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FEATURE ARTICLE

Introducing peer-group clinical supervision: An action research project

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ABSTRACT: *Clinical supervision (CS) has been found to be beneficial in the role development of nurses and can contribute to increased job satisfaction and reduced burnout. However, implementing CS can be resource intensive, and there are few accounts of it being implemented in developing countries. Ten psychiatric nurses in Trinidad engaged in an action research project over a 5-month period to develop, implement, and undertake an initial evaluation of a model of peer-group CS for use in routine practice. The participants were involved in undertaking peer-group CS and contributing to monthly focus groups to reflect on the practices and further refine the model. This inexpensive form of CS was perceived by participants to have positive effects on the way they viewed and practiced nursing. An outline of the model and initial evaluation is presented, but further research is necessary to establish the sustainability of the model in practice.*

KEY WORDS: *action research, clinical supervision, group supervision, peer-group supervision.*

INTRODUCTION

Clinical supervision (CS) may be loosely defined as an exchange between practising professionals to enable the development of professional skills (Butterworth & Faugier 1992). Proctor (1986) suggested that it has three main functions: to enhance professional accountability (normative), to increase skills and knowledge (formative), and to facilitate collegial and supportive relationships (restorative). Recent reviews confirm that CS can realize these functions (Brunero & Stein-Parbury 2008; Butterworth *et al.* 2008). CS has also been associated with reductions in staff burnout (Edwards *et al.* 2006), increased job satisfaction (Hyrkäs *et al.* 2006), and the improved mental health of nurses (Ohlson & Arvidsson 2005). Nurses who receive CS have been found to value and express satisfaction with it (Hancox *et al.* 2004; Veeramah 2002). Yet the availability and uptake of CS has been found to be inconsistent, even in relatively well-resourced countries (Butterworth *et al.* 2008; White & Roche 2006).

There are numerous models of supervision that stress different functions or processes within CS. Models also have differing underlying assumptions regarding the nature of the nurse–patient relationship and how this relationship might best be examined and developed. As Fowler (1996) observed, accounts of models of supervision often lack precision in describing how the model may work and tend to focus on philosophical assumptions rather than pragmatic considerations. This contributes to difficulties in introducing CS, particularly when resources are scarce.

Nurses have been found to view with suspicion and react with resistance to the perceived imposition of CS (Cottrell 2002; Walsh *et al.* 2003; Wilkin *et al.* 1997). Having a choice of supervisor, and convening sessions away from the workplace (and management gaze), have been found to be associated with greater satisfaction with CS (Edwards *et al.* 2005). It has also been suggested that clear demarcations between management supervision and CS should to be made in nursing (Cutcliffe & Hyrkäs

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2006; Yegdich 1999). Nevertheless, managerial support and a sense of collaboration between clinicians, educationalists, and management appear important for successful implementation (Spence *et al.* 2002).

There have been no published examples of CS being implemented in any form in Trinidad and Tobago. This twin island republic has a population of approximately 1.3 million people of largely African and east Indian ethnicity. It is a 'developing' nation that enjoys high literacy, low infant mortality, and relatively high life expectancy, but continues to experience relative poverty and related social problems. Trinidad and Tobago has one psychiatrist, 11.5 psychiatric nurses, and 102.9 psychiatric beds (in both general and psychiatric hospitals) per 100 000 people, and very few allied health staff relative to developed countries (WHO 2005). In a report for the World Health Organization, Austin (2007) asserted that the Caribbean faces challenges relating to the stigma of mental illness, retention, and professional development of personnel, and the regulation of health-care practice. She recommended the development of team building and leadership skills to address some of the problems. CS may assist in realizing these aims.

AIM

The aim of the present study was to develop, implement, and evaluate a form of CS that was acceptable to participant nurses, and sustainable, given a relative paucity of resources.

METHODS

Action research

An action research approach was chosen for this project, utilizing focus groups as the principle means to collect data, and content analyses as the means of analysis. Action research is a methodology whereby practitioners in a particular context work collaboratively with a researcher to find and enact solutions to problems that they are confronted with and that are important to them (Greenwood & Levin 2005; p. 54). As a research approach, it '. . . aims at both taking action and creating knowledge or theory about that action' (Coghlan & Casey 2001; p. 675). It is grounded in the constructivist paradigm that holds people as meaning making, constructing their own theories to make sense of the world (Koch *et al.* 2004). Hall (2006) argues that action research has reflective practice as its educative base, responds to the values and problems of practitioners, which form the content of change, and involves key stakeholders being involved in the change process. Action research has been used as a means to introduce and evaluate aspects of CS in a range of settings (Cerinus 2005; Lyon 1998; Marrow *et al.* 1997).

The form of action research implemented in this project might best be considered an amalgam of what Holter and Schwartz-Barcott (1993) describe as the technical collaborative and mutual collaborative approaches. The former entails a researcher entering the collaboration with an identified problem, a specific intervention, and an action plan. In this project, one author was familiar with the practice environment, having worked in the hospital prior to a course of study, which introduced her to the concept of CS and inculcated an enthusiasm for its implementation. However, the project was approached with no clear model of supervision (form, mode, or model). In the interest of developing a form of supervision that would be acceptable and sustainable, collaboration with participants to identify problems, needs, and possible solutions was emphasized. The result is a local solution to CS adapted to the identified needs and desires of the participant group.

Action research involves an iteration or spiral of cycles of assessment, planning, acting, observing, and reflecting. A number of iterations occurred in distinctive phases characterized by different types of participation and products of enquiry. The first phase addressed establishing collaborative relationships with the service and participants and establishing the need and preferred form of CS. The second addressed the commissioning and provision of education and the initiation of supervision groups. The third phase involved the implementation and adaptation of supervision groups and the initial evaluation.

Focus groups

Focus groups were the main vehicles for data collection and collaborative decision making. Focus groups have particular usefulness in eliciting opinions and provoking participants to consider different opinions in light of disclosures from others (Fontana & Fret 2005). The focus group meetings proceeded in a semistructured fashion, involving the presentation of data from previous groups and a series of open-ended questions related to the current phase of the action research cycle (assessment, reflecting, and planning). The focus group meetings were audiotaped and transcribed. Transcripts were subject to a content analysis, assuming an essentialist/realist position (Braun & Clarke 2006), with the aim to represent the viewpoints of participants; summarize points of consensus, and in latter stages, to present a rich description of opinions. As the aim was to represent rather than

interpret, summarized findings were presented back to the participants for validation and consideration.

Ethical considerations

Approval for undertaking this project was obtained from the Dublin City University Human Research Ethics Committee (Dublin, Ireland) and the hospital nursing administration. Concern was raised by the ethics committee regarding how sustainable the project might be in a developing country (i.e. whether the supervision would continue after the research phase was completed). This was addressed by assurances that the project would be ongoing for as long as people were willing to participate (one researcher was employed in the hospital and could make this commitment), and that participants were in a sense co-researchers rather than subjects. Potential participants were provided with information sheets relating to the project, and returned a consent form at a later date if they chose to participate (minimizing the potential for pressure or coercion to participate).

RESULTS

A group of nurses at the local psychiatric hospital attended an information session to discuss role development, CS, and the broad aims of this project. Ten people consented to involvement (as both participants in a supervisionary process and as co-researchers). They met monthly in a focus group and separately every 2 weeks for peer-group CS. The participants comprised of seven registered mental health nurses and three enrolled nurses who worked in all areas of the hospital for at least 2 years (range: 3–25 years). All were female with an average age of 43 years. The participants had no prior experience of CS. As action research is concerned with both action and reflection on action, elements of both process and content associated with the three phases of the project are presented.

Phase one: The need for CS

The participants met for the initial focus group meeting to ascertain needs relating to CS. Their initial understandings of CS was that it was '. . . like a support group, such as alcoholics anonymous', 'consulting with your head nurse', or analogous to other ward tasks. CS was framed as a method to influence the development of nursing roles (Consedine 1995; 2000; Peplau 1952), and participants were asked how they saw their roles at present and which roles they would like to develop. Two participants stated they felt stagnant, with few opportunities to improve or advance themselves professionally. Others identified interpersonal roles, such as advocate, educator/teacher, comforter, mother figure, and counsellor, which they assumed and wished to develop further.

The participants reported little experience of formalized reflection in or on practice. Some described actively suppressing recollections of work. For example, one participant who acknowledged feeling burnt out at times stated:

> 'I would not usually reflect. I would try to forget the day. Depending if there is a particular situation, you know, I would give it some thought, but I would usually try to forget the ward because sometimes the day is really hard, especially with those patients. I would try not to think about the patients when I get home. . . .'

Those participants that assumed management roles stated that they spent time reflecting on practice, particularly on the practice of others after critical incidents. Most, however, agreed that they did not spend a lot of time thinking about the work they did, and mostly followed routines that were neither growth enhancing for themselves or for service users.

The respondents were quick to identify potential obstacles in implementing any form of CS in the hospital and said they would find it difficult to leave the ward to attend supervision sessions. They described a general lack of human and material resources. The participants were pragmatic when considering the mode of supervision that would be most feasible. It was agreed that some form of group supervision would be preferred, because as one person commented, '. . . there would be more support, more ideas, and more interesting sessions than if one to one', and that supervision should focus on the development of nursing roles. The participants made commitments to attend to tasks to enable CS to take place. For example, some nurses were responsible for rostering, and were committed to ensuring the roster enabled attendance, while all agreed to make attendance a priority. It was agreed to commission external training, which would be informed by the preferences of the participants.

Phase two: Preparation and education

A peer-group model of CS was agreed as the preferred initial training model. Peer-group supervision is a variation of group supervision, in which the group is assumed to have the resources to help themselves and to make sense of practice. Forms of peer-group supervision have been used in developing psychotherapeutic skills (Bonnivier 1992; Brugger *et al.* 1962), in nursing education for lecturers and students (Burnside 1971; Claveirole & Mathers 2003; du Plessis 2004), in nursing

management (Hyrkäs *et al.* 2003), and with other nursing specialties and disciplines (Schreiber & Frank 1983).

The peer-group supervision model developed in this project was adapted from Heron's (1999) descriptions of peer supervision and peer-support group processes. Peers themselves facilitated the group sessions and were strongly encouraged to follow a prescribed process, whereby group members took turns presenting case material and selecting a process that they wished to follow. The participants are assumed to know their immediate supervisory needs, which on some days may be more restorative (e.g. through seeking and receiving validation for a good job or wanting to simply share a difficult experience), more normative (e.g. through seeking advice), or developmental (e.g. through reflecting on an interaction with a service user). Processes included sharing a positive experience, reviewing a general practice problem, seeking advice, reviewing a shared problem, reviewing a critical incident or stressful experience, or reviewing interpersonal practice (and these processes were outlined in a manual). The facilitator role was rotated among members, and involved ensuring that the chosen process was followed (thus maintaining a clear focus), by soliciting comments, observations, or feedback in 'rounds', and ensuring that participants had the opportunity to speak uninterrupted.

Most processes might be considered applicable to reflecting on any field of practice. The interpersonal practice review (see Table 1), however, draws on a number of theoretical strands particularly useful for mental health work and role development. These include the concept of role, as described by Peplau (1952), role development, as described by Consedine (1995; 2000), Heron's (2007) six-category interventions and the idea of reflecting on the intent of interactions, and Peplau's concept of pattern interaction and integration (Beeber 1998; Peplau 1989). The participants attended a 1-day intensive training course on peer-group supervision. Theoretical teaching and review around issues, such as professional boundaries, nursing theory, structuring stories, and analyzing interventions, was interspersed with the practice of group facilitation and using the different processes. The training was well received, although there was a general consensus that 1 day was insufficient to practice skills. Group members met 2 weeks after the training day to establish a contract for ongoing contact.

TABLE 1: *Interpersonal practice review process*

1. **Presentation.** The supervisee:
   - provides a brief profile of the person
   - provides an account of an interaction with the person, addressing the following questions, where relevant:
     - What role did they assumed?
     - What did they intend to achieve through the interaction?
     - How did they actually respond to the person? (Thoughts, feelings, and behaviour.)
     - How did the person respond? (Perceived thoughts, feelings, and behaviour)
     - Was this interaction a repetition of past interactions or patterns?
2. **Clarifying questions.** Peers ask questions for clarification (in a round)
3. **Critical comments.** Peers make critical comments or observations guided by (but not limited to) the following questions, while the supervisee observes:
   - Was this the appropriate role/intent with respect to timing or the phase of the relationship?
   - In what way is the person's response/behaviour part of a pattern?
   - Have other people been drawn into a similar pattern?
   - How might the pattern change?
4. **Positive feedback.** Peers describe what impressed them most about the supervisee's behaviour, approach, actions, or attitudes
5. **Reflection on learning.** The supervise reflects on learning, points that have become clearer, what they might do differently in future, or they simply thank peers

Phase three: Implementation and initial evaluation

The participants agreed to meet fortnightly, but there were difficulties between people when negotiating convenient times to meet. As a result, two peer supervision groups were formed (around work areas). Initially, the groups considered meeting in their own time, as being released from workplaces was difficult. The groups were closed (neither author attended) and lasted 1–2 hours, but the combined group met monthly (for 4 months) in a focus-group format to reflect on the process, resolve problems relating to attendance, and evaluate progress.

Group members reported using the interpersonal practice review the most during the peer supervision sessions. Group members decided (and formalized in a CS contract) that emphasis should be placed on critically discussing interactions with service users. The interpersonal practice review provided a framework for discussion. This formalized reflection was reported to have positive benefits in the day-to-day work of nurses who agreed that they were more mindful of how they were interacting with service users:

> 'You know, before, you did your nursing roles because you had to do it, but now you do it with an understanding. Before, I never really gave it a thought. . . . You know you had to do what you had to do without even thinking about it.'

The participants generally reported feeling more satisfied with their work, which they linked to being involved with the peer supervision group:

> '. . . I'm really happy that I did because it (CS) is helping me to appreciate what I do. There is more satisfaction and fulfilment in what I do. I am a caregiver. I know I just enjoy caring for my patients.'

The participants reported identifying with or enacting a greater repertoire of roles since commencing peer-group supervision. These included teacher, counsellor, advisor, advocate, negotiator, and protector, and the participants reported being more aware of assuming surrogate roles. The participants particularly identified with enhancing the counsellor role:

> 'I find myself acting in the role of a counsellor a lot; I am a counsellor.'

The participants stated that they did not find the benefits of CS, with respect to developing the counselling role extended to working with people on what they called the 'chronic' (long-stay) wards. This was related to a lack of time due to overcrowding and communicative difficulties ascribed to residents.

> 'I have learnt at the CS training how to use my questioning skills. When on a chronic ward, you forget these things. On the admission ward, you have no choice; you have to use your skills.'

One respondent described being 'lost' on the long-stay ward, whereas all agreed that on the acute wards, there was more time to talk with people, and counselling skills were demanded. Nevertheless, those who worked on the long-stay ward described trying to carve out small periods of 'protected time' to talk with people during the course of their day.

Most respondents thought that the experience of peer-group supervision contributed to improvements in the care provided.

> '. . . We find that the level of patient care that we are giving is improved. I think it is because we are trying together to come up with solutions for some cases.'

Some participants stated that there were advantages in having peers from the same ward in the supervision group, as they would understand the context and nuances of the interaction being discussed more fully. Others stated that this was not important, as people learned from hearing about other people's experiences. All participants agreed that they felt more supported by their colleagues through participation in the group.

DISCUSSION

The methods used to introduce CS and the means to evaluate it have some inherent limitations. Using the preferences of staff with no experiences of CS as the basis for building a model may not lead to the most efficient, effective, or even the most acceptable model. The participants' self-reports suggest that most of the nurses involved perceived the experience as helpful, and that they felt supported. This is clearly valuable, particularly given the reported sense of 'burnout' from some participants at the beginning. However, there are limits to the extent that the self-reports of a small sample of volunteers can be used as a basis to generalize the usefulness of this model of supervision to others in the workplace or elsewhere. It is also uncertain whether or not actual rather than perceived improvements in 'patient care' occurred.

Fidelity to the peer-group supervision model depends on strong facilitation skills and a commitment to following the prescribed or chosen process. Although group supervision was probably the only feasible structure, given resource constraints, a supervisor-led group or expert facilitator may have been a more useful model to commence with in order to model and strengthen the facilitation skills of members. Consedine (1992) asserted that although in everyday life supervisor and supervisee relate as peers, in a supervision setting, the relationship is one of authority rather than peer. There are risks (that were discussed during training) that peers may not challenge each other to the degree necessary to extract the optimum amount of learning from the experience. As Cutcliffe *et al.* (2001) note, both supervisors and supervisees can share the same blind spots, and this is perhaps more likely when the roles of supervisee and supervisor are blurred (as they are in peer-group supervision).

The participants appeared to easily appreciate and discuss nursing as a series of role enactments according to the needs of the recipient of care (Peplau 1952), and to focus on the specific encounters that take place between the nurses and the client (Consedine 1992). The participants warmed to this way of conceiving practice and with the simple but elegant idea of reflecting on the intent of their interventions (Heron 2007). The participants were less inclined to utilize the idea of pattern and pattern integration (Peplau 1989) in discussing their work. These ideas regarding recognizing and addressing patterns of behaviour might have been helpful in addressing the therapeutic pessimism that people expressed regarding the long-stay wards. The utilization of only a selection of concepts may be a reflection of the need for further and ongoing education. Peer-group supervision might work

best alongside ongoing education, and further research might illuminate what and how nursing theory and research is integrated or reinforced through supervisionary processes.

Action research, as a means to introduce this practice initiative, was economical and efficient. The participants made a considerable personal investment in the project, as they had a sense of ownership of it. The action research process of reflecting on action in a group paralleled the supervision process to some extent, and may have been mutually reinforcing. As with most models of supervision, the evidence of the impact on actual clinical care and the outcomes for service users are limited (Bradshaw *et al.* 2007). A different research methodology would be more appropriate to examine the impact of peer-group supervision on actual standards of care. The relative advantages and disadvantages of peer-group supervision compared to other modes such as one to one, or forms, such as a supervisor-led group, should be examined in future research.

CONCLUSION

This project demonstrated the feasibility of introducing a form of CS in an institutional practice environment with no history of CS, little recognition of the role of the nurse as a therapeutic agent, and with severe resource constraints. The peer-group model is promising as a means to rapidly overcoming resistance to reflection on practice, developing psychotherapeutic orientation among nurses, and consolidating learning. As an ongoing action research project, participants will continue to address problems that arise in peer-group supervision, and the actual model of practice will be adapted and amended over time.

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