Journal of Nursing Management

Abstract

Aim: To explore the lived experience of utilising peer group supervision in practice for community health nurses.

Background: Community health nursing is an autonomous and challenging role where quality clinical supervision has benefits for the registered nurse. The structured New Zealand Coaching and Mentoring model of peer group supervision provides the foundation for this research.

Design: An interpretative hermeneutic study explored the experience of peer group supervision in a regional health service in Australia.

Method: Qualitative in-depth interviews were conducted with all levels of nursing staff to gain an understanding of their experience of peer group supervision.

Results: Data interpretation through hermeneutic analysis revealed the value and professional sustenance gained by participants. Identified game changers include adherence to rules and the influence of group dynamics. These areas were found to impact the quality of supervision.

Conclusions: This research provides different perspectives of peer group supervision that shares the experience of staff immersed in the process. Peer group supervision yields benefits for community health nurses, however the research has implications for practice.

Implications for nursing management: Nurse managers require information when making key decisions regarding workplace implementation. Effective supervision is only possible when balance between benefits and game changers are achieved.

Keywords: community health nurse, peer group supervision, clinical supervision, hermeneutic interpretation

Introduction

Community health nursing is an increasingly complex, autonomous Registered Nurse role (Barrett et al, 2016). Professional isolation, dynamic changes in practice, legislation and policy, plus increasing community chronicity present unique challenges for Registered nurses in the community (Cookson et al, 2014; Hall, 2018; Taylor, 2014). Other than informal or corridor conversations there is often no formal place to reflect on the more vulnerable aspects of practice. Given the paucity of opportunity to reflect on practice, it is not surprising that the literature identifies community health nursing or advanced practice nurses as professionals who would benefit from clinical supervision (Taylor, 2014).

A review of the literature reveals gaps and potential opportunities to better understand the experience of Peer Group (Clinical) Supervision in Australian community health nursing. Findings of qualitative studies may be difficult to apply to alternative settings and there is limited Australian literature outside the mental health clinical arena that has a specific focus on peer group supervision in use (Kenny & Allenby, 2013). Minimal research has focused on the experience of peer group supervision for semi-autonomous/ autonomous clinicians in community health. This paper reports on the findings from an interpretive hermeneutic study conducted with community health nurses participating in peer group supervision in an Australian regional health service. The New Zealand coaching and mentor model has been utilised by the participants to provide a structured model of peer group supervision (McNicholl, 2008). The recommendations arising from the research have relevance for both national and international nursing management practices.

Background

For this research, clinical supervision refers to the facilitation of reflection on practice, where learning and support can be experienced by health care practitioners and focused to enable safe clinical practice (Pollock et al, 2017). Clinical supervision has predominantly been utilised by allied health professionals and mental health nurses and is deemed essential for clinical competence (Bernard, 2019; Kuipers et al, 2013; MacLaren et al 2016; Martin et al., 2016). High quality clinical supervision has been demonstrated to: increase staff satisfaction; decrease the effects of nursing stress and burnout; be beneficial to patient care; and have a positive impact on organizational outcomes such as recruitment and retention (Bifarin & Stonehouse, 2017; Martin et al, 2016). It is suggested that clinical supervision should be incorporated into the day to day clinical routine (Bifarin & Stonehouse, 2017).

Models of clinical supervision may include one-to-one, peer group, group facilitated or a combination of these models (Bond & Holland, 2010). The model chosen for clinical supervision should reflect the needs of the clinicians, their experience, have acceptance by the profession, and be organisationally feasible and

supported (Evans & Marcroft, 2015; Martin et al., 2014). Whilst traditionally a one-to-one model, clinical supervision can be administered in groups with a designated supervisor or in a peer group.

Group supervision can be more rewarding than one-to-one supervision because of the breadth of experience and reflection to draw upon (Bond & Holland, 2010; Mastoras & Andrews, 2011). In peer group supervision, there is no defined supervisor, it is a group or team approach. Group supervision and peer group supervision are increasingly utilised by nurses in diverse clinical settings such as acute and specialty areas including community, emergency and oncology (Brunero & Lamont, 2012; Pollock et al., 2017).

Bond and Holland (2010, p.212) define peer group supervision as: "…*three or more people form a fixed membership group and have planned, regular meetings in which each person does in-depth reflection on complex issues relevant to their own practice and on the role they, as individuals engage. The group discussion surrounds the quality of practice and is facilitated by the other group members who cooperate as joint clinical supervisors*".

The definition by Bond and Holland reflects the NZ coaching and mentoring model utilised by the research participants. Broadly in health, the benefits of the peer group supervision model include: ongoing support mechanisms, case scenario critical reflection, reduced burnout, decreased stress, increased quality and quantity of feedback and confirmation of scope and contribution (Andersson et al., 2013; Bernard, 2019; Bond & Holland, 2010; Evans & Marcroft, 2015; Golia & McGovern, 2015; O'Connell et al, 2013; Taylor, 2013). There is debate in the literature about the use of peer group supervision in nursing practice. Whilst positive effects are attributed to clinical supervision, the strength of the effect is open for debate and varies depending on the study (Francke & Graaff, 2012; White & Winstanley, 2010). A systematic review by Pollock et al (2017) found there was a lack of high-quality research evidence concerning group clinical supervision. It is asserted that while there may be confusion about how exactly to quantify the benefits of group clinical supervision, the qualitative opportunities to share knowledge and to capture this experience is possible (Gonge & Buus, 2015).

Aims:

The research aim was to explore Community Health Nurses' lived experience of peer group supervision, to understand the contributions, scope of shared practice, benefits and challenges from which interpretations can be made to inform clinical practice.

Ethical considerations

To ensure the rights of the participants were protected, ethical approval was sought through the University (H19REA099) and the Regional Health Service (LNR/2019/QWMS/51406) where the participants are employed. Participants were invited via email and a resultant snowballing effect in the organisation occurred. Informed consent was obtained in writing from willing participants. Participation was voluntary and participants had the option to withdraw if desired.

Methodology:

Phenomenology is compatible with understanding the lived experience of Community Health Nurses participating in peer group supervision (Gadamer, 2004; Skea, 2016). Phenomenology seeks to discover what is unique about an experience and what is the essence of this approach personally and professionally. Interpretive hermeneutics was selected as the preferred methodology to bring forth via dialogue and interpretation, an understanding of peer group supervision as experienced by the participants (Finlay, 2014; Gadamer, 2004). Gadamer (a 20th century philosopher) considered ontology not in the terms of absolutes, but as understanding through dialogue, "the universality that is language" (Taylor & Francis, 2013, p. 83). Prejudices, preunderstanding or presuppositions are experiences that are brought to the phenomena.

Gadamer believed that you cannot ignore these existing understandings but rather should bring these preunderstandings to the fore and be open to the experience, despite any existing prejudices (Moules, 2015). The researcher's preunderstanding of the topic was obtained via experience as a community health nurse participating in peer group supervision. Whilst this preunderstanding assisted with knowledge of the process, the deep understanding of participant's experiences enabled a process of research rigour and credibility brought to the fore throughout all aspects of the research process. Credibility relies on the reader being able to see the decision-making processes of the research by ensuring that the experiences of the participants are accurately represented, and the interpretation is true to what the text is saying (Benner, 2008; Debesay et al., 2008; Fleming et al., 2003). It is important to make very clear what is original text and what is interpretation of the text (Austgard, 2012).

Data analysis sought to translate the experiences of the participants into resonating dialogue that could be understood and interpreted. The advantages of this methodology enabled the lived experience to be heard and deep understanding gained (Holloway, 2017). The research intent is not to validate the experience through numbers of participants, but rather to achieve the deep, full understanding that interpretation will bring (Moules, 2015). Thus, a smaller sample size is consistent with the phenomenological methodology

chosen. The data analysis process followed the principles of Gadamer's interpretive phenomenology structure with each step of this process represented in Figure 1.

Participants:

Site selection was based on the desire of the nurse leaders who supported the implementation of peer group supervision to know more about the experience. Supervisors offer a support to the process rather than input in the process, consistent with the New Zealand coaching and mentor model (McNicholl, 2008). Purposeful sampling occurred via email invitations sent by Nurse Managers in the Health Service to all staff participating in peer group supervision. Snowball sampling occurred as the staff referred or invited other participants (Liamputtong et al, 2017). Thirteen (13) female community health nurses from the following nursing grades: Registered Nurse, Clinical Nurse, Nurse Manager, and Clinical Nurse Consultant participated. Participants had at least six (6) months experience of peer group supervision.

represented seven (7) community health teams from an outer metropolitan, regional health service with at least six

Method:

For consistency and reliability, the data was collected by one individual, the author interviewed each participant. Staff were provided with the interviewers contact details to access the researcher independently. Participants were interviewed face to face in a location suitable for the participant. The interviews were conducted in areas near to but distant enough from the workplace to ensure privacy and confidentiality. Each interview was approximately one hour in length. Semi-structured in-depth face-to-face interviews using open-ended questions were utilised. This allowed the participants to speak quite freely and have a degree of control over the process (Holloway, 2017; Polit, 2017). All interviews were recorded, and subsequently transcribed verbatim. Participants were invited to review their transcript for accuracy prior to the commencement of data analysis.

Questions included:

Can you share with me your experience of peer group supervision?

Can you share an example of a situation that demonstrated the positive aspects of peer group supervision?

Can you share an experience where you have had concerns with peer group supervision?

Data analysis:

The purpose of hermeneutic analysis is to provide a deep understanding of the phenomenon to add to both knowledge and practice of the topic whilst remaining true as possible to the text (Austgard, 2012). Naïve reading commenced the data analysis process. The "hermeneutic circle" enables the participants' experience to unfold as the researcher moves continuously between the participant experience and their knowledge of the phenomenon. Data was read and re-read and key words from the initial reading noted.

A process followed of re-reading the text and interpretation to the point where broad themes and meaning were identified.

Figure 1 represents the interpretive hermeneutic analysis of the data leading to new horizons of understanding

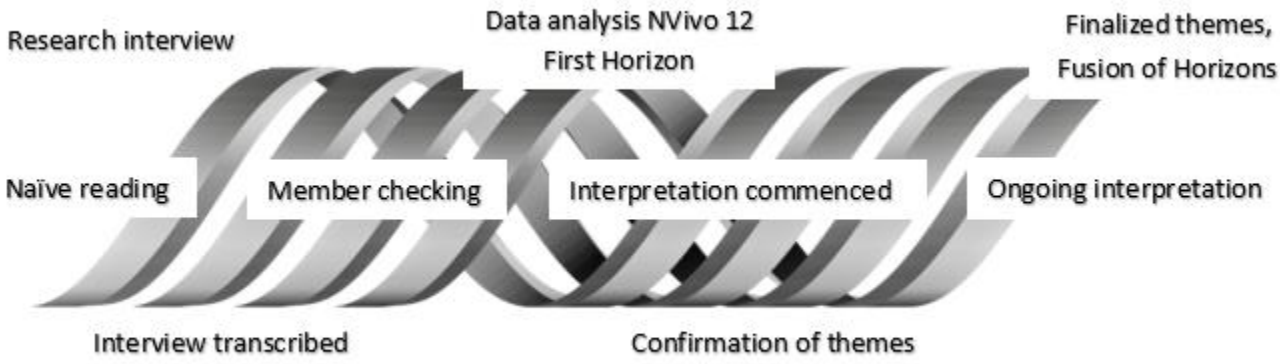


Figure 1 – The interpretive research method

Acquiring meaning and a deep understanding of the research questions enabled interpretations to be made (Austgard, 2012). These meaningful assumptions were coded using NVivo 12 software. Utilising hermeneutics, themes are merely a means to an end, with interpretation through new understanding of a fusion of horizons being the end product. According to Gadamer acquiring a horizon means “one learns to look beyond what is close at hand - not in order to look away from it but to see it better” (Gadamer 2004, pp.316). The fusion of horizons is the arising of new understanding of what is known about peer group supervision including context, culture and history.

Results:

The premise of hermeneutic analysis is not to present interpretation in terms of frequency but rather to provide in depth understanding of meaning or horizons. The results were collated into an initial first horizon to examine the data through an interpretive lens. This first horizon enabled the researcher to identify key areas of peer group supervision that were collated more succinctly in the interpretative analysis.

First Horizon:

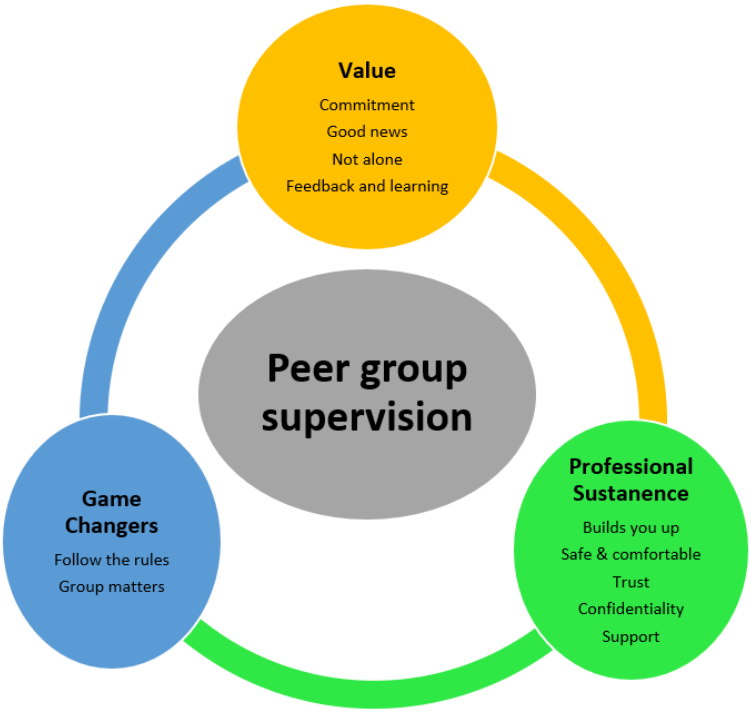
The participants brought with them history, culture and prior experiences. They shared their individual experiences but also reflected on the experiences of the group and nursing as a profession. They saw themselves as a part of the larger whole. They shared aspects of their horizon, some commonality of thoughts and some new horizons of understanding to the experience of peer group supervision. All participants defined peer group supervision in a way that was unique to their horizon despite having received

the same training in the concepts and definitions of peer group supervision. What we can interpret from this is that peer group supervision is all about perspective. Every person shared a different horizon depending on their history, culture and context. The summary of findings relating to what the participants brought to the experience is viewed from excerpts from the interviews. These included:

Table 1: The First Horizon: Participants' unique perspectives of Peer Group Supervision

"An opportunity to get support and feedback from your peers in a professional sense". (P1
"It is where you can come and bring absolutely any concerns you have regarding your practice, about your job, anything at all". (P 10)
"That's something you can do in confidentially while at the same time getting other people's viewpoint about how they feel about it". (P11)
"Sharing your thoughts and experiences with like-minded people". (P 13)
"A structured way of reflecting on your own practice". (P 2)
"Supportive, building connections between different teams across the community sector, helpful to get different people's perspectives on different issues or different situations, challenging sometimes". (P 4)
"A professional learning experience". (P 5)
"It's a supportive group of peers – so people who are your level, who are able to get together in protected time to discuss their issues pertinent to them personally or to the workplace". (P 6)
"It gives you an avenue of how to discuss things in a way that is productive, still defusing, still de-briefing but productive". (P 8)
"It's like a pre-organised pre-set time, quarantined time". (P 9)
"It's a time out, it's morale boosting". (P 3)

The hermeneutic process enabled the gathering of the text, the review of the first horizons and the capturing of key emerging interpretations. The key interpretations arising from the data analysis process are represented in Figure 2. The first key interpretation is value. Having value was outlined by participants in four ways; having commitment, sharing good news, not being alone and sharing feedback and learning. Secondly, the formation of professional sustenance developed with five noted areas emerging; it builds you up, being safe and comfortable, having trust, being confidential and having support. Represented as 'the game changers' the final section of analysis provides key insight into the learnings offered. The two key areas emerging titled 'follow the rules' and 'group matters'. Each aspect of the analysis is discussed commencing with the interpretation of 'there is value'.



There is Value

The first interpretation identified there is value in undertaking peer group supervision. Participants referred to the value of their own experience and considered the value for others, including nurses and other colleagues who currently do not have access to peer group supervision. There was value in the objectivity that others could bring to a situation. Some persevered even when their overall enthusiasm was waning because of the perceived value. Participants enjoyed the autonomy in the process, the opportunity for professional reflection, and the value of learning from others. The reflections brought to the wider group encouraged participants to feel safe to share, providing a safe space for reflective practice.

The spirit behind it is very different. It's run by us and it's completely up to you as to what you want to bring to it". (P4)

"I definitely think it's valuable and I like my nurses going to it". (P7)

"I just think it's essential for nursing and even now, I can't understand why nurses don't have it routinely". (P5)

1. Commitment

A level of individual nurse commitment was needed to get value out of peer group supervision. Success was dependent upon each member's participation. Not wanting to let the team down was a key motivator. Managers placed emphasis on staff attendance often over their own attendance. Managers identified the challenge of finding time to attend sessions, especially when the workplace was busy. However, attending peer group supervision provided opportunities to hear and share good news.

"I think if you're not committed to it, then you're not going to engage fully and if you don't engage fully, you miss out on so much but it's to the negative of the group as well". (P10)

"I feel that I let the others down if I don't go" (P9).

2. Good News

Good news was important as it was found that patient stories tended to "go around". Commencing as a situation where feedback or support was required then sharing with the group a success, added a rewarding element to sometimes stressful and complex situations. Hearing good news stories from colleagues was just as important to the experience as sharing their own. Sharing good news stories enabled participants to feel supported, worthy and not alone.

"Peer group supervision isn't all about problems. You need to celebrate your successes as well. We do good stuff; we change people's lives daily". (P5)

"I really get excited about sharing something good that's happened" (P1)

3. Not alone

Connections and relationships were built through the process of sharing experiences and was an unexpected benefit. Teamwork was enhanced as there was a sense that someone understood and shared the same experience. Decisions made could be validated resulting in a sense of relief as others gave positive affirmations.

"I think it's just that you're not there doing it on your own and knowing other people are reflecting on similar sort of things that they are experiencing". (P2)

"There is the caring aspect, not just as colleagues but we are all professionals trying to get better in what we are doing". (P12)

4. Feedback and learning

Participants reported an increase in their skills and knowledge. The focus of the experiences was not solely on skills learnt, but rather how the learning took place. For example, nurses acknowledged that no matter how experienced they were, all participants brought something to the discussion. Frequent learning and feedback were actively sought and experienced. It was important that the feedback was honest, objective and came from multiple perspectives. Often it was used not only to assist with current client situations but stored away for future reference.

"There's been some really interesting and challenging clinical and professional issues brought up in our group and it's been brainstormed in a really respectful way. There's empathy and understanding and problem solving". (P12)

"We learn huge amounts from each other". (P8)

Professional sustenance

Professional sustenance was gained in five (5) ways. Each of these identified areas contributed to the professional learning and establishment of the professional nurse in practice.

1. It builds you up

In this area, nurses gained increased confidence and morale through sharing experiences. It was important to come away from peer group supervision satisfied with the outcome of the discussions.

Now I feel a lot more confident". (P1)

"Everyone has their time to shine". (P12)

"Getting satisfaction is really important". (P11)

2. Safe and comfortable

Nurses needed to feel safe to bring issues to peer group supervision. Safety and comfort in the group allowed for growth, learning and development.

"This is like a kindred kind of group that, you know, you are safe and we are here to nurture and grow with each other". (P12)

"Because it's a safe place otherwise there's no point going". (P6)

3. Trust

Trust in each other and the process was pivotal. A lack of trust meant people withheld their experiences. The consensus was that trust builds and is earnt. However, trusting means you make yourself vulnerable and this was identified as a risk for participants.

"I would say that I had built up that trust in the group and now I'm quite comfortable sharing any of my experiences to anyone within our group". (P11)

"Over time, it is earned. It is earned because there is mutual respect. Because it just deletes all the hiding, you know, you become open". (P12)

4. Confidentiality

Trust and confidentiality were described as going hand in hand. The nurses described experiences where trust allowed members to bring concerning incidents to the group. Participants described how the group balanced confidentiality and accountability in supporting members to escalate an issue to a manager. Nurses were mindful of their environment and the potential to breach confidentiality and would address this with colleagues if it occurred in the group.

"If I didn't think it was confidential, I wouldn't go. If I didn't think that was going to be held confidential, I certainly wouldn't discuss it, I would be just very general and very non-engaged". (P6)

"Whatever is said there, stays there, people don't gossip". (P8)

5. Support

Support was an integral part of professional sustenance. It was as important to feel the support of colleagues as it was to give support. Manager support was considered vital, so nurses had protected time to attend.

"It's nice to have that support network where you don't feel so much of an idiot when things haven't gone so well". (P4)

"Work schedules are sometimes hard but I think if you have the support of your boss which we do, we usually get there". (P13)

Game changers

The final analysis identified two key game changers that determined whether peer group supervision was effective or not from the participant experiences.

Two key game changers appeared with "follow the rules" being dominant alongside aspects of "group matters".

1. Follow the rules

The model incorporated rules about the process and structure for peer group supervision. The use of the rules either added or subtracted from the peer group supervision experience. This was especially true when nurses had been in multiple groups and had different experiences. The rules contributed to feeling safe and supported and could be adapted over time to meet the group's needs. Not following the rules contributed to dissatisfaction and a decrease in the perceived value of peer group supervision.

Successful peer group supervision was dependent on a safe environment, where the capacity to speak openly and confidentially was respected, supported and visible. Not all nurses felt that peer group supervision was a safe or comfortable place: not because something had happened, but because trust was not yet built. The concept of trust opened nurses to a layer of vulnerability in nursing practice. A sense of vulnerability appeared when clinical situations were outside the normal and the two-way process of discussion of such issues explored the vulnerability.

Table 2: Follow the Rules

"You need to make sure that your group is engaged, that you have got to know the rules, because each group will have their own set of what their rules are, but, you know, the boundaries are there that are set in peer group supervision. I felt quite safe in that respect". (P5)
"Now we've established the group rules, it seems to be flowing a little bit better". (P13)

2. Group matters

Who was in the group, what that meant for trust and confidentiality and how it impacted positively or negatively was important to the peer group supervision experience. Peers were deemed to be nurses of the same nursing grade i.e. Registered Nurse or Clinical Nurse. However, questions around equality arose. Occasionally differences in peers created a perceived imbalance of power. Andersson et al (2013) noted that group members can unconsciously adopt behaviours from other groups that they have experienced. Whilst Borders (2019) note that working with group members can impact trust and self-disclosure.

Different personalities within the group potentially impact on the dynamics and influence the outcomes. For some a reluctance to be vulnerable in peer group supervision was challenged. However different personalities were not always an issue and it was recognised that this could be somewhat mitigated by following the rules and keeping each other in check. The experience was more valuable and effective when there was consistency of group members. Coming into established groups could be hard, as could having a new person join the group.

Expanding the group to increase the effectiveness and decrease the risk of elitism or becoming too familiar was raised. There was concern that over familiarity could lead to less productivity. In this leaderless model, the question was raised about who had oversight or was managing "the business" of peer group supervision. Setting foundational rules and boundaries of exchange were outlined.

Table 3: Group matters

"Because we're autonomous, you don't really know how good people are until you need their advice, and you see they "have really got the goods basically". (P1)
"I've found it challenging recently because we've had a new person in the group, so that takes time to sort of settle in so I think as far as that side of things go, it's just still in the "getting to know each other" phase". (P4)
"I felt like a bit of an outsider because everyone worked in the same team. But then we had a few more people added to our team, so I think it's kind of evened out". (P13)
"The dynamics change quite a bit depending on who's present. There were a couple that I found positive, and I think it was mainly to do with consistent group members that have been there at every single one". (P2)
"It's group dependent". "Having that objective outsider perspective is valuable and I've been openly encouraging the girls to expand our group" (P7)
"I am a little bit concerned about the oversight of it, who's actually stepping in at different times to see that the structure is being followed". (P 2)

Discussion:

The findings indicate that a peer group supervision model can be used with community health nurses and is not limited to nurses of a designated grade, years of experience or working with certain cohorts of patients. Importantly, peer group supervision is considered effective in practice, with an inclusive set of guiding rules. Respect, trust and boundaries of confidentiality are critical elements alongside engagement in meaningful and confidential discussion.

There is value for individual clinical nurses in participating in peer group supervision, but there is also potential for the wider nursing profession. Peer group supervision offers nurses the capacity to share expertise and experiences (Andersson et al, 2013; Blomberg et al, 2016; Brunero & Lamont, 2012). The opportunity to share experiences whilst providing and receiving feedback is valuable. Professional accountability to patients/clients is demonstrated through the continual desire to improve clinical practice and professional understanding. Professional sustenance was vital, not only for the nurses' personal wellbeing and confidence but also as a requirement for being able to trust in safe, confidential places to discuss clinical challenges.

Key interpretations of value and professional sustenance correlate with current literature (Atik & Erkan Atik, 2019; Bailey et al, 2014; Beal et al, 2017; Borders, 2019; Dungey et al , 2020; Sheppard et al, 2018). What has not been as clearly articulated are the experiences the nurses described as game changers for the peer group supervision experience. It could be argued that value and sustenance cannot be guaranteed in any clinical supervision experience but if the game changers are not considered, then peer group supervision may be like a rudderless boat, aimlessly drifting with little direction and no clear destination.

The nurses were forthcoming in describing the impact that not following the rules or group dynamics can have on the peer group supervision experience. Whilst this has not been well articulated in nursing research, some suggestions for mitigating these issues have been described in peer group supervision literature. Andersson et al (2013), describes the requirement for preparation and Dungey et al (2020) considers multidisciplinary groups, the use of structured arrangements and the introduction of peer group supervision in the undergraduate curriculum. Martin et al (2018) suggests proper labelling and the use of contracts. In peer group supervision there is no expert, and everyone is a supervisor. However, Bailey et al (2014) notes that even in leaderless groups, someone needs to take responsibility. Vulnerability is linked with this concept and one that outlined the need for boundaries, safe places and confidentiality in conversations.

Limitations

The lack of male participants may be regarded as a limitation. This may be reflective of the low number of male nurses working in this community health service. Future research should seek to achieve a more representative sample. Another limitation may be the small participant sample size however, this is consistent with the methodology chosen which seeks to explore the lived experience.

Conclusion

This research provides a different perspective of peer group supervision that shares the experience of staff immersed in the process. However, as is appropriate for hermeneutics, this research raised further questions that require consideration and investigation surrounding the game changers that emerged. Learning more about what constitutes peers requires consideration and review. Specifically, how this knowledge impacts on the game changers is required. The decision by nurse leaders and managers to implement clinical supervision into nursing practice is becoming a necessity in Australia (Australian College of Nursing (ACN, 2019). However, what model to implement to provide effective supervision is not clear. The role nurse managers play in the implementation of evidence-based practice is pivotal (Kueny et al, 2015). Managers need to consider resources available such as finances and time. Peer group supervision may be an attractive model of supervision in this regard.

Implications for Nursing Management

If the concepts related to peer group supervision are poorly understood and it is implemented without consideration of all the benefits and challenges, then it could potentially be setting up both staff and managers for failure. Poor quality supervision may be harmful to the clinician and to patient outcomes (Beddoe, 2017). However, this should not discourage managers from seeking to implement peer group supervision.

This research does not proclaim to have all the answers but rather serve as a prompt to assist managers to ask more questions. What model best considers the game changers such as rules and group dynamics whilst providing support and structure for staff so that they can get value and professional sustenance from their peer group supervision experience. This is especially important as the managers are not just embarking on their own supervision but also providing guidance for many staff. Whilst this study has reported on community health nurse experiences, the implications are relevant for nurse managers everywhere.

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