Abstract

Background: Resilience is important to sustain hospice nurses through a challenging career. Clinical supervision is a commonly cited support strategy, but there is limited evidence which focuses on its influence on the development of resilience in hospice nurses. Aims: To explore how group clinical supervision might affect the development of resilience in hospice nurses. Method: A pragmatic approach and mixed methods research design was employed. Quantitative questionnaire data and qualitative focus group data were collected from community hospice nurses participating in group clinical supervision. Findings: The findings identified the importance of an effective group reflective process on the benefits to be gained from clinical supervision. Clinical supervision was found to affect the development of resilience by developing confidence at work, regulating emotions, offering a coping strategy, managing expectations, and developing self-awareness. This was dependent upon individual preference and experience, the local organisational context, and wider social and political factors. Conclusion: This research contributes insight into group clinical supervision as an intervention to support resilience in hospice nurses. It offers recommendations for practice, to enhance the development of resilience through clinical supervision, and recommendations for future research.

Key words: Resilience, Clinical supervision, Hospice, Palliative care

Nursing is a challenging profession (Jackson et al, 2007), and working in palliative care may be particularly challenging due to stressors such as exposure to death and dying, exposure to pain and suffering, and managing professional boundaries (Gillman et al, 2015; National Palliative and End of Life Care Partnership (NPELCP), 2015).

Personal resilience is considered important in sustaining nurses through such a challenging career (Jackson et al, 2007). For the purposes of this research, resilience is defined as the ability to make it through stressful events, feel confident and in control at work, self-regulate emotions and expectations, and ultimately maintain equilibrium. Resilience is recognised as a factor in managing the inherent challenges of hospice nursing, rather than as a single solution to workplace adversity.

Group support, and exploring feelings, are thought to be important aspects of nurturing resilience of palliative care staff and Hospice UK (2015) have recommended that hospices consider strategies to support staff in their work. Commonly cited support strategies include self-care, clinical supervision, reflection, mindfulness and meditation (Gillman et al, 2015; Hospice Friendly Hospitals Programme (HFHP), 2013). Of these strategies, clinical supervision is the most commonly implemented and studied.

The group clinical supervision described in this research involves nurses reflecting on practice with an external supervisor. According to Proctor’s (1986) influential model of clinical supervision, its three main functions are: formative, to develop skills and understanding; normative, to maintain and improve professional standards of care; and restorative, to support the emotional needs of the nurse. The restorative and supportive benefits, involving helping staff to manage personal and professional demands (Care Quality Commission, 2013), may be especially relevant to the hospice environment. However, there is little in the literature focusing on resilience (Wallbank, 2013), and a paucity of research...
specifically relating to resilience in hospice nurses. Hospice UK (2015) have therefore recommended that interventions to support resilience should be more systematically evaluated. The context for this research is a local NHS Foundation Trust hospice which had recently implemented monthly group clinical supervision for its team of community specialist hospice nurses.

Research aims

The aim of this research was to explore how group clinical supervision might affect the development of resilience in community hospice nurses. The objective was to gather hospice nurses’ perceptions of group clinical supervision, and to gain insight into the processes that might affect the development of resilience.

Research design

This study used a mixed methods research design, based on a pragmatic philosophical framework (Creswell and Plano Clark, 2011). The research is comprised of two parts, a quantitative strand (part 1) and a qualitative strand (part 2).

Method

Part 1

A quantitative electronic Clinical Supervision Evaluation Questionnaire (CSEQ) for part 1 provided deductive data on nurses’ perceptions...
of clinical supervision (Horton et al, 2008). Permission from Horton to use the CSEQ was gratefully received. The CSEQ includes 14 questions, three of which specifically relate to impact on resilience, and the remaining questions provide insight into factors relating to resilience outcomes. Three additional questions were included separately to consider how previous experience might affect nurses’ perceptions of clinical supervision and the development of resilience.

Part 2
A follow up focus group for part 2 explored nurses’ experiences, understandings, and interpretations of clinical supervision specifically relating to resilience in more depth. The analysis from the questionnaire helped to inform the design and data collection for the focus group, and both sets of data were subsequently integrated and interpreted.

Sample and data collection
Purposive sampling was used to recruit participants from the team of community palliative care nurses currently taking part in clinical supervision. Nurses were invited to take part via a Participant Information Sheet. Participants could choose to take part in either part 1, or part 1 and part 2. Data collection occurred between October and December 2017, after approximately one year of clinical supervision. The time and date of the focus group was prearranged by the hospice to be the most convenient and accessible to the team, and the venue was the same as for clinical supervision. The 66-minute focus group was audio recorded and transcribed by a transcriber.

Method of data analysis
Part 1 questionnaire data from 14 participants were analysed using descriptive statistics, and the strength of correlations between questions were measured using the Spearman rank correlation. Significant or interesting results from part 1 were then developed as prompts for discussion in the focus group, to explore in more depth. For part 2, focus group data from five participants were analysed by thematic analysis, based on Braun and Clarke’s (2006) process. The findings from the questionnaire and the focus group were finally interpreted together. This process is represented in Figure 1.

Findings: part 1
Responses to the questionnaire are summarised in Table 1 and responses to the three questions associated with ‘impact’ on resilience are detailed in Figure 2. Spearman rank correlation coefficients ($r_s$) compared the relationship between both the ‘process’ and ‘purpose’ of clinical supervision with the group’s ‘impact’. The results in Table 2 reveal a significant positive correlation between ‘purpose’ and ‘impact’, and between ‘process’ and ‘impact’. The bivariate correlations also revealed a weak negative correlation between total scores and length of time working in palliative care; a weak positive correlation between total scores and length of participation in clinical supervision; a significant

![Figure 2. Breakdown of answers to questions associated with ‘impact’ on resilience](image_url)
negative correlation between the resilience questions and length of time working in palliative care; and a very weak negative correlation between the resilience questions and length of participation in clinical supervision.

Overall, the questionnaire results provided a valuable insight into some of the factors that might affect the development of resilience. They suggest that a good understanding of the purpose of clinical supervision, and a constructive process, could help to facilitate a positive impact. The length of time working in palliative care could also play a role in the impact on resilience.

Findings: part 2

Key findings from thematic analysis of the focus group are presented under four themes: Fitting it in; opportunity to share; individual coping strategies; and seeking solutions to support group reflection.

Fitting it in

While most participants appreciated having protected time to stop and reflect, there was a feeling that clinical supervision added to the pressure of their working day:

‘So coming here for supervision… I’ve got so much work to do… it is quite stressful to try and fit that in.’

The group identified that part of the pressure they felt was due to the nature of their pivotal and nebulous role as specialist palliative care nurses. This was linked with a strong sense of dedication to their role and a sense of altruism. They highlighted that within their specialism it is ingrained that there is only ‘one chance to get it right’, and that they automatically go the extra mile and put their patients’ needs first. As a result, the group agreed that they sometimes struggled to prioritise themselves:

‘Because you tend to give quite a lot in your role, it’s something that may be a little bit uneasy to accept, some investment in you is actually quite hard to adjust to when you spend most of your time giving … it doesn’t sit easy when there’s still needs out there.’

The workload and pressures of the role were also felt to impact upon attentiveness and what they could gain from clinical supervision. The group reflected on sometimes feeling fatigued, preoccupied and distracted during clinical supervision:

‘It’s very interesting because we’ve all got strategies for visiting patients at home, so we can have full on days, we can go into people’s houses and … you box everything. But for some reason that doesn’t happen in supervision … Whether it’s because you have to give to yourself in supervision, so you’re in a different place.’

Opportunity to share

The group reflected on how the autonomous and busy nature of their role meant that they sometimes carried issues around for a while, and clinical supervision was seen as an opportunity to share some of these issues. This was linked with a sense of trust within clinical supervision, in a non-judgemental and safe space with skilled and insightful facilitation. Consequently, the group reflected on the benefits of hearing other people’s experiences and perspectives, which was felt to contribute towards learning, generating ideas, feelings of affirmation and managing emotions. This was associated with a consensus that ‘mixed team’ supervision groups were valuable for hearing different representations and viewpoints:

‘So having that sort of supportive environment to kind of explore what’s going on … and your response to it, but also, hearing other people’s response to how they may have reacted or they’ve had a similar experience, for instance, and how it made them feel.’

However, it was also acknowledged that the pressures of the job sometimes made it difficult to identify issues to reflect on:

‘It’s accumulative, so the next day might
happen and the next day. And by the end of the week, you can’t remember the issues that you thought you’d like to reflect on … And then when you get the opportunity, your head, it’s so full you can’t identify what it is that has perhaps challenged your resilience.’

For some, sharing issues did not always help because there were not always answers:

‘One of the repeating themes that comes up in our supervision group, is managing people’s expectations … it’s a reoccurring theme but we never fix it … we’ve got no solutions because we haven’t got the authority to sort of sort it out.’

The opportunity to share was felt to be restricted by the implicit limit to bringing something from their professional life, despite the perceived influence of their personal life on their professional wellbeing:

‘It didn’t even enter my head to bring a personal issue, even though that’s probably, you’re right, what’s going on outside of work so influences our resilience in work, to be honest.’

**Individual coping strategies**

There was a self-awareness among the group about how they employed and used their individual coping strategies, although there was a lack of consensus about the extent to which clinical supervision was perceived as a coping strategy in itself. There was a perception that their team was self-aware and experienced, meaning they had the ability to choose their own approach and alternative coping strategies such as headspace time in the car, calling colleagues to debrief, and exercising:

‘We’ve all got different needs in the way we learn, the way we off-load … we’re all practitioners that have lots of experience and different coping strategies, if supervision isn’t your way of coping … then why do it?’

Therefore, it was recognised that prior to clinical supervision, many issues may have already been dealt with. However, clinical supervision was seen by some as an additional resource and as providing equity for the team:

‘They have the same access to support at whatever level, if people feel they need to use it, it’s available.’

Despite differences in the extent to which participants used clinical supervision as a coping strategy, there was consensus about wanting to support the process and support their colleagues, especially those new to the team.

**Seeking solutions to support group reflection**

The group continually sought solutions to the problems of fitting in clinical supervision, identifying issues to reflect on, and benefitting from clinical supervision as a coping strategy. These solutions were generally connected with the ability to self-care.

‘To support the clinical supervision process, you need to be working in an environment where you can self-care and it isn’t always possible … because of the demands on the service.’

There was a sense of understanding about the issues that were difficult to address, such as issues external to their organisation, or finding a practical time to hold clinical supervision. However, there was an awareness that some practical solutions could give people space to engage more deeply in the clinical supervision process:

‘It might be useful, within clinical supervision, to have a practical element to it … relaxation techniques or … visualisation techniques.’

‘Investing in self on a practical level feels, I agree, I don’t know why it feels better, but it feels, the two would complement each other.’

There was an element of seeking ownership of clinical supervision, whether in choosing when to attend to suit their own needs, or in seeking to gain some headspace before engaging in the process.

**Integration and interpretation of findings**

The integrated findings revealed that understanding the purpose of clinical supervision, and a constructive group process, can provide a foundation for effective group reflection. Subsequently, clinical supervision provides an opportunity for nurses to share experiences, which can contribute towards feelings of confidence at work and the regulation of emotions. This was found to be a particular benefit due to the isolated nature of the community nurses’ autonomous role.

The findings reflected some variation in the...
extent to which clinical supervision was perceived as a coping strategy. This could depend on personal preference, availability of other coping strategies, and on the length of time working in palliative care. Clinical supervision was seen as an additional resource to support coping, and appreciated as providing equity in the team. It was felt to be less helpful as a coping strategy when there were no internal solutions to managing expectations, when it was perceived as adding to the workload, and because of the limit to reflecting on professional rather than personal issues.

Clinical supervision was felt to help participants to develop their self-awareness, especially for less experienced members of the team. However, it was felt that the team already had good self-awareness owing to their role, which enabled them to identify their own coping strategies, and critically consider how clinical supervision could support their needs.

Despite reports of the positive impact of clinical supervision on the development of resilience, the pressure of fitting it in when there was so much work to do was felt to impact upon the opportunity to identify issues to reflect on, attentiveness, and therefore the benefits to be gained from group reflection. Feeling able to prioritise and invest in self, owning and preparing for clinical supervision, and approaching clinical supervision in a mindful state, could enhance group reflection and the subsequent benefits on the development of resilience.

**Discussion**

**Sharing and reflecting in a constructive and safe environment**

The findings build on existing evidence that a sense of safety and mutual trust in clinical supervision helps nurses to share and reflect on experiences with colleagues. For example, a pertinent comprehensive systematic review by Gillman et al (2015), found that a safe and secure environment can enable oncology and palliative care nurses to connect and share with each other.

Furthermore, the findings suggested that a good understanding of the purpose of clinical supervision, and a constructive process facilitated by a skilled and insightful supervisor, provided a foundation for effective group reflection. Jones (2001) and Dawber (2013) have also found that a clear understanding of the purpose of supervision is necessary for effective group reflection. In addition, Jones (2006) and Kenny and Allenby (2013) correspondingly found that a constructive process depended upon a competent and trusted supervisor to guide reflection.

Sharing and reflecting in a group enabled people to hear and learn from different perspectives and experiences, feel more confident in their role, gain a sense of affirmation, and manage emotions. As with this research, Gillman et al (2015) have suggested that sharing experiences can promote learning, support a sense of confirmation, and help to vent and process emotions, which in turn can support coping and reduce stress. Bulman (2013) has stressed the importance of sharing experiences during reflection, which in the case of this research has been enhanced by the ‘mixed team’ nature of the groups.

Being able to reflect with colleagues and share issues could be a particular benefit due to the isolated nature of community palliative care nurses’ role. Indeed, Hospice UK (2015) have reported that feelings of isolation are intrinsic to hospice care, and Jones (2001) has also observed that community Macmillan nurse specialists commonly experienced professional isolation, which could be constructively addressed through clinical supervision.

**Clinical supervision as a coping strategy**

This research demonstrated variation in the extent to which clinical supervision was perceived as a coping strategy, and suggested that other individual coping strategies may be selectively used. Teasdale et al (2001) have likewise identified that while nurses felt they had better access to support through supervision, they continued to use and value informal support networks. This research found that as well as personal preference, the availability of other coping strategies could affect how clinical supervision was perceived and used as an additional resource to support coping. Gillman et al (2015) have suggested that team relationships, existing social networks, and the ability to make time for conversations could play a role. Therefore, this research highlights the contribution of external factors and individual preference in determining the extent to which clinical supervision supports nurses’ coping with stress.

Jones (2006) found that hospice nurses typically convened informal networks to seek support, and reported similar issues in terms of nurses at times having already resolved professional issues prior to clinical supervision. McDonald et al (2010) explored workplace
conversations between nurses and suggested that talking with colleagues was the primary method of coping with workplace demands. Gillman et al (2015) have proposed that this preference towards seeking the immediacy of peer support could be because it allows nurses the ability to re-gain a sense of control. This research adds that clinical supervision represented an option in gaining support towards feeling more confident and in control at work, especially when informal opportunities to gain support were not available.

The findings suggested that nurses with more palliative care experience were less likely to benefit from clinical supervision as a coping strategy. Gillman et al (2015) have suggested that more experienced practitioners may be able to apply insights, skills and knowledge to palliative patient care, and may have already developed more realistic expectations of their care. This fits with qualitative research by Sandgren et al (2006) that showed how experience in a healthcare environment provided insights that improved palliative care nurses ability to cope. Furthermore, the findings suggested that clinical supervision could be a particularly useful means of support for those new to the team. This could be because it takes time to develop trust and rapport with colleagues and to establish the supportive relationships that underpin informal peer support networks as an alternative coping strategy (Gillman et al, 2015).

In line with these findings, Hospice UK (2015) have advocated that a mixture of personal strategies and organisational support is integral to assist coping and resilience for palliative care nurses. Individuals may have a preference for a particular coping strategy, suggesting that different options should be provided and supported to cater for different people’s needs and to provide equity (Allbutt et al, 2017). Significantly, the findings highlighted that nurses recognised the influence of their personal life on their professional resilience, but were conscious that it was not felt appropriate to reflect on personal issues during clinical supervision. Support for alternative strategies which have a greater potential for nurses to explore the influence of their personal life on their professional wellbeing might therefore complement the more professional focus of group clinical supervision.

Bulman (2013) adds that reflection is also about learning about and developing oneself as a person, as well as a nurse, because the two are intertwined and nurses inevitably bring themselves to their practice. This is synonymous with Barnett’s (1997) concept of ‘critical being’ which has emphasised the importance of critical self-reflection and the development of oneself to engage with knowledge, and to take action. Therefore, finding a way to reflect on one’s personal life could contribute towards the development of resilience for hospice nurses by developing self-awareness to express oneself as a nurse.

The findings highlight the importance of providing nurses with equal access to support, and creating a democratic workplace in which colleagues have the space to explore challenges. This has potential to confront matters of social justice, and goes some way towards what Traynor (2017) describes as ‘resilience’, for nurses to understand themselves in relation to their society and the pressures that affect their working life. However, there was recognition that there were sometimes no internal solutions to the issue of managing expectations from outside of the organisation. In such instances, clinical supervision is less likely to offer a coping strategy because fostering individual resilience may be ineffective on its own if it cannot challenge and change the cause of dysfunction (Traynor, 2017). Even so, clinical supervision could help hospice nurses to recognise and accept things that they do not have control over (Dawber, 2013) and recognise when unrealistic personal demands and those from colleagues cannot be met (Jones, 2001). Being able to objectively evaluate a situation so that adjustments can be made to expectations could contribute towards coping and resilience when individuals feel that they cannot influence events (Gillespie et al, 2007).

Hospice UK (2015) have highlighted that an ageing population, an ongoing shift towards community-based palliative care, and the current economic environment, have increased the pressure on community hospice services. In line with this research, Hospice UK have also identified that unrealistic perceptions, expectations and managing relationships with professionals in other parts of the health system are particular stressors for hospice nurses. The findings therefore highlight the influence of the wider organisation and social and political factors on the development of resilience through reflection in clinical supervision.

**Development of self-awareness**

Clinical supervision was perceived as helping to develop self-awareness. Shimoinaba et al (2015) have highlighted that self-awareness is a key
component in the development of resilience for palliative care nurses. Research by Gillman et al (2015) and Shimoinaba et al (2015) suggested that clinical supervision could help develop resilience by encouraging participants to explore and develop insight and meaning from their experiences and its impact on their thoughts and feelings. Furthermore, this research suggested that the impact on the development of self-awareness was more pronounced for less experienced members of the team. Shimoinaba et al (2015) have also suggested that nurses with a longer experience of working in palliative care may have had longer to develop their self-awareness through their work, by reflection and a gradual growth of insight into who they are as a person and as a professional.

The findings also revealed that some participants already felt that their team had good self-awareness, which was felt to enable them to identify their own coping strategies. Indeed, Shimoinaba et al (2015) have noted that knowledge of self is a lifelong learning process, which can enhance the use of effective coping strategies, self-care, and the development of resilience. This is supported by Gillman et al (2015) who have found that self-awareness can contribute towards resilience by helping to achieve work-life balance and self-care.

Maximising benefits

Fitting clinical supervision around a busy workload sometimes affected nurses’ ability to identify issues to reflect on and fully engage in supervision. This is in line with findings by Kenny and Allenby (2013), where nurses experienced competing demands, and clinical supervision was considered a low priority when nurses were busy.

Part of the pressure for nurses to fit in clinical supervision to their workload was feeling able to prioritise and invest in themselves against competing priorities, where nurses had a preference to put patient needs first. Participants expressed a sense of altruism and of dedication to their role where there is only ‘one chance to get it right’. Correspondingly, Ablett and Jones (2007) have found that hospice nurses demonstrated high levels of commitment to the role, and Gillman et al (2015) have also suggested that palliative care nurses are innately motivated and committed to their work. While Ablett and Jones and Gillman et al have concluded that nurses can gain a sense of meaning and purpose from such commitment, which can increase satisfaction and promote resilience, Shimoinaba et al (2015) add that it is also necessary to make time for oneself and gain support. Gillman et al (2015) have therefore recommended that the use of such support should be normalised and valued.

Lack of organisational support is commonly cited as a barrier to the clinical supervision process (Gillman et al, 2015; Allbutt et al, 2017). This research highlighted good organisational support, but also emphasised the need for participants to value and prioritise the process as integral to their role. Participants identified that having the time and the space to self-care and to

Box 1: Recommendations for practice

- Clinical supervision should offer ‘mixed team’ groups as a means of hearing different people’s representations and sharing experiences with colleagues
- Hospice nurses should take steps to invest in and value clinical supervision as a support strategy, as a means of developing and maintaining their resilience. It is important to note that individual nurses may have preferences for different personal strategies to support coping, which should also be supported
- Organisations should support clinical supervision, alongside alternative strategies which have potential for hospice nurses to explore the impact of their personal life on their professional wellbeing
- In order to maximise the benefits to be gained from clinical supervision, practical techniques to ‘bring the mind home’, as a precursor to group reflection to better focus and engage in the process, could be considered

Box 2: Recommendations for research

- There is a need for further research into how clinical supervision might affect self-awareness. Self-awareness has been linked with identifying coping strategies and developing and expressing oneself as a nurse, but it remains unclear how this aspect of resilience is affected by clinical supervision
- Given the reported impact of hospice nurses’ personal life on their resilience at work, future research should consider how this issue can be explored through clinical supervision
- This research identifies an interesting opportunity to explore how hospice nurses can be enabled to better focus and engage in clinical supervision, through a practical element to ‘bring the mind home’ as a precursor to effective group reflection
- Future research should continue to include resilience as a specific outcome measure of clinical supervision for hospice nurses.

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prepare for clinical supervision could support
the process. This supports findings by Gillman et
al (2015) that different coping strategies can
support and complement each other. For
example, Fitch et al (2006) have found that
techniques that assist self-regulation, such as
breathing techniques, relaxation, and
visualisation can loosen the stresses of work and
enable more mindful connection with others.

Furthermore, the findings suggested that
having a practical element in clinical
supervision, such as relaxation or visualisation
techniques, could complement the process by
enabling participants to better focus and
engage. This is an interesting finding which
corresponds with Johns’ (2017) notion of
‘bringing the mind home’ as a precursor to
reflection, to become more mindful and bring
attention to experiences within practice. Johns
(2017:21) adds that ‘having the mind full of
stuff also offers an excuse not to look at self in
any deep way’, and he asks us to consider how
we can ‘create the space in our crowded minds
to bring the mind home’ to enable us to see and
think more clearly. Jones (2001) has asserted that
clinical supervision should be calibrated to
meet the needs of nurses. Therefore, the
potential benefits of such techniques to enhance
the reflective element of clinical supervision
could be further explored.

Conclusions and recommendations
This research adds to the limited existing
evidence on how group clinical supervision can
affect the development of resilience for hospice
nurses. It is clearly complex and dependent
upon an effective group reflective process.
Clinical supervision can affect the development
of resilience through developing confidence at
work, regulating emotions, offering a coping
strategy, managing expectations, and
developing self-awareness. The development of
these aspects of resilience has been shown to
depend upon individual preference and
experience, the local organisational context, and
wider social and political factors. Recommendations for practice and research are
included in Boxes 1 and 2.

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Key points

● Sharing and reflecting in a constructive and safe environment can enable hospice nurses to learn from different perspectives, feel more confident in their role, gain a sense of affirmation, and manage emotions.

● Group clinical supervision can offer a coping strategy, alongside personal coping strategies to support individual resilience.

● Group clinical supervision can support the development of self-awareness, particularly for less experienced hospice nurses.

● Group clinical supervision can be difficult to fit into hospice nurses’ busy role, but could be maximised through organisational support, being valued by participants, and through practical techniques to engage in the process.

Continuing professional development: reflective questions

● Considering the definition of resilience described in this research, reflect on the role of resilience for the hospice nurse.

● Is group clinical supervision available in your organisation, and do you feel that accessing it would benefit your personal resilience in any way?

● How might group clinical supervision affect the development of resilience among nurses in your own work place?

● Do you have any personal strategies to support your own resilience, and how are these strategies supported by your workplace?

Have an idea for IJPN?

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