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ORIGINAL ARTICLE

WILEY

Nurses and midwives' experiences with peer-group clinical supervision intervention: A pilot study

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Abstract

Aim: This study aimed to evaluate differences in supervisees' understanding of clinical supervision and their perceptions of organisational functioning before and after engaging in peer-group clinical supervision.

Background: Protected reflective time allows discussion of complex issues affecting health care. Peer-group clinical supervision is one model of clinical supervision that could facilitate this, but it is poorly understood.

Methods: A pre–post intervention pilot study was performed. The intervention was delivered over a 12-month period. Data were collected using surveys on demographic and work-related factors and experience of clinical supervision pre- and post intervention.

Results: Adaptability increased significantly between the pre- and post surveys. The post survey data showed finding time for clinical supervision scoring lowest with open-ended comments reinforcing this. The supervisees found the sessions to offer a safe place despite initial concerns.

Conclusion: The peer-group model of clinical supervision allowed supervisees to build a rapport and trust with their colleagues and share experiences.

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Implications for Nursing Management: The benefits to participating in peer-group clinical supervision traversed the individual and organisation. These data support the implementation of such sessions while addressing workload and time pressures to aid participation.

KEYWORDS
clinical supervision, intervention, nursing, peer group, pilot study

1 | BACKGROUND

Clinical supervision has been defined as a formal regular event, supervised by trained individuals, in which qualified nurses can reflect on their clinical practice with the purpose of advancing their care (Cleary et al., 2010). Clinical supervision is internationally recognized as being an integral part of professional health care practice (Gonge & Buus, 2015) and recommended as a process of learning and professional support (Fowler, 2010). In Ireland, national policy recommends its use with all mental health nurses (O'Shea et al., 2019), and indeed, the Irish health service has made recommendations for its implementation across all health and social care disciplines (Health Service Executive [HSE], 2015) similar to Australia (Australian College of Nursing, 2019) and the United Kingdom (Nursing and Midwifery Council, 2018). Despite these mandates, there is limited empirical evidence on the format, nature and outcomes of clinical supervision for nurses (Markey et al., 2020; Pollock et al., 2017).

While it has been well established that nurses require clinical supervision throughout their career (Driscoll et al., 2019), Pollock et al. (2017) found the majority of studies have been conducted in mental health or counseling settings, with limited research from a broader nursing perspective. Further, there is a paucity of research on the direct benefits of clinical supervision for patients (Rousmaniere et al., 2016), but there is evidence to suggest that clinicians benefit from enhanced self-awareness, self-efficacy and increased knowledge (Watkins, 2011; Wheeler & Richards, 2007).

The role of clinical supervision on the functioning of the organisation is an important consideration (Best et al., 2014; Martin et al., 2019). Organisational functioning refers to the core activities conducted in that organisation, and clinical supervision can highlight organisational factors that need improving, such as resources or organisational climate. Establishing staffs' views of organisational factors and determining if these are improved through clinical supervision can be informative for the organisation, particularly in directing resources for the delivery of high-quality care. Conversely, organisational factors, such as staffing, are important to the effective delivery of clinical supervision (Gonge & Buus, 2016). However, nurses and midwives' understanding of clinical supervision is not fully known, and there is a lack of obvious measurable benefits for organisations (Dilworth et al., 2013; Saab et al., 2020).

There is no one model of clinical supervision that suits all settings (Milne et al., 2008; Saab et al., 2020). Peer-group clinical supervision, where staff at the same or similar levels support each other in the advancement of clinical practice, is a form of clinical supervision. It is poorly defined in the literature, and as a result, facilitated peer-group clinical supervision is understudied with little published research on its effect or impact on clinical practice (Borders, 2012).

2 | AIM

This study aimed to evaluate differences in supervisees' understanding of clinical supervision and perceptions of organisational functioning before and after engaging in 12 months of peer-group clinical supervision.

3 | MATERIALS AND METHODS

3.1 | Design

A quantitative pilot study using a pre–post intervention design was conducted. Data were collected, using structured surveys with some open-ended questions, before and after the intervention. The EQUATOR network recommendations for quantitative data (STROBE) were used in the reporting of this study (Vandenbroucke et al., 2007).

3.2 | Intervention

The intervention was the delivery of peer-group clinical supervision to nurses and midwives (Nursing and Midwifery Planning and Development Unit, 2018) using Proctor's model (Proctor, 2008). Proctor's model delineates the purpose of formative, restorative and normative functions in clinical supervision (Figure 1), which linked well with the goal of the intervention to enable lifelong learning through reflection for nurses and midwives.

In total, twelve sessions were held, one a month over a 12-month period. Each session lasted an hour. The focus of the sessions was on the role of the individual staff member to enable effective professional practice and included sessions addressing quality of work, decision-making, information receipt/delivery and work issues (Nursing and Midwifery Planning and Development Unit, 2018). Staff were nominated for the intervention by their direct manager. Before the intervention began, the supervisors and supervisees (participants) agreed and signed a document relating to learning goals, legal and



FIGURE 1 Proctor's model of clinical supervision

ethical considerations, working relationships and feedback from the intervention (Nursing and Midwifery Planning and Development Unit, 2018).

The sessions were facilitated by four supervisors who held appropriate accreditation for this role. Although supervisor-led peer-group clinical supervision is unusual, it was the structure chosen for the intervention due to limited numbers of supervisees with clinical supervision experience (Sheppard et al., 2018). Supervisees were given the chance to relay their experiences with colleagues and get feedback from both their colleagues and the experienced supervisors. This process was adopted in order to improve teamwork, team cohesion and quality of work (Nursing and Midwifery Planning and Development Unit, 2018). Supervisors maintained written records of the sessions, and supervisees were advised to keep a reflective journal.

3.3 | Setting and sample

The sessions took place at a work-based location that was free from distraction and offered privacy from the participants' day-to-day activities. As this was an intervention being delivered to staff, there were restrictions on group size and delivery. Supervisees were invited from four different service areas (Figure 2). The service areas represented were acute care five groups, $n = 29$ supervisees; intellectual disability nursing two groups, $n = 12$ supervisees; public health nursing (community) two groups, $n = 11$ supervisees; mental health nursing one group, $n = 5$ supervisees. Therefore, peer-group clinical supervision was offered to 10 groups of staff across nine sites in the south of Ireland, beginning in September 2018.

All supervisees were eligible to participate in this study ($n = 57$). Attendance rates at each of the sessions ranged from 50% to 87% at the various sites throughout the 12-month period. Each of the 10 groups consisted of 4–6 staff of the same grade. Five supervisees did not complete the full 12 months due to leave (maternity, sick), and one supervisee joined a group after the project began.

3.4 | Procedures

Prior to the start of the peer-group clinical supervision intervention, supervisees were told that the outcomes of the project were being evaluated using research methods, and they were not obliged to participate. They were reassured that non-participation in the research would not affect their participation in the sessions. All supervisees were provided with a written information leaflet that gave further details of the study. Participation in the research study involved completing a survey before the commencement of the peer-group clinical supervision intervention (pretest) and after completing the intervention (post-test).

Once consent was obtained, the project lead distributed the surveys to consenting supervisees. Data were confidential, and no identifying information appeared on the surveys. To ensure anonymity but to enable pre- and post intervention data to be matched, supervisees were asked to complete a unique code using the first letters of their parents' names and the last three digits of their mobile phone number.

3.5 | Ethics

The Clinical Research Ethics Committee affiliated to the researchers' university granted ethical approval (Reference Number: ECM 4 (m) 03/07/18). All participants gave written informed consent.

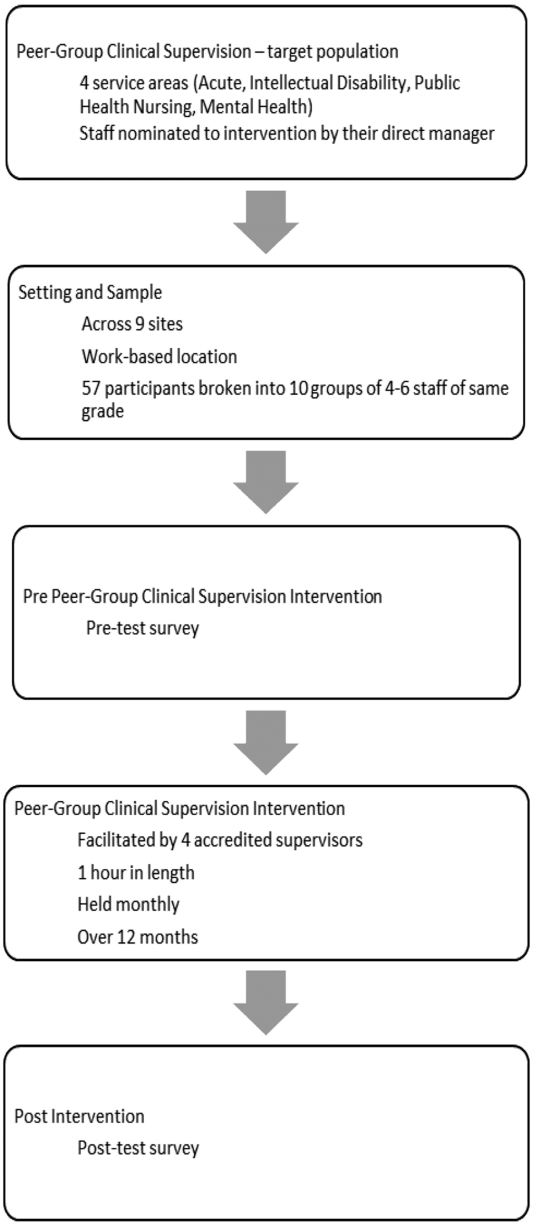


FIGURE 2 Study process

3.6 | Data sources/measurement

The survey was purposefully designed comprising of standardized and validated instruments and was reviewed by experts in relation to content before use. The pre-intervention survey included several demographic and work-related questions in addition to questions about supervisees' prior experience of clinical supervision.

Supervisees' perceptions of how their organisation functions were measured using selected items from the Survey of Organisational Functioning (SOF) (Institute for Behavioral Research, 2008). This is a standardized tool with subscales from the Organisational Readiness to Change instrument, which have been validated and demonstrate good internal consistency (Lehman et al., 2002). Five scales were used: Motivation for change, Resources, Staff attributes, Organisational Climate and Job attitudes, and these accounted for 19 subscales (Table 1). Items were scored on a 1–5 Likert scale with 1 = *strongly disagree* and 5 = *strongly agree*.

Four open-ended questions sought information on supervisees' understanding of clinical supervision: reasons for participating in peer-group clinical supervision, concerns around their participation and what they would like to achieve from the process.

3.7 | Post-intervention data

Supervisees' perceptions of organisational functioning were remeasured, using the SOF, post-intervention. In addition, their overall experiences of participating in peer-group clinical supervision were measured using the 26-item version of the Manchester Clinical Supervision Scale© (MCSS-26©) (Winstanley & White, 2011). The MCSS-26© is a validated measure of the effectiveness of clinical supervision and contains twenty-six items (divided into six subscales), scored on a 5-point Likert scale, with 0 = *strongly disagree* through to 4 = *strongly agree*, and a theoretical range of 0–104. The total scale score was calculated by summing all six subscales (Table 1). The MCSS-26© is only suitable for use after a participant has gone through the clinical supervision process (Winstanley & White, 2019) and was included in the post-intervention survey only.

Finally, three open-ended questions were asked enquiring about the meaning of clinical supervision to supervisees, the benefits (if any) of participation in peer-group clinical supervision and the perceived facilitators and inhibitors to participation in peer-group clinical supervision.

3.8 | Data analysis

All statistical analyses were performed using SPSS Version 26 (IBM, Armonk, NY, USA). Age was categorized (21–30; 31–40; 41–50; 51–60; >60 years). A small number of items had missing data in the SOF and MCSS scales. These were replaced by item mean substitution (for SOF, no more than five responses were missing for any one item, one supervisee had not completed any of the MCSS scale, and they were eliminated from the analysis).

Scores on the SOF were reversed for 12 items, and total scores for each subscale were calculated by adding together the scores for each set of items, dividing the sum by the number of items included and multiplying by 10 to rescale the final scores. As a result, total scores for each subscale ranged from 10 to 50.To test for differences between pre- and post-survey responses, paired samples *t* tests were performed.

Scores on the MCSS-26© were reversed for nine items, and total scores for each subscale were calculated by adding the scores for each item together. As a result, the range of raw scores for each subscale differed.

Data from open-ended responses were subjected to analysis for commonly recurring themes (Braun & Wilkinson, 2003).

TABLE 1 Survey of organisational functioning and Manchester Clinical Supervision Scale©—Scales, subscales, pre- and post-test scale reliability (Cronbach's α)

Instrument, scales and subscales	Items	Pretest α	Post-test α
Survey of organisational functioning (SOF)			
Motivation for change			
Programme needs	8	.85	.80
Pressures for change	7	.65	.64
Resources			
Staffing	6	.74	.70
Training	4	.74	.65
Computer access	7	.47	.57
e-Communications	4	.70	.58
Staff attributes			
Growth	5	.85	.81
Efficacy	5	.60	.65
Influence	6	.81	.71
Adaptability	4	.62	.54
Organisational climate			
Mission	5	.64	.69
Cohesion	6	.81	.83
Autonomy	5	.60	.54
Communication	5	.73	.58
Stress	4	.81	.77
Change	5	.72	.63
Job attitudes			
Burnout	6	.78	.75
Satisfaction	6	.73	.76
Director leadership	9	.97	.96
Manchester Clinical Supervision Scale© (range 0–104)	26	--	.88
Importance/value of clinical supervision (range 0–20)	5	--	.68
Finding time (range 0–16)	4	--	.80
Trust/rapport (range 0–20)	5	--	.34
Supervisor advice/support (range 0–20)	5	--	.76
Improved care/skills (range 0–16)	4	--	.81
Reflection (range 0–12)	3	--	.74

4 | RESULTS

4.1 | Sample characteristics

A total of 51 supervisees completed pretest surveys (Table 2). The majority ($n = 48$; 94%) were female aged between 31 and 60 years ($n = 47$; 92%). Most had a bachelor's or a master's level qualification in nursing ($n = 36$; 71%), and almost all had >5 years of nursing/midwifery experience. Most supervisees were working in a clinical nurse/midwife manager role ($n = 42$; 82%). Over half were working in general acute nursing settings ($n = 26$; 51%), and 49% ($n = 25$) had been in their current role for >5 years.

4.2 | Perceptions of organisational functioning

A total of 36 supervisees completed pre- and post-surveys (29% lost to follow-up). There was a significant increase in adaptability for supervisees between the pre- and post-surveys. However, albeit non-significant, mean scores for cohesion and training decreased between the measurements and communication increased (Table 3).

Table 4 gives details on the supervisees' perceptions of the effectiveness of clinical supervision. These data were collected in the post-intervention survey. Overall, the total mean score on the MCSS-26© for all supervisees was 80.3, which is above the indicative threshold (mean 73.0) for efficacious clinical supervision provision

TABLE 2 Sample characteristics ($n = 51$)

	n	(%)
Sex		
Female	48	(94)
Male	3	(6)
Age		
21–30 years	3	(6)
31–40 years	17	(33)
41–50 years	16	(31)
51–60 years	14	(28)
>60 years	1	(2)
Level of education		
Apprenticeship nurse training	7	(14)
Diploma in nursing/midwifery	8	(16)
Degree	31	(60)
Masters	5	(10)
Experience in nursing		
4–5 years	1	(2)
Over 5 years	50	(98)
Current role		
Staff nurse/midwife	4	(8)
Clinical nurse/midwife manager	42	(82)
Clinical nurse/midwife specialist	4	(8)
Advanced nurse/midwife practitioner	1	(2)
Current area of practice		
General acute nursing	26	(51)
General community nursing	10	(20)
Midwifery	1	(2)
Mental health nursing	5	(10)
Intellectual disability nursing	9	(17)
Length of time in current job		
Under 6 months	4	(8)
6–11 months	6	(12)
1–3 years	13	(25)
4–5 years	3	(6)
Over 5 years	25	(49)
Prior experience of clinical supervision		
Yes	6	(12)

(Winstanley & White, 2019). The subscale 'Finding Time' obtained the lowest mean score although still above benchmark data.

4.3 | Open-ended question themes—Pre-peer-group clinical supervision

A total of 51 supervisees provided responses to the four open-ended questions. Almost all supervisees understood clinical supervision as one or more of the following: a means of giving/getting support to/from colleagues, a means of reflecting on their practice, shared learning through discussion or developing professional knowledge. One supervisee reported not having any understanding of clinical supervision. Two themes were identified from the data: fears around role/position and feasibility to complete peer-group clinical supervision and positives peer-group clinical supervision would bestow on supervisees.

4.3.1 | Theme 1: Fears around role/position and feasibility to complete peer-group clinical supervision

Several supervisees identified isolation in their role/area of work or being new to a team/role as a reason for participating in peer-group clinical supervision. Others reported the sharing of information, development of practice, learning from and liaising with others and reducing stress as their reason for participation. Eight supervisees reported being involved because their line manager selected them, or they wanted to help others or to get 'time off the floor.' However, some supervisees had concerns about participating in clinical supervision. Two major concerns reported were maintaining confidentiality and not having the time to commit to supervision. Supervisees who expressed concerns about confidentiality were worried that they would feel 'judged by fellow group members.' Concerns about time were related to the apprehension about not being able to commit to supervision, but some supervisees viewed supervision as an addition to their workload: 'Current workload very demanding, having anything extra to do on top of this may add extra stress.'

4.3.2 | Theme 2: Positives peer-group clinical supervision would bestow on them

Supervisees had expectations in relation to the positive results peer-group clinical supervision would bestow on them. The main expectation held by supervisees was that engagement in clinical supervision would help to improve their practice. One supervisee commented that through developing 'better self and professional awareness,' they could become 'a better manager and caregiver.' Other supervisees sought support from their peers, highlighting the importance of 'greater bonding and understanding, ability to support and be supported.' Four supervisees voiced concerns about occupational stress and hoped that clinical supervision would result in experiencing 'less stress' at work. A small number of supervisees felt their role was ill-defined or that they felt invalidated in their role. One supervisee hoped that engagement in clinical supervision would result in 'greater understanding of [their] role,' whereas another had no expectations for the process and that they were only engaging in clinical supervision in order 'to appease management.'

TABLE 3 Survey of organisational functioning—Differences in responses pre- and post-participation in peer-group clinical supervision, mean and standard deviation (SD) ($n = 36$)

	Presurvey mean (SD)		Postsurvey mean (SD)		Mean difference	Significance[a]	
						t	*p*
Motivation for change							
Programme needs	34.5	(7.5)	33.7	(7.7)	−0.8	0.59	.56
Pressures for change	34.8	(5.8)	34.0	(6.2)	−0.8	0.72	.48
Resources							
Staffing	28.1	(7.5)	28.1	(7.2)	0	0.00	1.00
Training	32.0	(9.4)	30.8	(8.8)	−1.2	0.91	.37
Computer access	27.9	(5.4)	27.9	(5.7)	0	−0.11	.92
e-Communications	34.4	(9.3)	33.6	(7.8)	−0.8	0.75	.46
Staff attributes							
Growth	32.6	(9.7)	33.4	(8.4)	0.8	−0.75	.46
Efficacy	39.5	(4.9)	40.2	(4.9)	0.7	−0.96	.34
Influence	39.1	(5.6)	39.6	(5.0)	0.5	−0.80	.43
Adaptability	37.6	(5.6)	39.2	(5.2)	1.6	−2.24	.03*
Organisational climate							
Mission	32.4	(6.8)	32.7	(6.6)	0.3	−0.30	.77
Cohesion	37.9	(7.0)	36.1	(7.4)	−1.8	1.82	.08
Autonomy	33.7	(6.7)	33.1	(6.2)	−0.6	0.62	.54
Communication	30.1	(7.3)	32.2	(7.4)	2.1	−1.96	.05
Stress	37.6	(8.8)	36.7	(8.4)	−0.9	0.77	.44
Change	32.8	(7.4)	32.8	(6.3)	0	−0.07	.95
Job attitudes							
Burnout	28.7	(7.9)	28.3	(6.9)	−0.4	0.36	.72
Satisfaction	37.5	(6.7)	37.5	(6.4)	0	0.52	.96
Director leadership	35.5	(10.8)	35.6	(9.6)	0.1	−0.06	.95

[a]*t* statistic and *p* value from paired sample *t* tests.
*$p \leq .05$ statistically significant.

TABLE 4 Mean scores and standard deviation (SD) on MCSS-26© for supervisees in addition to benchmark MCSS-26© scores $n = 46$

MCSS© 26 factor	(Minimum, maximum)	Mean (SD)	Benchmark data from MCSS-26©
Importance/value of clinical supervision	(10, 20)	16.8 (2.8)	15.8
Finding time	(0, 16)	9.2 (3.9)	8.6
Trust/rapport	(9, 20)	16.1 (2.9)	15.7
Supervisor advice/support	(6, 20)	14.9 (3.4)	14.1
Improved care/skills	(4, 16)	12.9 (2.8)	12.2
Reflection	(6, 12)	10.5 (1.6)	10
Total score	(48, 103)	80.3 (12.6)	73

Abbreviation: MCSS©, Manchester Clinical Supervision Scale©.

4.4 | Post-peer-group clinical supervision

A total of 47 supervisees provided responses to the three open-ended questions in the post-intervention survey. Two overarching themes were identified: shared experiences and other demands.

4.4.1 | Theme 1: Shared experiences

Supervisees reported peer-group clinical supervision sessions to represent a space to meet with their colleagues and peers to engage in discussion and reflect on any issues and concerns that

they may have in their workplace settings. Many saw it as a 'safe place' and as an opportunity to learn from their colleagues' experiences. Key words that frequently arose in supervisees' responses were 'support,' 'reflect,' 'sharing,' 'learning,' 'safe' and 'confidential.'

The main perceived benefit of peer-group clinical supervision was that it offered staff dedicated and protected time to share their clinical experiences, problems and vulnerabilities with colleagues. Supervisees valued the opportunity to work as a group to solve problems, rather than in isolation. For many, participation in peer-group clinical supervision lessened feelings of isolation, where everyone was 'in the same boat.' Three supervisees commented specifically that participation made them better understand the limitations of their role.

Peer-group clinical supervision also offered supervisees the opportunity to get to know colleagues, including those that may work in different departments, with one supervisee commenting that supervision 'allowed me to get to know and spend time with my peers … gave deeper understanding of our colleagues' pressures and stresses' and another stating that it helped in 'developing a good working relationship with colleagues from different departments within the hospital.'

4.4.2 | Theme 2: Other demands

'Time' was a frequent response for supervisees when asked about factors that facilitated and inhibited their participation in peer-group clinical supervision. The provision of protected time and an acceptance of this by line managers was identified as one of the most important facilitators for attending peer-group clinical supervision sessions. Travel time to attend the sessions was an issue for those who worked outside of the settings in which the intervention took place. Other factors that were perceived to inhibit participation were heavy workloads, competing demands and difficulties 'coming off the floor,' with one supervisee commenting that there are 'plenty of jobs to be done instead.' Factors that were perceived to facilitate participation in the sessions were having rooms booked and dates planned out well in advance.

5 | DISCUSSION

5.1 | Summary

The aim of this pilot study was to evaluate supervisees' understanding of clinical supervision and their perceptions of organisational functioning prior to and following engaging in peer-group clinical supervision for 12 months. The pre-intervention data suggest that nurses and midwives have a limited understanding of peer-group clinical supervision and may not fully appreciate the benefits of this process. However, concerns around confidentiality and being 'judged' expressed prior to engaging in peer-group clinical supervision were alleviated, with supervisees perceiving peer-group clinical supervision as a safe, confidential space and reporting an enhanced sense of trust and rapport amongst colleagues. Furthermore, the item 'importance/value of clinical supervision' obtained the highest mean score on the MCSS-26©, indicating that peer-group clinical supervision was experienced as a meaningful and important process for supervisees.

5.2 | Comparison with previous knowledge

Although 'clinical supervision' as a concept is poorly understood (Sheppard et al., 2018), it is known that this process is highly valued by attendees (Cook et al., 2020; Martin et al., 2019; Saab et al., 2020). The current study suggests that such benefits also extend to the group model of clinical supervision. However, given the lack of research around peer-group clinical supervision (Borders, 2012; Pollock et al., 2017) and the benefits available to nurses and midwives, this process needs to be further promoted, and prejudices challenged.

Engaging in peer-group clinical supervision was perceived to enhance organisational adaptability. Organisational adaptability relates to its staff members' willingness to embrace new approaches and procedures, in addition to the speed at which they are comfortable making changes. Health care organisations are often criticized for how slow they are to adapt or how reluctant they are to implement changes (Bermúdez-Tamayo et al., 2017; Brooks, 2017; Côté-Boileau et al., 2019; Dugstad et al., 2019). Interventions that have a positive impact on organisational adaptability, such as peer-group clinical supervision, should be embraced within health care to ensure patients receive the highest quality evidence-based care. Further, Proctor's model facilitated a structured and organized delivery of peer-group clinical supervision (Turner & Hill, 2011).

Although our data did not show a statistically significant change in communication, there was an improvement to this. Conversely, mean scores for both cohesion and training decreased post-intervention, though both were non-significant. Open-ended responses indicate that supervisees felt a sense of cohesion within the group and commented positively on how they were able to support one another and share information with each other. This discrepancy suggests that some of the direct benefits of peer-group clinical supervision were limited to supervisees and may not impact on the health care organisation itself. It should be noted that clinical supervision can benefit multiple stakeholders, including patients, organisations and the health care staff themselves (Martin et al., 2019). Furthermore, although supervisees may not have observed changes, satisfied staff members have a positive effect on organisational performance (Kuzey, 2018). Future studies on peer-group clinical supervision should consider a longitudinal approach to identify how engaging in supervision indirectly benefits the health care system over an extended period.

5.3 | Implications for nursing management

Prior to the intervention, supervisees expressed concerns about their ability to commit to supervision, citing time as a significant perceived barrier. Despite the protected time afforded to supervisees, our data indicated that 'finding time' was still a challenge. Having protected time is a crucial component of supervision (Hall, 2018); nevertheless, staff who have engaged in clinical supervision (Cook et al., 2020; Dawson et al., 2012; Martin et al., 2016, 2019) and peer-group clinical supervision (Buus et al., 2018) consistently report time to engage as challenging. Dawson et al. (2012) reported that although those who engage in supervision are afforded protected time, the commitment to attend supervision increases work-related pressure. In order to reduce such pressures, it has been recommended that additional staff members are employed, thus allowing for adequate time to engage in supervision (Martin et al., 2016); however, ensuring adequate staffing can be a challenge for any health service (Bridges et al., 2019). A paradigm shift is necessary, with provisions made to accommodate nurses and midwives in attending clinical supervision and considerations made for how this impacts on workload.

5.4 | Strengths and limitations

This pilot study has allowed the evaluation of a peer-group clinical supervision intervention and provided valuable information in relation to how this could be rolled out on a larger scale. Future studies on peer-group clinical supervision should adopt a longitudinal design to assess if the benefits of supervision are prolonged rather than surveying participants at only one point in time. Researcher observation of the peer-group clinical supervision sessions may allow reflexivity on the issues raised in the open-ended responses (Williams, 2008); however, this may also have a negative effect on the sessions. The pilot study was conducted in one area in the south of Ireland with a small sample size, limiting its generalizability of results to other settings. Males were underrepresented, as were advanced nurse/midwife practitioners and midwives.

5.5 | Conclusion

With clinical supervision becoming standard practice within health care settings, it is crucial that staff members are more aware of its purpose. Participants in this pilot study displayed initial skepticism towards peer-group clinical supervision; however, after participating in this process, several benefits were reported. These included direct benefits (shared knowledge with peers, support) and benefits to the organisation (enhanced adaptability). The implementation of peer-group clinical supervision requires further development as supervisees perceived their attendance as supplemental to their role and struggled to maintain their usual practices. Such practical concerns need to be considered when embedding a sustainable model of clinical supervision within nursing and midwifery roles.

ETHICAL CONSIDERATIONS

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

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CONFLICT OF INTEREST

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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