Author/s:
Ryu, H;Buus, N;Naccarella, L;Zarb, L;Hamilton, B

Title:
Factors that influence the clinical supervision implementation for nurses: A scoping review

Date:
2025-11-01

Citation:
Ryu, H., Buus, N., Naccarella, L., Zarb, L. & Hamilton, B. (2025). Factors that influence the clinical supervision implementation for nurses: A scoping review. Journal of Advanced Nursing, 81 (11), pp.7297-7310. https://doi.org/10.1111/jan.16390.

Persistent Link:
https://hdl.handle.net/11343/367699

Received: 16 February 2024 | Revised: 10 June 2024 | Accepted: 31 July 2024

DOI: 10.1111/jan.16390

REVIEW

JAN Leading Global Nursing Research WILEY

Factors that influence the clinical supervision implementation for nurses: A scoping review

Hosu Ryu[1,2] | Niels Buus[3,4] | Lucio Naccarella[5] | Lauren Zarb[6] | Bridget Hamilton[1]

[1]Centre for Mental Health Nursing, Department of Nursing, Faculty of Medicine, Dentistry, and Health Science, University of Melbourne, Melbourne, Victoria, Australia

[2]School of Nursing and Midwifery, La Trobe University, Bundoora, Victoria, Australia

[3]School of Nursing and Midwifery, Monash University, Clayton, Victoria, Australia

[4]Department of Public Health, Aarhus University, Aarhus, Denmark

[5]Centre for Health Policy, Melbourne School of Population and Global Health, University of Melbourne, Melbourne, Victoria, Australia

[6]Department of Nursing, Faculty of Medicine, Dentistry, and Health Science, University of Melbourne, Melbourne, Victoria, Australia

Correspondence
Hosu Ryu, School of Nursing and Midwifery, La Trobe University, 320 George Singer Building, Bundoora, VIC 3086, Australia.
Email: h.ryu@latrobe.edu.au

Abstract

Aims: The aim of this review is to identify and map the evidence available on the factors that influence the implementation of clinical supervision for nurses.

Design: The scoping review was conducted and reported following the JBI methodology for scoping reviews.

Data Sources: Searches were conducted on MEDLINE, PsycINFO, and CINAHL databases on 28 March 2023.

Review Methods: A total of 1398 studies were imported into Covidence for screening. Researchers screened the papers according to the inclusion criteria. Empirical studies in English focusing on the implementation of clinical supervision for nurses were included, without year restrictions. Data from 16 studies were extracted and organized according to the constructs within the Consolidated Framework for Implementation Research (CFIR) domains: intervention characteristics, outer setting, inner setting, characteristics of individuals, and process.

Results: When compared with the CFIR constructs, it was found that the influence of the outer setting on implementation was less explored in the literature. Most of the reviewed data highlighted recurring factors, particularly logistical challenges of nursing work such as shift work and lack of control over work time. Organizational culture and managerial support were also identified as significant factors in the implementation. Another significant challenge in implementation was the variety in clinical supervision's design, purpose, and application, despite sharing the same label, leading to questions about whether studies are implementing the same practice.

Conclusion: Policy documents should clearly define both the design and purpose of clinical supervision, beyond just its conceptual definition. Greater emphasis on equitable implementation of clinical supervision is necessary to prevent perpetuating existing inequalities. We conclude that implementation of such complex interventions is not linear, and the implementation strategies need to align with expected implementation challenges.

Impact: The advantage of using the implementation framework lies not only in observing what exists as a form of evidence but also in identifying what is underdeveloped. Healthcare services and policy developers can utilize our review to recognize

and address potential challenges in introducing, modifying, scaling up, or sustaining their clinical supervision implementation.

Patient or Public Contribution: No patient or public contribution.

KEYWORDS
clinical supervision, implementation science, nurse, work organization

1 | INTRODUCTION

Clinical supervision can be defined as "a support mechanism for practising professionals within which they can share clinical, organizational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and skills" (Lyth, 2000, p. 728). It has been widely acknowledged for promoting growth, development, and learning and ultimately providing a more therapeutic service to patients and consumers (Lynch, 2008).While there is a lack of agreement on the definition or theory of clinical supervision, there is consensus that it differs from coaching or mentoring because its focus is on reflection rather than necessarily sharing knowledge or learning specific skills (Department of Health, 2018). The literature spanning nearly four decades is robust regarding clinical supervision's potential benefits, especially for mental health nurses (Buus & Gonge, 2009; Platt-Koch, 1986; White et al., 1998).

Studies highlight that clinical supervision is perceived as a process where nurses engage in supportive, trusting, and respectful relationships with colleagues, facilitating the development of nursing identity (Arvidsson et al., 2001; Severinsson & Hallberg, 1996), and enabling nurses to reach their full potential (Farkas-Cameron, 1995). Personal growth and improved sensitivity to consumers' needs are also reported benefits from engaging in clinical supervision (Severinsson & Hallberg, 1996). Moreover, nurses report a sense of development and increased confidence and self-esteem by discovering resources within themselves and other nurses (Arvidsson et al., 2001; Berg & Welander Hansson, 2000; O'Neill et al., 2019). Nurses also describe improved communication with their colleagues and support in their career development by engaging in clinical supervision (Newman et al., 2023). Finally, studies support that clinical supervision can help redress emotional exhaustion that nurses experience and may be effective in lowering levels of burnout (Edwards et al., 2005; Hyrkäs, 2005; MacLaren et al., 2016). More recently, nursing specialities other than mental health, such as cancer nursing and intensive care nursing, started to recognize the potential benefits of clinical supervision (Hession & Habenicht, 2020; van Dam et al., 2023). A recent systematic review by Zonneveld et al. (2024) also argues that well-structured supervision can provide an opportunity to share professional concerns and develop identity for advanced practice nurses. This growing body of literature has contributed to the acknowledgement of the potential benefits of this practice across diverse nursing specialities and roles.

Owing to a plethora of research, fewer nurses now question the value of clinical supervision (Masamha et al., 2022). While there are still arguments that evidence for clinical supervision is inconclusive, contradictory, and inadequate (Buus et al., 2018; Buus & Gonge, 2009), researchers also support that the divide between ideals and reality of clinical supervision can be narrowed through effective implementation (Gonge & Buus, 2016).

Therefore, the current focus has shifted from debating its benefits to exploring how to effectively implement and integrate this practice in the nursing workforce. After all, the benefits of this practice cannot be realized unless it is implemented and integrated effectively into regular practice. As there are high quality reviews focusing on the experience and potential benefits of clinical supervision for nurses (Aparício & Nicholson, 2020; Brunero & Stein-Parbury, 2008; Buus & Gonge, 2009; Cutcliffe et al., 2018), our focus in this paper is to provide insights into the process by which benefits are realized, examined here through the lens of implementation science.

Implementation science is defined as the study of theories, processes, models, and methods of implementing evidence-based practices (Nilsen, 2015). The goal of implementation science is not merely to assess the impact of an intervention but to identify factors influencing its adoption within practice (Bauer & Kirchner, 2020). It focuses on intervention design, implementation processes, and implementation context, as all of these can influence how an intervention, such as clinical supervision, is adopted, implemented, and sustained.

A review is necessary to understand the factors influencing clinical supervision implementation. Several reviews on clinical supervision predominantly focus on outcome measures, such as benefits perceived by nurses. While studies that investigate enablers and barriers to effective clinical supervision do offer insights (Masamha et al., 2022; Rothwell et al., 2021), our review will delve into these factors from an implementation science perspective, using the Consolidated Framework for Implementation Research (CFIR), a framework that explains determinants and variables to implementation effectiveness (Damschroder et al., 2022). We believe that the unique implementation focus of our review will add value to the current body of knowledge identifying what is missing in implementation of this practice, potentially helping to shape further policy recommendation.

2 | THE REVIEW

2.1 | Aim

This scoping review aims to identify the available evidence about the factors affecting clinical supervision implementation for nurses and map this evidence according to the CFIR.

2.2 | Review question

What are the factors that influence the implementation of clinical supervision for nurses?

3 | METHOD

3.1 | Design

The scoping review was conducted and reported following the JBI methodology for scoping reviews (Peters et al., 2020). A scoping review is deemed most suitable for understanding and synthesizing the existing implementation evidence. Compared to a systematic review, a scoping review allows a more exploratory approach, focusing less on the assessment of methodological limitations or risk of bias of the evidence and more on identifying key characteristics and concepts (Munn et al., 2018). We first include studies that reported factors influencing this implementation for nurses. We then categorize and synthesize the factors according to the domains of the updated CFIR, including innovation, outer setting, inner setting, individuals, and implementation process (Damschroder et al., 2022).

The CFIR was initially developed by Damschroder and colleagues in 2009 to articulate "what works where and why" (Damschroder et al., 2009, p. 2), and it was updated in 2022 based on user feedback. Since its inception, CFIR has been one of the most commonly used frameworks in implementation of healthcare delivery, quality improvement, and health promotion, spanning a wide variety of health-related topics (Kirk et al., 2016). Its primary objective is to guide a systematic assessment of the factors influencing implementation. The CFIR offers a consistent taxonomy, terminology, and definitions related to implementation context and stands as one of the most widely adopted frameworks in implementation science (Damschroder et al., 2022).

This categorization will offer insights into various determinants of implementation that either facilitate or hinder the process. Healthcare services can utilize this information to introduce, modify, scale up, or sustain their clinical supervision practices for all nurses.

3.2 | Search method

A search was conducted on the 28th of March 2023 across three electronic databases: MEDLINE, PsycINFO, and CINAHL, after consultation with a senior librarian. As the population is nurse, the concept is clinical supervision and the context is implementation, the keywords used were "implement*" or "evaluat*", "clinical supervis*", and "nurs*". For PsycINFO, the MeSH "professional supervision" was included. In CINAHL, the subject headings "clinical supervision" and "clinical supervision, mental health" were also included, along with "clinical supervis*". The "AND" operator was used to connect all three concepts. We exported the citations from these databases to EndNote, a reference management software, and subsequently to Covidence, a tool used for screening and data extraction in review processes. Table 1 displays our search strategy.

3.3 | Inclusion and exclusion criteria

Our selection criteria were empirical studies in English that introduce clinical supervision for nurses as a new intervention, evaluate the implementation process, or explore the factors involved in adapting, sustaining, or scaling existing clinical supervision practices. Papers had to include a clear research methodology and report original research or audits with an emphasis on implementation. We did not set restrictions on the year of publication to ensure that seminal papers offering significant insights were not overlooked. Finally, we did not include grey literature because of the problems related to searching and retrieving it systematically and exhaustively (compared to studies indexed by databases) and because of its inconsistent quality and credibility (compared to peer-reviewed studies).

TABLE 1 Search strategy.

Database	MEDLINE	PsycINFO	CIHANL
Search strategy	1. (implement* or evaluat*).mp 2. clinical supervis*.mp. 3. nurs* 4. 1 AND 2 AND 3	1. (implement* or evaluat*).mp 2. exp Professional Supervision/ 3. clinical supervis*.mp. 4. 2 or 3 5. nurs* 6. 1 AND 4 AND 5	S1. implement* or evaluat* S2. (MH "Clinical Supervision") S3. (MH "Clinical Supervision, Mental Health") S4. "Clinial supervis*" S5. S2 OR S3 OR S4 S6. nurs* S7. S1 AND S5 AND S6

3.4 | Search outcome

A total of 1398 studies were imported for screening. After removing 454 duplicates across three databases, 944 were eligible for title and abstract screening. All titles and abstracts were screened by HR and one researcher selected from a pool of three (NB, LZ, BH). The authors met to discuss any conflicts and reached a consensus. Of the screened studies, 841 were found irrelevant, leaving 47 studies for full-text screening. Two authors separately assessed these full-text studies, excluding 31 that did not meet the eligibility criteria. They were mostly excluded as the focus was not at all on implementation. Some studies were excluded due to wrong intervention, such as de-briefing, or wrong population, such as student nurses. In the end, 16 studies remained for review. We have also additionally employed citation chain searches using the Scopus citation index. We reviewed the reference lists of all included papers and examined the papers that had cited these studies. No further studies were added as they did not meet the inclusion criteria, which indicated a high level of recall in the search. The following PRISMA flow diagram (Figure 1) illustrates this search process.

3.5 | Quality appraisal

In scoping reviews, the primary objective is to map and synthesize existing literature to identify the breadth of available evidence and research gaps. Unlike systematic reviews, scoping reviews typically do not include a formal quality assessment of individual studies (Levac et al., 2010). The focus of this scoping review is not on methodological critique rather collating data to provide a comprehensive overview of real-life implementations.

3.6 | Data extraction

Data were extracted using a standardized Excel form. The extracted data included: citation, country, study design, study aim, data collection procedures, population, settings, sampling methods, factors influencing implementation, and limitations.

All 16 studies had their unique methodologies, sample sizes, settings, and geographical factors. Qualitative studies were the most common, with 10 of the studies using various collection methods such as individual interviews, documentation review, or focus

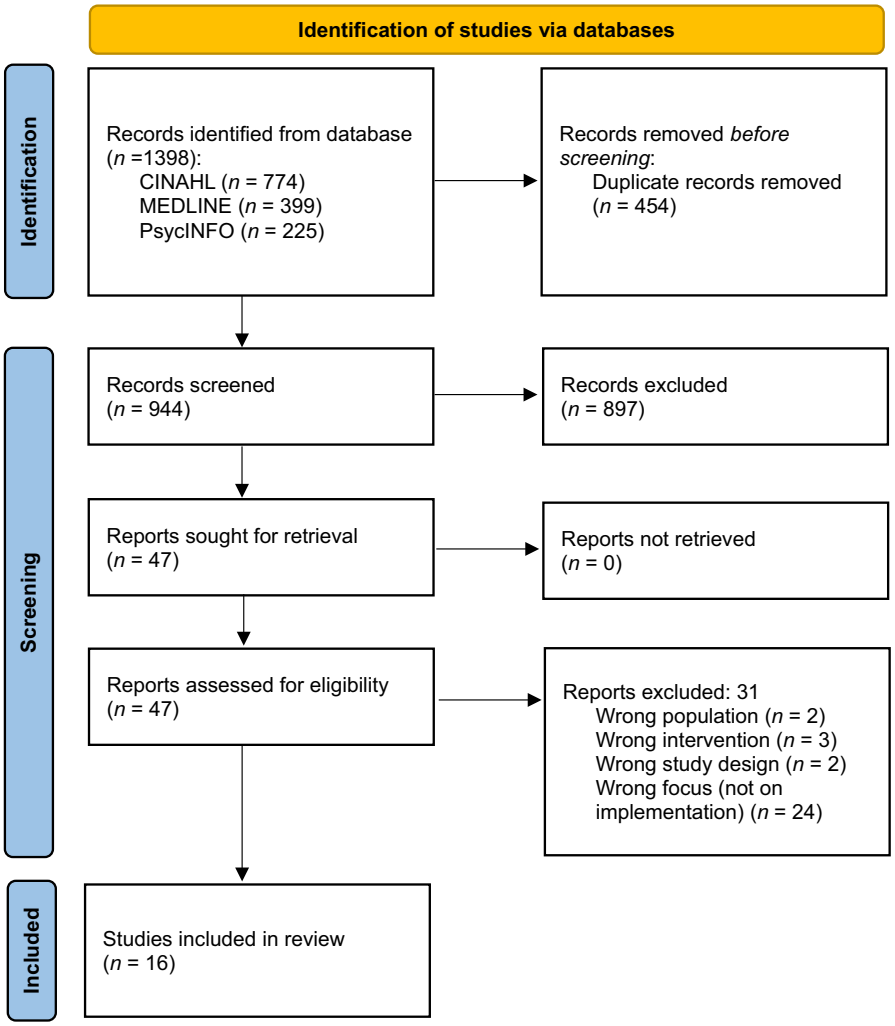

FIGURE 1 PRISMA chart.

TABLE 2 study characteristics.

Characteristics		Number (%)
Year of publication	1991–2000	1 (6)
	2001–2010	9 (56)
	2011–2020	3 (19)
	2021 and after	3 (19)
Country	Australia	8 (50)
	Denmark	2 (13)
	UK/England	6 (38)
Study design	Qualitative study	10 (63)
	Longitudinal intervention studies	4 (27)
	Survey study	1 (6)
	A supplementary analysis of data from sequential mixed-method study and an randomized controlled trial	1 (6)

groups to collect qualitative data. There were also pre-post studies and longitudinal implementation studies that used surveys as a data collection method. One study provided supplementary analysis of data from another pilot study, which was a sequential mixed-method study and a randomized controlled trial (RCT).

Eight of these studies were from Australia, with the rest from Europe, including Denmark, Ireland, and the United Kingdom. The settings of the studies varied and included hospital inpatient units, community health services, and mental health services. All the participants were nurses, encompassing both mental health nurses and general nurses. The sample sizes ranged from seven to 115. Table 2 shows the characteristics of included studies.

3.7 | Data synthesis

Once the factors influencing implementation were extracted, these data were mapped and organized according to constructs of the updated CFIR's five domains: innovation, outer setting, inner setting, individuals, and implementation process (Damschroder et al., 2022). This approach aimed to maintain fidelity to the original study data and avoid reanalysis. We carefully considered the context of the data to ensure the most appropriate alignment with CFIR constructs and sometimes assigned data to multiple constructs. While these constructs are interconnected in influencing implementation, examining each separately allows for a systematic assessment of potential factors. It also provides a pragmatic organizing structure for identifying potential gaps.

4 | RESULTS

We mapped and aligned the implementation factors with the most relevant constructs of the CFIR. We present the results with narratives along with a complementary table. Table 3 displays the themes or codes from the study, authors, year, the corresponding CFIR construct, and its domain. We presented this information in the order of our data synthesis process, where we initially extracted data that influenced implementation and then aligned it with the CFIR. The shaded areas in the table indicate the absence of corresponding data for that CFIR construct. We included this information in the table to make it easier to identify what is missing in the current evidence of clinical supervision implementation.

4.1 | Innovation

In CFIR, innovation refers to the "thing" being implemented (Damschroder et al., 2022), which, in this instance, is clinical supervision. The innovation domain focuses on the characteristics of the innovation or intervention being implemented. Key concepts in this CFIR domain include the evidence base, complexity of the innovation, and its adaptability to local needs. Additionally, this domain explores the innovation's relative advantage over existing practices and its costs and benefits (Damschroder et al., 2022).

Out of the 16 articles reviewed, eight studies provided data related to innovation characteristics, with synthetized themes including perceived usefulness, adaptability, and the characteristics of clinical supervision.

Five studies discussed the usefulness of clinical supervision from the nurses' perspectives (Buus et al., 2016; Kenny & Allenby, 2013; McCarthy et al., 2021; Saab et al., 2021; Willson et al., 2001). Prior to attending clinical supervision, nurses expected peer-group clinical supervision to help with their work-related stress and improve their practice (McCarthy et al., 2021). This was also reported in Saab et al. (2021), where nurses found peer-group clinical supervision to reduce stress, increase self-awareness, increase peer support, and have a positive impact on patients and the organization. Nurses believed individual clinical supervision could also assist their professional growth and practice, which could eventually contribute to staff recruitment and retention (Willson et al., 2001).

Not all nurses perceived clinical supervision as a useful intervention (Buus et al., 2016; Kenny & Allenby, 2013; Willson et al., 2001). Some nurses did not understand the purpose and process of clinical supervision, preventing them from recognizing its potential benefits (Kenny & Allenby, 2013). Negative prior experiences with clinical supervision also influenced their perceptions. Disappointing outcomes from previous supervision sessions led some nurses to conclude that it was not worth attending further sessions (Buus et al., 2016). Furthermore, while some nurses believed that it was a "good idea in theory" (Willson et al., 2001, p. 620), they had reservations about its adaptability due to implementation challenges.

The design and characteristics of clinical supervision were also identified as innovation-related factors affecting the implementation. Firstly, the term "supervision" was often

TABLE 3 Findings compared to the Consolidated Framework for Implementation Research (CFIR).

Theme or code as per the study	Study (studies)	CFIR construct (domain)	
		A. Innovation source	Innovation characteristics
		B. Innovation evidence base	
Disappointing outcome reduces the motivation	Buus et al. (2016)	C. Innovation relative advantage	
Perceived usefulness	Kenny and Allenby (2013), Willson et al. (2001), Saab et al. (2021)		
Positive expectation of clinical supervision	McCarthy et al. (2021)		
"Good idea in theory—no time to allocate to it"	Willson et al. (2001)	D. Innovation adaptability	
		E. Innovation trialability	
		F. Innovation complexity	
Content of the supervision	Buus et al. (2016), Kenny and Allenby (2013), Lakeman and Glasgow (2009)	G. Innovation design	
Supervision group composition and dynamics	Buus et al. (2016)		
The word "supervision"	Cross et al. (2010)		
Confidentiality (in group supervision)	McCarthy et al. (2021), White and Winstanley (2010)		
Frequency and duration of clinical supervision sessions	Buus et al. (2016)		
		F. Innovation cost	
COVID-19 pandemic	Smith et al. (2022)	A. Critical incidents	Outer Settings
		B. Local attitudes	
		C. Local conditions	
		D. Partnerships & connections	
Lack of policy direction	Lynch and Happell (2008a)	E. Policies & laws	
State government funding	Lynch and Happell (2008a)	F. Financing	
		G. External pressure	
The logistics (shift work, space, rostering)	Buus et al. (2016), Cross et al. (2010), Hughes and Morcom (1998), McCarthy et al. (2021), Saab et al. (2021), White and Winstanley (2010), White and Winstanley (2009)	A. Structural characteristics	Inner settings
Workload, competing demands, finding time	Buus et al. (2016), Gonge and Buus (2016), Kenny and Allenby (2013), McCarthy et al. (2021)		
Lack of control over work	Hughes and Morcom (1998)		
Lack of human and material resources	Lakeman and Glasgow (2009)		
Disruptions and interruptions	Cross et al. (2010), Saab et al. (2021)		
		B. Relational connections	
Communication	Smith et al. (2022)	C. Communications	
Psychological conflict on the ward	Buus et al. (2016)	D. Culture	
Social support	Gonge and Buus (2016)		
Level of paranoia/suspiciousness	Lynch and Happell (2008b), White and Winstanley (2010)		
Culture, "Dispassionate resignation" to organization	White and Winstanley (2010)		
Point of resistance	White and Winstanley (2009)		
		E. Tension for change	
		F. Compatibility	
Not priority	Kenny and Allenby (2013)	G. Relative priority	
		H. Incentive systems	
		I. Mission alignment	
		J. Available resources	
		K. Access to knowledge & information	

TABLE 3 (Continued)

Theme or code as per the study	Study (studies)	CFIR construct (domain)	
Ongoing organizational support	Lynch and Happell (2008a)	A. High-level leaders	Individual characteristics
Support given by clinical managers (enabling, encouraging, permission-giving, helpful, acknowledging, and enthusiastic)	Buus et al. (2016), Hughes and Morcom (1998), McCarthy et al. (2021), White and Winstanley (2009)	B. Mid-level leaders	
		C. Opinion leaders	
		D. Implementation facilitators	
Right leadership (in implementation)	Lynch and Happell (2008b)	E. Implementation leads	
		F. Implementation team members	
		G. Other implementation support	
The professional and personal competence of the supervisor	Buus et al. (2016)	H. Innovation deliverers	
Supervisor from same unit or other services	Hughes and Morcom (1998)		
Adequate training and perceived expertise as a supervisor	Hughes and Morcom (1998)		
Positive supervisor characteristics	Saab et al. (2021)		
Feeling unsafe and vulnerable	Buus et al. (2016)	I. Innovation recipients	
Prior experience (or exposure) to CS or reflective practice	Kenny and Allenby (2013)		
A lack of knowledge and experience of CS, low level of understanding	Hughes and Morcom (1998), Lynch et al. (2008), Kenny and Allenby (2013)		
Fears around confidentiality (in a peer-group supervision)	McCarthy et al. (2021), White and Winstanley (2009)		
Suspiciousness	White and Winstanley (2010)		
Staff commitment	White and Winstanley (2010)		
"Dispassionate resignation" to organization	White and Winstanley (2010)		
Developing the implementation committee	Lynch and Happell (2008c)	A. Teaming	Implementation process
Identifying the need	Lakeman and Glasgow (2009), Lynch et al. (2008)	B. Assessing needs	
Review of existing mechanisms or informal supervision	Lynch and Happell (2008b)		
Assessing organizational culture	Lynch and Happell (2008b)	C. Assessing context	
		D. Planning	
"Being strategic"	Lynch et al. (2008)	E. Tailoring strategies	
Exploring possibilities	Lynch and Happell (2008b)		
Developing the strategic plan	Lynch and Happell (2008c)		
Education and training; Preparation and education	Lynch and Happell (2008b), Lakeman and Glasgow (2009), Lynch et al. (2008)	F. Engaging	
Marketing strategy "growing together" and official launch	Lynch and Happell (2008c)		
"Making it happen"	Lynch et al. (2008)	G. Doing	
Lack of CS documentation	Smith et al. (2022)		
Internal evaluation	Lynch and Happell (2008c)	H. Reflecting & evaluating	
Sustainability (ongoing research, evaluation, and quality assurance)	Lynch and Happell (2008c)		
Fear of losing momentum	Saab et al. (2021)		
Participants' desire for continuation of the programme	Willson et al. (2001)		
		I. Adopting	

associated with "oversight" and "watching", creating an intimidating impression of the intervention (Cross et al., 2010). Additionally, four studies discussed how the mode (i.e., group or individual) affected the clinical supervision implementation (Buus et al., 2016; Kenny & Allenby, 2013; Lakeman & Glasgow, 2009; White & Winstanley, 2010). While some nurses

believed that group supervision would be more interesting and feasible (Lakeman & Glasgow, 2009), there were concerns among others about confidentiality and exposure (Buus et al., 2016; McCarthy et al., 2021; White & Winstanley, 2010). Group supervision also meant that individual nurses had less control over the content of the clinical supervision. Some nurses believed that it should focus on the development of nurses' roles (Lakeman & Glasgow, 2009), while others believed it should centre on the clients they are caring for (Kenny & Allenby, 2013). Some nurses believed that the supervision "only talk about the patients while problems are rather related to the staff and the management" (Buus et al., 2016, p. 8).

4.2 | Outer setting

In CFIR, the outer setting refers to the broader context in which an organization or system operates, considering external factors that can influence the implementation process (Damschroder et al., 2022). Factors within this domain encompass external policies and laws, local attitudes and conditions, as well as external partnerships and connections. This domain also considers the socio-political and economic context in which the organization operates, exploring external pressures that may drive implementation, such as social pressure, market pressure, and performance measurement pressure (Damschroder et al., 2022).

Two studies identify factors that can be interpreted as influences from CFIR's outer setting. First, Smith et al. (2022) describe how the coronavirus disease of 2019 (COVID-19) acted as both a barrier and an instigator for clinical supervision implementation. While the pandemic initially halted the clinical supervision implementation, it was later leveraged to support staff during the difficult times. Furthermore, Lynch and Happell (2008a) reported that state government funding was released to support the introduction of clinical supervision via local education teams. However, the absence of policy direction or specific guidelines for systematic implementation was seen as a significant problem, despite the provided funding.

4.3 | Inner setting

In the CFIR framework, the inner setting refers to the environment in which the innovation is implemented (Damschroder et al., 2022). This domain delves into the specific characteristics of this setting and how they can impact the implementation process. Damschroder et al. (2022) identify relevant constructs within the inner setting, including structural features, relational connections, communication dynamics, organizational culture, the readiness for change, compatibility within the existing setting, relative priority, incentives, alignment with the mission, available resources, and access to knowledge and information.

Twelve of the sixteen reviewed studies provided data that could be mapped to inner setting characteristics, specifically around organization's structural and cultural components. Factors related to the structural characteristics were often reported in the inpatient unit for both individual and group supervision. The most commonly reported factor was logistics in relation to shift work, rostering, and space (Buus et al., 2016; Cross et al., 2010; Hughes & Morcom, 1998; McCarthy et al., 2021; Saab et al., 2021; White & Winstanley, 2009, 2010). The unpredictable nature of the inpatient unit, such as shift patterns and changes, low staffing levels, and staff sickness, was the most obvious challenge to clinical supervision implementation reported for more than two decades (Hughes & Morcom, 1998; Saab et al., 2021; White & Winstanley, 2010). Additionally, a general lack of human resources in the healthcare service was seen as a significant obstacle (Lakeman & Glasgow, 2009). To accommodate these challenges, Cross et al. (2010) reported that clinical supervision was often held during double staffing that occurred at shift changes. However, timing was still a barrier for staff allocated to evening and night shifts where staffing is typically lower (Buus et al., 2016). Additionally, not having enough spaces that can ensure confidentiality was also an issue (Hughes & Morcom, 1998). While most of the structural characteristics were related to inpatient nurses, Willson et al. (2001) identified that geographical differences were a main barrier to clinical supervision for community nursing staff who work in remote and isolated areas.

In the structural characteristics, workload, competing demands, and finding time were also common factors influencing staff attendance to clinical supervision, as reported in both quantitative and qualitative studies (Buus et al., 2016; Gonge & Buus, 2016; Kenny & Allenby, 2013; McCarthy et al., 2021). Clinical supervision was sometimes seen as a disruption to work, as nurses had to stop their activities to attend the supervision (Saab et al., 2021). It was seen as the least priority for Australian rural nurses when faced with competing demands (Kenny & Allenby, 2013). Additionally, even when nurses find time to attend, this time is not always protected as emergencies or other work priorities may interrupt the sessions (Cross et al., 2010). This lack of control over work, experienced by both supervisors and supervisees, was seen as a barrier to planning or participating in clinical supervision (Hughes & Morcom, 1998).

Moreover, organizational culture was seen as an important factor in clinical supervision implementation. Three studies identified the staff's level of trust and perceived safety towards the organization as crucial factors in implementation (Gonge & Buus, 2016; Lynch & Happell, 2008b; White & Winstanley, 2010). Staff reported feeling suspicious about the intention of clinical supervision implementation (White & Winstanley, 2010) and the organization's capacity for sustaining the implementation (Lynch & Happell, 2008b). Studies described this as "level of paranoia" (Lynch & Happell, 2008b, p. 61) towards management and resistance from staff (White & Winstanley, 2009). However, Kenny and Allenby (2013) also noted that clinical supervision may not be perceived by staff as the organization's priority, which can affect

effectiveness implementation. Therefore, the organization's communication strategies among stakeholders around implementation have been identified as an important component (Smith et al., 2022).

When group supervision is implemented, any psychological conflict on the ward would negatively impact the participation of the nurses, if nurses did not want to face these conflicts in front of other colleagues (Buus et al., 2016). On the other hand, social support within the supervision group and in organization was a critical factor in clinical supervision implementation (Gonge & Buus, 2016).

4.4 | Individuals

This CFIR domain centres on the individual-level factors of those engaged in the implementation process, such as healthcare providers, educators, or staff members. It examines the roles and characteristics of various-level leaders, implementation facilitators, and innovation deliverers and recipients. It considers how their attributes interact and influence the implementation process (Damschroder et al., 2022).

Most of the individual-related factors revolved around the deliverers and recipients of the innovation, with some focusing on leadership. Four studies emphasized the importance of mid-level leaders in the implementation, discussing support of line managers (Buus et al., 2016; Hughes & Morcom, 1998; McCarthy et al., 2021; White & Winstanley, 2009). They emphasized that managers need to be accepting (McCarthy et al., 2021), encouraging, and giving permission (Hughes & Morcom, 1998). While not many studies focused on the role of high-level leaders, Lynch and Happell (2008a, 2008b) argue the importance of ongoing organizational support and right leadership in implementation.

Furthermore, many studies discussed the role of the innovation deliverer in the implementation, which is the characteristics of the supervisor in this instance. These characteristics included positive supervisor characteristics such as experience (Saab et al., 2021); professional and personal competence (Buus et al., 2016) and adequate training and perceived expertise (Hughes & Morcom, 1998). Supervisors working in the same area were reported to have both advantages and disadvantages. While supervisors working in the same area offered a shared understanding that led to a better grasp of supervision issues, supervisees tended to speak more freely when the supervisor was external to their unit (Hughes & Morcom, 1998).

In regard to innovation recipients, two primary characteristics emerged: knowledge level and psychological factors. A lack of knowledge and experience in clinical supervision influenced level of engagement in clinical supervision (Hughes & Morcom, 1998; Kenny & Allenby, 2013; Lynch & Happell, 2008a). Nurses' commitment to clinical supervision was notably impacted by their understanding of its purpose, particularly when they were unfamiliar with the practice (White & Winstanley, 2010). This commitment was further influenced by their past experiences, with positive prior exposure leading to increased participation (Buus et al., 2016; Kenny & Allenby, 2013).

Additionally, nurses felt vulnerable and unsafe, especially in group supervision settings where there were confidentiality concerns (Buus et al., 2016; McCarthy et al., 2021; White & Winstanley, 2009). A sense of suspicion and mistrust towards management was identified as an individual factor hindering the implementation process (Lynch & Happell, 2008a; White & Winstanley, 2010). Furthermore, individuals "dispassionate resignation" to the realities of the healthcare system led nurses to not participate in clinical supervision (White & Winstanley, 2010, p. 691).

4.5 | Process

The process domain focuses on strategies and activities used to facilitate the implementation of the innovation. This domain involves examining the actions taken to plan, execute, and evaluate the implementation effort.

Seven studies discussed factors related to the process of implementation, with some studies describing the details of implementation steps (Lakeman & Glasgow, 2009; Lynch et al., 2008; Lynch & Happell, 2008a, 2008b; Saab et al., 2021; Smith et al., 2022; Willson et al., 2001).

Lynch and Happell (2008c) highlighted the importance of teaming in the implementation process and recommended the development of an implementation committee. The assessment of needs was identified as an essential step, including the identification of needs from the nurses' perspective (Lakeman & Glasgow, 2009; Lynch et al., 2008) and the review of existing practices such as informal reflective practice (Lynch & Happell, 2008a). It was also crucial to assess the context of the implementation, especially the organizational culture, and explore the possibilities (Lynch & Happell, 2008b). After assessing needs and context, adopting a strategic approach to the delivery of the implementation was considered essential (Lynch et al., 2008).

Additionally, adequate education and training were recognized as key steps in the process of implementing clinical supervision (Lakeman & Glasgow, 2009; Lynch et al., 2008; Lynch & Happell, 2008b). Moreover, developing a marketing strategy (Lynch & Happell, 2008c), ensuring effective communication, and developing broad organizational documentation regarding clinical supervision were also identified as helpful factors (Smith et al., 2022).

Finally, the sustainability of the practice was a topic explored in four studies. Nurses expressed concerns about the potential loss of momentum and a desire for the continued practice of clinical supervision (Saab et al., 2021; Willson et al., 2001). To facilitate this, Lynch and Happell (2008c) emphasized the importance of internal evaluation, ongoing research, and quality assurance.

5 | DISCUSSION

5.1 | Summary of findings

In this scoping review, we extracted data from 16 studies and categorized it according to the most relevant constructs of the CFIR's five domains: Innovation characteristics, outer settings, inner settings, individual characteristics, and implementation process. Under the innovation characteristics domain, nurses' perceptions of the usefulness of clinical supervision, along with the characteristics of the supervision such as design, content, mode, and frequency, were the factors that influenced implementation. Limited data were found in the outer setting characteristics, with one study discussing the impact of COVID-19 on implementation and another mentioning policy and external funding. The majority of data pertained to the inner setting characteristics, particularly focusing on the structural nature of the nursing work and the culture of the organizations. Our findings predominantly highlight recurring factors related to the logistical challenges of nursing work, such as shift work and a lack of control over work time. In the individual characteristics' domain, studies emphasized the impact of managers' characteristics and those of individual nurses on implementation. Findings suggest that a supportive organization and managers are important for nurses to attend clinical supervision, as well as adequate training for nurses to understand the purpose and benefits of clinical supervision. This result is consistent with multiple reviews that have been conducted (Buus & Gonge, 2009; Howard & Eddy-Imishue, 2020; Masamha et al., 2022). Finally, in the implementation process domain, studies identified teaming, assessing needs, education, and documentation as necessary steps for successful implementation.

Certain codes were aligned to multiple domains and constructs, reflecting the multidimensional and non-binary nature of implementation factors. For instance, fears around confidentiality in group supervision may be interpreted as innovation characteristics as they relate to the mode of clinical supervision. However, they can also be related to the culture of the organization, which is part of the inner setting domains, or to innovation recipients, which are in the individual characteristic domain. While we carefully examined the context provided in the original studies to accurately identify the most relevant construct, there were instances where the original studies did not provide enough context, making this alignment challenging. This is not a criticism of the original research, as providing such a detailed context of certain data might not have been their main aim. Nonetheless, the lack of detailed context made it difficult to align the data with just one construct. By aligning them to multiple constructs, we can gain insights into the complex challenges of implementation and identify how and where implementation effort should be focused.

5.2 | What is under-developed when compared to CFIR

The advantage of aligning the data with CFIR constructs is not only in observing what is present as a form of evidence but also in identifying what is missing. We would firstly like to acknowledge that not all CFIR constructs necessarily carry the same level of significance. Therefore, we are not suggesting that the absence of data aligning with certain constructs should be considered equally important. Instead, these observations should be interpreted in the context of each reader's understanding of local implementation.

Moreover, we are not suggesting that the non-existence of certain CFIR constructs simply means the absence of awareness in the clinical supervision implementation. For instance, the missing corresponding data for the construct “evidence base” under the “innovation characteristics” domain does not imply insufficient evidence of clinical supervision per se. Rather, this aspect is reflected in the reviews, not in the primary studies, due to the empirical nature of the studies. The quality of the evidence base for clinical supervision is well-documented in other literature reviews (Buus & Gonge, 2009; Masamha et al., 2022).

One significant gap we identified in the available studies is data reporting the impact of outer setting factors on implementation. While we cannot underestimate the influence of policy, external pressure, and nursing culture outside the organization on implementation, these factors have not been adequately explored empirically. Often, these aspects are tacitly understood within nursing communities but are not explicitly documented in research. We acknowledge the importance of recognizing the influence of outer settings on implementation. Therefore, we recommend that future research explicitly describes any assumed knowledge to provide a better contextual understanding of implementation.

Other important factors that did not receive much consideration within the reviewed studies include, but are not limited to, innovation complexities, innovation cost, compatibility, and the process of adoption. Therefore, the novelty of our insights lies not only in the data collected but also in questioning why the field persistently revisits similar studies without giving much consideration to other implementation challenges. We wish to highlight that the use of the CFIR extends beyond retrospective evaluations; it can also aid in planning implementation, such as in the design of a logic model (Smith et al., 2022). Consequently, the gaps identified here through CFIR can inform not only the identification of research gaps but also the planning and optimisation of future implementation efforts. Table 4 below presents a snapshot of the areas that have received attention within clinical supervision implementation research and identifies areas that were underexplored but would benefit from further attention when compared to CFIR domains.

5.3 | Are we talking about the same thing?

Commonly identified issues such as high workload and shift work can be interpreted as technical challenges within implementation, which are well-defined logistical challenges solvable by enhancing existing processes or systems (Blase et al., 2015). These challenges tend to affect more the nurses working in inpatient settings, which poses a question whether the clinical supervision implementation reaches the nurses that may need it the most. Being aware of this

TABLE 4 snapshot of the areas that have received attention within clinical supervision implementation research and identifies areas that were underexplored but would benefit from further attention when compared to Consolidated Framework for Implementation Research (CFIR) domains.

CFIR domains	Areas that have received research attention	Areas that were underexplored that would benefit further attention
Innovation characteristics	Clinical supervision relative advantage, design of clinical supervision	Cost of clinical supervision implementation
Outer settings		External financing, external pressure, partnerships, and connections for clinical supervision implementation
Inner settings	Structural characteristics of the organization, communication, and organizational culture	Compatibility with the organization, incentive, available resources, access to knowledge and information, mission alignment
Individual characteristics	Clinical supervision supervisor characteristics, supervisee characteristics, leader's role	Roles of implementation facilitators and team members
Implementation strategies	Assessing needs, tailoring strategies, engaging, reflecting, and evaluating	Adopting

gap can avoid unintended exacerbation of inequity in implementation and enhance its impact (Shelton & Brownson, 2023). Saying that a focus solely on these technical challenges is inadequate when adaptive challenges persist. Adaptive challenges are more intricate, tied to the beliefs and behaviours of key stakeholders (Blase et al., 2015).

One of the key adaptive challenges we have identified while synthesizing these studies was the realization that they may not be evaluating the same practice, not only across the studies but also within the same study. Despite the common use of the term "clinical supervision", its design, purpose, and application vary significantly depending on location, time, and diversity in values, beliefs, and ways of working. While some studies may refer to group debriefing as clinical supervision, others limit this practice to individual supervision with senior clinicians discussing presented client cases. However, the specific details of the implemented supervision were not often adequately described, with authors relying instead on assumed knowledge or a common definition. We suggest that detailed descriptions of the clinical supervision characteristics in implementation studies will enhance accurate interpretation of data and the transferability of findings.

Some of the reviewed studies acknowledge that the lack of consensus in defining clinical supervision is a challenge. We also note that its operational design and underlying purpose vary, beyond its conceptual definition. Traditionally, the nursing workforce has expected clinical supervision to primarily fulfil what Proctor (1991) describes as a normative function, focusing on adherence to policies and procedures (Yegdich & Cushing, 1998). However, the increasing pressures on recruitment and retention within the nursing workforce have shifted the desired function of clinical supervision more towards a restorative role, related to supporting the emotional work demands of nurses (Proctor, 1991). This indicates that the key stakeholders in the implementation process have differing intentions and expected outcomes for the practice. An organization aiming to implement individual clinical supervision with a formative intent, to develop nurses' skills and knowledge, cannot simply replicate the implementation strategies of organizations that have adopted group supervision with a restorative goal, focused on supporting nurses' emotional work demands.

In the realm of implementation, we need to be clearer about our assumed knowledge and expectations of the practice and aim to have a shared theoretical and practical understanding of the practices we are trying to implement. Then, we can be more aware of the interaction between different intervention designs, implementation processes, and implementation contexts.

6 | CONCLUSION

6.1 | Recommendation

In this review, we offer recommendations for policy, practice, and research. Firstly, policy documents should clearly define both the design and purpose of clinical supervision, beyond just its conceptual definition. Acknowledging these variations highlights the inherent complexities in implementing a practice with diverse purposes, emphases, and modes.

In practice, recognition of the impact of external factors on clinical supervision is crucial, as is the need to address both technical and adaptive challenges. Also, while we used the CFIR framework in this review to organize available evidence, it can be used in all stages of implementation. During the planning phase, it can be used to identify the determinants that could influence the implementation process. In the implementation phase, the framework can be used to guide and develop effective strategies. In the

evaluation phase, the CFIR framework supports the assessment of both the implementation process and the outcomes. Finally, in the sustainment phase, it provides insights into strategies that can help maintain and continue the implementation of clinical supervision over time, ensuring its long-term success and integration into practice.

Finally, for future research, more focus should be given to the equitable implementation of clinical supervision. This involves exploring various implementation methods, frameworks, and theories to make clinical supervision more accessible and consistent across various nursing settings and roles. Future research should examine the ways in which implementation may potentially perpetuate existing inequalities in clinical supervision, particularly for nurses who lack access to quality supervision.

6.2 | Limitations

The CFIR is used here as an organizing framework, not as a tool to deductively analyse data to predefined constructs. We were cautious not to reanalyse the data presented in the original studies during this process; however, we accept that there may be a limitation in this process and that original authors may not agree with the aligned construct. To uphold the fidelity of the original studies, we attempted to retain the precise wording or themes reported in the studies. We also thoroughly considered the available contexts of the data for the most appropriate alignment with the CFIR constructs.

6.3 | Conclusions

This scoping review has reviewed findings from 16 empirical studies related to the clinical supervision implementation and organized it to CFIR to identify essential determinants and gaps in implementation evidence. We conclude that implementation of such complex interventions is not linear, and the implementation strategies need to align with expected implementation challenges. Being aware of the interaction between various clinical supervision designs, implementation processes, and the implementation context should result in a more effective approach to implementation challenges. We recommend approaching implementation by addressing the fundamental question, "Are we talking about the same thing?". Then, the strategies can be aligned with the expected challenges to optimize the resources and efforts invested in the implementation of clinical supervision.

AUTHOR CONTRIBUTIONS

HR, NB, LN, BH, LZ: Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data. HR, NB, LN, BH, LZ: Involved in drafting the manuscript or revising it critically for important intellectual content. HR, NB, LN, BH, LZ: Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. HR, NB, LN, BH, LZ: Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

ACKNOWLEDGEMENTS

This review is part of a Doctor of Philosophy study which received the following scholarships: University of Melbourne Research Training Program Scholarship and Australian Nurses Memorial Centre Scholarship. These scholarships assisted with the student researcher's living allowance and the purchase of a survey licence needed for a study following this review. Open access publishing facilitated by The University of Melbourne, as part of the Wiley - The University of Melbourne agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

FUNDING INFORMATION

This review did not receive any funding apart from scholarships as mentioned above.

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.16390.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

ORCID

Hosu Ryu https://orcid.org/0000-0002-0561-7347
Niels Buus https://orcid.org/0000-0003-4980-4096
Bridget Hamilton https://orcid.org/0000-0001-8711-7559

REFERENCES

Aparício, C., & Nicholson, J. (2020). Do preceptorship and clinical supervision programmes support the retention of nurses? *British Journal of Nursing*, *29*(20), 1192–1197. https://doi.org/10.12968/bjon.2020.29.20.1192

Arvidsson, B., Löfgren, H., & Fridlund, B. (2001). Psychiatric nurses' conceptions of how a group supervision programme in nursing care influences their professional competence: A 4-year follow-up study. *Journal of Nursing Management*, *9*(3), 161–171. https://doi.org/10.1046/j.1365-2834.2001.00220.x

Blase, K. A., Fixsen, D. L., Sims, B. J., & Ward, C. S. (2015). *Implementation science: Changing hearts, minds, behavior, and systems to improve educational outcomes*. The Wing Institute.

Bauer, M. S., & Kirchner, J. (2020). Implementation science: What is it and why should I care? *Psychiatry Research*, *283*, 112376. https://doi.org/10.1016/j.psychres.2019.04.025

Berg, A., & Welander Hansson, U. (2000). Dementia care nurses' experiences of systematic clinical group supervision and supervised planned nursing care. *Journal of Nursing Management*, *8*(6), 357–368. https://doi.org/10.1046/j.1365-2834.2000.00191.x

Brunero, S., & Stein-Parbury, J. (2008). The effectiveness of clinical supervision in nursing: An evidenced based literature review. *Australian Journal of Advanced Nursing*, *25*(3), 86–94.

Buus, N., Delgado, C., Traynor, M., & Gonge, H. (2018). Resistance to group clinical supervision: A semistructured interview study of non-participating mental health nursing staff members. *International Journal of Mental Health Nursing*, *27*(2), 783–793. https://doi.org/10.1111/inm.12365

Buus, N., & Gonge, H. (2009). Empirical studies of clinical supervision in psychiatric nursing: A systematic literature review and methodological critique. *International Journal of Mental Health Nursing*, *18*(4), 250–264. https://doi.org/10.1111/j.1447-0349.2009.00612.x

Buus, N., Lynch, L., & Gonge, H. (2016). Developing and implementing 'meta-supervision' for mental health nursing staff supervisees: Opportunities and challenges. *The Cognitive Behaviour Therapist*, *9*, 1–15. https://doi.org/10.1017/S1754470X15000434

Cross, W., Moore, A., & Ockerby, S. (2010). Clinical supervision of general nurses in a busy medical ward of a teaching hospital. *Contemporary Nurse*, *35*(2), 245–253. https://doi.org/10.5172/conu.2010.35.2.245

Cutcliffe, J. R., Sloan, G., & Bashaw, M. (2018). A systematic review of clinical supervision evaluation studies in nursing. *International Journal of Mental Health Nursing*, *27*(5), 1344–1363. https://doi.org/10.1111/inm.12443

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*, *4*(1), 50. https://doi.org/10.1186/1748-5908-4-50

Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., & Lowery, J. (2022). The updated Consolidated Framework for Implementation Research based on user feedback. *Implementation Science*, *17*(1), 1–75. https://doi.org/10.1186/s13012-022-01245-0

Department of Health. (2018). *Clinical supervision for mental health nurses: A framework for Victoria*.

Edwards, D., Cooper, L., Burnard, P., Hanningan, B., Adams, J., Fothergill, A., & Coyle, D. (2005). Factors influencing the effectiveness of clinical supervision. *Journal of Psychiatric and Mental Health Nursing*, *12*(4), 405–414. https://doi.org/10.1111/j.1365-2850.2005.00851.x

Farkas-Cameron, M. M. (1995). Clinical supervision in psychiatric nursing: A self-actualizing process. *Journal of Psychosocial Nursing and Mental Health Services*, *33*(2), 31–37. https://doi.org/10.3928/0279-3695-19950201-08

Gonge, H., & Buus, N. (2016). Exploring organizational barriers to strengthening clinical supervision of psychiatric nursing staff: A longitudinal controlled intervention study. *Issues in Mental Health Nursing*, *37*(5), 332–343. https://doi.org/10.3109/01612840.2016.1154119

Hession, N., & Habenicht, A. (2020). Clinical supervision in oncology: A narrative review. *Health Psychology Research*, *8*(1), 8651. https://doi.org/10.4081/hpr.2020.8651

Howard, V., & Eddy-Imishue, G. K. (2020). Factors influencing adequate and effective clinical supervision for inpatient mental health nurses' personal and professional development: An integrative review. *Journal of Psychiatric and Mental Health Nursing*, *27*(5), 640–656. https://doi.org/10.1111/jpm.12604

Hughes & Morcom. (1998). Clinical supervision in a mental health inpatient area … including commentary by Northcott N. *NT Research*, *3*(3), 226–235. https://doi.org/10.1177/174498719800300310

Hyrkäs, K. (2005). Clinical supervision, burnout, and job satisfaction among mental health and psychiatric nurses in Finland. *Issues in Mental Health Nursing*, *26*(5), 531–556. https://doi.org/10.1080/01612840590931975

Kenny, A., & Allenby, A. (2013). Implementing clinical supervision for Australian rural nurses. *Nurse Education in Practice*, *13*(3), 165–169. https://doi.org/10.1016/j.nepr.2012.08.009

Kirk, M. A., Kelley, C., Yankey, N., Birken, S. A., Abadie, B., & Damschroder, L. (2016). A systematic review of the use of the consolidated framework for implementation research. *Implementation Science: IS*, *11*(1), 72–72. https://doi.org/10.1186/s13012-016-0437-z

Lakeman, R., & Glasgow, C. (2009). Introducing peer-group clinical supervision: An action research project. *International Journal of Mental Health Nursing*, *18*(3), 204–210. https://doi.org/10.1111/j.1447-0349.2009.00602.x

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: Advancing the methodology. *Implementation Science*, *5*(1), 69. https://doi.org/10.1186/1748-5908-5-69

Lynch, L. (2008). *Clinical supervision for nurses*. John Wiley & Sons.

Lynch, L., & Happell, B. (2008a). Implementing clinical supervision: Part 1: Laying the ground work. *International Journal of Mental Health Nursing*, *17*(1), 57–64. https://doi.org/10.1111/j.1447-0349.2007.00511.x

Lynch, L., & Happell, B. (2008b). Implementation of clinical supervision in action: Part 2: Implementation and beyond. *International Journal of Mental Health Nursing*, *17*(1), 65–72. https://doi.org/10.1111/j.1447-0349.2007.00512.x

Lynch, L., & Happell, B. (2008c). Implementation of clinical supervision in action: Part 3: The development of a model. *International Journal of Mental Health Nursing*, *17*, 73–82. https://doi.org/10.1111/j.1447-0349.2007.00513.x

Lynch, L., Happell, B., Sharrock, J., & Cross, W. (2008). Implementing clinical supervision for psychiatric nurses—The importance of education. *The International Journal of Psychiatric Nursing Research*, *14*(1), 1785–1796.

Lyth, G. M. (2000). Clinical supervision: A concept analysis. *Journal of Advanced Nursing*, *31*(3), 722–729.

MacLaren, J., Stenhouse, R., & Ritchie, D. (2016). Mental health nurses' experiences of managing work-related emotions through supervision. *Journal of Advanced Nursing*, *72*(10), 2423–2434. https://doi.org/10.1111/jan.12995

Masamha, R., Alfred, L., Harris, R., Bassett, S., Burden, S., & Gilmore, A. (2022). Barriers to overcoming the barriers': A scoping review exploring 30 years of clinical supervision literature. *Journal of Advanced Nursing*, *78*(9), 2678–2692. https://doi.org/10.1111/jan.15283

McCarthy, V., Goodwin, J., Saab, M. M., Kilty, C., Meehan, E., Connaire, S., Buckley, C., Walsh, A., O'Mahony, J., & O'Donovan, A. (2021). Nurses and midwives' experiences with peer-group clinical supervision intervention: A pilot study. *Journal of Nursing Management*, *29*(8), 2523–2533. https://doi.org/10.1111/jonm.13404

Munn, Z., Peters, M. D. J., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology*, *18*(1), 143. https://doi.org/10.1186/s12874-018-0611-x

Newman, C., Eason, M., & Kinghorn, G. (2023). Forensic mental health nurses' experiences of clinical supervision. *Journal of Forensic Nursing*, *19*(1), 12–20. https://doi.org/10.1097/JFN.0000000000000377

Nilsen, P. (2015). Making sense of implementation theories, models and frameworks. *Implementation Science*, *10*(1), 53. https://doi.org/10.1186/s13012-015-0242-0

O'Neill, L., Johnson, J., & Mandela, R. (2019). Reflective practice groups: Are they useful for liaison psychiatry nurses working within the emergency department? *Archives of Psychiatric Nursing*, *33*(1), 85–92. https://doi.org/10.1016/j.apnu.2018.11.003

Peters, M. D. J., Marnie, C., Tricco, A. C., Pollock, D., Munn, Z., Alexander, L., McInerney, P., Godfrey, C. M., & Khalil, H. (2020). Updated methodological guidance for the conduct of scoping reviews. *JBI Evidence Synthesis*, *18*(10), 2119–2126. https://doi.org/10.11124/JBIES-20-00167

Platt-Koch, L. M. (1986). Clinical supervision for psychiatric nurses. *Journal of Psychosocial Nursing and Mental Health Services*, *24*(1), 6–9. https://doi.org/10.3928/0279-3695-19860101-03

Proctor, B. (1991). Supervision: A co-operative exercise in accountability. In M. Marken & M. Payn (Eds.), *Enabling and ensuring: Supervision in practice* (pp. 21–23). National Bureau and Council for Education and Training in Youth and Community Work.

Rothwell, C., Kehoe, A., Farook, S. F., & Illing, J. (2021). Enablers and barriers to effective clinical supervision in the workplace: A rapid evidence review. *BMJ Open*, *11*(9), e052929. https://doi.org/10.1136/bmjopen-2021-052929

Saab, M. M., Kilty, C., Meehan, E., Goodwin, J., Connaire, S., Buckley, C., Walsh, A., O'Mahony, J., McCarthy, V. J. C., & Horgan, A. (2021). Peer group clinical supervision: Qualitative perspectives from nurse supervisees, managers, and supervisors. *Collegian*, *28*(4), 359–368. https://doi.org/10.1016/j.colegn.2020.11.004

Severinsson, E. I., & Hallberg, I. R. (1996). Systematic clinical supervision, working milieu and influence over duties: The psychiatric nurse's viewpoint—A pilot study. *International Journal of Nursing Studies*, *33*(4), 394–406.

Shelton, R. C., & Brownson, R. C. (2023). Advancing the science and application of implementation science to promote health equity: Commentary on the symposium. *Annual Review of Public Health*, *45*(1), 1–5. https://doi.org/10.1146/annurev-publhealth-062723-055935

Smith, C., Bennett, C., Morgan, K., Carrier, J., Klugarova, J., & Klugar, M. (2022). Enhancing the clinical supervision experience of staff members working within primary and community care: A best practice implementation project. *JBI Evidence Implementation*, *20*(S1), S23–S31. https://doi.org/10.1097/XEB.0000000000000317

van Dam, M., van Hamersvelt, H., Schoonhoven, L., Hoff, R. G., ten Cate, O., & Hennus, M. P. (2023). Clinical supervision under pressure: A qualitative study amongst health care professionals working on the ICU during COVID-19. *Medical Education Online*, *28*(1), 2231614. https://doi.org/10.1080/10872981.2023.2231614

White, E., Butterworth, T., Bishop, V., Carson, J., Jeacock, J., & Clements, A. (1998). Clinical supervision: Insider reports of a private world: Nursing and health care management issues. *Journal of Advanced Nursing*, *28*, 185–192. https://doi.org/10.1046/j.1365-2648.1998.00743.x

White, E., & Winstanley, J. (2009). Implementation of clinical supervision: Educational preparation and subsequent diary accounts of the practicalities involved, from an Australian mental health [corrected] nursing innovation. *Journal of Psychiatric and Mental Health Nursing*, *16*(10), 895–903. https://doi.org/10.1111/j.1365-2850.2009.01466.x

White, E., & Winstanley, J. (2010). Clinical supervision: Outsider reports of a research-driven implementation programme in Queensland, Australia. *Journal of Nursing Management*, *18*(6), 689–696. https://doi.org/10.1111/j.1365-2834.2010.01071.x

Willson, L., Fawcett, T. N., & Whyte, D. A. (2001). An evaluation of a clinical supervision programme. *British Journal of Community Nursing*, *6*(12), 614–623.

Yegdich, T., & Cushing, A. (1998). An historical perspective on clinical supervision in nursing. *Australian and New Zealand Journal of Mental Health Nursing*, *7*(1), 3–24.

Zonneveld, D., Conroy, T., & Lines, L. (2024). Clinical supervision experience of nurses in or transitioning to advanced practice: A systematic review. *Journal of Advanced Nursing*, *80*(9), 3547–3564. https://doi.org/10.1111/jan.16126

How to cite this article: Ryu, H., Buus, N., Naccarella, L., Zarb, L., & Hamilton, B. (2025). Factors that influence the clinical supervision implementation for nurses: A scoping review. *Journal of Advanced Nursing*, *81*, 7297–7310. https://doi.org/10.1111/jan.16390