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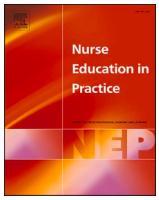

Contribution of peer group supervision to nursing practice: An interpretive phenomenological study

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ABSTRACT

Aim: To provide insight into peer group supervision practices through understanding the lived experience of community health nurses.
Background: The recent Covid-19 health crisis highlights the importance of supportive mechanisms to sustain and retain nurses in the workforce. While the support of quality clinical supervision for registered nurses is recognised, the benefits and challenges of peer group supervision are less clearly articulated.
Design: Nurses' experiences of peer group supervision in an Australian tertiary health service were explored using a Gadamerian philosophical hermeneutic approach.
Method: Semi-structured in-depth interviews were conducted in 2021 and provided nurses with the opportunity to share their experiences of using the New Zealand Coaching and Mentoring Model of peer group supervision. The study included a total of 31 nurse participants across multiple community health contexts. Interview data were analysed using a hermeneutic approach from which themes arose.
Findings: The findings demonstrated that strong peer group supervision foundations that include personal and professional preparation and active participation are essential. Dual pillars of "the unique individual" and "the unique group" with responsibilities identified in each pillar that enable interactions and worthiness in peer group supervision practice. The foundations and pillars support peer group supervision in nursing practice to provide a mechanism for reflection, support and professional guidance.
Conclusions: Peer group supervision is a worthy, contributory process in community health nursing when implementation processes are supported and teams are educated and prepared. Perceptions of peer group supervision are unique and varied across individuals. The individual experience has an impact on the group experience and vice versa. Knowledge of the process and group by participants is required to enable professional reflection through nursing peer group supervision.

1. Introduction

Peer group supervision participation benefits nurses through the provision of opportunities to reflect and respond to clinical and organisational demand in the workplace (Bernard and Goodyear, 2019; Schumann et al., 2020: Salomonsson, 2023). However, peer group supervision is neither widespread in its use nor well understood in nursing practice. Recommendations to embed clinical supervision into nursing practice (Australian College of Nursing, 2019; Saab et al., 2021) prompts questions from organisations, managers and clinicians about the time, preparatory work and potential beneficial outcomes. Competing demands prompt nurses to question if peer group supervision would increase efficiency, enhance the provision of person-centred care and provide the supportive guidance often sought, or just add to an already overburdened workload.

This research extends on previous findings that identified benefits and "game changers" that influenced the peer group supervision experience (Tulleners et al., 2021). This paper provides insights regarding peers and group dynamics when participating in peer group supervision to inform nurse decision-makers considering implementation into practice. This paper shares the benefits and challenges of implementation and recommends strategies for success.

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2. Background

In mental health nursing contexts, clinical supervision practice has been used for several decades (Cutcliffe et al., 2018). In settings such as community health, Allied health clinical supervision reflective practice is likewise well-established (Kuipers et al., 2013; Pager et al., 2018). Despite having multidisciplinary teams the roles, responsibilities and implications in practice for nurses in this context are very different. Reflective practice is not reserved for any specific discipline and opportunities exist for nurses to use peer group supervision as a mechanism for support, guidance and practice improvement.

Group and peer group supervision are terms used interchangeably in the clinical supervision literature (Basa, 2019; Blomberg et al., 2016). Peer group supervision entails collegial networks where no designated facilitator is present. Peers meet, discuss, explore and recommend as a professional group without guidance or support from managers or facilitators. In this model, the absence of designated leaders is managed internally with each member maintaining a supervisee and supervisor role and no one person assuming responsibility for the supervisory tasks. Whereas in group supervision, the presence of a facilitator or supervisor is identified (Bernard and Goodyear, 2019).

Peer group supervision develops collegial networks whilst exposing members to diverse perspectives (Tulleners et al., 2023). The process provides a space for increased self-awareness and resilience building, whilst decreasing stress levels. It also allows for nonjudgmental feedback to be shared whilst exploring challenging episodes of care (Barron et al., 2017; Beal et al., 2017; Dungey et al., 2020).

Challenges of the peer group supervision model include losing focus, sharing incorrect information, unresolved conflict, differing perspectives on what constitutes contribution, leaders inadvertently emerging and power differentials (Lewis et al., 2017; Mills and Swift, 2015; Pelling and Armstrong, 2017; Somerville et al., 2019). Peer group supervision is often seen as an advanced adjunct to receiving individual clinical supervision rather than a standalone practice (Bernard and Goodyear, 2019). More information and evidence are required to enable nurse decision-makers to consider peer group supervision as an option.

2.1. Aim

To provide insight into peer group supervision practices through understanding the lived experience of community health nurses.

2.2. Methodology

An interpretive phenomenological approach guided by Gadamer's philosophical insights was selected to explore the experiences of peer group supervision for community health nurses. Congruency of this methodological approach and peer group supervision is evidenced by the way Gadamer describes understanding of phenomenon occurring through conversation and dialogue. Understanding also occurs through acknowledgement of the topic's presuppositions or pre-understandings. Presuppositions can either enhance or hinder understanding of the topic and therefore cannot be ignored (Gadamer, 2013). The researchers' presuppositions arose from previous peer group experiences that ceased prior to the research. The presuppositions of the researcher aided understanding of both processes and language used by the participants.

Semi-structured in-depth interviews with registered nurses who had experience in peer group supervision practices in at least the last six months were engaged in the research. Data analysis used the hermeneutic circle, moving back and forth between the presuppositions, parts and the whole of the text until meaning was uncovered in key themes in the data (Lawn, 2006; Suddick et al., 2020). Interpretations emerged allowing the participants experiences to be understood through dialogue with their story that shared their experiences as new horizon (Gadamer, 2013).

3. Method

3.1. Participants

Participants were recruited from two Australian health service providers that use peer group supervision in the workplace. The health services included a large tertiary provider and a regional provider of services. Eighteen and thirteen participants respectively were recruited from the health services. Purposive sampling with snowballing was used to recruit participants. Information sessions were conducted with Nurse managers and email invitations were sent to all staff. Staff responded directly to the researcher and no further engagement occurred with the manager (Table 1).

3.2. Data collection

Interviews were conducted face to face or via Microsoft Teams to align with participant preferences and/or Covid-19 contact restrictions. Open-ended questions and prompts developed by the research team with a semi-structured approach were used to provide opportunity for in-depth discussion of experiences (Moules and Taylor, 2021). Interviews were audio recorded with consent and were approximately one hour in duration. Although not methodologically required, participants could review the verbatim transcribed interviews for accuracy prior to analysis.

3.3. Interview question examples

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

What is your understanding of peers within peer group supervision?

Describe the positive and challenging dynamics of your peer supervision group?

3.4. Data analysis

Understanding of the phenomenon begins with naive reading of the whole text. Reading and re-reading continues commence the analysis until the whole is understood. Key themes arise from the sum of the parts aiding interpretation of the topic (Moules, 2015). NVivo release 1.5.1 was used for coding of themes and journaling of the researchers' presuppositions. Following Gadamer (2013), continual movement between presuppositions and the participant experience allowed the researcher to enter and stay in the hermeneutic circle and this process occurred until themes were identified and line by line coded. Coding was initially completed by the researcher and then discussed with the supervisory team. Codification of data occurred until no new themes emerged. Fig. 1 represents the Gadamerian philosophical data analysis approach.

3.5. Rigour and credibility

Rigour and credibility in reporting the findings from this qualitative research was supported through transparency when acknowledging researcher presuppositions and using the Standards for Reporting Qualitative Research: a synthesis of recommendations (SRQR) (O'Brien

Table 1
Number of participants recruited, and their nursing role titles.

Phase	Number of participants recruited	Nursing roles represented
1	13	Registered Nurse, Clinical Nurse, Nurse Manager, Clinical Nurse Consultant, Nurse Educator, and Nurse Practitioner
2	18	Clinical Nurse, Nurse Manager, Clinical Nurse Consultant, Nurse Educator, Nurse Navigator and Nurse Practitioner
Total	31	

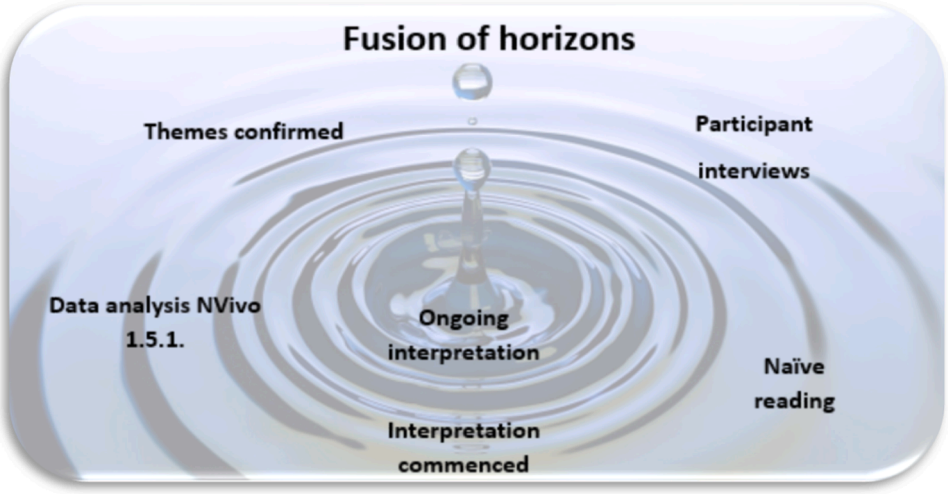

Fig. 1. Gadamerian philosophical data analysis approach (Image source Arek Socha from Pixabay).

et al., 2014).

3.6. Findings

Participant engagement in peer group supervision varied from those new to the process to those with years of experience. Some participants reported sustained peer group supervision experiences whilst others had a newly formed horizon:

> "It's probably been five or six years since we started peer group supervision" (Participant 11) "It has only been a few months" (Participant 6)

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Optimal nursing peer group supervision occurs when there is simultaneous support between the participants and the peer group supervision practice. This research shares the benefits and challenges

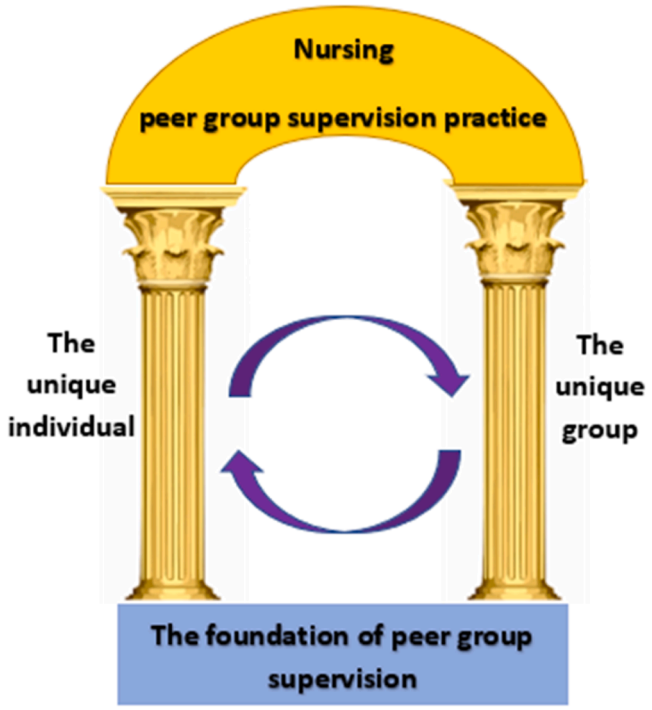

Fig. 2. Peer group supervision practice

associated with developing and sustaining the practice of nursing peer group supervision. (Fig. 2)

The first interpretation explores the foundation of peer group supervision. Foundations provide the basis on which the practice of peer group supervision is possible. Weak or unstable foundations set peer group supervision up for failure. The foundation supports the "unique individual and the unique group". This foundation of peer group supervision interpretations arising from the data analysis contains the following elements.

3.7. Foundation

3.7.1. Professional obligations

Providing excellent patient care is ingrained in professional nursing identity. Patient care or clinical work is prioritised over peer group supervision, potentially to participants detriment. In contrast, other health professionals were perceived to prioritise and "drop everything" for supervision (Snowdon et al., 2020): *"Nurses, I think don't possibly value it enough and don't put enough time aside, nursing as a profession"* (Participant 17). Time spent participating in peer group supervision is less valued as a contribution to nursing practice: *"I think the biggest barriers is overcoming our own prejudice towards it. Why would I protect time for myself? I can see two clients in two hours"* (Participant 18) *"We always come last"* (Participant 8).

3.7.2. Participation is important

Participation is a prerequisite for realising benefits (Gonge and Buus, 2015). Participants believed peer group supervision should be available to all nurses who wish to receive it, from undergraduates onwards (Australian College of Nursing, 2019) and should be a mandated professional expectation: "*I totally believe that all nurses should be given the opportunity. I believe that for everyone that wants to access it, we need to make it available. The professional foundations include the culture of supervision"* (Participant 1*)*. Despite logistics such as rostering, peer group supervision was seen to be transferable to any area of clinical practice: *"I can't say how much it would be valued to have it mandated for all nurses, regardless of what grade, regardless of level"* (Participant 13).

3.7.3. Finding peers

Peers are an essential foundation, however, participants encountered organisational barriers to finding a group: *"So, I as yet haven't been successful in being able to set up any kind of peer group"* (Participant 2). Some participants had received the prerequisite training on the New Zealand Coaching and Mentoring model, were eager and committed but were unable to locate a group because of unavailability or lack of

knowledge on vacancies*: "That's probably the only thing, finding out which groups are going and who's in the groups"* (Participant 5).

3.7.4. Attendance matters

Organisational support to attend peer group supervision was essential to promote long term attendance: *"We've definitely had support for this current group…it feels very supported from our bosses' perspective"* (Participant 10*)*. Despite organisational support, redeployment, Covid-19 lockdowns, fatigue, rostering, technology, travel/parking and backfilling nurses were all identified as challenges to attendance. Barriers arose when nurses lacked education in the peer group supervision model or were not deemed peers in terms of nursing level. Attendance also related to the perceived value of the group in assisting with the work challenges. One participant noted: *"You'll always be busy, but this is part of helping you manage the busy and help coping with the busy"* (Participant 5).

The foundational components identified that peer group supervision practice can be a safe, confidential space where shared values prioritise reciprocal, structured feedback. Nursing peer group supervision practice can potentiate professional reflection leading to insight, learning and changes to practice. However, consideration of the unique individual and the unique group that make up the exchange are critical themes that arose.

Once the foundation was established, the need to identify the challenges and experience of the individual and the group became critical parameters to the success or demise of peer group supervision in community health nursing practice. Two themes arose in this context: "the unique individual and the unique group". These themes were identified as supporting the practice of peer group supervision and collectively may be solid and robust, however each alone cannot support peer group supervision. The individual is pivotal to the group experience and vice versa and any irregularities or inconsistencies in either theme potentially have an impact on the individual, the group and ultimately the practice.

3.7.5. The unique individual

Representation of the themes is visualised as pillars arising from the established foundational support. The first pillar provides the overall key interpretation of the unique individual. Nurses may be peers in grade, work in the same location and follow the same model yet will experience peer group supervision uniquely. They are unique in what they bring, gain and contribute to peer group supervision. The unique individual comprises the interpretations through three subcategories of "For me, About me and Beyond me" (Fig. 3).

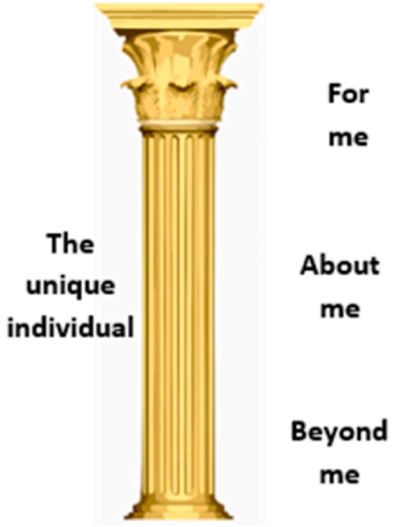

Fig. 3. The unique individual

From the data analysis arose the following interpretations and subcategories. "*For me"* is represented by: A new lens, support and restore and a safe place. *"About me*" is represented by: Owning my story, peer group supervision purpose and two-way street. "*Beyond me*" is represented by: We are in this together and not just for me.

3.8. Subcategory 1: for me

3.8.1. For me: a new lens

Participants identified benefit from seeing things through someone else's "lens". A new lens provided a fresh perspective and promoted insight*: "You think of it in a completely different way that you hadn't thought about it and that might be the thing that gives you that lightbulb moment"* (Participant 10). There is objective affirmation that correct decisions are made: *"Sometimes you do change the way you approach something …. But sometimes it affirms that what you think is right is right"* (Participant 18).

Different perspectives assisted in enhancing the nurse's reflective process. A new lens helps nurses go beyond what they knew and enabled problem-solving approaches from a different angle: *"Like looking through that different lens of how they support their clients.it's like an aha moment"* (Participant 13). This encouraged creative thinking to find solutions not previously realised. Richness arose from sharing experiences and ideas thus influencing current and future practice in community health nursing. One participant noted: *"No one person can know everything. At the end of the day your patient care is only as good as the amount that you know"* (Participant 8).

3.8.2. For me: support and restore

Peer group supervision restored and supported staff personally and professionally regardless of experience or grade: *"It is encouragement, personal encouragement for each other, professional and personal as well"* (Participant 12). Manifestations of support and restoration were experienced uniquely by the individual. Some reported an overall sense of support whilst others linked support to specific situations such as the loss of a client: *"Honestly, some things we're doing and some things we're seeing or being exposed to, we've got no one to unpack that with. So, that's had a toll on a lot of us"* (Participant 13).

Support and inspiration were derived from connecting with peers, building networks and friendships. Peer support, enhanced participants' confidence regarding patient care: *"It's just the way the conversation flows that makes it feel like they're just listening and supporting rather than criticising decisions or questioning"* (Participant 9). Some participants reported "missing" the peer support when work priorities took precedence. One participant noted: *"the times that you cancel it is when your workloads the greatest, which is when you really probably need that peer support"* (Participant 15).

3.8.3. For me: safe place

Participants reported confidentiality and trust allowed them to express vulnerability without fear of judgement: *"It's a safe place for people to talk about any challenges they might be facing"* (Participant 7). It gave them confidence to ask for help and to have difficult conversations: *"That trust in each other has improved to the point that you can be vulnerable amongst it. And you can say to them, "I have no idea how to move forward from this. Can you please help me?* (Participant 18).

However, individuals' levels of confidence take time to develop within a group and can have an impact on safety and trust: *"It's very safe and I think the formal approach in peer group supervision keeps it safe. I guess this was a safety net built over time. It didn't happen from the very first meeting"* (Participant 16). Being safe meant different things to different participants and did not always come quickly or at all. Vulnerability related to feeling less experienced than peers. Being vulnerable and seeking feedback may not come naturally for some nurses and lead to the individual holding back until a safe environment was perceived: *"It's nothing to do with them, it's all me. I'm the one with the issue. So, I guess it's*

probably just time and it's probably as we get to know each other a bit better" (Participant 8). Whilst the peer group supervision structure helped, there were no absolutes about when, how or if the individual will feel safe making the determination that safety was an individual construct and linked to both the overarching themes of the unique individual and the unique group.

3.9. Subcategory 2: about me

3.9.1. About me: owning my story

Owning peer group supervision meant committing to the process and prioritising attendance: *"That was what I owned from day one. You need to commit that this is important…. you need to plan* (Participant 1); *"I think it's about being true to that and just keeping that space. That's our time"* (Participant 8). Participants prepared what to bring, determined how the story unfolded and decided what outcome was desired. Investing time and energy meant there was an expectation of an outcome: *"If you're going to invest the time, then what do you want to get out of it and how are you going to make sure that happens?"* (Participant 3). Barriers to owning peer group supervision were institutional or individual such as redeployment or personal capacity. Not owning the process had repercussions for the individual and group experience such as disengagement or disruption to the group functioning: *"I mean the only one that can make it happen is me"* (Participant 14).

3.9.2. About me: peer group supervision purpose

Whilst owning your peer group supervision was deemed important (Fitzpatrick et al., 2015), understanding the purpose was essential (Driscoll et al., 2019): *"There's certain principles around peer group supervision. And it also helps you understand the purpose of it, why you do it"* (Participant 8). Whilst participants reported variations in purpose, there was generalised consensus that it was protected time to reflect on practice: *"Really have a firm understanding of why you are doing it. It's not just another meeting"* (Participant 3).

3.9.3. About me: two-way street

Peer group supervision required give and take or as one participant stated a "paying it back" approach: *"I might think, well, I'm fine this time, but somebody else might want to get a bit of support"* (Participant 5). A safe trusting space confirmed participants were not alone and could benefit from shared learning: "*I think definitely, it's a two-way street. You need to be able to be comfortable to speak, but equally have something to contribute and provide some support"* (Participant 9). Participants wanted to receive objective, honest, transparent feedback. Open discussion was valuable even if there was disagreement as this challenged action and change: *"I don't care if it's a disagreeing discussion, as long as it's a discussion"* (Participant 18). It was important to feel that contribution was being made and that value was gained by all members of the group. Not contributing or value adding to the discussion caused concern.

3.9.4. Beyond me: we are in this together

Providing nursing care for complex patients is challenging in a pressured health care environment such as during the Covid-19 pandemic (Mabin and Bridges, 2020). The knowledge that there was support and collegiality, not to solve problems, but to have access to peers who understood the situation, the context and the health language was empowering. Knowing someone understood helped participants feel less isolated and alone: *"You won't be judged because we have all been there"* (Participant 15). Even when physically separated, they were in the same "space," spoke the same language and they "got it." Peer group supervision changed participants' perspectives of where they fit together: *"They know exactly where I am coming from, we're not on our own"* (Participant 12).

3.9.5. Beyond me: not just for me

Peer group supervision went beyond the nurses involved: *"We are always patient focused"* (Participant 6). The experience brought accountability, a patient focus and a desire to share and celebrate positive stories. Shared experiences were seen as valuable for patients, colleagues and the profession.

3.9.6. The unique group

The final theme and second pillar describe the key interpretation, "*the unique group"* broadly defined as no two groups are ever the same. Like the "unique individual" pillar, cracks or weakness in this pillar will compromise the practice of peer group supervision. Key areas emerging were the subcategories: My peers; our rules; working together and broken trust (Fig. 4).

3.9.7. The unique group: my peers

Participants were inspired by, in awe of and often supported by peers: *"I definitely consider them my peers, they're just giants in my mind… I've learnt so much from them* (Participant 13). Peers (usually of the same grade) self-selected, were invited, or were allocated to groups. However, not all peers were equal. For some, the diversity of experiences in groups where there were varying levels of seniority, was preferred. For others, the difference in experience was perceived to be too diverse and instead of adding value, led to decreased feelings of "peer-ness" or even inferiority.

Self-selection of membership to a group enhanced the participant experience and was preferred. The total number of peers within a group had an impact, both positively and negatively. Fewer than three peers in the group membership posed challenges for outcomes. Participants reported that too many peers were simultaneously overwhelming or enriching due to the number of perspectives.

3.9.8. The unique group: our rules

Following the rules contributed to perceived safety and satisfaction

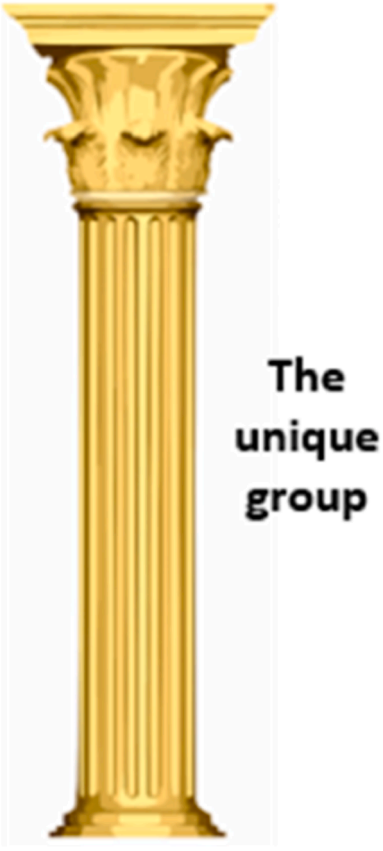

Fig. 4. The unique group.

in peer group supervision. Several participants concurred and found setting group rules was useful: "*One of the rules of the group is that whatever is spoken in here is confidential unless of course it's something that you probably need to discuss with your superiors"* (Participant 7). Participants used consent forms, agreements and allocated roles within the group.

Many groups adapted the rules and structure to suit their needs, sometimes abandoning the rules entirely: *"Although you can move around the boundaries of peer group supervision, I think it's important to stick to the main principles about everybody can have a say and it's not all about two people in the room"* (Participant 8). Rules helped groups "stay on track" and keep personalities in check to provide equal opportunity for contribution. Regularly revisiting and evaluating the rules was suggested but not often implemented: *"I think we need to go back to the rules and let's reinforce them. It's been a while"* (Participant 1).

3.9.9. The unique group: working together

Participants who did not "own" their peer group supervision were a source of frustration in groups. Being comfortable to speak up with peers about this took courage. Power imbalances within groups were seen, even when members were technically peers. This was attributed to widely different experiences or personalities. Various levels of experience added to the group knowledge but for some, there was fear of judgement due to position and perceived power balance or imbalance. When rules were not part of the structure, dominant personalities potentially contributed more than others. As the group dynamic developed, participants revealed more of themselves: *"The human being in all of us doesn't want to show ourselves as being vulnerable initially. The group has probably been cohesive for at least the last year"* (Participant 18).

One participant likened group functioning as taking "baby steps." Members can take time to adjust to different group styles. The group forms over time and trust builds with sharing: *"Other people's personalities are always challenging because they're not you"* (Participant 8*)*. Differences in opinion were welcomed, however personality conflicts were sometimes seen to cause cracks to form in this pillar, having an impact on the experience. There was acknowledgement that issues such as negativity, noncommitment or contribution were not discussed or resolved. Instead, issues were often accepted as "part and parcel" of groups.

In this leaderless model, leaders did emerge either through experience, taking on administrative tasks or keeping the group on track: *"So, it always landed on this one person and that shouldn't be the case"* (Participant 4). The ramifications of informal leadership in a leaderless group required consideration. Likewise, evaluation of groups for satisfaction and "fit of members" was inconsistent. It was assumed that silence meant consent, potentially to the detriment of the group. Having the right fit for the group was important: *"It's an opportunity to work out if they're the right fit for the way it's structured"* (Participant 9). Participants acknowledged that peer group supervision may not suit every person and that should be accepted: *"Maybe I didn't have the right group of people"* (Participant 17).

3.9.10. The unique group: broken trust

Infrequently, despite best intentions, structure and rules, broken trust can shatter this pillar causing irreparable damage *"I could never ever have confidence in anything that I said from there on to her, because the trust was broken"* (Participant 1). Groups sometimes felt like an unsafe place for some participants. Feeling safe within a group requires cultural safety, confidentiality, trust and respect for everyone within the group. For some, it was considered an area where more work, orientation and ground rules were needed to build trust in teams: *"I've sometimes found that what some people were saying didn't match what I knew"* (Participant 17).

4. Discussion

From this research two major conclusions arose. Firstly, it is the unique nature of peer group supervision that separates it from other reflective practices. Secondly, reflection is powerful and peer group supervision holds great possibilities. Peer group supervision practice for community health nurses is realised through the alignment of multiple aspects of foundations, self and group that lead to benefits for nurses, patients and the profession. Strong foundations are the building blocks of the peer group supervision experience. If not considered during planning and implementation, the structure will fail. Components of a solid foundation include developing a peer group supervision culture from the undergraduate nurse level onwards (Felton et al., 2012) and ensuring all nurses who want to participate, may do so with support given to assist with peer group identification (Bernard and Goodyear, 2019).

Issues relating to participation can undermine the foundations (Buus et al., 2018; Howard and Eddy-Imishue 2020). Therefore, supporting and valuing the contribution of peer group supervision from the individual and organisational perspective is required (Colthart et al., 2018). The research identifies that strong foundations do not guarantee effective outcomes. The interplay between the pillars either supports or destabilises peer group supervision practice.

The participants described support and different perspectives as pivotal to their professional reflection. Feedback provided a new lens through which to affirm decision making or to challenge nurses to think differently about their practice (Chui et al., 2021; O'Neill et al., 2022). Reflection with "others" counteracts the nurses' personal filters facilitating joint rather than merely individual learning (Davys and Beddoe, 2020) Confidentiality, trust and a non-judgemental atmosphere equated with a safe place where nurses could be vulnerable and share their experiences (Feerick et al., 2021; Harvey et al., 2020).

However, benefits are not realised through passive attendance. This study described the importance of owning the process in a way not previously articulated. New knowledge is identified in the foundations of attendance matters and finding peers that add a fit to the team and team dynamics. Peers and an absence of supervisor experts makes peer group supervision unique. Locating peers is a foundational priority but determining whether they are true peers requires consideration (Kuipers et al., 2013). A logistically easy option is allocating nurses in "peer groups" according to their grade. However, experiences can be vastly different and power balances unequal (Basa, 2019; Mills and Swift, 2015).

The interplay between the group and the individual is powerful, therefore establishing the right peer group membership is essential (Lewis et al., 2017). For this to occur foundational constructs of team building, group self-determination and trial and error discussions were needed. The development of groups, trust and positive, honest relations took time and perseverance. However, participants noted that when achieved the positive outcomes of the peer group supervision approach could not be underestimated. Group formation and functioning changes and evolves over time (Johnson and Johnson, 2017; Tuckman and Jensen, 1977; Vaida and Șerban 2021). Forsyth (2014) suggests all groups require cohesion to exist. Absence of trust and cohesion is identified as a threat to the group that can also fracture the unique individual pillar.

Group dynamics have an impact on group longevity, individual satisfaction and potentially lead to poor supervision experiences (Lewis et al., 2017). The model used by participants provided a structure designed to mitigate group issues (New Zealand Centre for Coaching and Mentoring, 2012). Despite these structures, group dynamics provided challenges. Initially groups felt disjointed and disorganised as peers determined their role within the group, especially if members were unfamiliar to each other. Established groups noticed changes in dynamics in the presence of new members.

Whilst positive outcomes were associated with cohesion (Somerville

et al., 2019), not all groups achieved this (Forsyth, 2014). Peer group supervision models that include structure, rules and evaluation help support participants (Pager et al., 2018). However, using a structured model does not guarantee effective peer group supervision for all.

Finally, nurses cannot "set and forget" peer group supervision. It is a live and fluid process that may benefit from regular evaluation and review to sustain the momentum (Colthart et al., 2018).

When the foundations were set and the subcategories enacted, the unique individual was able to develop, belong to a group, explore differences and have a more lateral approach to decision making and reflective practice. When the unique group established its norms, identified its boundaries and a safe group culture prevailed, positive reflective approaches and strategies were born, and staff felt supported. The worthiness of peer group supervision was contingent on establishing solid foundations, learning and accepting the unique self and gaining insight and practice in group formation and participation.

5. Limitations

A small proportion of male participants in the research (n=2) may be a limitation however this is reflective of the current nursing workforce (Australian Government, 2022). The sample size of participants may be perceived as a limitation; however, the contribution of their experience is valuable and consistent with the methodological philosophy.

6. Conclusion

This research provided insight into the lived experienced of community health nurses participating in peer group supervision. The research demonstrated that peer group supervision could be a valuable and viable option for nurse managers to implement with all nursing staff. Understanding who nurses identify as peers is important as is the option of self-selection into groups. Knowledge that no two groups are the same is important and equipping staff with the knowledge and skills to develop and sustain peer group supervision practice is a worthwhile venture. Individuals and groups have the power to have an impact on personal and professional nursing practice. The challenge for nurses and nurse decision -makers is to harness this power to better understand, own and progress nursing peer group supervision practice.

Ethical considerations

Ethical approval was sought and obtained from the University (H21REA069) and Health Service (HREC/2021/QMS/72302). Voluntary participation was initiated by a positive response to the email invitation, and participants were advised that they could withdraw at any time without penalty.

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CRediT authorship contribution statement

Tulleners, Tracey: Conceptualization, Methodology, Writing - original draft preparation, Investigation, Visualisation. **Taylor, Melissa:** Supervision, Methodology, Writing- reviewing and editing. **Campbell, Christina:** Supervision, Writing- reviewing and editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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