Clinical supervision is a key component of professional practice (Pollock et al, 2017), despite evidence suggesting it is still not a regular part of nursing practice (White and Winstanley, 2021). It is distinct from formal line management and professional supervision (Driscoll et al, 2019), and supports safe and effective practice in complex clinical environments (Saab et al, 2021). There is a lack of consensus over its exact components or how it is best facilitated (Pollock et al, 2017), but a small, emerging evidence base suggests it directly benefits patient outcomes (Stacey et al, 2020). Practitioners undergoing clinical supervision also report:

- Feeling valued, safe and cared for;
- Benefits of personal and professional development such as a safe space for self-care, resilience and collective learning;
- Positive working environments;
- Improved staff retention and job satisfaction;
- Increased patient safety;
- Improved quality and effectiveness of care;
- Fewer major missed-care incidents (Rothwell et al, 2021; Markey et al, 2020; Driscoll et al, 2019).

There are many definitions of clinical supervision (Cutcliffe et al, 2018). Broadly speaking, it is “regular protected time for facilitated, in-depth reflection on complex issues influencing clinical practice” (Bond and Holland, 2010).

While not advocating one specific model, a recent subject expert group argued for a consistent standard of clinical supervision for nurses in a sustained manner (Sainsbury and Stacey, 2022). The model used in this article is based on that of Brigid Proctor (2008), involving:

- Formative (supervisee training and learning);
- Normative (accountability and consistency of care);
- Restorative (emotional support and wellbeing of supervisee).

Evidence from dementia and mental health settings points to the benefits of
Clinical supervision in supporting care workers to provide person-centred care and to communicate with people living with dementia (Blake et al, 2020). Others have argued that clinical supervision improves nurse–patient relationships, as well as nurses’ skills and attitudes in dementia care (Francke and de Graaff, 2012). Galletti et al’s (2021) systematic review highlights that clinical supervision improves practitioner competence, prevents burnout, should be encouraged and funded, and that supervisors external to the supervisee’s organisation are more effective than their internal counterparts.

Admiral Nurses provide specialist case management for families affected by dementia (Harrison-Dening et al, 2017). The value of clinical supervision for them has been described as providing a safe space for self-care, promoting resilience, supporting peer and collective learning, enabling wide perspectives and shared participation, as well as for unpicking complex cases and role modelling for newer nurses (Driscoll et al, 2019). In this article, the professional and practice development (PPD) team at the national charity Dementia UK describe how, during the Covid-19 pandemic, they adapted an in-person, group clinical supervision model for Admiral Nurses into an online, synchronous version, using video conferencing in real time. Reflections for future practice are also provided.

### Background
At the time of writing in 2021, unpublished figures by Dementia UK showed there were nearly 300 Admiral Nurses (bands 6, 7 and 8) employed in health and social care settings across England, Scotland and Wales. Dementia UK supports Admiral Nurses in their practice through clinical supervision, continuing professional education, scheduled formal learning, peer support and self-study platforms (Butterworth and Shaw, 2017). This took the form of all Admiral Nurses accessing one of 18 regional PPD education groups, as well as small clinical supervision groups, and additional topic-related workshops, an annual conference and online learning opportunities.

Until 2020, Admiral Nurses accessed monthly in-person, two-hour, small-group clinical supervision sessions facilitated by supervisors with expert knowledge in supervisory processes and techniques. In 2019, more supervision groups were needed because of the increasing numbers of Admiral Nurses.

The PPD team started to look at other ways to retain the quality and quantity of clinical supervision, unconstrained by geography, group size and travel concerns.

### Pilot study
In 2019, the feasibility, quality and effectiveness of online clinical supervision (via video conferencing using Zoom or Microsoft Teams) was tested with seven Admiral Nurses working remotely on the Dementia UK telephone helpline. The pilot suggested it was an effective and accessible form of clinical supervision, giving insight into online facilitation skills as well as logistical considerations.

### Impact of Covid-19
In March 2020, the Covid-19 pandemic abruptly ended all in-person group clinical supervision for Admiral Nurses in the UK. Simultaneously, conversations with them illustrated the importance of providing safe, constructive spaces for them to reflect on practice and articulate the challenges of providing specialised case management during a pandemic – especially as many of the nurses were working remotely.

From April to July 2020, the PPD team held monthly, two-hour, online Zoom or Microsoft Teams ‘drop-in’ clinical support and discussion sessions for all the Admiral Nurses in the 18 PPD education and support groups across the UK. The sessions enabled the nurses to access peer and Dementia UK support; in each of the 18 PPD groups between 50% and 90% of group members attended each monthly session.

Informed by PPD team reflections, discussions with Admiral Nurses and an evaluation of the PPD team support and activity during the first lockdown, a structured, online clinical supervision model was developed in the form of practice action learning sets (PALS). Its aim was to provide high-quality, small-group, online clinical supervision with the formative, normative and restorative experiences.

Central to PALS was the importance of reflective practice and clinical supervision in an action learning process (as defined below) and the concept of high challenge and high support in a trusting relationship (Dewing, 2008). By August 2020, all Admiral Nurses could access one of the 34 small online groups organised by, for example, band, work setting, geography, session time, day, or role.

### The PALS model and action learning
PALS is influenced by action learning theory as described by, for example, Pedler and Abbott (2013), enabling learning through collaboration and problem solving. The approach provided a vehicle for an online action learning model because of the value of discussing case studies and practice issues (Maddison and Strang, 2018), and the use of critical questions to explore

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**Box 1. Core PALS resources/logistics**

- Working agreement/supervision contract based on a values-clarification exercise (individualised by each group)
- Session structure, professional and practice development question prompts and check-in examples (to be used during sessions)
- Summary of session template (as a prompt and to enable personal reflection)
- Self-facilitation guide (if the group needed to self-facilitate)
- Attendance register (kept centrally and including reasons for non-attendance)
- Quarterly review of attendance (to identify individual or organisational patterns)
- Bespoke frequency and pro-rata attendance to accommodate part-time working patterns

PALS = practice action learning sets; PPD = professional and practice development.
different perspectives when engaged in problem-solving (Hopkins et al, 2021). It supports critical reflection on practice and attention to the supportive, formative and developmental needs of the nurses, as well as giving space to sharing norms of practice (Bond and Holland, 2010; Proctor, 2008).

Drawing on Kolb’s (2014) learning theory, with its focus on the relationship between experience, discovery, active participation and knowledge construction, the PALS model encouraged an analysis of practice using a range of lenses and theoretical perspectives through skilled questioning by group members.

PALS session facilitation

The facilitators were nurses at band 8a or above, from Dementia UK, who took part in a bespoke in-house education programme between June and December 2020. The programme incorporated different models, theories and tools of clinical supervision and action learning. It discussed establishing groups, group agreement, record keeping, roles and expectations; attention was paid to developing supervision skills, trust, confidentiality and boundary management.

A core set of facilitator resources was also developed to promote consistency across all PALS sessions (Box 1). As supervision of supervisors is important to sustain and build good practice (Hall, 2018), an external consultant facilitated action learning sets for the PALS facilitators to provide a space to reflect and learn on the experience of facilitating. An online ‘escape pod’ was also introduced where informal, post-facilitation debrief sessions could take place with fellow facilitators, and time was given in team meetings to discuss issues or considerations.

The social distancing restrictions put in place as a result of the Covid-19 pandemic, combined with the immediate need to provide a form of clinical supervision, prevented Admiral Nurses from being extensively consulted about the supervision changes. However, exploration sessions were provided about the rationale of action learning as a form of clinical supervision, and the PALS model, principles and process. These included opportunities for nurses to express their thoughts and feelings about the end of the previous model of clinical supervision and the start of a new one.

The first PALS session for each group included a values clarification exercise, as described by the Foundation of Nursing Studies (2015), to establish a working agreement and develop a shared sense of purpose.

<table>
<thead>
<tr>
<th>Table 1. PALS session structure</th>
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<tbody>
<tr>
<td><strong>Overarching principles</strong></td>
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</table>
| Session is clearly structured; the whole group takes responsibility for the discussion | Group discuss and agree  
- Refresh working agreement if necessary  
- A check-in exercise  
- Who will take the register of attendees  
- Who will summarise the session |
| Emphasis is placed on listening and questioning, exploring and reflecting |  |
| Learning and thinking happens, even for those who do not present a case |  |

<table>
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<tr>
<th><strong>Action</strong></th>
<th><strong>Introduction (15 minutes, approx)</strong></th>
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</table>
| **Check in with each other – short, focused and structured** | Group discuss and agree  
- Refresh working agreement if necessary  
- A check-in exercise  
- Who will take the register of attendees  
- Who will summarise the session |
| **Bid for time to present a case to explore in more detail** |  |
| **Select two presenters** |  |

<table>
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<tr>
<th><strong>Case discussion 1</strong></th>
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<tbody>
<tr>
<td><strong>Presenter (5 minutes)</strong></td>
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<tr>
<td>Talks, uninterrupted, about:</td>
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<tr>
<td>- What happened/so what/what next…</td>
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<tr>
<td>- What I want to explore is…</td>
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<tr>
<td><strong>Group (3-5 minutes)</strong></td>
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<tr>
<td>- Asks presenter to clarify facts/questions</td>
</tr>
<tr>
<td>- Avoids drilling into detail to understand the whole picture rather than focusing on only one aspect</td>
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| **Group (5-7 minutes)** | Consider how the presenter may feel while silently listening  
- Use PPD prompt of how to reflect on what you do next and ask different types of questions if necessary |
| - Asks presenter to clarify facts/questions |  |
| - Avoids drilling into detail to understand the whole picture rather than focusing on only one aspect |  |
| **Group (3-5 minutes)** |  |
| - Asks the presenter further questions to explore the case more |  |
| **Presenter (5-10 minutes)** |  |
| Identifies and reflects on the group discussion and what might be useful for participants for the future |  |

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<tr>
<th><strong>Break</strong></th>
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<tr>
<td><strong>Case discussion 2</strong></td>
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<tr>
<td><strong>Repeat as above</strong></td>
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<tr>
<th><strong>Whole-group reflection</strong></th>
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<tr>
<td><strong>Think about the take-away message for both Admiral Nurse and individual practice (10 minutes)</strong></td>
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</table>
| Potential questions:  
- What resonates with you?  
- What will you take away from today for your practice?  
- In my practice, I will…  
- What this has made me think is…  
- For myself, I will take away or think more about… |
| - Group members reflect on how the discussion links with their own practice |  |
| - Group members reflect on what they will take away for themselves |

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<thead>
<tr>
<th><strong>Whole-group review (5 minutes)</strong></th>
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</table>
| **Group reviews the session. Ask:** | Ask, is there something you could:  
- Stop or do less of?  
- Start or consider doing?  
- Continue doing? |
| - What will you do next? |  |

<table>
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<tr>
<th><strong>Whole-group check out (5 minutes)</strong></th>
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<tr>
<td><strong>Enables closure of the session</strong></td>
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<tr>
<td><strong>PALS = practice action learning sets; PPD = professional and practice development.</strong></td>
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</tbody>
</table>
PALS session structure
Each PALS session has a consistent structure, enabling members to discuss and reflect on cases (Table 1). A group of around eight Admiral Nurses and the facilitator meet online for two hours via Zoom or Microsoft Teams. Both platforms enable participants to see each other and add comments in the chat box. A pre/post-PALS ‘water-cooler’ or ‘tea-and-chat’ moment is an optional addition to the session, which includes a refreshment and comfort break.

Evaluation
An attendance register is kept for each PALS group. This is reviewed every quarter to understand, support and respond to Admiral Nurses who do not attend. In March 2021, to explore the experience of attending, impact on practice and views on facilitating, all Admiral Nurses (via 18 regional PPD groups), 17 PALS facilitators (via SmartSurvey) and one external supervisor (via email) were invited to contribute to an evaluation survey (Box 2).

“Many respondents reported the benefits of being able to attend remotely with nurses from a variety of backgrounds and locations, to discuss cases, access support and critically reflect on their practice”

Results
In July 2021, 270 Admiral Nurses attended 34 PALS groups sessions. Out of these, 31 groups were monthly (242 nurses), two were bi-monthly (11 nurses) and one was an ‘as-and-when’ group (17 nurses). Across all groups, the average attendance was 75%. In total, 17 people (15.6 whole-time equivalents) facilitated the PALS groups, taking one to four groups each, as part of their usual practice development, clinical or leadership roles.

All 17 facilitators, the external supervisor, and Admiral Nurses from the 18 regional PPD groups responded to the survey. The PPD team recorded each response verbatim and discussed and agreed what could be mapped to Driscoll et al’s (2019) seven themes. Using the same approach, six more themes were identified from the “least useful” aspects and “other comments”. The feedback from the survey suggested that, even with the challenges of rapid adjustment to a new
structure (PALS) and vehicle (video-conferencing platforms), PALS provided an accessible, effective and regular form of supervision that was consistent with Proctor’s (2008) formative, normative and restorative functions.

Many respondents reported the benefits of being able to attend remotely with nurses from a variety of backgrounds and locations, to discuss cases, access support and critically reflect on practice (Table 2). Reported challenges included participants being released from their workplace to attend, holding professional conversations in a personal domestic space, finding private space in the work environment to attend the sessions, and missing the informal moments of in-person relationships (Table 3).

The organisation of PALS session membership, frequency and consistency of structure enabled the process and principles of PALS – rather than familiarity between a specific group of nurses – to drive facilitation and participation. For example, new nurses or those moving to another group rapidly participated because of the similarity of structure and facilitation across all groups.

“The process and principles of PALS – rather than familiarity between a specific group of nurses drove facilitation and participation”

Discussion

The PALS session facilitators’ education programme and external clinical supervision was important to enable supervision in the online space. This is vital as supervision is most effective when the supervisor possesses the skills and attributes to facilitate a constructive supervisory relationship, as well as to sustain and build good practice and resilience (Rothwell et al, 2021; Martin and Snowden, 2020; Hall, 2018). The benefits of meeting remotely, reported by nurses in our survey, support those identified by Tarlow et al (2020), who argues that tele supervision (remote supervision using technology) is a viable alternative to in-person supervision. Slipp (2020) has pointed out that virtual clinical supervision is helpful in:

- Providing resources, ideas and emotional support;
- Decreasing isolation;
- Normalising experiences.

Meanwhile, Martin and Snowden (2020) have highlighted the importance of protected time for clinical supervision – both online or face to face – during the Covid-19 pandemic and, long ago, Wood et al (2005) commented on the value of video conferencing to provide clinical supervision across a range of geographical regions. However, Miller (2020) has reported that more research will be needed post-Covid-19 to understand the experience, effectiveness and processes of virtual or online platforms.

Some of the challenges experienced were not unique. Martin and Snowden (2020) reminded us about organisations’ governance and financial responsibilities to enable attendance or facilitation of clinical supervision. Keane (2020) has described the difficulties around releasing staff to attend supervision, and Martin and Snowden (2020) have pointed out the low prioritisation of clinical supervision, relative to other professional duties. White (2014) highlighted the difficulty of establishing meaningful connections and authenticity in virtual meetings, while the challenge of accessing and navigating technology has been reported by Martin et al (2017). Further, Miller (2020) has highlighted issues of safety, online security, privacy and confidentiality.

The mourning of the loss and value of formal and informal in-person interactions, as expressed by survey participants, is striking. The latter aligns with Miller (2020), who highlighted the importance of ‘coffee-and-corridor’ conversations to answer ‘grey’ or informal dilemmas that may not be brought to a formal discussion.

Learning and reflections

Our experience of online PALS sessions is that they are an effective, accessible and credible form of clinical supervision for a specific group of specialist nurses working across various locations and settings. Overall, the potential benefits of the PALS model appear to outweigh its challenges.

PALS’ strength is in its consistency of preparation, structure and format, grounded in action learning and practice development principles. However, the importance of recognising and responding to the organisational challenge of enabling, funding, experiencing and facilitating clinical supervision in the online space should not be underestimated if nurses are to feel adequately supported. It must also be
remembered that one size does not fit all. Attention must be paid to those who cannot, or do not want to, attend or facilitate online supervision. In addition, organisational support is crucial to enable participants to participate, facilitators to facilitate and PALS to survive and thrive. Other considerations include retaining the quality and effectiveness of the model, ensuring organisational commitment, and developing and sustaining skilled supervisory practice and facilitators.

References