J. C. McCarthy*: Conceptualisation, writing - review and editing; *Aine Horgan*: Conceptualisation, methodology, investigation, writing - original draft, writing - review and editing, project administration, funding acquisition.

Funding

This work was commissioned and funded by the Nursing and Midwifery Planning and Development Unit, (Cork and Kerry), Health Service Executive South, Ireland.

Ethical statement

This study confirms to the Declaration of Helsinki and has received ethical approval from the Clinical Research Ethics Committee at University College Cork, Ireland (ECM 4 (n) 13/08/19).

Conflict of interest

None. The proposed publication does not concern any commercial product, either directly or indirectly.

References

Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th edn). Boston, MA: Pearson.

Bifarin, O., & Stonehouse, D. (2017). Clinical supervision: an important part of every nurse's practice. *British Journal of Nursing, 26*(6), 331–335.

Bogo, M., & McKnight, K. (2006). Clinical supervision in social work: a review of the research literature. *The Clinical Supervisor, 24*(1-2), 49–67.

Bond, M., & Holland, S. (2011). *Skills of clinical supervision for nurses: A practical guide for supervisees, clinical supervisors and managers*. UK: McGraw-Hill Education.

Borders, L. D. (2012). Dyadic, triadic, and group models of peer supervision/consultation: what are their components, and is there evidence of their effectiveness? *Clinical Psychologist, 16*(2), 59–71.

Bradshaw, T., Butterworth, A., & Mairs, H. (2007). Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with? *Journal of Psychiatric and Mental Health Nursing, 14*(1), 4–12.

Brunero, S., & Lamont, S. (2012). The process, logistics and challenges of implementing clinical supervision in a generalist tertiary referral hospital. *Scandinavian journal of caring sciences, 26*(1), 186–193.

Care Quality Commission (2013). Supporting Information and Guidance: supporting Effective Clinical Supervision. http://tinyurl.com/zhngqvc.

Carter, C., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41*(5), 545–547.

Cope, D. G. (2014). Methods and meanings: credibility and trustworthiness of qualitative research. *Oncology Nursing Forum, 41*(1), 89–91.

Cross, W., Moore, A., & Ockerby, S. (2010). Clinical supervision of general nurses in a busy medical ward of a teaching hospital. *Contemporary Nurse, 35*(2), 245–253.
Cutcliffe, J. R., Sloan, G., & Bashaw, M. (2018). A systematic review of clinical supervision evaluation studies in nursing. *International Journal of Mental Health Nursing, 27*(5), 1344–1363.
Datta, L. E. (1997). A pragmatic basis for mixed-method designs. *New Directions for Evaluation, 1997*(74), 33–46.
Dilworth, S., Higgins, I., Parker, V., Kelly, B., & Turner, J. (2013). Finding a way forward: a literature review on the current debates around clinical supervision. *Contemporary Nurse, 45*(1), 22–32.
Duram, C. (2010). Pragmatic study. In A. Leslie (Ed.), *Encyclopedia of research design* (pp. 1073–1075). SAGE Publications, Inc: Thousand Oaks, CA.
Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107–115.
Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: a focus on trustworthiness. *SAGE open, 4*(1), Article 2158244014522633.
Fowler, J. (2011). Case studies from Leicestershire UK. In J. R. Cutcliffe, K. Hyrkäs, & J. Fowler (Eds.), *Handbook of clinical supervision: Fundamental international themes* (pp. 148–156). Taylor Francis Group: New York.
Golia, G. M., & McGovern, A. R. (2015). If you save me, I'll save you: the power of peer supervision in clinical training and professional development. *The British Journal of Social Work, 45*(2), 634–650.
Gonge, H., & Buus, N. (2015). Is it possible to strengthen psychiatric nursing staff's clinical supervision? RCT of a meta-supervision intervention. *Journal of Advanced Nursing, 71*(4), 909–921.
Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105–112.
Health Service Executive (2020). Assistant Directors of Nursing. https://www.hse.ie/eng/staff/jobs/eligibility-criteria/assistant-directors-of-nursing.html.
Holloway, I., & Galvin, K. (2016). *Qualitative research in nursing and healthcare*. Chichester: West Sussex: Wiley Blackwell.
Kaushik, V., & Walsh, C. A. (2019). Pragmatism as a research paradigm and its implications for social work research. *Social Sciences, 8*(9), 255.
Lambert, S. D., & Loiselle, C. G. (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing, 62*(2), 228–237.
Landers, M., Hegarty, J., Saab, M. M., Savage, E., Cornally, N., Drennan, J., et al. (2020). Nurses' and midwives' views of the "Leaders for Compassionate Care Program": a qualitative analysis. *Collegian, 27*(1), 2–10.
Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Thousand Oaks.
National Council for the Professional Development of Nursing and Midwifery. (2008). Clinical supervision: a structured approach to best practice. https://www.pna.ie/images/ncnm/Clinical%20Supervision%20Disc%20paper%202008.pdf.
Nursing and Midwifery Planning and Development Unit (Cork/Kerry) (2018). Peer group clinical supervision framework for nurses and midwives working in HSE South Cork/Kerry. https://www.lenus.ie/bitstream/handle/10147/627799/PGCS%20Framework%20HSE%20South%20CorkKerry.pdf?sequence=1&isAllowed=y.
Nursing and Midwifery Planning and Development Unit Health Service Executive North East (2017). Peer group clinical supervision strategic plan 2017-2020. https://healthservice.hse.ie/filelibrary/onmsd/hse-north-east-nursing-and-midwifery-peer-group-clinical-supervision-strategic-plan-2017-2020.pdf.
O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: a synthesis of recommendations. *Academic Medicine, 89*(9), 1245–1251.
Office of the Nursing and Midwifery Services Director (2015). Clinical supervision framework for nurses working in the mental health services. https://www.lenus.ie/bitstream/handle/10147/559243/National%20Framework.pdf?sequence=1&isAllowed=y.
O'Shea, J., Kavanagh, C., Roche, L., Roberts, L., & Connaire, S. (2019). Clinical supervision for nurses working in mental health services: a guide for nurse managers, supervisors and supervisees. https://www.lenus.ie/bitstream/handle/10147/626949/clinical%20supervision%20for%20nurses%20working%20in%20mental%20health%20services%20a%20guide%20%20final.pdf?sequence=1.
Patton, M. Q. (2015). *Qualitative research and methods: Integrating theory and practice*. Thousand Oaks: CA: SAGE Publications.
Pollock, A., Campbell, P., Deery, R., Fleming, M., Rankin, J., Sloan, G., et al. (2017). A systematic review of evidence relating to clinical supervision for nurses, midwives and allied health professionals. *Journal of Advanced Nursing, 73*(8), 1825–1837.
Proctor, B. (2008). *Group supervision: A guide to creative practice*. London: Sage.
Quality and Qualifications Ireland (2020). Irish National Framework of Qualifications (NFQ). https://nfq.qqi.ie/.
Rothwell, C., Kehoe, A., Farook, S., & Illing, J. (2019). The characteristics of effective clinical and peer supervision in the workplace: a rapid evidence review. https://www.hcpc-uk.org/globalassets/resources/reports/research/effective-clinical-and-peer-supervision-report.pdf.
Rousmaniere, T. G., Swift, J. K., Babins-Wagner, R., Whipple, J. L., & Berzins, S. (2016). Supervisor variance in psychotherapy outcome in routine practice. *Psychotherapy Research, 26*(2), 196–205.
Saldaña, J. (2009). *The Coding Manual for Qualitative Researchers*. SAGE: London.
Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health, 23*(4), 334–340.
Tashakkori, A., Teddlie, C., & Teddlie, C. B. (1998). *Mixed methodology: Combining qualitative and quantitative approaches (Vol. 46)*. California: Sage.
Van Ooijen, E. (2013). *Clinical supervision made easy: A creative and relational approach for the helping professions*. Ross-on-Wye, UK: PCCS.
Watkins, C. E. Jr (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. *The Clinical Supervisor, 30*(2), 235–256.
White, E., & Winstanley, J. (2010). A randomised controlled trial of clinical supervision: selected findings from a novel Australian attempt to establish the evidence base for causal relationships with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. *Journal of Research in Nursing, 15*(2), 151–167.
Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research, 11*, 522–537.
Zutshi, H., McDonnell, F., & Leay, D. (2007). Providing effective supervision: a workforce development tool, including a unit of competence and supporting guidance. http://tinyurl.com/pppzqk3.