Nurse Education Today 94 (2020) 104564

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/locate/nedt

# The implementation of resilience based clinical supervision to support transition to practice in newly qualified healthcare professionals

Gemma Stacey[a], Grace Cook[a,*], Aimee Aubeeluck[a], Beth Stranks[a], Louisa Long[a], Miriam Krepa[a], Kate Lucre[b]

[a] University of Nottingham, United Kingdom of Great Britain and Northern Ireland
[b] Compassion Focus Therapist Compassionate Mind Foundation, United Kingdom of Great Britain and Northern Ireland

ABSTRACT

*Background:* Healthcare workforce shortages are an international issue. This service development targets the contributory element of poor retention amongst newly qualified nurses. Resilience Based Clinical Supervision is underpinned by the principles of Compassion Focused Therapy. It aims to alleviate work related stress and support individuals to reframe their experiences through structured and reflective discussion. It incorporates skills which develop proficiency in mindfulness, distress tolerance and positive reframing.
*Objectives:* To explore the acceptability, feasibility, and experience of Resilience Based Clinical Supervision to support transition to practice in newly qualified nurses.
*Design:* An extensive program of champion (N = 40) and cascade (N = 78) training for facilitators was implemented as a development of their standard transition to practice package.
*Settings:* Six pilot sites within the UK.
*Participants:* Newly qualified nurses (266) received a minimum of six Resilience Based Clinical Supervision sessions over a one-year period.
*Methods:* Data were gathered via eleven focus groups (n = 48). A deductive and collaborative approach to content analysis was utilised to consider the perceived outcomes, challenges, experience and best practice amongst both facilitators and nurses' transitioning from student to registered practitioner.
*Results:* Analysis showed the new registrants were extending and accepting compassion to and from their peers, signifying the compassionate flow within the group setting. This was continued through the development of self-care strategies utilised in practice, which allowed compassion to flow into patient care and towards colleagues.
*Conclusions:* The main perceived outcome of RBCS was recognised as restorative. However, the growth of skills for self-care, emotional intelligence, and confidence to challenge poor working conditions also indicated a developmental function. These perceived outcomes have the potential to result in positive implications for workforce retention. Importantly, findings draw attention to the importance of wider organisational commitment and structures which support and respond to RBCS facilitator and participant concerns.

## 1. Introduction

The transition from student to registered practitioner is a challenging progression which is defined by a difficult period of adjustment involving significant personal and professional adaptation. Kramer (1974) originally described this phenomenon as a 'reality shock,' defined as 'the reactions of new workers when they find themselves in a work situation for which they have spent several years preparing and for which they thought they were going to be prepared, and then suddenly find they are not'. The continued relevance of this term has been attributed to the widespread occurrence of workplace adversity involving hostile, abusive or unrewarding environments (McDonald et al., 2016).

The consequences for newly qualified nurses are significant as the coping strategies they employ to rectify this challenging period of adjustment are shown to have negative effects on quality of care (Maben et al., 2007). The lack of compassion within nursing is an international concern (Wolf, 2012). If not addressed in the early stages of the career then it is suggested that workplace adversity can alter the compassionate ability of the practitioner (Upton, 2018). Consequently, workplace adversity is correlated with decreased quality of care, higher mortality, and failure to rescue (Coetzee and Klopper, 2010).

The experience of transition is of fundamental concern to healthcare practitioners entering the world of work (preceptees). Much of the focus has been on structured transition programs (preceptorship) supported by qualified practitioner (preceptor). Whilst preceptorship is relied on to support professional adjustment, socialisation and enculturation into the nursing profession, there is a strong debate within the literature about the effectiveness of this approach (Whitehead et al., 2016). It is argued that programs are usually homogenous, clinical competency

* Corresponding author.
*E-mail address:* grace.cook@lancashirecare.nhs.uk (G. Cook).

https://doi.org/10.1016/j.nedt.2020.104564
Received 23 November 2019; Received in revised form 15 May 2020; Accepted 26 July 2020

driven, variable in length, content, and structure and didactic in nature (Stacey and Cook, 2019). Little attention has been given to extensively and rigorously documenting transition support interventions that focus on professional adjustment (Adams and Gillman, 2016).

The service development, which is the focus of this paper, aimed to address this shortfall via the addition of a novel form of clinical supervision, Resilience Based Clinical Supervision (RBCS), to the standard preceptorship program. The guidelines for reporting evidence-based practice educational interventions and teaching (GREET) (Phillips et al., 2016) will be utilised to report this project. These guidelines are endorsed by the Equator Network (2016) as a method of enhancing the quality and transparency of reporting educational interventions.

## 2. Intervention

RBCS offers a forum for alleviation and prevention of stress. The practitioner is encouraged to consider and explore emotional reasoning underpinning their behaviours and responses. Over time the practitioner learns to regulate their responses and observe their own well-being whilst also giving attention to exploring the complex social context in which they practice (Stacey et al., 2017).

RBCS is a facilitated reflective discussion characterised by:

1. The identification of the unique group conditions needed to create a safe space.
2. The integration of mindfulness-based stress-reduction exercises.
3. An explicit focus on the 3 emotional systems model (Gilbert, 2014) motivating the response to a situation.
4. A consideration of the role of the internal critic in sustaining or underpinning the response to a situation.
5. A commitment to cultivating and maintaining a compassionate flow to self, to be open to the flow from others and also to develop the flow to others (Stacey et al., 2017).

## 3. Why this educational process

It is evident, that strategies which aim to support newly qualified practitioners during this transition period should account for the complex organisational, relational, and personal processes influencing their experience. RBCS was developed with this perspective in mind and is underpinned by an ecological definition of resilience. This standpoint assumes that resilience offers the solution to how we respond to living in a world of complexity (Walker and Salt, 2006). However, it asserts that this will require change in the wider system which will lead to significant restructuring. In this sense, resilience is viewed as a collective response to adversity, which requires diversity, non-linear behaviours, and mobilisation of complex resource systems. When resilience is viewed from this perspective, it has potential to enable communities to withstand future disturbance and promotes the collective capacity for renewal (Joseph, 2013).

The process of RBCS is also underpinned by the principles of compassion-focused therapy (CFT) (Gilbert, 2010). A central focus in CFT is to help people access and stimulate affiliative motives, emotions and competencies underpinning compassion that play important roles in threat regulation, well-being, and prosocial behaviour (Gilbert, 2014).

A core element of CFT utilised in RBCS is the model of emotional regulation (Gilbert, 2014). CFT proposes that humans have evolved three emotion regulation systems: The Threat system which includes our threat emotions (e.g. anger, anxiety, disgust, sadness) and associated defensive behavioural responses (e.g. fight, flight, freeze, submit, immobilise). From an evolutionary perspective, these enable immediate detection and response. The Drive system, including activating/energising emotions and those linked to rewards (e.g. drive, excitement, joy, pleasure). The functions of this system relate to identifying, seeking out and obtaining resources that are essential to survival and reproduction. The third, Affiliative/Soothing system, is associated with affiliative emotions (e.g. contentment, soothing, safeness), and is intricately linked with the social engagement system signalling and responding to signals of safeness and connectedness.

Porges (2007) asserts that through evolution the Soothing system has been adapted to enable affiliative and attachment behaviours to emerge. One of the most significant functions of the Soothing system is to provide a natural regulatory function for the threat and drive systems. This function was believed to be an important underpinning for supervisory process, complemented by positive reframing and role to focus on enacting a preferred outcome.

Staff stress can compromise the effectiveness of teams and within organisations. Teams that are operating in conditions of threat can lead to staff having lower levels of compassion (Henshall et al., 2018). Whereas there is growing evidence to show that explicit development and practice of compassion can result in individuals better able to manage their own distress, be less reactive to social threats and reduce experience of self-criticism, anxiety and depression (Gilbert, 2005; Neff et al., 2007; Allen and Leary, 2010; Arch et al., 2014).

As a developing framework for supervision, the specific evidence base for RBCS is limited. Stacey et al. (2017) implemented RBCS with one cohort of student nurses. Findings indicated RBCS had the potential to support student nurses in developing resilience-based competencies that allowed them to recognise and attend to workplace stressors. This was achieved through suitable and helpful alleviation approaches. Students highly valued the supportive environment, which enabled them to learn about themselves and from others. This motivated them to challenge negative working conditions which had an impact on patient care.

### 3.1. RBCS learning objectives

1. To develop competence in mindfulness-based stress reduction strategies, positive reframing, and distress tolerance.
2. To apply the emotional regulation systems model to clinical challenges to explore and reflect upon emotions associated with practice.
3. To identify and implement positive action in relation to self-care.
4. To engage in reflective and meaningful dialogue with peers, involving appropriate challenge and contribute to the group development of a collective resilience.

## 4. Implementation

Six Healthcare Trusts across the East Midlands (UK) implemented RBCS as part of their preceptorship package. A broad program of champion (N = 40) and cascade (N = 78) training for RBCS facilitators was implemented in each pilot site. Champion training entailed attendance at a one-day masterclass facilitated by researchers which utilised experiential learning strategies to enable facilitators to observe and develop the knowledge and skills underpinning RBCS. This was then cascaded within each organisation via open access facilitator resources (https://www.fons.org/learning-zone/clinical-supervision-resources). Facilitators were registered healthcare practitioners working predominantly as clinical educators who were already contributing to the standard preceptorship program.

Over a one-year period, 266 preceptees received at least six RBCS sessions. This was provided monthly for a period of 2 h and was scheduled into protected non-clinical time. The group sizes varied from 5 to 15.

### 4.1. Evidence based practice content

The evaluation of this service development aimed to explore the acceptability, feasibility, and experience of RBCS in preceptorship. This involved exploring facilitators' and new registrants' experiences of and views towards RBCS along with the perceived outcomes.

The project was reviewed by the Health Research Authority and classified as a service development and did not require NHS research ethics approval. Permission to undertake the service evaluation was granted by pilot sites. All participants gave informed, written consent. Data were collected and stored in line with General Data Protection Regulations.

Eight focus groups were facilitated with newly qualified nurses, directly after they had attended a minimum of six RBCS sessions (N = 42). Three focus groups were carried out with RBCS facilitators (N = 18). Participants were invited by the Trust lead for clinical education. All participants who opted to take part in the focus groups were included.

Focus groups were transcribed verbatim and confidentiality was maintained through the anonymisation of transcripts. The deductive approach to content analysis involved independently applying a broad framework to the data which considered the perceived outcomes, challenges, experience, and best practice relating to RBCS. The approach followed convention advocated by Elo and Kyngäs (2008). This phase was followed by independent memo development to describe the incidence and nature of categories in the data. Six members of the project team independently examined the data to tentatively identify relevant concepts relating to the pre-defined framework. These were collectively reviewed, discussed and debated during the phase of axial coding which identified the linkages amongst the concepts and categories. During this phase transcripts were regularly revisited to ensure close adherence to the data. Finally, selective coding was performed to pinpoint the core category from which the phenomenon evolved (Corbin and Strauss, 1990).

## 5. How well?

Key findings are indicated in Table 1.

### 5.1. Experience of RBCS

#### 5.1.1. Critical reflection through group dialogue

The safe space and group dialogue provided by RBCS appeared to encourage engagement in **critical reflection**. Peers provided **validation** of feelings and offered reassurance by normalising thoughts related with self-criticism and unrealistically high expectations of self.

> *I think we also put a lot of pressure on ourselves as a newly qualified. Like we want to go there and do the best, save everybody. And I think they put us in place to say you can't do everything, you're just a human being. It's okay to feel overwhelmed. It's okay to not manage to do everything on shifts and its okay to pass it onto other people.*
>
> (Preceptee)

RBCS offered a forum to share and contain feelings they were experiencing as these were explored in their full complexity.

> *They were looking at the three emotional systems we actually asked them how they feel about things rather than just saying "what are you going to do about it?" So we are using more of the language and that is why where getting a different sort of freshness from things.*
>
> (Facilitator)

**Positively reframing** a challenging situation facilitated this perceived outcome. Preceptees were encouraged to identify their constructive contribution whilst also acknowledging their personal limitations.

> *When you're newly qualified, it is learning by experience and it's about being compassionate to yourself and I wasn't being compassionate to myself. I was judging myself as not being good enough as a newly qualified nurse, not trusting my own instincts. Part of that journey is about being more compassionate to myself.*
>
> (Preceptee)

The preceptees noted a change in their response over time by considering the emotional regulation systems. They noticed how they had moved from Threat (red) to Drive (blue) or Soothing (green) which was viewed as a helpful reflection of progress.

> *And it's like you're constantly moving through blue red blue red, initially anyway. At the minute I'm kind of a flip between the green and the blue a lot. But there is obviously, especially when I'm on duty in the afternoon, as soon as I get a call that's like red, it's like 'who's on the other end, what's going to happen.' But then you just kind of learn to deal with the situation and I've kind of learned that it's okay to say, you know, I'm not too quite sure at the moment.*
>
> (Preceptee)

Through support and motivation provided by the group, participants identified an increased **courage to act** and address negative working conditions. Examples included having permission to ask for help, where they would previously have continued, regardless of the negative impact on their wellbeing. This finding resonates with the ecological definition of a resilient act.

> *They taught me to raise the problem with the manager and deal with it that way. So I raised the problem with my manager.*
>
> (Preceptee)

### 5.2. Perceived outcomes

#### 5.2.1. Self-care as priority

An association between self-care and retention was suggested by facilitators and perceived as a priority outcome.

> *You will still get a ward sister saying why are all newly qualified nurses getting this much time out of clinical areas? I'd be like we need to invest in them right now or they won't be here in 6 months.*
>
> (Facilitator)

Attendance at RBCS was recognised as a means of self-care. Both facilitators and preceptees remarked on the peer support occurring within the group and perceived it as a distinctive and psychologically safe space. Preceptees shared how the permission to reflect on experiences and have their feelings **validated**, in an atmosphere which felt free from judgement, positively influenced their wellbeing. Preceptees described a sense of **belonging** and that they were not alone with their current feelings.

> *I think it is the ability to be able to open up and feel safe about opening*

**Table 1**
Key findings.

| Initial predefined categories | Key concepts | Categories | Core category |
|---|---|---|---|
| Experience of RBCS | • Critical reflection through group dialogue | • Belonging | • Compassionate flow |
| Perceived outcomes | • Self-care as priority | • Validation | |
| | • Mitigation of compassion fatigue | • Containment | |
| | • A vehicle to challenge workplace culture | | |
| Challenges | • Professional role | • Organisational culture | |
| | • Relational dynamics | | |

*up. Because you know in that room that everything is confidential.*
(Preceptee)

Strategies for self-care were developed from attending RBCS. This included mindfulness, which was used to ground in preparation for or following a stressful event. Additionally, fresh methods to time management were identified, which helped to give a sense of improved control over their personal wellbeing when at work.

*When I'm in the car or when I'm facing a tough patient. I will sit for a couple of minutes and think just breath, say to myself "you can do it" and put my mind in the right way.*
(Preceptee)

The motivation to re-establish a work/life balance and reconnect or commence new hobbies was inspired by other group members. Where individuals were struggling to prioritise these principles, the group challenged and encouraged them.

*I think before I didn't push myself to do things. So I would get home, I'll be tired so I would think that all I want to do is get in the shower, have my tea and I would just sit and watch TV. And that isn't necessarily the best thing to do because it's not working out, it's just sitting there waiting to go to bed. But just recently I have started to go out and do things.*
(Preceptee)

A commitment to seeking out and providing ongoing supervision had been encouraged. It was viewed as a means of preserving wellbeing at work and participants were motivated to ensure RBCS was provided post preceptorship. This was strengthened by an overtly positive attitude towards supporting colleagues and future preceptees.

*A lot of people in our groups now want to be preceptors when they qualify and do their mentor training because they want to make sure that they can give the support that they might not get or that they are not getting.*
(Facilitator)

#### 5.2.2. Mitigation of compassion fatigue

The strategies they had developed to manage workplace stress were described as mitigating early experiences of compassion fatigue. It was suggested that an overall improvement in wellbeing was associated with improved capacity for compassion towards others.

*You offload and then you feel like you can go in again and refresh.*
(Preceptee)

*I find that some of the patients that I deal with, you get kind of compassion fatigue almost. But in one of these sessions I remember someone saying that you always have to think about that your patient is always having a worse day than you are. … I think for me, that's really helpful.*
(Preceptee)

The ability to focus on the specific needs of the patient was an example of this and was associated with adopting a mindful approach to practice.

*On really busy days it is hard to take that time with a patient because you're thinking of got to get to the next one. But you've got to focus on this is my patient for now. And I guess it just helps in that way because the sessions have made me think more about, stress wise, not getting through the week but getting through this morning are to put it into smaller chunks.*
(Preceptee)

#### 5.2.3. A vehicle to challenge workplace culture

Facilitators were motivated by their perception that RBCS may offer a vehicle to challenge engrained workplace culture by promoting the courage to prioritise self-care. There were numerous examples of where this had been achieved.

*They judge themselves very easily but I think it gives them the courage. I think it gives them the courage to challenge perhaps this is why I think knowing that you can now speak to your senior nurses, your ward sisters if there is an issue and knowing that you can challenge it.*
(Facilitator)

However, facilitators were also concerned that the organisation may receive the preceptees challenge negatively.

*They are thinking about themselves and because they're insisting "I'm going to get a, clinical supervisor" and "I'm going to make sure that I plan my time differently", I am thinking oh my gosh. I'm waiting for the managers to knock on my door and say "what are you doing".*
(Facilitator)

### 5.3. Challenges

In providing the RBCS forum, facilitators encountered several challenges. These related to perceived expectations and unsupportive organisational culture. Each of these aspects requires accounting for in future implementation.

#### 5.3.1. Professional role

A minority of facilitators suggested that a mental health qualification is required in order to have the skills to respond to and contain the distress or emotional disclosure shared. This was evident where the groups had large and inconsistent membership. In these circumstances' facilitators described a lack of control which could be overwhelming to them.

*Because we were inviting them to bring emotions and because they were newbies into work and into new positions, there were lots of emotions and often we weren't able to move on from that because you can't, you couldn't just leave it out there.*
(Facilitator)

This tension was acknowledged by other supervisors, however they seemed more willing to hold the disquiet.

*I left that session thinking they shouldn't have to feel like that in their practice areas. I think that's so wrong. I was actually quite emotional about it myself but I think I shared that with my assistant and recognised it's a system process, not an action that needs escalating.*
(Facilitator)

#### 5.3.2. Relational dynamics

The facilitators who questioned the value of a focus on emotions also expressed nervousness about the potential for the model to encourage a paternalist response. They felt the preceptees held an expectation that the facilitators would fix any problems. There was vagueness around how issues should be escalated within the organisation and facilitators were concern about the organisations response where challenge was required due to an organisational culture which did not promote open and authentic dialogue. The facilitator was left with personal guilt and apprehension about their professional duty of care to the individual.

*You almost get a sense of that you're letting them down, the fact that you can't just fix that. They have brought this to us. We started this ball rolling and then we say maybe you should go and see one of our councillors. It kind of felt like we started something that we couldn't finish.*
(Facilitator)

## 6. Discussion

The safe space was valued by preceptees as it enabled them to offload, explore emotions, learn from others, positively reframe

challenging situations, and gain reassurance. Positive effects on well-being and self-care were self-reported. Contrary to the perception of some facilitators, preceptees were satisfied with the containment the sessions offered in helping them to manage challenging staff relationships or high expectations of self and a desire for a solution or to influence change was not their priority. This suggests the restorative function (Proctor, 1987) of clinical supervision is the most dominant perceived outcome of this model. Also reiterating the importance of the group aspect which reinforced the significance of the collective process.

The key concept which linked the categories together was interpreted as 'compassionate flow'. Analysis showed the new registrants were extending and accepting compassion to and from their peers, signifying compassionate flow within the group setting. This was continued through the development of self-care strategies utilised in practice, which allowed compassion to flow into patient care and towards colleagues. This supports current compassion-based research which advocates the idea that actively cultivating the flow of compassion to the self and being available to receive from others can address a variety of issues related to emotional wellbeing, response to stress and ability to manage work based threats (Arch et al., 2014). It is evident therefore that RBCS also had a formative function (Proctor, 1987). The facilitators were recognised as key to enabling this process as they provided compassionate containment to the group. This was successful in organisations that provided compassionate containment to the facilitators. In these organisations this enabled escalation or challenge of working conditions which were leading workplace adversity. Where the organisational culture was open to the need to acknowledge and respond to these issues, the normative function (Proctor, 1987) of RBCS was also evident. This was achieved through actions which challenged traditional way of responding and demonstrated the influence when an ecological or collective approach to resilience is promoted (Walker and Salt, 2006) (Fig. 1).

RBCS explicitly focuses on the emotional consequence of healthcare practice and some facilitators felt the desire to contain, manage and control the content of the sessions. This appeared to be underpinned by perceived professional accountability and their aspiration to elevate distress amongst preceptees. The solution for some facilitators to manage this threat was to discourage disclosure. Others grew to be comfortable with their role in listening, positively reframing and action planning. There was appreciation that the model differed from the dominant workplace culture as it gave permission to challenge non-compassionate responses and focus on self-care amongst staff. This is suggestive of the ecological definition of resilience which stresses a community response to adversity that leads to change in the way groups react to negative cultures and typical practices (Walker and Salt, 2006).

In organisations where the culture undermined a clear process or commitment to responding to the distress of preceptees, facilitators felt overwhelmed and saddled with holding the emotion of their group. It could be argued that due to compassion only flowing from the facilitators this led to feelings of threat. As a consequence, there was a reluctance to offer a forum which focused on the emotional impact of healthcare practice. Facilitators perceived themselves as individually responsible for alleviating the preceptees adversity as well as being as tasked with governing the complexity of the issue without a clear sense of how issues could be escalated. They expressed concern about how this would be received by senior management leading to a feelings of isolation.

**Table 2**
Recommendations for RBCS structure and process.

- Consider group membership and continually assess influence of group dynamics
  - Establish expectations of facilitator and preceptee roles with the RBCS forum
  - Preceptees set the agenda for the RBCS session
  - Maintain small and consistent group membership and facilitation (10 maximum)
  - Facilitator preparation and support
  - Commitment to personal practice of the principles of the model
  - Opportunity to shadow RBCS prior to leading the facilitation
  - Opportunity to be observed and receive feedback on approach
  - Clear structure for facilitators to receive their own supervision
  - Organisational commitment
  - Clear processes for escalation of workplace issues
  - Clear processes for escalation of safeguarding issues relating to staff wellbeing
  - Widespread implementation
  - Commitment to respond positive towards strategies which promote self-care

## 7. Recommendations for best practice

Table 2 indicates recommendations for best practice guidance to maximise the positive perceived outcomes of RBCS and mitigate the challenges experienced by both preceptees and facilitators highlighted in this study.

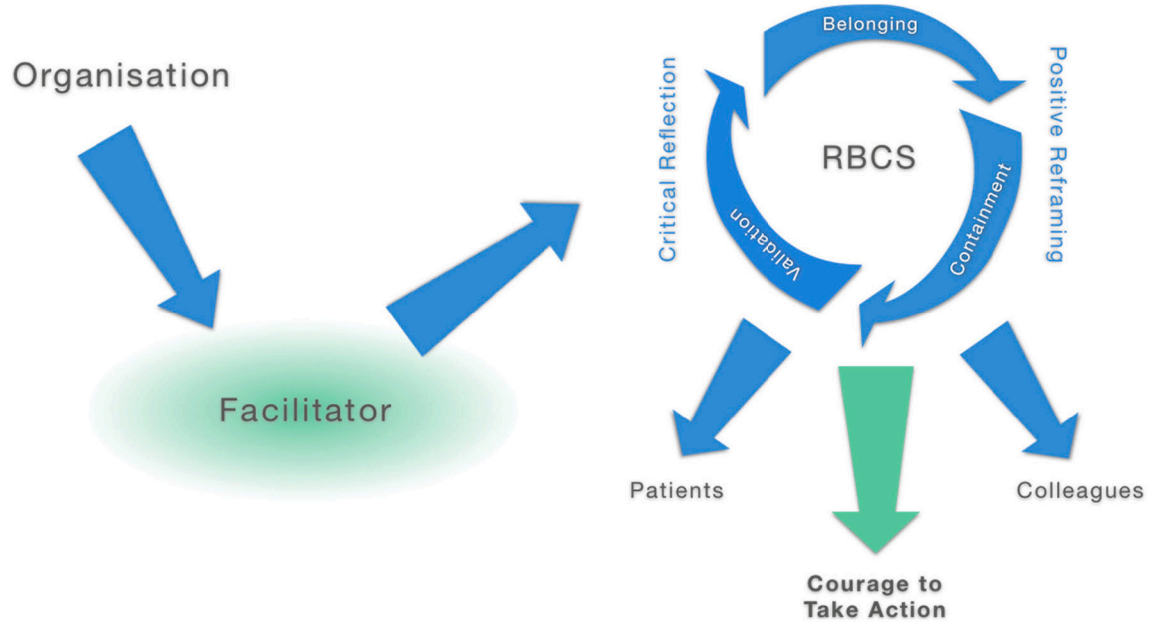


**Fig. 1.** Compassionate flow in facilitation of RBCS.

## 8. Conclusion

The restorative/affiliative function of clinical supervision is clearly demonstrated as a perceived outcome of RBCS. Additionally, the formative function is evident through the development of skills for self-care, emotional intelligence, and subsequent confidence. In organisations, where there is support for the premise of RBCS and clear pathways are in place to address uncovered workplace adversity, the normative function is achieved. This was demonstrated when preceptees and facilitators had the courage to challenge working conditions which were negatively affecting staff wellbeing and subsequently patient care. Where organisational support was absent the facilitator was left burdened with the knowledge of the preceptee's distress. This had a negative effect on their wellbeing and reduced their willingness to facilitate reflective forums that were explicitly focused on the emotional impact of healthcare practice. This study has provided a platform for exploring the acceptability, feasibility, and experience of RBCS utilising pilot sites. However, it is limited by the absence of a control group and limited consideration of the wider organisational influences which have evidently impacted on the facilitators experience. Future research will test a standardised model of RBCS to further assess its impact on the resilience of newly qualified practitioners in practice.

## Funding source

This project was funded by The Burdett Trust for Nursing.

## Ethical approval

Ethical approval was not required for this project however permission was sought from relevant parties. Further information in regards to this is available within the manuscript.

## Declaration of competing interest

There are no known conflicts of interests associated with this work.

## References

Adams, J., Gillman, L., 2016. Developing an evidence-based transition program for graduate nurses. Contemp. Nurse 52 (5), 511–521. https://doi.org/10.1080/10376178.2016.1238287.

Allen, A., Leary, M., 2010. Self-compassion, stress and coping. Soc. Personal. Psychol. Compass 4 (2), 107–118. https://doi.org/10.1111/j.1751-9004.2009.00246.x.

Arch, J., Brown, K., et al., 2014. Self-compassion training modulates alpha-amylase, heart rate variability, and subjective responses to social evaluative threat in women. Psychoneuroendocrinology 42, 49–58. https://doi.org/10.1016/j.psyneuen.2013.12.018.

Coetzee, S., Klopper, H., 2010. Compassion fatigue within nursing practice: a concept analysis. Nurs. Health Sci. 12 (2), 235–243. https://doi.org/10.1111/j.1442-2018.2010.00526.x.

Corbin, J., Strauss, A., 1990. Grounded theory research: procedures, canons, and evaluative criteria. Qual. Sociol. 13 (1), 3–21. https://doi.org/10.1007/BF00988593.

Elo, S., Kyngäs, H., 2008. The qualitative content analysis process. J. Adv. Nurs. 61 (1), 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x.

Equator Network, 2016. Reporting guidelines. Last accessed 114/05/2020 at. https://www.equator-network.org/reporting-guidelines/greet/ (online).

Gilbert, P., 2005. Compassion: Conceptualisations, Research and Use in Psychotherapy. Routledge, London.

Gilbert, P., 2010. Compassion Focused Therapy: Distinctive Features. Routledge/Taylor & Francis Group, New York.

Gilbert, P., 2014. The origins and nature of compassion focused therapy. Br. J. Clin. Psychol. 53 (1), 6–41. https://doi.org/10.1111/bjc.12043.

Henshall, L., Alexander, T., et al., 2018. The relationship between perceived organisational threat and compassion for others: implications for the NHS. Clin. Psychol. Psychother. 25 (2), 231–249. https://doi.org/10.1002/cpp.2157.

Joseph, J., 2013. Resilience as embedded neoliberalism: a governmentality approach. Int. Policies Pract. Discourses 1 (1), 38–52. https://doi.org/10.1080/21693293.2013.765741.

Kramer, M., 1974. Reality Shock; Why Nurses Leave Nursing. Mosby, St. Louis.

Maben, J., Latter, S., et al., 2007. The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study. Nurs. Inq. 14 (2), 99–113. https://doi.org/10.1111/j.1440-1800.2007.00357.x.

McDonald, G., Jackson, D., et al., 2016. Surviving workplace adversity: a qualitative study of nurses and midwives and their strategies to increase personal resilience. J. Nurs. Manag. 24 (1), 123–131. https://doi.org/10.1111/jonm.12293.

Neff, K., Kirkpatrick, K., et al., 2007. Self-compassion and adaptive psychological functioning. J. Res. Pers. 41 (1), 139–154. https://doi.org/10.1016/j.jrp.2006.03.004.

Phillips, A., Lewis, L., et al., 2016. Development and validation of the guideline for reporting evidence-based practice educational interventions and teaching (GREET). BMC Med. Educ. 16 (1), 237. https://doi.org/10.1186/s12909-016-0759-1.

Porges, S., 2007. The polyvagal perspective. Biol. Psychol. 74 (2), 116–143. https://doi.org/10.1016/j.biopsycho.2006.06.009.

Proctor, B., 1987. Supervision: a co-operative exercise in accountability. In: Marken, M., Paynes, M. (Eds.), Enabling and Ensuring: Supervision in Practice. National Youth Bureau and the Council for Education and Training in Youth and Community Work, Leicester.

Stacey, G., Cook, G., 2019. A scoping review exploring how the conceptualisation of resilience in nursing influences interventions aimed at increasing resilience. International Practice Development Journal 9 (1), 9. https://doi.org/10.19043/ipdj.91.009.

Stacey, G., Aubeeluck, A., et al., 2017. A case study exploring the experience of resilience-based clinical supervision and its influence on care towards self and others among student nurses. International Practice Development Journal 7 (2), 5. https://doi.org/10.19043/ipdj.72.005.

Upton, K., 2018. An investigation into compassion fatigue and self-compassion in acute medical care hospital nurses: a mixed methods study. J. Compassionate Health Care 5 (7). https://doi.org/10.1186/s40639-018-0050-x.

Walker, B., Salt, D., 2006. Resilience Thinking: Sustaining Ecosystems and People in a Changing World. Island Press, Washington DC.

Whitehead, B., Owen, P., et al., 2016. Supporting newly qualified nurse transition: a case study in a UK hospital. Nurse Educ. Today 36, 58–63. https://doi.org/10.1016/j.nedt.2015.07.00.

Wolf, Z., 2012. Nursing practice breakdowns: good and bad nursing. MedSurg Nurs. 21, 6–36.