

Introduction

In the United Kingdom, National Health Service (NHS) recruitment and retention within the nursing profession is a cause for concern, and this impacts all areas of the healthcare system (NHS, 2019a). This has been compounded by the global pandemic, which led to high rates of burnout among nurses (Galanis et al., 2020). Clinical supervision has been established within nursing in the NHS for around 30 years, and has been described as a place for learning, growth, support and restoration (Proctor, 2011). Within the UK the most widely used model of clinical supervision is Proctor's model (Buus & Gonge, 2009; Sirola-Karvinen & Hyrkäs, 2011; Sloan, 2011; Franklin, 2013; Driscoll et al., 2019). The model incorporates three elements: *normative* (the monitoring and maintaining of clinical practice), *formative* (development of skills and abilities) and *restorative* (responsivity to emotional needs). The regulator for health and social care in England (Care Quality Commission; CQC) states that staff must receive the clinical supervision necessary for them to carry out their role and responsibilities (CQC, 2022). However, despite it being widely recognised that nurses benefit from ongoing clinical supervision (Driscoll et al., 2019), it continues to be inconsistently implemented. Driscoll et al. (2019) note that clinical supervision is not a mandatory requirement for UK nurses, and that the Nursing and Midwifery Council (NMC) does not have a policy or standards for organisations or nurses to follow in relation to clinical supervision.

Since its inception within nursing in the NHS in the early 1990s, multiple definitions of clinical supervision have been offered but no clear consensus reached (Hyrkäs, et al., 1999; Yegdich, 1999; Davey et al., 2006; Grant & Townend, 2007; Buus & Gonge, 2009; Driscoll et al., 2019; NHS Education for Scotland, 2021); this may act as a barrier to its implementation. The absence of a universal definition impacts supervisors too, with some viewing clinical

supervision as anxiety provoking and burdensome (Jones, 2006). Therefore, encouraging nurses to engage in clinical supervision before its ideas and ideals are properly explained, understood and assimilated, may lead to clinical supervision being less effective (Jones, 2006). Additionally, the blending together of managerial and clinical supervision presents particular risks, with the fear of being “watched” by managers within clinical supervision contributing to a negative experience of the clinical supervision process (Sloan, 2011).

Nurses who believe the space to be punitive and hold a belief that clinical supervision is a managerial tool to find fault in practice, are less likely to engage (Department of Health, 2000); likewise worries around confidentiality and feeling threatened also impact on its uptake (Butterworth et al., 2008). These beliefs help explain why in busy environments, clinical supervision is often the first casualty when demands are high (Stevenson, 2011), with key barriers to implementation of clinical supervision being time and resource (Davey et al., 2006). It appears that nursing’s relationship with clinical supervision is a complex one.

Inpatient mental health nurses are required to contend with a particular set of challenging circumstances including work with acutely unwell people who may be at high risk, shift-working patterns and highly unpredictable environments. In their study of clinical supervision within an inpatient mental health ward in Australia, Cleary and Horsfall (2011) observed that although participants understood the purpose of clinical supervision and were aware of its advantages, they tended to use more informal “ad hoc” methods of support. There was also a perception that accessing clinical supervision may indicate an absence of coping or resilience.

Given negative attitudes towards clinical supervision among nurses can be a cause for reduced engagement in clinical supervision as well as low overall uptake, research through

the lens of nondisclosure may provide valuable insights. Research with other professional groups has suggested nondisclosure to be a complex issue within the context of clinical supervision, with potential for impact on the quality of clinical supervision and in turn for safe and effective clinical practice (Mehr, Ladany & Caskie, 2010; Sweeney & Creaner, 2014). For the purposes of this research, nondisclosure is defined as the intentional withholding of information for example, personal, professional or relational by a supervisee or supervisor within clinical supervision. The phenomenon of nondisclosure is complex and still not fully understood. Although most often broken down into three main types; personal nondisclosure (ie Hess et al., 2008; Sweeney & Creaner, 2014), clinical nondisclosure (ie Mehr et al., 2010) or supervisory nondisclosure (ie Hess et al., 2008; Cook, Jones & Welfare, 2020; Singh-Pillay & Cartwright, 2018; Sweeney & Creaner, 2014), interactions between these three types can make a clear understanding difficult. Reported prevalence rates are highly variable (Hutman & Ellis, 2019; Cook, Welfare & Jones, 2020; Mehr, Ladany & Caskie, 2010).

This is the first study to address the phenomenon of nondisclosure within nursing clinical supervision, which is of importance in the field due to the potential consequences of nondisclosure for both effective practice, service delivery and patient experience.

Methodology

Design

A consultation team comprising three mental health nurses was heavily involved throughout to enhance quality and integrity. The team was chosen in response to an advert seeking consultants and via snowball sampling. As research into nondisclosure within clinical

supervision comprises a small body of literature and is in its infancy within nursing clinical supervision, it was felt by the researcher and consultation team that a qualitative exploration would offer valuable findings. Using semi-structured interviews, data were collected on participant experiences and opinions of nondisclosure and clinical supervision. This was then analysed using Thematic Analysis in line with Braun and Clarke's recommendations (TA; Braun and Clarke, 2022). Identified themes were shared with participants with the aim of "member checking" (Birt et al., 2016), with the nurse consultation team also being consulted to shape themes. The researcher kept a reflective journal throughout the research. The researcher also utilised regular clinical supervision with the research and nurse consultation teams.

Participants

Ten mental health nurses were recruited. Guidelines around sample sizes in thematic analysis are varied with large ranges of numbers quoted (Fugard & Potts, 2015). Opting for ten participants is considered reasonable for small projects such as the one being conducted (Fugard & Potts, 2015), acknowledging that the depth, richness and complexity of a study impact the required dataset size (Braun & Clarke, 2022). The study's inclusion criteria asked that participants were: mental health nurses at bands 5/6¹, who currently worked or had experience within the last three years of working within inpatient settings, who accessed individual clinical supervision and were permanent staff; preceptee nurses could also participate. Community based nurses were excluded due to having different pressures in

¹ These banding refer to the staff grades as defined by the Agenda for Change pay scales, widely used across the NHS in the UK (NHS Terms and Conditions of Service Handbook, 2024)

terms of cases, time and environment. Likewise, band 7 and above nurses were excluded due to the differences in type, frequency and focus of supervision. Finally, dual-trained nurses were not excluded but the focus was on their experiences of supervision as a mental health nurse. All nurses in the study received clinical supervision from a nurse of a higher banding, allocation of clinical supervisor were made by the senior management team.

Participant demographics are included in the table below. To gauge representativeness, the final column includes available demographic data of inpatient mental health nurses from one of the Trusts involved in the study.

	Sample demographics		Comparative employing Trust demographics
Age range	24-66y		20-70y
Self-described gender identity	Female	n = 8 – 80%	75%
	Male	n = 2 – 20%	25%
Self-described racial background / ethnicity	White British	n = 4 – 40%	36%
	Black African	n = 2 – 20%	41%
	White Irish	n = 1 – 10%	0.2%
	British Pakistani	n = 1 – 10%	1%
	British Asian	n = 1 – 10%	2%
	Chinese	n = 1 – 10%	2%
Disability status	Disabled status	n = 1	
	Non-disabled status	n = 9	
Agenda for Change banding	Band 5	n = 4	
	Band 6	n = 6	
Time range as registered nurse	5m – 7y		

Table 1: participant demographics

Recruitment was carried out across three large mental health NHS Trusts in the East of England spanning urban and rural areas. Purposive sampling was used via NHS Trust comms and local collaborators.

Ethics

The research obtained approval from the Health Research Authority (HRA) and the University within which the research was completed. All procedures were performed in compliance with relevant laws and institutional guidelines and appropriate institutional committees approved them.

Procedure and Data collection

The interview schedule was developed through a review of the existing literature, in collaboration with the nurse consultation team and the research clinical supervision team. The interview schedule was piloted with a separate nurse volunteer, who was identified via word of mouth.

Analysis

Braun and Clarke (2022) outline six phases for effective thematic analysis (*familiarisation with the dataset, coding, generating initial themes, developing and reviewing themes, refining, defining and naming themes, & writing up*) their methodology was followed for this research. The qualitative data analysis computer software package Nvivo, was used to support coding and theme generation.

A thematic map highlighting the key findings from the analysis is included in figure 1. Quotes are used to exemplify the themes generated. Where names are provided, pseudonyms have been applied to protect the identity of the participants.

Five themes were identified, which operated at different levels. On the broader cultural level, two themes spoke to a belief that nurses were expected to be superhuman, and the

challenges brought about by the necessity to work closely with colleagues leaving little room for navigating conflict. Two further themes operated at the clinical supervision level and described inconsistent set ups and invalidating experiences that felt relationally unsafe. The final theme operated on the individual supervisee level and spoke to in-the-moment responses made to cope and adapt with the situations they found themselves in. Each of the themes relating to the narrower levels, was situated within the context of those relating to the broader cultural narrative, but was not necessarily a direct result of them.

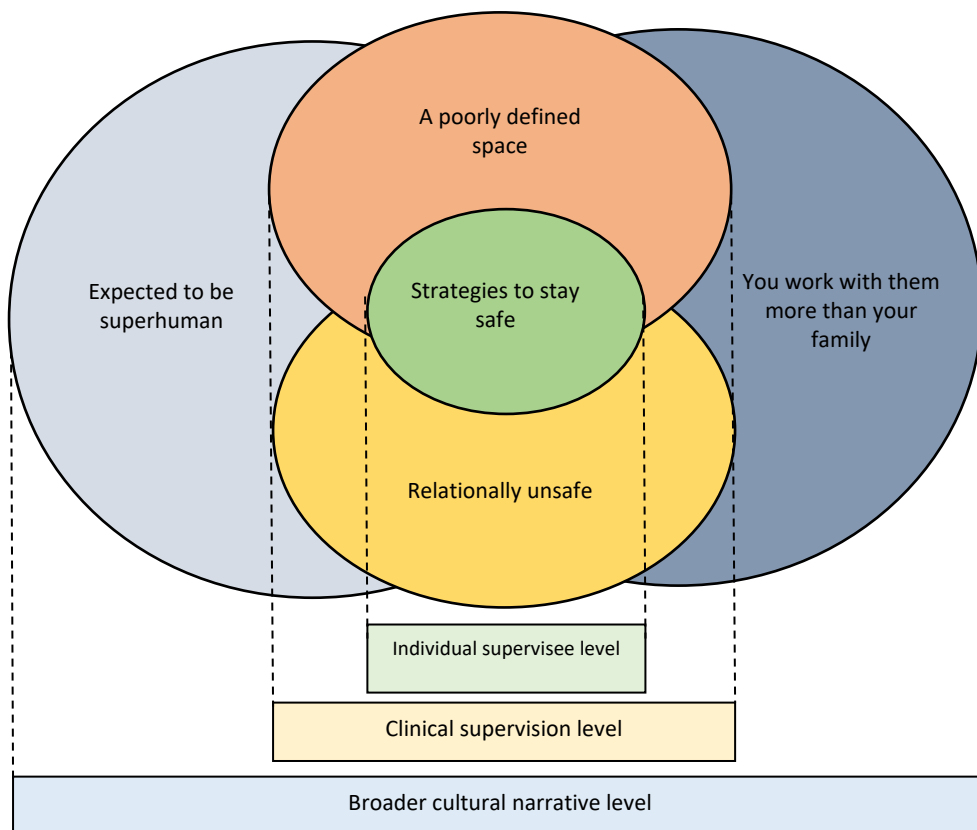


Figure 1: Thematic map

Theme one - Needing to be Superhuman

This theme spoke to the internalised belief held by participants regarding the perceived expectation to be 'the strong one' and to 'suffer in silence'. The ability to be able to 'carry on' appeared to be a cultural belief held by the nurses. It is possible that this is reinforced by a narrative held more broadly in society, evidenced by the popularity of the 'clap for heroes'² at the height of the pandemic.

"Sometimes I think you just ... want to put on this brave face, and just carry on really ... and you're not really expressing and letting out ... what you are feeling. I suppose as you go higher, they expect you ... they expect you to handle it, isn't it? You're supposed to ... you're expected to ... to be this strong person ..."

Theme two - You work with them more than your family

This theme encompassed the context of working in a very close environment with colleagues, with consequent impacts on how able participants felt to reflect on issues in supervision or discuss concerns.

"I think obviously ... because you work with these people ... you work with everyone ... you work with them more than you would with your family at home ... and I think sometimes it can be quite difficult sort of saying "I'm really ... I don't like how this person's done this, this, this and this" ... because, I think sometimes you don't want to get ... it carry on in a sort of ..."

² In the UK during the height of the Covid-19 pandemic many people clapped from their windows or front doors at a designated time of day as an expression of gratitude to front-line healthcare workers.

*go into something a bit more ... not serious – it's not the right word to use – but sort of ...
tumble you into something a bit bigger"*

The theme had two subthemes. The first spoke to participants holding the team and their supervisor in mind, which impacted on their ability to be fully present in clinical supervision and to prioritise attendance over other ward demands. This drive to put other's needs before their own appeared linked to participants views on their role as providers of care, and the importance of working as a team when supporting vulnerable patients in challenging situations.

"I can't always focus 100% on the supervision because my ... yeah ... like my mind was on the supervision, but then also thinking of what's going on outside the ward, I'm like "I hope they're OK"

Participants spoke of feeling worried that speaking up might be an unwanted additional source of stress in an already pressured environment, resulting in participants choosing not to disclose in order to protect others. This belief may have originated internally within individual nurses, but its prevalence suggested it was also a ward cultural belief.

"When the ward environment is so stressful already, you didn't want to be pushy ... and add like this extra stress on top of everything else you're doing already"

The second subtheme spoke to a belief that raising concerns about their colleagues would lead to the issue being escalated which might negatively impact on their colleague and potentially disrupt the team dynamic, suggesting a level of fragility within the team.

“I don’t want to feel like I am ... I am grassing my colleague, you know, so those are ... those are difficult issues that you need to talk about it. It’s like the elephant in the room – we both know – but it’s quite difficult to ... sort of bad mouth a colleague who’s on the same level”

Theme three - A Poorly Defined Space

This theme talks to the challenges brought about by a lack of a definition for clinical supervision within the setting and the resulting impact on the supervisee’s experience, along with a lack of space in a more literal sense. Participants described a problem narrative; clinical supervision was there to identify problems, fix issues and learn from mistakes.

“I felt like ... it was like a tick box sort of thing – like they knew that they had to get it done – so, like they tried to squeeze it in wherever they could basically”

“I think ... the ... the purpose of it is just to sort of vent really, and just talk about what’s ... what sort of issues I have on the ward”

Participant accounts noted the challenges of setting up a predictable and consistent space within the inpatient environment.

“My allocated supervisors were ... were either working different shifts to me, like ... because they do day and night shifts ...like I could be doing the day shift, but then they’re doing night shifts, so it was difficult to like find like a time to do it”

“I probably ... I worked there for three ... three years and I maybe had two supervisions”

Theme four – Relationally Unsafe

This theme related to the relationship between the supervisor and supervisee. Participants described how they chose to present themselves in a positive light to their supervisor. It highlights the power differential that were felt in the space and possibly a sense of implied consequences of getting something wrong.

“You don’t want to ... to appear incompetent and, you know not being able to handle the pressure, so I suppose you put a little pressure on yourself as you ... as you progress”

“I probably covered up in all of them. Just to get ... you know... I didn’t want to cause any trouble for myself, so I just, you know, covered up a bit”

Theme five – Strategies to stay safe

Participants described several strategies they used to navigate difficult clinical supervision spaces. These may be the result of feeling relationally unsafe within a poorly defined environment where a culture of managing other’s expectations is perpetuated.

“I’d probably say ... the tip of the iceberg if I want to talk about something ... if I say like the tip of ... I’d probably sort of make it PG if that makes sense ... I really sort of dampen it down sort of ... I don’t know ... I think it ... it’s just that once you’ve said something, it’s like you can’t ... it’s like once you’ve said it, you can’t go back and put it in”

A pattern emerged for some participants which involved sticking to topics which were ‘safer’ such as development and training. It is possible these topics were considered safer because there is less relational risk taking and the focus is on positives. It is possible these topics are therefore also safer for the supervisor.

“I think more ... trust ... topics that are more comfortable to talk about are just general stuff like training and development”

Discussion

The identified themes in this research suggest that nondisclosure can be influenced at three different levels: the broader cultural level, the clinical supervision level and the individual level, each with its own ways of precipitating and perpetuating nondisclosure. As illustrated in the thematic map the levels inter-relate, with broader levels forming the context for the individual level, but not necessarily with a direct causal relationship. At the broader cultural level, how nurses are viewed by external sources, as well as the values and beliefs that are held by the profession, can act to maintain an unhealthy status quo. At the clinical supervision level, a supervision space that is poorly defined, misunderstood, rarely prioritised, inconsistently contracted and facilitated by those with limited experience, may not allow for an interpersonally safe space to be created. At the individual level, supervisees use their own strategies to stay relationally safe by guarding what they say within the context of the other two levels.

Participants described a felt sense of needing to carry on regardless of the impact on themselves; they needed to be superhuman. This cultural narrative of nurses as superheroes has become popular across the UK and other countries since the start of the global pandemic, although viewing nurses in such a way is not new (McAllister et al., 2020). Although this public perception and resulting communal actions such as ‘clap for heroes’ in the UK, is meant as a show of gratitude, it is argued to have additional unintended consequences. Stokes-Parish et al. (2020) note that seeing nurses as something other than human (e.g. angels) leads to a failure to acknowledge their suffering resulting in

disempowerment and the silencing of nurses. It also places added pressure on exhausted nurses (Rees, 2022) whose needs often become misunderstood resulting in them being ignored and exploited (McAllister et al., 2020). The superhero narrative centres the need for nurses to deal with problems at an individual level (Traynor, 2018). Nurses are routinely encouraged to ‘roll with the punches’ and develop their resilience skills to better manage adversity, and the implication that it is their responsibility to cope, can perpetuate the inequalities of the status quo within the healthcare organisation (Traynor, 2018). Maben and Bridges (2020) argue that it is “not acceptable” that nurses are made to feel at fault for not being ‘resilient enough’ as resilience is not an individual responsibility but an organisational one³. This need to look beyond individuals, aligns with Grant & Townend’s (2007) perspective on the importance of viewing nurses within their moral, cultural and professional contexts with regards the need to demonstrate competence and accountability. This also points to a paradox; within a clinical supervision space that requires one to be open: how do nurses enable vulnerability when they are expected to be invulnerable. This has important implications for policy development and nurse training, with openness and transparency featured as key competencies. Also, in how the function of clinical supervision is explained in its training; that it holds the role of development and support in addition to oversight.

An interesting observation was that although participants held their team in mind during clinical supervision, always putting them first and not wishing to “get them into trouble”,

³ The authors are aware of the contentious nature of the term resilience, and would guide the readership to wider literature which interrogates this.

the content of most nondisclosure was linked to relations within the team. These nondisclosures referred more to relational dynamics within the team, for example in ways of working and interacting, as opposed to being about clinical issues. Although these relational differences are not necessarily any cause for concern, participants appeared to think they would be interpreted as such. This highlights the challenge of reflecting on difficulties in relationships without feeling that the relationship is being undermined or weakened by such an act: *how do I talk badly about family?* Or put another way: in an unpredictable and potentially risky environment that requires nurses to look out for one another, how does a supervisee balance the tension between discussing difficulties about a colleague alongside their need for possible support from that colleague. This dynamic may be mitigated by a genuine shift to a 'just culture' where staff experience psychological safety and do not fear blame for speaking up. 'A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution' (Williams, 2018). However, our findings suggest that while this is central to the Patient Safety Strategy (2019b), staff on the ground may not experience this in day-to-day practice.

The focus on nondisclosure in the context of the relationships within teams is another finding from the research. It highlights both the importance of team working but also the pressures that are placed on nurses, which have been considerably impacted over the last few years as the health service has navigated a global pandemic (Muller, et al., 2020; Foye, et al., 2021; The King's Fund, 2020). When thinking about the effects of burnout and wellbeing, it might be important to broaden out the focus from the individual to the team, especially in environments that rely heavily on team connection and collaboration to

function effectively. Schwartz rounds (Dawson et al., 2021) or reflective practice groups that are implemented with consideration for the logistics of a busy ward with varying shift patterns, may facilitate these conversations.

Thinking about the supervision level, participants described a relationship with their supervisors that did not always appear conducive with a context of safety. Concerns around confidentiality and how their supervisor might react became barriers to disclosing. These findings align with those described by Butterworth et al. (2008). Driscoll et al. (2019) notes that there is no agreed or accredited training for new clinical supervisors, and it is unclear what constitutes ongoing support for supervisors. Research by Jones (2006) also found that supervisors can find supervision anxiety provoking and burdensome, whilst others have described supervisor's reports of feeling ill-equipped, out of their depth, overwhelmed and powerless (Singh-Pillay & Cartwright, 2021). Although views of supervisors were not collected in the present study, by the lack of a reported standardised approach, it is plausible that supervisors fell back on their own experiences of supervision as a guide for facilitation.

The findings identify key recommendations for the development of clinical supervision spaces which are regular, structured, clearly defined, predictable and safe. Considerations in nurse training to build an understanding of how to effectively use clinical supervision, as well as, simulation training (Brown, 2008) to support supervisors in how to introduce and contain difficult conversations.

Conclusions

The phenomenon of nondisclosure was found to be present in this sample of inpatient mental health nurses. Reports of how it manifested and perpetuated suggest that overtime it could impact on nurse wellbeing and consequently indirectly impacting on patient care. A worrying narrative that emerged was one of resignation that things would not improve. The use of contracting, openly discussing power, sameness and difference, and outlining the expectations roles and responsibilities of both the supervisor and supervisee could help mitigate these barriers. This is in line with existing recommendations and Proctor's model (Proctor, 2011; Driscoll et al., 2019).

With the ongoing nurse shortage, recruitment and retention issues, coupled with the 'perfect storm' of interacting variabilities in supervisor, content and environment, it appears vital that facilitating a space that enables disclosure will improve wellbeing and retention. Furthermore, if the broader patient safety agenda is to be realised, it is imperative that staff feel able to disclose concerns. It is hoped, therefore that the voices of the mental health nurses who participated in this study will inform policy and practice going forward.

Development of supervision for nurses holds key importance in delivering safe, accountable care to our most vulnerable patients and in retaining well-supported practitioners. In this way, the reported concern of one participant that disclosing in their supervision "would probably do more harm than good" can be understood and effectively responded to.

Keywords

Clinical supervision, mental health nursing, nondisclosure, openness, transparency.

Key points

Mental health nurses working in inpatient settings report that it can be difficult to disclose sensitive information in clinical supervision. This tends to be related to concerns about issues with the availability of clinical supervision, perceptions of resilience within the profession, a sense of needing to protect both individual and team needs, and fears regarding lack of psychological safety. The findings identify the importance of creating a regular and structured space, clearly defined and understood by both supervisee and supervisor, and one that feels predictable and safe. Previously unreported findings included the internalised belief that nurses should be 'superhuman' and the importance of team cooperation. These interacted with the other findings to create an environment that facilitated nondisclosure.

Reflective questions

1. Thinking about your clinical supervision, do you ever find it difficult to be open within the space? Why do you think that is?
2. If you needed to broach a difficult topic with your supervisor, how would you do it? What would make it easier/harder?
3. For you, what are the benefits of clinical supervision? What are its challenges? And what changes would you make?
4. From the answers to your previous questions, is there anything you would like to be different in your clinical supervision? How could you action these changes?

References

Birt, L., Scott, S., Cavers, D. Campbell, C. and Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Res.* 26(13): 1802-1811.

Braun, V. & Clarke, V. (2022). *Thematic Analysis A Practical Guide*. Sage.

Brown, J. F. (2008). Applications of simulation technology in psychiatric mental health nursing education. *Psychiatric and Ment. Health Nurs.* 15(8):638-644.

Butterworth, T., Bell, L., Jackson, C. & Pajnkihar, M. (2008). Wicked spell or magic bullet? A review of the supervision literature 2001-2007. *Nurs. Educ Today.* 28(3):264-72. doi: 10.1016/j.nedt.2007.05.004.

Buus, N. & Gonge, H. (2009). Empirical studies of supervision in psychiatric nursing: A systematic literature review and methodological critique. *Int J of Mental Health Nurs.* 18: 250-264.

Cleary, M. & Horsfall, J. (2011). The realities of supervision in an Australian acute inpatient setting. In Cutcliffe, J.R., Hyrkäs, K. & Fowler, J. (eds) *Routledge Handbook of Supervision, Fundamental International Themes*. Routledge.

Cook, R.M., Jones, C.T. & Welfare, L.F. (2020). Supervisor cultural humility predicts intentional nondisclosure by post-master's counsellors. *Counsel Educ. & Super.* 59:160-17.

Cook, R.M., Welfare, L.E. & Jones, C.T. (2020). Incidence of intentional nondisclosure in supervision by Prelicensed Counselors. *The Prof Couns.* 10(1):25-38.

CQC (2022). Regulation 18: staffing. Available from <https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing>

Davey, B., Desousa, C., Robinson, S. & Murrells, T. (2006). The policy–practice divide who has supervision in nursing? *J of Res in Nurs.* 11(3):237-248.

Dawson, J., McCarthy, I., Taylor, C., Hildenbrand, K., Leamy, M., Reynolds, E. & Maben, J. (2021). Effectiveness of a group intervention to reduce the psychological distress of healthcare staff: a pre-post quasi-experimental evaluation. *BMC Health Services Res.* 21(392).

Department of Health (2000). Making a difference supervision in primary care. Department of Health.

Driscoll, J., Stacey, G. & Harrison, K. (2019). Enhancing the quality of supervision in nursing practice. *Nurs Standard.* doi: 10.7748/ns.2019.e11228.

Duncan-Grant, A. (2000), Supervision and organisational power: a qualitative study. *Mental Health Care.* 3(12):398–401.

Franklin, N. (2013). Supervision in undergraduate nursing students: a review of the literature. *e-J of Bus Educ & Scholarsh of Teach.* 7(1):34-42.

Foye, U., Dalton-Locke, C., Harju-Seppänen, Lane, R., Beames, L., Juan, N.V.S., Johnson, S. & Simpson, A. (2021). How has COVID-19 affected mental health nurses and the delivery of mental health nursing care in the UK? results of a mixed-methods study. *J of Psychiatric and Ment Health Nurs.* 28:126-137.

Fugard, A. & Potts, W.W. (2015). Supporting thinking on sample sizes for thematic analyses: a quantitative tool. *International Journal of Social Research Methodology*. 6: 669-684.

Galanis, P., Vraka, I., Fragkou, D., Bilali, A. & Kaitelidou, D. (2020). Galanis P, Varka I, Fragkou D, et al. Nurses' burnout and associated risk factors during the COVID-19 pandemic: a systematic review and meta-analysis. *J of Advanced Nurs*. 77: 3286-3302.

Grant, A. & Townend, M. (2007). Some emerging implications for supervision in British mental health nursing. *J of Psychiatric and Mental Health Nurs*. 14:609-614.

Hess, S.A., Knox, S., Schultz, J.M., Hill, C.E., Sloan, L., Brandt, S., Kelly, F. & Hoffman, M. (2008). Predoctoral interns' nondisclosure in supervision. *Psychotherapy Res*. 18:(4).

Hutman, H. & Ellis, M.V. (2019). Supervisee nondisclosure in supervision: cultural and relational considerations. *Train and Educ in Prof Psychol*. 14(4):08-315.

Hyrkäs, K., Koivula, M. & Paunonen, M. (1999). Supervision in nursing in the 1990s—current state of concepts, theory and research. *J of Nurs Management*. 7:177-187.

Jones, A. (2006). Supervision: what do we know and what do we need to know? a review and commentary. *J of Nurs Management*. 14:577-585.

The King's Fund. (2020). The courage of compassion supporting nurses and midwives to deliver high-quality care. Available from

<https://www.kingsfund.org.uk/sites/default/files/2020->

[09/The%20courage%20of%20compassion%20summary_web_0.pdf](https://www.kingsfund.org.uk/sites/default/files/2020-09/The%20courage%20of%20compassion%20summary_web_0.pdf)

Maben, J. & Bridges, J. (2020). Covid-19: supporting nurses' psychological and mental health. *J of Clin Nurs*. 29:2742-2750.

McAllister, M., Brien, D.L. & Dean, S. (2020). The problem with the superhero narrative during COVID-19. *Contemporary Nurs.* 56(3):199-203.

Mehr, K.E. Ladany, N. & Caskie, G.I.L. (2010). Trainee nondisclosure in supervision: what are they not telling you? *Couns and Psychother Res.* 10(2):103-113.

Muller, A.E., Hafstad, E.V., Himmels, J.P.W., Smedslund, G., Flottorp, S., Stensland, S.O., Stroobants, S. Van de Velde, S. & Vist, G.E. (2020). The mental health impact of the covid-19 pandemic on healthcare workers, and interventions to help them: A rapid systematic review. *Psychiatry Res.* 293.

NHS. (2018). A just culture guide. Available from https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf

NHS. (2019a). Interim NHS people plan. Available from https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

NHS. (2019b). The NHS Patient Safety Strategy. Available from https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf

NHS Education for Scotland. (2021). Supervision: Nursing and midwifery workforce mission statement. Available from https://nesvleprdstore.blob.core.windows.net/nesndpvlecmsprdblob/4cc238de-d4a2-4f39-9098-c8177bc425a5_Clinical%20SupervisionNM_NES%20position%20statement_SEPT21.pdf?sv=2018-03-

[28&sr=b&sig=ReSPSSStauwr3oIjN3%2Bkox53t2FB6A%2FjBbWR6YwtFkc%3D&st=2022-03-07T20%3A12%3A37Z&se=2022-03-07T21%3A17%3A37Z&sp=r](https://www.nhs.uk/terms-and-conditions-of-service-handbook/)

NHS Employers (2024). Terms and conditions of service handbook. Available from

[NHS Terms and Conditions of Service Handbook | NHS Employers](https://www.nhs.uk/terms-and-conditions-of-service-handbook/)

Proctor, B. (2011). Training for the supervision alliance attitude, skills and intention. In Cutcliffe, J.R., Hyrkäs, K. & Fowler, J. (eds) Routledge Handbook of Supervision, Fundamental International Themes. Routledge.

Rees, J. (2022). Covid: Superhero images unhelpful, says nurse chief. Available from <https://www.bbc.co.uk/news/uk-wales-61412032>

Singh-Pillay, N. & Cartwright, D. (2018). The unsaid: In- depth accounts of non-disclosures in supervision from the trainees' perspective. *Couns Psychotherapy Res.* 19:83-92.

Sirola-Karvinen, P. & Hyrkäs, K. (2011). Supervision for nurses in administrative and leadership positions. In Cutcliffe, J.R., Hyrkäs, k. & Fowler, J. (eds) Routledge Handbook of Supervision Fundamental International Themes. Routledge.

Sloan, G. (2011). Supervision in the United Kingdom – ten years on a review of the United Kingdom supervision literature. In Cutcliffe, J.R., Hyrkäs, K. & Fowler, J. (eds) Routledge Handbook of Supervision, Fundamental International Themes. Routledge.

Stevenson, C. (2011). Postmodernising supervision in nursing. In Cutcliffe, J.R., Hyrkäs, K. & Fowler, J. (eds) Routledge Handbook of Supervision, Fundamental International Themes. Routledge.

Stokes-Parish, J., Elliott, R., Rolls, K. & Massey, D. (2020). Angels and heroes: the unintended consequence of the hero narrative. *J of Nurs Scholar*. 0:0:1-5.

Sweeney, J. & Creaner, M. (2014). What's not being said? recollections of nondisclosure in supervision while in training. *Br J of Guidance & Couns*. 42(2):211-224.

Traynor, M. (2018). Guest editorial: what's wrong with resilience. *J of Res in Nurs*. 23(1): 5-8.

Williams, N. (2018). Gross negligence manslaughter in healthcare The report of a rapid policy review. Available from https://assets.publishing.service.gov.uk/media/5b2a3634ed915d2cc8317662/Williams_Report.pdf

Yegdich, T. (1999). Supervision and managerial supervision: some historical and conceptual considerations. *J of Advanced Nurs*. 30(5):1195-1204.