ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

A case study exploring the experience of resilience-based clinical supervision and its influence on care towards self and others among student nurses

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Abstract
Background: Healthcare organisations are increasingly recognising their responsibility to support the wellbeing of nurses as a result of the accumulative demands of their role. Resilience-based clinical supervision is a newly developed intervention that encourages practitioners to pay attention and apply reasoning to behaviours and responses to emotive scenarios through a process of stress alleviation and prevention.
Aims: To evaluate an intervention aimed at supporting pre-registration nursing students to develop resilience-based competencies that enable them to regulate their response to stress and monitor their own wellbeing using mindfulness, reflective discussion and positive reframing.
Method: Case study methodology was used to explore how the characteristics associated with the expression and maintenance of resilience have been influenced by the intervention. Data were collected through focus groups at three timepoints with students and at the end of the intervention period with supervision facilitators, and then analysed by pattern matching to theoretical propositions.
Findings: Participants expressed positive experiences of resilience-based clinical supervision. Their perception of the importance of self-care increased and their commitment to caring for others was maintained. They continued to demonstrate competencies of self-care six months after qualifying as nurses, despite the complexities of the workplace. As qualified nurses, participants recognised the implications of limited time and resources on the quality of care they were able to provide to patients, but they externalised this as organisational failings as opposed to personal inadequacy, and worked around such constraints where possible to maintain personal standards.
Conclusion: Resilience-based clinical supervision has the potential to support healthcare practitioners in developing resilience-based competencies that allow them to recognise and attend to workplace stressors through appropriate and effective alleviation strategies.
Implications for practice:
- There is potential to foster resilience where practitioners and healthcare organisations commit to a sustained investment in strategies that promote reflection and self-care

Keywords: Compassion, resilience, self-care, clinical supervision, mindfulness, retention

Introduction
Media coverage of pre-registration nurse education has consistently implied that it is overly theoretical and detached from the reality of clinical practice, with newly qualified nurses being depicted as lacking the resilience to meet the demands of contemporary healthcare practice and the clinical competence to practice safely (Adams, 2012; Smith, 2012; Chapman and Martin, 2013). Despite these negative representations, an in-depth UK report into nursing education concluded that higher levels of education did not reduce standards of care (Willis, 2012). A pan-European study also found higher levels of education among nurses to be associated with more positive outcomes in terms of quality of care interactions and patient mortality (Aiken et al., 2014).

The transition from student nurse to newly qualified nurse can be an extremely stressful period (Pickens and Fargostein, 2006; Mooney, 2007). Research has found increases in pressure can quickly lead to individuals feeling overwhelmed and frustrated (Mackintosh, 2006; Murphy et al., 2009; Kumara and Carney, 2014). Nurses who leave the profession cite a lack of support, poor work environment and exhaustion as key reasons, along with the emotional impact of their role (MacKusic and Minick, 2010). This highlights the importance of individual resilience in the transition to practice (Chesak et al., 2015).

Resilience is the ability, both inherent and learned, of an individual to resist adversity and respond in a positive manner (Stephens, 2013). Research suggests resilience can be learned, developed, and enhanced through cognitive transformational practices, education, and environmental support (Grafton et al., 2010). However, there has been little research focused on evaluation of strategies to enhance resilience within professional education, despite the acknowledgement that this attribute is central to reducing attrition in the profession (Grant and Kinman, 2014; Chesak et al., 2015).

Nevertheless, evidence to support the efficacy of resilience-based approaches on patient outcomes in a range of settings is developing (Gilbert and Proctor, 2006; Frederickson et al., 2008; Laithwaite et al., 2009; Judge et al., 2012; Lucre and Corten, 2012; Goss and Allan, 2014). Heriot-Maitland et al. (2014) reflected with staff on an acute mental health ward following their facilitation of therapy groups, and reported that they felt an increased sense of resilience and ability to tolerate distressing situations due to an awareness of the emotional response that was being triggered by the stressful working environment. Additionally, research has concluded that by focusing on and practising resilience-based competencies, individuals can influence both their neurological and immune systems in a positive way (Pace et al., 2009; Klimecki et al., 2014). This suggests such strategies may help healthcare workers develop increased levels of resilience, regardless of level or specialty. The evidence base does not, however, extend to pre-registration education and the role of such strategies in supporting the transition to registered practitioner.

More than 20 years ago the UK Department of Health recommended that clinical supervision be an integral part of pre-registration nursing programmes (Department of Health, 1994). The UK regulator, the Care Quality Commission (2013) more recently underlined that the aim of this is to provide individuals with an opportunity to reflect and review their practice, yet the evidence base remains limited. However, the supervision process has been shown to help individuals develop knowledge, skills and confidence, as well as resulting in more resilient practitioners who are better able to cope with the various demands placed on them (Taylor, 2014). Group clinical supervision in pre-registration education has the potential to support personal and professional development (Arvidsson et al., 2008; Lysaker et al., 2009; Berglund et al., 2012), and also has a restorative element because attendees feel that their experiences are normalised (Carver et al., 2014). On the other hand, it has been found that this process can increase students' anxieties and feelings of vulnerability caused by comparing themselves with other group members and feeling pressure to appear confident. This can lead to defensiveness and a reluctance to self-reflect (McGrath and Higgins, 2006). However, this can be addressed by the presence of a consistent and stable group (Carver et al., 2014). Also, introduction to clinical supervision within pre-registration education has been shown to increase uptake following qualification (Severinsson et al., 2014), which has positive implications for enhancing resilience and improving patient care (Alleyne and Jumaa, 2007).

Educational intervention

Resilience-based clinical supervision (RBCS) is underpinned by the principles of compassion-focused therapy (Gilbert, 2010), which maintains that behaviours are motivated by three emotional regulatory systems, guided by a desire to: protect the self from threat; to compete with the self or others for external validation and success; and to soothe the self to enable contentment and self-acceptance.

While each of these systems is effective in some circumstances, the ability to recognise and make choices about the most beneficial mode of response is a key aspect of RBCS. This is complemented by the integration of mindfulness, positive reframing and roleplay focused on enacting a preferred outcome. The format of the RBCS session is captured by Figure 1 and set out in more detail in Table 1. There is also an animation explaining the process at youtu.be/YQsAS3co51U.

All nursing students from one cohort received RBCS on a two-weekly basis during clinical placement in the final six months of their programme. Each session lasted two hours and was facilitated by a nursing academic who had attended a three-day training course, aided by compassion-focused therapy practitioners. Facilitators engaged in ongoing peer supervision throughout the intervention period to sustain fidelity to the RBCS model.
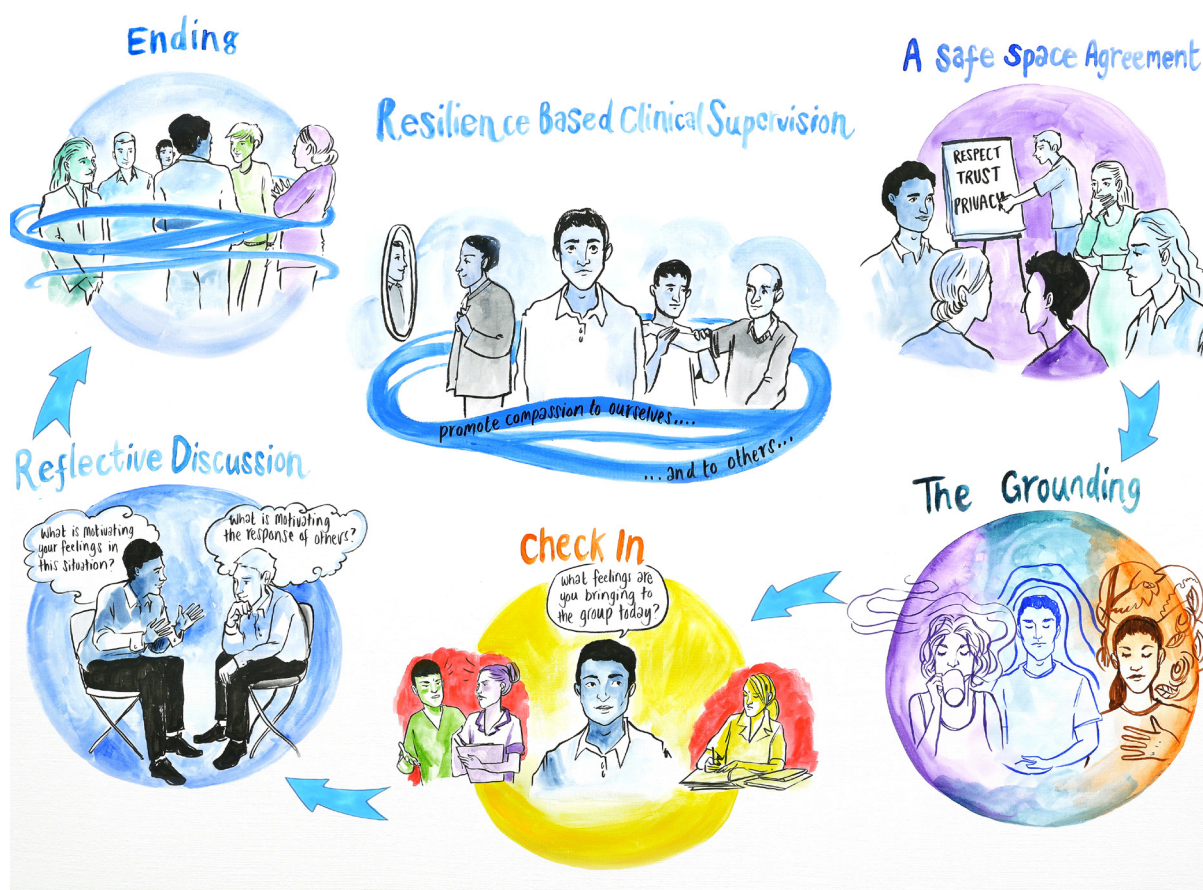
Figure 1: The RCBS process

Table 1: Resilience-based clinical support format	
1. Grounding exercise	This can be in any format that you feel comfortable with
2. Check-in	A brief 'check-in' of how people have been. This could start with, 'so how are we all feeling today?'
3. Set agenda	Are there any themes you have identified from the check-in? Is there anything attendees are keen to discuss? Have people had similar experiences? Pick three or four of these, starting with what you have identified as the most important

4. Main discussion

Remember to 'notice and explore'
Use a picture of the emotional regulation systems as a tool (Figure 2). This could be in the centre of the room and can be used to bring the focus back to what emotional system someone may be in at that moment
Remember the critical voice, this may answer the question initially. You may be able to explore this, name it, be aware of it. You are there to enable others to make their own decision: take a step back, do not become a problem solver

Prompts for the different facets of a compassionate mind:

Care for others' wellbeing	• What did you feel you wanted to do in this situation? • What was your aim in doing this?
Distress and need sensitivity	• Were you aware of how they were feeling at that point? Did you understand why? • What emotional cues did you see? How did you respond to them?
Sympathy	• How did supporting someone in that emotional state make you feel?
Distress tolerance	• How did you behave in that way despite your thoughts at the time? • How did it affect your mood? • How did you deal with this?
Empathy	• Did you feel like you were able to relate to this persons feelings? • Did you feel like you understood these feelings? • How did you communicate your understanding?
Non-judgement	• How do you think you would behave in the situation? • How do you think you would feel? • How do you think they were feeling at this time? What thoughts do you think they had?
Warmth	• How were you feeling at this time? • How did you portray this?
For all facets	• How did you behave in this instance? • What influenced you to do that? • What were you thinking? • What were you feeling? • Would you expect others to react like that? • How does everyone else think you would feel if you were in that situation? How do you think this would impact on your behaviours? • Can anyone else relate to this situation? • Did you feel like you were being compassionate at this point?

5. Summarise/round of appreciation

• Summarise what you have discussed and the main learning points
• You could do a round of appreciation where everyone says thank you to a person for something they have done

6. Get supervision

• If you need any support do not hesitate to contact someone. We will run supervision groups for those that have attended the training as well

The most important thing to remember is you are creating a safe space for people…
there is no right or wrong way to do this!

Figure 2: Emotional regulation systems (Gilbert, 2010)

Aim

To evaluate an intervention aimed at supporting pre-registration nursing students to develop resilience-based competencies that enable them to regulate their response to stress and monitor their own wellbeing using mindfulness, reflective discussion and positive reframing.

Method

A total of 120 students received RBCS supervision from all fields of practice and all were invited to take part in the study. Recruitment involved a verbal information session complemented by a written information sheet. Students were asked to complete a reply slip to request further information if they were interested in taking part. This was provided via email and resulted in a convenience sample of nine students representing all field of practice. Additionally, all eight academic tutors who had facilitated RBCS were invited to participate in the study, which resulted in a further convenience sample of five. Ethical approval to conduct the study was granted by the host university's research ethics committee. All students eligible to take part in the study were informed of the process, and their right to full confidentiality and to withdraw at any time.

The intervention was evaluated through the method of exploratory case study, underpinned by a social constructivist theoretical framework (Goffman, 1959; Berger and Luckmann, 1967). This theoretical position focuses on experience as individual and reality as being constructed through individual knowledge and experience (Bryman, 2004). This is based on the premise that individuals have personalised identities and also differ from each other in their actions when they are expressing care towards self and others (Neff, 2003). There are also other factors that may affect an individual's view of self-care, including past experiences, knowledge, gender, class and race (Blackstone, 2009). This is also true, therefore, for how individuals may perceive RBCS.

For this research project, the case in question was RBCS as an educational intervention. The purpose of the case study methodology was to investigate the innovation in its real-life context. Guidelines posited by Yin (2014) were used to ensure rigour. For example, the aim was not to make statistically generalisable conclusions based on the exploratory case study; Yin argues that developing theoretical propositions arising from in-depth consideration of the existing literature allows you to generalise at a conceptual level known as analytical generalisation. The use of this approach allowed the researchers to corroborate, modify and reject theoretical concepts based on an in-depth review of the case. The following theoretical propositions were developed from consideration of the background literature:

- *Proposition 1*: RBCS has the potential to increase the level of resilience among student nurses, which has positive implications for the transition to practice
- *Proposition 2*: The underpinning framework of RBCS could enhance effectiveness of clinical supervision in pre-registration nurse education as a forum that promotes the development of resilience

Research design

To evaluate the experience of RBCS, focus groups were facilitated with the students at three timepoints: T1 (n=9, immediately prior to the intervention); T2 (n=8, at the end of the intervention period); and T3 (n=4, six months post intervention). Availability goverened the number of participants at each timepoint. For consistency, the focus groups were conducted by the same two members of the research team (GS and GC). Students were asked to relay stories of emotionally meaningful experiences and then prompted to discuss their thoughts and feelings around these and their view of how they had responded to them. This enabled the identification and exploration of resilience-based competencies and assessment of whether these changed over the time periods. Additionally, a focus group was conducted with a sample of the nursing academics (n=5) who had undergone the training for RBCS and facilitated the RBCS sessions. The aim of this was to explore their experiences of the supervision model and how they thought students had responded to the intervention. Each focus group was treated as a unit of data, which contributed to the exploration of the case (Yin, 2014).

Data analysis

Data were analysed using a pattern-matching approach advocated by Yin (2014). This involved comparing patterns emerging from the empirical data with the theoretical propositions developed from the literature review (Yin, 2014). Data analysis was conducted using the QSR International NVivo software to enhance the transparency and organisation of the process. Analysis was conducted independently by three members of the research team, followed by a process of analytical synthesis through ongoing discussion to ensure rigour.

The following section highlights the most significant findings for each proposition, which have been synthesised from the analytical process. The findings take into account the different timepoints and the experiences of RBCS from the perspective of students and facilitators.

Findings

Theoretical proposition 1: RBCS has the potential to increase the level of resilience among student nurses, which has positive implications for the transition to practice.
The nature of the emotionally meaningful events identified by students at the pre-intervention stage related to a range of scenarios, including: the potential for the student to be a victim of physical harm in the workplace; encountering human suffering that surpassed any prior experiences; and significant self-criticism related to the inability to uphold the standards of care delivery they expected of themselves due to the constraints of the clinical environment. These experiences each left the student feeling vulnerable due to fear of external criticism from established professionals if they disclosed their difficulties.

In terms of the competencies promoted within RBCS, six of the participants displayed an ability to tolerate distress within their situation and sit with uncomfortable feelings:

> 'My mentor asked, do you still feel uncomfortable talking to her about it and I said I do… but if I don't… then it's just gonna be uncomfortable forever.'

The participants' reflections on what motivated their response to an emotionally meaningful situation were clearly underpinned by a sensitivity to the distress of others and a desire to alleviate that distress. Their motivations included a deep empathy with the individuals they encountered and a passion to ensure they provided care that protected the patient's dignity and considered their holistic needs:

> 'I think my motivation was I saw someone in distress and I wanted to try and ease that distress.'

A proportion of the pre-intervention data were attributed to factors that conflicted with the expression of care towards others. This primarily related to negative views that the participants held of established staff. Four participants expressed discontent with the way they observed established staff responding to people in distress. Participants were able to reflect on possible reasons for the non-compassionate practice they had observed but their tolerance and empathy for this remained limited:

'Looking at it from one perspective they maybe don't have a broad experience of people with a history of drug use, they maybe haven't had exposure to different people with different backgrounds so maybe they are responding... in the best way they can.'

'I don't think it's a valid excuse, I think something needs to be done to challenge that, it's not acceptable to maintain… that belief or that view of a person.'

In relation to self-care, at the pre-intervention stage participants displayed a conscious awareness of their own feelings and emotions, particularly around personal triggers within the emotionally challenging situations:

'I guess with my situation, usually you've kind of got the patient, the professional… because I related to her so much that kinda made me go, oh my gosh it's so linked and it kind of broke down those traditional barriers.'

The participants' desire and motivation to express compassion was acknowledged to have potentially negative implications for them. Failure to act on their compassionate feelings due to organisational or relational restrictions led to some self-criticism and shame:

'Well I thought I managed it quite badly actually. I took it home with me… I kept thinking about it… and actually did not really talk about it.'

Overall, the pre-intervention data demonstrated a high level of motivation to respond to patients in a way that alleviated suffering and offered empathetic care. Participants were critical of the practices of established nursing staff when they did not do so. While they attempted to understand what might be behind this, they remained judgemental of their actions and positioned themselves as different to the established workforce.

Post-intervention
During the post-intervention focus group, there was a difference in the emotionally meaningful situations participants chose to discuss, with a significant proportion of the dialogue focused on a situation where they felt 'targeted' by a patient. This referred to situations where a patient expressed verbal and or physical aggression towards the student for a prolonged period of time:

'About five days in a row basically, constantly targeting me, he could be quite volatile, quite abusive, you know it got to the point where every day he would threaten to knock me out.'

Despite the high stress levels posed by such scenarios, participants continued to perceive themselves as actively caring towards their patients and adopting a different approach to the line commonly taken by others in practice:

'Staff were saying "oh don't, don't engage with him" but I thought that's just gonna show more rejection so I was trying to work with him, I'm not like them.'

Participants also expressed concerns about other patients whose care may have been negatively influenced as a result of the high need of one individual:

'It neglects a lot of care towards other patients as well, it's like the focus has to be always on them.'

This reflected the dissonance they were experiencing in relation to a sensitivity to multiple people in distress and competing motivations to relieve this. This dissonance appeared to raise questions of self-doubt, leading participants to be concerned about their personal emotional response to these situations and lack of ability to 'switch off' outside their placement hours.

> 'Yeah it's upset me, I've found it really quite difficult and it's the sort of thing that I talk about a lot at home – the things that have upset me in that day.'

> 'I don't know where to put it.'

Participants reflected that this could be as a result of the increased responsibility they now felt for the outcome of these situations, and the greater investment they had in the external approval of others due to the requirement to be positively assessed to pass their programme of study. They were beginning to recognise the need to find some way of managing the internalisation of such emotions and discussed strategies such as maintaining a focus on understanding the person behind the targeting behaviour and attempting to work with the person's strengths as opposed to their problems. Their ability to do this was attributed directly to the reflective discussion facilitated within the RBCS forum, where the motivations of others and the use of the three emotional systems were used to encourage empathic understanding.

> 'I also feel I've been given some techniques which I just I didn't even know existed.'

The increased level of self-criticism identified at the post-intervention stage in Proposition 1 appeared to be associated with a greater awareness of the need to prioritise self-care. It was acknowledged that this would have a positive impact on their ability to remain in their role in the longer term:

> 'So I just need to work on that and recognise that I probably need to do that a little bit more.'

Encouragingly, at the post-intervention stage two participants had used mindfulness and grounding techniques independently to support this:

> 'I cannot sleep when I come back on a late, my head's whirring and then you're thinking, what about the breathing exercises that the tutors did at the last supervision. You're thinking, actually I've just done that without knowing... and I wouldn't have done that a year ago. I think I sat and... moaned and probably got fed up.'

Furthermore, over time participants appeared to be demonstrating the ability to accept what may not be within their control as a counter argument to the previous internalisation of responsibility arising from the internal critical voice:

> 'But it's something you don't actually have any control over it because people make their own decisions and it's learning to accept that as well. You do what you can, ultimately it's what they choose to do, it's not anything that you've done.'

At the post-intervention stage, participants remained critical of practice seen as undermining a compassionate philosophy of practice and appeared to make a more concrete association between the role of self-compassion in sustaining compassionate values.

In summary, the complexity of the social processes the participants engage in were evident. This was demonstrated by the dissonance they described regarding their motivation to express care to people in the context of competing demands. The personal implication of this was significant and RBCS was cited as a key forum for processing these dilemmas.

Post-registration experiences

As qualified nurses, six months post intervention, there was a definitive shift in the care individuals felt able to express towards others:

'I find it difficult to be compassionate just because there may not be opportunity to be compassionate.'

All participants at this stage expressed a belief that this was due to organisational factors such as resources. This was cited as opposed to a lack of desire or ability to express compassion. The data arising from this focus group highlight the participants' awareness of the constraints that impact on their ability to express compassion to others. There was a dissatisfaction with this situation and a sustained desire to work around constraints to make a connection with patients:

'I just feel quite sad as well that this isn't why I trained. And those few moments that I do get where I will make that effort, I'm gonna go and speak to my named patients today and even if I just have a few minutes just to go in and say hello.'

This demonstrates that the desire to uphold a caring philosophy of practice can be sustained alongside practice that may appear detached from these principles. While participants were clearly frustrated with this position they did not internalise responsibility:

'I suppose there's a bit of inadequacy for me… I don't think I'm doing something wrong, I just don't think I'm being allowed to do it right so I don't have the time or the resources to do it correctly.'

This mitigated the self-criticism and moral conflict present at the post-intervention stage. Associated with this, as qualified nurses, participants discussed the coping strategies they used to manage the ongoing exposure to the suffering of others. One of these was the maintenance of boundaries between themselves and the patient, which they conceptualised as a form of self-protection. It was recognised by two of the participants that this could be done in a compassionate way that helps to model compassion to both self and others:

'So I suppose that's sort of against being compassionate but I try and limit it so it doesn't back me in too far, in case it takes out too much compassion out of my compassion reservoir. So I don't want to run on empty at any point just in case. Yeah, it is a barrier I put up but it's a safety barrier. That's how I rationalise it, is it's a safety barrier for me and also for them so they then don't get too dependent on me.'

Despite criticising established practitioners for maintaining this distance in earlier focus group discussions, they now appeared to view this as an essential coping strategy, notably in relation to targeting, which represented a shift in perception. The difficulties individuals had had in taking emotions and distress home with them appeared to have decreased after six months in practice and there was a heightened awareness that a failure to manage this may lead to burnout:

'I have a really rigid rule that if I leave the ward as I go past the double, double doors, that's it, no more.'

One participant found this difficult at times, but used appropriate strategies to manage it:

'I sometimes take home the frustration that I'm feeling of being in that environment where… I need more support and I can't get it. But then I try and look for another task, I try and do something constructive with that and try and find ways of doing something about the situation.'

All participants at this stage had used grounding and mindfulness as coping strategies; two had done so during their work time:

> *'Sometimes I try and do the mindful breathing and things like that. I'll go and have a little moment. Yeah most of the time it can help. Sometimes I walk back onto the ward and the situation on the ward is exactly as it was but it can help to just make me pause and then go rather than just continuing to go... just having that moment to just think before I act... yeah, I've found it really helpful.'*

Finally, as detailed above, by virtue of maintaining boundaries and challenging their self-criticism, all individuals felt their levels of self-care had increased. This was recognised as a conscious effort that had beneficial effects on their ability to manage stressors at work:

> *'I deal with things that are thrown at me without kind of, you know, blaming myself or having the same sorts of feelings towards things that I was then... I really struggled then and I think I would have found it quite hard if I still felt like that.'*

The significance placed on self-care was increasingly prominent over time, with a rising emphasis on the link between inadequate self-care and non-compassionate practice.

Theoretical proposition 2: The underpinning framework of RBCS could enhance effectiveness of clinical supervision in pre-registration nurse education as a forum that promotes the development of resilience. Before the start of the RBCS, there were inconsistent views around supervision, which appeared to be highly dependent on the quality and consistency of the facilitator. Students appreciated a collaborative style, with a clear structure and process leading to a resolution. Factors that undermined this process included the dominance among peers of negative views that were viewed to have no direction or outcome.

> *'People just use it as a platform to moan really without anything constructive.'*

There could also be a tendency for some students to focus on themselves and their own priorities. Finally, while the opportunity to learn from others could be a valuable outcome, some students compared themselves with each other, potentially reinforcing self-criticism.

Despite the varied experience of supervision, students agreed it offered an opportunity to reflect on their practice, clarify values, consider alternative perspectives and think about the bigger picture. Individuals who found supervision helpful reported on the importance of the quality of facilitation in promoting a reflective space and addressing group dynamics:

> *'I think your experience of it is based on the lead... whoever's leading the supervision.'*

Following the implementation of the RBCS, six of the eight participants in the second focus group felt there had been minimal change to their supervision experience as they had always found it beneficial:

> *"Ours hasn't changed a whole lot. Since this compassion model's been introduced, I have found our groups, because of the facilitator, have all been absolutely brilliant.'*

The other two participants felt there was a marked difference in their supervision sessions, noting the change in structure, a focus on positive reframing and the integration of mindfulness:

> *'It's a more... productive way to address things that happen...every day. I found I hardly used to go to clinical supervision cause I just couldn't stand all the whining but I've gone to every one since.'*

All six who felt that there was little difference in supervision felt their sessions may have been resilience based before to the facilitators' training:

'I think our supervision group was resilience based even before we had all the grounding exercises.'

Again, it was expressed that the relationship with the facilitator and the group dynamics were the most important aspect of supervision:

'I think it's worked because we are quite free in talking... you know, trust each other.'

Facilitators' viewpoints
From the perspective of the facilitators, all expressed that they had personally found the training beneficial, most noticeably in helping to be mindful of the here and now:

'I'm a lot more aware of, you know, what's happening now.'

Four of the facilitators expressed positive opinions of the model:

'The actual structure of the model, the emotional regulatory system circles are absolutely fantastic, really useful, really beneficial. Having the model in the room, keep it as a midpoint that we all refer to and think about, you know how are we feeling, how are we responding, how are we reacting, where do we fit. That's absolutely superb, lovely.'

Of the other two, one had not facilitated many sessions and still felt at the stage where she was learning a new approach. The other had the following thoughts:

'I've been modelling that mindfulness approach as far as I know. I've read nothing to make me think I haven't been, you know I've made no adjustment apart from I tried a few of the grounding exercises.'

This was echoed by one other facilitator and mapped with the experience of the students who did not feel that there had been a notable change in supervision. This led to a question, which others also agreed with:

'I just wonder really if, as long as the... facilitator is modelling kindness and support, I'm just wondering isn't that all you kind of need.'

Two facilitators made a comparison between their previous supervision sessions and the RBCS; they felt it helped their students to develop independent coping skills:

'The stuff that came out today was totally different from normal so in some ways they've felt they've had the permission to explore outside this standard, oh I dunno how I'm going to do this and how I'm going to do that. More about the feelings... and showing compassion for themselves.'

As qualified nurses, none of the participants was receiving clinical supervision in their workplace. There was a motivation to seek out this type of support and advocate its benefits among the group, but the limited provision appeared to emphasise the importance of self-care strategies.

Discussion
The above findings suggest RBCS has the potential to support individuals in the development of resilience, taking into consideration the complex social processes and organisational constraints they are exposed to. Engagement in mindfulness-based stress-reduction strategies and the use of positive reframing was associated with a self-reported increase in levels of resilience.

In line with the established evidence base (Curtis et al., 2012), participants at the pre-intervention stage demonstrated high levels of sensitivity to the suffering of the people they were caring for. Their motivation to alleviate this suffering demonstrated the presence of a number of the components of a compassionate mind, including empathy, non-judgement and distress tolerance (Gilbert, 2010). This developed over the RBCS intervention period, with a commitment to the wellbeing of others appearing to be the overarching motivation for the participant's response to a situation.

Participants displayed the ability to use individualised skills introduced, rehearsed and reinforced within RBCS to manage the complex processes they were exposed to, both directly after RBCS and also six months after qualifying. This effect agrees with earlier findings from Heriot-Maitland et al., (2014), where staff who had facilitated resilience-based group therapy sessions felt better able to deal with challenging situations.

Initially participants were critical of established professionals, whom they judged to be distancing themselves from the suffering of patients by dismissing their distress or discouraging active engagement. While the participants attempted to understand what might underpin these attitudes, they did not view them as acceptable. This continued throughout the intervention period despite their acknowledgement that the supervision offered them the opportunity to step into the shoes of others to better understand their response. There appeared to be an increased distinction between 'them' (the established workforce) and 'us' (the student participants).

Associated with this was the participants' difficulty with applying the principles of compassion to themselves. It was evident that they had high standards for themselves in terms of delivering high-quality care and being perceived by their practice assessors as competent and confident. Participants recognised their difficulty with 'switching off' from the emotional impact of their work and noted the implications of this for their wellbeing, due to self-criticism and personalisation of responsibility. At the post-intervention stage, the need to refocus this commitment to self was acknowledged as the link between the distancing practices they had criticised as a consequence of lack of self-care was clearly recognised.

This focus on self-care was more evident in the follow-up focus group, as the participants, now newly qualified nurses, spoke about strategies they used to allow themselves to sustain their compassion and personal wellbeing. These included: mindfulness and grounding exercises; the maintenance of boundaries between themselves and the patient, aided by cognitive strategies that helped to establish a distinction between work and home; and the positive reframing of challenging situations by identifying the limitation of their influence and the responsibility of the organisation.

It is evident that some of the strategies employed could be viewed as distancing techniques similar to those they had previously found unacceptable. However, participants offered a clear rationale for these approaches, which they described as offering consistency and safety to the patient while also enabling them to maintain their 'compassion reservoir'.

In terms of times series analysis, the data demonstrated a sustained commitment to care of others alongside increasing awareness over time of complex social processes and organisational constraints. These impacted on the expression of care in practice and led to conflict and dissonance among the participants, which they were acutely conscious of and actively attempted to manage.

While it appears the participants have maintained their commitment to expressing care towards others, as predicted from the literature, a complex psychological process of internal dissonance, alleviation and prevention occurred. Furthermore, a rival pattern associated with the participants' ability to depersonalise responsibility for the effects of organisational constraints, such as poor resources, existed. This has previously been reported as the erosion of compassion among newly

qualified nurses' due to the desire to prioritise efficiency and tasks (Mackintosh, 2006; Murphy et al., 2009; Kumara and Carney, 2014). These data suggest, however, that this is an active strategy whereby participants recognise the limited influence they have on the wider system and exercise strategies of self-care to mediate the influence of the self-criticism. This was achieved by acknowledging that they were often doing the best they could in challenging circumstances.

Participants expressed that the RBCS model encouraged a more positive experience of clinical supervision, whereby their relationship with their facilitator was aided by the structure and format of the process. Previous research has found the most important factor in clinical supervision is a supportive yet challenging professional relationship with the facilitator (Severinsson and Sand, 2010). The importance of this was reflected throughout the project, and a safe, trusting space was seen as beneficial to all participants. This aspect is viewed as an essential component of the RBCS model as it advocates that all interactions are enacted with warmth (Gilbert, 2010). This is likely to produce a safe space in which individuals feel comfortable disclosing and questioning their thoughts about emotionally challenging situations.

Conclusion
In relation to the proposition regarding the potential of RBCS to improve resilience and consequently the transition to practice, these findings suggested the model may support individuals to develop competencies that would allow them to recognise the emotional motivations underpinning their responses. Furthermore, the implementation of stress-reduction strategies and positive reframing were shown to enable them to maintain and prioritise self-care, with positive implications for levels of resilience and facilitation of the transition from study to practice. However, the underpinning framework of RBCS only enhanced the effectiveness of clinical supervision where there was a continued commitment to and practice of the approach. Such commitment is required at an individual and organisational level.

Limitations
The exploratory nature of this single-case study presents a positive basis for further implementation and research around RBCS. However, the numerous variables that could have influenced the participants' transition to practice represent a significant limitation of the study. Additionally, the variation reported by both students and facilitators in how the RBCS model was implemented limits the conclusions that can be drawn regarding the relationship between the students' experience of the transition process and engagement with RBCS.

The exploratory case study method enabled this research to capture this variance and acknowledge the confounding factors, which arguably represents a naturalistic account of the implementation of educational innovations. However, the research was carried out with a small sample size within a single university setting. Although the findings corroborated the theoretical propositions, there are no other research studies associated with the use of RBCS. Therefore, further research is required in different populations, including newly qualified nurses, in order to further evaluate the efficacy of this innovation.

Implications for practice
The findings demonstrate learning that has occurred over time in relation to the challenges of maintaining and expressing resilience in practice. It is acknowledged that a number of factors could have influenced this learning process and the ability to distinguish a direct connection with RBCS is limited. It is clear, however, that nursing students and facilitators value the space that supervision offers to explore these challenges. Furthermore, it appears that the structure and format of RBCS addresses some of the criticisms previously expressed about supervision, to create an experience more in line with students' support needs. In addition, the practice of mindfulness appears to be a valued feature and one that was reported to be transferable outside the supervision setting. This

is particularly relevant as no participants were receiving any form of clinical supervision once they transitioned to being qualified nurses. These findings confirm the proposition that the underpinning framework of RBCS could enhance the value of clinical supervision in pre-registration nurse education.

Additionally, they suggest that an ongoing commitment among individuals and organisations to the practice of RBCS could have long-term positive implications for the wellbeing of nurses. Many newly qualified nurses feel overwhelmed and frustrated with the lack of support (Kumara and Carney, 2014), which this project has reflected. It has been argued that investment should be made in newly qualified nurses from an early stage in their career (Hollywood, 2011), and the Care Quality Commission (2013) advocates clinical supervision as beneficial in doing this.

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