THE INTERPRETATION OF PEER GROUP SUPERVISION IN NURSING: A GADAMERIAN PHILOSOPHICAL HERMENEUTIC STUDY

A Thesis submitted by

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ABSTRACT

The ability to reflect on clinical nursing practice with the aim of developing personally and professionally, is essential for nurses. This research study explores a peer group supervision model used to enhance reflective capacity. A Gadamerian philosophical approach was selected to explore nurses' experiences of participating in peer group supervision. Peer group supervision is distinct from other models of clinical supervision due to the absence of a singular expert or leader. This does not imply that the participants in the model lack leadership or expertise, but rather that it is shared amongst the members of the group. This unique model has benefits for clinicians personally, professionally, and organisationally. Whilst the helping professions have utilised models of clinical supervision for decades, there is limited research on peer group supervision specifically for nurses. This research study explored peer group supervision through the experiences of participating nurses. Using a two phased, purposive approach, 13 participants were recruited in Phase 1 and 18 participants in Phase 2 from a regional and from a tertiary health service in Australia. A Gadamerian philosophical approach guided the research, and semi structured interviews were utilised for qualitative data collection. Data analysis consisted of reading and re-reading the verbatim transcribed interviews intertwined with the presuppositions of the researcher. Coding was iterative and the themes arising were verified by the supervisory team. The results demonstrated that peer group supervision was a valuable method for supporting nurses' reflective practice. To optimise the benefits and mitigate the challenges, key elements to improve success were identified and discussed. Peer group supervision needs to be supported by strong foundations, that consider the unique individual and the unique group. The foundations comprise four elements; professional obligations, participation is important, finding peers and peer group supervision attendance. These foundations when optimal allow the unique individual and group benefits to be realised. The unique individual comprises three concepts: a new lens, support and restore and a safe place, whilst the unique group comprises my peers, our rules, working together and broken trust. The unique individual and groups are intertwined where one cannot exist without the other. Where weak elements exist then the likelihood of peer group supervision being less optimal may result. This research provides recommendations for nurses and nursing decision-makers to utilise. The 10 guidelines provide strategies to enhance the likelihood of the benefits being realised. The guidelines propose risk mitigation strategies to address challenges.

CERTIFICATION OF THESIS

I, Tracey Tulleners declare that the PhD Thesis entitled *"The interpretation of peer group supervision in nursing: A Gadamerian philosophical hermeneutic study*" is not more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references, and footnotes.

This Thesis is the work of Tracey Tulleners except where otherwise acknowledged, with the majority of the contribution to the papers presented as a Thesis by Publication undertaken by the student. The work is original and has not previously been submitted for any other award, except where acknowledged.

Date: 18th October 2023

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Student and supervisors' signatures of endorsement are held at the University.

STATEMENT OF CONTRIBUTION

Chapter 3: A Qualitative Systematic Review

Paper 1 is published in Nurse Education in Practice.

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Contributor	Statement of contribution
Tracey Tulleners	Concept and design (70 %) Literature search (100%) Analysis and literature interpretation (70%) Wrote and edited paper (70%)
Christina Campbell	Concept and design (15%) Wrote and edited paper (15%)
Melissa Taylor	Concept and design (15%) Analysis and literature interpretation (30%) Wrote and edited paper (15%)

Chapter 6: Phase 1 Results

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Tracey Tulleners	Concept and design (70 %) Literature search (100%) Data collection (100%) Data analysis and literature interpretation (80%) Wrote and edited paper (70%)
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Christina Campbell	Concept and design (15%) Analysis and literature interpretation (10%) Wrote and edited paper (15%)

Chapter 8: Phase 2 Results

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Contributor	Statement of contribution
Tracey Tulleners	Concept and design (70 %) Literature search (100%) Data collection (100%) Data analysis and literature interpretation (80%) Wrote and edited paper (70%)
Melissa Taylor	Concept and design (15%) Analysis and literature interpretation (10%) Wrote and edited paper (15%)
Christina Campbell	Concept and design (15%) Analysis and literature interpretation (10%) Wrote and edited paper (15%)

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I have always considered lifelong learning to be a natural part of my nursing career. To develop my knowledge, I have completed a Certificate IV in Training and Assessment, a Graduate Certificate in Child and Adolescent Health and a Master of Advanced Practice. Whilst this has seemed a natural way to progress my nursing career, it is born out of a genuine desire to know more. Whilst it may sound trite, improving my nursing practice and the practice of others has been a genuine career goal.

Studying is rarely a solo effort, and I would sincerely like to thank my supervisory team. I have the greatest respect for Christina Campbell (principal supervisor) and Melissa Taylor (associate supervisor). I respect the fact that they let me take the lead in my research pathway and determine what and when I wanted to do things. Mostly though I respect and appreciate the frank way they would tell me I was “crazy” when I most needed to hear it. I thank them for being direct, for helping me find the words to say what I wanted to say and for the laughs when the words did not always come out right. Thank you both for your expert advice and guidance I truly could not have done it without you.

Thank you to my friends, who by going through their own PhD experience inspired and encouraged me to try in the first instance and then to keep going. Thank you for helping bring perspective to the ups and downs that occur when doing a PhD. A heartfelt thank you to the nurses who shared their experiences with me, without you the research would not exist. Finally, thanks to my family for listening patiently to me talk about my research.

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ABBREVIATIONS

Clinical Supervision (CS)

Group supervision (GS)

Structured peer group supervision (SPGS)

Peer group supervision (PGS)

Registered Nurse (RN)

Clinical Nurse (CN)

Clinical development facilitator (CDF)

Nurse unit manager (NUM)

Clinical nurse consultant (CNC)

Nurse Educator (NE)

Nurse Practitioner (NP)

Australian College of Nursing (ACN)

Queensland Health (QH)

University of Southern Queensland (UniSQ)

Health service (HS)

CHAPTER 1: INTRODUCTION

"Our understanding is shaped by the way we belong to the world".

(Mootz et al, 2011)

1.1 Introduction

This thesis explores the concept of peer group supervision as a professional and personal supportive practice for nurses. The research begins with the premise that nurses come to the profession with the intention of providing quality care in an ever-changing healthcare environment. Peer group supervision is a model of clinical supervision delivery characterised by clinicians utilising protected time to meet without a designated leader or expert. Engagement in this practice ensures a professional space for nurses to debrief, reflect and consider personal and professional work practices. The purpose of peer group supervision is to reflect upon individual practice whilst giving and receiving feedback from other group members. Peer group supervision literature reports multiple benefits for clinicians (Dungey et al., 2020; Golia & McGovern, 2015; Murphy-Hagan & Milton, 2020) however the concept is often misaligned with other concepts of supervision including group and supervised clinical supervision. This thesis specifically focuses on peer group supervision and its relevance to personal and professional nursing practice improvement.

The thesis is presented as three articles embedded into a thesis discussion. The provision of nursing care is increasingly complex. Reflection purposefully seeks to challenge and develop new insights in practice (Paterson & Chapman, 2013; Patel & Metersky, 2022). Through reflection, a responsive rather than reactive clinician can professionally grow and improve clinical outcomes and professional practice (Hawkins & McMahon, 2020). Professional growth is dependent on the capacity of a nurse to adapt and respond to changes. As a nurse, the challenge is to respond to changes in a way that maintains societal, professional, and personal expectations. Reflective practice provides a supportive framework for nurses to develop professionally and personally (Bulman & Schutz, 2013).

Clinical supervision is underpinned by the concepts of reflection from the seminal works of Kolb (1984) and Schön (1987) (Davys & Beddoe, 2020). Schön (1987) describes the dual aspects of reflection as “in reflection” occurring during practice and “on reflection” occurring after clinical practice. Both aspects have the potential to influence decision-making and improve the practice of a nurse in clinical settings. This type of reflection enables both an “in the present” construct of reflection and an “in the future” acknowledgement and awareness of practice improvements needed. Reflection to improve practice is beneficial for all areas of nursing and is not restricted to nursing grade, context or time spent in the profession.

There is a plethora of nursing literature that describes reflection in and on practice and its benefits and challenges to nurses in the quest to improve practice (Barbagallo, 2021; Barbour, 2013; Bulman & Schutz, 2013; Caldwell & Grobbel, 2013; Goulet et al., 2016). Debate continues about the optimal way to reflect including the parameters of who to reflect with, in what context and under which circumstance (Rolfe, 2014). The need to identify an emotional depth to reflection and the frequency of reflection is required. Further discussion relating to the type of reflection either guided or led, autonomous or peer supported are options for consideration. Figure 1 further shares the context, assisted and guided reflective opportunities identified in the literature.

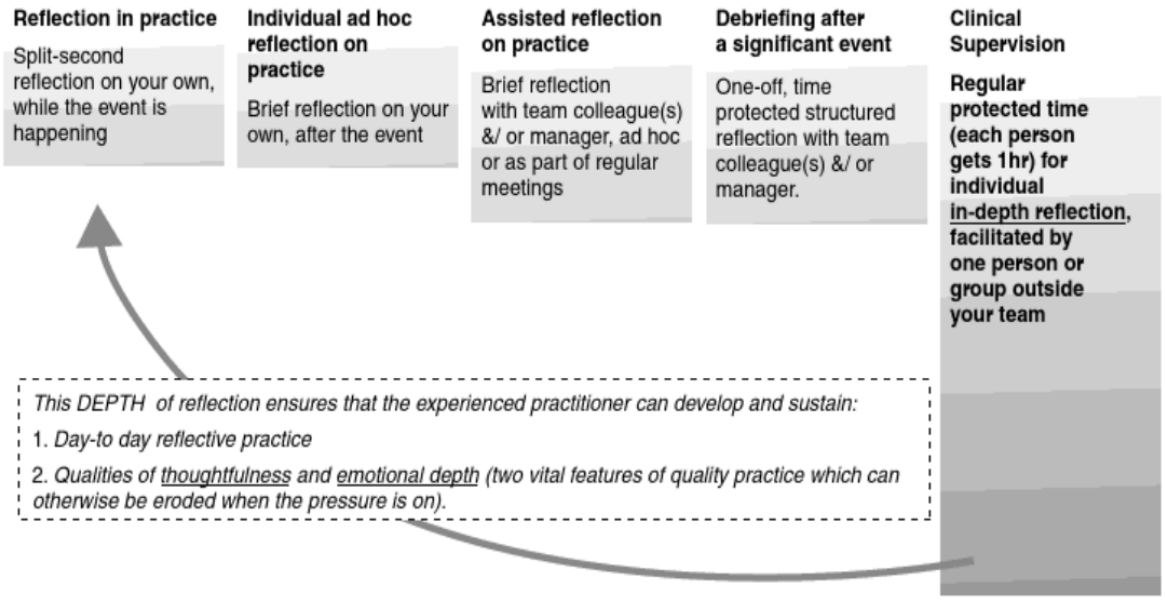


Figure 1: Skills of Clinical Supervision for Nurses: A Practical Guide for Supervisees, Clinical Supervisors and Managers Bond & Holland (2011 p. 128) McGraw-Hill Education Reproduced with permission from Open International Publishing Limited

Clinical supervision is not a new concept. Health professional colleagues including psychologists and counsellors have utilised clinical supervision to support their clinical practice for many years (White & Winstanley, 2014). Nursing literature details clinical supervision practice use for several decades particularly within mental health contexts (Cutcliffe et al., 2018). Despite the continued utilisation of clinical supervision practices, the literature suggests further research is required into defining peer group supervision, its priorities, relevance, and importance in clinical practice for nurses and its implications in improving client outcomes (Goodyear et al., 2016).

A variety of definitions exist to discuss differing concepts of clinical supervision and to gain an understanding of peer group supervision it is firstly important to identify the definition of each model. These variations in clinical supervision terminology have created confusion among clinicians and clarity is sought (Martin et al., 2017). For the purpose of this research three definitions have been provided to guide the research. The initial definition is provided by Bond and Holland (2011) who share a definition of clinical supervision that incorporates a facilitator (supervisor) – supervisee approach. This definition describes clinical supervision as:

> *"Regular, protected time for facilitated, in-depth reflection on complex issues influencing clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part she plays as an individual in the complexities of the events and the quality of practice. This reflection is facilitated by one or more experienced colleagues who have expertise in facilitation and the frequent, ongoing sessions are led by the supervisee's agenda (Bond & Holland, 2011. p15)".*

The second definition provides a perspective from group supervision where individual members share leadership responsibility based on a formal agreement. Bond and Holland (2011) define group supervision as: *"The group members take turns to share an issue and reflect on it, with supportive, catalytic, challenging, and informative help from other group members. The facilitator facilitates the process of group interaction (p.211)."*

Finally, peer group supervision is defined. Peer group supervision is unique as unlike other models of clinical supervision delivery it is leaderless with a flattened hierarchy (Bernard & Goodyear, 2019). In this research, peer group supervision is defined 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 part they as individuals play in the quality of that practice, facilitated in that reflection by the other group members who cooperate as joint clinical supervisors (Bond & Holland, 2011. p.212)".*

Figure 2 provides a visual representation of the varying models of clinical supervision delivery and the reporting relationships as outlined in the definitions provided.

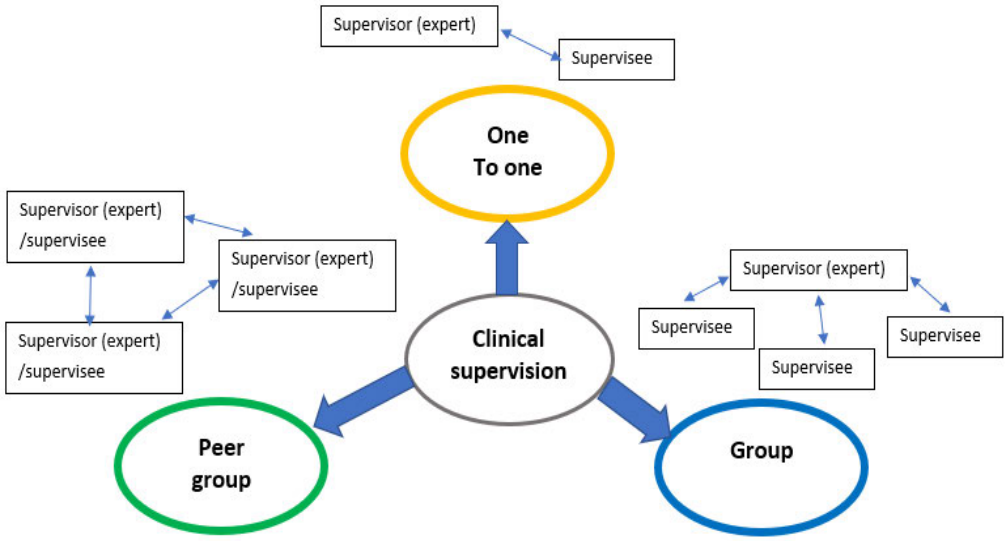


Figure 2: Models of clinical supervision delivery

Information on all models of clinical supervision delivery has been provided for contextual background. However, the focus of this research study is peer group supervision due to the unique qualities of this model and its relevance to the Australian health context.

This thesis explores nursing peer group supervision practice by presenting the voices and the language of nurses articulating their experience of peer group supervision in practice. Exploring these phenomena provides opportunity to gain insight into the benefits and challenges of peer group supervision for nurses and its implications in practice. The results will be presented as a descriptive discussion and three published papers providing an interpretive lens that shares the peer group supervision experience. The results provide insights that guide recommendations to assist and inform nursing decision-makers considering implementation into practice. This chapter presents the background and context of the research and then outlines the purpose and significance of the contribution to peer group supervision knowledge.

1.2 Background context- situating the researcher

The desire to research rarely comes from a random, or isolated thought. Rather it stems from a topic that calls upon us to respond and investigate further (Moules et al., 2015). The desire to research also comes from a place of being in the experience and wondering if the experience I have had, is like that of others, or is it entirely unique. This research project begins with learning more of the experience of nurses working in acute care community nursing within an Australian State Health Service.

Whilst working as a nurse educator in community health, I became increasingly aware of the changes in the clinical practice environment. Patients were more complex, with increased health needs and care requirements (Barrett et al., 2016). The practice environment was likewise more complex with evolving staff expectations, changes in technology and research developments. The role of the clinician is ever-changing, and while nurses tend to be adaptable, it is not always easy to know if you are doing a good job or know how to improve the quality of care for a patient.

It was in this Australian nursing context that I first became aware of clinical supervision and the peer group supervision delivery model. I became interested in the potential benefits of this model to support my practice and that of my nurse colleagues in community health. I believed there could be benefit not only professionally, but importantly, as a mechanism to improve clinical outcomes for patients. Following approval from the Health Services Nursing Executive, the New Zealand Coaching and Mentoring model of peer group supervision was implemented into the community health setting (McNicholl, 2008). In 2016, I initiated peer group supervision education and training for approximately 80 nursing staff across seven community health teams. The staff were from all grades/designations of nursing and included registered nurse, clinical nurse, clinical nurse consultant, nurse educator, nurse manager and nurse practitioner. The peer groups were formed according to nursing grade.

Whilst allied health colleagues from disciplines such as social work, psychology and dietetics worked alongside the nurses in the community health teams, they were not included in the peer groups due to having access to their own health discipline clinical supervision practice. The nurses were allocated to groups following recommendations from the New Zealand Coaching and Mentoring Model regarding optimal group size (approximately four-six members) and time required (1.5-2 hours) (New Zealand Coaching & Mentoring Centre, 2012). The nurse managers supported nurses to have monthly sessions in work time.

Once all nurses were educated, peer group supervision commenced. Whilst I allocated nurses to their groups, they determined where and when they met. I likewise was a member of a peer supervision group. My group contained nurses from grades seven and eight who were in clinical roles, whereas I was in an education role. My experience of peer group supervision was interesting and mostly positive. I was able to explore with my peers the situations that I encountered, concerns that I had and successes that I achieved in my nursing practice. Reflecting upon my practice helped me develop strategies to improve my nursing skills and knowledge. However, I also experienced the challenges of being busy and having competing priorities in the workplace that made peer group supervision difficult. I wondered what other nurses' experiences were like and what benefits and challenges arose for them.

1.3. Introducing the research

The research consists of two phases. Phase 1 explored the experience of community health nurses working in a regional health service in Queensland, Australia. The nurses in this research utilised the New Zealand Coaching and Mentoring model of peer group supervision. The selection of this model was informed by the experiences of the researcher as described in Section 1.2. Whilst this research offers insight into the experiences of community health nurses, it also raised questions about peers and group dynamics. Upon completion, the findings of this research project were published as “Peer group clinical supervision for community health nurses: Perspectives from an interpretive hermeneutic study”, which is presented in Chapter 6.

In this article, Tulleners et al. (2021), raise further questions regarding the meaning of peer group supervision and the benefits and challenges of the practice. Therefore Phase 1 provided the impetus for Phase 2 as there was a need to know more about peer group supervision in response to emerging changes in Australian healthcare. One of these changes was the release of the joint statement on Clinical Supervision for Nurses and Midwives from the Australian College of Midwives, Australian College of Nursing and Australian College of Mental Health Nurses (State of Queensland (Queensland Health) 2021). The position statement reports:

> “It is the position of the Australian College of Midwives, Australian College of Nursing and Australian College of Mental Health Nurses that Clinical Supervision is recommended for all nurses and midwives irrespective of their specific role, area of practice and years of experience” (Australian College of Nursing (ACN), 2019, p.3).

As there are approximately 373,000 nurses/midwives in Australia (Australian Government (Department of Health and Aged Care), 2021), the Australian College of Nursing Joint Statement has implications for practice for each nurse/midwife within the Australian healthcare context. It follows that there are also implications for nurse managers and decision-makers. (See Table 1 for 2022 Nursing/midwifery numbers).

309, 851	Registered nurses
53, 612	Enrolled nurses
5,560	Midwives with midwife-only registration
20,003	Midwives with dual registration
There are around 372, 759 registered nurses and midwives in Australia, making it the largest clinical workforce in the country.	

Table 1: 2022 Nursing Workforce numbers Ref: Australian Government retrieved from https://hwd.health.gov.au/resources/data/summary-nrmw.html

In alignment with the Australian College of Nursing Joint Statement, health services have considered the impact of clinical supervision implementation on nursing staff. In Queensland, health services have incorporated clinical supervision as a supportive measure for nurses across all learning pathways (see Figure 3). The learning pathways are defined in the framework for lifelong learning in Queensland Health. In this pathway, career development and sustainability are outlined with the resulting learning and career pathway trajectories shared.

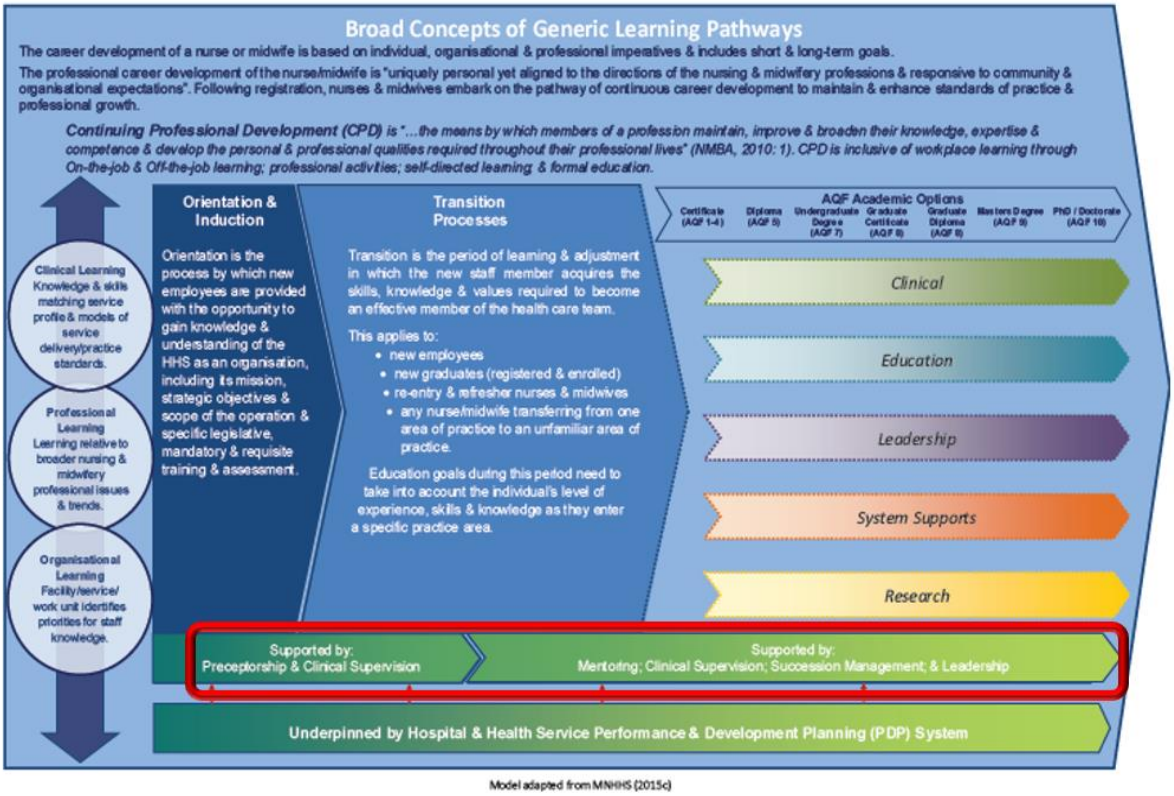


Figure 3: Clinical supervision support for the "Framework for lifelong learning for nurses and midwives- Queensland Health (State of Queensland (Queensland Health, 2018).

This framework and the supportive professional development framework embed clinical supervision in nursing practice. Queensland Health (QH) have initiated the “Clinical Supervision Framework for Queensland Nurses and Midwives” (State of Queensland (Queensland Health, 2021). In this framework, clinical supervision is an expectation in the practice standard. Figure 4 identifies clinical supervision as part of supportive professional development activities for employees in Queensland Health in the mental health sector.

Figure 4: Supportive Professional Development Activities. Adapted from the Clinical Supervision Guidelines for Mental Health Services (Queensland Health, 2009, p.10) (State of Queensland (Queensland Health, 2021).

Despite the Framework for lifelong learning and the supportive professional development model, a sporadic approach to clinical supervision is seen within Queensland Health. There are some clinical areas that currently use a peer group supervision model and others may be considering this as an option due to the appeal of time efficiency and cost resource usage (Andersson et al., 2013). This research seeks to understand the experience of the registered nurse participating in peer group supervision practice in their nursing area. It is recognised that poor supervision practices may have dire outcomes for staff regarding their confidence and competence (Beddoe, 2017; Cook et al., 2018; Ladany et al., 2013).

This research is required to explore the peer group supervision phenomenon and address the questions arising. What does peer group supervision offer as a benefit to participants and what are the challenges? What does the nurses experience add to the literature and what impact does this have for the implementation of peer group supervision in practice? Recommendations will be made about peer group supervision in this research including which model benefits the professional development of nurses whilst mitigating the challenges.

1.4 Research question

The overarching research question is: “How might the phenomena of peer group supervision be understood through the lived experience of nurses participating in a peer group supervision model”?

1.5 Research aim

To explore the peer group supervision phenomenon through the lived experience of nurses to understand the integral elements of peer group supervision, including the benefits and challenges to participation.

1.6 Research design and methodology

Qualitative research is an appropriate methodology for nursing research studies where the focus is on the participants' experiences (Liamputtong, 2017). Beck (2013) states *“*qualitative methods provide researchers with a way of seeing, and a way to understand; a way of listening, and a way to hear; ways of accessing and empathetically knowing the most intimate parts of the other” (p. 13).

Nursing research studies need to demonstrate congruence between the selected philosophy, research approach, and research aim (Beck, 2013; Ellis, 2016; Liamputtong, 2017; Matua & Van Der Wal, 2015; Zahavi & Martiny, 2019). The challenge of nursing research is to reflect the multiple realities that clinicians experience of the phenomena of study. Phenomenology is both a philosophy and a qualitative research method that considers the meaning of the everyday lived experience for the person, and then seeks to describe and give voice to this experience (Johnston et al., 2017; Sloan & Bowe, 2014).

The premise of phenomenology is that the subjective experience will be understood through an insider's perspective (Gerrish & Lathlean, 2015). In this study, the insider's perspective is provided by the researcher. For these reasons, phenomenology is compatible with understanding the lived experience of nurses participating in peer group supervision (Giorgi, 2012; van Manen, 2017). The philosopher Gadamer (1900-2002) contributed to the development of hermeneutics through consideration of ontology in terms of understanding through dialogue, "the universality that is language" (Taylor & Francis, 2013. p. 83). His magnum opus "Truth and Method" focuses on the need to consider the historical context of the understanding. A distinctive aspect of Gadamer's work is the emphasis given to language, conversation and the sharing of community and culture that comes with conversation. He discusses prejudices, which are the presuppositions that people bring to a topic or experience. Like his teacher Heidegger, Gadamer believed that one could not ignore these existing understandings but rather need to be open to the experience despite one's prejudices (Moules et al., 2015).

For Gadamer, language was far more than a tool, "it was the universal horizon of hermeneutic experience" (Nelms, 2015, p.2). Gadamer describes the fusion of horizon as "the interpreter and the text each possesses his, her or its own horizon and every moment of understanding represents a fusion of these horizons" (Gadamer, 2006, p.45). Fusion of horizons arises when history and the present day come together to bridge the gap between what is known and what could be (Paterson & Higgs, 2005). In this research, the historical horizon will be the literature associated with peer group supervision. The present horizon will be the text collected through the transcribed participant interviews, embedded in the emerging interpretation of the researcher.

A Gadamerian philosophical approach is the preferred methodology for this research project to bring forth, through dialogue and interpretation, an understanding of the benefits and challenges associated with peer group supervision for the nurses experiencing it (Finlay, 2014; Gadamer, 1975/2013; Willis et al., 2016). This research seeks to translate the experiences of the participating nurses into resonating dialogue. The ordinary, everyday is invited to stand out in hermeneutics and is presented with the premise that it is possible to interpret the world (Moules et al., 2015). Semi-structured interviews were utilised in the research design to seek information about the participants' experience of peer group supervision.

Gadamer describes the “hermeneutic circle” whereby the researcher moves backwards and forwards between their knowledge of the phenomenon and the experience of the participants. It considers the parts and the whole of the phenomenon as a circle or a spiral that increases with additional understanding (Bynum & Varpio, 2018; Earle, 2010; Hopkins et al., 2017; Moules et al., 2015; Taylor & Francis, 2013). To understand the experience is to recognise that all is not obvious. This is about understanding the concepts and constructs of peer group supervision as we learn more about each part of the experience from participants to see the whole arising from each of these components.

In the search for new understanding, the participant experiences are hermeneutically explored and analysed until deeper meaning or interpretations arise and are identified (Gadamer, 1975/2013; Moules et al., 2015). This backward and forward motion included the literature, the interviews and the interpretations of the phenomenon to add new understandings or horizons. From this understanding, recommendations for peer group supervision practice arise.

1.7 The phenomena of interest

Nursing is a highly respected healthcare profession. This has never been more obvious than during the recent Covid-19 pandemic (Catton, 2020). The pandemic impacted nurses in many ways. Patient acuity increased, interruptions to work through the redeployment of staff and the potential health risks to self, family, and friends were clear (Martin & Snowden, 2020).

Nursing, as a profession, experienced loss and hardship. This loss has included colleagues lost to the disease itself as well as those lost to policy changes including mandatory vaccination. Each change, restriction or alteration of circumstances place additional pressure on the nurses that remain in the system. Whilst the focus in the media has been on frontline nurses within acute care sectors, all areas of clinical practice have been impacted (Roberts et al., 2021). Not only have nurses experienced loss but they have also experienced a need to rapidly acquire new skills and knowledge. All these changes are additional to the already high expectations placed on nurses. Now more than ever nurses are reflecting on their practice and requiring support to continue in their chosen career. Opportunities exist for nurses to utilise peer group supervision as a mechanism for support, guidance, and practice improvement.

Many health professionals utilise clinical supervision as a reflective practice to support staff in their clinical practice. Allied health clinical supervision reflective practice is well-established in many settings including community health (Kuipers et al., 2013; Pager et al., 2018). Despite working together in a multidisciplinary team, the roles and responsibilities, of nurses within these teams are very different. Therefore, the reflective practice of participant needs, are also different. However, the skill of reflection and the desire to improve and provide quality nursing care are not reserved for a single grade of nurse, nor a particular area of clinical practice. Therefore, the phenomena of interest for this research are registered nurses and their experience of peer group supervision.

1.8 Research setting

The research setting for Phase 1 of the research was a regional health service in Queensland. Phase 2 extended the results identified in Phase 1 to explore the topic in greater depth and detail at a tertiary health service in Queensland where the New Zealand Coaching and Mentoring model peer group supervision had been currently implemented for nurses. This specific peer group supervision model had been selected by the Nursing Executive and subsequently embedded in this setting and operational for up to seven years. The community health setting provides care to patients across a variety of teams and care settings such as chronic conditions, transition care programs, refugee health services, wound care, and acute care at home.

The nursing staff were physically located across a large geographical area in the health service. Nursing staff in community health are highly autonomous and provide a valued service as they care for vulnerable and complex patients (Casey et al., 2017; Gardner et al., 2013).

1.9 Research justification

This research provides an understanding of peer group supervision experience from the voices of nurses engaged in peer group supervision in a community health setting. Specifically, the research seeks to understand the peer group supervision process that nurses undertake and to determine the practice of peer group supervision according to those participating in the process. The research contributes significantly to understanding the phenomenon by providing interpretation of the lived experience of peer group supervision for nurses in various community contexts in Australia.

The interpretations provide insight for recommendations relating to all integral aspects of peer group supervision. Thus, informing nursing decision-makers choosing to enact recommendations in line with the Australian College of Nursing (2019) statement: “clinical supervision…should be embedded into student curriculum, graduate programs and lifelong learning” (p.3). Insights may apply not only to the nursing discipline but other health care disciplines utilising peer group supervision. These insights are important because nurses are participating in peer group supervision and the need to share the positives and challenges of the process must be explored to increase engagement and to add quality improvement initiatives to the overall experience. These outcomes provide evidence-based and informed information to enhance professional capacity of the RN in insightful reflective practice.

A gap currently exists in understanding the lived experience of peer group supervision for nurses in the Australian healthcare context. Minimal research describes how nurses perceive and integrate peer group supervision into their practice. It is presumed that a peer group supervision model impacts the support processes of registered nurses however these experiences have not been documented. This research has added to the body of knowledge to help understand and improve the application of the peer group supervision model in practice, thus improving the quality of supervision leading to increased work satisfaction for nurses and ultimately, better outcomes for patients.

1.10 Research significance

The significance of this research is in the knowledge gained from learning more about the experience of peer group supervision in practice from those using it. It is hoped that clinicians will have the opportunity to participate in supportive practices such as quality clinical supervision throughout their nursing careers. However, the models of clinical supervision they experience may vary depending on the preferences and knowledge of decision-makers within the health services (State of Queensland (Queensland Health) 2021).

White (2017) suggests that clinical supervision has become "exalted in public policy statements" through espousing the benefits to nursing staff (p.1251). An example of this is the following statement from Queensland Health.

> "Clinical supervision is an important professional development activity that benefits nurses and midwives, the people we care for and the organisations in which we work. It is becoming increasingly recognised as a core component of contemporary nursing and midwifery practice. Additionally, it supports reflective practice approaches that align with an important way to manage health and wellbeing" (State of Queensland (Queensland Health) 2021. p.3).

However, White (2017) observes there is a lack of visibility regarding clinical supervision research and suggests this is due to a lack of understanding of the concepts. This lack of understanding may lead to inadequate or poor practices. Through the following chapters, this research intends to increase the visibility of peer group supervision to increase understanding and acceptance of the peer group supervision model that has the potential to significantly improve practice. At present there is no consensus on what model of clinical supervision is preferred and when and how models should be implemented (Bernard & Goodyear, 2019; Pollock et al., 2017). This research is significant because it provides a voice for nurses who have insight into the peer group supervision model. Peer group supervision is not a scaled-up version of one-to-one clinical supervision (Heffron, 2016), it is a unique model with distinct benefits and challenges. The insights shared from this research contribute knowledge and understanding regarding peer group supervision practice which will impact the experiences of nurses now and into the future.

1.11 Thesis outline

The thesis is structured into the following nine chapters.

Chapter 1: Presents an overview of clinical supervision as a model for facilitating reflective practice. Peer group supervision was introduced as a specific model of clinical supervision. The background to the research was presented and the research question and aim were outlined. The research design, methodology and setting are described. Finally, the justification and significance of the research are outlined.

Chapter 2: Provides an in-depth overview of the peer group supervision literature. It begins with clinical supervision to establish the context and history of this practice. From this overview, the peer group supervision model is discussed. The literature review examines participation and non-participation, benefits, and challenges.

Chapter 3: The experience of peer group supervision in the literature is further explored through the Tulleners et al. (2023) publication titled “The experience of nurses participating in peer group supervision: A qualitative systematic review”.

Chapter 4: Provides an in-depth description of the chosen methodology through which peer group supervision practice may be understood. A variety of methodologies could have been utilised to explore this topic however a Gadamerian philosophical approach was selected for its congruence with the research phenomena.

Chapter 5: Provides an overview of the design for the research project. This chapter provides detail into the research setting, participant selection and recruitment, ethical considerations, positioning of the researcher, data collection and data analysis.

Chapter 6: Reports the findings from Phase 1. The findings and interpretations of this initial research phase are described in the article titled “Peer group clinical supervision for Community Health Nurses: Perspectives from an interpretive hermeneutic study” (Tulleners et al., 2021).

Chapter 7: This chapter provides a narrative description of the findings from Phase 2 of the research. The participants' voices are clearly heard through the descriptions of their experiences.

Chapter 8: The interpretations of Phase 2 are reported in the article titled “Contribution of peer group supervision to Australian nursing practice: An interpretive phenomenological study” (Tulleners et al., 2024).

Chapter 9: The final chapter of the thesis provides a summary of the research including discussion and commentary of the future directions and implications of nursing peer group supervision. This chapter provides a synopsis of the strengths and limitations of the research study. Recommendations for nursing policy and practice are outlined. The chapter concludes with recommendations for future research into peer group supervision.

1.12 Chapter summary

The first chapter of this thesis has provided an overview of the research background and context. The research question has been clearly articulated and the research aim described. Finally, there has been a clear articulation of the significance of the research, why it is required and how the research can benefit nurses moving forward. The following chapter presents an extensive review of the literature to discuss peer group supervision practice and what this means for nursing.

CHAPTER 2: LITERATURE REVIEW

"Nothing exists except through language" Hans-Georg Gadamer

2.1 Introduction

Chapter two presents key concepts that will form the foundation for this doctoral research through review and analysis of the published, peer-reviewed research. This literature review will outline the concept of peer group supervision and its use in healthcare. Discussion will include the context of clinical supervision (section 2.2), and clinical supervision definitions (section 2.3). Discussion relating to participation in the phenomena of peer group supervision (sections 2.4 & 2.5), the functions and purpose (section 2.6), and frequency of participation (section 2.7) will be outlined. The effectiveness of clinical supervision (section 2.8), and benefits (section 2.9) are shared. An analysis of the models of clinical supervision (section 2.10), clinical supervision delivery models (section 2.11), individual and group supervision (sections 2.12 & 2.13), peer group supervision characteristics, and peer group supervision models including a brief overview of the New Zealand Coaching and Mentoring model, peer group supervision advantages and challenges (sections 2.14, 2.15, 2.16, 2.17, 2.18 & 2.19) is provided. Finally inadequate, or harmful clinical supervision is discussed (section 2.20) and the chapter summary outlined (section 2.21).

This chapter will outline the supervision process in the practice of nursing. A review of the clinical supervision literature will occur through the iterative process of going back and forth from the literature to the researcher's presuppositions. The sum of the parts and the whole together will form a new horizon of clinical supervision understanding from which the essence of clinical supervision literature will be revealed. The purpose of this review is not merely to identify literature gaps or areas for future research but to "provoke thinking" about peer group supervision and its construct in nursing practice in a community health setting (Smythe & Spence, 2012.p.14)

This provocation to think about peer group supervision began for me when I read an editorial from Martin and colleagues, (2018) describing the international problems and prospects of peer group supervision. Whilst this editorial did not directly refer to nursing it utilised powerful language such as “fraudulent” and implied that participation in peer group supervision may “jeopardize their professional registration” if not properly conducted (p.998).

Likewise, it was suggested that peer group supervision was not appropriate for new staff or new contexts. This was very provocative as it contrasted with my experience of peer group supervision. A particular peer group supervision session of my own exemplified this contrast for me. It involved a peer group supervision session where a peer brought a complex patient safety situation to the group. The resulting action was group support to our peer who was then able to escalate the situation to nursing management. The reassurance from the reflective discussion provided the rationale and clinical support needed to confirm and assure the right decision was made. We were supportive, accountable and person centred which is why this editorial challenged me to want to know/learn more about this phenomenon. It is with this presupposition or prejudice that I come to the literature acknowledging that this can either open my perceptions or close them down (Gadamer, 1975/2013).

There is a plethora of literature relating more generically to clinical supervision. Taking a deep dive into the clinical supervision narrative creates an understanding of the concepts. This comprehensive review includes hermeneutic mapping and classification that explores the concepts of peer group supervision and what they mean in the professional nursing context. Figure 5 provides a visual representation of the circular movement of a hermeneutic literature review that has been used to guide this review of the literature.

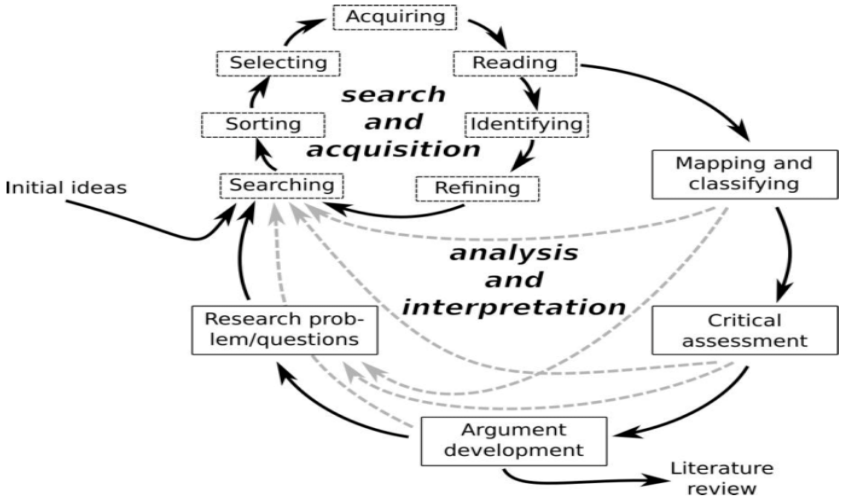


Figure 5: The hermeneutic literature review. Reproduced with permission of the authors (Boell & Cecez-Kecmanovic, 2014 p. 264).

In consultation with the graduate research school librarian, search terms and selection of the electronic databases were determined in early 2019. An initial literature search of Prospero -International prospective register of systematic reviews, was conducted in Phase 1 utilising keywords such as clinical supervision, peer group supervision and nursing.

A further review of the literature was conducted utilising the following databases selected for their relevance to the topic and discipline: Cumulative Index to Nursing and Allied Health Literature (CINAHL), EBSCOhost, ScienceDirect and Clinicalkey. Keyword searches included: clinical supervision “and” and “or” peer group supervision, nursing “and” and “or” nurses. Due to the plethora of publications related to the topic of clinical supervision, inclusion criteria included peer reviewed journal articles, books, and theses published from 2009 onwards to ensure contemporary research was located. In consultation with the supervisory team, the date range was developed to ensure the most contemporary information was included except where seminal or earlier literature was relevant to support the concepts discussed.

This literature search was updated in Phase 2 to identify any newly published research. When conducting the systematic review for the publication titled “The experience of nurses participating in peer group supervision: A qualitative systematic review” (Tulleners et al., 2023) a comprehensive search of eligible qualitative literature in the electronic databases (EBSCO MegaFILE Ultimate, Web

of Science, PubMed, ProQuest dissertations and thesis) was conducted to retrieve all English language literature containing studies relating to nursing peer group supervision. No date limits were applied to ensure all relevant research including seminal work was included and integrated into the proposal.

The comprehensive literature review also explored relevant methodology literature with the following search terms: phenomenology, hermeneutic phenomenology, interpretive phenomenology and Gadamer. Inclusion of English language or English translation texts was to avoid errors in translation and potential loss of meaning.

2.2 Clinical supervision context

To clearly establish the context of peer group supervision, the literature review commences with a discussion of the broad concept of clinical supervision. As mentioned in Chapter 1, clinical supervision has a long, evolving, international history of utilisation in health care, with beginnings dating back to the eighteenth century (White & Winstanley, 2014). From those early beginnings, clinical supervision has evolved from meetings in Sigmund Freud's home to the practice as it is known today and as it is widely used by health professionals.

The extensive utilisation of clinical supervision is reflected in the international helping professions literature. Bernard and Goodyear (2019) describe clinical supervision as being the signature pedagogy that "most categorises the preparation of mental health professionals" (p.2). White and Winstanley, (2014) noted that the "historical affinities among charity work, social work, nursing and midwifery allowed a cross pollination of professional practises, on both sides of the Atlantic" (p.13). The clinical supervision literature is not limited to a singular profession or context.

Nursing clinical supervision dates from "the 1920s" (Cutcliffe & Sloan, 2014, p.183). However, more recent literature offers insight into the development and utilisation of clinical supervision practice. The United Kingdom utilised clinical supervision in several ways. In the 1980s clinical supervision was recommended as an integral part of the mental health nursing structure (White & Winstanley, 2014).

Within midwifery, clinical supervision was originally utilised as a statutory requirement to safeguard the public (White & Winstanley, 2014; Darra et al., 2016; United Kingdom Central Council, 1993). Enquiries into adverse patient safety events in the 1990s, led to clinical supervision being recommended for maintaining patient safety in general nursing contexts (White & Winstanley, 2014; United Kingdom Central Council, 1993). In the Australian health context clinical supervision policy became prominent from approximately 2010, although its use has been documented for several decades prior (White, 2017).

2.3 Clinical supervision defined

Review of the literature demonstrates there is no one definition that fully encapsulates clinical supervision terminology, concepts, and elements (Cutcliffe et al., 2018). Terminology is important to ensure understanding, therefore, this review begins with the language of clinical supervision. There is power in words and terms, and they are not always understood in the same way by all people, even within disciplines (Zhang et al., 2021). Determining a universally accepted definition for clinical supervision has been challenging and even creates barriers (Davys et al., 2017; Falender & Shafranske, 2014; Kenny & Allenby, 2013; Martin et al., 2017; Rushton, 2011). This concept is clearly seen in the literature through the use of various definitions.

The term clinical supervision can have different meanings in different contexts which is where the confusion arises. Vandette and Gosselin (2019) noted that in the Canadian context “Psychology and social work make clear the distinction between supervision and consultation, whereas the profession of nursing defined supervision as consultation” (p.305). Bond and Holland (2011) suggest the number of definitions may equal the number of instances clinical supervision is referred to in the published literature. It may be asserted that different professions try to explain or define supervision in a way that is acceptable and relevant to their context. Butterworth (2022) suggests we will “eventually arrive at a useful and commonly understood definition for nurses” (p.21) however more work in this area is still needed.

Outside the nursing profession, clinical supervision terminology differs depending upon the health discipline and may relate to competence or regulation of practice (Cruz et al., 2012; Cutcliffe et al., 2018; Falender & Shafranske, 2014; Love et al., 2017; Pollock et al., 2017). Within nursing, clinical supervision terminology has become synonymous with other terminology such as buddying, preceptorship, and mentorship and has been used interchangeably with these labels (Fowler, 2013a; White, 2017).

The alignment with buddying systems is seen in the extension of support and in this context clinical supervision refers to students undertaking practical experience in the clinical environment (Kenny & Allenby, 2013; King et al., 2020). Ekstedt et al., (2019) noted that clinical supervision when offered by multiple buddies is especially beneficial. Clinical supervision can be provided to staff returning to the workplace after an absence, changing their scope of practice or because of disciplinary action related to breaches of professional standards (Nursing and Midwifery Board of Australia (NMBA), 2016; Australian Health Practitioner Regulation Agency (AHPRA), 2022).

Given the variation in definitions of clinical supervision, it is not surprising there is an element of confusion surrounding the concept. It follows that the terms clinical and supervision have additional connotations in nursing. The word clinical may be interpreted by some to mean an acute care nursing context rather than clinical practice more broadly (Bishop, in Cutcliffe et al., 2011). Supervision may imply authority and denote someone watching and critiquing clinical practice. This may be viewed as managerial or even as a punitive process related to performance (Bailey et al., 2014; Basa, 2019; Bond & Holland, 2011; Davis & Burke, 2012; Dawber, 2013a; Love et al., 2017; Masamha et al., 2022). Concerns about the intent of supervision may lead to resistance or caution even before nurses are introduced to the proactive reflective clinical supervision concepts (Love et al., 2017; O'Keeffe & James, 2014; Rothwell et al., 2021; Taylor, 2013).

A definition that is supportive of the mentorship and buddy approach to clinical supervision is that of Pollock et al. (2017) who defined clinical supervision as: “the facilitation of support and learning for healthcare practitioners enabling safe, competent practice and the provision of support to individual professionals who may be working in stressful situations” (p.1826).

Bond and Holland (2011) in a practical guide to nursing clinical supervision identify:

> *"Clinical supervision is regular, protected time for facilitated, in-depth reflection on complex issues influencing clinical practice (p.15). It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part she plays as an individual in the complexities of the events and the quality of practice.*
>
> *This reflection is facilitated by one or more experienced colleagues who have expertise in facilitation and the frequent, ongoing sessions are led by the supervisee's agenda. The process of clinical supervision should continue throughout the person's career, whether they remain in clinical practice or move into management, research, or education"* (p.15).

MacLaren et al. (2016) suggest it may be "helpful to think about supervision 'practices' (what is done) rather than try to accept a singular concept" (p.2425). Whilst Cutcliffe et al. (2011) offered a list of posited parameters for clinical supervision including provide support, be regular and challenge the clinician's practice. It is possible to define clinical supervision through either an experiential or regulatory lens. For example, clinical supervision can also satisfy the regulatory practice requirements for the Registered Nurse (RN) who "develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice" (Nursing and Midwifery Board of Australia, 2016, p. 3).

Comparisons can be drawn between clinical supervision and mentorship. Though definitions of clinical supervision may vary, the common thread that sets clinical supervision apart from terms like mentoring is the element of reflection (Buus et al., 2013; Fitzpatrick et al., 2015; Francke & de Graaff, 2012; Gardner et al., 2021; Howard & Eddy-Imishue, 2020; Koivu et al., 2012; Love et al., 2017). Mentorship can be "described as a process through which an experienced person (mentor) guides another (mentee) in developing skills and knowledge for their professional development" (Burgess et al., 2018.p.198).

Whilst reflection can be a part of the mentorship relationship, Cutcliffe et al. (2011) describes clinical supervision as providing a forum for reflection which then underpins clinical supervision practice. Having the right environment can facilitate learning or teaching of reflection. Fowler (in Cutcliffe et al., 2011) goes further and notes that whilst reflection can stand separate from clinical supervision, the opposite is not true. Without reflection playing a pivotal role, clinical supervision may not exist. It is these understandings of clinical supervision that inform this research project.

2.4 Participants in clinical supervision

Participants of clinical supervision have included mental health professionals from disciplines such as psychology, social work, and counselling (Amanvermez et al., 2020; Atik & Erkan Atik, 2019; Barron et al., 2017; Basa, 2019; Borders, 2012; Gardner et al., 2021; Martin et al., 2016; Murphy-Hagan & Milton, 2019; Pager et al., 2018; White & Winstanley, 2014). Participation is a clinical supervision expectation that has been embedded in nursing and other health disciplines and has been deemed essential for competency by regulatory and accrediting bodies (Alfonsson et al., 2018; Bailey et al., 2014; Bernard & Goodyear, 2019; Borders, 2012; Love et al., 2017; Pelling et al., 2017; Tugendrajch et al., 2021; White & Winstanley, 2014). What exists is often a non-uniform and informal reflective process that requires a professional to engage and document. Participation more formally is not clearly defined.

Participation is not exclusively restricted to the mental health professions. The international literature describes clinical supervision utilisation by medical practitioners. Nielsen and Davidsen (2017) report that in Denmark, group supervision is a regular part of “professional development in general practice” (p.258). O'Keeffe and James, (2014) report that participating in clinical supervision was appropriate for medical practitioners due to parallels paediatricians' have “with the mental health workforce” (p.947). Allied health clinicians including occupational therapists, physiotherapists, speech pathologists and dieticians have been reported in the literature to utilise clinical supervision as part of their established practice (Davis et al., 2022; Kuipers et al., 2013; Martin et al., 2016).

Clinical supervision was originally utilised in the mental health nursing context due to similarities and linkages between the counselling professions. Whilst Bernard and Goodyear (2019) assert that clinical supervision skill acquisition is essential for all mental health professionals, discussion on clinical supervision now features prominently in the non-mental health nursing literature (Butterworth, 2022; White, 2014). Clinical supervision became evident in child protection and midwifery literature due to its use in addressing concerns about clinical practices (Driscoll et al., 2019; Lavery et al., 2016; Love et al., 2017; White & Winstanley, 2014).

Whilst the following is not exhaustive, the contemporary literature reports the implementation of clinical supervision into many varied contexts such as acute medical-surgical wards (Koivu et al., 2012), child and family health (O'Neill et al., 2022), midwifery (Love et al., 2017; Merits et al., 2019), neonatal intensive care (Johansson, 2015), hospice (Francis & Bulman, 2019), community health (Tulleners et al., 2021), cancer care (Cook et al., 2020) and rural nursing (Kenny & Allenby, 2013). It is asserted that clinical supervision should be available to nurses in all contexts and form a part of everyday practice (Bifarin & Stonehouse, 2017; Davis & Burke, 2012; Evans & Marcroft, 2015; Love et al., 2017). The expansion of clinical supervision in nursing contexts aligns with the Australian College of Nursing's recommendation that clinical supervision should be available for all nurses regardless of expertise, clinical context, or role (Australian College of Nursing, (ACN), 2019).

The clinical supervision literature predominantly focuses on the health clinician postgraduate education, however, participation in clinical supervision by undergraduate nursing and allied health students is articulated in the literature (Atik & Erkan Atik, 2019; McKenney et al., 2019; Murphy-Hagan & Milton, 2019). Blomberg and Bisholt, (2016) offered clinical supervision to first and third-year nursing students to assist with developing ethical reasoning. Cutcliffe et al. (2011) notes that educating undergraduate nurses on the principles of being a supervisee not only sets a good foundation for reflective practice but also negates the need for extensive education later. This research explores peer group supervision concepts among registered nurses however transition of students in the community health setting as part of their undergraduate student placement program provides opportunity for them to engage.

Undergraduate education could influence acceptance and uptake of clinical supervision as students are assisted to understand the purpose of clinical supervision leading to an expectation of participation when entering the workforce. This was reinforced by Dungey and Bates (2021) who suggested that an earlier introduction may make it easier to follow the peer group supervision rules and structure. The introduction of standardised education into the undergraduate curriculum may also alleviate clinical supervision diversity of practice and offer a sense of professional inclusion at time of graduation and entry to practice (Cutcliffe et al., 2011; Dungey et al., 2020).

The patient is at the centre of supervision even if not directly discussed as an active participant. As Corey et al. (2014) state, “supervision is the unique relationship between a supervisor, supervisee and the clients served” (p.2). Proctor, (2008) describes the patient as one of the powerful off-stage characters. Clinical supervision is for or about the patient which is why it is important to understand and strive for quality supervision. Understanding and quantifying the benefit to the patient has been problematic and less clearly articulated in the literature (Carpenter et al., 2013; Davys et al., 2017; Rast et al., 2017; Saab et al., 2021). Losing focus on the patient during clinical supervision could cause discontent for the clinician participating (Kenny & Allenby, 2013). Edgar et al. (2022) suggest that further research is required into the potential enhancement of person-centred care through clinical supervision.

Clinical supervision always occurs in a professional context. The final, previously unmentioned participants are the professional associations that determine the requirements for quality, ethical clinical practice (Borders, 2012; Sloan & Grant, 2012). Health professionals are accountable for their decisions and actions and are held to account for these decisions through their professional associations and registration bodies. Whilst not obvious participants in clinical supervision per se, they are nevertheless an important consideration.

2. 5 Non-participation in clinical supervision

It is worth noting that just because clinical supervision may be for clinicians, this does not mean all clinicians participate in clinical supervision. The literature identifies multi-pronged barriers to clinical supervision participation that cannot be identified as pertaining to a single discipline, person, or cause.

The literature reports that reasons for non-participation may include organisational barriers such as being understaffed or difficulties relating to attendance such as rostering practices (Buus et al., 2018; Dilworth et al., 2013; Evans & Marcroft, 2015; Love et al., 2017). Other barriers were more personal in nature such as motivation (Gonge & Buus, 2015). When staff were unmotivated to achieve their aims, they did not participate in clinical supervision. Another important barrier to participation is the concern that peer group supervision is a managerial tool used to check up on staff (Howard & Eddy-Imishue, 2020). MacLaren et al., (2016) noted in the multidisciplinary team setting that feelings of inferiority related to group members expertise can be a barrier to participating.

Being too busy and not having time was frequently reported by nurses as a reason for non-participation (Davis & Burke, 2012; Driscoll et al., 2019). Rothwell et al. (2021) in a rapid review identified “lack of time and heavy workloads” as a major barrier to participation (p.4). Buus et al. (2018) explored the resistance to group clinical supervision and found that a nurse may take two distinct positions “either ‘legitimately’ forced into non-participation or deliberately rejecting participation” (p.790). There were clinicians who felt they had no opportunity to participate because sessions were held at times when they were unable to attend and there were clinicians who purposefully chose not to attend. Unsurprisingly, Buus et al., (2018) reported that having a previous poor experience during clinical supervision made participants unwilling to participate. Poor experiences such as feeling unsafe or hearing unwanted disclosures, being silenced and disempowered are powerful barriers to attendance.

Bond and Holland (2011) explored the reasons for resistance to clinical supervision and found they related to both the individual and the organisation. The authors identified levels of resistance from nil to outright rejection of supervision and noted that hidden issues such as fear could impact resistance (Bond & Holland, 2011). Fear can include fear of the unknown, fear of what will be found out or even fear of what others may think. At times of increased clinical demand, such as during the Covid-19 pandemic, staff may benefit most from clinical supervision and yet it may be the time when they are least likely to participate (White, 2017).

Dilworth et al. (2013) contend that resistance to clinical supervision could be decreased if it is seen to be “real work’’ and therefore prioritised as such. This may include embedding clinical supervision into nursing culture (Cook et al., 2020; Saab et al., 2021). Fowler (2013d) goes further and says nurses need to not just “find time but make time” (p.1322). Hall (2018) speculates that making participation mandatory might increase the benefits. Masamha et al. (2022) in their scoping review, identified that nurses may not participate in clinical supervision due to the “lack of clarity surrounding definitions and models, the availability of parallel forms of support and having the time, resources and skills” (p.8).

2.6 The functions/purpose of clinical supervision.

It is important to develop an in-depth understanding of the functions and aims of clinical supervision in practice (Colthart et al., 2018). The previously explored definitions identify a multitude of functions or purposes associated with clinical supervision. Bernard and Goodyear (2019) describe the enhancement of professional development and ensuring optimal client outcomes through professional standards as the dual purposes of clinical supervision. Falender and Shafranske (2021) concurred that these dual purposes are recognised internationally in clinical supervision practices. Corey et al. (2014) suggests that in addition to the purpose outlined by Bernard and Goodyear (2019), the goals of supervision are to monitor performance and enable self-supervision.

Nurses have many competing priorities within their clinical practice and day-to-day workload. There are many decisions made about what is essential for patient care and what is not (Suhonen et al., 2018). Given this, clinical supervision is questioned as a priority for patient care and sometimes viewed more as a trend of the moment (Davis & Burke, 2012; Kenny & Allenby, 2013; Wright, 2012). Cutcliffe et al. (2011) state:

> “At its worst, clinical supervision has the potential to be a time-consuming negative experience but at its best, clinical supervision has the potential to galvanise and motivate individuals and teams and to be a significant part in the quality assurance process” (p.8).

Several systematic reviews have explored clinical supervision effectiveness and reported limited empirical evidence (Carpenter et al., 2013; Cutcliffe et al., 2018; Pollock et al., 2017). Martin et al. (2021) noted that effective clinical supervision can positively impact burnout and retention. The literature reports variations in the identified functions of supervision. These variations may be influenced by the nature of the discipline and the context. Bernard and Goodyear (2019) state it is important to recognise the uniqueness of clinical supervision from other common functions such as teaching, counselling, or consultation. Health professionals need to identify and clarify the purpose and functions of supervision prior to commencement.

As part of the Supervision Alliance Model, the functions or tasks of clinical supervision are described in the counselling and psychotherapy context (Butterworth et al., 2001). These functions are "normative (monitoring and self-monitoring, standards, and ethics), formative (learning and facilitating learning) and restorative (support and refreshment)" (Sheppard et al., 2018. p. 297). These share a similarity with Kadushin et al. (2009) who describe the functions of clinical supervision for social work as being administrative, educational, and supervisory.

Three functions suggested by Proctor (2008) have been readily adapted into nursing and allied health clinical supervision (Cutcliffe & Sloan, 2014; Snowdon et al., 2019). It was noted by Pollock et al. (2017) that Proctor's model was "the most frequently cited model of clinical supervision" (p.1831). This discussion highlights that clinical supervision sessions may focus on all or some of Proctor's functions depending upon the situation presented or discussed. The premise is that the clinician chooses which function they are requiring dependent upon their needs at the time. Proctor in Cutcliffe et al. (2011) states that if the restorative function is not experienced then the other functions (normative and formative) may not follow.

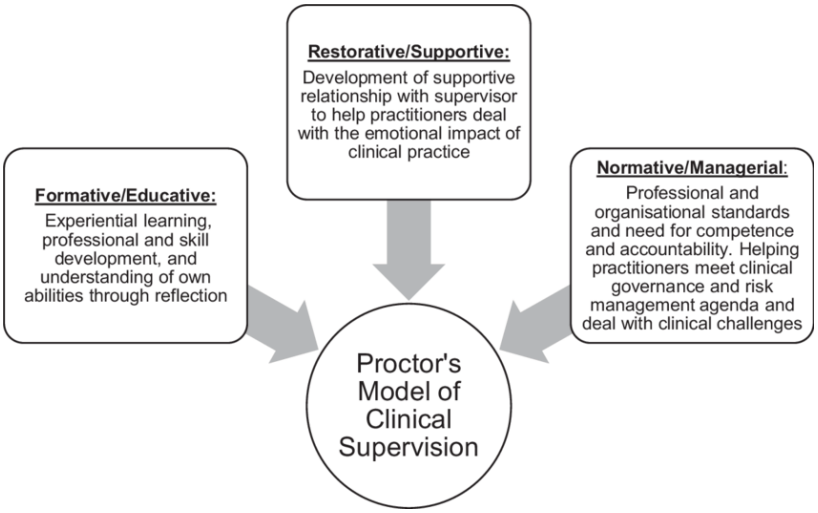


Figure 6. Proctors model of clinical supervision. Reproduced with permission from Saab et al., 2021.

Despite these three functions being first described several decades ago, the literature continues to identify their relevance and application in clinical supervision today (Barron et al., 2017; Bernard & Goodyear, 2019; Bulman & Schutz, 2013; Driscoll et al., 2019; Evans & Marcroft, 2015; Fowler, 2013a; Lee et al., 2019; Markey et al., 2020; McCarthy et al., 2021; Saab et al., 2021; Sheppard et al., 2018).

Further research describes the benefits related to focusing a supervision model solely on one function such as restorative supervision. Key et al. (2019) reported on a Scottish clinical supervision model developed with the intention of increasing and improving self-care and morale. Wallbank's, (2013) study described the benefits of restorative supervision for both nurses and the families they worked alongside. Tuck's, (2017) study involving acute care mental health nurse's reports using all three functions as described by Proctor.

Clinical supervision is noted to have multiple functions, purposes and aims. Pelling et al. (2017) state the aim of clinical supervision is "to increase self-awareness and enhance professional competence" (p.20). This aim aligns with the Registered Nurse Standards for Practice where the nurse "develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice" (Nursing and Midwifery Board of Australia (NMBA) 2016, p. 3).

What is surmised from the literature is that the function and purpose of clinical supervision needs to be carefully considered and articulated. For example, the function may be restorative, but the purpose is to manage the emotions associated with nursing work (MacLaren et al., 2016). Clarity prior to implementation is clearly needed to ensure alignment with the professional expectations and requirements.

2.7 Frequency of participation in clinical supervision

The research literature indicates that effective supervision is associated with frequent attendance (Lee et al., 2019; Martin et al., 2014). Rothwell et al (2021) in their rapid review reported the importance of "regular and constructive feedback" (p.4). However, it is noted that whilst regular clinical supervision practice is preferred, it should be based on clinician need (Bernard & Goodyear, 2019; Davis & Burke, 2012; Dawber, 2013b; Dilworth et al., 2013; Driscoll et al., 2019; Kenny & Allenby, 2013). Frequency of participation is not only based on the decision making of the participant. Influences on the frequency of attendance can be also related to organisational and policy guidelines of the professional. Certain health professions, such as counselling, specify a designated frequency of supervision participation (Wahesh et al., 2017). Nicholas & Goodyear (2020) report minimum weekly supervision sessions as potentially best for new psychology trainees becoming less frequent as competence develops.

Frequency of clinical supervision attendance is not often specified in the literature (Rothwell et al., 2021). Those reports that do mention frequency suggest anywhere from weekly to monthly (Dilworth et al., 2013; Tulleners et al., 2021). Whilst there is no magic number for attendance, there can be no benefits if individuals do not participate or if participation is limited (Gonge & Buus, 2015; Howard & Eddy-Imishue, 2020). A systematic review by Huday et al. (2023) reported that there was a relationship between frequency of attendance, job satisfaction and positive engagement. Unexpected influences such as Covid-19 resulted in contrasting experiences of frequency and duration. A rapid review by Martin et al (2022) found some clinicians experienced a reduction in frequency from fortnightly to monthly with a decrease in time allotted whilst others reported continued support throughout the pandemic. Failure to articulate parameters such as frequency of participation expectations can impact the outcomes of clinical supervision (Cutcliffe et al., 2018).

2.8 Effectiveness of clinical supervision

Howard & Eddy-Imishue's (2020) integrative review explored the notion of adequate and effective clinical supervision. The review found that adequacy is hard to define due to the wide variation in clinical supervision delivery. Factors that could influence whether clinical supervision was effective included regular participation and understanding of the concept, process, and benefits.

Snowden (2019) noted that clinical supervision focus, skills and environment can impact effectiveness. This concurs with elements suggested by Martin et al. (2014) who provided insight into practical ways clinicians could facilitate effective clinical supervision. In the position statement on Clinical supervision for nurses and midwives, the Australian College of Nursing (ACN), Australian College of Midwives (ACM) & Australian College of Mental Health Nurses (ACMHN) identify contributing elements to effective clinical supervision such as confidentiality and cultural safety. Figure 7 shares a visual representation of these contributing elements.

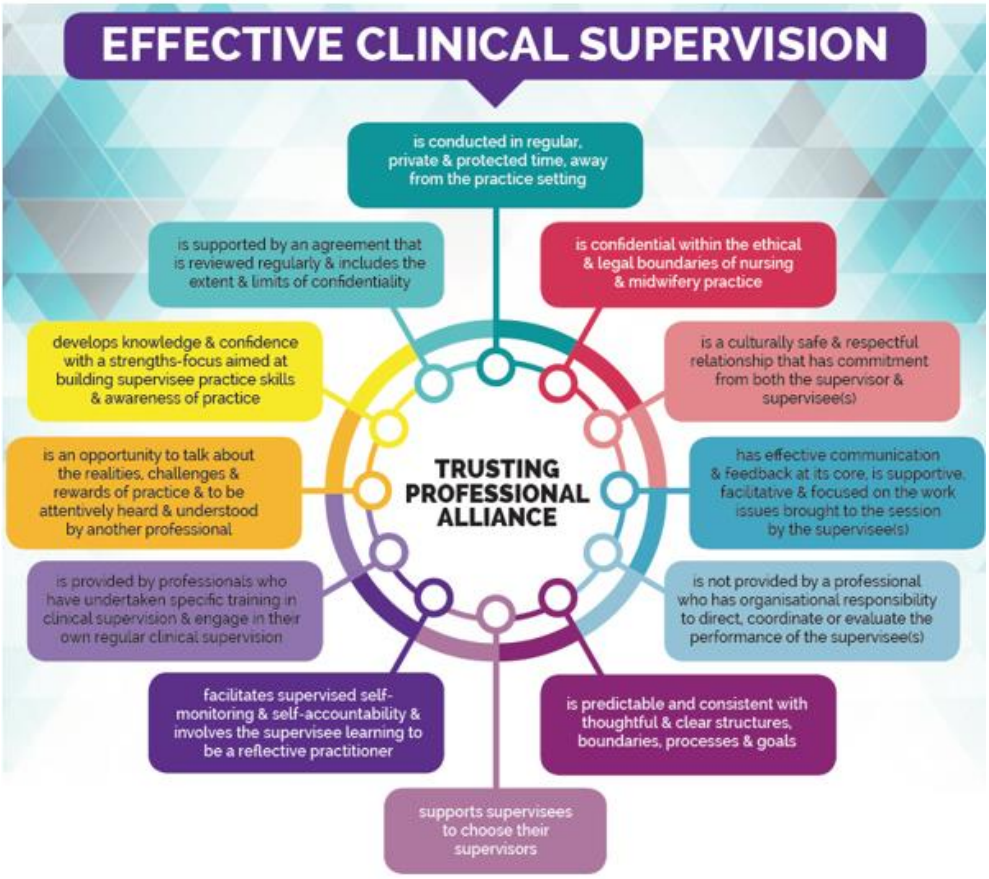


Figure 7: Australian College of Nursing (ACN), Australian College of Midwives (ACM) & Australian College of Mental Health Nurses (ACMHN) poster

Evaluation is a vital step in the implementation of interventions be they related to patient care and clinical decision making (Boswell & Cannon, 2018) or the introduction of supportive practices such as clinical supervision (Martin et al., 2014). There is difficulty in evaluating clinical supervision effectiveness as it is individual, complex, and hard to discern what is attributed purely to the supervision process rather than some other additional factor (Fowler, 2014). The complexity of attribution contributes to the identified lack of evaluation research (Bernard & Luke, 2015). This lack of evaluation could impact effectiveness as regular evaluation has been shown to support clinical supervision practice (Driscoll et al., 2019). Methods for evaluating effectiveness may be aligned to certain frameworks like Proctors, formative, normative and restorative aspects (Fowler, 2014). Tools to assess the quality of supervision are required no matter which evaluation method is selected (Beckman et al., 2020). Careful consideration of tool selection is required to provide meaningful information (Gabrielsson et al., 2019; White, 2018).

Zhu and Luke (2021) suggest that clinical supervision outcomes can be explored through a “heuristic framework” that considers a holistic view of categories of outcomes rather than a single outcome (p.105). Whatever the chosen evaluation method, it is important to consider from inception how clinical supervision will be implemented and its effectiveness as this can be a weakness in the procedures of organisations (Colthart et al., 2018; Lee et al., 2019).

2.9 Benefits of clinical supervision

Clinicians engage in clinical supervision for a variety of reasons (Edgar et al., 2022) but other than just providing a “contribution to staff well-being” there should be an expectation of beneficial outcomes (White, 2018. p.1438). Martin et al. (2021) suggest that effective clinical supervision and supervisors may be “pre-cursors for the realisation of beneficial effects” (p.22). It can be argued that there can be no benefits unless clinical supervision is effective and therefore these two elements are closely linked.

Benefits are reported in the literature as being professional, organisational, and individual. Bernard and Goodyear (2019) suggest that professions benefit from clinical supervision through the preparation and increased competence of clinicians and the safeguarding of patients/clients. Benefits for organisations may include a positive impact on recruitment and job retention (Carpenter et al., 2013) potential reduction of "missed care" by nurses (Markey et al, 2020) and a desire of staff to "give back" (Love et al., 2017. p.277).

Cutcliffe et al. (2018) found narrative/anecdotal benefits were described by nurses and included increased support, confidence, teamwork, and a decrease in isolation. Whilst the following information is not exhaustive, peer-reviewed literature reports high-quality clinical supervision has been demonstrated to provide supportive feedback and decrease the effects of nursing stress and burnout (Cook et al., 2020; Feerick et al., 2021,) enhance teamwork and skills development (Darra et al., 2016), and enhance professional growth and development (Edgar et al., 2022).

Clinical supervision further creates a suitable environment for self-care and builds resilience (Driscoll et al., 2019), increases staff satisfaction (Carpenter et al., 2013), improves practice, (Kumar et al., 2015: Love et al., 2017), assists with nurses' emotional work (MacLaren et al., 2016) and mitigates compassion fatigue (Stacey et al., 2020). Benefits for clinicians have been widely reported in the clinical supervision literature. Whilst reported anecdotally, it is important to note that benefits to the patient remain difficult to quantify (Alfonsson et al., 2018; Kühne et al., 2019). This lack of empirical evidence can be challenging for the profession and the organisation leading to hesitancy in implementing clinical supervision. It is important to firstly understand and implement clinical supervision before appropriate and needed patient impact evaluations can be conducted. Understanding clinical supervision models and their implementation and importance to staff and workplaces is first required.

2.10 Clinical supervision models

To fully understand the concept of clinical supervision a brief discussion on the models underpinning this practice is required. Bernard and Goodyear (2019) describe various models as underpinning clinical supervision in the psychotherapy and counselling professions. The purpose of utilising a specific model is to provide a perspective or lens through which clinical supervision will be underpinned for the participants. These models may emphasise theoretical, developmental or process elements and perspectives of clinical supervision. Whilst clinicians may prefer one model, they may incorporate aspects from several models into their practice depending upon the requirements at the time (Bernard & Goodyear, 2019). Cade and Tauscher (2020) describe clinical supervision models as providing a guide for participants to “navigate the supervisory process” (p.4).

Understanding the theoretical models may inform both how a clinician practices as a counsellor and a supervisor. They offer a theoretical lens through which to view practice cases and issues and to develop as a clinician (Cade & Tauscher, 2020). An example of a theoretical model may be supervision that utilises cognitive behavioural therapy (Bernard & Goodyear, 2019; Cummings et al., 2015). Developmental models focus on the progression of the clinician from one stage to another through learning goals (Pelling et al., 2017). The progression is not necessarily linear but occurs in a way that aids the development of the clinicians’ skills and knowledge (Cade & Tauscher, 2020; Bernard & Goodyear, 2019).

Process models of clinical supervision “primarily step back to observe the supervision process itself” (Bernard & Goodyear, 2019. p.46). For example, Hawkins and Shohets provided a process model called the seven-eyed model that can empower and guide the clinicians' reflective process (Regan, 2012). Hawkins and McMahon (2020) further suggest the seven-eyed model can assist both supervisors and supervisees to develop supervision styles and even review the supervision process.

The selection of a guiding model can be potentially problematic. A systematic review by Carpenter et al. (2013) found that many research studies did not clearly identify the model used creating uncertainty for clinicians. In a review of twenty-five years of clinical supervision research, Watkins (2019) noted that no one model was preferred over another. It is important to note that, the selection of models depends upon the profession and should meet the outcome requirements of the clinician.

An example of this was reported in Gardner et al. (2021) study where facilitators in the research were offered two models from which they could select the model that best encouraged allied health staff to reflect deeply. The lack of clarity in the literature regarding underpinning models or competencies specific to clinical supervision in nursing may influence understanding and usage (Cookson et al., 2014; Cutcliffe & Sloan, 2014; Howard & Eddy-Imishue, 2020; Love et al., 2017; Martin et al., 2014; Pearce et al., 2013; Sheppard et al., 2018).

2.11 Clinical supervision delivery models

Models of clinical supervision delivery vary across health organizations and ideally reflect the needs of the clinician, profession, and the organisational resources (Cross et al., 2012; Davis & Burke, 2012; Gardner et al., 2021; Martin et al., 2014). Traditionally a one-to-one individual model has been utilised and may be considered the “cornerstone for professional development” (Bernard & Goodyear, 2019, p.190). Other models include dyad, triad, group, or peer group supervision or a combination of aspects of these approaches (Martin et al., 2014). Each model has its own definition, benefits, and challenges. The models differ regarding the relationship between the supervisor and supervisee, for example, expert vs non-expert. There is no consensus on which is the ideal or preferred model with more research needed in this area (Alfonsson et al., 2018; Borders, 2012; Fowler, 2013c).

2.12 Individual clinical supervision model

Figure 8: One to one/individual clinical supervision (Image source: Toa Heftiba Unsplash)

The traditional one-to-one model of individual supervision is characterised by usually an experienced clinician (expert) whose role is to provide supervision and accountability to the practice of the supervisee (Basa, 2019; Bernard & Goodyear, 2019, Bifarin & Stonehouse, 2017, Bond & Holland 2011; Falender & Shafranske, 2014; Fowler, 2013c; Pack, 2012; Pelling et al., 2017). This traditional model appears to be preferred by supervisees working in helping professions (Livni et al., 2012; Bernard & Goodyear, 2019; Bond & Holland 2011;).

While the supervisee may select their supervisor depending on the context and profession, finding a match is not always easy. This is important as choosing a supervisor is considered to contribute to high-quality clinical supervision (Kumar et al., 2015; Martin et al., 2016; Pack, 2012; Sloan & Grant, 2012). Supervisors are usually people at senior levels and ideally should not be the supervisees' line manager (Bifarin & Stonehouse, 2017, Livni et al., 2012, Martin et al., 2014, Sloan & Grant, 2012). Supervision relationships are unequal; therefore, it is important in the traditional one-to-one model to consider power differentials that may impact the supervision experience for both the supervisor and supervisee (Bernard & Goodyear, 2019; Cook et al., 2018).

Bernard and Goodyear (2019) describe factors that can influence the supervision relationship. From the supervisee's viewpoint, factors can include motivation and engagement with the supervision process, level of development, and trust in the supervisor and process. Supervisor factors may include their trust in the supervisee and the use or abuse of the power differential. Bond and Holland (2011) suggest that both the supervisee and supervisor have responsibilities. The supervisee/supervisor roles have similar responsibilities in some respects such as engagement, preparation, reflection, and accountability. Supervisor responsibility is to challenge the supervisee whilst providing constructive feedback.

The ability to supervise is not an innate skill and as such must be developed to prepare supervisors for practice (Watkins et al., 2014). There is no consensus in the literature on the optimal educational requirements for supervisors and this may be contextualised for the profession (Driscoll et al., 2019; Fitzpatrick et al., 2012; Glover & Philbin, 2017; Hall, 2018; Harvey et al., 2020; Kühne et al., 2019). In the Australian context, a recent positive evaluation of the “Clinical Supervision for Role Development Training” may provide options for supervisor education for nurses. The education program seeks to develop skills and knowledge through the adoption of a “strengths-based approach” (Harvey et al., 2020. p3).

Supervisors are described in the literature as requiring certain qualities and skills. Barnett and Molzon (2014) describe skills that may include the ability to ethically create a safe space for the supervisee whilst balancing the need to gatekeep the profession. Love et al. (2017) identified the need for supervisors to create a safe space and be credible whilst demonstrating “neutrality, openness, reassurance, and confidentiality” (p.275). Credibility and professional expertise are identified as important supervisor qualities (Dawber, 2013; Snowdon et al., 2019). It is also suggested that supervisors should possess qualities such as emotional intelligence and highly developed communication skills (Temane et al., 2014). Alongside supervisor qualities and skills, behaviours such as providing challenging feedback can also greatly influence the supervision experience (Ladney et al., 2014). Whilst the one-to-one model of clinical supervision has been traditionally utilised, clinicians also avail themselves of alternatives such as group supervision.

2.13 Group supervision model

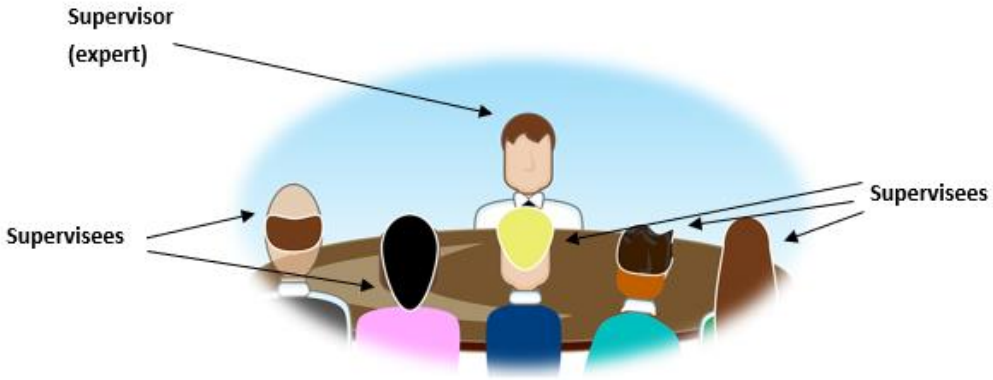


Figure 9: Group supervision (Image source: Clker-Free-Vector-Images from Pixabay)

Group supervision may be a standalone practice or combined with one-to-one clinical supervision (O'Neill et al., 2022; Smith et al., 2012). The group supervision model with an educated supervisor has become an increasingly popular clinical supervision option in many professions (Borders, 2102; Dilworth et al., 2013; Driscoll et al., 2019; Knight, 2017; Reschke et al., 2021; Saab et al., 2021). In group supervision, the presence of the designated supervisor (Bernard & Goodyear, 2019) clearly differentiates this model from peer group supervision.

As seen with clinical supervision, there is likewise confusion and debate in the literature in relation to group and peer group supervision terminology (Bailey et al., 2014; Bernard & Goodyear, 2019; Dawber, 2013; de Lange & Wittek, 2018; Golia & McGovern, 2015; Martin et al., 2017). This is evident in the use of “peer group” terminology to describe supervisor-led peer groups and leaderless peer groups (Andersson et al., 2013; Atik & Erkan Atik, 2019; Merits et al., 2019; Sheppard et al., 2018). Negative connotations associated with clinical supervision terminology have resulted in additional terms such as “reflective practice groups., or reflective circles” appearing in the literature relating to supervision practices (Dawber 2013; Gardner et al., 2022; Thomas & Isobel, 2019).

The literature reports multiple benefits resulting from participation in group supervision. The advantages of this model include building and improving preceptoring skills (Andersson et al., 2013; Borch et al., 2013), an increase in the variety of perspectives from the supervisees (Bernard & Goodyear, 2019) and opportunities for learning, collaboration, and mentoring (Valentino et al., 2016). Professionally, group clinical supervision can provide a pragmatic solution to supervising multiple clinicians at once (Davis et al., 2022; Gardner et al., 2021) as well as economic benefits from reduction in staff burnout (Cross et al., 2012). Personal benefits may include building self-esteem (Atik & Erkan Atik, 2019), vicarious learning through sharing experiences (Love et al., 2017; McCarthy et al., 2021) whilst increasing resilience and coping strategies (Francis & Bulman, 2019). Benefits can differ depending upon the stage in the nurse's career. Blomberg et al. (2016) noted that group supervision may impact the stress levels of graduate nurses which is important for career longevity. However, the benefits are not always immediate and can require perseverance (Taylor, 2013).

Proctor (2008) states another benefit is that it is harder to hide the "unmentionable" or collude in a group as accountability increases with additional group members. Hawkins and McMahon (2020) describe an advantage to group supervision as "exposing our blind spots, deaf spots and dumb spots" (p.185). The group can transcend the sum of its parts by sharing their collective experiences thus forming a distinct group identity (Dawber, 2013a). Wallbank (2013) noted that participating in group supervision and navigating group dynamics provided additional insight into participation in other groups.

As with one-to-one clinical supervision, models have been proposed in the literature which can assist with guiding the group supervision process (Bernard & Goodyear, 2019). A frequently reported model utilised for group supervision is the Borders (1991) structured peer group supervision (SPGS) model. Despite being called a "peer group" this structured model utilises a trained supervisor as lead. The model has prescribed steps that "allows for dealing with subtleties and sophisticated dynamics" (p. 248).

Borders (1991) model is utilised in contemporary group supervision practice and supported in the current literature (Atik and Erkan Atik, 2019; McKenny et al., 2019; Toros & Falch-Eriksen, 2021). In recognition of the distinction between one-to-one and group supervision, Wilbur et al. (1991) share a structured peer group supervision model. The goal of this model is to facilitate meaningful group supervision as opposed to individual supervision within a group setting. Notably Wilbur et al. (1991) do not suggest that group supervision replaces individual clinical supervision.

Group supervision models vary in the literature and must meet the needs of the clinician (Basa, 2019; Lawrence, 2019). Group supervision model selection may be based on contextual factors as demonstrated by several authors who utilise a model developed within the Nordic countries (Andersson et al, 2013; Blomberg & Bisholt, 2016; Borch et al., 2013). Contextual models can relate to the clinician's need. For example, Haans and Blake (2018) provided vignettes in their study that demonstrated a trauma-informed model of group supervision. Baruch (2009) reports a variety of models which could be utilised and discussed specifically how an integrative approach could benefit clinicians.

The literature describes the role of the group clinical supervisor as being like the role of the supervisor in one-to-one clinical supervision. Proctor (2008) describes the role of the group supervisor as being the facilitator of useful supervision to the benefit of the client. Chui et al. (2021) suggest supervisors may “set the tone” and influence how members react to each other (p.464). The supervisor has a role in “holding” the group which Lavery et al. (2016) note is complex. Holding the group has multiple aspects. They include personal aspects such as: managing group dynamics including resistance, modelling expected behaviours, providing encouragement and calm when participants most need it (Amanvermez et al., 2020; Hawkins & McMahon, 2020).

The supervisor manages the learning needs of those within the group (Dawber, 2013), addressing any group issues (Knight, 2017), keeping the balance between constructive and challenging feedback (Borch et al., 2013; Reschke et al., 2021) and assisting supervisees to transition through their agenda. The group supervisor has administrative functions such as: keeping group members on track (Merits et al., 2019) and providing structure and clarification (Taylor, 2013). Supervisors aid the group to identify, attend to and learn from group dynamics (Hawkins & McMahon, 2020). Wallbank (2013) notes that supervisor abilities are likewise enhanced by group experience.

Supervising groups can present challenges (Blomberg & Bisholt, 2016) however Bifarin and Stonehouse (2017) suggest that facilitator knowledge of the stages of group formation can help make group supervision successful. Whilst this may be true, the supervision experience can be challenging for all members if leadership from the supervisor is poor (Andersson et al., 2013; Kenny & Allenby, 2013; Knight, 2017). Learning more detail about groups and dynamics is an important aspect of further understanding peer group supervision in the clinical setting.

Poor leadership is a major challenge to effective group clinical supervision however it is not the only challenge identified in the literature that can impact the supervision experience. Challenges are reported as being related both to self and the group. The literature reports group members can have concerns about themselves and their abilities within and outside the group (Andersson et al., 2013). For others, there was a real concern about receiving judgement and negativity from other group members (Buus et al., 2018; McCarthy et al., 2021). A common theme with any model of supervision is the ability of the clinician to fit it into an already crowded workday (Francis & Bulman, 2019; Galletti et al., 2021; Love et al., 2017).

Saab et al. (2021) reiterated that protected time is challenging but also noted that a lack of member buy-in could influence the outcomes. Lees et al. (2021) additionally identified poor attendance and poor reflection as being challenges in group supervision. Finally, Valentino et al. (2016) noted that poorly designed group supervision can lead to missed professional opportunities such as not receiving peer feedback or developing social networks (p.327).

2.14 Characteristics of peer group supervision

Figure 10: Peer group supervision (Image source: Harish Sharma from Pixabay)

Peer group supervision is the focus of this research and is best described as a model without hierarchy, or leadership. It can be also described as a horizontal model of clinical supervision due to the lack of identified expert (Amanvermez et al., 2020; Bailey et al., 2014; Basa, 2018; Beal et al., 2017; Bernard & Goodyear, 2019; Dungey et al., 2020; Kuipers et al., 2013; Newman et al., 2013; Pager et al., 2018). A distinct characteristic of peer supervision groups is that multiple clinicians can attend simultaneously which may be attractive for nurse managers when organising staff with limited time, and resources (Bailey et al., 2014; Brunero & Lamont, 2012; Counselman, 2013; Nickson et al., 2016).

Additional characteristics of peer group supervision include that it is “honest and transparent, self-directed, confidential, reciprocal” and identifies that “content and the process are equally important” (Napan, 2021. p.273). It is these unique characteristics that set peer group supervision apart from other models of clinical supervision delivery.

2.15 Models of peer group supervision

As with clinical and group supervision, clinicians may utilise various models to ground or underpin the peer group supervision processes. The literature reports models such as the structured peer group supervision model of Borders (1991) and Wilber et al. (1991) being adapted and utilised in practice (Newman et al., 2013; Schumann et al., 2020; Stone et al., 2019). Other research reported groups being offered a selection of models such as the structured peer group format (Borders,1991), a reflecting team format (Lowe & Guy,1996) from which to choose (Bailey et al., 2014) with not all literature clearly describing which model is being utilised. Amanvermez et al. (2020) reported using an online delivery model of peer group supervision however the model used to guide the research was unreported. Regardless of the model selected for peer group supervision, the literature highlighted the importance of reviewing the model regularly to ensure it continues to meet the needs of the group (Borders, 2012; Counselman, 2013).

2.16 The New Zealand Coaching and mentoring peer group supervision model

The New Zealand Coaching and Mentoring model is a peer group supervision model used by participants in this research study. The model identifies the functions of education, support and accountability and works on the premise that “no one knows as much as all of us” (New Zealand Coaching and Mentoring, 2012. p.5). Despite the terms “coaching and mentoring” being used in the model’s title, a supervision focus is clearly differentiated for the participants and differs from earlier definitions of clinical supervision where mentoring and buddying are noted. Features of this model include a structure that facilitates creativity and self-determination as the clinician selects the tool to use and how they will enact the information received (Napan, 2021). Other features are the recommendation for the development of group rules and contracts for agreement.

The model recommends four to six participants in a group to meet for one and a half to two hours per session. A rotating facilitator from within the group keeps the group on track with the tools and timeframes. The session structure is as follows:

- Check-in. This is a time for members to share how they have been and outline the tool they will be using for the session.

- Each group member presents their situation using the format of the tool they have selected. Tools have the following titles: a good new analysis, veridical report, practice review, critical incident, professional issues review, technical coaching, dress rehearsal, peer review and peer responses. Each tool has steps for its presentation and expected responses from peer supervisors.
- Check-out. The check-out period allows peers the opportunity to briefly verbalise what was valuable for them on reflection and provide suggestions for future sessions (New Zealand Coaching and Mentoring, 2012).

A key premise of the model is that no one other than the clinician has the complete story therefore individuals take what they need from the group and leave the rest. Finally, the model clearly outlines that structure is what creates safety within the group. The New Zealand Coaching and Mentoring model has been utilised within multiple professional contexts (Dungey et al., 2020; Fakalata et al., 2020; Tulleners et al., 2021). Interestingly, Davis et al. (2022) adapted this leaderless model to include supervisors/facilitators to ensure “only safe, evidence-informed practice was propagated” (p.3).

2.17 Advantages of peer group supervision

The clinical supervision literature reports the benefits and limitations of each model of supervision. In the literature, peer group supervision is reported as a valued model in nursing. Benefits reported in the peer group supervision literature are multifaceted and include personal, professional, or organisational elements. Understandably some of the benefits are similar to those reported in the group clinical supervision literature. Professional benefits may include the increased quality and quantity of feedback from multiple and diverse perspectives (Amanvermez et al., 2020; Bailey et al., 2014) in a space where ideas can be shared and developed (Goodman et al., 2014. p.234).

Another professional benefit was to meet the professional development requirements of clinicians (Pager et al., 2018). A benefit strongly agreed on in the peer group supervision literature was that it provides a supportive environment for learning (Bulman et al., 2016; Calcaterra & Raineri, 2020; Pager et al., 2018; Somerville et al., 2019). This includes support to acknowledge failings that might ordinarily result in feelings of shame (Schumann et al., 2020). In addition, developing the ability to reflect with others is powerful and empowering (Mills & Swift, 2015; Yasky et al., 2019) and develops self-awareness (Toros & Falch-Eriksen, 2021).

The ability to build skills and vicariously learn from others is not to be underestimated (Newman et al., 2013; Nickson et al., 2016; Tulleners et al., 2021). Nielsen and Davidsen (2017) describe how different perspectives can result in a positive shift in thinking about care provision. Interestingly, a participant in their study goes so far as to describe peer group supervision as a “survival strategy” (Nielsen & Davidsen, 2017. p.260). Feedback provided by peers may also have fewer authoritarian connotations making it more acceptable to clinicians (Bernard & Goodyear 2019). Wencour et al. (2021) recount how the connections and support, group members provided to each other allowed feelings of isolation to be contained and trust and safety to develop. From an organisational perspective, the possibility of reducing staff burnout and stress makes peer group supervision attractive (Dungey et al., 2020; Nielsen & Davidsen, 2017) as does the option of multiple staff participating simultaneously (Tulleners et al., 2021).

A significant benefit to the peer group supervision model is that no one person leads the group and opportunities abound for all. Homer (2017) notes there is a richness that comes from the social interaction in the peer supervision group. Whilst Barron et al. (2017) study demonstrates that even in extreme circumstances such as an unstable war environment clinicians can benefit from peer group supervision. Bernard and Goodyear (2019) concur with the previously mentioned advantages and add that adult learners would find this environment attractive.

2.18 Challenges of peer group supervision

Each model of clinical supervision has its associated challenges and concerns. Challenges can relate to the individual, for example on a personal level peer groups can at first be scary and uncomfortable (Wilkinson, 2015). Barron et al. (2017) reported that members may feel uneasy about disclosing perceived limitations of practice. Furthermore, participants may have concerns about making mistakes and feeling vulnerable (Tulleners et al., 2021).

Additional challenges identified in the literature are that groups without leaders can develop a lack of structure and poor leadership which can result in a loss of focus and direction (Dungey et al., 2020; Fakalata & St Martin, 2020). Newman et al. (2013) does not elaborate deeply but notes that groups do not always start well. Another challenge members can face is becoming too familiar with each other leading to “group think” or alternatively challenging each other too much leading to discomfort (Nielsen & Davidsen, 2017).

Hawkins and McMahon (2020) identify the risk of negative games that can occur within a peer supervision group such as competing and colluding and suggests careful planning to mitigate these risks. Taking time away from work to attend peer group supervision or feeling that patients/clients must always be prioritised first can be an ongoing challenge for many clinicians (Bulman et al., 2016; Nickson et al., 2016). Napan (2021) identified that participants' “conflicting interests and hidden agendas” can impact the experience (p.276). Despite Bernard and Goodyear (2019) describing disadvantages as being “rarely mentioned” (p.204) they can be significant. Pager et al. (2018) reported that a third of their 248 respondents experienced group problems at some stage. Similarly, Somerville et al. (2019) noted that struggles with the structure and tensions are often left unresolved within groups. These instances may be indicative of challenges experienced within other groups.

The notable difference between group and peer group supervision models is the absence of a designated leader. Bailey et al. (2014) describes a juxtaposition where the group wishes to be leaderless and non-hierarchal. However, someone needs to take responsibility for organising the logistics of the peer group supervision. When this happens members may inadvertently find themselves being positioned as leaders instead of peers which has the potential to create dilemmas (Beal et al., 2017). Leaderless groups can struggle with managing conflict as no one is the designated arbiter of disputes (Somerville et al., 2019).

When people come together in a group there will always be differences of ideas, opinions, and personalities. These differences influence how people interact in groups and even if they wish to join groups (Forsyth, 2018). Having different perspectives is one of the reported strengths of peer group supervision (Atik & Erkan Atik, 2019). Whilst group dynamics don't always become a preoccupation for members, they may play a part in group success (Johnson, 2016). Given the variations in human nature, it is important to attend to any issues relating to functions in the group as soon as they arise (Borders, 2012). Trying to understand the different personality types within a group can assist with group functioning (Lewis et al., 2017; Johnson, 2016). Further exploration of this area is needed as group and group dynamics is not clearly articulated in the literature in any depth of detail.

The final challenge is terminology. There is debate and confusion in the literature about whether peer group supervision is really supervision or consultancy, and this lack of clarity leads to ambiguity unless the distinctions are clarified (Bailey et al., 2014; Basa, 2019; Bernard & Goodyear 2019; Borders, 2012; Murphy-Hagan & Milton, 2019). Bailey et al. (2014) and Martin et al. (2018) describe peer group supervision as serving a consultancy function as opposed to having a supervision role, as the individual maintains their own accountability.

Golia and McGovern (2015) describes the differences between supervision and consultancy as the provision of emotional support and suggest that the power of peer supervision should not be minimised. While Counselman (2013) states that peer group supervision participants are not responsible for directly supervising each other “they simply offer suggestions which members can accept or reject” (p. 15). It could be argued that the Registered Nurse (RN) “accepts accountability for decisions, actions, behaviours and responsibilities inherent in their role” therefore the debate over terminology may add unnecessary confusion to the conversation about peer group supervision (NMBA, 2016, p.4).

2.19 Peers in peer group supervision

The overarching concept of peer group supervision was explored in the previous sections through discussion on peer group supervision definitions and the reported characteristics, benefits, and challenges in the literature. It follows that it is also necessary to define the term ‘peer’ in greater depth and detail with a specificity to nursing. Familiar terminology related to peers in nursing can include peer review, peer teaching, peer support and work peers (Bulman et al., 2016; George & Haag-Heitman, 2015; Green, 2018; Irvine et al., 2017). Peers are defined as “one that is of equal standing with another especially one belonging to the same societal group including race, age and gender” (Merriam-Webster, 2023). Hendry et al. (2014) describe peers in terms of those who identify themselves to be a peer and who are then willing to share that experience with others as a peer.

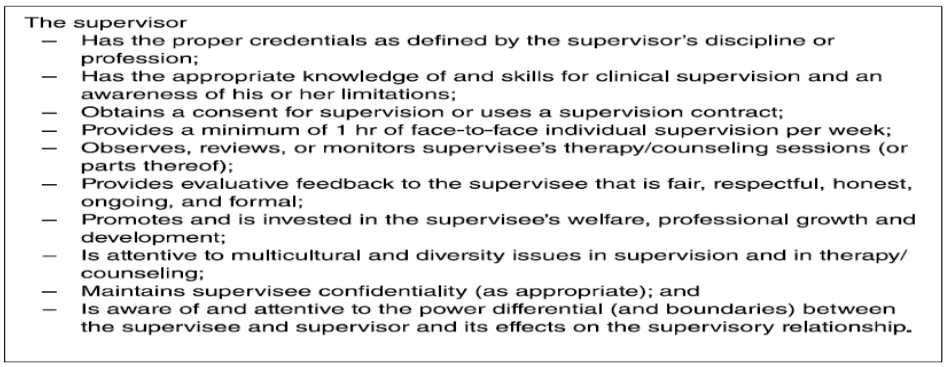
Peers and the purpose they play are not clearly identified in the nursing and allied health peer group supervision literature. In nursing, peers may be more difficult to define as variations depend on context. People of the same nursing grade may be considered peers yet have vastly different nursing contexts, years of experience and roles. Very experienced nurses may feel they do not require peers with whom they reflect, believing instead that they can do so on their own (Buus et al., 2018). Within allied health and medical professions, having peers with different experiences within the group can lead to unspoken power differentials thus impacting the group balance (Hølge-Hazelton & Tulinius, 2012; Mills & Swift, 2015).

Non-participation in peer group supervision may be due to not identifying other members of the group as peers (Johnson, 2016). The lack of reported literature surrounding the notion of peers in peer group supervision may lead to ill-considered group composition.

2.20 Inadequate or harmful clinical supervision

Peer group supervision should not just be “a tick box exercise” (Fowler, 2013a, p. 786). Indeed, the aim or priority for peer group supervision should not only be to get it right but to take necessary measures to avoid potentially causing harm (Beddoe, 2017; Pager et al., 2018). The clinical supervision literature identifies that harm from supervision is not a rare phenomenon (McNamara et al., 2017).

Harm can be experienced across all models, come in many forms, and relate to all participants of clinical supervision. Harm can range from a feeling of unease to outright trauma (McNamara et al., 2017) “Inadequate clinical supervision occurs when the supervisor is unable or unwilling to meet the criteria for minimally adequate supervision” (Ellis et al., 2014. p. 439). Figure 11 shares the criteria for minimally adequate clinical supervision. Harmful supervision is defined “as supervisory practices that result in psychological, emotional, and/or physical harm or trauma to the supervisee” (Ellis et al., 2014. P. 440). Whilst Ellis et al (2014) identifies face to face clinical supervision as a minimum requirement it is recognised that this is not always possible for clinicians. Tele-supervision provides an alternative for this minimum requirement and this concept provides options for staff not on-site or working in community settings with limited staff numbers (Martin et al., 2018)


The supervisor

- Has the proper credentials as defined by the supervisor’s discipline or profession;
- Has the appropriate knowledge of and skills for clinical supervision and an awareness of his or her limitations;
- Obtains a consent for supervision or uses a supervision contract;
- Provides a minimum of 1 hr of face-to-face individual supervision per week;
- Observes, reviews, or monitors supervisee’s therapy/counseling sessions (or parts thereof);
- Provides evaluative feedback to the supervisee that is fair, respectful, honest, ongoing, and formal;
- Promotes and is invested in the supervisee’s welfare, professional growth and development;
- Is attentive to multicultural and diversity issues in supervision and in therapy/ counseling;
- Maintains supervisee confidentiality (as appropriate); and
- Is aware of and attentive to the power differential (and boundaries) between the supervisee and supervisor and its effects on the supervisory relationship.

Figure 11: Criteria for minimally adequate clinical supervision across disciplines (permission for use obtained from the authors Ellis et al., 2014)

The supervisee may experience discrimination and power differentials. These are common narratives in the literature which can lead to a person doubting both their personal and professional abilities (McNamara et al., 2017; Chircop Coleiro et al., 2022). In one-to-one or group supervision, uneducated or poorly educated supervisors may practice outside their scope or not follow best practice, thereby resulting in harm (Andersson et al., 2013; Borders, 2012, Cook et al., 2020). Likewise, if ethics or group dynamics are not considered, supervision may be harmful (Barnett & Molzon, 2014; Smith et al., 2012). In all models, feedback provision can potentially be harmful and may diminish trust in the supervisee (Weallans et al., 2021). A final key point is that supervision should "benefit and prevent harm to the client" (Tugendrajch et al., 2021. p.80).

2.21 Chapter summary

This chapter explored the contemporary literature relating to clinical supervision. It "provoked thinking" about the elements associated with clinical supervision through to peer group supervision. The chapter began with definitions and ended with a cautionary tale of potential harm. The literature noted challenges and limited literature exist in the definition of peer group supervision in nursing and the dynamics presenting in teams and groups. Understanding the construct of both individuals and groups and their relationship in a peer group supervision practice is needed in the nursing context.

Defining peer group supervision in nursing requires greater clarity and differentiation to other models of supervision. Research into models is sadly lacking and the answers remain unclear on the optimal model, especially for peer group supervision in nursing clinical practice (McPherson et al., 2016). White (2017) notes that clinical supervision is being practised regularly and yet is invisible in the nursing and midwifery policy agenda.

CHAPTER 3: PAPER 1 – THE EXPERIENCE OF NURSES PARTICIPATING IN PEER GROUP SUPERVISION: A QUALITATIVE SYSTEMATIC REVIEW

3.1 Introduction

The literature describes the multiple benefits and challenges of clinical supervision for health professions. Despite this plethora of literature, there is a clear gap in understanding the phenomenon of nursing peer group supervision. To aid understanding, the systematic review by Tulleners et al. (2023) titled “The experience of nurses participating in peer group supervision: A qualitative systematic review presented in Chapter 3, explores the synthesised evidence of the experience of peer group supervision in nursing.

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The experience of nurses participating in peer group supervision: A qualitative systematic review☆

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ABSTRACT

Aim: This systematic review will identify, appraise, and synthesise the best available qualitative studies exploring nurses' experiences of peer group supervision. The review purpose draws from the synthesised evidence recommendations to enhance policy and implementation of peer group supervision in practice.

Background: Clinical Supervision is increasing in acceptance as a means of professional and best practice support in nursing. Peer group supervision is a non-hierarchical, leaderless model of clinical supervision delivery and is an option for implementation by nursing management when prioritising staff support with limited resources. This systematic review will provide a synthesis of the qualitative literature regarding the nursing peer group supervision experience. Understanding the experience of peer group supervision from those participating may provide constructive insights regarding implementation of this practice to benefit both nurse and patient driven outcomes.

Design: Included are peer reviewed journals focused on nurses' experiences of participating in peer group supervision. Participants are registered nurses of any designation. Qualitative articles, written in English and relating to any area of nursing practice and/or speciality are included.

The standards of the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) Statement were used to guide the review. Two investigators independently screened titles, abstracts and selected full text studies describing the experience of peer group supervision. Pre-designed data extraction tools were utilised, and the review followed the Joanna Briggs Institute qualitative meta-aggregation approach with a hermeneutic interpretive analysis.

Results: Results identified seven studies that met the inclusion criteria. A total of 52 findings that described the experiences of nursing peer group supervision are synthesised into eight categories. Four overarching synthesised findings resulted: 1. facilitating professional growth 2. trusting the group 3. professional learning experience and 4. shared experiences. Benefits such as sharing of experiences whilst receiving feedback and support were identified. Challenges identified related to group processes.

Conclusions: The paucity of international research into nursing peer group supervision poses challenges for nurse decision makers. Significantly, this review provides insight into the value of peer group supervision for nurses regardless of clinical context and setting. The ability to share and reflect with nursing peers enhances both personal and professional aspects of practice. The worth of the peer group supervision model varied across studies however the outcomes provided important insights into facilitating professional growth, enabling a space to share experiences and reflect, and to build teams where trust and respect develops in groups.

1. Background

The recent Covid-19 pandemic has seen nurses face challenges never before encountered in their careers (Catton, 2020; Turale et al., 2020). As professionals, nurses rise to meet challenges but require personal and professional support to optimally care for themselves and their patients

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(Catton, 2020; Dyson and Lamb, 2021; Fernández-Castillo et al., 2021) Times of crisis are when nurses require the most support to provide best practice and quality patient care (Dilworth et al., 2013; Martin and Snowdon, 2020; Sainsbury and Stacey, 2022). Ironically, this may be the time when nurses receive the least support.

Terminology describing accepted support measures in nursing includes mentoring, coaching, precepting, and debriefing (Fowler, 2013b; Martin et al., 2017). Some areas of nursing have expanded this support to include clinical supervision (Bernard and Goodyear, 2019; Fowler, 2013a). For many decades, mental health nursing has endorsed clinical supervision to support practice (Cookson et al., 2014; MacLaren et al., 2016; McCarron et al., 2018; White and Winstanley, 2010). The literature reports benefits from implementing clinical supervision into a variety of nursing and midwifery contexts (Dilworth et al., 2013; Evans and Marcroft, 2015; Lavery et al., 2016; Saab et al., 2021). Despite being described as beneficial, implementation has been patchy or even resisted from within the profession (Buus et al., 2018; White and Winstanley, 2010).

Health service organisations are recognising the imperative for staff to access clinical supervision opportunities (Australian College of Nursing (ACN), 2019; Saab et al., 2021). Pollock et al. (2017) define clinical supervision as "the facilitation of support and learning for healthcare practitioners enabling safe, competent practice and the provision of support to individual professionals who may be working in stressful areas" (p. 1826). Proctor (2008) and Kadushin et al. (2009) describe the numerous functions of clinical supervision as being normative, formative, restorative and administrative. Each function varies in practice depending on the clinician's situational context. Importantly, the provision of protected time for reflection and contemplative thinking is beneficial to both nurses and their patients (Bulman and Schutz, 2013; Patel and Metersky, 2021; Rothwell et al., 2021).

Clinical supervision delivery models include one-to-one, group, and peer group. There is no consensus on a preferred model (Bernard and Goodyear, 2019). One-to-one and group supervision require a trained supervisor whose expertise guides the supervision process (Bond and Holland, 2011; Cutcliffe et al., 2011). Group supervision has the additional benefit of incorporating multiple perspectives (Borch et al., 2013; Calcaterra and Raineri, 2020; Francke and de Graaff, 2012; Golia and McGovern, 2015; Knight, 2017). Challenges arise as resources required to provide trained supervisors make the approach less appealing in nursing.

Peer group supervision, a horizontal, non-hierarchal, leaderless model of clinical supervision may provide an attractive alternative for nurse managers when staffing, workloads and finances are already stretched to the limit (Dungey et al., 2020; Golia and McGovern, 2015; McKenney et al., 2019). Developing the professional sense of self and self-reflective practice, empathy, validation, insight into strengths and weaknesses and two-way development through diverse perspectives are benefits reported in the peer group supervision literature (Basa, 2019; Counselman, 2013; Goodman et al., 2014; Kuipers et al., 2013; Schumann et al., 2020). There remains a lack of clarity regarding elements of peer group supervision, including terminology (peer group supervision, consultation, or mentoring), purpose, process, and outcomes (Basa, 2019; Counselman, 2013; Golia and McGovern, 2015; Martin et al., 2017; Stone et al., 2020).

Previous systematic reviews about clinical supervision identify important limitations. For example, the accurate measurement and determination of effects continues to be an area where more research is required (Cutcliffe et al., 2018; Kühne et al., 2019; Pollock et al., 2017; Saab et al., 2021). Absence of agreed definitions leads to less optimal outcomes as does the evidence regarding clinical supervision content (Cutcliffe et al., 2018; Pearce et al., 2013; Pollock et al., 2017). Additionally, lack of a competency framework and agreement over the nature of clinical supervision in nursing, continues to impede clinical supervision progression (Cutcliffe et al., 2018; Pollock et al., 2017). Francke and de Graaff's (2012) review found that many group supervision studies identified positive effects. However, the effects on patients were less clearly articulated. Likewise, the review noted that identification of the supervisor in the research was problematic. The review recommended robust effect orientated future studies.

A preliminary library database search of MEDLINE, Cochrane dataset of systematic reviews, PROSPERO and Joanna Briggs Institute database of systematic reviews and implementation reports revealed no systematic review on the experiences of peer group supervision for nurses. Documentation of the experience of peer group supervision is not available and findings from group supervision reviews may not be transferable due to the unknown influence of the supervisor in the experience.

Understanding what transpires behind closed doors is important (McCarthy et al., 2021; McKenney et al., 2019; Newman et al., 2013). Models and processes may be reasonable in theory but not appropriate when applied. The participants' perspective provides deeper meaning from which insights can be gained (Daher et al., 2017). Through the participants lived experience, insights into the positive or challenging aspects of quality peer group supervision are shared. Recommendations for the provision of peer group supervision may be informed by this sharing of experiences.

The rationale for this systematic review is to summarise and appraise existing evidence from studies reporting on the experiences of nurses participating in peer group supervision. The standards of the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) Statement were used to guide the review (Page et al., 2021). The objective is to develop a meta-aggregation synthesis of qualitative reviews to contribute to recommendations for policy and implementation practices in relation to peer group supervision in nursing.

The review question is: "What is the experience of nurses participating in peer group supervision?".

2. Methods

2.1. Protocol registration

The systematic review was conducted according to the registered Joanna Briggs Institute protocol. The protocol was registered with reporting for systematic reviews. (PROSPERO CRD42021289091).

2.2. Inclusion and exclusion criteria

Qualitative research from peer reviewed journals that met the following inclusion criteria were contained within the review: 1. English language studies, where the participants were adults with no restriction on age, gender, ethnicity, clinical practice setting, specialty, or designation. 2. All participants were registered as nurses by the relevant nursing body in their jurisdiction and had completed requisite training and 3. Study participants were currently or previously participating in peer group supervision practice. Qualitative studies that articulated the experiences of nurses were considered.

Methodological designs considered interpretive qualitative studies that drew on the experiences of nurses. Narrative, opinion, and discussion papers were considered in the absence of qualitative research studies. The context is all nurses in any clinical or speciality area. This paper sought to explore the literature on nurses' experiences of participating in peer group supervision utilising a hermeneutic approach. Hermeneutics encourages the "horizon of possible meanings established by the body of literature" to come forth through a comprehensive process of thematic analysis (Boell and Cecez-Kecmanovic, 2014. p.267).

A hermeneutic approach to the systematic review is congruent with aiding deep understanding of the topic. This study systematically reviewed all aspects of nurse's experiences to identify the benefits, challenges and enablers that may influence the decision to participate in

or provide peer group supervision. The phenomenon of interest was the experience of nurses participating in peer group supervision. Peer group supervision is leaderless and has no hierarchy (Bernard and Goodyear, 2019). Exclusion criteria included one-to-one individual clinical supervision or group supervision models involving supervisors or facilitators and studies reporting student nurse experiences.

2.3. Search strategy

The university's Graduate Research Library staff provided advice on the search terms and subsequent electronic database searches. A systematic review commenced in January 2022 according to the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA). A comprehensive search of eligible qualitative literature in the electronic databases (Ebsco Megafile Ultimate, Web of Science, Pubmed, Proquest dissertations and thesis and Trove) was conducted to retrieve all English language literature containing studies relating to the experiences of peer group supervision. Only studies published in English were included to avoid errors in translation and potential loss of meaning.

No date restriction was applied to ensure pivotal studies were not excluded. The search strategy for each database or platform consisted of both Medical Subject Headings (MeSH) and using a combination of key terms as described here. Boolean operators were used for search terms to capture variations in terminology. Search strategy terms included: ("peer group supervision" OR "peer supervision" OR "group supervision" OR "group-based supervision") AND (nurs*) AND (experienc* OR concept*). An additional seven studies were retrieved from manually searching the references of included studies. A search of Google Scholar produced an additional 37 peer reviewed studies (Bronshteyn and Tvaruzka, 2008; Martin-Martin et al., 2017). Cross referencing of studies located in Google scholar with the University library database identified the studies were accessible from Wiley, Sciencedirect, Proquest, Researchgate, Ebescohost, Sobelle education, National library of medicine and CINAHL with Full Text databases (See Appendix 1).

2.4. Screening

At the completion of the literature search, citations were imported into Endnote (Version 9.3.3) reference manager for storage, screening, and the removal of duplicate studies. The remaining studies were screened independently by title and abstract. Two reviewers (TT and MT) screened all article abstracts retrieved using standard systematic review procedures (inclusion and exclusion criteria). Following the title and abstract screening, full texts were obtained and screened. Studies not meeting the inclusion criteria were excluded. Disagreements if they occurred were resolved through discussion and consensus, or by consulting the third reviewer (CC).

2.5. Methodological quality assessment

Data appraisal of studies was conducted, and risk of bias assessed using the Joanna Briggs Institute Critical Appraisal checklists for qualitative research and text and opinion papers (See Appendix 2 & 3). Quality of the selected studies was assessed independently (by MT and TT) using these appraisal tools (Lockwood et al., 2020; McArthur et al., 2020). The checklist evaluates qualitative studies using ten screening questions. Elements evaluated were congruity between the philosophical approach, methodology, methods, representation, and interpretation of the data, positioning of the researcher and the conclusions flowing from the data analysis and interpretation. Likewise, the checklist for text and opinion papers evaluates the source, interests and position of the opinion with reference to the literature. The rationale for inclusion or exclusion of studies following the critical appraisal was clearly identified. The two reviewers (MT and TT) independently appraised the studies and resolved disagreements through discussion and consultation with the third reviewer (CC). Study authors were contacted as required, for example to determine if there was a supervisor in the group if this was unclear (See Table 2).

2.6. Data extraction

Data extraction was conducted in Joanna Briggs Institute SUMARI software. Extraction included methods, country, phenomena of interest, setting/culture/context, participant characteristics, sample size, and key findings. Independent reading and rereading of the articles led to identification of the findings by the two reviewers (MT and TT).

Findings were discussed for agreement and if disagreements arose the third reviewer was consulted. Findings and illustrations were subsequently extracted. The themes or terminology used were taken directly from the original study.

2.7. Data synthesis

Data synthesis commenced with an extraction of the findings from each study. The findings were verbatim text from the studies. The findings were assigned a credibility level as per the Joanna Briggs Institute SUMARI data synthesis procedure. The findings are either "unequivocal, credible or not supported" (Lockwood et al., 2020).

The credibility levels assigned to each finding with its associated illustration were discussed by the reviewers (MT and TT). The findings from the study by Tulleners et al. (2021) and Johnson (2016) were themes and interpretations. The findings from the other five studies were taken from the phrases and firsthand participant accounts in the results section. These findings were accompanied by an illustration of the participants voices from the studies. The illustrations in four of the studies were direct quotes from the participants. Three articles (Fakalata and St Martin, 2020; Harker et al., 2015; Rich et al., 1995) had limited use of direct quotes and therefore verbatim phrases were utilised that shared the findings. (See Appendix 4).

Each finding and illustration were then assigned a level of credibility (unequivocal, credible, or not supported). Illustrations were carefully selected for each of the findings. The reviewers determined the level of credibility through examining the illustration and determining if it accurately represented the finding. This was discussed at length and agreement was reached on each of the final levels of credibility. Credible or unequivocal level findings were included in the synthesis.

Categories were developed through reading and rereading the findings and illustrations. Similar concepts or experiences that best represented the phenomena of interest determined how the findings were grouped. This thematic analysis process was conducted initially by the first author. The second reviewer then independently reviewed the categories and discussion was had to determine consensus. Any disagreements were discussed and if necessary, taken to the third reviewer.

The extraction was completed with the synthesis of findings. Meta-synthesis of the categories occurred leading to comprehensively described synthesised findings that share information that can inform nursing practice. Category descriptions were developed to best capture the essence of the phenomena. (See Table 1 for synthesised findings).

2.8. Ethical consideration

Ethical approval is not required for a systematic review and therefore was not sought.

3. Results

3.1. Study selection

The initial search identified 259 studies. This was reduced to 135 after duplicates were removed. These studies were screened for title and abstract. From these, 75 studies were full text screened. One was a poster presentation; 65 were excluded initially, however it was noted during

Table 1
Synthesised findings, categories and findings.

Synthesised finding	Categories	Findings
Facilitating professional growth. When considering professional growth, the clinician may experience both positive aspects and challenges. Professional growth occurs through the desire to improve nursing practice. Being aware of and understanding the challenges can influence this opportunity for growth	Facilitating professional growth	Feedback and Learning Aptitude to analyse professional actions Facilitates autonomy Formalised reflection Work satisfaction Greater repertoire of roles Improvements in the care Positive impact on nurse's practice PGS has helped us Achieving the goals Professional benefits Positive outcomes Positive effect on psychological and emotional well being
	Challenges to professional growth	Commitment We lost some momentum Protected time Benefits of experience Technology impacted the experience Technology impacts the experience Concerns expressed
Trusting the group. The dynamics within group settings have the potential to influence trust and the outcomes of peer group supervision.	Peer supervision group matters	Follow the rules Group matters Remote communication Structure and rules in peer group supervision Being part of a group Changes to the group dynamic Group processes Changes in group dynamics Termination Progress Benefits and cautions
	Trust in people and the process	Trust Confidential Building trusting relationships Group cohesion Trust and cohesion
Professional learning experience. Every clinician has differing learning needs. To achieve the desired outcomes support is required when one is at their most vulnerable.	Supportive environment to reflect and learn	Safe and comfortable Support It was very supportive Reflective practice Emotional connectedness
	Peer group supervision perspectives	Unique perspectives of peer group supervision There is value It builds you up
The shared experience. There is power that comes from the sharing of stories. To know that someone understands leads to increased confidence and self efficacy.	Shared experiences	Not alone Speaking the same language Group supervision preferred Linking with others Strong commitment
	The supervision story	Good news Telling the story Two sides of the coin

the critical appraisal phase that a further three did not meet the inclusion criteria and needed to be excluded (See Appendix 5 for excluded studies and rationales). Five studies and two narrative/opinion papers were included in the final review (See Fig. 1).

3.2. Methodological quality

The five studies and two narrative/opinion papers were assessed for quality using the Joanna Briggs Institute Critical appraisal tools. Three studies clearly outlined their ethical considerations. All the qualitative research studies demonstrated congruence between the research methodology and the research question and methods used to collect data. Over half the studies and papers situated the researcher and outlined the influence within the study. Only two studies overall met all critical appraisal criteria.

One study met six out of ten criteria for methodological quality (Fakalata and St Martin, 2020). Importantly the areas not identified in the study were the positioning and influence of the researcher. Therefore, whilst the article was included there was careful consideration of the potential for researcher bias in the findings. Another study only met four of the ten criteria for methodological quality (Marrow et al., 2002). The study from which this article originated included additional methodological quality indicators (Marrow and Yasen, 1998). Therefore, whilst the study was included, the possible limitations associated with the appraisal were acknowledged and considered throughout. (See Table 2).

3.3. Study characteristics

Characteristics of included articles comprised country of origin, setting/context, participant characteristics, models of peer group supervision utilised if known and description of the main results (See Table 3). Two studies were from the United Kingdom, one from Australia, two from New Zealand, one from the United States of America and one from Trinidad and Tobago. The studies were not limited by date and consequently spanned the years from 1995 to 2021. Five studies utilised qualitative approaches including hermeneutic interpretation, action research, reflexive accounts, and narrative description. Two studies were narrative/opinion papers.

All articles included the experience of nurses. The 55 participants in the studies consisted of various levels of nursing including enrolled nurse, registered nurse, registered nurse/midwife, clinical nurse, clinical nurse consultant, nurse manager and nurse practitioner. One study was inclusive of an occupational therapist and podiatrist among their participant cohort. The nursing contexts included, acute wards, a day unit, psychiatric/mental health, practice nursing and community health settings. Each study utilised peer group supervision without a designated leader or supervisor with one study utilising the terminology peer consultation group. Models of peer group supervision varied. Data collection methods included observation and audio recording, semi-structured interviews, written case studies, focus groups and personal narratives. Analysis when described, included thematic analysis and interpretation.

3.4. Review findings

All findings identified as either credible or unequivocal were included in the meta-aggregation. From the five studies and two narrative/opinion papers, 52 findings were aggregated into eight categories. From these eight categories the following four synthesised findings subsequently arose (See Table 4).

3.4.1. Synthesised finding 1: facilitating professional growth

When considering professional growth, the literature shared that the clinician may experience both positive aspects and challenges. Professional growth occurs through the desire to improve nursing practice. Being aware of and understanding the challenges can influence this opportunity for growth.

This synthesised finding identified multiple benefits which facilitated the professional growth of the nurses. Study participants reported the process of reflecting on practice enhanced their skills, increased

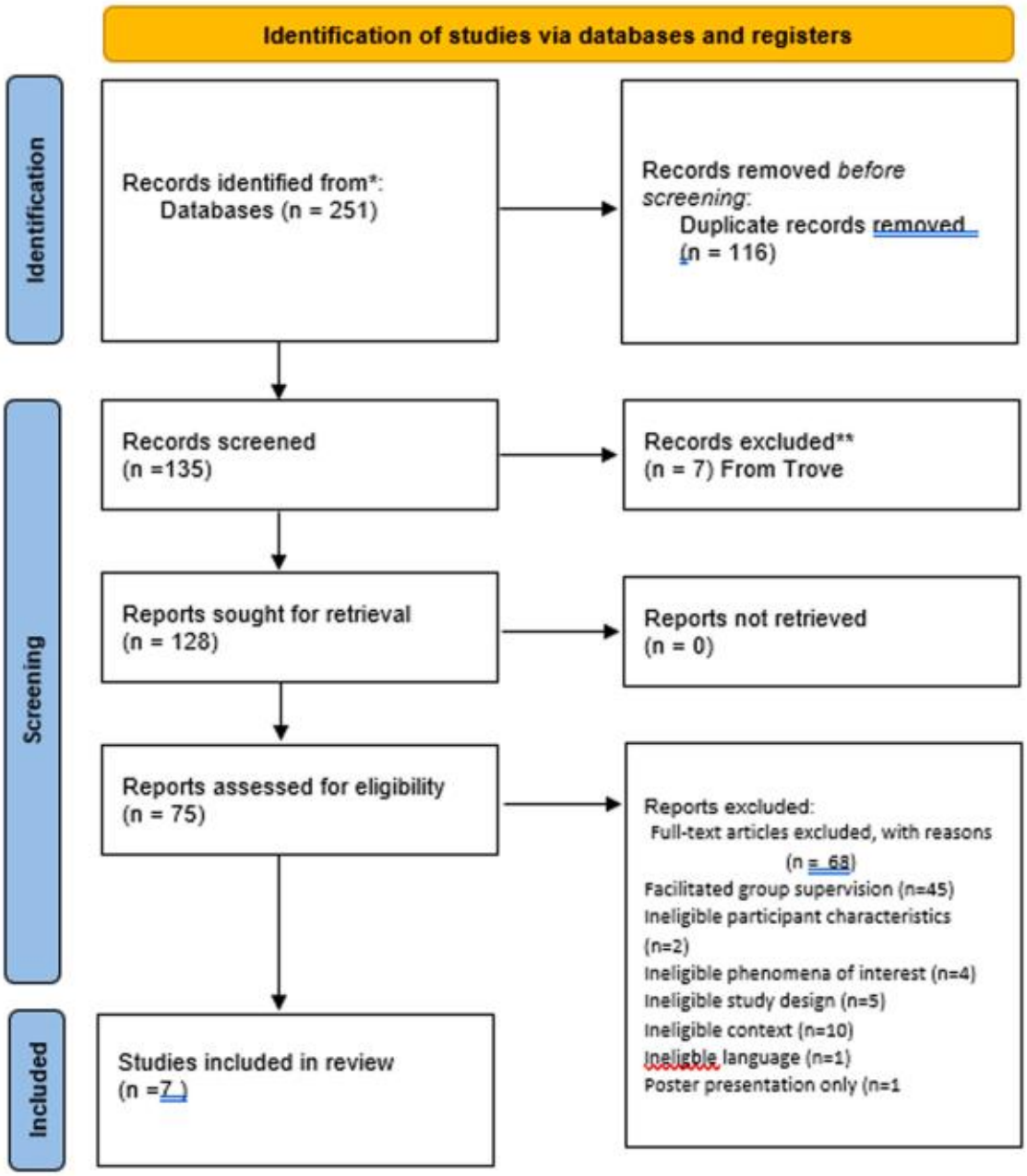

Fig. 1. Prisma Flow Diagram.

confidence and self-awareness and believed it would impact their future professional performance (Marrow et al., 2002). The process of reflecting did not come naturally for all nurses and peer group supervision encouraged deeper introspection (Lakeman and Glasgow, 2009).

Receiving and giving constructive criticism and feedback challenged nurses to improve their practice through the care and roles they provided to patients (Fakalata and St Martin, 2020; Lakeman and Glasgow, 2009; Marrow et al., 2002). Not only did peer group supervision challenge nurses, but it also increased personal and professional satisfaction levels (Lakeman and Glasgow, 2009).

Peer group supervision was suggested to improve patient care through discussion of concerns and issues (Fakalata and St Martin, 2020). How patient care was improved was not articulated in any of the studies rather generic improvement statements were noted. Professional growth was discussed and included career decision making and achieving goals (Harker et al., 2015; Rich et al., 1995; Tulleners et al., 2021). Additional benefits reported by participants included fulfilment of professional requirements, opportunities for learning and enhanced peer relationships (Rich et al., 1995; Fakalata and St Martin, 2020; Tulleners et al., 2021).

Challenges in relation to peer group supervision were noted. Commitment had two sides; being committed benefitted the individual, but a lack of commitment could impact the group (Tulleners et al., 2021). Attendance at peer group supervision was not always within the nurses perceived control. Other priorities such as work meetings would take precedence (Fakalata and St Martin, 2020) or duty rosters, for example shift work, could prohibit attendance (Marrow et al., 2002). No studies discussed or questioned whether nonattendance was also a sign of nurses decreased commitment.

Whilst peer group supervision models do not specify face to face

Table 2
Joanna Briggs Institute Critical Appraisal Results.

Qualitative research	Fakalata and St Martin (2020)	Johnson, 2016	Lakeman and Glasgow (2009)	Marrow et al. (2002)	Tulleners et al. (2021)	% of articles meeting qualitative standard
Is there congruity between the stated philosophical perspective and the research methodology?	Yes	Yes	Yes	No	Yes	80%
Is there congruity between the research methodology and the research question or objectives?	Yes	Yes	Yes	Yes	Yes	100%
Is there congruity between the research methodology and the methods used to collect data?	Yes	Yes	Yes	Yes	Yes	100%
Is there congruity between the research methodology and the representation and analysis of data?	Unclear	Yes	Yes	Yes	Yes	80%
Is there congruity between the research methodology and the interpretation of results?	Yes	Yes	Yes	Unclear	Yes	80%
Is there a statement locating the researcher culturally or theoretically?	No	Yes	Yes	No	Yes	40%
Is the influence of the researcher on the research, and vice- versa Yes addressed?	No	Yes	Yes	No	No	40%
Are participants, and their voices, adequately represented?	Yes	Yes	Yes	Yes	Yes	100%
Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	Unclear	Yes	Yes	No	Yes	60%
Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	Yes	Yes	Yes	Unclear	Yes	80%
	6/10	10/10	10/10	4/10	9/10	

Text and Opinion papers	Harker et al. (2015)	Rich et al. (1995)	% of articles meeting qualitative standard
Is the source of the opinion clearly identified?	Yes	Yes	100%
Does the source of opinion have standing in the field of expertise?	Yes	Yes	100%
Are the interests of the relevant population the central focus of the opinion?	Yes	Yes	100%
Is the stated position the result of an analytical process, and is there logic in the opinion expressed?	Yes	Yes	100%
Is there reference to the extant literature?	Yes	Yes	100%
Is any incongruence with the literature/sources logically defended?	No	No	0%
	5/6	5/6	

attendance, lack of this mode of communication was identified as a potential barrier (Harker et al., 2015). Technology had positive and negative effects. When technology worked, the experience was positive, however technology issues could impact peer group supervision, making it feel invasive (Harker et al., 2015; Marrow et al., 2002). Harker et al. (2015) noted that having a group member familiar with the peer group supervision process encouraged focus and staying "on track". However, this may lead to issues of assumed leadership in a non-hierarchical model (See Appendix 6 for category illustrations). The onus of equal participation and a non-facilitated approach assumed all members as equal leaders.

3.4.2. *Synthesised finding 2: trusting the group*

Dynamics within group settings have the potential to influence trust and the outcomes of peer group supervision. Rich et al. (1995) focused their entire narrative study on peer consultation group processes. Identifying there was a lack of discussion about group processes even when there were group contract violations (Rich et al., 1995). Group dynamics was often altered by the addition of new members. This was reflected in the Tulleners et al. (2021) study where the "getting to know each other" phase can take time. Not only does the addition of new members effect the group but the loss of members impacts cohesion (Rich et al., 1995). Members terminating from a group can alter the dynamics and leave some feeling rejected. Openness and future planning helped make termination an opportunity for group growth rather than a painful experience.

Physical separation led to isolation for those involved (Harker et al., 2015). However, Marrow et al. (2002) found that remote communication enhanced attentive listening as the participants were mindful not to interrupt each other. Concerted effort to maintain connectivity was found to be vital for the experience. The length of time the group were together combined with open communication was shown to lead to group maturity. However, Rich et al. (1995) noted that dissatisfaction arises when there is a lack of acknowledgment of group processes. The study recommends making group processes a visible component of peer consultation.

Group dynamics require time to develop. Learning the roles within the group take time and requires honesty between members (Johnson, 2016). However, Johnson (2016) notes that the instigation of a model may not be sufficient to influence group practice. It may require explicit intent of the members to maintain group cohesion. Rules and setting boundaries may assist with this cohesion (Tulleners et al., 2021). It is important to be aware of potential competition between participants or feeling disconnected all of which could lead to a poor experience (Rich et al., 1995). Even if the experience is poor, Rich et al. (1995) suggests keeping an open mind. Despite the challenges, being part of a group assisted nurses with managing multiple professional issues and provided a format for professional discussion through trust and group communication.

Trust was identified as being an important part of the group process. Trust was not instantaneous; it built and grew among the group members as time progressed. When there is trust there can be revelation of experiences (Fakalata and St Martin, 2020; Tulleners et al., 2021). Johnson (2016) likewise found there was reluctance to share if there was likely to be disclosure and there was consideration of ramifications should something leave the room. The group trusted each other to speak up (Johnson, 2016). Trust was individual but also for the whole group (Rich et al., 1995). None of the studies explicitly discussed how trust is built among members and more research is needed in this space (See Appendix 6 for category illustrations).

Table 3
Study characteristics.

Characteristics of Included Studies - Text and Opinion Study Form

Study	Type of text	Population represented	Topic of interest	Setting/ context/ culture	Stated allegiance/position	Model of peer group supervision	Description of main argument (s)
Rich et al. (1995).	Opinion piece written in narrative format	Six psychiatric and mental health nurses	Peer consultation group	Adult and child adolescent mental health	Group processes are always present and evolving however it is not discussed and can impact the peer group supervision experience	Utilise Yaloms therapeutic factors not a peer group supervision model	Developing trust and cohesion is important. Dynamic issues such as denial, rebellion and power were not examined. Termination was difficult and had significant impact on the group members. Phases of group formation need to be considered and discussed. Consideration of benefits and pitfalls of peer consultation groups needs to be highlighted
Harker, . et al. (2015).	A group self reflection narrative	Four nurses in practice and research settings	Peer group supervision	Practice nursing	The four authors describe the experience positively and are encouraging other nurses to participate	New Zealand Coaching and Mentoring model	Commitment is required. Peer group supervision can adjust to changes within the group such as loss of members to other locations. It is cost effective. Nurses will feel more empowered to meet the challenges in difficult nursing situations. Regular evaluation to meet individual goals is important. Peer group supervision has been enjoyable, positive and benefits all.

Characteristics of Included Studies - Interpretive and Critical Research Form

Study	**Methods for data collection and analysis**	**Country**	**Phenomena of interest**	**Setting/ Context/ culture**	**Participant characteristics and sample size**	**Model of peer group supervision**	**Description of main results**
Fakalata and St Martin (2020).	Questionnaires and semi-structured individual interviews. Survey results were a Likert scale. The qualitative data was descriptively analysed and a summary of results were provided	New Zealand	Peer group supervision	Epsom day unit in the Auckland medical aid clinic	Registered nurses working in Auckland Health board Epsom Day unit EDU. Invitation to 16 participants for surveys. 12 responded 5 participants for the interviews	Not described	Descriptive analysis with a survey showing that emotional labour contributed to reported stress levels. The qualitative data showed that as a result of peer supervision nurses benefited in terms of professional confidence knowing they could access useful advice, planning follow up of complex patients and their capacity to address more personal impacts such as stress. Peer supervision time needs to be protected as it was often delayed or cancelled to allow for other meetings. The makeup of the peer supervision group could benefit from regular review to ensure nurses can move around groups. The current model is beneficial to nurses. Access to an external professional supervisor with mental health expertise would be advantageous

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Table 3 (*continued*)

Characteristics of Included Studies - Text and Opinion Study Form							
Study	Type of text	Population represented	Topic of interest	Setting/ context/ culture	Stated allegiance/position	Model of peer group supervision	Description of main argument (s)
Johnson 2016.	Four phased action research process. Data was collected using audio recording over 6 planned sessions. The author was a participant observer. Each session was 1.5 h. Template analysis was the thematic data analysis process used. Data was manually coded and assigned to priori themes and themes were merged and reassigned via an iterative process. The final template provided the structure for further analysis and interpretation of the findings	United Kingdom	Peer group supervision	Community health organisation	Nurses and allied health. 6 participants including 4 nurses of differing grades and roles, 2 allied health (1 Occupational therapist, 1 podiatrist)	Page & Woskets five stage model	Effective peer group clinical supervision for health care practitioners can be accomplished with a relatively modest allocation of time. Establishing expectations before and during the processes contributed to equalising the power relationships within the group and established democratic principles within supervision. The most critical feature was the rotation of the functional roles of the facilitator, supervisee and supervisor to establish mutual trust between members. The value of the review stage in group supervision was demonstrated in enabling behaviours, emotions and skills to be noticed, challenge and reflection to take place and for actions and outcomes to be monitored. Substantial common ground between members showed professional values, beliefs and experiences. Hierarchical issues did not impinge on group relationships or undermine supervisory relationships. Safe space provided by peer group supervision enabled work generated emotion to be processed and managed rather than masked. Failure to address this may have a paralyzing effect on professional performance. Challenge each other was an indication of mutual trust and a signal of authenticity- so challenge became the antidote to collusion
Lakeman and Glasgow (2009).	Action research. Data collection methods were focus groups. Semi structured and open ended questions, audio taped and transcribed. Transcripts were subject to content analysis (Braun and Clarke)	Trinidad and Tobago	Peer group supervision	Nurses at a local psychiatric hospital	10 participants. 7 registered mental health nurses and 3 enrolled nurses worked at the hospital for at least 2 years. Were female and average age was 43. No prior experience of clinical supervision	Adapted Heron model	Fidelity to the peer group supervision model depends on strong facilitation skills and a commitment to following the prescribed or chosen process. A supervisor led group or expert facilitator may have been a more useful model to commence with to strengthen the facilitation skills of members. There was a focus on specific encounters that take place between patients and nurses. The participants warmed to this way of conceiving practice and with the simple but elegant idea of reflecting on the intent of their interventions. A different methodology would be more appropriate to examine the impact of peer group supervision on actual standards of care

(*continued on next page*)

Table 3 (*continued*)

Characteristics of Included Studies - Text and Opinion Study Form							
Study	Type of text	Population represented	Topic of interest	Setting/ context/ culture	Stated allegiance/position	Model of peer group supervision	Description of main argument (s)
Tulleners et al. (2021).	Semi-structured face to face interviews of approximately 1 h were conducted using open ended questions. Naive reading commenced the data analysis process. A process followed of re-reading the text and interpretation to the point where broad themes and meaning were identified	Australia	Peer group supervision	Community Health setting	Thirteen female participants from the following nursing grades (Registered Nurse, Clinical Nurse, Nurse manager and Clinical Nurse consultant from an outer metropolitan regional health service with at least 6 months experience of peer group supervision	New Zealand Coaching and Mentoring model	Three key interpretations arose from the data analysis process. First interpretation identified there is value in undertaking peer group supervision. A level of individual commitment was needed to get value out of peer group supervision. Good news was important. There was feedback and learning. Professional sustenance was gained through 5 ways: It builds you up, safe and comfortable, trust, confidentiality, and support. There were 2 game changers that determined whether peer group supervision was effective or not and these were group matters and following the rules. peer group supervision can be used with community health nurses and is not limited to a certain designation, years of experience or working with certain patients. There is value for the individual nurse and more widely for the nursing profession. The game changers need to be considered for effective peer group supervision. If peer group supervision is implemented without consideration of all the benefits and challenges it could set staff and managers up for failure
Marrow CE, Hollyoake K, Hamer D, Kenrick C. 2002.	The overarching research project collected data via pre-post study questionnaires, repertory grids, focus group interviews and written narratives. Data analysis was completed through 2 descriptive synopses of 2 reflective accounts	United Kingdom	Peer group supervision	Acute and Community Health	40 practicing community and hospital nurses. 3 participants voices were extracted for discussion. 2 were peer group supervision. 1 detailed one to one supervision	One participant utilised the Heron model	Effective clinical supervision can be an empowering experience. Health practitioners need a form of mediation to help them develop professional practice. Employers should recognise the importance of quality time and invest in the value of clinical supervision whether using VC technology or not. Training and education of supervisors and supervisees should be a major investment. Clear frameworks for supervision practice should be identified

3.4.3. *Synthesised finding 3: professional learning experience*

Every clinician has differing learning needs. To achieve the desired outcomes, support is required when one is at their most vulnerable. Reflection and learning are more likely to occur when there is a supportive environment. Receiving empathy and understanding whilst being challenged to brainstorm ideas is desirable (Tulleners et al., 2021; Marrow et al., 2002). Guidance and support for therapeutic reflection was noted to be important. Further, nurses felt safe when they were together in a supportive environment. It follows that when there are feelings of being safe, experiences will be shared, thoughts and opinions discussed, even when things haven't gone well (Tulleners et al., 2021; Johnson, 2016). Tulleners et al. (2021) note that support also takes the form of managerial approval to attend the group.

Nurses participating in peer group supervision have different perspectives of the experience. Some participants viewed it as a learning experience undertaken in protected time. Others appreciate the value of bringing practice concerns to a place where likeminded nurses can provide a different perspective. The nurses described gaining confidence and satisfaction, even saying it is essential for nursing (Tulleners et al., 2021) (See Appendix 6 for category illustrations).

Table 4
Credibility level within synthesised findings.

Synthesised Finding (SF)	Unequivocal	Credible	Not supported	Total
SF 1 Facilitating professional growth	10	10	0	20
SF 2 Trusting the group.	11	5	0	16
SF 3 Professional learning experience	8	0	0	8
SF 4 The shared experiences	7	1	0	8
Overall totals	36	16	0	52

3.4.4. *Synthesised finding 4. The shared experience*

There is power that comes from the sharing of stories. To know that someone understands leads to increased confidence and self-efficacy. Every supervision experience has a supervision story. Tulleners et al. (2021) noted that sharing good news stories was important. The nurses wanted to celebrate the successes of their work and not just the challenges. Knowing the story could be told without fear of being judged was important especially when processing emotions associated with work (Johnson, 2016). Johnson (2016) also noted that there are always two sides to a peer group supervision story and the participants are only sharing their perspective. This is not identified as an issue per se but

rather a consideration. Participants highlighted the need to challenge assumptions and maintain professional accountability.

The nurses identified that a beneficial element of peer group supervision is the opportunity to share experiences. The notion of receiving multiple ideas and support is appealing (Lakeman and Glasgow, 2009). As caring, responsible professionals, the idea that you are not alone meant something to the nurses (Tulleners et al., 2021). Linking with others who share the same problems and experiences was important. There is support and respect whilst reducing professional isolation (Marrow et al., 2002). The sharing of experiences does not just appear, rather this needs commitment to both the process and the group. Likewise, peer group supervision needs to be a priority for nurses for it to be worthwhile (Harker et al., 2015) (See Appendix 6 for category illustrations).

See Appendix 7 for the Meta-Aggregative Overview Flowchart for each synthesised finding.

4. Discussion

The systematic review examined the experiences of nurses' participating in peer group supervision. The review identified four synthesised findings. The first finding identified the personal and professional benefits to nurses participating in peer group supervision. This is consistent with peer group supervision studies in the helping professions (Atik and Erkan Atik, 2019; Dungey et al., 2020; Nickson et al., 2016).

The benefits vary greatly from person to person and are not always guaranteed. Benefits to patients have not been clearly articulated in the literature. This can lead to scepticism by both nurses and managers about what they will "get out of supervision". When it comes to prioritising time, participation by nurses could be influenced by the perceived benefits (or not) from attending peer group supervision. The articles emphasised that trust and communication is critical. The development of group is dependent on the group dynamics and structure that presents.

This review provides relevant information to prospective participants in the establishment of groups and in the time required for trust to develop. Both challenges and successes were identified in the establishment of groups. Challenges arose that relate to finding the time, knowledge of the model and commitment to attend which reinforces the idea that peer group supervision needs to be considered worthwhile for nurses to be motivated to participate.

This review emphasised professional and personal growth and developing trust in teams as the point of difference with peer group supervision. Whilst there are benefits with multiple perspectives, groups, and people within groups, can create inherent challenges. The vulnerability experienced when reflecting on practice is difficult and developing groups where comfort and professional etiquette is respected is needed. It is hard enough to share personal stories in a professional space, let alone when it is in front of an audience. If group trust can be built and teams established that respect both personal and professional traits, then the experience is very rewarding. This was reiterated several times unequivocally across the studies.

Several studies identified the potential risks associated with groups (Tulleners et al., 2021, Johnson, 2016). However, only Rich et al. (1995) reported comprehensively on the group processes. The issue of stability within groups regarding members coming and going made a difference to the experience. Most of the studies described how groups are formed. Harker et al. (2015) and Rich et al. (1995) were clear in their description of group formation. Not all studies provided detail on the structure of the peer group. Self-selection of group members was mentioned in several studies. However, self-selection to groups does not prohibit issues or guarantee success. Further exploration on group formation and its impact on peer group supervision experience is needed.

The key point arising from the third synthesised finding was that each person saw peer group supervision differently. Individually peer group supervision was perceived from a viewpoint that was meaningful to the participant. The learning and reflection on practice was individual and unique. Reflective learning opportunities occurred when the environment was supportive. Support was pivotal, both from each other and from managers who approved time to attend.

A unique finding from the review was the importance placed on the sharing of experiences. Sharing was powerful and the important message arising from the studies was that nurses do not want to feel alone in their practice. Feelings of isolation without the capacity to debrief and share was identified as a reality for some. Having someone who understood what was being experienced whilst sharing links and networks provided confidence. Sharing knowledge and insights when caring for complex patients made nurses stronger especially when no one person within the group led or assumed superiority (Marrow et al., 2002).

Several studies described peer group supervision using a particular supervision model (See Appendix 6). Harker et al. (2015) and Tulleners et al. (2021) described use of the New Zealand Coaching and Mentoring model. Fakalata and St Martin (2020) did not specifically mention a model however the references and discussion indicated the use of the New Zealand Coaching and Mentoring model. Johnson (2016) identified the use of Page and Woskets five (5) stage model of supervision. Lakeman & Glasgow (2009) identified the participants as using an adapted model by Heron (1999). In Marrow et al. (2002) one participant referred to the Heron model whilst the other case study made no mention of a model. Rich et al. (1995) identified group theory rather than a specific model. This reinforces the review finding that no one model is recommended or used however the importance of group is highlighted. The lack of clarity surrounding model choice further complicates the decision making of those considering whether to use peer group supervision or other alternative models that use a facilitated approach.

4.1. Limitations

Restrictions on language inclusion may have resulted in nurses' experiences going unreported. Likewise, two studies Rich et al. (1995) and Harker et al. (2015) were included despite being narrative/opinion papers however the content aligned with the review, its purpose, and the experience of the nurse. Johnson (2016) included two allied health professionals in their study with data analysis de-identified, thus it may be possible that findings from the study were allied health and not nursing only. Additionally, two studies Fakalata and St Martin (2020) and Marrow et al. (2002) were identified as having met fewer of the methodological research quality criteria. Therefore, caution may be applied to the findings of these studies.

Finally, it is acknowledged that one study was conducted by the authors of this review. The influence of the author on the review was considered and discussed within the review team. Bias was determined to be mitigated by the strict adherence to the review process and use of the quality tools from the Joanna Briggs Institute to maintain transparency throughout each step of the process. An independent review of this article occurred by an academic that was neither an author on the paper, nor a colleague of the authors.

4.2. Implications for nurse's practice

The review highlights the need for nurses to develop an understanding of the peer group supervision process prior to commencing. It is important for the nurse to recognise and understand the power that arises from the sharing of experiences. Group processes can impact the nurse's experience. Therefore, consideration should be given to the skills nurses require to maximise the group sharing opportunities. As experiences are very individual, nurses may want to consider how peer group supervision can influence their nursing practice and advocate for this within their organisations. Being aware of the potential challenges particularly of group formation and the time needed to develop trust can impact the peer group supervision experience. There is a need for nurses to identify and plan for successes and challenges and acknowledge that

this requires both individual and group cohesion to achieve success. Organisational support and time are needed to enable teams time to form, develop and establish trust and group cohesion.

4.3. Implications for organisational policy

The review highlighted the need for organisations to consider all elements of the process of forming, establishing, and maintaining groups and boundaries when implementing peer group supervision into nursing practice. This includes what supports are required to assist nurses to achieve the benefits and how can organisational barriers such as providing and protecting time for regular participation be considered. This review identifies a positive outcome for staff with reflective time and the capacity to build strong, resilient teams. It is recommended that further research that explores the outcomes from a self-efficacy perspective may be beneficial, likewise research that explores benefits to care needs to be considered.

4.4. Recommendations for additional research

There is limited research that specifically explores peer group supervision that is group led and not facilitated by a leader or facilitator. Additional research that specifically focuses on peer group supervision for nurses from a professional self-care perspective is required. This review has provided a glimpse into the potential of peer group supervision and the development of greater resilience, the capacity to debrief and the potential to increase professional self-efficacy. However more in-depth understanding of the potential for improving care is required.

Future research needs to ensure that all aspects of the peer group supervision processes are reported adequately to inform decision making. For example, future research may report why certain models were chosen thus providing pertinent information on which supervision model work best in what environmental and clinical situations. Research that captures the importance of peer groups, their meaning, and the process of forming and establishing groups requires consideration with a better understanding of group processes needed. A longitudinal approach to future research could explore the impact of peer group supervision on nurses practice and care outcomes.

5. Conclusions

This systematic review demonstrated that whilst there is a plethora of research on nursing clinical supervision there is a paucity on nursing peer group supervision. It was noted that studies regarding the experiences of nurses primarily focused on group supervision with a supervisor (Johnson, 2016). There were limited studies that purely explored nurses' experiences from a peer led approach.

It is interesting that only seven studies were located from the literature and only a few of these described qualitative methodology. This review could have explored peer group supervision from alternative methodologies but the richness that comes from the thoughts and feelings of the participant cannot be ignored, nor can the experience at the coalface by participating registered nurses This experience provides richness into the impact felt by nurses in their day-to-day practice. The concept of sharing was strong, and the concept of appreciation of time and discussion was noted.

The results of the meta-aggregation demonstrated that the peer group supervision experience comprised both individual and group elements. Nurses can reap benefits from peer group supervision for their professional practice but there are challenges that need to be considered. As these challenges are not always within their control, it is necessary to have organisational support for the process.

Challenges with group formation, developing trust and respect to share and engage are areas that require greater understanding and processes for the future. Peer group supervision is a valuable and worthy process for nurses as the ability to share, reflect and adjust both personal and professional aspects of practice are noted. The need to be engaged in teams that are cohesive and offer trust, respect, and the time to meet was highly regarded.

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Declaration of Competing Interest

The authors declare the following personal relationships which may be considered as potential competing interests: Conflict of interest. There is potential for conflict of interest in conducting the systematic review. There were only seven (7) articles included in the review and one (1) was authored by the review research team. The risk of bias was mitigated through the use of the robust PRISMA reporting guideline and the use of a qualitative meta-aggregation approach as outlined by the Joanna Briggs Institute. Additionally, the reviewers independently reviewed all articles and a 3rd independent reviewer was asked to read the final results prior to article submission.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.nepr.2023.103606.

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3.3 Links and implications

This chapter links inherently with the outcomes shared in the narrative literature review conducted in Chapter 2. This chapter provides a systematic review of the peer group supervision literature to better understand the experience from those having used it. The review identified that whilst the literature on clinical supervision is plentiful there is scant evidence specifically detailing nursing peer group supervision experiences from clinicians in practice. Importantly the systematic review focused on group supervision containing a designated supervisor which could impact the processes and outcomes of the supervision experience. This model aligns with the Australian College of Nursing and Queensland Health in recommendations for best practice in an Australian health setting.

The results of the review indicated that there were individual and group components that required consideration in peer group supervision practice. Whilst benefits were noted to be found in this worthy and valuable professional reflective practice process more knowledge was needed to mitigate the potential challenges. The implications arising from this research are that all aspects of the peer group supervision process need to be evaluated. This includes group aspects as well as individual considerations. The literature review in Chapter 2 and this systematic review clearly demonstrates that there is a gap in our understanding and more needs to be understood about the nursing peer group phenomena. Additional research is required into the processes of peer group supervision to accommodate staff needs in known busy workplaces. Without this knowledge the successful implementation is likely to be hampered. The following chapters provide detail on the research process including methodology and method used to identify and share the experience according to participants. This knowledge can be used to provide answers to this gap in collective knowledge.

CHAPTER 4: METHODOLOGY

"The essence of the question is the opening and keeping open,
of possibilities"
Hans-Georg Gadamer

4.1 Introduction

Reflecting philosophical concepts in research can be particularly difficult when there are no clear frameworks or methods (Adams & van Manen, 2017; Alsaigh & Coyne, 2021; Austgard, 2012). There is no one definitive or preferred methodology for researching peer group supervision. Within a peer group supervision model, nurses come together to potentially reflect and be vulnerable in their practice which is unique from other nursing activities where greater structure, process and reporting exist. To fully understand the implications of this model for nurses, this research seeks to explore the "what is" of peer group supervision practice for nurses individually and as a professional in practice. It is through exploration of the peer group supervision experience that meaningful insight is gained into this phenomenon.

The nature of qualitative research is to search for meaning and explore what lies beneath a person's thoughts or actions (Beck, 2013; Liamputtong, 2017). Qualitative research relies on the storytelling of people from a social perspective (Creswell, 2016; Liamputtong et al., 2017). This is an element that is missing from the peer group supervision literature.

There are multiple approaches that might be utilised in qualitative research to bring forth the participant's story including phenomenology, ethnography, and grounded theory (Beck, 2013; Holloway & Galvin, 2017). The approach utilised should be the one that best reflects the expression of the lived experience and demonstrates congruence with the research question. A hermeneutic interpretive approach was selected based on the research question posed. Review of the literature reveals that hermeneutics and nursing research can go hand in hand (Bradshaw, 2013; Hennessy, 2018; Moules et al., 2015; Rising Holmstrom & Söderberg, 2021; Smythe et al., 2014; Williams et al., 2020).

Gadamer (1975/2013) stated that “hermeneutics developed here is not, therefore, a methodology of the human sciences, but an attempt to understand what the human sciences truly are” (p.xxii). The meaning of hermeneutics is founded in Greek philosophy whereby messages were delivered among the gods to humans via Hermes (Bynum & Varpio, 2018; Lawn, 2006). Hermes provided an interpretation of these messages that aided the understanding and interpretation of sacred texts (Gadamer, 2006). Hermeneutics provides an interpretation to bring about an understanding of the topic, in this instance peer group supervision. Moules et al. (2015) state, “It is neither replication nor is it justification. It is an acknowledgement that things come from somewhere; they are not simply fabricated” (p.3).

The purpose of peer group supervision in practice is to seek understanding, meaning and in many instances resolve professionally related situations or practice issues. Learning more about the professional self and engaging in constructive and meaningful reflections on practice, provides a sense of power to transform practice and professional understanding of self.

To elaborate further on the interpretive phenomenological methodology relating to the research question, this chapter will provide an overview of qualitative research focusing on phenomenology (section 4.2) and interpretive phenomenology (hermeneutics) (section 4.3) before outlining the research through Gadamer’s philosophical approach (section 4.4). The congruence of the philosophical approach to peer group supervision will be outlined (sections 4.5, 4.6, 4.7, 4.8, 4.9, 4.10 and 4.11). Finally, the rigour and credibility of this approach will be discussed (section 4.12) and the chapter summary provided (section 4.13).

4.2 Phenomenology

Phenomenology assists researchers to understand or develop knowledge about the everyday experience of patients in our care (Matua & Van Der Wal, 2015; Moxham & Patterson, 2017). Phenomenology in nursing does not offer empirical observation but rather an insight into the experiences of health or illness. Phenomenology is a preferred research methodology when exploring phenomena that are less well-understood (Matua & Van Der Wal, 2015).

Phenomenology describes the story of lived experience within its context and in this instance provides a voice to registered nurses to share their experience, both positive and barriers to success of peer group supervision (Zahavi & Martiny, 2019). As a methodology, phenomenology is firmly grounded in philosophy which must be reflected in the research study (de Chesnay & Bottorff, 2015; Ellis, 2016; Errasti-Ibarrondo et al., 2018; Holloway & Galvin, 2017; Skea, 2016; Sloan & Bowe, 2014). Phenomenology is grounded in philosophy and as such there are no definitive rules or regulations (Tufanaru & Attard, 2012) prompting discussion in the literature about the application of the philosophical tenets (Zahavi & Martiny, 2019; Paley, 2018).

Different schools of phenomenology include descriptive, interpretive and the Utrecht or Dutch school (Dowling & Cooney, 2012; Holloway & Galvin, 2017; Liamputtong et al., 2017) with the humble beginnings attributed to the German philosopher Edmund Husserl (1859-1938). Husserl expanded on the work of earlier philosophers with the establishment of phenomenology as a response to concerns that the essence of life was being lost and reduced to a positivistic paradigm (Abalos et al., 2016; Gerrish & Lathlean, 2015). Husserl had the idea of wanting to view consciousness with a “God’s eye view”. He is often quoted as describing “to the things themselves” (Zu den Sachen) meaning that the phenomenon is where understanding takes place (De Chesnay & Bottorff, 2015. p.3; Eberle et al., 2020; Taylor & Francis, 2013).

Husserl describes the suspension of knowing to be replaced with transcendental philosophical questioning of “what is” (Sloan & Bowe, 2014; Taylor & Francis, 2013). Events and situations shape human consciousness and when human beings self-reflect, this lived experience can be shared (Willis et al., 2016). Phenomenology promises insight into the inside experience to shed light on commonalities and describe what the experience was like (Galvin & Holloway in Gerrish & Lathlean, 2015; van Manen, 2017).

In descriptive phenomenology, the everyday lifeworld experiences begin with rich description (Liamputtong et al., 2017). However, this description does not require explanation or suggest causation (Converse, 2012; Dowling & Cooney, 2012, Tufanaru & Attard, 2012). Rather the phenomenon is described and analysed unhindered by presuppositions (Abalos et al., 2016). Husserl describes the concept of intentionality. This concept proposes that humans are conscious of what is going on in the world, but understanding can occur through the direction of this consciousness (Dowling & Cooney, 2012; Taylor & Francis, 2013; Holloway & Galvin, 2017).

Intentionality occurs when we notice the everyday and pay attention to the experience without taking it for granted. We see the essential qualities or essence of the object. Husserl noted that humans come to situations or experiences with judgements and preconceptions (Willis et al., 2016). Husserl felt that it was necessary to separate these insider perspectives so as not to influence or bias the experience, thus, allowing the experience to stand. Coming from a mathematical background he called this shifting of consciousness or a fresh way of viewing, bracketing (Smith, 2013).

Bracketing sets aside preconceptions or judgements so that the data can be seen for itself (Galvin & Holloway in Gerrish & Lathlean, 2015; Matua & Van Der Wal, 2015; Taylor & Francis, 2013). This facilitates epoché or the suspension of belief. Husserl's process of slowing down inhibits the researcher leaping ahead and pre-empting the phenomenon (Holloway & Galvin, 2017, Patocka in Drummond, 2019). Bracketing leaves behind only the unburdened essence of the phenomenon (Dowling & Cooney, 2012; Merriam & Tisdell, 2016; Taylor & Francis, 2013).

4.3 Interpretive Phenomenology

Many contemporary philosophers, including his student Heidegger, disagreed with Husserl's viewpoint. Heidegger asserted that contemplating these abstract philosophical ideas is difficult because people are embedded in the world view and therefore it is impossible to be all-knowing or see things "with a God's view" (Skea, 2016). Heidegger (1889-1976) was an influential German philosopher known as the father of interpretive phenomenology or hermeneutics.

“Hermeneutics is a modified transliteration of the Greek verb “hermeneuein”, which means to express aloud, to explain or interpret and to translate” (Schmidt, 2016. p.5). Where language exists so does interpretation, be it from religious texts to the interpretation of the classics (Schmidt, 2016). Hermeneutics brings “something out of one world into another” (Gadamer, 2006. p.29).

The focus for Heidegger was to ascertain “the meaning of being” not just knowledge about certain phenomena (van Manen, 2017, p. 104). For Heidegger phenomenology did not stand alone, detached from consciousness rather it is a way for researchers to understand what it means to “be” (Heidegger, 1962). Heidegger introduces the notion of Dasein (being there) as meaning existence is inseparable from the world.

Understanding the inner workings and philosophical tenets of Heidegger can be as difficult as reading his works (Smythe & Spence, 2020). However, his influence on nursing research can aid understanding of the lived experience (Horrigan-Kelly et al., 2016). Describing a phenomenon was not sufficient, understanding is also required. Heidegger was concerned with ontology and what is the nature of being, the interpretation or unveiling of it and exploring moments where the everyday, is not taken-for-granted and life becomes visible (Given, 2008; Heidegger, 1962, Liamputtong et al., 2017).

A major characteristic of descriptive phenomenology research is the need to bracket researcher presuppositions to transcend and thus understand the experience. In interpretive phenomenology, the experiences of the researcher are acknowledged as being impossible to separate and essential to the interpretation (Benner, 2008; Bynum & Varpio, 2018). For this reason, preunderstanding or one’s own experiences cannot be separated from the interpretation (Bynam & Varpio, 2018; Dowling & Cooney, 2012, Matua & Van der Wal, 2015; Sloan & Bowe, 2013). Van Manen, (2017) notes that the mere act of reflecting on a lived experience means it has passed. The challenge then is to stay true to the experience as it was in that moment.

Heidegger poses the question: “What does it mean?”, rather than “What is the experience?” (Heidegger, 1962; Horrigan-Kelly et al., 2016). Being in the world is an elusive concept but Heidegger proposed that it was a circular process where understanding occurs within many contexts (Converse, 2012). Understanding does not come from an enclosed circle that feeds on itself rather reinterpretation builds and leads to comprehension.

4.4 Gadamer history and philosophy

Hans-Georg Gadamer (1900-2002) was a German philosopher and former student of Heidegger who produced his greatest work “Truth and Method” at the age of 60 (Grondin & Plant, 2014). Husserl and Heidegger provided a methodology of description where findings outlined the essence of what was said. The philosophical tenets of phenomenology continued to evolve with later philosophers focussed more on interpretation as understanding. In contrast to Heidegger, Gadamer emphasised that understanding occurs through language and conversation with the power to transform the topic and the person themselves (Binding & Tapp, 2008).

Researchers are at risk of portraying hermeneutics as a method or way of doing things. This is not the purpose as Gadamer prescribes not a theory, but rather, sharing a way to be open to deeper understanding (Binding & Tapp, 2008). Gadamer discusses the different ways one might understand, such as intellectual understanding and the application of this understanding. Intellectually understanding something shares the authority to say “yes, I get this”, and being able to apply that understanding proclaims “yes, I can do this” (Grondin,2021). Understanding through knowing becomes self-understanding, which is influenced by underlying tradition (Binding & Tapp, 2008).

Bildung can be interpreted to mean formation or becoming (Gadamer, 1960/2013) or even cultivation (Moules et al., 2015). *Bildung* is transformative, in that we understand differently and something new arises from the experience (Davey, 2006). *Bildung* “grows out of an inner process of formation and cultivation” (Gadamer, 1960/2013. p.10).

When nurse researchers utilise a hermeneutic philosophical approach to explore a research topic there is *Bildung.* As the research progresses the formation or becoming of the experience of peer group supervision will arise. It is through this revolution that understanding the experience differently will occur. To see this clearly, the research needs to pay attention to, and acknowledge the hermeneutic elements throughout (McCaffery et al., 2012). This begins with tradition which is more than just the handing down from one to another the “way things are done”. Tradition is changed and reimagined as it does not stand separate or siloed but rather, we are part of tradition and tradition is part of us (Lawn, 2006). In nursing, culture, and tradition form part of everyday practice. The contemporary nurse is a professional practitioner where law, regulation and national competency standards provide a platform for governance. Tradition is matched through the historical lens of a nurse as carer, through trust, competence, respect, and dignity. This historical lens shifting from a role of subservience to one of contemporary practitioner.

Alongside tradition, language, dialogue, or conversation also requires the researcher’s attention. Gadamer (1975/2013) states “being that can be understood is language” (p.xxxiii). It must be recognised that the use of language and conversation does not mean that every conversation is fruitful or that there is agreement. However, there may be understanding which arises from not just putting forward a point of view but shifting the view to a different direction (Gadamer, 1975/2013).

Gadamer related this shift in point of view to Aristotles ideas about *phronesis* (ethical or practical wisdom) (Gadamer, 1975/2013). Phronesis is moral wisdom or knowledge that arises from habits and traditions but is not retrained by these. Technical knowledge alone is insufficient when reflecting on practice (Jenkins et al., 2019; Moules et al., 2015). The application of phronesis has considerations for the nurse such as reflecting on whether this is the best course of action for this situation, currently, in this context. This application considers the history and context so as not to mindlessly repeat what has gone before but to act as required in the current situation.

We pay attention to and acknowledge the hermeneutic circle. Whilst both Heidegger and Gadamer describe the hermeneutic circle there are stark differences. Heidegger describes a process of understanding leading to interpretation and so on, whereas Gadamer notes that there are parts to the whole. “Understanding presupposes that the meaning to be understood builds a perfectly coherent whole…until all else fails” (Grondin, 2021).

Being open to possibilities that may arise can be difficult due to prejudices or preunderstanding. Every person comes with prior knowledge or understanding that has arisen from life experiences and no one can claim to be a blank page. The term prejudice has developed negative connotations (Gadamer, 1975/2013). However, in the hermeneutic context, a person’s prejudices can facilitate acceptance or rejection of possibilities because they differ from their worldview. These prejudices unless acknowledged, can inhibit the ability to develop new horizons.

For Gadamer, language was the universal horizon and was far more than just a tool (Nelms, 2015). Gadamer describes the fusion of horizon or *horizonverschmelzung* as follows: “the interpreter and the text each possesses his, her or its own horizon and every moment of understanding represents a fusion of these horizons” (Gadamer, 2006, p.45). Fusion of horizons occurs when the past or historical horizon intersects with the present horizon not to obliterate or overpower but rather to create new understanding (Lawn & Keane, 2011; Paterson & Higgs, 2005; Smythe & Spence, 2012).

In this discussion, the historical horizon is the literature associated with peer group supervision and its context within clinical supervision. This horizon includes the peer group supervision experience of the researcher. The present horizon will be the text obtained through conversation with the participants and the subsequent transcribed interviews, embedded in the emerging interpretation of the researcher. Interpretation does not lead to a definitive endpoint, there is no one definitive horizon rather future horizons which continue to evolve as understanding changes (Lawn, 2019). This research provides a new horizon of what peer group supervision could be for nurses. Figure 12 provides a visual representation of this new horizon.

Figure 12: Peer group supervision (PGS) fusion of horizon

We cannot enter into dialogue about this nursing practice without understanding the history and traditions of the topic (Moules et al., 2015). As Gadamer (1975/2013) reminds us “historically effected consciousness is an element in the act of understanding itself” (p.312). This does not mean reciting the historical milestones of peer group supervision. Rather, the literature is saying we come from a place of history and tradition and there is more to know as we have not yet reached understanding. There is a link between this concept and the role of a nurse, where practice and reflection are intertwined with history and tradition in nursing. When Gadamer describes the hermeneutic experience, it is the experience that comes from the everyday that pulls you up, is unique and unrepeatable (Lawn, 2006). The challenge is to take the ordinary everyday experience of peer group supervision and ask nurses to share what was unique or stands out for them. From this experience, the question is asked: “what is new about this?”.

In peer group supervision, reflective practice is used to debrief, recount, or explore clinical or professional situations in greater depth (Davys & Beddoe, 2020). The determination of professional meaning gained from reflection on practice for the registered nurse is not well understood. Reflection through a formalised peer group supervision process is established in some settings in nursing practice. Learning more from peer group supervision and the analysis of professional reflections provides a way of establishing meaning. The utilisation of hermeneutic phenomenology offers a solution to understanding the experience of peer group supervision and its use of reflection on practice.

4.5 Peer group supervision: a Gadamerian philosophical approach

The peer group supervision delivery model utilises dialogue and conversation to develop new insights into and understanding of a nurse's practice (Bernard & Goodyear, 2019). By the very nature of this model, every experience of peer group supervision is unique to the nurse's history, practice, and context. Developing an understanding of these experiences is possible through listening to the voices of those participating.

There is no one method that will lead to a total understanding of the peer group supervision experience. However hermeneutic interpretation is the most appropriate methodology to provide illumination and new horizons. There is congruence with hearing the voices of the participants as well as with the practice of peer group supervision itself. Hermeneutics also acknowledges the role of the researcher as integral for bringing forth that which might have otherwise been unknown. As Gadamer does not provide a step-by-step manual, the research must clearly reflect the philosophical concepts and key elements and bring them to life for the reader (Adams & van Manen, 2017; Austgard, 2012; Fleming & Robb, 2019; McCaffery & Moules, 2016; Regan, 2012). The literature describes guidelines, methods and frameworks designed to guide novice researchers who identify with Gadamer's philosophy but are unsure of where to begin (Alsaigh & Coyne, 2021; Fleming et al., 2003; Moules et al., 2015). Whilst this research project did not apply a particular guideline, the literature provided insight into the research considerations.

4.6 Address of the topic

My curiosity about this topic initially came when I heard a nursing colleague describing their peer group supervision experience. The nurse and I used the same peer group supervision model and worked in the same community health setting, yet our experiences were utterly unique. Asking the right research question unlocks possibilities of understanding (Alsaigh & Coyne, 2021; Austgard, 2012; Gadamer, 1975/2013). There is still much that is unknown about peer group supervision and the goal of interpretation is to shine a light on the unknown. Therefore, the research question; "What is the lived experience of nurses participating in peer group supervision?" is congruent with a Gadamerian philosophical approach.

4.7 Prejudices & prejudgement

The prejudices of the researcher are the means through which a new understanding of the phenomenon may be revealed (Binding & Tapp, 2008). The research process began with a recognition that I come to this nursing topic with curiosity but also with prejudices (Corcoran & Cook, 2022). As a novice researcher, I was averse to contemplating prejudices due to the term's negative connotations (Gadamer, 1975/2013). However, prejudice in this context does not automatically denote bias but rather prejudgement (Lawn, 2019). Alternative terminology utilised in the literature describes this concept as preunderstanding and presuppositions (Fleming et al., 2003; Maxwell et al., 2020).

Prejudices are not always uncovered prior to research commencement. Some remain hidden until the text or conversation with the participant provokes a revelation (Spence, 2017). Some may never be truly revealed and yet still influence understanding (Corcoran & Cook, 2022). I came to the research project with opinions and knowledge developed through first-hand experience of nursing peer group supervision within a community health setting. From this experience, I developed my understanding of the process, benefits and challenges associated with this model.

My participation in peer group supervision ceased prior to commencing the current research. This prejudice allowed me to be present and engaged in the research (Stenner et al., 2017). It allowed for understanding the terminology and ideas and for hearing what might be. Throughout the interviews, I heard and understood the language of peer group supervision practice utilised by the nurses. This understanding lent credibility to the process as I could make their experiences accessible to the reader (Moules et al., 2015). However, I knew that my horizon was only one way of viewing the world and therefore sought to understand the phenomenon differently. Although peer group supervision attendance had ceased prior to research commencement, my prejudice remains.

I discussed my prejudgement with the research team. Thoughts, feelings, and prejudices were journaled during each stage of the research process. Identifying prejudgement isn't always as simple as described in the literature (Fleming et al., 2003). Focusing on prejudices as they change through reading the literature, gaining understanding through dialogue with the participants and then during analysis, poses challenges for the novice researcher. Support from the research team during this process was essential as changing views can be uncomfortable (McCaffery et al., 2022).

Prejudices change and alter as the research progresses. What was known before loses relevancy with new horizons of understanding. Maxwell et al. (2020) report multiple facets as contributing to prejudice and suggest there is an arc where preunderstanding becomes altered understanding. Prejudgements cannot be forgotten or ignored. Nor is it possible to separate your prejudices prior to commencing research. Gadamer (1975/2013) notes that "separation must take place in the process of understanding" (p.306). Therefore, it is important to understand that prejudice identification is constant and fluid and occurs continually throughout the research process (Lawn, 2019; Regan, 2012).

4.8 Dialogue with the literature

A review of the literature was conducted to explore the peer group supervision horizon. Whilst literature reviews demonstrate a gap in the literature or critically assess what is known, the key purpose in utilising a hermeneutic approach is to "provoke thinking" (Smythe & Spence, 2012. p.14). Guided by this approach, the literature review pays attention to the current knowledge, application, tradition, and context of peer group supervision to achieve an understanding of the topic and to identify gaps in what is known about this approach to peer group supervision (Boell & Cecez-Kecmanovic, 2014; Pollock et al., 2017). The review of the literature exposes layers of perspectives on what the true meaning of clinical supervision is in the context of nursing. Disparities were shared, and commonalities were identified, however, it was clear that a deeper reflective process of uncovering was needed.

This research delves into the reflective experience of nurses professionally through the construct of peer group supervision. The hermeneutic circle is utilised during both the “search and acquisition” and “analysis and interpretation” phases (Boell & Cecez-Kecmanovic, 2014. p.264). Reading the literature requires us to seek the possibilities of the text not just its literal meaning (Moules et al., 2015).

Individual texts were read leading to the understanding of the part, then reading new texts iteratively increased understanding of the whole. New horizons of understanding were created as the researcher was open to the meaning of the text. It is important at this point to again consider the prejudices of the researcher. In fact, Smythe and Spence (2012) suggest this is the place to begin the literature review.

The researcher’s prejudgements include past and present experiences and knowledge of peer group supervision. These were integrated into the literature review from the beginning. The titles selected, and the search terms used were indicative of prejudices and therefore need to be carefully considered. It is impossible to set aside what is known about peer group supervision.

The known cannot become the unknown. Likewise, when reviewing the literature, it was impossible to guess what the authors' presuppositions might have been (Debesay et al., 2008; Smythe & Spence, 2012). Reading and engaging with the dialogue enabled understanding of the text to occur. Simultaneously this can challenge the researchers’ prejudgements about the topic (Boell & Cecez-Kecmanovic, 2014). It is inevitable that the reader “interprets” the text based on their own prejudices however this serves as a catalyst for provoking thinking about the topic (Smythe & Spence, 2012).

The literature review is the starting point for understanding the peer group supervision horizon across dimensions of history, culture, context, and language. As the topic of peer group supervision is nestled within the history and context of clinical supervision the available literature is vast. The researcher determined where to enter the hermeneutic circle to address the topic whilst not overlooking textual dialogue that may have added to the horizon of understanding. It seemed logical to enter the hermeneutic circle by reading articles on peer group supervision, yet I quickly realised that this was akin to reading a book from the middle chapter.

My prejudice led me to begin at a point that later required reconsideration. The literature review is never complete as there is always more that can be discovered and interpreted. It is important to consider when to leave the hermeneutic circle and the time within the review where the experience and the specific learnings about peer group supervision are captured. Boell and Cecez-Kecmanovic (2014) suggest considering saturation and what this might mean in the context of the research. Leaving the hermeneutic circle should be considered when commencing the literature review. Whilst this can be challenging for the novice researcher, leaving the circle must consider many factors including the determination that the literature meets and addresses the topic.

4.9 The players

The research is not intended to be a portrayal of the participants in a study but rather the portrayal of the experience. Gadamer describes this as the play (*spiel*) is not about the players but rather the players provide a representation of the play (Gadamer, 2006; Keane & Lawn, 2016; O'Connor, 2016). Purposive sampling of the players was selected to be credible to the reader (Polit & Beck, 2017). Purposive selection includes those individuals who can clearly articulate their self-reflective capacity and whose contribution significantly aids in understanding the phenomenon (Glover & Philbin, 2017; Holloway & Galvin, 2017; Liamputtong et al., 2017; Moules & Taylor, 2021).

Each participant brings their own horizon of understanding based on their peer group supervision history, culture, context, and experiences. This meeting of horizons provides new understanding (McCaffery et al., 2022). The participants were sought from nurses who seek to share their experience of peer group supervision. Moules et al. (2015) make the point that ethically, nurses who wish to volunteer may have a reason for doing so. Whilst a valid point, this does not discount the valuable insight their horizon can add to understanding peer group supervision. A hermeneutic research approach does not seek validation in the number of participants. Rather there are sufficient examples to demonstrate the experientially rich accounts of the lived experience (Moules et al., 2015; van Manen, 2014). As the research intent is to gain an understanding of nurses' lived experiences, the sample size needs to be consistent with the interpretive methodology (Hennick et al., 2017).

4.10 Conversations with participants (Data Collection)

Peer group supervision may be understood in a variety of ways. One authentic way is through dialogue and conversation with the nurses experiencing it (Moules et al., 2015). Gadamer notes “When two people come together and enter into an exchange with one another, then there is always an encounter between, as it were, two worlds, two worldviews and two world pictures” (Vessey & Blauwkamp, 2006. p.354). Whilst there is no framework for conducting the hermeneutic interview (Dahlberg & Dahlberg, 2020) it has been described as an art or craft (Moules et al., 2015).

This terminology should not discourage researchers who fear they lack the creativity to conduct the ideal hermeneutic interview. Indeed, the art or craft of the hermeneutic interview is being open, curious, and willing to listen for a truth that may or may not differ from our own (Moules et al., 2015).

Whilst researchers may “fall into conversation” with participants, in that we do not know the direction the conversation will take, there is a purpose to the interview (Hovey et al., 2022; McCaffery et al., 2012; Moules et al., 2015). There needs to be consideration of the time, place, and structure of the interview to best elicit engagement (Holloway & Galvin, 2017). The use of semi-structured in-depth face-to-face interviews encourages free discussion of the topic whilst being inclusive of the participants' context and history (Creswell, 2016; Galletta, 2013; Gerrish & Lathlean, 2015; Polit & Beck, 2017). Like the introductory bars of a song, open-ended questions begin the interview. An example of which is: Can you share with me your experience of peer group supervision? Follow-up or probing questions are utilised to follow where the topic leads (Moules et al., 2015; Polit & Beck, 2017).

Approaching the interview with openness and curiosity allows the “play” to come forth and be less inhibited (Smythe et al., 2008). Being open, transparent, and the appropriate use of humour creates a trusting space where the story can unfold (Moules & Taylor, 2021). Whilst challenging at times the researcher listens intently (Vandermause & Fleming, 2011) and seeks to encourage the participant to share not their interpretation of the experience but rather what their experience has to say about peer group supervision (Adams & van Manen, 2017; Moules et al., 2015).

Fleming et al. (2003) suggested returning to the participants multiple times. The nurses in this research gave freely of their time but to do so repeatedly was not possible due to competing demands. Therefore, the researcher decided to offer participants the opportunity to review their transcripts if desired for clarity and accuracy. Whilst this is not methodologically required it was determined to be beneficial for building rapport, clarifying meaning, and enabling registered nurses to provide additional knowledge, wisdom, and experience of peer group supervision. This approach ensured that the researcher was able to understand the perspectives of participants to aid the analysis of data in its most correct and rich context.

The researcher's familiarity with the nursing context and peer group supervision model can enhance the interview process by drawing forth information that may not have been otherwise possible (Stenner et al., 2017). However, without foresight into the participants' views, the researcher may be subconsciously pre-empting or making assumptions (Regan, 2012). For this reason, it is important to consider prejudices prior to, during and after the interviews. What did the researcher think would be heard, what was heard and what was thought about this afterwards? The researcher needed to be open to the possibility that what was told may be totally unexpected. The unfamiliar and the familiar intertwined until there was new insight and a new horizon (Regan, 2012).

It is acknowledged and accepted that "the one truth" is not sought but rather what is true for the participant at that moment in time (Crowther et al., 2017) This does not detract from its meaning as the interpretation of peer group supervision can still resonate with other nurses hearing this truth.

4.11 Interpretation of the experience (Data Analysis)

Language is influenced by the associated culture, values and beliefs and can therefore never be truly unbiased (Earle, 2010). Hermeneutic analysis begins with an inquiring mind that aims to stay as true as possible to the text whilst at the same time providing a new understanding of the phenomenon (Benner, 2008). An integral part of hermeneutic analysis is the constant movement between the researcher's knowledge of the phenomenon and the data.

The reader becomes part of the text and part of the meaning elicited from the text (Gadamer 1975/2013). The role of the researcher is clear, the prejudgements allow the researcher to hear things that may not have been noted previously but ultimately “the writing is by us but not about us” (Moules et al., 2015, p. 120).

Data collection and analysis go hand in hand. Following the interview process, the data was transcribed verbatim and then read sequentially, at first as the whole, then coming back to the parts (Moules et al., 2015). Data encompassed verbal and nonverbal text (Fleming et al., 2003; Moules et al., 2015). Nonverbal text such as the noting of excitement in the participants' voices or hesitancy when searching for a word added to the richness of the interpretation. Data analysis began by listening to the text as if participating in a conversation (Lawn, 2019) to identify what was meaningful and essential to the participants thus making sense of the revelations (Willis et al., 2016).

The “play” or “dance” as described by Gadamer is the constant movement between the text, the interpreter, and the data. Interestingly, the peer group supervision process mirrors this “play”. For example, the participant shares parts of the patient’s whole story they wish to receive feedback and reflect upon. Their horizons of preunderstanding fuse with, but are not subsumed by, the dialogue of their peers to form a new horizon of understanding that seeks not an endpoint but new insight (Austgard, 2012; Gadamer, 2006).

The hermeneutic circle examines the parts and the whole of the text in a circular/spiral movement with the prejudices/prejudgements of the researcher interwoven throughout (Gadamer, 2006; Spence, 2017; van Manen, 2014). The initial stage of data analysis familiarised me with the content of the transcripts. The evolution of the participants’ experience unfolds through extensive reading. This is followed by re-reading the text and then reflecting on how this relates to the whole. There is a conversation with the text then interpretation and further re-interpretation until a shared understanding emerges. Applebaum (2011) reminds us that interpretation is not a “license to draw whatever you will of research data” (p.4). The challenge is to find the balance between description and interpretation lest it reflect my thoughts rather than the phenomenon (Thorne, 2016).

Other qualitative methods may develop theories or themes whilst hermeneutics seeks deep understanding through interpretation (Bynum & Varpio, 2018). Interpretations are derived through resonating moments where the participants' experiences and researchers' prejudgements create a new horizon of understanding (Binding & Tapp, 2008; Moules et al., 2015). The researcher zooms out for a view of the bigger picture and then zooms in to the detail of the experience (Crowther et al., 2017). It is for these reasons that hermeneutics is the most appropriate methodology for exploring peer group supervision experiences.

4.12 Rigour and Credibility

There can be doubt about the veracity of the interpretation as it does not conform to the evaluation techniques of the natural sciences (Moules et al., 2015). Gadamer does not espouse a research manual, so the onus is on the researcher to demonstrate rigour, trustworthiness, and congruence with the underpinning philosophy (Johnston et al., 2017). Credibility is enhanced by congruence between the research question and the chosen methodology (Moules et al., 2015). Trustworthiness is not demonstrated through rigidly providing detail for others to replicate but rather through recognition of the contribution the research makes to understanding the topic (Moules et al., 2015).

De Witt and Ploeg, (2006) suggest rigour can be evaluated in hermeneutic research approaches through identification of the following elements: "Balanced integration, openness, concreteness, resonance and actualisation" (p.226). Rigour is also demonstrated through clear identification of the researcher's prejudices. Prejudices identified throughout this research's' stages from literature review to data analysis are discussed and then recorded in a reflective journal (Fleming et al., 2003; Spence, 2017). Self-reflection is intrinsic to a hermeneutic research approach; therefore, the Guidelines for Self-reflection ten step process was used to enhance rigour and credibility (Pool, 2018). Whilst providing guidance the steps are neither prescriptive nor absolute.

Step	Guidelines	Commentary
1	Make a plan	Objectives and timelines for research were developed
2	Obtain materials, schedule time, and arrange the writing space	Writing materials were gathered including poster boards and regular writing time allocated
3	Attempt a first draft	A first raw handwritten draft of experiences was developed
4	Transcribe and continue reflecting	The draft was transcribed into a Microsoft Word document with journalling noting prejudices arising
5	Dwell with lifeworld-based queries and feedback	Sitting with and stepping back from the writing was challenging
6	Resume (more focussed writing)	Writing resumed
7	Embrace ongoing critique and probing questions	Critique and feedback from supervisors were valuable
8	Intensify your writing	Writing continues
9	Evaluate and organise	Interpretations arise
10	Suggest tentative meaning	A summarising interpretation and possible meaning are suggested

Table 2: Ten Steps for Producing Self-Reflective Text (Pool, 2018 pp.250-251)

The researcher validated the verbatim transcription with the participant, to ensure the accuracy of the transcript. This process of member checking provided the eighteen participants with opportunity to review, amend and clarify any part of their interview response with the researcher. One participant made a minor amendment, whilst six participants opted not to check the transcript and the remainder were satisfied with their responses (Birt et al., 2016). The role of the participant was not to be the topic but to provide illumination by which the topic was seen in a new light therefore verification of the interpretation was not required.

Credibility relies on the reader being able to see the decision-making processes of the research by ensuring 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). When the participants' views and experiences resonate with the reader, credibility is enhanced (Cope, 2014; Polit & Beck, 2017). Consistency between the original text and the researcher's interpretation was required and is demonstrated through the inclusion of the participants' verbatim words (Austgard, 2012).

Another researcher's history, context and prejudices may have resulted in alternative fusions of horizon arising from the research. However, hermeneutics does not make a declaration of absolute truth, but rather offers a different way of viewing it. From this way of viewing, veracity and credibility are demonstrated when the findings with the interpretations of peer group supervision resonate and are acceptable to the reader (Moules et al., 2015). The dialogue plays back and forth but is never entirely over as there is always more to say (Gadamer, 1975/2013; Lawn, 2019). Through a detailed analysis of data obtained from participants, and a comparative analysis of the literature, the discovery of the essence, the 'what is and what could be' of peer group supervision is derived.

4.13 Chapter summary

"An address is the feeling of being caught in some aspect of the world's regard, of being called or summoned" (Moules et al., 2015. p.72). This topic addressed me in a way that no other topic had before. Contemporary research has provided pieces that help understand the peer group supervision puzzle. Valuable insights have been shared from the helping professions' perspective (Dungey et al., 2020; Goodman et al., 2014; Kuipers et al., 2013; Schumann et al., 2020; Somerville et al., 2019). The missing puzzle piece is understanding shared through the nurse's voice.

The understanding gained from peer group supervision research is neither final nor absolute (Debesay et al., 2008). Indeed, the researcher acknowledges that future readers may understand this research differently (Gadamer, 1975/2013). However, gaining an understanding of the phenomenon is important because without this insight, implementation, practice, and reflective processes of learning may be less beneficial or even harmful (Francke & Graaff, 2012; Beddoe, 2017). Every reader involved in the conversation of peer group supervision will have their own horizon. This horizon when fused with the research horizons will suggest future possibilities of what the peer group supervision experience could be in the nurse's context.

The advantage of a Gadamerian philosophical research approach is that *there is no "one truth"* but rather multiple truths of what could be (Caputo, 1988; Smythe et al., 2008). Thus, interpretation of the phenomenon continues long after the research has been completed (Gadamer, 2006; Lawn, 2006; Miles et al., 2013). The power of this methodology is that it provokes thinking. It provokes decision-makers to consider why they should implement a model of peer group supervision for their nurses. It provokes thinking about what the peer group supervision experience could be like, what supports might be required and what challenges might need to be overcome.

CHAPTER 5: RESEARCH DESIGN

"To conduct a conversation means to allow oneself to be conducted by the subject matter to which the partners in the dialogue are orientated".

Hans-Georg Gadamer

5.1 Introduction

Chapter 5 outlines the approach used for the research design and methods. The design of this research project drew on the philosophical foresight of Gadamer as noted in the Methodology Chapter 4. A hermeneutic approach was taken when considering each element of the research design. This chapter begins by outlining the research-phased approach. Following this, the research setting is discussed (section 5.2) and the research participant selection and recruitment process is outlined (section 5.3 and 5.4). The ethical considerations of the research are described (section 5.5) and the positioning of the researcher is detailed (section 5.6). The data collection methods and the process for data analysis is discussed (sections 5.7 and 5.8). Finally, a chapter summary is provided (section 5.9). Figure 13 provides an outline of the research's staged approach.

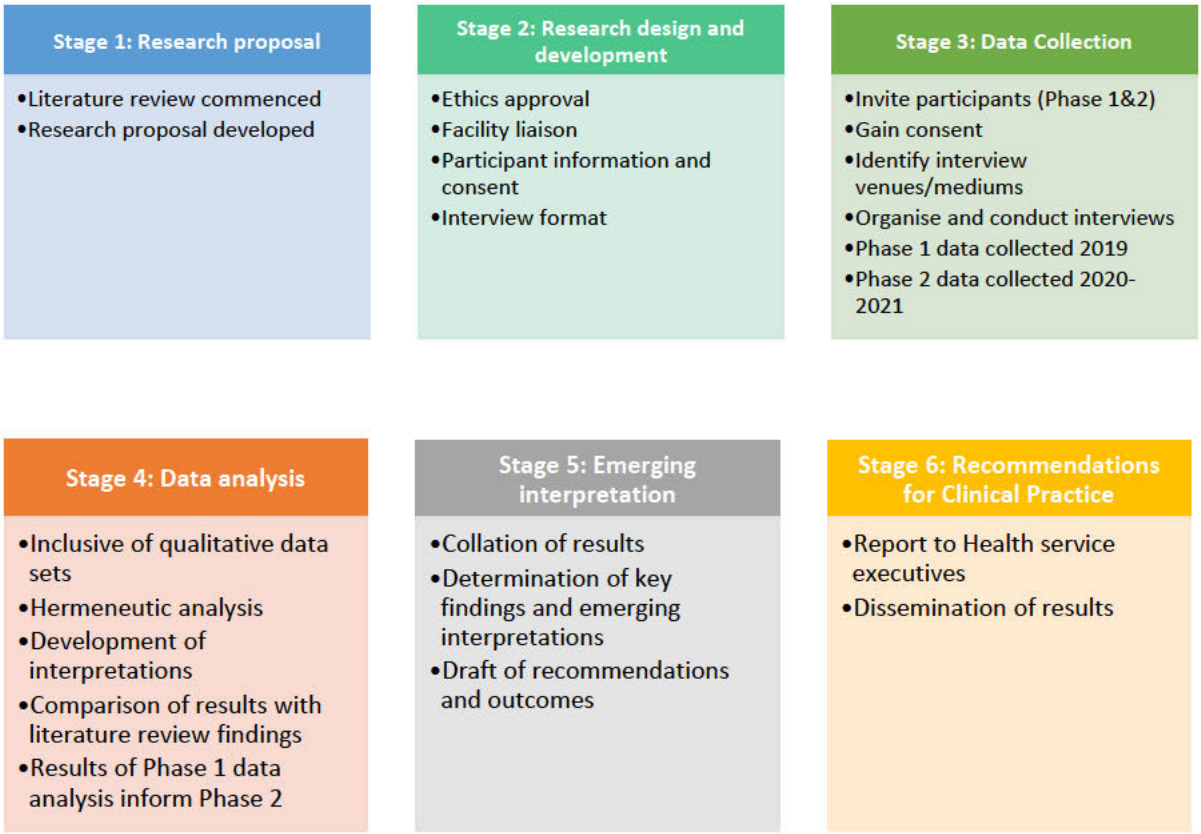


Figure 13: Research design stages

This research project utilised a phased approach for the conduct of the research. Phase 1 included recruiting participants from community health nursing staff based at a regional health service. The researcher was based at this site during the inception of peer group supervision in February 2017. Knowing the workplace, its structure and governance processes enabled the researcher to access key stakeholders and participants due to already established networks. This phase collected and analysed data via semi-structured interviews from thirteen nurses of the following designation: Registered nurses, Clinical nurses, Nurse unit managers, Clinical nurse consultant and Nurse practitioner across six different community health teams.

In Phase 1, the results indicated there were multiple benefits experienced by the community health nurses participating in peer group supervision. These benefits correlated with the current literature. However, the results also indicated that there were potential game changers for peer group supervision which could determine or influence the effectiveness and experience. Phase 1 results are published and presented in Chapter 6. The results of Phase 1 informed Phase 2 of the research.

Phase 2 of the research included eighteen nursing staff in a tertiary health service who have worked within an established peer group supervision model for greater than six months. The data collected from this phase was analysed to see if and how, the lived experience differs for nurses who have been participating in a peer group supervision model. An alignment with the research question and research strategy is present, as hermeneutic phenomenology explored the phenomenon, history, and context together (Bynum & Varpio, 2018). Each stage of the research design is outlined in this chapter.

5.2 Research setting

The research setting was purposefully selected. To understand the experience of nurses participating in peer group supervision, the research setting needed to utilise a leaderless, non-hierarchal model of peer group supervision. Clinical supervision and group supervision are offered to nursing staff at multiple health services within Australia. However, a truly leaderless peer group supervision model has not been routinely implemented.

The setting for Phase 1 of the research was a regional health service located in Queensland, Australia. The setting was chosen for several reasons including the researcher's familiarity with the physical setting and knowledge of the organisation. The New Zealand Coaching and Mentoring model of peer group supervision had been implemented into the setting. No formal evaluation had been conducted and a need for this evaluation was present and coincided with the release of an Australian College of Nursing White Paper on the importance of peer group supervision to clinical practice and professional outcomes.

The setting for Phase 2 included clinical practice areas within a tertiary health service in Queensland, Australia. This large tertiary health service setting was chosen for several reasons. The health service selection was based on the knowledge that nurses' peer group supervision had been practised in this setting for up to seven years. Secondly, the nursing executive within this setting were interested in understanding peer group supervision practice within their teams and formalised evaluation was needed. As mentioned in Section 1.8, participants working within this setting provide care to patients through a variety of teams and care settings such as chronic conditions, transition care programs, refugee health services, wound care, and acute care at home.

Accessing the participants within their physical locations was challenging because of contact restrictions due to the Covid-19 pandemic. Whilst the participants were spread across a variety of locations, where possible or convenient they were offered face-to-face interviews. Lack of private physical space at times within the work environment made this difficult if not impossible. Several staff members were interviewed either in their homes or at a place of their choice often via the use of Microsoft Teams (Lobe et al., 2020). Ethical requirements were upheld using audio recording only. Microsoft Teams was utilised for interviews as Covid-19 restrictions raised challenges in accessing staff at periods throughout the research.

5.3 Participant selection

The purposive selection of participants was sought for the research project. In congruence with hermeneutic interpretation, participants were selected from those nurses who could meaningfully contribute to knowledge regarding peer group supervision. Nurses with first-hand knowledge of peer group supervision can credibly discuss their experience (Merriam & Tisdell, 2015). As mentioned in Chapter 4, Gadamer described how language and conversation are essential for understanding. Therefore, it was anticipated that dialogue and conversation with the participants about their experiences would reveal a new horizon of knowledge and understanding. Eligibility criteria was determined with participant selection that included nurses who had six months or more peer group supervision experience. This was to ensure they had the opportunity to be exposed to the peer group supervision model (Campbell et al., 2020). The participant selection was homogenous, and the participants were all nurses located at a selected health service (Robinson, 2014). Snowballing occurred as nurses conversed with colleagues about the research project (Merriam & Tisdell, 2015). Participants differed in their roles and their nursing experiences and were selected regardless of role title, years of clinical experience or physical location. Likewise, nursing staff working full-time or part-time were included.

5.4 Participant recruitment

In both Phase 1 and Phase 2, a multifaceted approach to recruitment was used. This included contact with nursing executives and nurse managers in the health services and recruitment through established professional networks. From this initial phase, letters of invitation were emailed via the nurse managers to their nursing staff who were identified as potential participants in the research. Inclusion criteria included male and female nursing staff from the tertiary health service. Figure 14 shares the participant recruitment process.

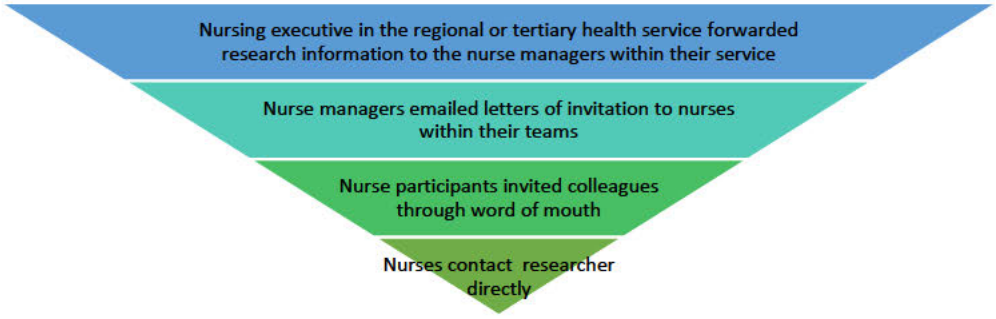


Figure 14: Participant recruitment

Phase 1 inclusion criteria include nurses registered with the Australian Health Practitioners Regulation Agency (AHPRA) from the following designations: Registered nurse, Clinical nurse, Nurse manager, Nurse educator, Nurse practitioner and Clinical nurse consultants, who have experience with the phenomenon of peer group supervision. In phase 2, all clinical staff within the health service setting were nurses registered with the Australian Health Practitioners Regulation Agency (AHPRA). The nursing role titles included Clinical nurse, Nurse manager, Clinical nurse consultant, Nurse educator and Nurse navigator. These role titles reflect nursing positions that demonstrate leadership in clinical decision making and some roles demonstrate advanced specialised knowledge and experience (Queensland Health, 2020).

Invitations to participate in Phase 1 and Phase 2 was inclusive of all grades of registered nurse. No grade five registered nurses volunteered to participate in Phase 2 of this research project (See section 9.9 Strengths and Limitations). Grade five registered nurses may be less frequently recruited or employed in the community health setting due to the complexity of the patient group and the autonomous nature of the nursing positions. Clinical nurses working in community health frequently have skills and knowledge acquired in the acute sector prior to recruitment to the community setting. Likewise, Clinical nurse consultants, Nurse managers and Nurse navigators have extensive clinical experience and may also have additional tertiary qualifications.

All participants must have participated in peer group supervision for more than six months to allow for the establishment of groups and processes. One voluntary participant was included in the study who did not meet the six-month participation requirement. The inclusion of this nurse was discussed with the supervisory team. The participant was included as they had completed the peer group supervision education as required by the organisation but had not yet been able to join a group. This participant added to the conversation about peer group supervision experiences from yet another unique perspective that was relevant to the research question.

As is appropriate for qualitative research, no pre-determined sample size was set, and participant numbers depend on voluntary enrolment in the research and consideration of the concepts of the sufficiency and richness of the data and how it related to the methodology and aims of this study (Braun & Clarke, 2019; Malterud et al., 2016; Sim et al., 2018). Moules et al. (2015) note a contrast where "hermeneutic inquiry begins in saturation, with a topic that is already overloaded" (p.83).

The sample of participants for **Phase 1 consisted of thirteen nurses** and in **Phase 2 a total of eighteen nurses.** Whilst this may seem a potentially large sample size for phenomenological methodologies (See section 9.9 Strengths and Limitations), it was determined necessary to ensure rich accounts from which meaning could be understood (Hennick et al., 2017; Moules, 2002). As Hovey et al. (2022) state, "hermeneutics is shaped by the belief that while any interpretation cannot embrace the whole of a story, concerning a given topic of interest, this very particularity contributes to interweaving the individual story with other stories of the same experience for a more complete community of understanding" (p. 7).

5.5 Ethical considerations

Multiple steps were taken to ensure that the rights of the participants were upheld and that the research was ethical (Polit & Beck, 2014). During both phases, ethical approval was sought and obtained from the participant's health service organisations (LNR/2019/QWMS/51406) and (HREC/2021/QMS/72302). Ethical approval was also obtained from the University of Southern Queensland (UniSQ) (H21REA069). Participants were provided with an information sheet that supplied relevant details on how the research was to be conducted (See Appendix B & D). All interviews were recorded as per the ethics application. However, where interviews were conducted over Microsoft Teams due to participant preference or Covid-19 pandemic restrictions, all cameras were turned off to preserve anonymity.

Participation was voluntary and could be withdrawn at any time with no penalty. In the event of participant withdrawal, the data collected remained with the researcher and was stored as per the data requirements of the university. Following the provision of the research details, participants were asked to sign a written consent form. Consent information included how the participant remained anonymous, how confidentiality was maintained (including the location of interviews away from work areas) and how information would be used and stored (Gerrish & Lathlean, 2015). Ethics progress reports were completed and approved as per the university and health service requirements.

5.6 Positioning the researcher

Barron et al. (2017), suggest that it is important to be explicit in describing the position of the researcher. As highlighted in the Methodology Chapter 4, prejudices or presuppositions are described by Gadamer as the knowledge brought to a particular experience by the researcher (Gadamer, 1975/2013; Moules et al., 2015). Prejudices can either close off or encourage openness to a subject and therefore must be acknowledged and brought to the fore. As Moules (2002) states “I cannot remove my subjectivity from my work, but I can take it up with a sense of responsibility in recognizing how it translates into the way I listen to my participants, what I hear, what stands out to me, and how I interpret it” (p.12).

The positioning of the researcher began prior to Phase 1. The researcher implemented and participated in peer group supervision when employed as a Nurse educator within the regional health service. However, this employment and participation in peer group supervision ceased prior to the commencement of the Phase 1 research study. In Phase 1 the researcher was previously employed in the community health setting and therefore was known to senior nursing staff and some participants in a professional capacity.

In Phase 2 of the research, the researcher was not an employee of the health service. This was seen to be an advantage when building rapport as nurses were talking to someone outside their workplace. Initially, there were nurses who were known professionally to the researcher through education networks. These nurses provided support for the research project including recruitment though their roles in nursing management. Participant recruitment stagnated briefly when the key contacts were redeployed due to the Covid-19 pandemic or went on extended leave.

In Phase 2, the researcher had prior knowledge of the phenomenon however, there was limited knowledge of the settings, governance structure, processes and strategies that were employed in the implementation of the selected peer group supervision model. The researchers' understanding of the community health context enabled rapport to be developed with the nursing staff. The researcher had prior experience and knowledge of the New Zealand Coaching and Mentoring peer group supervision model utilised in the health service. This allowed the researcher to understand terminology such as the “tools and the little blue book” when described by the participants. The handbook was provided with the New Zealand Coaching and Mentoring model training. The tools were suggested formats for providing peer group supervision and were outlined in the participant handbook. This insider knowledge aided rapport development and allowed the interview to flow uninterrupted.

The researcher acknowledged that existing presuppositions may have arisen from prior peer group supervision experience and the results of the Phase 1 research. These were addressed through the following:

- A detailed description of the researchers’ positioning within the research was documented.
- A pre-interview using semi-structured participant interview questions was discussed with the supervisory team prior to both phases of the research.
- Reflective journalling (Meyer & Willis, 2019) and follow-up discussions occurred with the supervising team prior to participant recruitment to uncover potentially

closed prejudices/presuppositions regarding Phase 1 research results and subsequent Phase 2 participant recruitment.

- Throughout data collection, the researcher journaled and discussed with the supervisory team any arising presuppositions.
- Member checking of the written interview transcripts was offered to each participant to ensure that the data collected aligned with the experience of each participant.
- Following data collection, the researcher independently analysed and then discussed the data meaning and analysis outcomes with the supervisory team through a process of conversation and dialogue prior to the determination of interpretations arising.

5.7 Data collection

The premise of data collection in hermeneutic methodology is to seek out the everyday experiences of the nurses as they participated in peer group supervision. The everyday then stands out and through conversation and dialogue, the essence of peer group supervision is revealed and understood in this context. As discussed in Chapter 4 Methodology, free discussion of the peer group supervision topic including nursing context and historical perspectives was encouraged through semi-structured face-to-face or digital interviews (Creswell, 2016; Gerrish & Lathlean, 2015; Holloway et al., 2017; Polit & Beck, 2014). These open-ended questions were followed up as required through prompts or requests for further examples in practice (Moules et al., 2015; Polit & Beck, 2014). Participants were encouraged to share their experience, their examples in practice and their story. Open ended questions specifically sought a shared experience of peer group supervision in practice.

The interview length was approximately one hour duration to ensure courtesy to busy clinicians (Creswell, 2016). Interviews were audio recorded, with the consent of the participant. Participants were informed that the purpose of the audio recording was to avoid potential distraction/disruption to the conversation through researcher note-taking and to ensure a completely accurate account of

the interview when transcribed verbatim. An interview guide was developed to assist with the flow of the interview. (See Appendix A and C).

Examples of open-ended questions provided to the participants included:

- Can you share with me your experience of peer group supervision?
- Can you share with me your understanding of peers within peer group supervision?
- Can you describe the positive and negative dynamics of your peer supervision group?

In hermeneutics the conversation cannot be inhibited or pre-empted therefore whilst the guide was utilised, questions flowed from listening and responding to the participants' insights. The researcher followed or led depending on the conversation with the intent of keeping the topic in focus (Moules et al., 2015) as it related to each participant's experiences in practice. Prompting was used to engage in greater depth and detail of the topic with words like, please elaborate more, continue with your story, you mentioned... can you share more of what this means...

5.8 Data Analysis

Data analysis sought to gain an understanding of the experience of community nurses and their interaction in peer group supervision. Interpretation of the experience (data analysis) began with being open to the possibilities arising from dialogue with the participants (Moules et al., 2015). Following the interview, the researcher journaled notes and thoughts about the individual interviews to ensure no part of the conversation was omitted (Phillippi & Lauderdale, 2018). The researcher then listened to the recordings in their entirety to get an overall sense of what the participant was saying about the peer group supervision experience. This process familiarised the researcher with the content of the interviews as a starting point to data analysis. This initial descriptive analysis is presented in Chapter 7 and then further analysed interpretatively and presented in Chapter 8. The inclusion of both descriptive and interpretive analysis enabled the essence expressed to be shared in its entirety.

A transcriptionist was employed to transcribe the de-identified interviews verbatim. Whilst it was offered to participants, only a few took up the offer to review their transcript for accuracy. Upon receipt of the transcript, the researcher re-read each interview in its entirety. Each interview was read in the same order that the interview was conducted. This made sense to the researcher as there was the ability to go back to the presuppositions and the themes generated from the previous interviews. The meaning was evolving and growing with each new interview iteration. Figure 15 provides a visual representation of the hermeneutic data analysis process.

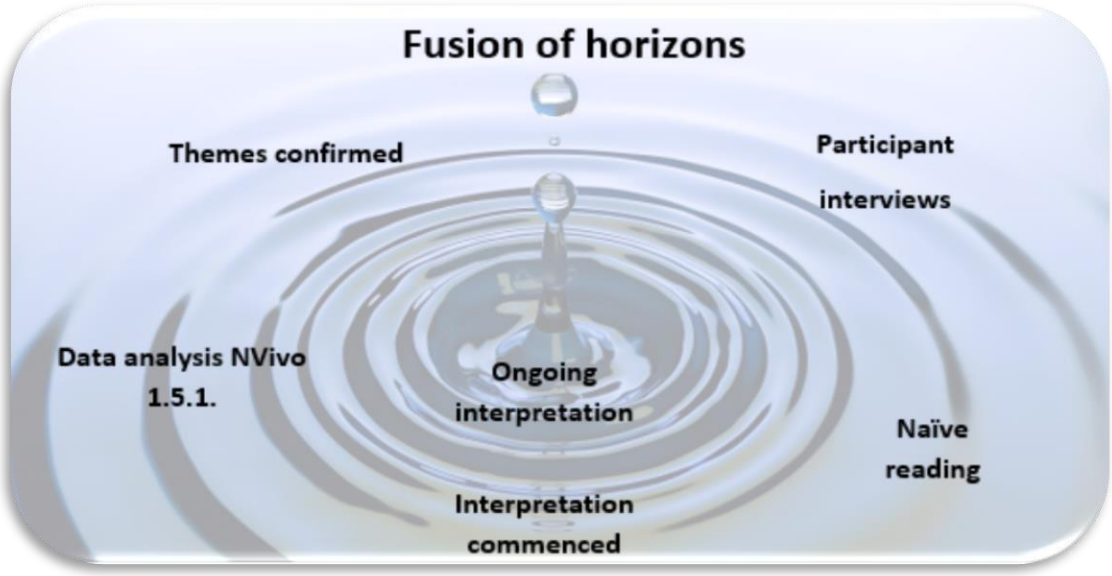


Figure 15: Hermeneutic data analysis

NVivo release 1.5.1. was used to continue a more formalised data analysis process. All interviews from Phases 1 and 2 were included in NVivo. Coding commenced by reading and re-reading each. Journalling of memos in NVivo occurred simultaneously with the reading to note any thoughts, feelings, presuppositions, and “ah-ha” moments. From this, line-by-line coding occurred. Coding was initially completed by the researcher and then discussed with the supervisory team. Initial themes arose from the codes. (See Appendix E) These themes were interpreted through an iterative process of going back and forwards between the text and the researcher’s presuppositions.

5.9 Chapter summary

The purpose of this chapter was to provide an outline of the design used for this research project. The design elements discussion included research setting, ethical considerations, participants, data collection, and data analysis. The following chapter begins by describing and sharing the findings of the peer group supervision research.

CHAPTER 6: PAPER 2 PHASE 1 RESULTS

6.1 Introduction

Chapter Five outlined the peer group supervision research design and identified how the rich experiential data was to be collected and analysed. This chapter presents findings from Phase 1 that shared the participants' voices from an Australian regional community health service. The structured New Zealand Coaching and Mentoring model of peer group supervision provided the foundation for this peer group supervision research. An interpretative hermeneutic approach was utilised to explore the experience of peer group supervision. Thirteen community health nurses participated in the study, sharing their experiences through in-depth interviews. The results revealed the value and impact of quality of peer group supervision. This uniqueness of this research is that it provides different perspectives of peer group supervision including the benefits and the challenges. The chapter is presented as a publication with findings published in the Journal of Nursing Management.

Phase 1: Tulleners, T., Taylor, M., & Campbell, C. (2021). Peer group clinical supervision for Community Health Nurses: Perspectives from an interpretive hermeneutic study. *Journal of Nursing Management*. DOI:10.1111/jonm.13535 (7 citations)

6.3 Links and implications

Chapter six outlined the findings from Phase 1 that heard the participants' voices from a regional community health service. The article findings published in the Journal of Nursing Management identified two significant findings. Firstly, it was identified through sharing the participant experience that professional sustenance and value could be gained through participating in peer group supervision. This was significant because it demonstrated that participants gained personal and professional benefits from the peer group supervision experience. However, the second significant finding identified that there were game changes that needed to be considered if peer group supervision was to be optimised. The game changers related to rules and group dynamics and as mentioned in the published article could impact the benefits identified. Importantly these aspects had not been well articulated in the literature. These findings and the subsequent implications they could have for the implementation of peer group supervision by nursing decision makers formed the impetus for Phase 2.

CHAPTER 7: FINDINGS: THE EXPERIENCE OF PEER GROUP SUPERVISION

"Unlike seeing, where one can look away, one cannot 'hear away' but must listen ... hearing implies already belonging together in such a manner that one is claimed by what is being said."

Hans-Georg Gadamer

7.1 Introduction

Chapter 7 presents the horizon of peer group supervision as experienced by the participants in Phase 2 of the research. Phase 2 incorporates the learnings established from Phase 1 and extended participant interviews into a tertiary community health service. Phase 1 findings raised questions about peer group supervision, identifying that all was not yet known and there were elements that had not yet been considered. Consequently, Phase 1 formed the basis for Phase 2 of the research. In this chapter Phase 2 is presented as a descriptive narrative of the Phase 2 findings. The descriptive narrative invites us to listen to the voices of the participants as they share their unique perspectives of peer group supervision history, context, and culture. Where there is shared collective meaning among participants, the individual participant number is not identified.

This depiction of this descriptive narrative demonstrates congruence with the methodology where the voices and conversation of the participants is what creates meaning. I have presented the narrative description in the following way to avoid losing or overpowering the participant voices. This chapter reveals the essence of the essential structure of the phenomenon of peer group supervision through the collation of the voice through the sharing of the anecdotes and quotes from participants. Initial meaning is derived and will be hermeneutically analysed and presented in Chapter 8.

The descriptive analysis commenced with a manual initial analysis of the data. Naïve reading of the transcripts commenced. Following the subsequent naïve reading, the researcher developed wall posters to visually represent the individual horizons of the participants (See Figure 16). This highlighted elements that were calling the researcher's attention.

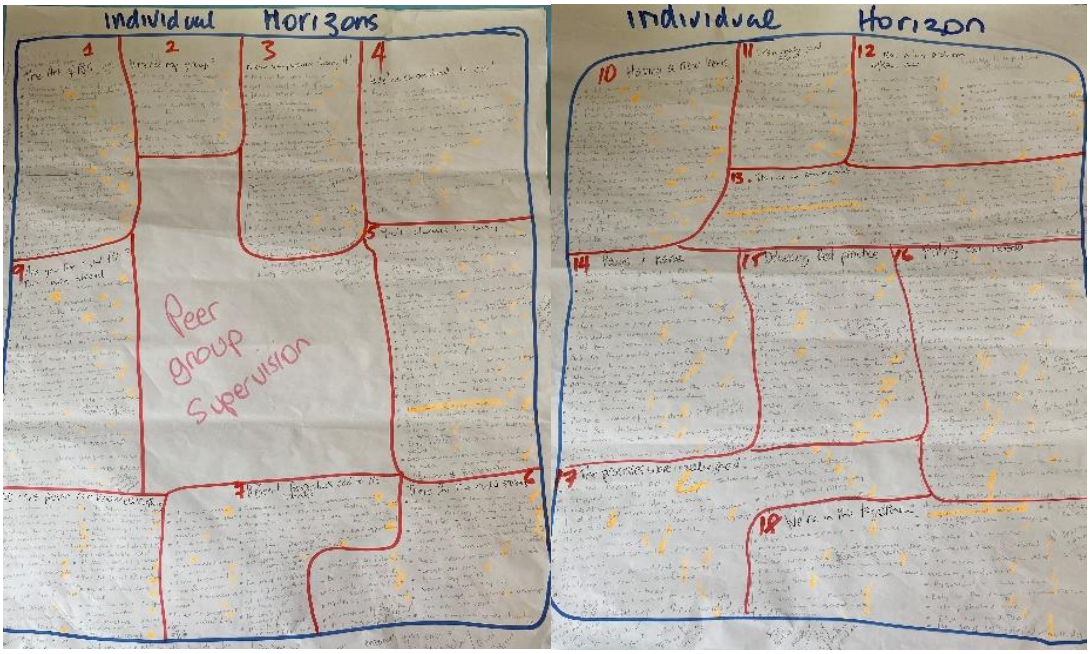


Figure 16: Participants' individual horizons

From this, additional posters were developed outlining the initial meaningful assumptions (See Figure 17)

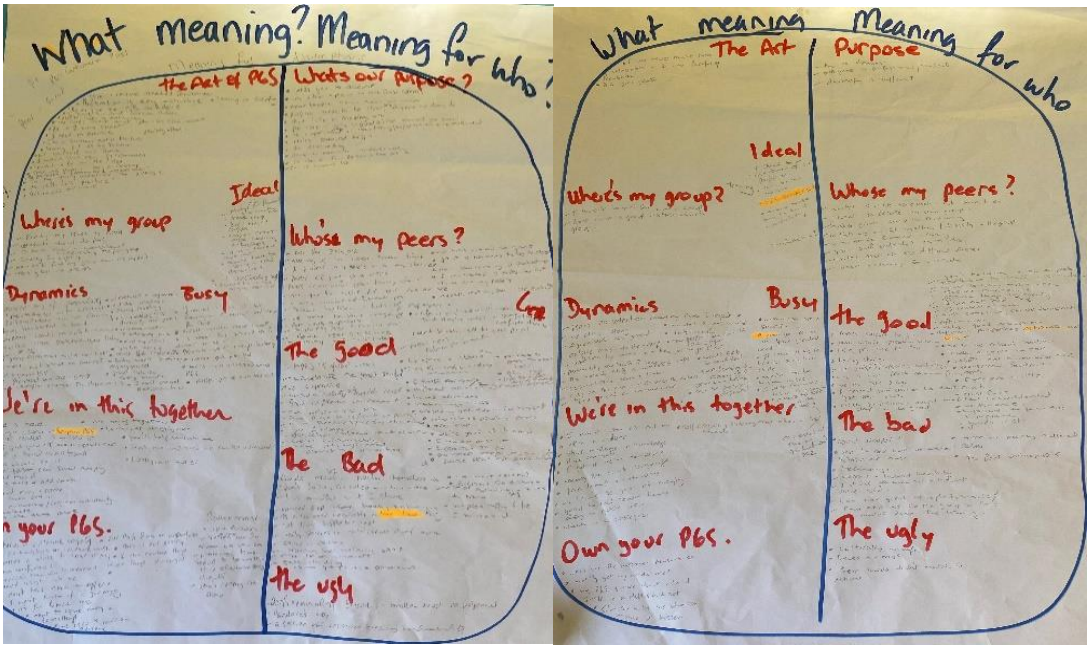


Figure 17: Participants' meaningful assumptions

From the iterative process of reading and re-reading the 18 participant interviews, 21 codes were initially generated. High-level analysis of the themes continued with further conceptualising the themes into 16 codes (See Appendix E). The aim of each code was to encapsulate the understanding of the essence of peer group supervision for the nurses. Re-reading of the whole and the parts of the text continued. Single phrases or sentences provided insight and meaning into the whole experience. The parts and whole provided back-and-forth commentary (Schwartz-Shea & Yanow, 2015) that continued until the overarching interpretations emerged.

The interpretations that emerged from the data analysis identify there is a peer group supervision foundation. The *foundation* interpretation is explored through "Professional obligations, Participation is important including finding peers, and Peer group supervision attendance" (Section 7.4, 7.4.1, 7.4.2, 7.4.3 and 7.4.4). This foundation supports the pillars of both the unique individual and the unique group. The descriptive narrative is presented utilising the interpretation headings as illustrated in Figure 18 with two areas for consideration – the unique individual and the unique group.

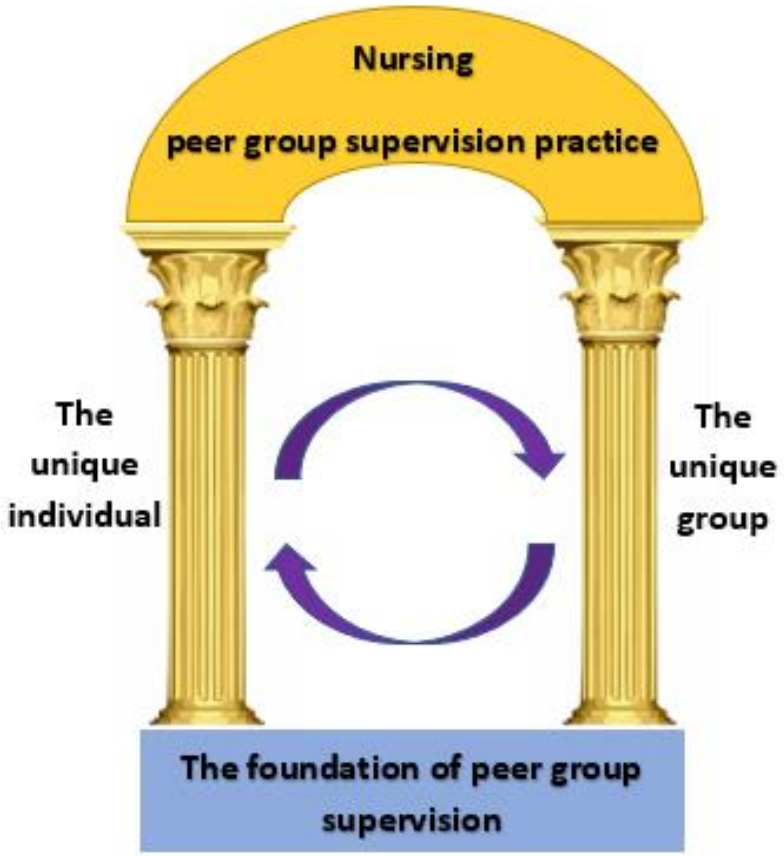


Figure 18: Nursing peer group supervision

The *unique individual* interpretation is described through the headings “For me, About me and Beyond me” (Section 7.5 to 7.5.8). The *unique group* interpretation is described through the headings “My peers, Our rules, Working together (Section 7.6 to 7.6.3) and Broken trust” (Section 7.7).

7.2 Peer group supervision context

We begin the narrative with a description of the research participants. Through this description, the reader is introduced to the participants, identifying where insights and perspectives arise. The participants had diverse clinical backgrounds. One of the unique aspects of nursing is that within one career, nurses can have many different roles/positions. Some participants had worked extensively in the current health service whilst others were new to the health service, the teams and in some cases the public health system. Some of the clinicians held unique roles that if disclosed in detail here would allow them to be identified, therefore, to protect the participants’ anonymity only general teams’ and role titles are shared.

Collective experience is captured in Table 3 where over 200 years of knowledge, skill and practice are identified from the collective clinical experience of all clinical nurses, navigators, educators, and managers. Table 3 shares this context.

Nursing Grade	Nursing Role title	Nursing teams	Collective years of nursing experience
6	Clinical Nurse	Chronic conditions, transition care program, refugee health service, wound care and acute care at home.	18 years
7 & 8	Clinical nurse consultant, Nurse navigator, Nurse educator, Nurse unit manager		204 years approximately

Table 3: Participants' Collective Experience.

In this peer group supervision context, all participants worked within one health service. All were educated and trained in the New Zealand Coaching and Mentoring model by the health service Nurse Educator and used this model for their peer supervision groups. Some interview participants were members of the same peer supervision group however several different peer supervision groups are represented. Despite these commonalities, every experience the participants described was unique, every horizon different to another's. The interviews began with participants sharing information about their current roles/positions within the health service. This set the scene for understanding the participants' unique experiences and the perceptions through which they viewed the process of peer group supervision in their practice.

7.3 Nursing peer group supervision practice

The overarching pillar in Figure 18 is an arch connecting the individual and the group and represents nursing peer group supervision. Participants were asked to identify and describe the peer group supervision phenomenon. When asked in the interview how they might describe peer group supervision, the participants did not have a rigid definition but rather outlined a collection of concepts and ideas.

From the participants' quotes, key elements emerge. The first key element was the arch linking themselves and the group. The arch is significant because it reflects the participants descriptions of self and the group being interwoven as will be demonstrated in more detail throughout this chapter. In describing peer group supervision, they shared words such as safe, confidential, support, sharing, feedback, reflection, and perspectives. Together these words create a powerful picture of what peer group supervision was for them. It is asserted that no two descriptions were identical because each participant experienced peer group supervision uniquely. The words and anecdotes and their meaning for participants are shared in greater detail throughout this chapter.

The participants described connecting with their peers and sharing not just clinical situations but also their values. This means that peer group supervision is more than just a clinical handover or case discussion. There was value in having a place to reflect on practice and bounce ideas off each other without being judged. Participants described the richness in coming together with very diverse peers and each member bringing their expertise to share. This initial description highlights the descriptive analysis and forms the initial stage of data analysis. One participant described being thankful for the opportunity to share no matter what the situation (Participant 1).Many of these key elements are described in greater detail throughout this chapter with the initial elements shared in Figure 19.

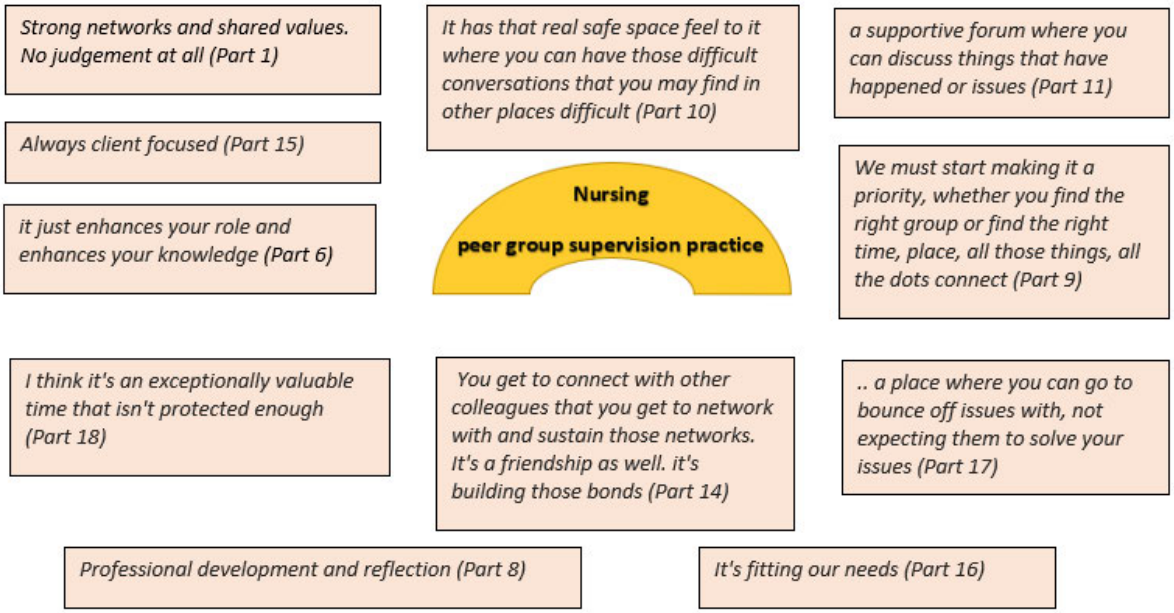


Figure 19: Nursing peer group supervision practice

7.4 The foundation of peer group supervision

The base of the pillars of peer group supervision was constructed to form a strong foundation. Learning more about the foundation and its makeup is key to understanding the link between the individual, the group, and the organisation. From the participants accounts participants describe the elements that impacted their peer group supervision experience. These elements came up again and again and shared commonalities across the participants yet were not related to the individual or the group. It is asserted that these sharing's form the foundation or base of peer group supervision practice. Four sections of the descriptive narrative provide insight into the participants' experiences adding to the interpretation of "the foundation of peer group supervision". The four sections include professional obligations, participation is important, finding peers and peer group supervision attendance.

7.4.1 Professional obligations

The foundations of peer group supervision begin with the professional obligations of the nurses. Individuals juggled professional obligations in prioritising peer group supervision and clinical practice demand. Participants described instances where they would cancel peer group supervision and prioritise patient/client care.

A descriptive summary is provided in Figure 20 that shares the reasons, rationales and justification for cancellations or postponements. Participants saw themselves as missing out on non-clinical time due to the needs to the patient coming first. Several participants noted that this was different for allied health colleagues. There was comparison and commentary that allied health clinicians would always prioritise supervision (either one-to-one or peer group) over clients.

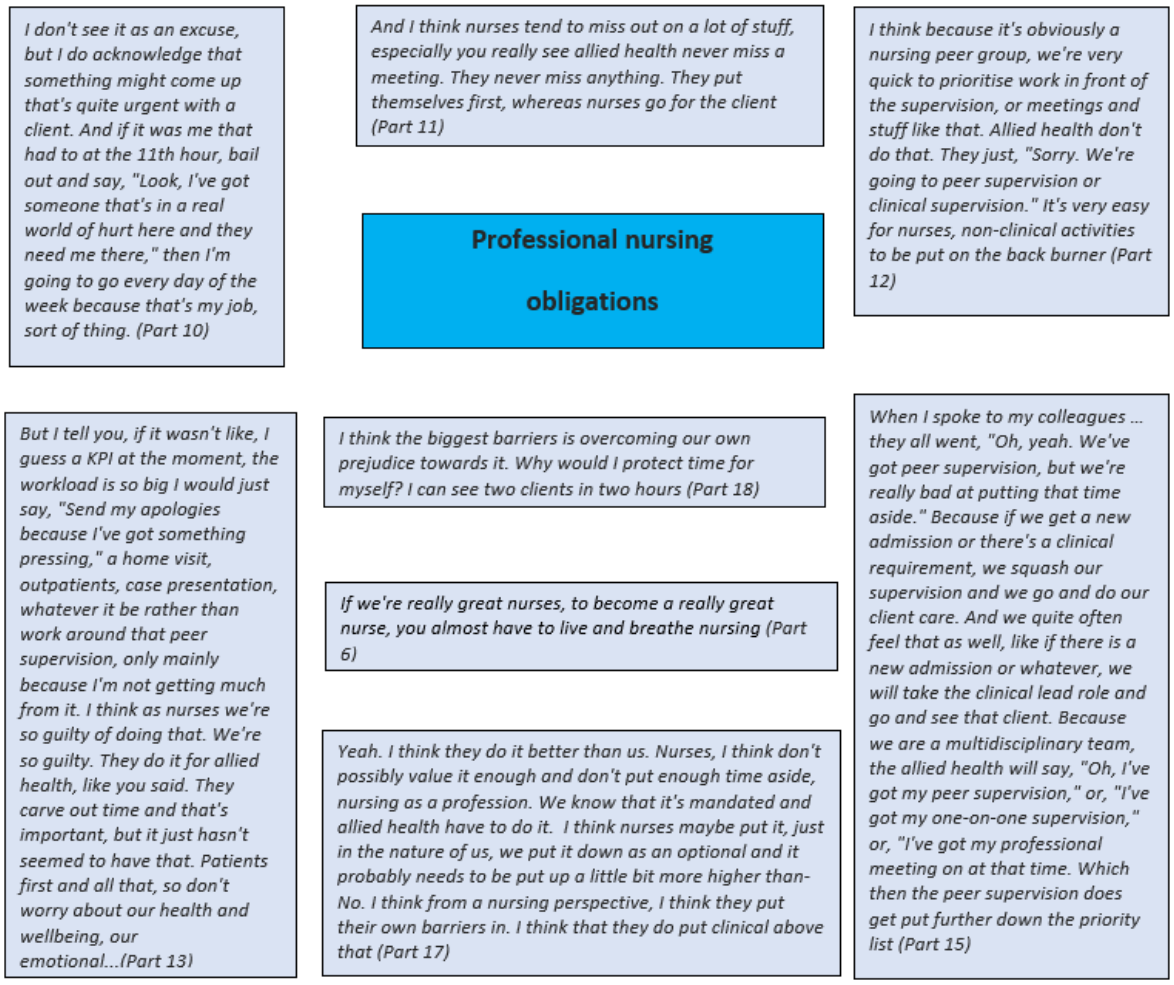


Figure 20: Professional obligations

Allied health was noted to “do it better than us” (Participant 17). Occasionally it was perceived that the nurse in the multidisciplinary team would then attend to the patient whilst the allied health staff went to supervision. In contrast, another participant noted that nurses create their own barriers when they compare time for themselves with time for their patients. Two participants described nurses as needing to “give ourselves permission to engage” (Participant 1 & Participant 18).

The perception of many of the participants was that the needs of nurses always come last. This idea of nurses coming last is interesting to consider. Especially as this contrasted with the perception that peer group supervision was supported by nursing management. Indeed, none of the participants verbalised the directive to look after their patients at the expense of protected peer group supervision time. Therefore, this obligation comes from the nurse and their own instinctive priorities. When presented with pressing patient needs it is identified that most nurses will prioritise the patient above all else. Likewise, if peer group supervision did not meet the participants needs at the time it was easy to put it lower on the priority list. This element raises the point about understanding the priorities of other health professionals and the need to understand why and how they prioritise supervision practice.

7.4.2 Participation is important

Participation in peer group supervision was deemed an important foundation for the group and the individual. There was unanimous agreement about who should participate in peer group supervision. The participants described peer group supervision as being transferable to all nursing areas (clinical and non-clinical) and stated it should be available to all nursing grades. It was considered important for all grades of nursing from executive levels to undergraduate nurses and assistants in nursing (AINs) to be provided with the opportunity to participate. The participants were forthcoming with the reasons why all nurses should participate. It was suggested that peer group supervision may standardise practice amongst nurses. Other participants suggested that not feeling like you were on your own and having opportunities to reflect were important for all nurses.

An important point made by the participants was that nurses should be given the opportunity to participate. Opportunity can be presented in several ways, firstly opportunity implies that there is free will about participating which may not always the case. In this research, most participants described being encouraged by their line managers to participate. In contrast one person reported their group being told it's time to start going again to peer group supervision (Participant 4). These examples demonstrated that opportunity may be seen as compulsory in some instances similar to the requirements of mandatory training. The implications are that participation that carries mandatory requirements may impact the outcomes of peer group supervision and should therefore be carefully considered.

Whilst the participants had limited reservations about who should participate, it was suggested that lower grades for example Registered, and Clinical Nurses be provided with additional support such as how to manage conflict within the group, or rostering support. The specific support needs of these nurses were not identified however was noted to depend on the engagement of staff in the problem-solving process. Figure 21 shares the participants' thoughts on "who" should participate.

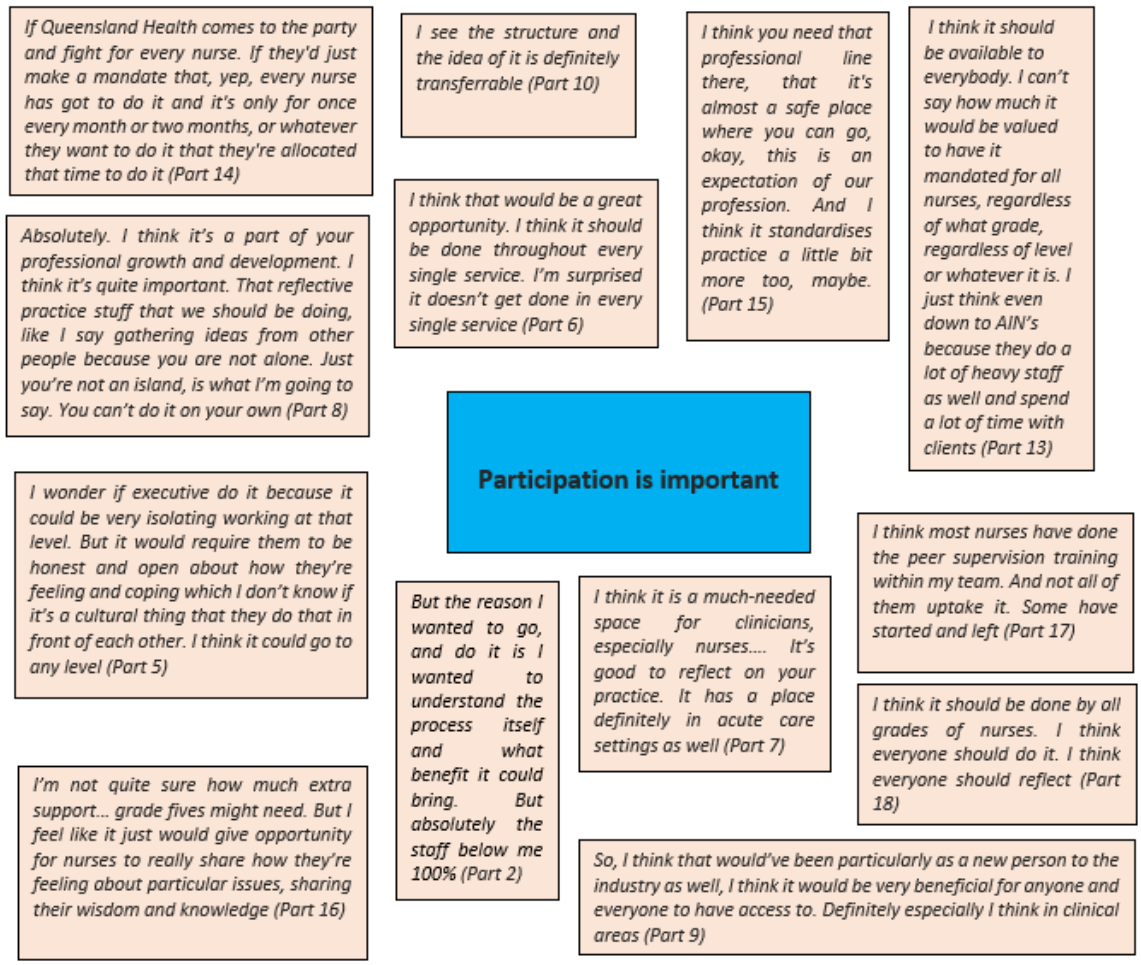


Figure 21: Participation is important

7.4.3 Finding Peers

A major barrier reported by some participants was finding a peer group. In this health service there was a formal process of peer group identification. Peer supervision groups were based on the level of nursing grade and most participants were allocated based on this grade. Groups could be composed entirely of Clinical Nurses or Nurse Navigators.

Participants reported a lack of information regarding where to find peer groups and knowing whether they were a suitable grade. For some this was not an issue but for others it was perceived to be a significant barrier. Knowing if existing groups had vacancies was difficult with greater need for organisational and managerial support noted in participant discussions. Finding peers should not be person dependant as this can lead to disruptions when that person is no longer available.

Participants also reported informal processes for group allocation. Some participants described how they incidentally found their group by talking with colleagues. Others were invited by colleagues who were made aware they were looking for a group. Others made their own groups when they felt there no-one else to join. One participant identified being at a separate site where no groups were available and thus felt they were missing out on the experience (Participant 2).

Another challenge was wanting to be in a group but not being allowed to, due to differences in nursing grade. There were different ideas about who could be peers within a peer supervision group, and it was not always nurses that were included. The participants described wanting to include allied health professionals and nurses from different grades. Finding peers is a barrier that can greatly impact the experience of peer group supervision. It is also a barrier that can be mitigated with careful planning. Further work is needed in this area to articulate better the circumstances where health professionals may work in groups across disciplines. A summary is provided in Figure 22 that shares the challenges encountered when finding peers.

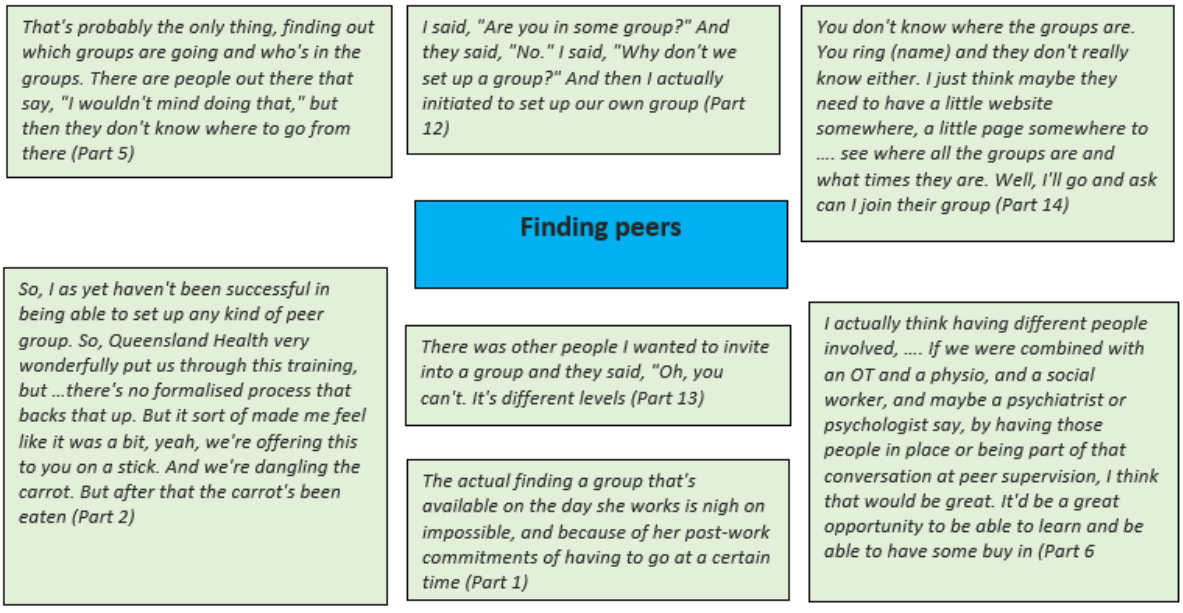


Figure 22: Finding peers

7.4.4 Peer group supervision attendance

Participant attendance varied across the health service. This section of the narrative description relays the positive and challenging aspects of the participants' peer group supervision attendance. The participants' description of their peer group supervision attendance is shared in Figures 23a and 23b. There were significant variations in the length of time participants had been utilising peer group supervision. Some participants had attended peer group supervision for many years and for others it was only months. On average nurses within this health service had attended peer group supervision for three years. One participant had attended the peer group supervision education program but was yet to commence in a group (Participant 2). This was a source of frustration that had no timeline for resolution. The participants noted that length of time attending did have an impact on peer group supervision. Attendance impacted on group cohesion, feeling safe and outcomes of the group which are reflected and explored further in the descriptive analysis presented in section 7.6.1.

The biggest organisational and personal challenge that nurses faced was the Covid-19 pandemic. This was a time of great uncertainty for everyone and was a time of great change for the participants. The research participants were concerned about their patients and colleagues. The stress of caring for extremely vulnerable patients during a pandemic took its toll. Additionally, participants worried about their own health and potentially impacting the health of their families. Not only were workplaces disrupted, rearranged and staff redeployed but education and training were put on hold. This caused a conflict as it was an organisational expectation that only educated participants could attend peer group supervision therefore a lack of education opportunities posed yet another challenge to attendance. No alternative options were provided, and training remained unavailable to staff.

Prior to Covid-19 all groups met face to face regularly (usually monthly). During the Covid-19 pandemic peer group supervision ceased for everyone. At a time where support and reflection on practice could have been most important, it was considered that there were insufficient resources such as time and personnel to continue with the practice. At the time of the interview, some participants had yet to fully restart. This was interesting as the reasons were two-fold. Firstly, some participants did not miss going to peer group supervision and therefore were not keen to restart. Others did miss peer group supervision but reported workplace barriers for recommencement such as not being released (Participant 17). This proved to be difficult in terms of the practicalities of interviewing an individual, however, staff volunteered to participate in the research despite not restarting their peer supervision groups. For some, this time of reflection aided their acknowledgement of the need for peer group supervision as an outlet for professional reflection and team support.

Participants cited logistical barriers as impacting on their peer group supervision attendance. For some, travelling to attend the group and then securing parking was a barrier. For others, it was finding a quiet, private space to ensure confidentiality and safety during peer group supervision. For this reason, some participants met at a café which opens the discussion about content of peer group supervision and what can be discussed and where. It was clear that attendance cannot be at the expense of confidentiality and participants respected that their conversations were confidential and reflective, not to be shared beyond the peer group.

Not being able to meet face-to-face proved challenging at times. Some participants described how they learnt new skills and embraced the chance to connect with others using technology such as TEAMs meeting. Whilst others noted the increased isolation and disconnect associated with the lack of face-to-face contact with peers. Nurse management support was described by the participants as a pivotal enabler for attendance. No participants in this research reported management support as a barrier although some participants viewed attendance as an expectation rather than an option. The following narratives in Figures 23a and 23b highlight the duration, enablers, and challenges to attendance.

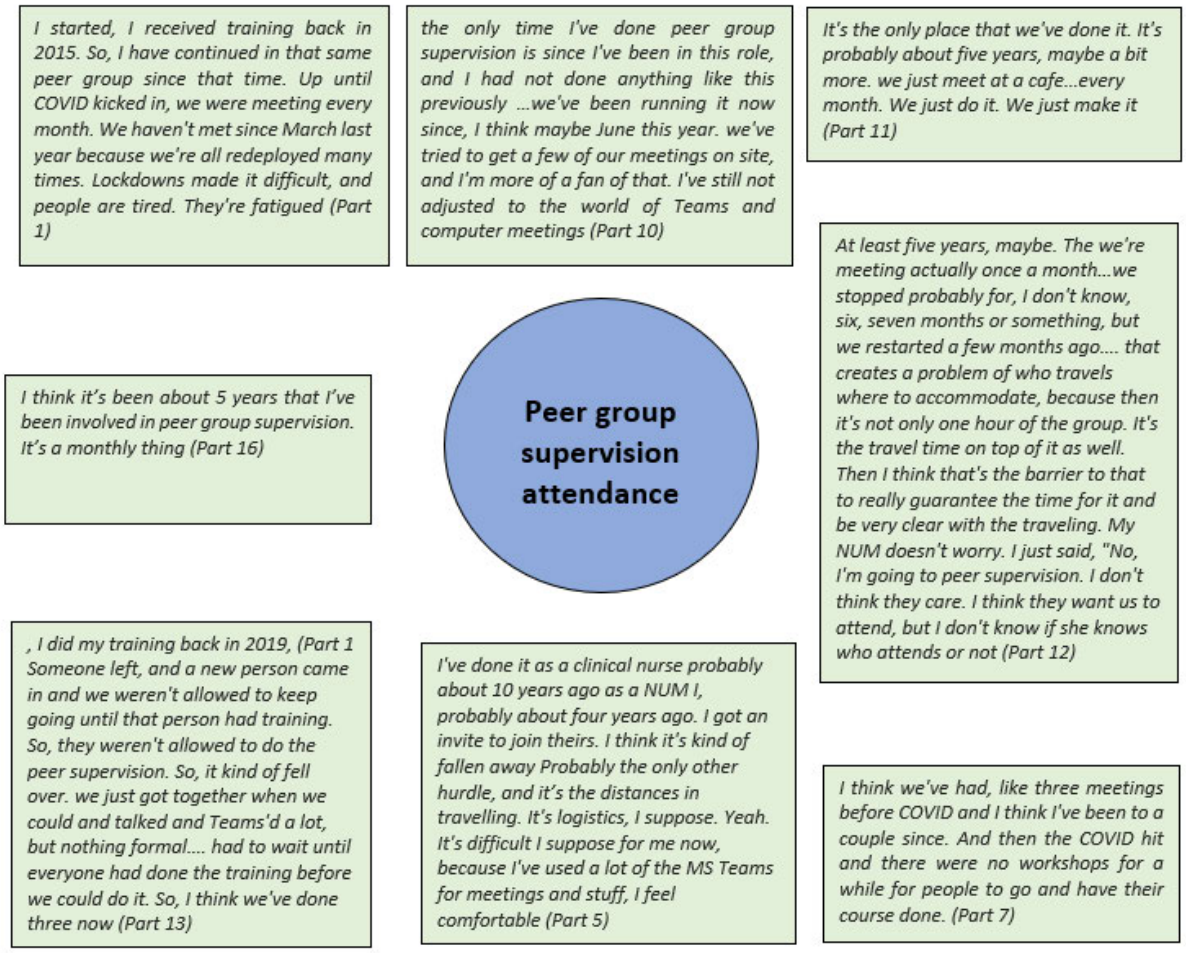
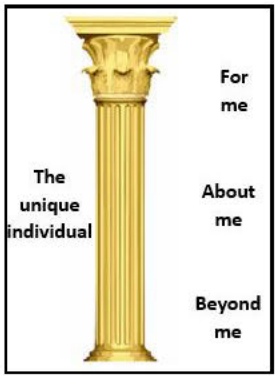


Figure 23a: Peer group supervision attendance

Figure 23b: Peer group supervision attendance

7.5 The unique individual



The *unique individual* pillar interpretation identifies that peer group supervision is "For me, About me and Beyond me". The following descriptive narrative provides insight into the interpretation "For me" through three concepts: a new lens, support and restore and a safe place.

The interpretation "About me" is described through the following: owning my story, peer group supervision purpose and two-way street. The final interpretation "Beyond me" is described through two concepts: we are in this together and not just for me.

7.5.1 For me: A new lens

The participants described positive or beneficial elements of the peer group supervision experience. The elements they described included what made them attend, participate in, and return to, peer group supervision. As the perspective of the individual participant is unique, perceived positives or benefits varied. Figure 24 shares a collection of participant responses describing the individual benefits participants perceived they had gained.

This research shared a new lens from peers that provided participants with support and encouragement. The new lens helped participants to clarify how they have, and could, manage situations. The participants reported that sometimes the new lens affirmed they were doing well and had done everything possible for the patient. Importantly the new lens provided objective feedback. The participants' backgrounds allowed them to share knowledge from differing perspectives. The opportunity to view a situation through a new lens was powerful.

Participants described having lightbulb moments. They described seeing things in a way they would never previously have considered due to their horizon of experiences. One participant noted that even when the information was not relevant to their role, the new lens provided by other peers was still useful. There was recognition that even if the participant peer were working in the same role, they conducted their role differently and they “nursed” differently.

Figure 24: For me: A new lens

7.5.2 For me: Support and restore

Each participant described numerous stories of support. One participant described how they felt good both physically and mentally after attending peer group supervision and felt the loss of this support when unable to attend (Participant 1). The participants described how they were supported by their peers in their nursing roles especially when they were novices in the role. This restorative function was noted frequently in the participant interviews.

One participant's narrative highlighted that the peers did not need to solve their problems to provide support, they just needed to listen and provide a different perspective. Participants recognised that at times they did not need as much from the group as others and would defer their turn to focus on someone else. Participants supported each other through the sharing of successes and good news and through the harder times of losing patients. The support peers provided to each other built participants' confidence in their abilities.

The participants described how during the early days of the Covid-19 pandemic they were able to support each other through all the changes that were occurring. The participants then experienced cessation of peer group supervision during Covid-19. When asked if they missed peer group supervision the responses were interesting. Some described missing the support and feeling like there was a void. Others felt they were too caught up in the pandemic to miss peer group supervision initially however as time passed, they missed their previous opportunity to meet with peers. Some participants reported they did not miss peer group supervision and were non-committal about the practice however this appeared to be a minority of nurses. Figures 25a and 25b, share the anecdotes and stories from participants relating to the unique individual, for me; support and restore.

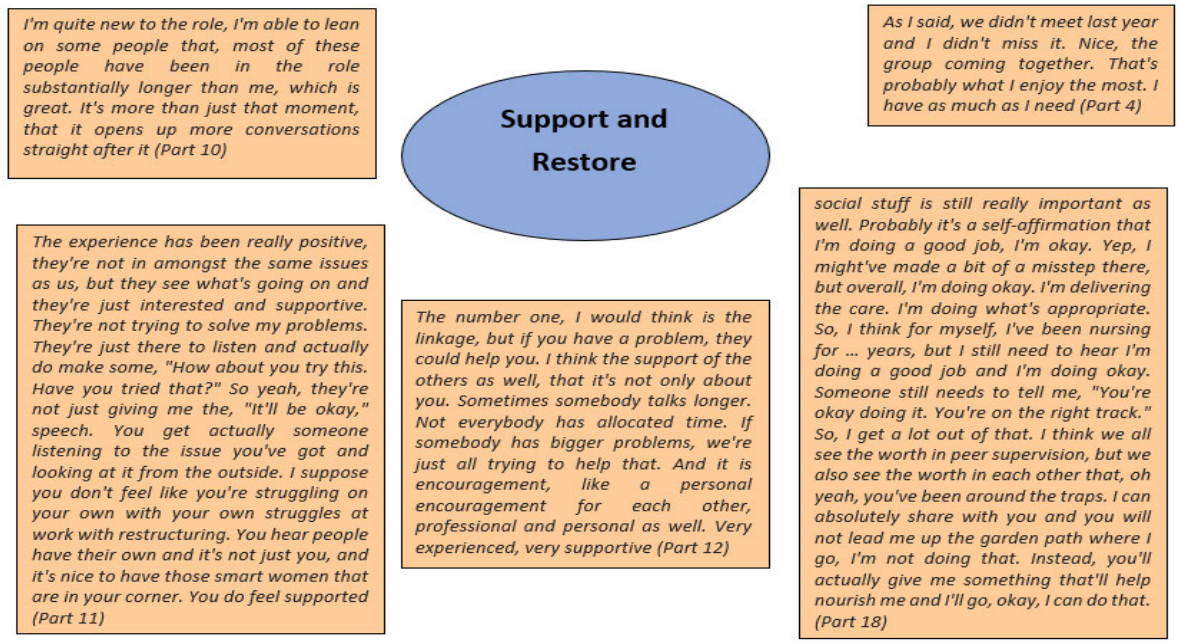


Figure 25a: For me: Support and restore

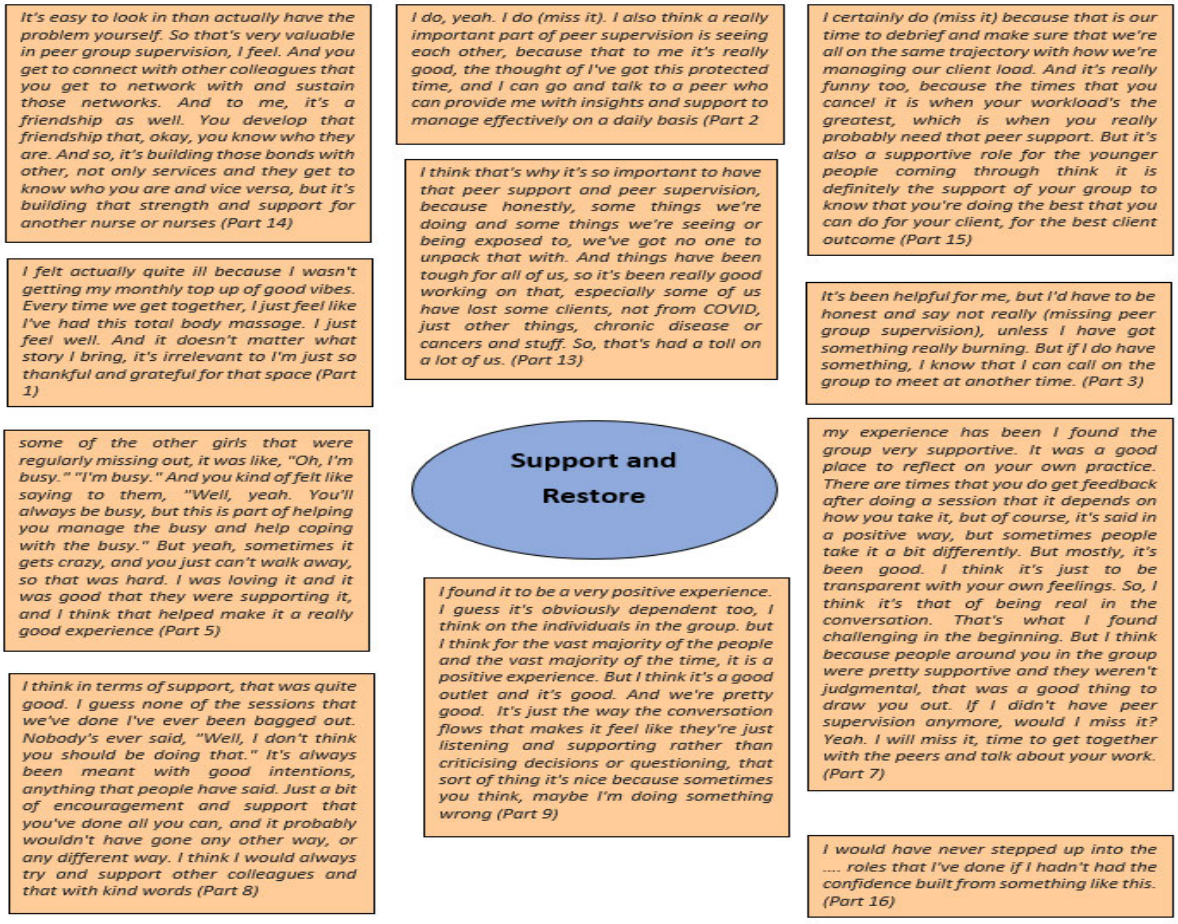


Figure 25b: For me: Support and restore

7.5.3 For me: Safe place

Peer group supervision was described by most participants to be a safe place. Participants described peer group supervision as a safe place to talk about issues without fear of judgement. One participant noted that this lack of judgement would continue into the future as well as the present situation (Participant 16). Some participants described safety as being linked to self-confidence and whether participants were able or willing to share information and be vulnerable.

Confidentiality was a very important aspect of safety. What was said in the room needed to stay in the room. Safety meant that information shared was not talked about outside the session. At the same time, one participant observed that you cannot stop people from talking (Participant 14). Some participants reported that it was the peer group supervision model that kept it a safe place because of the prescriptive structure for sessions. The tool kit provided by the New Zealand Coaching and Mentoring model provided a stop sign that members used to indicate that the story stops in the group and does not go outside unless required for patient or nurse safety. Likewise, many group members reported having a signed agreement that outlined the rules of engagement for sharing information. Setting baseline ground rules was seen as a need for participants.

Being safe in peer group supervision did not mean the group agreed with everything that was shared. Figure 26 share the participant comments relating to safety. Safety in the group meant being able to receive feedback that was honest and transparent. Importantly most participants reported it was a safe enough environment to disagree with each other. However, safety came with a note of caution from some participants. Knowing a group was safe did not always come from the first session but rather the sense of safety developed incrementally (Participant 16). Participants described trust as building over time as the members got to know each other (Participant 8). For some, there was a feeling of caution regarding confidentiality and what the participants thought could and should be brought to peer group supervision (Participant 9).

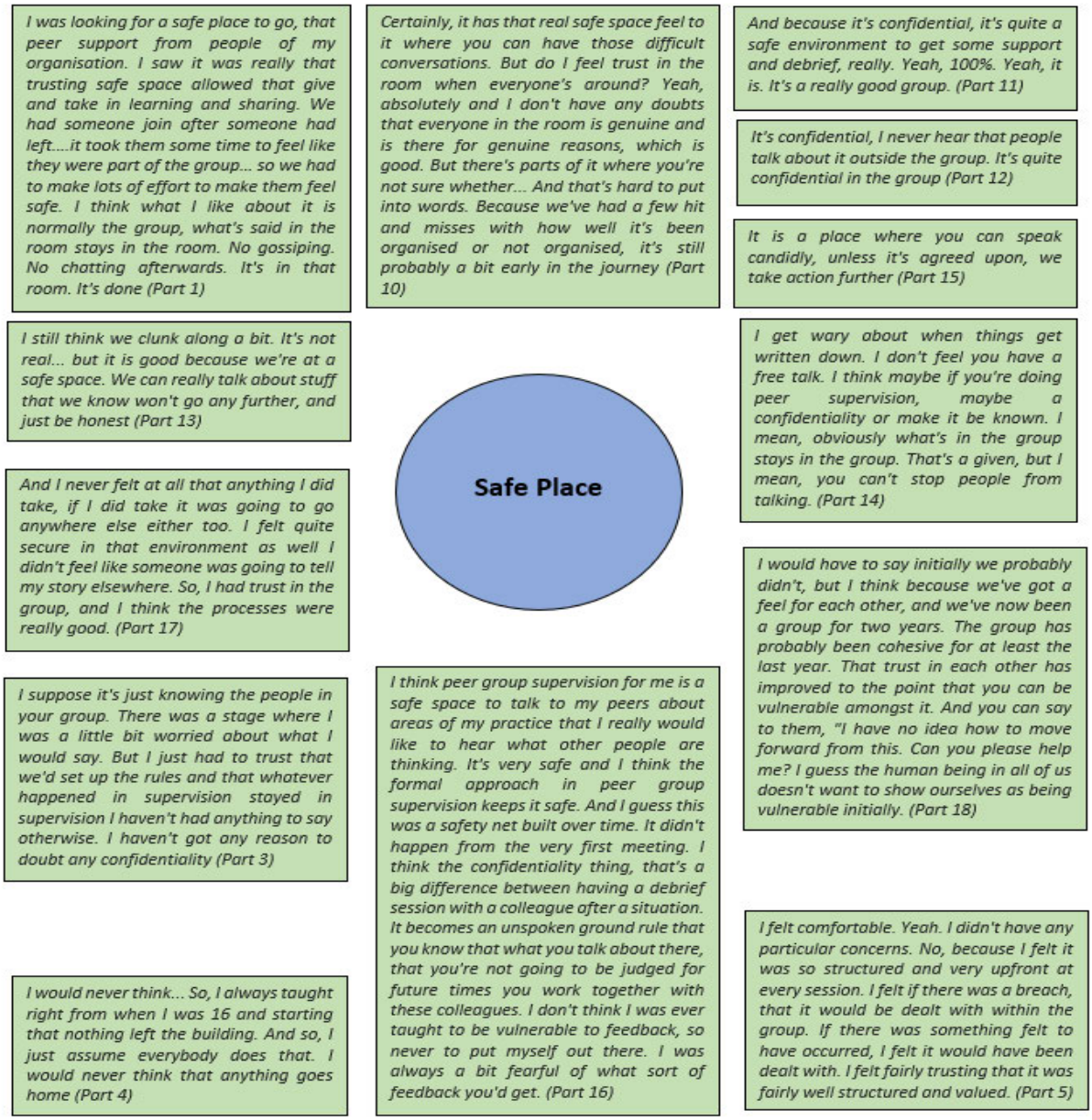


Figure 26: For Me: A safe place

7.5.4 About me: Owning my story

A key theme arising from the participants sharing was the need for ownership and accountability. Owning peer group supervision implied this was each participants own individual story. This was mentioned frequently by participants and included different aspects. Owning the process began with attendance. Participants described reorganising their workload, prioritising time, and showing commitment.

Commitment manifested in various ways. For example, participants reported that showing up for all sessions and not just participating when something was needed, demonstrated ownership of the peer group supervision story. Likewise, the seemingly simple act of answering a phone during peer group supervision was interpreted by others as not showing ownership. Frustrations arose when it was perceived that other participants in the group did not “step up” and show the same level of commitment. Some participants took this aspect very seriously and described this as being vital to the experience. For participants, owning peer group supervision was associated with being prepared to achieve an outcome. However, being prepared meant different things to different participants according to their horizon. Some participants liked to have everything meticulously documented and journaled prior to attending. Whilst other participants preferred to think “off the cuff” and prepared just prior to the group session.

Owning the peer group supervision process meant deciding what participants would do with the feedback provided by the group. Participants reported that owning their stories meant they could decide whether to accept or reject the information provided. Sometimes participants described having the mindset of “thanks but that’s not how I do things”. Participants also believed that owning their peer group supervision story meant being mindful of what to share with peers. All participants worked with patients/clients with complex care needs. The nurses selected and carefully considered the stories they brought to peer group supervision. Not only were they mindful of confidentiality but they were mindful of the potential impact to others from vicarious trauma. Figure 27 shares the participants' perspectives of what owning their peer group supervision meant to them.

Figure 27: About me: Owning my story

7.5.5 About me: Peer group supervision purpose

Each participant held a different perspective and horizon. One participant described the risk of peer group supervision turning into something other than its intended purpose (Participant 10). Several participants described using peer group supervision for the purpose of debriefing. Some identified that peer group supervision had been a forum to "whinge and moan" and that this was not the purpose.

Other participants described it as ‘protected time’ to share with peers or a platform for mentoring. Sometimes participants described peer group supervision as a place to vent. One participant suggested that it would be hard for new people to understand the purpose if they had not attended the educational training and learned about the structure (Participant 11). Participants agreed that they needed to know why they were there and what they hoped to achieve. If there was a lack of purpose the peer group supervision session could quickly change into something else such as a venting session as previously described. Participants described a lack of purpose as contributing to their dissatisfaction with peer group supervision. Figure 28 shares the descriptions of peer group supervision purpose.

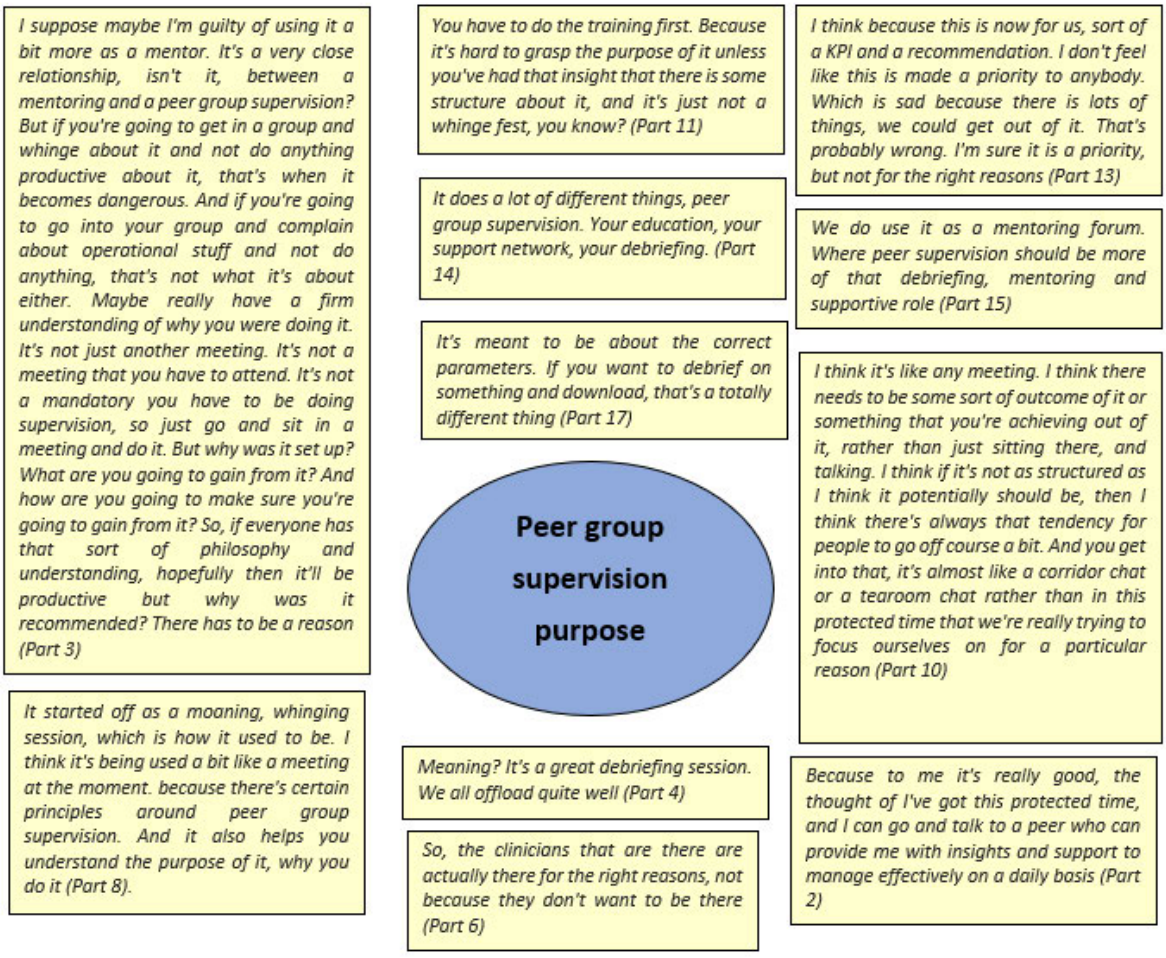


Figure 28: About me: peer group supervision purpose

7.5.6 About me: Two-way Street

Participants reported that a key element of peer group supervision was the feedback they received. A different perspective from peers was valued and identified as pivotal for learning. However, it was not just the feedback that participants valued but also the contribution that they could make to others. Owning peer group supervision was important from the point of view of gaining something from the experience to make it worthwhile. Of equal importance to the participants was sharing learnings and stories with peers. Participants shared their descriptions of give and take.

For most participants, helping peers was just as important as being helped. Not having something to contribute or feeling that you were not adding value to the other participants caused concern. Not experiencing the two-way street left participants feeling dissatisfied. There was acknowledgement that sometimes peers needed more time or support and their need for peer group supervision was greater. It was at times like these that the two-way street meant putting others' needs above your own. Figure 29 shares the participants' experience of the give-and-take of peer group supervision.

Figure 29: About me: Two-way street

7.5.7 Beyond me: We are in this together

The participants' descriptions articulated that they felt they were in this together. Words like “not alone” and “supported” were often part of the peer group supervision description. The participants reported that they were “on the same page” and their peers understood the challenges they were facing. Several participants described their peers as speaking the same language and this came across as being very important.

There was common understanding and acknowledgement of the skills peers had when sharing information. Participants checked in and supported each other when it was noticed they were struggling so they did not have to feel they were alone. Figure 30 shares a sample of commentary from participants as they relate to the theme, we are in this together.

Figure 30: Beyond me: We are in this together

7.5.8 Beyond me: Not just for me

Peer group supervision was noted by the participants to be bigger than just them and they expected both personal and professional outcomes. Participants described how the knowledge and learning they gained from peer group supervision was to provide quality, safe patient care. The participants described how useful peer group supervision was for sharing with colleagues. They shared their successful and less-than-successful moments. One participant described wanting to share the good news because they did not want their peer group supervision to always reflect challenging situations (Participant 1). In Figure 31 participants describe their accountability to themselves, their peers, the patients, and the organisation.

Figure 31: Beyond me: Not just for me

7.6 The unique group

The *unique group* pillar interpretation identifies that peer group supervision is impacted by the dynamics and functioning of the group. The following descriptive narrative provides insight into the interpretation "*the unique group"* through the following: My peers, Our rules, Working together and Broken trust.

7.6.1 My Peers

The identification and allocation of peers was an important part of the experience. Participants shared their experience of identifying allocated peers. Section 7.4 (The foundation of peer group supervision) outlined the challenges that could be experienced by participants when trying to find peers within a peer group supervision model. This section describes who peers are in this context as determined by the participants and what this means to their experience of peer group supervision. In this section, the participants share their horizon and perspective on who they believe to be peers.

Peers came to their groups through a variety of methods. Some participants described being allocated to a peer group. In these cases, the participants reported the process of determining who were their peers was made at an organisation level. There was no reported consultation with the participants about this allocation. Several participants described knowing who they considered to be peers but faced barriers forming groups. In one instance the participant described not being allowed to join with certain peers because they were a different nursing grade to them (Participant 13). Other participants were invited by nurses of the same grade to join their peer group. Participants described the membership in groups as remaining relatively stable once allocated or invited. Once the group was settled peers tended to remain.

Several participants described themselves using words like “misfit” and “motley crew”, because they did not belong anywhere else and therefore were peers by default (Participants 1 & 16). Another participant identified taking an allied health member into their group as they did not have anywhere else to go (Participant 11). This person was described to be a peer in the group even though their discipline and years of experience were vastly different.

Some peers were very comfortable and held similar if not the same roles and accountabilities which meant people were on the same page. In contrast peers who came from different areas were valued because of the different spheres that they worked within. Peers who didn’t know each other found it took time to build rapport within the group and therefore trust and safety took longer to develop. Some peers went beyond the peer’s description and described themselves as friendship groups. Working with peers who were friends could be either positive or challenging. Positive as it felt comfortable but challenging because it could become a social group rather than the reflective professional group it was intended. No participants reported having a line manager in their peer group. This was important not only because the New Zealand Coaching and mentoring model of peer group supervision advised against this but because of the perceived “un-peerness” of the manager/clinician dynamic. Figures 32a & 32b share the diversity and variations of peers.

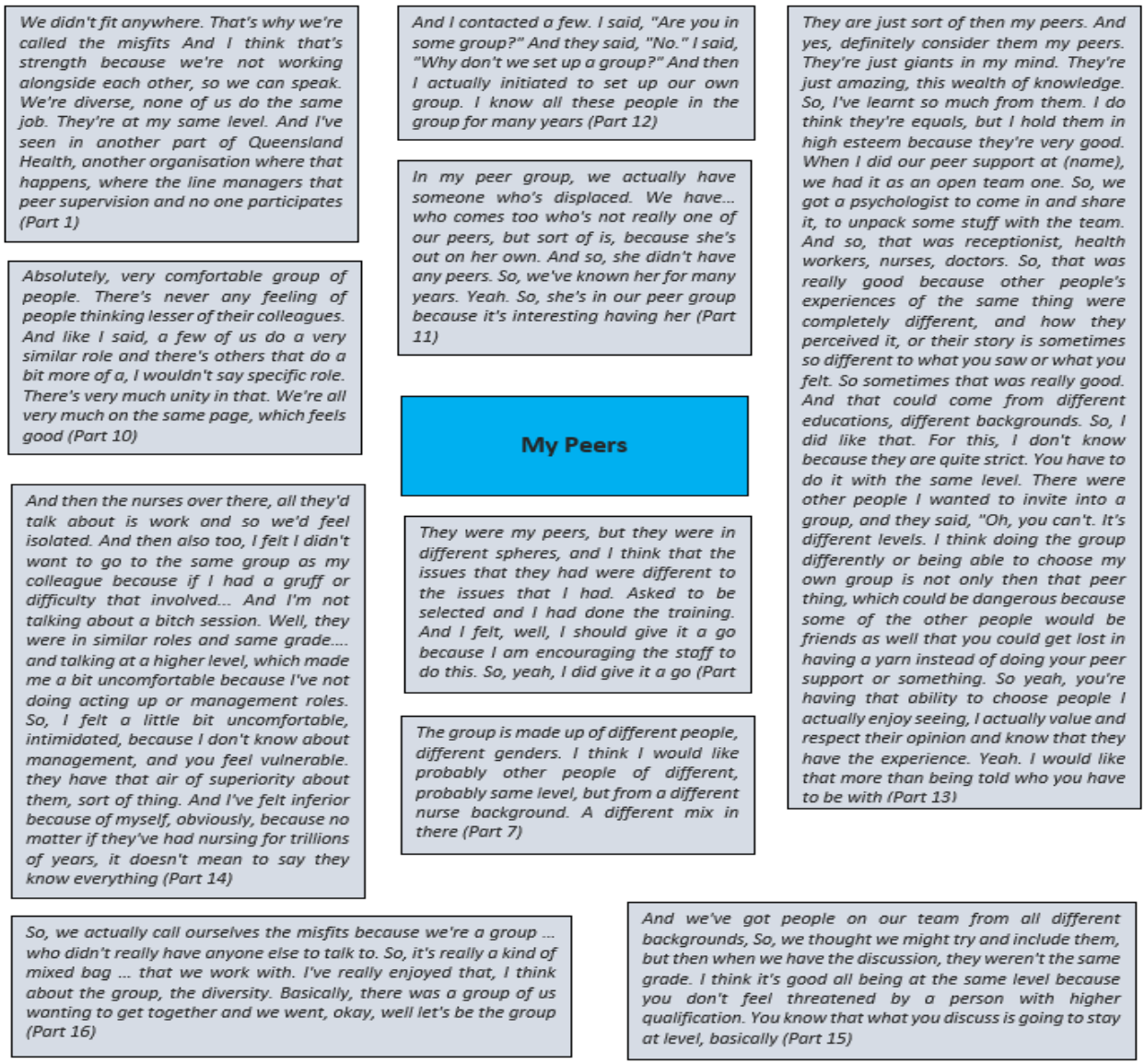


Figure 32a: My Peers

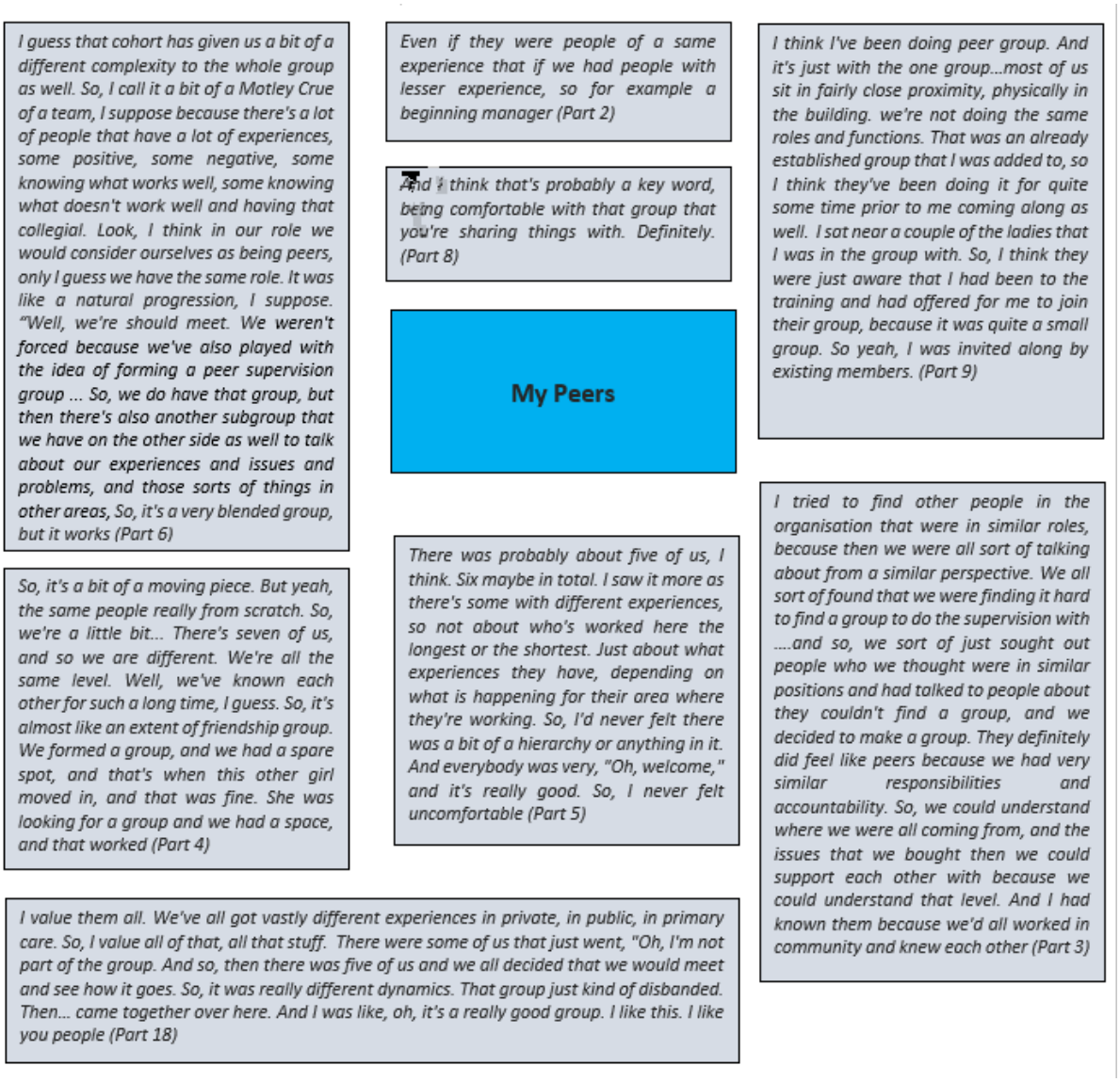


Figure 32b: My Peers

Group size was described by participants as impacting their peer group supervision experiences and thus forms part of the “My peers” interpretation. There was no consensus on group size reported in the participants' descriptions. The peer group supervision model used by the participants recommends four to six members in a group. The participants described the size of their groups and provided insight into the benefits and challenges of the supervision experience. Some participants suggested that three peers would be acceptable and even provide an intimate connection whilst others thought that this small a group of peers would not be effective.

In contrast, some participants were in the same group yet reported vastly different experiences of the group size. Some participants reported feeling overwhelmed by the large group of peers for example up to ten people. Whilst other participants reported benefits and richness coming from so many peers all together. There was consensus among the participants that group size can alter the experience and needs to be considered. Figure 33 shares the experiences of participants in different-sized groups.

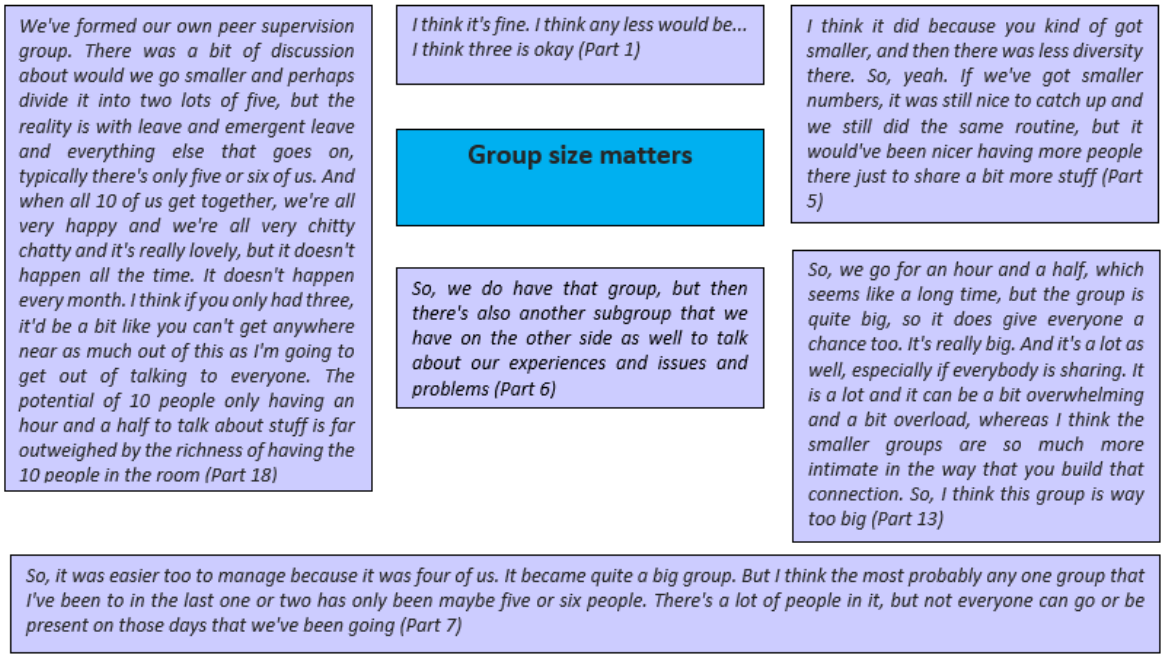


Figure 33: Group size matters

7.6.2 Our rules

Rules, boundaries, and structure are linked to psychological safety for members. Throughout the interviews, participants described their rules, their use and the positive and challenging aspects of using rules in their groups. Several participants from one group described how the initial absence of rules led to disorganisation and frustration for group members. The participants then described how this prompted them to develop rules about who would take on the facilitator role each month and manage the logistics of organising the group. Some participants reported their group strictly followed the rules whilst others reported a more relaxed approach.

Rules were important for order in groups. Some participants reported that it was preferable to refresh the rules especially when new people were joining the group. Several participants noted that the rules helped the group stay on track and allowed everyone to have an opportunity to contribute. One participant noted that rules kept dominant personalities from taking over (Participant 7). This descriptive narrative indicated that rules around confidentiality are highly valued by the participants. The participants described whether to refresh the rules and under what circumstances. There was inconsistency in this area with one participant stating their group looks at the terms of reference yearly. Whilst others commented that reviewing rules should be done but wasn't. Figures 34a & 34b share the wide variation and usage of rules within the groups.

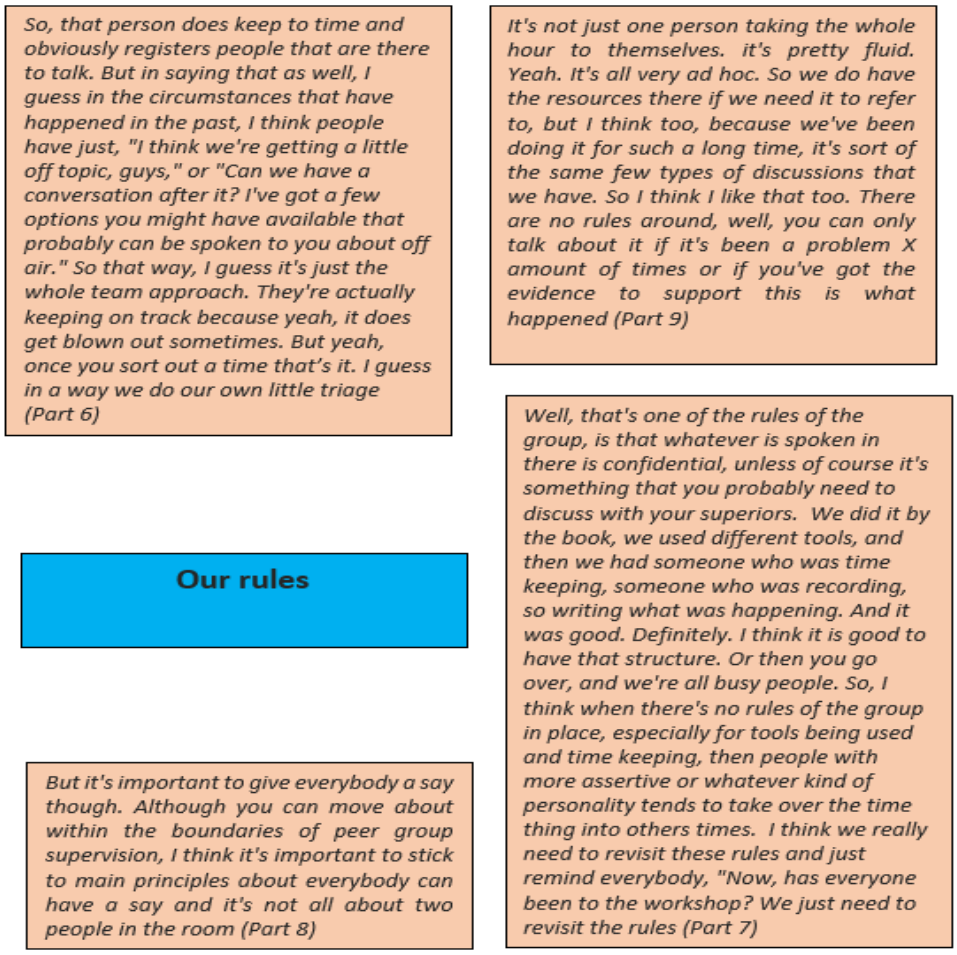


Figure 34a: Our rules

Figure 34b: Our rules

7.6.3 Working together

The *unique group* interpretation of working together highlights this separate yet intertwined aspect of peer group supervision. The group cannot exist without the individual and without the group there is no peer supervision. This section of the narrative description revealed the experiences of participants working together in their unique groups.

As mentioned in the “My peers” section, entry into the groups was either allocated or self-selected. Participants noted that once a group was established, it was sometimes challenging having new members join. One participant noted that it can take a while for new members to feel part of the clique (Participant 1). This participant described the importance of trying to make the new member feel safe so they can participate. Interestingly another participant described how their experience of being new to a group resulted in feeling intimidated when the other members talked about unknown people and situations. One participant described the group selection process that endeavoured to find nurses of similar roles and responsibilities in the hope that the group would be a good fit for them (Participant 3). In this group, all members were asked to decide who should be invited to join to ensure group agreement.

Likewise, a participant in another group noted that their dynamics changed when someone new joined the group. New people took time to adjust to the group and vice versa. This was related to getting to know both the people in the group and the process of peer group supervision. Participants that interrupted sessions by answering their phones in the session, were perceived to not “own” the process. A particular participant noted that it took a while to do so but they eventually raised the issue with the entire group and subsequently, the person left (Participant 1). This was thought to be a good decision and the participant noted that group functioning improved. The participant commented that speaking up can be hard for a nurse of a higher grade so wondered how less experienced clinicians would manage this situation (Participant 1).

The initial implementation of groups was sometimes described as being clunky, disorganised, and regimented and participants stated that it can take a while for groups to find their rhythm and function (Participants 8 & 10). One participant described the process of getting to know each other as being prolonged by circumstance (Participant 8). In this instance, the participant described the group as being thrown together with members not working together regularly. Participants who have been in groups for years described being relaxed, and less rigid with each other and the peer group supervision process. Participants mentioned how talk in the group was at first superficial then developed into deeper trust as time went on. Conflict external to the group impacted trust between some members. The participant described this issue as being unresolved and noted the group just moved on (Participant 16).

Personalities were acknowledged as a part of the working together narrative. It was noted that some participants share responses quickly in the group whilst others take time to think about and formulate a response. Likewise, some participants share frequently, whilst others contribute less often. Feeling comfortable in the group was perceived to facilitate this sharing and flow of information. Participants noted that some members dominated the conversation when there were no rules or boundaries. The session facilitator was seen to be the enforcer of these rules. Strong personalities were described but not always in a negative context when sharing terminology of personalities within the group.

Participants described finding it difficult to discuss group protocol issues with their peers. Participants stated that it was difficult to tell someone that you preferred them to come to the group all the time and not just when they had something to talk about. It was noted that it was also difficult to have the courage to say that this is not working for me. One participant noted that their group had been together for two years and cohesive “for at least the last year”, noting that cohesiveness takes time and effort (Participant 18). Another participant noted that there were always going to be negative people within groups however they did not describe how to resolve this (Participant 2).

Participants described a reliance on one person to organise the group which could be perceived as unequal and problematic. Sometimes this was only identified because a member said they were no longer going to do the role. Other participants noted that their groups “fell over” when the key people were not present demonstrating a reliance on the individual rather than the collective responsibility.

The participants narratives demonstrate that working together is complex. There can differences in the way people prepare and share within the group and this can be rewarding or frustrating. Working together can feel secure or intimidating depending on the members in the group and the length of time the group have been working together. Participants shared a narrative that expressed it can be uplifting or tedious and take time to determine your place in the group.

The descriptive analysis demonstrates that having clarity of expectations and roles can aid the group to work together. It also demonstrated that issues within the working group are not always easy to resolve. The same could be said for all groups however when there are expectations of safety and trust, this becomes an imperative for the peer supervision group. The nuances of working together collated from the participants narratives highlight the need for consideration prior to group formation rather than waiting to deal with issues when they arise. Figures 35a, 35b & 35c share the highs and lows of participants working together in peer group supervision.

Figure 35a: Working together

Figure 35b: Working together

Figure 35c: Working together

7.7 Broken trust

The final description outlined occasions when things did not go well with peer group supervision. This section brought forward my presuppositions. I was not naïve enough to believe that every peer supervision group would be perfect, but I had not personally experienced broken trust and therefore was apprehensive about what I was hearing. Whilst the descriptions were minimal, they were potent in effect. There were incidents where rules were broken, and the individual felt it was not a safe experience. That descriptions of broken trust were hard for some participants to share was reiterated through their nonverbal expression and behaviour. Not all situations occurred within the group however it was acknowledged that outside conflicts overflowed and impacted the peer group supervision experience.

One participant described the rule of confidentiality being broken (Participant 1). The story shared within the peer group supervision session was heard outside the group and the associated commentary led the participant to be concerned. The participant described how this changed their trust in the person who shared the story, but they refused to let it change their experience of peer group supervision. The participant described how they opted not to discuss the incident with the person as it was a good news story (Participant 1).

Another participant described feeling uncomfortable about what they perceived to be an incongruence between what was said within the group and what actions were observed outside the group (Participant 17). Whilst the description was not elaborated upon the incongruence was unpalatable enough to result in the participant leaving the group. The final description of broken trust was a participant who shared a disturbing story of feeling culturally unsafe in the workplace and then finding themselves in the same group as the other nurse who had caused these feelings (Participant 13). They described how it changed their experience as they shut down and did not share. There were feelings of anxiety that led to the participant eventually leaving the group. Figure 36 shares the infrequent yet impactful experiences of broken trust.

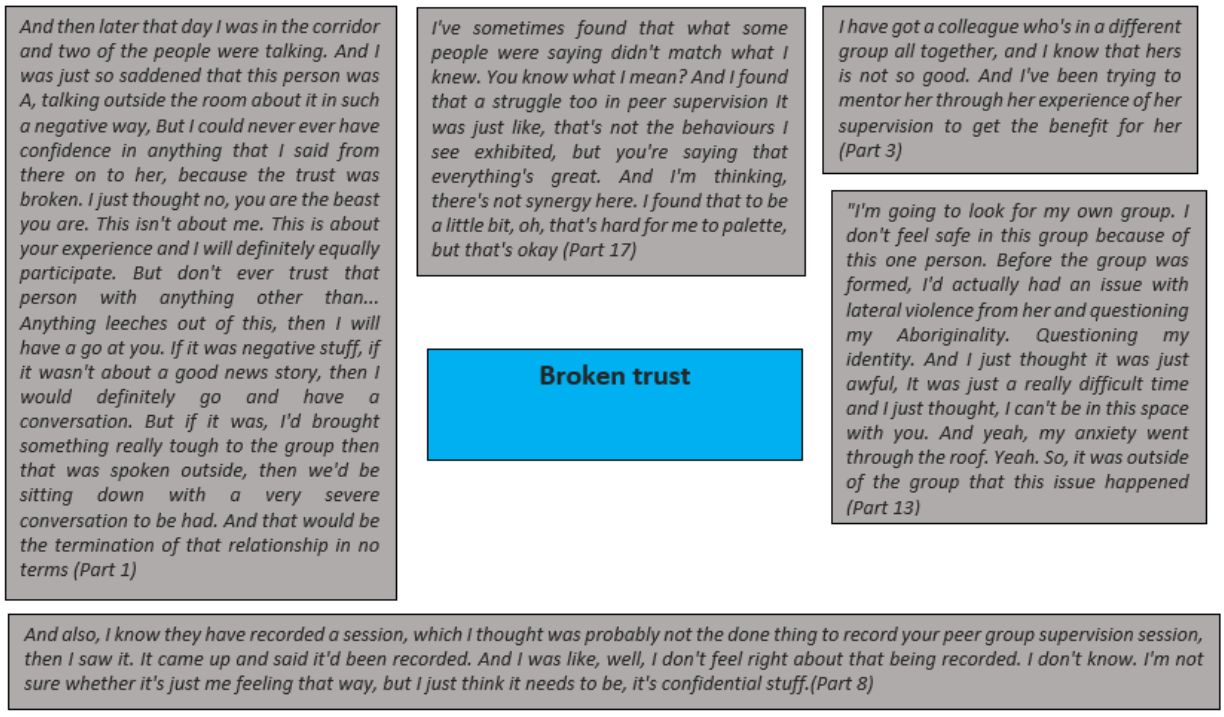


Figure 36: Broken trust

7.8 Chapter summary

The experience of nurses participating in peer group supervision has been described through their shared narratives. The descriptive analysis shares the participants' own words and the collective voice of the words spoken. The narratives highlight that there can be the same people in the same group yet the way they experience peer group supervision is unique to their horizon. This chapter has reported on concepts and elements of peer group supervision such as support, safety and group dynamics and has shared the context of participants in relation to themselves and as participants in groups during peer group supervision practice. The challenges, priorities and benefits have been descriptively shared. The next chapter shares the results from a deeper analytical perspective through themes and their contextual meaning.

Participant anecdotes were collated into initial concepts and provide a context for the participant voice shared through their interviews. Data drilling and codification through an iterative data analysis process refined the initial concepts into themes that became clear as the analysis progressed. The results of Phase 2 strengthened the initial themes that arose in Phase 1 and provided additional insight into the impact of peer group supervision on community health nurses. The results of the analysis are further outlined in the publication presented in Chapter 8

CHAPTER 8: PAPER 3 PHASE 2 RESULTS

8.1 Introduction

Chapter 8 shares the findings from Phase 2 of the research. The descriptive analysis has been shared and this chapter further shares the interpretive analysis. Themes were identified, condensed, and analysed alongside the presuppositions of the researcher. Understanding and meaning arose to form a new horizon of what is peer group supervision. Each of the themes and resulting implications in practice are included in the final publication of my thesis. The interpretation and results of Phase 2 of the research are shared in an article published in the Nurse Education in Practice journal.

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8.2 Published paper 3

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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.

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	

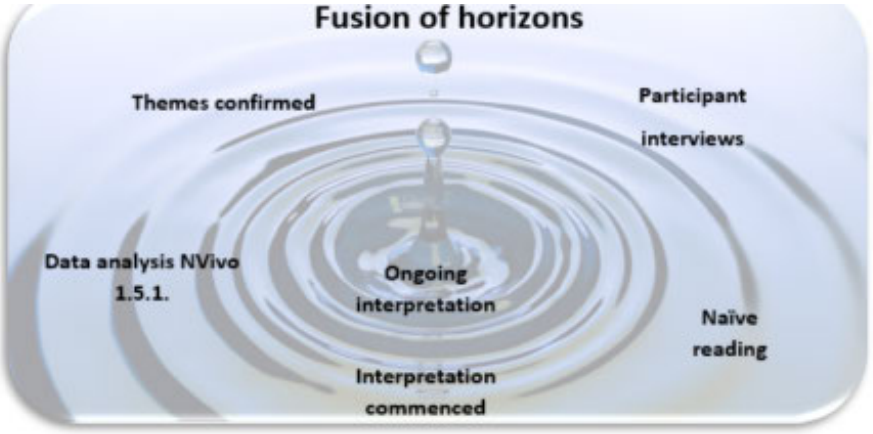

Fig. 1. Gadamerian philosophical data analysis approach (Image source Arek Socha from Pixabay).

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)

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

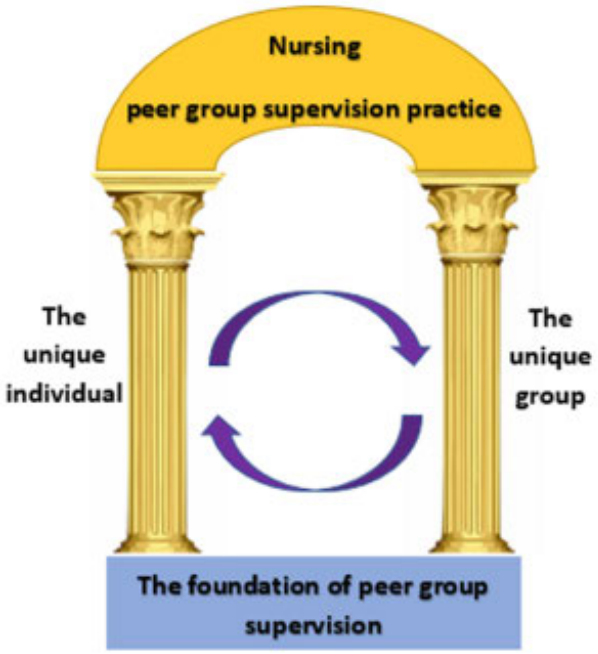

Fig. 2. Peer group supervision practice

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).

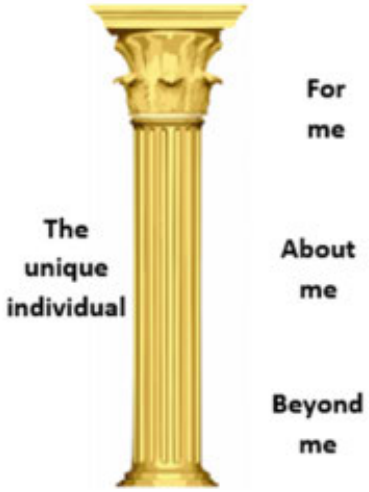

Fig. 3. The unique individual

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

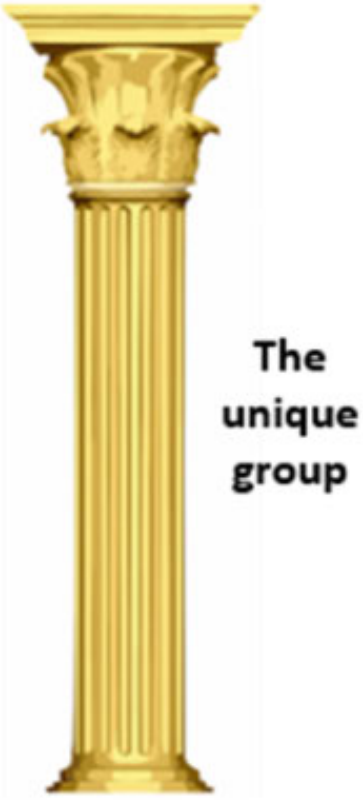

Fig. 4. The unique group.

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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8.3 Links and implications

Chapter 8 shared findings from the experiences of nurses participating in peer group supervision in a tertiary heath service. The article identified that there are both positive and challenging aspects of being an unique individual within an unique peer supervision group. The implications arising from this research concluded that each pillar (the unique individual and the unique group) could be strong and robust but alone cannot support optimal peer group supervision.

The interplay and interconnection between the pillars must not be underestimated. Likewise, nothing could stop the dual pillars from potentially cracking if the foundations are weak and unstable. The findings of this research have important implications for nurse decision makers as it demonstrates that individuals alone cannot guarantee success but that an all of organisation approach is required. The following chapter discusses the Phase 2 findings in detail and clearly discussed their implications for both the individual nurses and nurse decision makers.

CHAPTER 9: SUMMARY AND DISCUSSION

"Understanding does not occur when we try to intercept what someone wants to say to us by claiming we already know it".

Hans-Georg Gadamer

9.1 Introduction

This research aimed to explore the experiences of nurses participating in peer group supervision to better understand the benefits and challenges associated with this model. This chapter provides a discussion of research findings and their relation to the existing literature. New knowledge is presented and shared that specifically highlights the role of the individual and the group in peer group supervision. The sharing of this new knowledge provides key elements for organisational consideration when implementing peer group supervision in practice.

For context and clarity this chapter begins with a summary of each phase of the research. Phase 1 of the research is briefly summarised with key findings highlighted and the rationale for Phase 2 provided (Section 9.2). This is followed by a brief summary of the highlighted Phase 2 findings (Section 9.3). Following these summaries, the research findings and conclusions are discussed in relation to contemporary peer group supervision literature with the implications of this research asserted (section 9.4). Sections, 9.5, 9.6, 9.7 and 9.8 further continue this insightful discussion of all elements of peer group supervision practice. The strengths and the limitations of the research are explored (Section 9.9) then recommendations and guidelines for the future direction of peer group supervision are presented (Section 9.10). Implications for future research (Section 9.11) are outlined. Finally, the research conclusion is provided (Section 9.12).

9.2 Phase 1 summary

The research question that guided this hermeneutic interpretive study was: "How might the phenomena of peer group supervision be understood through the lived experience of nurses participating in a peer group supervision model?" Specifically, interpretations regarding benefits, challenges and the impact and influence of peers and groups were explored.

Phase 1 formed the background for this research and began by exploring the experiences of nurses participating in peer group supervision in an Australian regional community health context. The participants were registered nurses from Grade 5 to Grade 8. The research findings indicated that participants viewed peer group supervision from their own unique horizons. The interpretations from the findings indicated that "there is value in undertaking peer group supervision" (Tulleners et al., 2021. p.4). It was identified that commitment was required to realise this value. Other aspects associated with the perceived value were that nurses could share good news stories and feel that they were not alone in their practice.

Nurses engaged in the research sought and experienced learning and feedback. The findings indicated that nurses experienced "professional sustenance". This was gained through building confidence, developing trust, and experiencing confidentiality and support. However, the participants also described "game changers" that could influence the peer group supervision experience. These were articulated through the interpretations, "follow the rules and group matters" (Tulleners et al., 2021 p.7). Whilst this initial research project identified these game changers, the research raised further questions. The research identified that whilst peer group supervision has positive outcomes, further consideration of the impact of the game changers was required. Finally, the research identified that there was more to know and explore about the phenomenon of peer group supervision, particularly in relation to group matters and the individual.

9.3 Phase 2 summary

The Phase 1 research findings prompted the dialogue on peer group supervision. Phase 1 "lifted the lid" on nursing peer group supervision but acknowledged that whilst providing some answers, it raised questions that required deeper exploration. The literature revealed a paucity of research that sought to understand peer group supervision from the nurse's perspective (Bulman & Francis, 2016; Fakalata et al., 2020; Harker et al., 2015; Johnson, 2016). Specifically, no previous research had explored the participants' experiences through a Gadamerian philosophical approach. Phase 1 concluded that more information was required to guide both organisational and individual nursing decision-making about peer group supervision.

Phase 2 recruited nurses working in a tertiary health service where peer group supervision had been an established practice amongst allied health disciplines (Kuipers et al., 2013; Pager et al., 2018) and nursing professionals for several years. Participants in this phase of the research were nurses from varying grades who participated in peer group supervision as part of the health services' lifelong learning continuum (Queensland Health, 2018).

The participants' experiences were explored to reveal the meaning of nursing peer group supervision. The findings in Chapter 7 and Chapter 8 revealed that peer group supervision practice has many possibilities. The essential constructs of peer group supervision practice are the Foundation, the Unique individual, and the Unique group. Optimal peer group supervision practice is possible when all elements of peer group supervision are supported and aligned.

9.4 Discussion and implications of the research

Two major conclusions arose from the findings and interpretations of this research. The first conclusion is that **peer group supervision is unique**. Peer group supervision is distinct from other clinical supervision models and therefore needs to be considered differently. It is distinct and unique just like the nurse participants who utilise it. This research clearly demonstrates that the principles and practices applied to clinical supervision and group supervision cannot be automatically applied to this model.

The distinct difference is found in the presence/absence of a designated expert or supervisor; that is, peer group supervision does not include a designated leader or supervisor. The literature describes the roles and responsibilities of the supervisor and supervisee as being pivotal to the supervision experience (Bernard & Goodyear, 2019; Salomonsson, 2023). Factors such as supervisor style, behaviours and use of power and self-disclosure affect the supervision alliance and outcomes (Bernard & Goodyear, 2019; Hawkins & McMahon, 2020). The supervisor provides focused one-to-one feedback, guidance, evaluation, and support through their roles and responsibilities as gatekeeper for the profession. They also provide role modelling, education, and mentorship (Barnett & Molzen, 2014; Bond & Holland, 2011; Pelling et al., 2017; Watkins & Milne, 2014).

In the traditional and often preferred one-to-one model, there are no competing interests or opinions from peers. In contrast, my research highlights that the peer group approach to clinical supervision has potentially many competing interests and opinions. These can simultaneously have a positive or negative impact both professionally and personally. This research indicates that there is interconnection between the individual and the group matters, and the constructs of the group are crucial factors for the success or otherwise of the peer group supervision practice. Establishing group norms and behaviours is discussed and asserted as being foundational in peer group supervision.

The review of the literature demonstrated the interchangeable use of the terms group and peer group supervision (Golia & McGovern, 2015). This misnomer can be misleading for nursing decision-makers as group supervision requires a designated supervisor to guide the process. For this reason, my research emphasises the importance of understanding the concepts of peer group supervision. This is important because positive or negative experiences can be attributed to supervisor input (Shin, 2021). If peer group supervision is to be implemented, it must be understood that positive or negative experiences are attributed to all members of the group as each participant holds dual roles of supervisee and supervisor. My research reframes this element, increasing clarity for decision makers. In peer group supervision the inclusion of group rules and guidelines contributed to successful peer group supervision. My research found that organisational interference in determining groups and the construct of groups led to mixed success. Some groups lacked synergy between members and participants left groups because of questions surrounding trust and respect.

The research outcomes reveal that there is limited understanding at the health service and the individual level, of the implications of this distinction regarding the presence/absence of a supervisor on the individual participants and the group. The literature does not describe any clinical supervision model as superior or inferior but rather as having pros and cons (Bernard & Goodyear, 2019; Bond & Holland, 2011; Watkins & Milne, 2014). However, ignoring or making assumptions about the different models could result in a poor or inadequate supervision experience for the nurse (Bond & Holland, 2011). The absence of a designated leader in peer group supervision means the individual must be cognisant of fulfilling the dual roles of supervisee and supervisor. These roles are distinctive and if done well, lead to supportive quality peer group experiences.

The implications of this model are not clearly understood by all nurses, and I recommend that support is needed to find the balance between these roles to both experience and facilitate effective peer group supervision. Support can be internal or external. Internal from appropriately trained peers and external support from nursing management. Managers supported the concept of peer group supervision in the clinical area of their charge. They did not however engage in the conversations or practices of peer group supervision. So, although supportive to the process, managers remained external to the reflective processes that participants engaged in. Staff provided each other support through an active engagement in reflective practice in each of the designated peer group supervision sessions. Collectively, the research identified that both support from managers and peer staff was needed for the process to be fully implemented in practice.

9.5 Peer group supervision practice

The second major conclusion is that the overarching interpretation emerging from the research findings is that peer group supervision in nursing holds **great possibilities to potentiate professional growth through reflection on practice**. Reflection with others is powerful in uncovering the subjective truth of the here and now and exposing dissonance between theory and practice through multiple views. This interpretation aligns with the research methodology because to “have a horizon means not being limited to what is nearby but being able to see beyond it” to what is possible (Gadamer 1975/2013, p. 311).

The findings highlight the fact that no single element guarantees successful or effective peer group supervision. Rather there are collective elements that create opportunity and the possibility of an optimal experience. This research outlined **nursing peer group supervision practice as being optimised when key elements of protected time to reflect in a safe, confidential environment were supported by strong leadership and governance**.

Most importantly peer group supervision is enhanced when **nurses can reflect and receive feedback from multiple perspectives** that could impact their practice, particularly from peers where a relationship of trust and respect has been formed. Peer group supervision practice was further optimised when peers and group dynamics were considered. My research identifies that peer group supervision success cannot be guaranteed, however with careful consideration, personal and professional growth can be achieved.

In 2012, Borders suggested the evidence of peer group supervision effectiveness was “barely or not quite yet” there (p.69). Surprisingly despite the evidence of further peer group supervision research since this time, the literature does not appear to categorically state “we are there”. The aim of this research was not to specifically prove effectiveness however the implications are that peer group supervision knowledge will be enhanced through the experiences of nurses. This research provides greater insight into the needed or preferred relationships of participants particularly with respect to the needs of the individual practitioner and their engagement and fulfilment in groups.

9.6 Foundation

From the research findings emerged the interpretation of the peer group supervision foundation. The peer group supervision experience rests on and arises from the foundations which are important for success. Without solid foundations, the peer group supervision experience may be inappropriate or unattainable (Golia & McGovern, 2015). There are four elements to the foundations. The first element relates to the “professional obligations” which impact nurses' peer group supervision. Multiple participants felt prioritising patient care was appropriate and indeed they felt obligated to “drop everything” in response to patient needs a sentiment shared by the social work participants in the Nickson et al. (2016) study.

This research finding whilst not clearly articulated by participants in the nursing peer group supervision research literature may be reflective of the nursing ethos of caring (Karlsson & Pennbrant, 2020). Gonge and Buus (2015) study of group supervision found that prioritising supervision over workload could attract disapproval from colleagues. Whilst not expressing disapproval per se some participants did comment on their allied health colleague’s attendance.

It is recommended that ground rules for engagement be established. These rules are not generic and are part of the relationship formed between the individual and the group at the formation or time of joining.

The foundational element of “professional obligations” has multiple considerations. For example, workload and patients’ needs frequently came first whilst the nurses’ needs were shared by participants as being a secondary consequence. This attitude toward professional obligations whilst admirable could potentially lead to nurses experiencing stress and burnout (Dall’Ora et al., 2020). Whilst time and workload are frequently raised as challenges in the peer group supervision literature (Bulman et al., 2016; Dungey et al., 2020; Fakalata et al., 2020; McPherson et al., 2016; Nickson et al., 2016) linkage to the potential outcomes may not be recognised by all nurses. This was indeed reflected in the participants’ responses.

Unsurprisingly, when research participants did not find value in attending peer group supervision, they would prioritise their professional obligations and work activities. This perceived prioritisation aligns with clinical, group and peer group supervision literature (Buus et al., 2018; Dilworth et al., 2013; Kenny & Allenby, 2013; Koivu et al., 2012; McPherson et al., 2016). **Future consideration highlighting the benefits of peer group supervision and professional growth needs to be an organisational and personal consideration.** My research demonstrates that it is insufficient for individuals alone to identify the benefits of peer group supervision. To be perceived as valuable, endorsement of peer group supervision as an opportunity for professional growth needs to be an all of organisation approach.

Preventing stress and burnout are reported in the literature to be functions of clinical supervision (Feerick et al., 2021; Martin et al., 2021. p.21). The concern is that nurses may experience a paradox whereby their professional obligations and prioritising of work activities could lead to nonattendance at peer group supervision leading to potential stress and burnout (Gonge & Buus, 2015). Making time as opposed to finding time has been suggested by Fowler (2013d) as a positive attribute with successful peer group supervision. Some of the participants in this research recognised that competing demands of workload could result in the cancellation of peer group supervision and therefore scheduled their sessions accordingly.

This level of flexibility may not be possible in all nursing contexts and this research suggests it is an important element for consideration and discussion in groups at regular intervals. Interestingly, allied health professionals were perceived to value and attend peer supervision regardless of patient needs (Thomas & Isobel, 2019). This prioritisation by allied health could be related to differences in workload and/or professional differences where supervision is an unquestioned expectation. As this study concerned nursing exclusively, no allied health participants were included in this research, so any discussion is speculation. What is known is that nurses for whatever reason feel they cannot prioritise in the same way. (Masamha et al., (2022) suggests clinical supervision may not be viewed as “real work” by the nursing profession. Whilst the research participants did not articulate this viewpoint, they did highlight that patients come first.

As a participant in the study by Thomas & Isobel (2019) commented “There’s a huge problem with nurses handing over responsibilities” (p.156). This could be especially relevant for nurses who are working in autonomous roles where there are limited options for “handing over responsibility”. The implications of these findings are that peer group supervision, like clinical supervision (Colthart et al., 2018; Cook et al., 2020; Hawking & McMahon, 2020) needs to be accepted as a legitimate and essential aspect of nursing practice and organisational culture. Whilst the experience of participants in this research supports this premise it goes beyond this to state categorically that nurses need to understand the benefit peer group supervision can have for their patients.

The foundation's second element is “participation is important”. This is vital as there can be no benefits if there is no participation (Counselman, 2013). Participation in clinical supervision for all nurses is highly recommended by both the national (Australian) and international (United Kingdom) health services (Australian College of Nursing (ACN), 2019; Key et al., 2019; McCarthy et al., 2021; Nursing and Midwifery Council, 2018).

The research participants were unanimous in their opinion that peer group supervision was transferable to all clinical contexts and grades of nursing. In agreement with the peer group supervision literature, the participants felt that the benefits from peer group supervision could be derived regardless of experience levels (Mills & Swift, 2015; Toros & Falch-Eriksen, 2021; Tulleners et al., 2021). Despite this belief, peer group supervision is still not an established expectation in nursing practice. This reinforces the second conclusion that there is a continued lack of familiarisation and understanding of

the concepts of clinical supervision generally and more specifically with peer group supervision.

Research participants reported a lack of peer group supervision experiences prior to entering the nursing workforce. To build a culture of clinical supervision through health policy change as suggested by Butterworth (2022), nurses need to be introduced to the concepts when they are in the undergraduate stage of their career. Early familiarisation assists with setting up an expectation of participation upon entering the workforce (Dungey et al., 2020; Murphy-Hagan & Milton, 2020; Stone et al., 2019) and aids proactive management of stress (Dungey & Bates, 2021). This can be problematic if the workforce is unprepared to offer protected time for reflection (Driscoll et al., 2019). The implications of research such as Butterworth's (2022) is that consideration needs to be given to incorporating clinical supervision into nurses' lifelong learning continuum prior to entering the nursing workforce and within the early graduate year timeframe following completion of the initial study.

Developing awareness of peer group supervision concepts whilst a good start, is not equivalent to participation. Opportunities for protected time are essential. A secondary consideration is whether these opportunities will be mandatory or voluntary. Data analysis of the experience of community nurses identified that peer group supervision may provide the opportunity for reflective practice, but this does not mean that participants see benefit in participating. There needs to be responsibility from both sides. That is management drivers for nursing managers to prioritise and provide the opportunity to staff and secondly, for nurses to act on this opportunity for their own and their patients' benefit. As the nursing workforce has an ageing demographic further consideration is needed to realign and construct teams suitable to the level of experience, culture, and expertise to gain consensus and teams of trust and respect.

The next element of the foundations was "finding peers". This aspect has not been clearly articulated in the peer group supervision literature but was identified in this research as a major barrier to effective peer group supervision. If nurses cannot find their peers, then participation is impossible. Difficulty in locating peers creates frustration and may lead to reluctance to participate.

Participating with peers without similar understanding or values can have either a positive or negative impact. This research articulated that individuals must feel safe and valued with peers for the relationship to be positive. This did not mean that constructive feedback was not positive rather the relational link of comfort, safety and values was needed in positive peer relations. Trust and respect were seen in all interactions that resulted in positive outcomes.

The organisational system for finding peers needs to be considered at the implementation stage and needs to be built into policies and procedures rather than being person or position dependent. Systems need to provide a way for peers to a) identify groups who have vacancies and are accepting new members or b) identify individuals who are looking to form a new group. **There is the need to provide opportunities to have a meet and greet with peers and within groups before a collective decision is made relating to the final group members.** Group composition and group matters were recognised as complex and was deemed an important part of the success of peer group supervision in practice.

The final element of the foundation is “peer group supervision attendance”. Nurses cannot reap personal or professional benefits without frequent and consistent attendance (Counselman, 2013). However, there is conjecture and debate in the clinical supervision literature about what constitutes optimal frequency (Brunero & Lamont, 2012; Francke & de Graaff, 2012) and what the benefits of consistent attendance are for example decreased sick leave (Tuck, 2017).

Participants of group clinical supervision in Davey et al. (2020), noted “significantly lower intolerance to uncertainty and less performance hindering anxiety” (p.13). The peer group supervision model used by participants in this research suggests one and a half to two hours for four to six members (New Zealand Coaching and Mentoring, 2012). Whilst there is no clear guidance in the peer group supervision literature, lessons learnt from clinical and group supervision indicate attendance needs to be frequent (Gonge & Buus, 2015; Howard & Eddy Imishue, 2020) to be beneficial and to maintain momentum and group safety (Counselman, 2013; Kenny & Allenby, 2013; Saab et al., 2021).

Research participants were Advanced Practice Nurses who had a degree of flexibility when organising their peer group supervision. Yet they still experienced challenges related to attendance. Buus et al. (2018) in a study on group clinical supervision found the expectation to attend outside of work hours, created a barrier. This was consistent with both peer group supervision literature (Dungey et al., 2020) and the findings of my research where some participants found it difficult to attend due to their rostered days off. One participant found that the peer group sessions were frequently scheduled on rostered days off. This led to forced non-attendance and created an image of the lack of importance in the process. Consideration of who is in the group and when they can attend needs to be considered in the initial stages of organisational design and implementation.

Supervision principles suggest it is an opportunity to “wash off the grime of the work in the boss’s time” (Hawkins & McMahon 2020. p.70). The literature supports this concept of having protected time to attend peer group supervision (Bulman et al., 2016; Fakalata et al., 2020; Tulleners et al., 2021). My research findings correspond with the broader clinical and group supervision literature in reporting that organisational support is essential for attendance irrespective of the model chosen (Andersson, 2013; Blomberg et al., 2016; Davis et al., 2022; Gardner et al., 2021; Martin, 2016; McCarthy et al., 2021; McPherson et al., 2016; Pager et al., 2018).

Results indicated no one time suited all participants and disengagement was seen when peer group supervision occurred on a rostered day off. This highlighted a need for flexibility on times for peer group supervision and also the need for professional engagement in the process. This requires both the individual and organisational commitment to be successful. Our results stress the need for greater integration and an inclusive process that encourages personal accountability in self-development.

In clinical contexts where rostering and control over workload are less flexible, attendance can be variable (Cookson et al., 2014; Dawber, 2013; Reschke et al., 2021; Tuck, 2017). This element of the foundations needs to be considered at the implementation stage. Research participants noted relatively stable group membership. Once established some groups had the same membership for years.

If the peer group supervision model needs to have variable membership to accommodate nurses on rotating shifts, consideration must include how groups manage the changing dynamic of an open group. Brunero & Lamont (2012) suggested open groups can affect trust and noted that closed groups-maintained longevity. There is limited discussion in the peer group supervision literature about the benefits and challenges of closed or open groups.

Finally, attendance needs to include frequency, duration, and location. The selected model may provide guidelines on some of these aspects however nurses need to be able to adjust to meet their requirements. This research asserts there are twofold considerations required. Firstly, **the location/environment of the group needs to ensure there are no inadvertent breaches of patient confidentiality**. Secondly, **the location needs to be deemed conducive for nurses' safe self-disclosure** (Smith et al., 2012). There are many aspects that can impact the foundation of peer group supervision. Not all factors and risks can be mitigated however the implications of this research show that careful planning in the implementation stages is required to ensure the foundations are initially solid. Frequent evaluation thereafter of the foundation is required for the ongoing stability of peer group supervision.

9.7 The unique individual

My research discusses the *unique individual* pillar as essential to the practice of peer group supervision. Without the individual, there are no peers and there is no group. As Regan (2012) states "the individual is the *reason* for the group" (p.5 Author italics only). This research has demonstrated that each nurse is unique. No two horizons are identical because each nurse's history, education, context, and positions held vary depending on the person (Gadamer, 1975/2013). It is logical that peer group supervision will be experienced uniquely. The *unique individual* comprised the interpretations, "For me, About me and Beyond me". This correlates with Napan's (2021) suggestion that peer group supervision tends to "develop a liberating culture which is self-determining, self-directing and self-renewing" (p.272).

The interpretation, “For me” emerged through three elements of “a new lens, support and restore and a safe place”. Firstly, nurses in this research were able to view their practice through “a new lens”. This is important as the participants identified that they wanted to do the best for their patients and colleagues. For these participants, the ability to increase their knowledge and skills through multiple perspectives was powerful. This finding about “a new lens” highlights the importance of this element and adds to what is already known about the benefits of group or peer group supervision (Counselman, 2013; Gardner et al., 2021; O’Neill et al., 2022; Homer, 2017; O’Neill et al., 2019; Valentino et al., 2016).

There are several interesting aspects that arise from this interpretation. Nurses participating valued the different perspectives even when they held no relevancy at that time. Having a fresh view of a situation can have a major impact and regardless of experience, clinicians described “lightbulb moments”. My research results suggest that an important principle of peer group supervision is being open to, and receptive to new perspectives. Insight and transferable learning are outcomes of reflection on practice which the clinician then internalises and utilises for the next relevant clinical situation (Davys & Beddoe, 2020).

No one person can have all the answers and as Gadamer (1975/2013) notes people view the world through their own prejudices and presuppositions. Nurses practise according to their history, context, and culture so this opportunity to view things differently adds richness to their practice. Dialogue and conversation, the key elements of peer group supervision do not imply unthinking agreement but rather the opportunity to challenge and create new ideas or affirm existing ones. Gadamer (1975/2013) describes understanding as not just the point where you assertively state your viewpoint but instead where views and opinions are transformed. Every nurse attending peer group supervision had their professional practice potentially transformed through this new lens or perspective.

For me, this research has shared overarching professional benefits for individuals that participate in peer group supervision. The learnings from peer group supervision still appear to be in their infancy in the profession where no current established norm is seen broadly across the sector. More work is needed in this area to ensure the carriage of professional responsibility and reflection into future practice. As Napan (2021) asserts "Peer supervision makes practice more intentional and enables necessary space and time for reflection and reflexivity that can transform good practitioners into exceptional ones" (p.274). An important research implication is that perspectives are not just for the present but should also lead to new thinking and "reflecting forwards not backwards" (Hawkins & McMahon, 2020. p.22).

"Support and restore" correlates with the literature that describes the restorative aspects of all models of clinical supervision (Cook et al.,2020; Darra et al., 2016; Feerick et al., 2021; Love et al., 2017; MacLaren et al., 2016; Wallbank, 2013). The restorative benefits of peer group supervision were clearly articulated by participating nurses. The support was personal, and this agrees with the literature where peer group supervision is described as supporting clinicians dealing with the challenges of their profession (Beal et al., 2017; Bulman et al., 2016; Counselman, 2013; Johnson, 2016: Martin, 2020; Mills & Swift, 2015; Nickson et al., 2016; Nielsen & Davidsen, 2017; Salomonsson, 2023; Tulleners et al., 2021).

For nurses this can include the emotional burden of care which has never been more obvious than during the Covid-19 pandemic (Carnesten et al., 2022; Kelley et al., 2022; Labrague, 2021). Interestingly, despite support and restoration being identified as a benefit of the peer group supervision experience, the response to its absence during the pandemic was varied. There were nurses who felt the absence keenly, those who felt the lack of support only after they managed the changes of the pandemic and those who did not miss it at all. This spectrum of experiences demonstrates that although support and restoration are benefits, not all nurses described that.

Research participants articulated the professional support they gained through developing collegiality and networks which is congruent with the literature (Bell et al., 2014; Calcalterra & Raineri, 2020; Dungey et al., 2020; Gardner et al., 2021; Martin et al., 2021; Nielsen & Davidsen, 2017; O'Keefe & James, 2014).

Support increased the nurse's self-efficacy and normalised their situational responses (Atik & Erkan Atik, 2019; Davis et al., 2022; Fitzpatrick et al., 2015; Sundgren et al., 2021). The finding of support and restoration in this peer group supervision research was not surprising. However, the important implications from this research are that support, and restorative elements should not be taken for granted or assumed to be an outcome of peer group supervision. As the **individuals needs for support and restoration are so unique, the way in which it is provided needs to be considered and evaluated.**

Safety in peer group supervision is essential for the individual to share of themselves and their practice. The frequency with which research participants used the word "safe" when describing peer group supervision emphasises its importance. The literature highlights the differences in what safety can mean to the individual. For example, the individual may feel safe when ground rules are used (Kuipers et al., 2013), safe to share vulnerabilities in confidence, be challenged and feel safe from judgement (Calcaterra & Rainieri, 2020; Dungey et al., 2020; Neilsen & Davidson, 2017) and safe from repercussions such as shame (Schumann et al., 2020).

The presence or absence of safety is clearly important in peer group supervision. A lack of safety might potentially lead to superficial reflection or the absence of reflection (Thomas & Isobel, 2019) whereas the presence of safety can stimulate curiosity to learn more (Heffron et al., 2016). Napan (2021) notes that as clinicians become increasingly senior it can be hard to demonstrate vulnerability, therefore having a safe place to express this is critical for professional growth. This concept links with the discussion surrounding group factors and includes the need to be aware of vulnerability within group individuals and group formation.

This research demonstrates aspects of peer group supervision that contribute to members feeling safe. For example, participants reported feeling safe when the group had structure, a view supported by the literature (Dungey & Bates, 2021; Wenocur et al., 2021). Models of peer group supervision such as the structured peer group supervision model and the New Zealand Coaching and Mentoring model utilise contracts, rules and structured formats designed to mitigate potentially unsafe behaviours such as advice-giving and judgement from occurring (New Zealand Coaching and Mentoring, 2012; Schumann et al., 2020). Counselman (2013) also suggests that consistency amongst the

group membership contributes to feeling safe enough to take risks, which could be a compelling argument for the utilisation of groups with a closed membership. The regularity with which safety is mentioned within both these research findings and the literature indicates that this is a significant point of discussion.

Unsurprisingly safety is based on respect for each other (Lewis et al., 2017). Research participants identified safety through their unique horizon which varied from person to person. Just because peer group supervision is safe one day does not guarantee its safety forever. A link to vulnerability, trust and respect is apparent and the interplay of competing priorities and personal values and professional attributes is acknowledged at varying times in the research. The interplay that connects each element safely and supportively is needed. The implications of this research are that **all aspects of safety must be considered and reviewed frequently by the peer group.**

The next part of the discussion focusses on the interpretation “About me”. This encompassed the elements of “Owning my story, Peer group supervision purpose and Two-way Street”. The peer group supervision story is powerful. The premise of peer group supervision is that nurses direct their own stories (Napan, 2021). Individuals decide how their story is best shared with the group. Participants in this research used a model of peer group supervision that encouraged the principles of “sifting and sorting” information. This principle meant that once the participant shared their story, it was up to them to sift and sort what information they deemed useful to take and what would be left behind (McNichol, 2008; New Zealand Coaching and Mentoring, 2012).

Owning your peer group supervision also means being accountable for your story, for example thinking about and preparing what you wish to gain or contribute. This is consistent with the work of Bernard and Goodyear (2019) who suggest that the preparation should be the same as for supervisor-led supervision. Owning your story also means being accountable for any actions required post peer group supervision. As Proctor (2008) states “We are also, both within our profession and in the wider world, accountable to our human peers” (p.5). Napan (2021) goes further and suggests this is “owning your truth” (p.273).

Journalling was used by some participants to prepare their stories whilst others prepared in the car on the way to the session (Raterink, 2016). How preparation occurred was not a concern but just that it did occur (Andersson, 2013). What this research adds to the knowledge on peer group supervision, is that owning your peer group supervision means taking the lead. It means owning the entire process from setting the rules to being part of the group. The literature describes commitment as being important within supervision generally (Tuck, 2017; Tulleners et al., 2021) but commitment is only part of the story. An important highlight of this research is that you may be committed to attending for yourself but there is also the commitment to participate and contribute.

My research found that **peer group supervision attendance may be seen as an imperative or a key performance indicator**. Even if there is a compulsion to attend, the nurse still owns their contribution and participation. The degree of participation and contributions made are up to the individual and may vary. Thomas and Isobel, (2019) noted that it was difficult to tell if a group member was reflecting as it is not always obvious.

The implications are that peer group supervision may offer individuals the possibility of reflection on practice, but it is up to the person how they utilise this opportunity. Further, the implications of this research are that owning the peer group supervision story is not just the responsibility of the individual. All levels of the health service from clinician through to decision-makers should contribute to “owning it" Although as Heffron et al. (2016) notes this can require time to “acculturate and sanction” (p.631).

The purpose of peer group supervision was an area where the participants held differing viewpoints but most agreed that understanding the purpose was important. Whilst the participants used words like mentoring, and debriefing they also identified that the New Zealand Coaching and Mentoring model outlined reflective practice as the purpose of peer group supervision. **This research identified that a lack of understanding regarding the purpose of peer group supervision led to undesirable outcomes** such as moaning and venting that could be seen to waste the participant’s valuable clinical time. It is insufficient to state that individuals alone must understand the purpose. **This research highlights that clarity of purpose is vital for both the individual and the nurse decision-makers if peer group supervision potential is to be realised.**

Finally, peer group supervision is a “two-way street”. This is the major difference between peer and one-to-one models of clinical supervision. In this research, the participants took what they needed for themselves and then considered what they gave to their peers. Peer group supervision supports bidirectional professional growth through plural viewpoints (Mills & Smith, 2015; Toros & Falach-Eriksen, 2021). My research results extend on previous understanding and share that owning the process meant you did not just attend and expect to receive all the benefits. Frustration was felt by participants in this research when colleagues were perceived to only attend when they wanted something. This was felt to contravene the spirit of the supervision experience. What my research demonstrates is that there are expectations of peer group supervision. The implications of the “two-way” street need to be considered during the formation of the group. Members need to be made aware that whilst there is an expectation of gaining individual benefits from peer group supervision, of equal importance is the expectation of participation and contribution to others.

Research participants were aware of the vicarious trauma that could occur through the sharing of patient stories. Therefore, the details of what was shared were cautiously screened to protect peers. What was interesting but not surprising in this research was the altruistic nature of nurses. There were several occasions where the nurses put their stories on hold as a colleague was perceived to have a greater need to share. Nurses who did not have anything pressing to share would acknowledge they were there purely to support their peers. This aspect is not clearly articulated in the literature.

The final unique individual interpretation was “Beyond me”. The elements crucial to this interpretation are that “we are in this together and it is not just for me”. Research participants frequently highlighted that peer group supervision made them feel they were not alone or isolated in their practice. The research participants felt understood by the other nurses. This finding is consistent with the peer group supervision literature as being an important aspect of the peer group supervision model (Amanvermez et al., 2020; Bailey et al., 2014; Dungey et al., 2020; Homer, 2017; Nickson, et al., 2016; Tulleners et al., 2021; Wenocur et al., 2021). My research extends the concept of support and guidance to one of belonging and looking beyond just the self to the professional self. The nurses in this research were not an “island” and this was important. **Recommendations relating to onboarding, meet and greet and a getting-to-know-you phase with group formation are needed to ensure the basic foundations arising in the research are**

addressed in the early stages of group formation. Participants felt the knowledge, skills and networks gained through reflecting on their practice enhanced their ability to meet the patient's needs and increased their professional understanding of and standing with patients. The implication is that peer group supervision benefits are felt beyond the individual.

9.8 The unique group

Peer group supervision is a distinct model due to the interaction between the individual and the group. Groups are powerful (Hawkins & McMahon, 2020) and experiences within the group can make or break the experience for the individual and vice versa. The interpretation of the *unique group* is comprised of the elements "My peers, Our rules, Working together, and Broken trust".

As discovered in this research, the notion of peers in a peer group supervision practice is complex. The foundational interpretation discussed the importance of accessing and finding peers. This unique group interpretation extends upon the foundation to discuss who are 'peers'. One definition of peers is "one that is of equal standing with another" (Merriam-Webster, 2021). The research participants had unique horizons when it came to discussing their experiences with peers.

Some participants in this research were allocated to groups with nurses of the same grade and role. Other participants identified peers as being at the same grade but working in very different roles for example managerial or clinical. Still, others reported coming together as peers because they did not readily "fit" anywhere else. Significantly, nurses who were in managerial roles were not in the same peer groups as their subordinates. This is important as the presence of managers in group or peer group supervision could alter the group dynamic and inhibit staff from speaking freely (O'Neill et al., 2019; Gardner et al.,2022). This correlates with the clinical supervision literature that recommends the separation of those in organisational management from those in supervisory roles (Bifarin & Stonehouse, 2017; Cookson et al., 2014; Martin et al., 2014).

Whilst the dictionary defines peers as having equal standing not all peers are equal (Mills & Swift, 2015). This research found that peers may be the same grade for example clinical nurse but within the group, there could be a novice nurse and a nurse who has worked in the role for many years. The differences in experience and knowledge can create an unequal power balance and the peer is then no longer a peer (Beal et al., 2017; Mills & Swift, 2015; Somerville et al., 2019). Differences in experience can lead to perceptions of inferiority and intimidation as was experienced by participants in this research and supported by Wilkinson's (2015) narrative experience of peer group supervision. This research identified that power imbalance can change the dynamics of a peer group. This concept was not articulated in the literature. The importance of individuals feeling a sense of belonging and a sense of fit in the group cannot be underestimated. Therefore, I recommend that the composition of groups be discussed openly and opportunities to opt out of groups be offered if the "peerness" if not appropriate.

Alternatively, differences in experience can add immense value to the clinician's knowledge and skills through sharing of information (Newman et al., 2013; Taylor, 2014; Thomas & Isobel, 2019; Valentino et al., 2016). Familiarity with peers in groups has both positive and negative effects. Chui et al. (2021) discussed the relationship between being close to peers and learning from them. With the suggestion that closeness, whilst leading to a sense of belonging and a decrease in conflict, does not necessarily equate to learning and self-efficacy. My research noted that familiarity amongst peers allowed for understanding how others may respond or react to a situation. However, peers may not be willing or able to speak up and challenge each other because of perceived ramifications to the existing relationship. The implications are that constrained participation in peer group supervision can be superficial or potentially damage relationships.

This research noted that peer group size can impact upon the experience. Newman et al. (2013) noted that the structured peer group supervision model was useful for both small and larger groups. Whilst the peer group supervision model used by the participants in this research provided guidelines of four to six members per group, this recommendation was not always followed, and numbers varied greatly.

Some participants in this research found that when there were too few peers the experiences shared were not diverse enough whereas too many peers became overwhelming. This finding is consistent with Hawkins & McMahon (2020) who recommend five to six members being the optimal size. Circumstances make group size difficult to control at times therefore I recommend that consideration of size at the commencement of peer group supervision may optimise the experience for members.

Surprisingly the discussion on peers has not been clearly articulated in the literature and yet is an important element found in my research. There is no clear consensus in the literature on who constitutes peers, how many members should be in a group nor is there clear guidance on whether groups should allocate members or allow for self-selection. **The implications of this research are that whilst it may be convenient to select nursing peers based on grade alone, more in-depth consideration may be required to realise optimal experiences and sustained peer group supervision practice**.

The next element of the unique group interpretation discusses “Our rules” within peer group supervision. Structure and rules are a predominant feature of the peer group supervision model used in this research (New Zealand Coaching and Mentoring, 2012). Heffron et al. (2016), suggest structure is like a stabilising force where “one might use the edge to catch a breath in the deep end of a pool, the frame can continue to lend stability along the way” (p.631). This aligns with the literature that suggests that group members benefit from a structured approach that may include contracts and rules (Dungey et al., 2020; Kuipers et al., 2013; Newman et al., 2013; Mills & Swift, 2015; Somerville et al., 2019).

The structure and rules allowed the participants in this research to have equal opportunity for presenting their stories. The structure limited the responses that peers can give, to avoid judgment and advice giving which can be potentially detrimental to confidence and self-efficacy (Nielsen & Davidsen, 2017). Rules and structure assist with safety, confidentiality, and trust, all of which are vital for effective peer group supervision. Rules and structure may be a part of a model however this does not guarantee they will be followed or maintained.

The nurses in this research described a variety of interpretations, some individuals followed the rules diligently, whilst others reported that the rules were confining, stopped the flow and provided barriers to peer group supervision which concurs with the literature (Harker et al., 2015; McKenny et al., 2019). Other participants in this research found that their group dynamic meant they were able to find value from the experience without rigidly following the rules. Participants also reported differences in the way information was shared and processed amongst peers. For example, some participants processed information more slowly and therefore shared less frequently. This led to both individual frustration and the group being deprived of valuable information. It can also be interpreted by others as non-participation which again leads to dissatisfaction (Lewis et al., 2017).

Participants in this research used contracts and agreements provided by the New Zealand Coaching and Mentoring peer group supervision model. Models with built-in resources such as these, benefit nurses in that they do not have to develop these on their own. My research highlights the benefit of standardising processes across groups and organisations. This can be especially useful if nurses move between groups.

The participants used a model that encouraged members to regularly evaluate groups however there was inconsistency in reviewing group rules. Part of owning your peer group supervision is contributing to the development and evaluation of group rules. The implications of this research are twofold. Firstly, if nurses do not contribute and the rules are seen to be imposed, they may be less likely to conform to them. Secondly, the rules or structure need to be frequently reviewed to ensure they are still fit for purpose.

The next element in the unique group interpretation is “Working together”. My research has demonstrated there is great value to be found in the sharing and receiving of multiple perspectives from nursing peers. However, there is limited evidence in the literature on how best to implement and maintain peer group supervision for nurses. Even when a structured step-by-step model is utilised there is always variation. There is a deviation from the process simply because of human nature, and as such, people interpret things through a unique lens. Therefore, it is **important to consider group functioning and how working together may impact the peer group supervision experience** (Tulleners et al., 2023).

Whilst stages of group development are not always identified in the peer group supervision literature there is evidence of characteristics of several different stages. For example, Tuckman and Jensen (1977) describe the stages as forming, storming, norming, performing and adjourning. These stages are characterised by the following:

Stage	Characterised by:
Forming	Relationship establishment and orientation
Storming	Conflict and resistance to group influence
Norming	Ingroup feeling and cohesiveness develop
Performing	Structure can now be supportive of task performance
Adjourning	The termination stage

Table 4: Stages of group development Tuckman (1965. p.396) & Tuckman & Jensen, (1977)

In this research, participants noted that it took time for them to get to know each other especially when they only came together for peer group supervision. This could be likened to the forming stage. Other participants in this research describe cohesion as developing over time which may be similar to the norming stage. Likewise, a group may be functioning to their preferred methods, then someone leaves, or a new member joins the group. The group may then go through a period of uncertainty where everyone is unsure until the group eventually resets (Johnson & Johnson, 2017). As Hawkins & McMahon (2020) note group development may fluctuate between the stages at various times.

The impact of this research is that it **may be beneficial for groups to consider stages of development, how this may impact the group and what steps can aid group functioning so they can anticipate and if necessary, manage any arising situations**. Agreement around new member integration and management is recommended (Counselman, 2013; Nielsen & Davidsen, 2017; Tulleners et al., 2023). Consideration needs to be given to the management of the adjourning process including people leaving or the group disbanding so that the group itself is maintained. **Group stages and functioning require consideration as does group dynamics**. Proctor (2008) notes that peer supervision groups are unique and have the capacity to be "potentially ground-breaking" (p.4). Further, she describes peer supervision groups as being somewhat like siblings in that they have the "dynamics of cooperation as well as of competition" (Proctor, 2008. p.4). Any discussion on the impact of group dynamics must be balanced with strengths and deficits identified.

Lewin's (1951) group theory described the formula "B=f (P, E) that implies the behaviour (B) of group members is a function (f) of the interaction of their personal characteristics (P) and the environment (E)". Thus, groups are "more than the sum of the individual members" (Forsyth, 2018. p.21). This aligns with the principles of peer group supervision. The dynamics that occur within peer supervision groups are powerful and can have a positive or negative influence. Group dynamics can determine how long groups will stay together, how the individuals within the group relate to each other and if not considered can be detrimental to the individual and group (Counselman, 2013; Somerville et al., 2019; Tulleners et al., 2023). Staff education, support, mentorship and supporting procedures are needed to provide a scaffold for nurses using peer group supervision in practice.

The previous element "Our rules" described how rules and structure can assist participants to feel safe, be confident to share and be vulnerable to improve outcomes for themselves and their patients. It could be suggested that the rules and structure in peer group supervision are the de facto group supervisors. The structure outlines what members do, when they do it and how they respond. However, the inclusion of rules does not guarantee that they will be followed or used.

Where peer group supervision models may falter is with determining what to do when the structure cannot contain the group personality or dynamics and cohesion is threatened. Forsyth (2018) describes cohesion as indirectly signalling "the health of the group" (p.135). Additionally, Johnson and Johnson (2017) note members will stay in the group, take part, and try to recruit new members if cohesiveness is high (p.99). Group cohesion is identified as desirable in the peer group supervision literature. Somerville et al. (2019) noted that group cohesion was associated with better group goals and task achievement, whilst Johnson (2016) suggested cohesion may be related to the establishment of common ground. When discussing group clinical supervision, Reschke et al. (2021) also note that cohesion is linked to attendance. The more you go the greater the likelihood of group cohesion.

However, attendance is only one factor. An additional consideration is the part personalities play in group dynamics and cohesion. Everyone's personality is unique and can contribute to the group experience in different ways. Lewis et al. (2017) explored group members' personality types as a method for enhancing understanding and recognising the individual contribution that personalities make to the dynamics of a group. This research is not suggesting every group undergo personality testing however consideration of personality types may aid understanding. This type of assessment is usually completed during a leadership course making the connection for staff between their professional development and leadership development aligned with their professional reflective self.

Peer group supervision is a leaderless model therefore peers have equal standing thus creating a dilemma about who manages the group. Bailey et al. (2014) note that leaders can emerge and that this can be preferred by group members. Bailey et al. (2014) note further that leaders do not have to be authoritarian or experts but can be non-hierarchical which would be appropriate in this peer group supervision model. My research findings shared a mixed response to leadership and the responsibilities of individuals in groups. Participants in this research reported that personality conflicts did occasionally occur.

What was interesting was that often issues within the groups were not addressed or even spoken about. This aligns with the findings of the systematic review by the authors (Tulleners et al., 2023). It was suggested that people will be people, and this is just part of being a group. Not every person will get along with everyone but how might this mindset impact peer group supervision? Not all conflict is negative. As Johnson & Johnson (2017) suggest it is possible to create "conflict positive" groups that encourage, support and work through conflict in a positive way. As one participant in my research noted it may be that this group is not right for this person and nurses need to accept this possibility. Proctor (2008) suggests "ground rules that spell out responsibility for group maintenance and repair, as well as co-responsibility for 'good enough' practice, give permission for any member to address what is problematic if it is interfering with good work" (p.10). **The implication of this research is that group dynamics need not be feared but likewise, they cannot be ignored.**

The final point of discussion is “broken trust”. There must be a balance between the individual and the group horizons for peer group supervision to be a valuable experience. Whilst not a frequent occurrence, participants identified experiences where trust was irrevocably broken. Broken trust in groups has consequences. The outcomes resulting from broken trust range from caution about what to share with the group to disengagement mentally or physically from the group. Prevention of harm to participants needs to be an important consideration in the peer group supervision process. This research identified that trust could be broken in several ways. Confidentiality was breached despite the peer group supervision model rules about sharing information outside the group. Discussion in the hallway that is not positive can be detrimental to the ongoing experience. This is especially true if it is not addressed by the group.

Trust could also be broken when the cultural norms of the group do not feel safe. This is an element that is not clearly articulated in the literature. Another area of broken trust was incongruence. Participants reported discussions and perspectives that peers perceived to be different from those behaviours exhibited outside of the group setting. This could lead to conflict especially where there was no resolution or discussion. It can be very challenging for peers (or not peers) to speak up about areas of broken trust with participants in this research identifying that it would take courage.

The literature reports harmful supervision can happen and can be detrimental to not only the current experience but also set up anxiety and concerns about future supervision to the point where people will not engage due to past experiences (Cook & Ellis, 2021). What is interesting is that the literature is scant and not forthcoming on this element and how to mitigate it for nurses. It would be unlikely that incidents were not occurring, yet it is not widely reported. The implications of this research are that harmful peer group supervision can and does happen and must be considered when implementing this model.

Overall, this discussion demonstrates the following conclusions.

1. The possibility of peer group supervision practice is unique. It does not and cannot rely on one factor alone.
2. The elements of the foundation, the unique individual and the unique group must be considered to provide the optimal peer group supervision experience.

3. The characteristics of both the individual and the group play critical roles in the optimisation of peer group supervision.

9.9 Strengths and limitations

The strength of this research is that it has been guided by a Gadamerian philosophical approach. The congruence between this philosophy and peer group supervision are obvious in the emphasis that both place on the power of language and dialogue in facilitating understanding. Likewise, there is congruence between nursing and hermeneutics as Moules et al. (2011) note “these disciplines have recognised that their practices are already deeply hermeneutic” (p.2).

As mentioned previously, Gadamer did not provide a method for conducting hermeneutic research therefore sample size was determined by rigorous determination to provide rich description and insight into the phenomenon. A strength of this research is the sample size of thirteen participants in Phase 1 and eighteen participants in Phase 2 that were utilised to aid understanding of peer group supervision. Through the participants' voices, there is strength in the ability to provide insight into a model of clinical supervision that is not well articulated. Insights of peer group supervision from the literature came together with the context and horizons of the research participants to form a new horizon of understanding.

A definite strength is seen in the way nurses shared all aspects of their experiences including the positive and challenging aspects. This helps decision-makers understand all elements that need to be considered when embarking on peer group supervision implementation from both a professional and humanistic viewpoint. A limitation is that many of the participants were in advanced practice roles and if they experienced challenges in managing group dynamics then this may have ramifications for the success of novice nurses.

Limitations are also the smaller number of male nurse opinions in the research which could potentially influence the outcomes. Despite changes in nursing culture, it currently remains a predominantly female workforce. However, a strength is that the insights provided will resonate with non-advanced practitioners or even novice nurses of any gender identification.

Limitations are noted in the health service site selection for the research. Only two health service sites were represented in Phase 1 and Phase 2 of the research. However, homogeneity was modified through the diversity of the participants' clinical contexts. A final strength is that this research has clearly detailed the implications for nursing peer group supervision practice and provided clear recommendations for implementation.

9.10 Recommendations for Nursing Policy and Practice

This section acknowledges that nurses are currently participating in or providing peer group supervision. Recommendations are provided in this section for decision-makers of nursing policy, nurse managers and nurses to consider how to incorporate or improve peer group supervision practice. From these recommendations, 10 guidelines have been developed. These guidelines expand on the recommendations and demonstrate how they may manifest in nursing practice. This research has explored the experiences of nurses participating in peer group supervision. Through this sharing of experiences, it is identified that the potential benefits to nurses' professional growth from peer group supervision outweigh the potential challenges. However, organisations and nurses need to determine what is the most appropriate and effective peer group supervision implementation strategy to mitigate potential challenges. The findings and recommendation guidelines from this research seek to aid this determination.

My research suggests that peer group supervision practice is optimised by consideration of the foundation, individual and group pillars. Nurses and nurse decision-makers need to recognise the possible benefits of peer group supervision and embrace the practice as their own. This means not just as an adaptation from the helping professions but what the peer group supervision story is for nurses (Butterworth, 2022). On an individual level, nurses need to own their peer group supervision story. This means considering what they will bring, contribute, and gain.

The first recommendation is that nurses and nurse managers **underpin peer group supervision with a strong foundation**. This means valuing time out to reflect on practice through peer group supervision. It is real work and should be seen as such (See Guideline 1). Nurses need to shift their thinking to make time for supportive practices such as peer group supervision. It must be viewed with the same importance as "mandatory training and annual leave" (Fowler, 2013d p.1322). To shift perceptions, nurses and nurse decision-makers need to clearly communicate the purpose of peer group supervision for

their context to provide clarification on the benefits, avoid misunderstanding of the process and optimise peer group supervision experiences (See Guideline 6).

The Australian College of Nurses (ACN) recommends instilling the importance of supportive practices such as peer group supervision from the health policy level down (ACN, 2019). Recommendations for the implementation of peer group supervision are supported by regulatory authorities however the practical implementation of peer group supervision in practice in the clinical setting of community health is more complex. The foundations required need to be strong, a lens inclusive of the unique individual and the unique group require a delicate balance for success. Therefore, supporting and driving a culture of clinical supervision in nursing is vital for implementation and acceptance by nurses (See Guideline 2). To achieve this, it is recommended that health services **review their lifelong learning policies to ensure professional reflection is included**. These research findings suggest that all nurses regardless of history, context or position held may benefit from peer group supervision. Therefore, it is recommended that **all nurses from undergraduate through to experienced clinicians have access to education on the principles of peer group supervision and are supported to participate if they wish to** (See Guideline 3).

Supporting the inclusion of clinical supervision models early in a nurse's career may optimise acceptance and utilisation. It is recommended that careful **consideration be given to options for peer group supervision education pre-registration for nursing students** and first-year graduates (Felton et al., 2012; Power & Thomas, 2018). This should include peer group supervision principles being incorporated into relevant undergraduate nursing curricula and graduate programs (See Guideline 3).

Barriers were experienced by participants when finding their peers. It is **recommended that health services develop and provide efficient, easy-to-use systems for locating education opportunities and peer groups**. Participants in this research concurred with a suggestion by Sloan and Grant (2012) who recommended the use of a database to track and locate groups. Multiple barriers were identified within my research. It is **recommended that nurses consider the barriers to attendance and manage what is within their control** such as where they locate their group and **advocate for assistance with those barriers outside their control**, for example rostering (See Guidance 5).

It is important for nurses and nurse decision-makers to consider who peers are to optimise peer group supervision. It is **recommended that nurses be consulted on their preference for peer selection and where possible accommodated**. This is where nurses need to be creative and assertive in their solutions or be offered options such as self-selection or allocation to groups (See Guidance 4). Martin et al. (2018) notes that "a one size fits all approach does not work for clinical supervision" and this sentiment likewise applies to peer group supervision (p.9).

Another important finding arising from this research is that peer group supervision is a safe environment where nurses can benefit from reflecting with their peers. To optimise the outcomes, and to benefit from the multiple perspectives and richness of peer group supervision, nurses must be open to receiving and giving constructive feedback. It is also recommended that nurses be aware of the safety of their group and call out unsafe practices when they see them. The premise of peer group supervision must be to do no harm and nurses must advocate for this experience to be safe for all.

If there are instances of broken trust or harmful peer group supervision, there must be a group and organisation-wide approach to managing this (See Guideline 8). To aid optimal peer group supervision experiences, this research found that considering how groups work together is important. Careful selection of a peer group supervision model may assist with rules, structure, and dynamics and may mitigate some but not all potential issues (See Guideline 7). Therefore, **group functioning, and dynamics must be considered by both the individual and the organisation when planning, implementing, and evaluating peer group supervision**.

Nurses and nurse decision-makers should not assume that the presence of a peer group supervision model will manage all group dynamics and functioning. In fact, Borders (2012) suggests that effectiveness equates with the skills of the group members. Therefore, nurses need to be supported and provided with the knowledge and skills to assist them to experience optimal peer group supervision. Skills may include how to reflect on practice for professional growth and how to develop conflict-positive groups where conflict is discussed and worked through (Johnson & Johnson, 2016). This is important as managing group functioning could benefit group cohesion and aid longevity (See Guideline 8).

Another finding from this research suggested that evaluation was not frequently undertaken. Regular evaluation is key, and it is highly recommended that it be embedded in the peer group supervision process. A common mistake may be that groups are very diligent with the setting up and the getting the "front end" details right but not in developing a process that assesses how the group is continuing to function (Lewis et al., 2017) (See Guideline 9).

Group termination requires consideration from commencement to conclusion. It is important when beginning peer group supervision to also consider how it might end. This does not mean the group is expected to fail or disband but rather to consider that the initial group membership may change for example nurses resign, go on parental leave, or get promoted and there will be an inevitable movement among staff. The group needs to decide from the beginning how they will manage these changes to the dynamics of the group when these events happen.

Endings can also occur when someone recognises that the group is not for them. This may be due to different personalities within the group, or the group is not meeting their needs. The group needs to first set up expectations that this is not necessarily negative. The group needs to determine how they manage these situations. For example, will they try to resolve the issues, or will they just accept that some people need to leave? It is also important to consider traumatic endings such as during the Covid-19 pandemic when nurses left the groups as they were redeployed indefinitely. It is recommended that groups consider how they might manage unforeseen situations and future proof their peer group supervision. The identified ten guidelines for per group supervision based on the findings from this research and in congruence with already known literature is presented in Table 5.

Principles for Peer Group Supervision (PGS) Foundations	Strategy
1. Peer group supervision (PGS) should be valued as "real work". Nursing peer group supervision practice should be recognised as part of a	Each Health care organisation should: • Provide nurses with "Statements of peer group supervision value" highlighting the benefits to personal and professional practice. • Allocate time and support for staff attendance at PGS

nurse's lifelong learning and have equal importance as elements such as mandatory training and annual leave	
2. A culture of reflective practice is supported	Healthcare organisations should support a culture of reflective practice through: • Incorporating reflective practice into lifelong learning • Assessing for institutional culture for PGS. Assessment tools such as STAMINA (Osborn (2004) in Bernard & Goodyear (2019) can be utilised for this process
3. PGS is for all nurses	To ensure PGS is available for all nurses who wish to attend the following should be provided: • Accessibility of information and education on PGS for all grades of nurses • Opportunities for all grades of nurses to participate regardless of nursing context, for example, acute or non-acute clinical areas. • Inclusion of PGS principles into undergraduate curriculum for e.g.: in the Professional transition to practice capstone courses
4. Suitable peers are provided	To optimise successful PGS the following is essential: • Provide nurses with the option of being placed in a group or self-selecting their peers • Nurse managers are not to be included in groups with subordinates. • Nurses need to be made aware of group vacancies and locations and so forth. For example, using up-to-date PGS databases. Systems should not be person dependent.
5. Attendance for all	Barriers to attending PGS should be minimised through the following: • Support from nursing management to attend for example aid nurses to incorporate PGS into their nursing roster. • Provide timely education prior to commencement in a group for example if face-to-face training is not available for several months the nurses should have options for online training so as not to delay attendance. • Health service provision of quiet and safe/confidential locations • Options for minimising travel are explored for example the use of technologies if deemed appropriate by the group members.

Principles for the Unique Individual and the Unique Group	
6. Clear peer group supervision purpose	The purpose of PGS should be clearly understood by all nurses. Health care organisations should: • Develop a PGS implementation document that clearly states the purpose of PGS in their healthcare context • Ensure the purpose aligns with any existing current guidelines for example the Office of the Chief Nursing and Midwifery Office (OCNMO) Clinical Supervision Framework for Nurses and Midwives (State of Queensland (Queensland Health), 2021) • Individual nurses should ensure they understand the purpose of PGS as outlined by the organisation
7. An appropriate PGS model is selected	Appropriate model selection is essential and should be identified early in the planning process. Model selection should consider: • Types of PGS models available for example the New Zealand Coaching and Mentoring model or the structured peer group supervision model and suitability of the implementation for the organisation • The inclusion of rules/ structure, contracts, and agreements • The consideration of tools built in to standardise PGS across the organisation for example evaluation tools • Group size, frequency and duration of PGS
8. Supports a safe alliance between group members	Group member personalities and group dynamics can impact group functioning and retention. It is important to provide the following: • Provide education on the dual roles of how to supervise and be supervised • Provide support and training on positive conflict resolution alongside the PGS model training • Provide PGS champions for assistance with resolving conflict • Provide information on group stages and dynamics • Ensure PGS is culturally safe for example include education and training in the PGS model training • Clear articulation of who to escalate concerns to for example the nurses' line manager
9. Evaluation determines efficacy	To determine effectiveness for group members and the organisation: • Evaluation must be standardised and a regular part of the supervision model • Reporting timelines and requirements must be determined
10. PGS ownership is for everyone	Ownership of PGS is for all involved from policy makers to individual nurses.

	• Healthcare organisations and health services will provide PGS as an option for nurses and make it available with the appropriate support, for example a PGS coordinator • Individual nurses will own their PGS as demonstrated through their participation, preparation and contribution • Groups will own their PGS as demonstrated through the provision of a safe environment for individual nurses to enhance their clinical practice

Table 5: Guidelines for the implementation of peer group supervision

9.11 Recommendations for future research

This research has provided insight into the experience of peer group supervision through the voices of nurses participating. The benefits and challenges of peer group supervision have been articulated through this research however future research may further add to peer group supervision knowledge. This research explored peer group supervision at two Australian sites therefore further research could explore additional contexts.

Future research including evaluation studies of nursing peer group supervision is necessary, especially as Bernard and Goodyear (2019) suggest “evaluation could be viewed as the nucleus of clinical supervision” (p.222). Research into evaluation could potentially include the development of tools specifically designed to evaluate peer group supervision, model selection and reasons for selection. Research detailing the education and training of nurses in the enactment of these models could also be valuable (Bernard & Luke, 2015). The interview data from this research could potentially inform a survey instrument used to explore and compare models of peer group supervision. From this a quantitative study could be developed which would greatly enhance decision-making for nurse managers on the practical and organisational management practices needed for implementation of peer group supervision.

Future research on the effectiveness of open (rotating membership) versus closed (fixed membership) groups is also required. Finally, the conundrum of the correlation between peer group supervision and the impact on patients has not been resolved and exploring this would be beneficial for nurses and nurse decision-makers. Future research could explore an association between nurses' level of job satisfaction and patient care satisfaction. That is, look for a way to operationalise this idea.

9.12 Conclusion

The aim of this research was to explore the experiences of nurses participating in peer group supervision. The research utilised a two phased approach with nurse participants who provided insight into their personal peer group experience. A Gadamerian philosophical approach guided the research to assist with understanding this phenomenon. The research findings demonstrated that the individual gained new perspectives and support from their peers.

There is commentary in the literature expressing concern about the implementation and effectiveness of peer group supervision (Martin, 2017). Part of the issue is that nurses have been trying to fit a square peg into a round hole by trying to mould a concept that has been used in the helping professions into something suitable for nursing. As McCaffery & Moules (2016) note “nurses cannot resist picking at a wound of self-identity” (p. 3). Proctor (2001) in Butterworth (2022) states “each group of professionals- need to develop supervision training, models and skills which are immediately useful and practicable in their own tasks and responsibilities” (p.21). My research suggests it is time we looked at peer group supervision through the nursing lens and articulate how can we make this “for and about us”. It is time for nurses to own peer group supervision.

Davey (2006) in Moules et al. (2015) asserted, “hermeneutics is not aimed at simply understanding or interpreting events in the world, but as a result of such understanding, the world (or parts of it) are necessarily changed” (p.190). It could be argued that this research might not change the world, but the hope is that it may be a catalyst for change in nursing and professional reflective value. The results demonstrate that there is a need for changing the way in which nurses view and own their peer group supervision for both their own professional and personal growth and wellbeing. The nurses’ voices in this research provided insight into the experiences of peer group supervision. These insights aided in understanding of considerations that must be taken into account to optimise the possibilities of peer group supervision practice. There are a multitude of factors that need to be considered during implementation to achieve optimal practice.

It may seem easier to offer one-to-one traditional clinical supervision or group supervision. Having a designated supervisor may appear to be a sensible decision. After all, if a supervisor can be educated to manage the group dynamics and keep everyone on track and take on the leadership role then why would managers consider any other form of clinical supervision? The reality is that supervisors do not come with a written guarantee. There can still be issues with group dynamics, broken trust, lack of respect and participants being unclear on their purpose.

Additionally, there is the extra consideration of who the supervisors will be and how they will be sourced and educated. Professional courtesy is suggestive that peer-led supervision is empowering and rewarding whereas many other roles in nursing require orders and permissions from other disciplines. Owning and engaging strategies provide a powerful tool for positive behaviour changes.

There is no one method that guarantees effective peer group supervision. It follows that optimal peer group supervision cannot be achieved through the efforts of nurses or nurse managers alone. It requires a coordinated top-down and bottom-up approach with input and consultation from all nurses involved. Therefore, implementing and sustaining this valuable practice requires careful consideration.

My research concludes that peer group supervision is identified as a positive, constructive, and powerful tool that can be peer-led. Nurses seek and desire the independence to constructively reflect with peers and with structure, peer group supervision is identified as a positive motivator and outlet for participants in the research. As nurses engaged in the process, reward was derived from the effort to engage. The ultimate reflection was one of a self-led, self-identified and self-owned approach where group support, guidance and mentorship were reciprocated. What is clear is that there is a need for peer group supervision, there is a desire for reflection and a willingness to identify professional and personal inclusions to a productive reflective process with peers.

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APPENDIX A: PHASE 1 PARTICIPANT INTERVIEW QUESTIONS

1. To start the interview can you please tell me what your role is in the organisation? How long have you worked here?

   Have you worked within the community health sector before this position with West Moreton Hospital and Health Service (WMHHS)? If so, what was your previous experience like?
2. You work in the community health setting where a model of PGS exists. In your own words share with me how you would define peer group supervision.
3. The registered nurse role has responsibilities within registration and employment standards. For example, Standard 1.2 of the RN standards of practice states the RN develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice. The model used here at WMHHS to facilitate reflective practice is peer group clinical supervision (PGS). Can you share with me your experience of PGS?
4. Can you share an example of a situation that demonstrated the positive aspects of PGS? Take your time and share all the aspects that you regard as
   a. important,
   b. what worked,
   c. what benefits you can identify,
5. Can you share an experience where you have had concerns with PGS?

   Take your time and share all the aspects that you regard as
   a. important,
   b. what didn't work,
   c. what challenges did you identify,
6. Knowing that you understand and work in an environment where PGS is normal practice, can you share with me your perspective on the transferability of PGS to other settings?
7. There are many influences within the workplace. Some make our roles easier and some pose barriers. Can you tell me about what influences the registered nurse role regarding peer group clinical supervision?

APPENDIX B: PHASE 1 PARTICIPANT INFORMATION SHEET/CONSENT FORM

Non-Interventional Study - *Adult providing own consent.*

Title of Project: Peer group clinical supervision for Community Health Nurses (CHNs): A proposed interpretive phenomenology study.
Name of Researcher: Mrs Tracey Tulleners- University of Southern Queensland
Name of Associate Researcher: Dr Melissa Taylor- University of Southern Queensland
Research site name: Ipswich Community Health- West Moreton Hospital and Health service (WMHHS)

Part 1 What does my participation involve?

1. Introduction

You are invited to take part in this research project about *the lived experience of Community Health nurses (CHN's) participating in peer group clinical supervision (PGS) in a regional health service".*

Participation in this project will involve your participation in a face-to-face interview for the purpose of:

- Participation in this research project will involve participants being interviewed by the principal investigator about their lived experience of being a Community Health nurses (CHN's) participating in peer group clinical supervision (PGS) in a regional health service.
- This Participant Information Sheet/Consent Form tells you about the research project. It explains the procedures involved. Knowing what is involved will help you decide if you want to take part in the research.

- Please read this information carefully. Ask questions about anything that you don't understand or want to know more about.

- Participation in this research is voluntary. If you don't wish to take part, you don't have to.

- If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:
    - Understand what you have read
    - Consent to take part in the research project
    - Consent to the tests and research that are described
    - Consent to the use of your personal and health information as described
    -
- You will be given a copy of this Participant Information and Consent Form to keep.

2. What is the purpose of this research?

- The intention of the research is to explore the lived experience of Community Health nurses (CHN's) participating in peer group clinical supervision (PGS) in a regional health service. The information gathered will attempt to identify challenges, benefits and any possible organisational challenges as seen by the clinical staff.
- It is presumed that the PGS model improves the support processes to registered nurses in the community health setting however these experiences have not been documented.
- Minimal research has focused on the experience of PGS for semi-autonomous/autonomous clinicians such as community health nurses.
- It is anticipated that the significance of the research project is seen in knowing the first-hand experience of staff utilising the PGS model to support their professional practice.
- By participating in this research, you are providing key information into the lived experience of Community Health nurses (CHN's) participating in peer group clinical supervision (PGS) in a regional health service.
- The results of this research will be used by the researcher Mrs Tracey Tulleners to obtain a Master of Science- Advanced Research.

3. What does participation in this research involve and what do I have to do?

- Participation in this research project will involve participants being interviewed by the principal investigator about their lived experience of being a Community Health nurses (CHN's) participating in peer group clinical supervision (PGS) in a regional health service.
- The interviews will be approximately one (1) hour in duration. These interviews will be in the form of a selected number of open-ended questions related to the topic of

the lived experience of PGS. The interviews will be conducted in a quiet location convenient to your workplace, to avoid excess travel.

- The interview will be video recorded and later transcribed into written form. You will be sent a written copy of the interview so that you can verify the accuracy of its contents and change or add to your responses.
- All information gathered within the interview will remain confidential and at no stage will your name or any identifiable information be required. Data analysis utilizes de-identified data only and all interviews will be allocated a code only.
- All collected information both by recordings and written word will be stored securely in a locked filing cabinet and in a password protected computer file only accessible by the principal researcher.
- The principal researcher will independently analyse the data and discuss data sets and analysis outcomes with the supervisory team through a checking and auditing process prior to the determination of concepts arising.
- There are no costs associated with participating in this research project, nor will you be paid.

4. Do I have to take part in this research project?

- Participation is entirely voluntary. If you do not wish to take part, you are not obliged to.
- If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Any information already obtained from you will be destroyed.

5. What are the possible benefits of taking part?

- The benefit of the research is in documenting the experience of RNs engaged in PGS to further improve and inform the contribution of PGS in practice in the community health setting.
- The significance is in learning more about staff experience by hearing directly from the staff engaged in the PGS model in the community health context.

6. What are the possible risks and disadvantages of taking part?

- To minimise any risk to you, you will be sent the transcript or the interview once it has been completed and given the opportunity to verify, clarify or make any additions that you see appropriate.

7. What if I withdraw from this research project?

- Your decision whether to take part or not to take part, or to take part and then withdraw will not affect your relationship with the University of Southern Queensland or your workplace with West Moreton Hospital and Health Service.
- Please notify the researcher if you decide to withdraw from this project.

Part 2 How is the research project being conducted?

1. What will happen to information about me?

- All information gathered within the interview will remain confidential and at no stage will your name or any identifiable information be required. Data analysis utilizes de-identified data only and all interviews will be allocated a code only.
- All collected information both by recordings and written word will be stored securely in a locked filing cabinet or in a password protected computer file only accessible by the principal researcher.

2. Complaints

- The research has been approved and will be monitored by the University of Southern Queensland Human Research Ethics committee. If you have any questions or concerns about the research at any time, you can raise these with the Ethics officer using the contact details set out below.
- If you have any ethical concerns with how the research is being conducted or any queries about your rights as a participant, please feel free to contact the University of Southern Queensland Ethics Office on the following details:

  Ethics and Research Integrity Officer
  Office of Research and Higher Degrees
  University of Southern Queensland
  West St Toowoomba 4350
  PH: 4631 2690
  Email: ethics@usq.edu.au

3. Who is organising the research?

This research project is being conducted by Mrs Tracey Tulleners

4. Who has reviewed the research project?

- All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of

this research project have been approved by the HREC of West Moreton Hospital and Health service and University of Southern Queensland.

- This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

5. Further information and who to contact

The person you may need to contact will depend on the nature of your query.
Should you have any queries regarding the progress or conduct of this research, you can contact the principal researcher:

Mrs Tracey Tulleners
School of Nursing and Midwifery
University of Southern Queensland
[redacted]

Consent Form - *Adult providing own consent.*

Title of Project: Peer group clinical supervision for Community Health Nurses (CHNs):proposed interpretive phenomenology study.

Name of Researcher: Mrs Tracey Tulleners- University of Southern Queensland

Name of Associate Researcher: Dr Melissa Taylor- University of Southern Queensland

Research site name: Ipswich Community Health- West Moreton Hospital and Health service (WMHHS)

Declaration by Participant

I have read the Participant Information Sheet, or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future studies or employment.

I understand that I will be given a signed copy of this document to keep.

I confirm that I am over 18 years of age.

Name of Participant (please print)_____

Signature_____Date_____

Name of Witness to Participant signature (please print)_____

Signature_____Date_____

* Witness is not to be the investigator, a member of the study team or their delegate. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. Witness must be 18 years or older.

Declaration by Senior Researcher†

I have given a verbal explanation of the research project; its procedures and risks and I believe that the participant has understood that explanation.

Name of Principal Researcher (please print)_____

Signature_____Date_____

† A senior member of the research team must provide the explanation of, and information concerning, the research project. Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation - *Adult providing own consent.*

Title of Project: Peer group clinical supervision for Community Health Nurses (CHNs): A proposed interpretive phenomenology study.

Name of Researcher: Mrs Tracey Tulleners- University of Southern Queensland

Name of Associate Researcher: Dr Melissa Taylor- University of Southern Queensland

Research site name: Ipswich Community Health- West Moreton Hospital and Health service (WMHHS)

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my employment with WMHHS or my relationship with the University of Southern Queensland (USQ).

Name of Participant (please _____

Signature _____ _____

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher will need to provide a description of the circumstances below.

Declaration by Senior Researcher†

I have given a verbal explanation of the implications of withdrawal from the research project, and I believe that the participant has understood that explanation.

Name of Senior Researcher† (please print _____

Signature _____ _____

† A senior member of the research team must provide the explanation of and information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own signature.

APPENDIX C: PHASE 2 PARTICIPANT INTERVIEW QUESTIONS

1. To begin with, can you please tell me what your role is in the organisation?
   How long have you worked here?
   Have you worked in any other Hospital and Health Services (HHS) that offer PGS? If so, where and for how long
2. You work in the (insert clinical area title) setting where a model of PGS exists. In your own words can you please share with me how you would define peer group supervision?
3. The registered nurse role has responsibilities according to registration and employment standards. For example, Standard 1.2 of the RN Standards of Practice states: the RN develops practice through reflection on experiences, knowledge, actions, feelings and beliefs to identify how these shape practice. The model used here at Metro South Hospital and Health Service (MSHHS) to facilitate reflective practice is peer group clinical supervision (PGS). Can you share with me your experience of PGS?
4. Can you describe your PGS group?
    a. You've told me about your role, what roles do the other members of your peer group have?
    b. How does someone become a member of your PGS group?
5. Can you share with me your understanding of peers within PGS?
    a. What does it mean to be a 'Peer'?
    b. What responsibilities come with being a peer in your experience?
6. Can you describe the positive and negative dynamics of your PGS group?
    a. What seems to work well in your group?
    b. What sort of things might cause tension from time to time?
    c. How are differences resolved?
7. Can you share an example of a situation that demonstrated the positive aspects of PGS? Take your time and share all the aspects that you regard as:
    a. Important,
    b. What worked?
    c. What benefits you can identify,

8. Can you share an experience where you have had concerns with PGS?

    Take your time and share all the aspects that you regard as:

    a. Important,
    b. What didn't work?
    c. What challenges did you identify?

9. Knowing that you understand and work in an environment where PGS is normal practice, can you share with me your perspective on the transferability of PGS to other health care settings?

    a. Do you think this model could be used in a range of settings?
    b. What barriers do you think might exist to its being taken up in places where it is not currently used?

10. There are many influences within the workplace. Some make our roles easier and some pose barriers. Can you tell me what the influences on the registered nurse are in regard to peer group clinical supervision here?

    a. What are the challenges to PGS in this workplace?
    b. Does anything to need to be modified/updated? If so what?

APPENDIX D: PHASE 2 PARTICIPANT INFORMATION SHEET/CONSENT FORM

Non-Interventional Study - *Adult providing own consent.*

Title of Project: The interpretation of Peer Group (clinical) Supervision in nursing: An interpretive phenomenological study

Name of Researcher: Mrs Tracey Tulleners- University of Southern Queensland

Name of Associate Researchers: Associate Professor Christina Campbell and Dr Melissa Taylor University of Southern Queensland (USQ)

Research site name: Metro South Hospital and Health service (MSHHS)

Part 1 What does my participation involve?

1. Introduction

You are invited to take part in this research project to explore *peer group clinical supervision (PGS) through the lived experience of nurses participating in a PGS model.*

- This Participant Information Sheet/Consent Form tells you about the research project. It explains the procedures involved. Knowing what is involved will help you decide if you want to take part in the research.
- Participation in this project will involve your participation in a face-to-face interview for the purpose of being interviewed by the principal investigator about your lived experience of being a nurse participating in a peer group clinical supervision (PGS) model in a tertiary health service.
- Please read this information carefully. Ask questions about anything that you don't understand or want to know more about.
- Participation in this research is voluntary. If you don't wish to take part, you don't have to.
- If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:
    - Understand what you have read
    - Consent to take part in the research project
- You will be given a copy of this Participant Information and Consent Form to keep

2. What is the purpose of this research?

- The intention of the research is to explore the lived experience of nurses participating in peer group clinical supervision (PGS) model in a tertiary health service. The information gathered will attempt to identify challenges, benefits and any possible organisational challenges as seen by the clinical staff.
- It is presumed that the PGS model improves the support processes to registered nurses in healthcare settings, however these experiences have not been clearly documented.
- It is anticipated that the significance of the research project is seen in knowing the first-hand experience of staff utilising the PGS model to support their professional practice.
- By participating in this research, you are providing key information into the lived experience of nurses participating in peer group clinical supervision (PGS) model in a tertiary health service.
- The results of this research will be used by the researcher Mrs Tracey Tulleners to fulfil the requirements of the Doctor of Philosophy (PhD).

3. What does participation in this research involve and what do I have to do?

- Participation in this research project will involve you being interviewed by the principal investigator about your lived experience of being a nurse participating in peer group clinical supervision (PGS) model in a tertiary health service.
- The interviews will be approximately one (1) hour in duration. These interviews will be in the form of a selected number of open-ended questions related to the topic of the lived experience of PGS. The interviews will be conducted either in a quiet location convenient to your workplace, to avoid excess travel or via videoconferencing platforms such as Zoom.
- The interview will be video recorded and later transcribed into written form. You will be sent a written copy of the interview so that you can verify the accuracy of its contents and change or add to your responses.
- All information gathered from the interview will remain confidential and at no stage will your name or any identifiable information be required. Data analysis utilises de-identified data and all interviews will be allocated a code only.
- All collected information both by recordings and written word will be stored securely in a locked filing cabinet and in a password protected computer file only accessible by the principal researcher.

- The principal researcher will independently analyse the data and discuss data sets and analysis outcomes with the supervisory team through a checking and auditing process prior to the determination of concepts arising.
- There are no costs associated with participating in this research project, nor will you be paid.

4. Do I have to take part in this research project?

- Participation is entirely voluntary. If you do not wish to take part, you are not obliged to.
- If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. Any information already obtained from you will be destroyed.

5. What are the possible benefits of taking part?

- The benefit of the research is in documenting the experience of RNs engaged in PGS to further improve and inform the contribution of PGS in healthcare practice.
- The significance is in learning more about nurses 'experience by hearing directly from nurses engaged in the PGS model in the tertiary healthcare context.

6. What are the possible risks and disadvantages of taking part?

- To minimise any risk to you, you will be sent the transcript of the interview once it has been completed and given the opportunity to verify, clarify or make any additions that you see appropriate.

7. What if I withdraw from this research project?

- Your decision whether to take part or not to take part, or to take part and then withdraw will not affect your relationship with the University of Southern Queensland (USQ) or with your workplace, Metro South Hospital and Health Service (MSHHS).
- If you decide to participate, but later to withdraw from this project, please notify the researcher.

Part 2 How is the research project being conducted?

1. What will happen to information about me?

- All information gathered from the interview will remain confidential and at no stage will your name or any identifiable information be required. Data analysis utilises de-identified data and all interviews will be allocated a code only.
- All collected information both by recordings and written word will be stored securely in a locked filing cabinet or in a password protected computer file only accessible by the principal researcher.

2. Complaints

- The research has been approved and will be monitored by the University of Southern Queensland Human Research Ethics committee. If you have any questions or concerns about the research at any time, you can raise these with the Ethics Officer using the contact details set out below.
- If you have any ethical concerns with how the research is being conducted or any queries about your rights as a participant, please feel free to contact the University of Southern Queensland Ethics Office as follows:

  Ethics and Research Integrity Officer
  Office of Research and Higher Degrees
  University of Southern Queensland
  West St Toowoomba 4350
  PH: 4631 2690
  Email: ethics@usq.edu.au

3. Who is organising the research?

This research project is being conducted by Mrs Tracey Tulleners

4. Who has reviewed the research project?

- All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of Metro South Hospital and Health Service and University of Southern Queensland.
- This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

5. Further information and who to contact

The person you may need to contact will depend on the nature of your query.

Should you have any queries regarding the progress or conduct of this research, you can contact the principal researcher:

Mrs Tracey Tulleners
School of Nursing and Midwifery
University of Southern Queensland

[redacted]

Consent Form - *Adult providing own consent.*

Title of Project: The interpretation of Peer Group (clinical) Supervision in nursing: An interpretive phenomenological study

Name of Researcher: Mrs Tracey Tulleners- University of Southern Queensland

Name of Associate Researchers: Associate Professor Christina Campbell and Dr Melissa Taylor University of Southern Queensland (USQ)

Research site name: Metro South Hospital and Health service (MSHHS)

Declaration by Participant

I have read the Participant Information Sheet, or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future studies or employment.

I understand that I will be given a signed copy of this document to keep.

I confirm that I am over 18 years of age.

Name of Participant (please print)_____

Signature_____Date_____

Name of Witness to Participant signature (please print)_____

Signature_____Date_____

* Witness is not to be the investigator, a member of the study team or their delegate. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. Witness must be 18 years or older.

Declaration by Senior Researcher†

I have given a verbal explanation of the research project; its procedures and risks and I believe that the participant has understood that explanation.

Name of Principal Researcher (please print)_____

Signature_____Date_____

† A senior member of the research team must provide the explanation of, and information concerning, the research project. Note: All parties signing the consent section must date their own signature.

Form for Withdrawal of Participation - *Adult providing own consent.*

Title of Project: The interpretation of Peer Group (clinical) Supervision in nursing: An interpretive phenomenological study

Name of Researcher: Mrs Tracey Tulleners- University of Southern Queensland

Name of Associate Researchers: Associate Professor Christina Campbell and Dr Melissa Taylor University of Southern Queensland (USQ)

Research site name: Metro South Hospital and Health service (MSHHS)

Declaration by Participant

I wish to withdraw from participation in the above research project and understand that such withdrawal will not affect my employment with MSHHS or my relationship with the University of Southern Queensland (USQ).

Name of Participant (please _____

Signature _____ _____

In the event that the participant's decision to withdraw is communicated verbally, the Senior Researcher will need to provide a description of the circumstances below.

Declaration by Senior Researcher†

I have given a verbal explanation of the implications of withdrawal from the research project, and I believe that the participant has understood that explanation.

Name of Senior Researcher†

(please print) _____

Signature _____ _____

† A senior member of the research team must provide the explanation of and information concerning withdrawal from the research project.

Note: All parties signing the consent section must date their own sign

APPENDIX E: CODING PROGRESSION EXAMPLE

Coding 1	Coding 2	Coding 3	Coding 4	Coding 5
Employment position	Employment position	Employment position	Participant roles	The unique individual
Give and take	Give and take	Recommendations	Peer group supervision practice	For me
Group dynamics	Group dynamics	Not for everyone	There needs to be value	About me
Size matters	Exposure	The Art of PGS	Recommendations	Beyond me
Group rules	Size matters	There needs to be value	Not for everyone	The unique group
Is PGS vital	Group rules	The cohesive group	The foundations	Working together
Not for everyone	Is PGS vital	Group dynamics	Attendance matters	Our rules
Other sources	Not for everyone	Peers	Finding peers	My peers
Own your PGS	Other sources	Size matters	Participation is important	Broken trust
PGS attendance	Own your PGS	Group rules	Professional obligations	The foundations
PGS is not just for us	PGS attendance	The ugly- Broken trust	The unique group	Professional obligations
Safe place	PGS is not just for us	The foundations	Broken trust	Participation is important
Shared values	Safe place	PGS attendance	My peers	Finding peers
The Art of PGS	But cautious	Professional obligations	Our rules	Attendance matters
The bad (barriers to PGS)	Shared values	Where are our peers	Working together	Recommendations
The good (benefits)	The Art of PGS	Who should participate	Size matters	Not for everyone
Future me	There needs to be value	The unique individual	The unique individual	Peer group supervision practice
The purpose of PGS	The bad (barriers to PGS)	About me	About me	There needs to be value
The ugly- Broken trust	The good (benefits)	Own your PGS	My story	Participant roles

We are in this together	Future me	PGS is two way	There is purpose	
Where are our peers	Miss it	The purpose of PGS	Two way street	
Who is in my group	They understand	Beyond me	Beyond me	
Who should participate	The purpose of PGS	PGS is not just for me	Not just for me	
	The ugly- Broken trust	We are in this together	We are in this together	
	We are in this together	For me	For me	
	Where are our peers	New Lens	New Lens	
	Who is in my group	Safe place	Restore me	
	Who should participate	But cautious	Safe place	
		Support and restore	But cautious	
		They understand		