Nurse-Family Partnership and Supervisors

Nurse-Family Partnership Supervisor Roles and Responsibilities for Implementation of an Intimate Partner Violence Intervention: An Interpretive Description Study

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TITLE: Nurse-Family Partnership Supervisor Roles and Responsibilities for Implementation of an Intimate Partner Violence Intervention: An Interpretive Description Study

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Lay Abstract

The Nurse-Family Partnership® (NFP) is a home visitation program targeted to young mothers, pregnant with their first child. To support nurse home visitors identify and respond to intimate partner violence (IPV) experienced by NFP mothers and children, an IPV intervention was developed. Within the NFP implementing agencies, supervisors were instrumental in ensuring the IPV intervention was delivered as intended, forming what is known as the implementation process. This qualitative interpretive descriptive study involved interviews with 11 supervisors and 2 managers, as well as a secondary analysis of 7 focus groups (n=35 nurses) to understand and describe the roles and responsibilities supervisors had within this process. From the analysis of these data, an NFP supervision framework was developed that included articulation of 4 domains, 7 roles, 7 sub-roles and multiple responsibilities affiliated with this position. This framework offers a new language for supervision which may become a first step to better understanding, communicating, and developing supervision in home visitation, and in particular, articulating the functions supervisors are required to lead when faced with the responsibility for implementing a new innovation within their program. It is important to understand NFP supervisor functions of the implementation process to enable NFP strategies that will best support supervisors, ensure responsibilities belong to the right person, and meet implementation goals when adopting evidence into NFP nurse home visiting practice.

Abstract

The Nurse-Family Partnership® (NFP) is a home visitation program for young pregnant and first-time mothers affected by social and economic disadvantage. In response to intimate partner violence (IPV) experienced by women and children involved in the program, a nursing intervention was developed to support nurse home visitors identify and respond to IPV. Within each participating NFP team, supervisors were accountable for facilitating the implementation process of the IPV intervention for uptake into nurse home visitor practice. To understand the functions of NFP supervisors involved with the facilitation of the implementation process for the IPV intervention, an interpretive description approach was utilized involving primary data collection from interviews with 11 supervisors and 2 managers, and triangulated with secondary data from 7 focus groups (n=35 nurses). From this analysis, an NFP supervision framework was developed that included 4 domains, 7 roles, 3 sub-roles and multiple responsibilities. Supervision was found to involve roles and sub-roles functioning in oversight of implementation and others that functioned in the direct implementation of the IPV intervention, forming levels of supervision, and creating a hierarchy. A comprehensive appreciation of NFP supervisor domains, roles, sub-roles and responsibilities enacted during the implementation process is important to help identify the best alignment of human resources, recognize how the NFP can best support supervisors, and to champion achievement of current and future innovation implementation goals. Recommendations of support for supervisors include facilitating educational opportunities, creating transparency of the implementation process, developing a quality improvement strategy, providing supervisor mentorship, improving standardization, and recognizing the competing NFP priorities for supervisors and nurse home visitors.

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Resilience is the capacity to keep going, to dig deep despite adversity, to smile while tears streak your cheeks. To the abused women who keep going and who dig deep while experiencing intimate partner violence, I hope you hear the whispers that you are worth it, that your children are worth it, and you have the courage to find your peace and love in life. Thank you to the supervisors and nurses who participated in this study. Your work is most inspiring and beautiful. Your own resilience and dedication to keep improving the NFP program will be the facilitator of positive change for your community families and will help stop the perpetuation of abusive cycles for vulnerable women and their children. Thank you to the NFP National Service Office (Denver, Colorado) for continually trying to improve your program and shift to meet the needs of young families.

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Abbreviations and Symbols

DANCE	Dyadic Assessment of Naturalistic Caregiver-Child Experiences
i-PARiHS	Integrated Promoting Action on Research Implementation in Health Services
IPV	Intimate Partner Violence
MI-AIMH	Michigan Association for Infant Mental Health
NFP	Nurse-Family Partnership
NHV	Nurse Home Visitor
NSO	National Service Office
RCT	Randomized Controlled Trial
STAR	Strengths and Risk Framework
US	United States
WHO	World Health Organization

Declaration of Academic Achievement

This thesis is an original synthesis of the research presented and was conducted under the supervision of Dr. Susan Jack beginning September 2014. Thesis committee members Dr. Jenny Yost (McMaster University, 2011 to present and Villanova University, 2017 to present) and Dr. Ruth Chen (McMaster University) contributed to this work with input for thesis design, methods, data collection and analysis, Hamilton Integrated Research Ethics Board (HiREB) ethics protocol submission, and review with edits of thesis in draft versions and as a final document. Along with Dr. Susan Jack, I developed the interview guides for the primary data collection from the supervisors and managers. This thesis also includes a secondary analysis of data from focus groups with nurses, conducted by Dr. Susan Jack. I was responsible for all primary data collection involving supervisor and manager interviews, and coding and analysis of primary and secondary data sources.

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Introduction

The Nurse-Family Partnership® (NFP) program is an evidence-based public health intervention targeted to young, pregnant women, and first-time mothers (Olds et al., 1997). The overall goals of the NFP program are to improve health and social outcomes: 1) during pregnancy and the prenatal period for mother and child; 2) during child development by supporting parents to develop competency in providing safe and sensitive care to their infants and toddlers and; 3) by building maternal capacity for economic self-sufficiency through exploration of educational opportunities, job force skills, and subsequent pregnancy planning (Olds et al., 2004). The program provides specialized training for nurses and employs baccalaureate-prepared registered nurses, as nurse home visitors (NHVs), to facilitate health promotion and support for families. Families are home-visited up to 64 visits by NHVs starting early in pregnancy and continuing until the child's second birthday. Each NFP team has an assigned NFP supervisor who leads and manages an NHV team and provides nurses with regular reflective supervision (Prevention Research Centre for Family and Child Health, 2017).

The effectiveness of NFP in the United States (US) has been established through the conduct of three randomized controlled trials (RCTs), demonstrating repeated and enduring positive impact effects on a range of maternal and child health outcomes (Olds, Kitzman, et al., 2014). Based on this evidence, the NFP program has been identified internationally as a gold standard intervention for the prevention of child abuse and neglect (MacMillan et al., 2008). In the first NFP trial, conducted in Elmira New York, among a sample of nurse-visited young, unmarried adolescent mothers living in poverty, there were 80% fewer verifications of child abuse and neglect, 32 % fewer emergency department visits and 56% fewer visits for the treatment of injuries or ingestions compared to the control group (Olds, Henderson, Chamberlin

et al., 1986). In the subsequent trial, conducted in Memphis Tennessee, overall healthcare visits were reduced by 23% for NFP-visited children under 2 years and hospitalized care for children consisted of 79% fewer injuries and ingestions (Olds, 2006). The final trial in Denver compared baccalaureate-prepared NHVs and paraprofessionals to a control group to determine the impact of program delivery by both groups on maternal and child health outcomes (Olds et al., 2002). When compared to paraprofessionals, NHVs had greater impact on women's prenatal health, the provision of sensitive competent care of the child, child neuro-development, and on maternal life course in addition to approximately double the effect size for all health outcomes (Olds et al., 2002). Based on this evidence, the NFP has been internationally recognized as a public health intervention, effective for preventing child abuse and neglect as well as reducing injuries in children of low-income, first-time mothers (MacMillan et al., 2008).

The World Health Organization (WHO) reports that globally, almost one-third of women will experience physical and/or sexual intimate partner violence (IPV) throughout their lifetime (WHO, 2017). The risk for IPV is amplified among individuals who are young, single or divorced, of minority race or ethnicity, in financial hardship (Chu et al., 2010; Pave, 2007; Raghavan et al., 2009; Saltzman et al., 2003), who have a male partner who is employed less than part-time, or have a partner with an alcohol or drug problem (Wathen et al., 2008). The NFP is a program targeted to young women; this clinical population may be at increased risk for exposure to IPV due to age. In a review of program implementation data, the experience of IPV by women participating in the NFP program was reported by 4.7% of women within the first 36 weeks of their pregnancy, 12.4% in the 12 months following the birth of their child, and 8.1% of women reported IPV in their relationships 12 months prior to their pregnancy (Scribano et al., 2012.

The NFP has demonstrated in the first RCT, the program's effectiveness in preventing child abuse and neglect, and found this outcome to be attenuated where exposure to IPV was moderate to severe (Eckenrode et al., 2000). The third NFP RCT had evidence suggesting that NFP reduced IPV (Kitzman et al., 2010), however, replication of IPV reduction since has not been possible (Olds et al., 2013). Nurse home visitors did not feel adequately prepared to address IPV during home visitation, they lacked formal guidance, and had few evidence-based resources to utilize (Feder & MacMillan, 2011). Given the impact of maternal experiences of IPV, subsequent effects on child outcomes, and the need to develop an augmentation for the program, the development of a nursing intervention to identify and respond to IPV within the NFP context was prioritized.

A robust approach to intervention development, through the conduct of a multi-site case study, was applied to formatively develop an IPV intervention specific to the NFP program (Jack, Ford-Gilboe, et al., 2012). The complex, comprehensive intervention that was developed consisted of five unique components: 1) NHV and supervisor IPV education curricula; 2) a manualized intervention to guide clinical adoption of the IPV clinical pathway; 3) supervisor guidelines for reflective supervision and; 4) a site readiness checklist; and 5) clinical consultation (Jack, Ford-Gilboe, et al., 2012).

The NFP IPV intervention was evaluated by a cluster-based RCT by Jack et al. (2019) involving 8 US states at 15 different sites (May 2011-May 2015) to determine the effect on maternal quality of life at 24 months. Both the control group and intervention group demonstrated improvement in maternal quality of life and reductions in IPV with no significant differences measured between groups (Jack et al., 2019). A mixed methods evaluation of the IPV curriculum used for training nurses, however, demonstrated significantly large increases in

the nurse's knowledge of IPV and level of confidence to address IPV during home visitation (Jack et al., 2020; paper under development). The embedded qualitative component of the RCT suggested challenges existed to implementing this complex intervention (Jack et al., 2020; paper under development). The purpose of this thesis was, therefore, to explore NFP supervisor roles and responsibilities from the seven sites that participated in the trial; understanding that supervisors were integral to the introduction and uptake of this novel innovation by their NHV teams.

Background

The Evidence in Support of the NFP Program

The NFP program was originally developed by Dr. David Olds in the US and is a research-based and theory-driven intervention. Nurses visit first-time mothers starting early in pregnancy and continue in the postpartum period until the child reaches the age of 2 years. The NFP program is designed to modify risk factors associated with negative child outcomes: poor birth, child health, and developmental challenges (Olds, 2007). The NFP program is geared toward reaching women and their children who experience social and economic disadvantage (Olds, 2010). In the US, the NFP program has been rigorously tested and has demonstrated successful outcomes for both child and maternal health in three independent RCTs, with findings presented below.

Randomized Control Trial #1 NFP Health Outcomes: Elmira Trial.

The Impact on Prenatal and Postnatal Health. The first trial conducted in Elmira, New York, US, comprised a sample (N=400) of predominantly young, white, low socioeconomic status, semi-rural unmarried white women (Olds, Henderson, Tatelbaum et al., 1986). First-time

mothers were followed by NHVs during antepartum stages and through to postpartum until the child's second birthday. Women were allocated to one of the following four treatment groups: 1) screening of sensory and developmental capacities; 2) screening plus free transportation to prenatal and postpartum doctor's appointments for all health care related needs until the child was 2 years old; 3) screening and free transportation plus prenatal nurse home visits and; 4) screening, free transportation, prenatal nurse home visits plus nurse home visits for 2 years postpartum (Olds, Henderson, Tatelbaum, et al., 1986). Treatment groups 1 and 2 were combined due to no difference between groups and deemed the comparison group. Prenatal treatment outcomes for groups 3 and 4 were identical, they were combined for analysis and called the nurse home visited group. This study demonstrated long-term, positive health outcomes for both mother and child (Olds, Henderson, Tatelbaum et al., 1986). Mothers visited by a NHV had a significantly greater level of awareness of existing community services available, they attended educational sessions with greater frequency, and had more discussion around their stressors and experiences during pregnancy than their comparison counterparts (Olds, Henderson, Tatelbaum et al., 1986). Mothers paired with an NHV demonstrated a significant increase in prenatal health, improved nutrition in their diet, a reduction in smoking, and reduced kidney infection in relation to the comparison group (Olds, Henderson, Tatelbaum et al., 1986). Adolescents less than 17 years old who smoked were positively impacted by nurse home visits when compared to their counterparts, as reflected by a significant increase for their infant's birth weight (average increase of 395g), and a 75% reduction in preterm delivery rates (Olds, Henderson, Tatelbaum et al., 1986).

Impact on Abuse and Neglect. In a separate analysis of data from the Elmira trial, Chamberlin et al. (1986) measured the effects of nurse home visits with respect to child neglect

and abuse prevention after 2 years. Women considered high risk for abuse and neglect (unmarried and poor) showed a decreased trend for abuse and neglect of their children (Olds, Henderson, Chamberlin et al., 1986). Families visited by a nurse for 2 years had a lower rate of abuse and neglect rate (4%) than families without nursing home visits (19%), however, according to Olds, Henderson, Chamberlin et al. (1986) this difference was not statistically significant ($P = 0.07$). Rates of emergency department visits measured after both 1 year and 2 years were significantly less for children of the nurse visited group relative to their comparison group; families visited by nurses in their home had children with significantly fewer accidents and poisonings (Olds, Henderson, Chamberlin et al., 1986). The pattern of results from this study supported, with evidence, that nurse home visitation positively reduced state verified rates of child abuse and neglect through nurses working with families to create positive parenting conditions.

Long-Term Impacts. In follow-up studies to the Elmira trial, nurse home visited children at 3 and 4 years of age showed continued positive effects with 40% fewer injuries and ingestions, a 45% decrease in behavioural issues, and a 35% reduction in the number of emergency department visits (Olds et al.,1994). The positive outcomes from nurse-home visits were seen to persist 12 years later when a follow-up study was performed with first-born children from the Elmira trial (Kitzman et al., 2010). First-born children who had a nurse visit their home for the first 2 years of life had significantly decreased substance use, significantly greater mental health status demonstrated by acquiring less internalizing disorders, and significantly higher academic achievement scores at the age of 12 in the follow up study when compared to their counterparts (Kitzman et al., 2010).

In a subsequent follow-up study to the Elmira trial, children from mothers who participated in the NFP program at age 15 years continued to demonstrate enduring positive outcomes. The 15-year-old youths were found to have a significant reduction in the number of arrests, convictions, and adjudications when a nurse made home visits in contrast to their comparison group (Olds et al., 1998). The mothers of the adolescent children had significantly decreased rates of reported abuse and neglect and had children with significantly fewer behavioural-related outcomes of substance abuse and crime (Olds et al., 1997). Women at the time of the original Elmira study who were unmarried with low socioeconomic status, were shown 15 years later to have lower numbers of subsequent births, a greater elapsed time before a second pregnancy, a decreased use of family financial aid, lower behavioral impairments due to drugs and alcohol, and fewer self-reported arrests with significant findings when visited by a nurse in their home for 2 years (Olds et al., 1997).

Randomized Control Trial #2 NFP Health Outcomes: Memphis Trial.

Impact on Prenatal and Postnatal Health. The second RCT conducted in the US was a replication trial of the first Elmira trial however, this study was comprised of a predominantly urban-situated African-American population (92%) from Memphis, Tennessee (Kitzman et al., 1997). Women participating in this study were mostly young, first-time mothers (n=1139), with sociodemographic risk factors: <12 years of education, unemployed, unmarried, and impacted by low economic status (Kitzman et al., 1997). Women were randomized to one of the following four treatment groups: treatment 1) free transportation to all prenatal care health visits; treatment 2) free transportation to prenatal visits plus child developmental screening at 2, 12, and 24 months gestation, treatment group; treatment 3) free transportation to prenatal visits and developmental screening plus prenatal visits by a NHV in their home; or treatment 4) free

transportation to prenatal visits, developmental screening, and prenatal home visits plus home visits in postpartum until the child was 2 years of age (Kitzman et al., 1997). Evaluation of this trial looked at two different phases: prenatal and postnatal. For the prenatal phase of the trial evaluation, treatment groups 1 and treatment 2 were combined as one comparison group and contrasted with a comparison treatment group that included treatment 3 and treatment 4. The postnatal phase of the trial contrasted treatment group 2 with treatment group 4. Prenatally, Kitzman et al. (1997) found women visited by nurses in their home were significantly more likely to utilize community services, acquire fewer yeast infections, and have fewer instances of pregnancy induced hypertension. Postnatally, children followed by a NHV had significantly reduced numbers of injuries and ingestions, mothers attempted breastfeeding at a significantly higher rate, and reported significantly higher rates with respect to how conducive they were to their child's development when compared to their counterparts (Kitzman et al., 1997). Mothers visited by NHVs had significantly higher levels of perceived mastery in postpartum, including holding fewer beliefs around child abuse and neglect, around physical punishment of their child, and held fewer unrealistic expectations for their infants when contrasted with the comparison group according to Kitzman et al. (1997). At the end of 2 years, nurse-visited mothers had significantly fewer second pregnancies and fewer live births in succession than their comparator group (Kitzman et al., 1997).

Randomized Control Trial #3 NFP Health Outcomes: Denver Trial. To determine the effectiveness of the NFP program to first-time mothers (N=735) by nurses, a third RCT was performed comparing maternal and child outcomes for families visited by paraprofessionals compared to a control group and families visited by baccalaureate prepared nurses compared to a control group (Olds et al., 2002). This study was conducted in Denver, Colorado, US, and

allocated first-time mothers of Hispanic (47%), white (35%), black (15%) and American-Indian or Asian (3%) descent. This trial consisted of three treatment groups: 1) control; 2) paraprofessional home visitors and; 3) NHVs. Women in the control group were offered developmental screening and referrals for their child at 6, 12, 15, 21 and 24 months of age. Women in the paraprofessional group had the same control group offering, and in addition, they had paraprofessional home visitation prenatally and in postpartum until the child's second birthday. The NHV group had the same control group offering and had nurse home visitation prenatally and during the postpartum period until the child's second birthday. Results from this study showed mothers in both the paraprofessional and nursing groups to have a significantly greater ability to interact responsively with each other than demonstrated by the control-group (Olds et al., 2002). This was the only statistically significant finding for the paraprofessional group when compared to the control group. When compared to the control group, NHVs demonstrated a significant reduction in cotinine levels (a marker used to determine individual smoking exposure) for women who smoked prenatally, had significantly fewer subsequent pregnancies and births by the first-born child's second birthday, showed a significant delay in the interval length between the next pregnancy, and were a significantly higher engaged workforce with the amount of work they contributed (Olds et al., 2002). Overall, these data present NHVs as having a significantly greater impact on effecting positive healthy maternal outcomes than the paraprofessional group (Olds et al., 2002). These findings support the provision of NHV, rather than paraprofessionals, to generate the greatest health impact for the NFP program.

Summary of NFP Impact on Child Neglect, Abuse and Maltreatment. The NFP has been shown to be a program that has a positive impact on maternal and child health outcomes. The Elmira trial demonstrated that the NFP reduced the incidence of child abuse, child neglect,

punishment frequency, emergency department visits, and accidents and poisonings in the child's first 2 years of life (Olds, Henderson, Chamberlin et al., 1986). Follow-up studies show long lasting impact to families continuing with decreased rates of child abuse and neglect (Olds et al., 1997). Eckenrode (2000) concluded, after a 15 year follow up, mothers who participated in NFP's nurse home visitation program were involved in fewer maltreatment incident reports and had decreased incidents reported involving domestic violence. The effect of the NFP intervention on maltreatment has been shown to be intensified for this population as more time elapses (Olds et al., 1997). Women who experience low to moderate levels of IPV demonstrate concentrated positive treatment effects on reducing child maltreatment from participation in the NFP program (Eckenrode et al., 2016). Based on the findings from these trials, there is great potential for the NFP to positively effect change and reduce the incidence of abuse, neglect, and maltreatment.

IPV and Family Health

Prevalence

Intimate partner violence is a major public health concern that negatively influences the physical and mental health outcomes of women and children who are exposed (National Centre for Injury Prevention and control, 2014). The National Centre for Injury Prevention and Control (2015) defines IPV to include "physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)" (p. 11). Women are most often the survivors of IPV on a global scale, with a cyclic perpetuation of IPV persisting from one generation to the next (WHO, 2012). In a multi-country study conducted by the WHO involving

women who have experienced IPV in their relationships, 13-61% experienced physical violence, 6-59% experienced sexual violence, and 20-75% of women experienced at least one emotionally abusive act by a partner (WHO, 2012). In the US, the original context of the NFP program, nearly 1 in 4 women have experienced severe physical violence, 1 in 5 experiencing sexual violence, 10% have been stalked, and greater than 48 million women report psychological aggression on behalf of their intimate partner (National Centre for Injury Prevention and Control, 2019). According to the US 2010-2012 National Intimate Partner and Sexual Violence Survey State Report generated by the National Centre for Injury Prevention and Control (2017), 1 in 3 women were victims of a sexual violence, with 8.5 million women experiencing their first rape before the age of 18. Many women have experienced more than one form of violence, and many who have experienced violence early in life will have repeated episodes of violence across the lifespan (WHO, 2012).

IPV and Women's Health

Experiences of IPV have both short and long-term effects on physical, sexual, and psychological health. Physically, a woman can experience contusions, broken bones or teeth, lacerations, impaired vision or hearing, neck and back injury, head injury, abdominal, and/or thoracic injuries (WHO, 2012). Chronic physical disorders can arise from exposure to IPV, including stress-induced disorders of the bowel (irritable bowel syndrome), gastrointestinal disorders, exacerbations of asthma, and/or chronic pain conditions (National Centre for Injury Prevention and Control, 2014). Women who have experienced IPV are at higher risk for suicide, for diminished self-esteem, and higher likelihood to inflict self-harm (WHO, 2012). There is a higher risk for affected women to use alcohol or other substances as a coping mechanism (National Centre for Injury Prevention and Control, 2014; WHO, 2012). There are also negative

reproductive health outcomes from women who have experienced IPV including: unwanted pregnancies, higher rates of therapeutic abortions, and an increased rate of sexually transmitted diseases due to forced sexual encounters where protection was not negotiable (Campbell, 2002; Campbell, 2008; Heise et al., 1995).

IPV, Pregnancy and Fetal Health

Violence from an intimate partner is also experienced during pregnancy by women. The prevalence of IPV during pregnancy in the US has been reported to range from 4-9%. Adverse outcomes for the fetus increases when IPV is present: prenatal care can be late or missed, fetuses can have poor weight gain, and have exposure to increased levels of smoking, alcohol and substance abuse (Alhusen et al., 2015; Cha & Masho, 2014; Kingston et al., 2016). Violence during pregnancy has been associated with stillbirths, miscarriage, fetal injury, and low gestational weight (Devries et al., 2010).

IPV and the NFP Client Population

Women enrolled in NFP program are young, first-time mothers experiencing social and economic disadvantage. There is evidence that similar populations of women are at greater risk for poor birth outcomes, diminished child health and development, and decreased capacity for economic self-sufficiency (Elster & McAnarney, 1980; Furstenburg et al., 1987; Overpeck et al., 1998). In situations where IPV is present in this population, it is additionally concerning for children living in this environment, due to child maltreatment becoming amplified in these conditions (Scribano et al., 2012).

The number of IPV disclosures by women in the NFP program is typically low compared to the actual experience of IPV in a relationship (Jack et al., 2016). In a case study conducted to

develop the NFP IPV intervention, conducted by Jack et al. (2016), women who had experienced IPV shared that they were often hesitant to disclose their experiences of abuse to their nurse home visitors at the time of enrollment into the program. Additionally, Jack et al. (2016) found women held uncertainty about where the information would be reported, what would be done with the information disclosed, and were concerned their partner might find out about the disclosure-escalating their situation involving violence. There was little understanding by these women, what actions an NHV could take to effect change if they did disclose, so they often chose not to share this information (Jack et al., 2016). Recommendations from Jack et al. (2016) included that within the context of nurse home visitation programs that in order to support women to share their experiences of violence that nurses must focus on creating and establishing therapeutic relationships where the emotional and physical safety of the woman is prioritized.

The prevalence of IPV in the female population, the negative impacts of IPV on maternal, fetal, and child health, as well as the associated and intensified poor outcomes specifically related to the vulnerable NFP population, established the need for the development and evaluation of an IPV intervention specific to the NFP program.

The IPV Intervention

The IPV intervention was developed within the context of the NFP program and with the overall aim to improve maternal quality of life and decrease IPV prevalence among women enrolled in the program. To inform the development of the IPV intervention, a two-year multiple case study (Jack, Ford-Gilboe et al., 2012) was conducted.

The NFP IPV intervention is a complex and comprehensive innovation that contains five interrelated components: 1) educational curriculum to increase NHV knowledge, skills and

confidence in safely identifying, responding and then developing a tailored plan of care to support a women with response to the violence she and her infant are experiencing; 2) manualized intervention, including a clinical pathway, home visitation materials and NHV instructions; 3) guidelines for supervisors to engage in reflective practice with NHVs; 4) a check-list to determine implementation site readiness and; 5) continuous coaching support to enable adoption and integration of the intervention in home practice (Jack, Ford-Gilboe et al., 2012).

Nurse Home Visitor and Supervisor IPV Education

As part of this intervention, a three-phased approach to NHV and supervisor IPV education was developed to support NFP teams develop the knowledge, skills and confidence to first identify and then respond to IPV within their home visiting practice. In the first phase, through a series of online independent study and team-based discussions, NHVs and supervisors would review content related to: 1) defining IPV; 2) identification and response to IPV; 3) a risk assessment to determine what the level of risk was for the woman and child in the home and; 4) knowledge to facilitate understanding the process behind how a woman can leave and finalize a relationship of abuse (Jack, Ford-Gilboe et al., 2012). The second phase of education included a one-day intensive face-to-face workshop facilitated by a clinical and IPV content expert, where the NHVs and supervisors would have an opportunity to practice skills in IPV assessment and response, and to critically discuss how to apply the NFP IPV clinical pathway in practice (Jack, Ford-Gilboe et al., 2012). The third and final phase of the education consisted of a team-based learning module focused on system navigation and required NHVs to learn about the community supports and services available to women and children experiencing abuse in their community (Jack, Ford-Gilboe et al., 2012). In addition to the core IPV education, Jack, Ford-Gilboe et al. (2012) designed a ½ day in-person, face-to-face education for supervisors with content focused

on the integration of the IPV intervention into existing agency procedures, documentation, mandatory reporting, and the function of the clinical pathway. This additional supervisor education was deemed necessary as supervisors would have a key responsibility in supporting NHVs to comprehensively implement the clinical pathway and assist NHVs to overcome barriers to implementation in practice.

Manualized Intervention and the Clinical Pathway

To support NHV practice, a clinical pathway was developed as a functioning guide to assist with violence identification and help NHVs with decision making relative to next steps for women and children experiencing violence. The pathway was developed using data from the qualitative case study conducted by Jack, Ford-Gilboe et al. (2012), utilizing evidence-based strategies for risk assessment, as well as, an informed response based on client principles identified by the NFP program. An in-depth manual was developed to describe the purpose and function of each step in the clinical pathway (Jack, Ford-Gilboe et al., 2012). Home visitation facilitators were selected to guide NHVs' discussions with clients about a range of topics related to safety planning, awareness of IPV, self-efficacy and social supports, and corresponding instructions on how to use the facilitator in practice were developed (Jack, Ford-Gilboe et al., 2012).

Site Readiness Checklist

A site readiness checklist is an *a priori* list of items for review by the supervisor before implementing the IPV intervention. The purpose of the checklist was to confirm the standing of five important items: 1) whether policies existed for nurse home visit safety; 2) an articulated plan for documentation and recording IPV experienced by the client; 3) the level of awareness

surrounding mandates to report children's exposure to IPV to child protective services; and 4) how to navigate local systems to conduct mental health and substance use assessments and the existence of referral processes (Jack, Ford-Gilboe et al., 2012).

Coaching Support

To maintain the fidelity of the IPV intervention, coaching support was offered to each of the seven participating NFP teams. Coach eligibility criteria was identified by Jack, Ford-Gilboe et al. (2012) as a clinical consultant, a registered nurse, and considered an expert in the understanding of the IPV intervention's components. Teleconference sessions were organized for expert consult with supervisors implementing the intervention approximately every 4-6 weeks or at the request of the supervisor (Jack, Ford-Gilboe et al., 2012).

Guidelines for Reflective Supervision

The approach of NHVs during IPV-related client situations could be influenced by a nurse's own personal value system and added a layer of complexity to home visitation. Reflective supervision was considered by Jack, Ford-Gilboe et al. (2012) as a viable opportunity for supervisors to clarify nursing roles and expectations, to explore and strategize surrounding the challenges encountered by NHVs, mitigate harm and facilitate safe planning approaches and respond to issues raised by NHVs. Guidelines were developed to support supervisors for IPV reflective practice sessions with their NHVs and provided strategies to supervisors they could draw from if they encountered an IPV-related challenge reported by NHVs during formalized reflective sessions (Jack, Ford-Gilboe et al., 2012).

Supervisor Support in Community Nursing

Nursing roles in community practice are expanding and, more frequently, nurses are expected to implement evidence into practice in their community settings (Johnston et al., 2016). Community nurses require support beyond the traditional practice frameworks, and nurses look to supervisors for support with clinical supervision to reduce burnout, stress, and emotional exhaustion related to their roles (Blishen, 2016). The benefits of supervision in community nursing include: 1) increased retention of employees; 2) improved commitment and motivation to their employer; 3) maintained quality of clinical skills and practice; 4) effective communication between employees; 5) improved job satisfaction and; 6) ability to self-critique clinical and cultural practices (Blishen, 2016). With the roles of community nurses shifting and taking on the additional role of counselor (Blishen, 2016), reflective supervision of nurses fosters personal and professional growth by enabling knowledge of the self, and identifying the meaning in what they see, think and feel (Gilbert, 2001). Particularly for a response strategy like the NFP-IPV intervention, where the experience of IPV by a woman would require a high level of sensitivity, compassion, openness, and attuned communication skills on behalf of the NHV, reflective supervision is an essential area for effective NHV development.

Summary

With a robust evaluation, the NFP has demonstrated positive impacts on maternal and child health outcomes, with short and long-term effects for this vulnerable population. The NFP has established capacity to therapeutically influence and support high-risk, young mothers and their children, in the achievement of goals and their healthy development. Intimate partner violence is trending upward globally and has far-reaching physical and psychological effects that are carried through generations. Home visiting educational programming has potential to respond to IPV's growing prevalence, support women, and break the cycle of prevailing violence

within this particularly vulnerable demographic. The NFP's successful home visitation history positions this program with great potential to successfully lead the way in the prevention and reduction of IPV. Supervisors of NHVs tasked to deliver the NFP-IPV intervention are key facilitators for the implementation of this novel innovation into existing NHV practice. The identification of opportunities to support supervisors in this initiative are critical to implementation and its sustainability. Supervisor support can be enabled by elucidating process challenges and facilitators for supervisors during implementation, as well as acquiring a better understanding of the roles and responsibilities enacted by supervisors.

Positioning Myself

I will provide a summary of my background to offer an understanding of my approach to the analysis and interpretation of this study. My first degree was a Bachelor of Science in Biology. I completed a quantitative thesis measuring genetic diversity within *Picea pungens*. Upon completion of my degree, I was employed with the National Research Council of Canada and The Atlantic Genome Centre for 11 years leading primary DNA sequencing team staff and collaborating on various large-scale genomics research projects. I was co-author for several quantitative publications in the field of aquatic genomics. I returned to school for my second degree and completed a Bachelor of Science in Nursing. I have worked as a registered nurse in various hospital and community settings. I, myself, have made numerous home visits to patient homes providing clinical care to patients with tracheostomies and conducting comprehensive nursing assessments. In hospitals, I helped new moms with newborn care on postpartum units, assessed cardiac heart failure in emergency departments, and have been with patients and families in their dying moments. I am attuned to the pressures and stressors nurses face to provide quality care, and the endless struggle to document, understand the latest update or

upgrade, self-educate, and find work-life meaning at 2:00 A.M. This understanding affords a sense of gratitude and empathy for nurses, knowing they try their best with the limited resources they have. I am open to, and keenly interested in the perspective of front-line practitioners, knowing they acutely understand operational challenges and likely have plenty of solutions to offer. I have also had the privilege to work as a community nurse manager for the Victorian Order of Nurses: responsible for 120 home visiting nurses, supervising clinic operations, and collaborating on several clinical pilot programs. I understand the challenges to manage operations, ensure staff and patient safety, meet program targets, listen and respond to client concerns, and implement new program and updates. Currently I manage the delivery of home care services to adult and geriatric populations in the community setting. I am working toward a Master's degree in Science (Nursing), and have been introduced to quantitative, qualitative and mixed method research approaches as part of my program.

This is my first qualitative research study. My experiences have influenced my approach to this study by being open to receive new information and empathetically appreciate each person's experience, intuitively have an understanding of the multiple perspectives involved in this study (nurse, supervisor, manager, and researcher), having a sharp awareness of self, and having a root-cause approach to challenges. I have never worked for the NFP, and my first introduction to the NFP was for the purposes of conducting this study. Aside from this study, I have not been presented with any opportunity to work as an employee or researcher with the NFP in the future. My interest in this work is to facilitate an understanding of supervision in the field of home-visiting nursing, and to contribute (in some small way) to the advocacy of women and children experiencing IPV.

Chapter 1: Literature Review

A literature search was conducted to locate and synthesize evidence relating to supervision in the home visiting context, how supervision was described in the literature and across disciplines, and to identify what is already known about supervision. The search was conducted using CINAHL, Embase, Medline, PsychInfo and Central (Cochrane) electronic databases. The search strategy involved the combined use of medical subject headings (MeSH) and keywords relating to "supervision", "home visiting", and "intimate partner violence" using concept truncations, as well as Boolean operators and appropriate "wild cards" use to account for plurals and variations in databases and spelling (see Appendix A, Figure A1 database search strategy, and Tables A1 and A2 for literature search findings). Four empirical studies were identified as meeting the inclusion and exclusion criteria were critically appraised and the summary of this appraisal activity can be reviewed in Appendix B (Tables B1-B4). Inclusion criteria required studies to have supervisors as the population of interest, within the context of home visiting, performed in a developed country, published in English, and published between 1987 and 2020. Exclusion criteria included studies not focused on the supervisor population, studies outside of the context of home visiting, non-English publications, studies performed in low and middle income or developing countries, and articles published before 1987. Exceptions to exclusion criteria included studies that supported broad concepts of health care supervision that would aid in defining the roles and responsibilities of supervisors. These exceptions still required publication in English and after 1987, with application to home visiting, and developed country contexts. The Central database search did not result in any relevant systematic reviews based on the inclusion and exclusion criteria. The search for systematic reviews was broadened to include a manual search in Google Scholar, where one relevant systematic review was found.

A total of 12 relevant research articles were identified to match inclusion and exclusion criteria, once duplicates removed. Additional articles were identified through manual reference searches and from communication with experts in the field.

Descriptions of Nurse Supervision

Supervision is understood to involve a combination of activities including goal setting, conveying clear expectations, distributing information, monitoring staff, offering staff feedback, mentorship, and use of an empathetic approach (Rand et al., 1990). The broad concepts of supervision are captured in the home visiting literature and across disciplines to include: 1) supportive (Gillet et al., 2013; Nathans et al., 2019; Pohl & Galletta, 2017; Kadushin, 1976); 2) clinical (Acheson & Gall, 1997; Baglow, 2009; Bogo & McKnight, 2005; Clifford et al., 2005; Eisner, 1982; Girling et al., 2009; Glickman, 1980; Goldhammer, 1969; Grauel, 2002; Jack, Busser et al., 2012; Proctor, 1987; Waskett, 2009; Wheatley, 1999); 3) reflective (Andrews, 2016; Beam et al., 2010; Eggbeer et al., 2007; Jack, Busser et al. 2012; MAIMH, 2020; Shahmoon-Shanok, 2009; Tomlin, Hines et al., 2016; Watson, Bailey et al., 2016; Weatherston, Kaplan-Estrin et al., 2009; Zero to Three, 2020); 4) administrative; (MI-AIMH, 2018, Grauel, 2002, Kadushin, 1976, Radley & Stanley 2018); 5) education (Kadushin, 1976; Radley & Stanley, 2018); 6) personal wellbeing (Radley & Stanley, 2018) and; 7) mediation (Schulman, 1982). Each of these broad concepts will be examined further in the sections to follow.

Supportive Supervision

Conceptual Literature. Supportive supervision is presented as both emotional and instrumental, relating to the caring nature expressed from a supervisor with an employee, and by the provision of resources for an employee in the form of goods and services respectively

(Perrewe et al., 2003; Rooney & Gottlieb, 2007). Home visitors require guidance from supervisors to enable the development of their capacity to handle challenging and stressful situations, in-turn preventing staff burnout (Coffee-Borden & Paulsell, 2010; Lee et al., 2013) and staff turnover (Nichols et al., 2016). The ability for a home visitor to be able to deliver program requirements comprehensively may be related to whether a home visitor feels there is adequate support to meet both their structural and emotional needs (Harden et al., 2010).

Empirical Literature. Supportive supervision is also described by the concept of perceived supervisor support, the employee has a perception about the supervisor and the organization and how much they feel they are valued professionally and personally (Pohl & Galetta, 2017). Supervisor behaviours are seen to have a direct impact on the level of perceived supervisor support by employees, they can be favorable or unfavorable, and can impact workplace satisfaction positively (Pohl & Galetta, 2017). Pohl and Galetta (2017), in a cross-sectional study, demonstrate with supervisor support job satisfaction for nursing staff is increased significantly. Furthermore, important feelings of acceptance, caring, and trust are experienced by nursing staff when they are in a supportive supervisory environment, contributing to an overall feeling of well-being, engagement and satisfaction in the workplace (Pohl & Galetta, 2017).

According to Austin (2016), who conducted a study within the context of child welfare and the role of supervisors working with public health nurses, often there is an unpredictable nature to working with disadvantaged families, and public health supervisors are found to not often have structured support mechanisms in place. Austin and Holt (2017) further assert that for all community professionals who have influence, particularly related to child protection and welfare, supportive management structures are of critical importance.

Supportive supervision is described by Gillet et al. (2013) in relation to a supervisor's backing of autonomous practice with nursing staff and use of procedural justice methods when allocating outcomes for staff as a fair approach. Procedural justice, to explain with an example, would be whether a supervisor offers clarifying information about a particular item when requested by staff members (Gillet et al., 2013). Additional components indicated by Gillet et al. (2013) that have impact on nurse contentment in the workplace are: 1) need satisfaction (whether professional needs are met by the organization) and; 2) perceived organizational support, indicating the extent to which nurses feel valued by the organization. Gillet et al. (2013) conducted a cross-sectional study and found significant positive correlations of nursing work satisfaction, organizational identification and job performance when procedural justice and supervisor autonomy support were utilized, and organizational support was perceived as being effective.

Summary. Supportive supervision encompasses supervisory roles and responsibilities which predominately respond to personal and professional emotional supports. Supervisors who provide fair emotional supports enable home visitors to develop capacity to fulfil service delivery requirements, as well as create a culture where staff feel valued and autonomous in their practice and where they have their professional needs met. Supportive supervision, when carried out effectively, can have a positive impact on home visitor engagement, retention, and the prevention of burn-out.

Reflective Supervision

Conceptual Literature.

History. The influence of the mental health field impact the formal structure and evolving practices associated with clinical supervision (Tomlin & Heller, 2016). Over time therapists began to see the need to understand one's own experiences and the importance to examine the individual sense of self as a component to professional development (Dewald, 1987; Kohut, 1971; Wallerstein, 1981). Improving professional practice and growth was linked to an individual's capacity to become self-aware (Ekstein & Wallerstein, 1972). Professional supervisory development embraced a supervisor's transition from their responsibility to control situations, to relational responsibilities, resulting from its understood effectiveness in practice (Sarnat, 1992; Yerushalmi, 1994). The transition to the healthcare setting first occurred in the area of infant mental health and comparisons to the field of psychotherapy were made examining treatment and supervision in parallel (Tomlin & Heller, 2016). In reflective supervision, the process where the patient-therapist and therapist-supervisor relationships were considered and examined became known as the parallel process of supervision (Searles, 1955). Skills of self-reflection (Bertacchi & Coplon, 1989), reflection on action, reflection in action, and reflection for action became valued essential capacities to work performed with infants and families in practice (Killon & Todnem, 1991; Schön, 1983) and supported the development of an evolved area of supervision referred to as reflective supervision (Tomlin & Heller, 2016).

The *Zero to Three* organization, formerly as known the National Centre for Clinical Infant Programs, created multiple advisory roles and committees to develop training materials to support professionals working in the field of infant mental health. In the 1990s, a *Zero To Three* advisory committee published a series of articles on reflective supervision and its collaborative process, and understood this school of thought to be considered novel and new to the community of non-mental health professionals (Eggbeer et al., 2007). The committee responded to this

concern by formulating a subsequent *Zero to Three* task force that published the sourcebook for reflective supervision identifying the three main tenants: reflection, collaboration, and regularity (Feinchel, 2020). Reflective supervision was distinguished from clinical supervision, namely in its collaborative approach and departure from a formal, hierarchical process (Feinchel, 2020; Shahmoon-Shanok, 2009). The early works of reflective supervision in the infant mental health field have now shaped how practitioners engaged in infant-family work apply knowledge and build skills for improved practice (Gilkerson & Kopel, 2005; Virmani & Ontai, 2010; Watson, 2014).

A second infant mental health group with early influence on training and best practice standard development was the Michigan Association for Infant Mental Health (MI-AIMH). In 1986, the MI-AIMH Board of Directors published the MI-AIMH Training Guidelines which offered a standardized approach to training in the field of infant mental health. In the mid-1990's, federal government legislation called for the development of family-centered practices and competencies from professionals working with special needs infants and young children (Weatherston et al., 2010). As a response, MI-AIMH lead the gathering of a 12-member team of infant mental health professionals consisting of expert practitioners, faculty, and policy makers (Weatherston et al., 2010). Together, through focus group and committee work, they developed a comprehensive set of competencies that incorporated research from previous publications from the National Centre for Clinical Infant Programs and MI-AIMH Training Guidelines to compile and publish the MI-AIMH Competency Guidelines (MI-AIMH, 2016). The development of these guidelines has assisted supervisors and supervisees as they engage with families and reflect on their experiences and have been licensed in 14 states for use to guide reflective practice (Weatherston, Kaplan-Estrin et al., 2009).

In Health Practice. Reflective supervision is described as a learning relationship, where the focus is placed on both the client and the supervisee (e.g. home visitor) in effort to support their needs and support effective intervention delivery (Tomlin & Heller, 2016). It is particularly useful for professionals working with young children and vulnerable families, due to the complex and emotionally driven nature of this work; offering an opportunity to pause and reflect (Weatherston et al., 2010). Reflective supervision is also utilized in the health professions between a supervisor and practitioner, where discussion is facilitated by the supervisor and involves examination of healthcare situations to understand what was observed, thought, felt, and done to enable the realization of insights (Weatherston et al., 2010). In reflective supervision, both the supervisor and the supervisee become engaged in exploration and inquiry to reach beyond the mere facts and reach an experiential understanding of client relationships (Shamoon-Shanok, 2006; Weatherston, Kaplan-Estrin et al., 2009). The relationship commitment between supervisor and supervisee provides the supervisee with clinical support needed to conduct relational-based engagement with families (Davys & Beddoe, 2009; O'Rourke, 2011; Watson, 2014; Weatherston & Barron, 2009; Weatherston, Kaplan-Estrin et al., 2009). Tomlin, Hines et al., 2016) further describe this relationship as one that home visiting workers can utilize to bring about professional competence by having an opportunity to attend to personal and professional barriers in their practice.

Reflective supervision is unique in that it employs the exploratory use of the parallel process, where equal focus is given to all relationship holders: practitioner with supervisor, practitioner with parent and parent with child (Weatherston, Kaplan-Estrin et al., 2009). It is considered imperative that all relationships are explored. Additionally, an important component to the parallel process is for the supervisor to take a step back, to listen and wait, and foster the

discovery of the supervisee's own perceptions, concepts and solutions (Weatherston, Kaplan-Estrin et al., 2009).

NFP Practice. Reflective supervision is a central element in the NFP program (Beam et al., 2010). Working with the vulnerable and complex families eligible for the NFP program require the NHV to employ reflective practice to assist her with discovery and finding new possibilities to better assist families (Beam et al., 2010). Reflective supervision within the NFP was built on the guidelines developed by the *Zero to Three* Center for Program Excellence guidelines (Parlakian, 2001). Reflective supervision within NFP uses the following tenets for NHV-supervisor reflective practice: 1) regular supervisor engagement with the NHV to enable a relationship of trust and a modeling of the relationship that she will build with her clients; 2) collaboration between the NHV and her supervisor to enhance critical thinking and improve competency; 3) mutual respect of strengths and vulnerabilities within the dyad and; 4) open communication and active listening to show a shared belief in each other's thoughts, ideas and feedback; facilitating mature insights and resolutions (Beam et al., 2010). In the NFP program the expectation of the supervisor is to provide a safe opportunity for open exchange and collaboration with the NHV while modeling active listening and open-ended question techniques (Beam et al., 2010).

Nurse home visitors within NFP work with families that are managing complex health and social issues and challenges. Barriers to the relationship with the client can be a result of the client's previous experiences with trauma and, therefore, an inability to form trusting relationships (Dmytryshyn et al., 2015). Nurse home visitors working with women exposed to IPV, describe their caseload as time and resource intensive, involving the support of women experiencing extreme physical, emotional and financial abuse, and sometimes resulting in

hospitalization (Jack, Busser et al., 2012). Public health nurses, performing home visits in the Canadian NFP context, were reported to be wrestling with keeping the energy going in the nurse-client relationship, thinking and worrying about their client outside of work hours, and feeling emotionally drained to a point where they could no longer can give anything more to the relationship (Dmytryshyn et al., 2015). The complexity of these relationships in the NFP context demonstrate the need for reflective supervision support for NHVs.

Empirical Literature. Watson, Bailey et al. (2016), conducted a mixed methods study in the US to examine the impact of a statewide initiative to develop reflective practice capacity among home visitors and supervisors within a county-based, public health home visiting program. The quantitative component of this study consisted of a survey combined with standardized measures and the qualitative component included interviews with supervisors and home visitors (Watson, Bailey et al., 2016). One standard measure performed by Watson, Bailey et al. (2016) related to reflective functioning and reflective practice demonstrated no significant changes in scores for supervisors and home visitors over the course of the evaluation period, however, perceived knowledge and skills related to reflective practice increased. A second standard measure to determine employee burn-out over time showed no significant changes in relation to depersonalization (an indicator of burnout) or personal accomplishment (a factor responsible for moderating burnout) among home visitors and emotional exhaustion was found to increase over the duration of the evaluation period (Watson, Bailey et al., 2016). Conversely, interviews revealed home visitors felt accomplished in their reflective work and valued reflective supervision opportunities to be able to release emotions in a safe environment (Watson, Bailey et al., 2016).

Summary. Reflective supervision evolved from its traditional origins of clinical supervision to attend to the relational aspect of health professional practice and was first initiated in the infant mental health field. Reflective supervision adopts a collaborative approach, focused on the examination and discovery of emotions, experiences and relationships, resulting in improved professional competence. The parallel process is a method of reflective supervision where attention is directed to the exploration of relationships, fostering the realization of perceptions and barriers to help identify strategies for relational engagement.

The nature of the work performed by NHVs within the NFP program is highly relational and complex. As a result, the NFP has incorporated reflective supervision as a regular component to supervisory practice between supervisors and NHVs with the intention to serve as a support strategy and development of NHV practice.

While qualitative methods show reflective supervision to hold promise as a valued source of support in home visitation practice, quantitative evidence does not yet demonstrate reflective supervision to have impact on reflective function or practice and conversely has been shown to increase emotional exhaustion for home visitors. More study is needed in this area.

Personal Well-Being Supervision

Conceptual Literature. Personal well-being supervision has been described only in the literature involving social work by Radley and Stanley (2018) and from this literature search it should be noted that personal well-being supervision is not described in relation to other health professions involved in home visitation. Radley and Stanley (2018) describe personal well-being supervision as when the supervisor takes an active role in emotionally supporting workers who work with clients with traumatic experiences.

Administrative Supervision

Conceptual Literature. Jack (2010) describes administrative supervision as "a process where the supervisor is responsible for the development, implementation and evaluation of the home visitation policies and procedures" (p.7). Administrative supervision is considered distinct from clinical and reflective supervision. Administrative supervision is described as a position where oversight may be utilized with respect to regulations, program policies, procedures, and rules (MI-AIMH, 2018). Roles and responsibilities employed for administrative supervision include: hiring, training/education, paperwork surveillance, assistance with report generation, identification and elucidation of rules and policies, workload management, assessing productivity, and evaluation (MI-AIMH, 2018). Further, in the field of social work, administrative supervision relates to the coordination of caseloads, overseeing assessment, intervention planning and continuous work monitoring to support worker's effective implementation of agency policies and procedures (Shulman, 1993).

Weaver and Lindgren (2016) describe a void in the literature around characterizing the role of administrative supervision in nursing and discuss no data-based articles exist to support its understanding and function. No empirical studies were found in this literature search related to the concept of administrative supervision.

Health Administration. The Registered Nurses' Association of Ontario created a best practice guideline for nurses, other health care professionals, and administrators surrounding how to screen, identify, and respond to women experiencing abuse (Registered Nurses' Association of Ontario, 2005). Recommendations at the organizational level include the responsibility around 1) developing policies and procedures to be able to universally screen for

abuse and identify best response strategies; 2) the health administrators' need to facilitate an understanding in their frontline nursing providers so they feel prepared to provide care to women who experience abuse; 3) the health administrators' need to be accountable for the evaluation and revisions to their implemented interventions responding to abuse; 4) implementing an system approach that supports collaboration and integration of service among sectors (e.g. financial and housing assistance) and; 5) generating an organizational plan for implementation that includes an assessment of readiness, identification of most responsible individual to support education and implementation, as well as a plan for opportunities of discussion and reflection about education, personal, and organizational experience relative to implementation of guidelines (Registered Nurses' Association of Ontario, 2005). These outlined recommendations demonstrate the need for organizations to consider the administrative supervisory role and how they could best support supervisors in this function and assist with the plan of response to abusive home environments.

Family Nurse Partnership. Andrews and Oxley (2015), describe the roles of supervisors, within the British version of the NFP, called the Family Nurse Partnership (FNP), as supervisors engaging in education, support, and administrative roles. Andrew and Oxley introduce a new role of supervision and call it administrative supervision. They define this role as when supervisors adopt a managerial function with the goal to effect change relative to procedure and policy. Furthermore, it is when the supervisor performs the administrative components of the role (Andrews & Oxley, 2015).

Clinical Supervision

Conceptual Literature. The traditional understanding of clinical supervision situates the supervisor as having a structured and formalized function while occupying a status of

control. In this position, the supervisor's role is to teach and guide, with little consideration of the supervisee's personal history or experience (Tomlin et al., 2014). Fortunately, clinical supervision has evolved from this school of thought to be more collaborative and to incorporate practices that involve supervisors, peer groups, and reflection (Wheatley, 1999). One clear definition, however, for clinical supervision does not exist (Pollock et al., 2017; Waskett, 2009). While clinical supervision is mandatory for psychological patient services and routinely practiced in many areas mental health, it has had no formal uptake in nursing and allied health professional practice (Waskett, 2009).

Education Models. Several models of clinical supervision are found in the literature, with roots in both education and nursing. These models will be discussed here. Education-based clinical supervision models are summarized by Clifford et al., (2005) to include the following: 1) Original Clinical Supervision model created in 1969 by Goldhammer; 2) Artistic model approach in 1982 by Eisner; 3) Developmental Model by Glickman (1980); 4) Technical/Didactic model as applied by Acheson and Gall in 1997 and; 5) Reflective model, which gained recognition for use in clinical health practice (Schön, 1983; Ghaye, 2005; Jasper, 2003). Respectively, the role and responsibilities of the supervisor in these models are captured to comprise: 1) the identification of student strengths and teaching style; 2) the understanding of student strengths and abilities by teaching from an expert position and supporting as a coach; 3) student development of skills related decision-making and problem solving skills while promoting independence; 4) student refinement of learned skills as the knowledge expert, offering behavioural feedback and; 5) analytical and critical awareness of student self-practices. An adaptation of these five clinical supervision models to home visiting was performed by Jack (2010), providing greater insight into the local nursing context. Roles and responsibilities of

supervisors were identified by Jack (2010) to respectively include: 1) offering feedback and recommendations to home visitors with the goal of improved service delivery; 2) operating as expert in the area of home visitation with the capacity to guide and mentor supervisees; 3) imparting a gradual accountability onto home visitors for their independent lead of client home visits; 4) functioning as knowledge expert offering home visitor behavioural feedback to hone skill development and; 5) facilitation of home visitor reflection to discover and understand feelings related to home visitation and associated responses when confronted by challenges in practice. Considering the roles and responsibilities of the supervisor related to the education models of clinical supervision, and comparing with the seven broad concepts of supervision found in the literature, what becomes interesting is the reach of clinical supervision overlaps with other broad concepts of supervision namely: education, reflective and supportive supervision. This suggests there may be a divergence in the understanding of these concepts within the research.

Nursing models. Proctor (1987) is known for his contribution to the broad concept of clinical supervision with the creation of his three-function interactive nursing model of supervision, known as the most cited supervision model in nursing literature (Kleiser & Cox, 2008; Buus & Gonge, 2009). In Proctor's (1987) model, there are three key components of clinical supervision, they include: 1) normative/managerial; 2) formative/educative and; 3) restorative/supportive. According to Proctor (1987), the normative component functions in the area of quality control where the supervisor is responsible for monitoring and evaluating progress, the formative component is focused on professional development in the area of knowledge and skills, and the restorative component relates to the supportive functions of supervision tending to professionals who are working in stressful environments and helping to

maintain their well-being. Similar to the education models of clinical supervision, Proctor's (1987) model also stretches beyond the domain of clinical supervision and encompasses the education and supportive concepts of supervision, however, does not include the reflective supervision concept as incorporated in one of the education models. Unlike the education models, Proctor's (1987) model additionally includes the administrative concept of supervision found in the literature. Again, these findings suggest there are different views on how these concepts are "packaged" to operationalize clinical supervision.

The 4S nursing model of clinical supervision by Waskett (2009) involves four key elements with the overall goal to support employee development and enable growth in the direction of excellence: 1) structure; 2) skills; 3) support and; 4) sustainability. Structure determines how clinical supervision is first defined between manager and supervisor, the nature of meetings (individual vs group), the timing of meetings with supervisees, how resources are allocated, how outcomes will be evaluated, collaboration with other disciplines, the generation of new policies, and general logistics (Waskett, 2009). The skill element of the 4S model (Waskett, 2009) outlines requisite skills for supervisors executing clinical supervision in their nursing environments. The support element describes training and ongoing assistance that the supervisor will require to be effective in the facilitation of his or her roles (Waskett, 2009). The final element, sustainability, places much of the responsibility on the manager to create a working group and strategize how the scheme moving through forecasted challenges (Waskett, 2009). The 4S model of clinical supervision (Waskett, 2009) is different from the other education and nursing models as the elements of this model are directed primarily toward organizational managers and is intended to provide a comprehensive scheme for supervision. For this reason, it makes this nursing model difficult to compare directly with other broad concepts of supervision.

Empirical Literature. In a systematic review by Pollock et al. (2017), clinical supervision is articulated by merging the definitions presented by the Department of Health (Department of Health, 1993) and by Bond and Holland (1998). Clinical supervision is described by Pollock et al. (2017), as the "facilitation of support and learning for health care practitioners enabling safe, competent practice and the provision of support to individual professionals who may be working in stressful situations" (p. 1826). A standard model for clinical supervision has not been established according to Pollock et al. (2017), and in review of the research, there is lack of clarity of how clinical supervisory sessions are structured and it was found that training provided for supervisors is not consistent. Some supervisors, for instance, receive a written manual of roles and clinical supervisory functions, some received a 2-day university level course customized to a supervisor's needs, while some studies did not discuss any training that was provided (Pollock et al., 2017). The findings presented in the systematic review by Pollock et al. (2017) identifies there is not a comprehensive or consistent understanding of what clinical supervision is or how it is to be performed by supervisors. Furthermore, the empirical evidence, as presented, is weak and does not support the use of clinical supervision in practice for nurses, midwives, and allied health professionals (Pollock et al., 2017).

Summary. Clinical supervision is a broad concept of supervision, so much so that it can be found represented in home visiting literature by multiple concepts of supervision including: education, supportive, reflective, and administrative. Education and nursing models of clinical supervision have different representations of the seven supervision concepts identified in the literature, indicating that clinical supervision is not understood with consistency. Empirical

evidence corroborates the lack of consensus relative to defining the broad concept of clinical supervision found within conceptual research.

Education Supervision

Conceptual Literature. Education supervision has been captured as a concept of supervision by Radley and Stanley (2018) in the discipline of social work; however, education as an isolated concept in the area of nursing does not appear to have followed suit. Education and teaching are referred to more specifically as an action or role (to educate) rather than a broad concept with the associated and specific responsibility to impart knowledge and skills. Most descriptions of education in the nursing literature have been linked with both the broad concepts of administrative supervision (MI-AIMH, 2018) and clinical supervision (Clifford et al., 2005; MI-AIMH, 2018; Pollock et al., 2017 & Waskett, 2009).

Education supervision, within the area of social work, entails supporting the supervisee with respect to expertise and skills to meet the needs of the client (Radley & Stanley, 2016). The role of the supervisor within the broad concept of education is about building on the knowledge and the theory that workers already have, and for a supervisor to create a culture that is rooted in learning (Horwath & Morrison, 1999). Supervisors are also responsible for understanding and utilizing the principles of adult learning and identifying different modalities of supervisee learning (Moore, 1995; Rapp & Poertner, 1992).

Mediating Supervision

Conceptual literature. Similar to education as a concept of supervision, the mediation concept of supervision is found only in literature focused in the discipline of social work and not identified in this literature search to be represented by other health-related professions in home

visiting. The role of the supervisor in the broad concept of mediating supervision is to become the mediating facilitator between workers and the systems, communicating differences in facts and feelings between the worker and the system (Shulman, 1982). In this role, the supervisor becomes "a messenger with a two-way responsibility for effective communication" (Gibbs, 2001, p. 330). Mediating supervision is considered a practical way to raise concerns and reduce stress for the frontline worker and a method to address system-level issues such as caseloads, expectations, and resource shortages (Baglow, 2009). Baglow (2009) argues that supportive supervision is helpful, however, that it is not adequate to respond to system-related concerns of the frontline. The responsibility for the supervisor is dual in nature, where changes in policy and procedures from upper management to the frontline often require a timely response by workers and equally from workers to management (Baglow, 2009). Managing professional relationships within a complex system, such a child protection, is a challenging endeavor by supervisors, and requires an attuned focus on the cooperative process (Lawrence, 2004). Equally important, is for agencies to acknowledge the importance of mediating supervisors, especially in complex areas of work, rather than succumb to the administrative pressures or trends looking to reduce or erode its function (Morrision, 1996).

Literature Search Summary

The literature on supervision in home visiting presents supervision using both broad and refined descriptions to explain the functions of supervisors. The broad functions of supervision have been termed supportive, reflective, personal well-being, administrative, clinical, education and mediation. Broad descriptions have associated, more refined, descriptions of supervisor functions detailing the activities they fulfill. Variations exist between authors and disciplines (nursing and social work) with respect to the descriptions of refined functions that supervisors

execute, and particularly for the broad category of clinical supervision. Overall, there is a lack of consensus for how supervision is described in the literature; formalized and universal definitions are not used. For this reason, definitions to specifically characterize the terms "roles" and "responsibilities" within home visitation literature for supervisors are not clear.

Supervision was elaborately described in the literature with respect to "what" a supervisor does, and often in relation to the recipient (e.g. nurse). With the exception of the 4S nursing model of clinical supervision by Waskett (2009), suggestions or recommendations aimed to support supervisors within home visitation programs are not presented. More specifically, how to support supervisors for the implementation process of novel innovations remains unknown, validating the objectives to follow for this study.

Purpose

The purpose of this study was to explore and describe NFP supervisors' experiences with facilitating the implementation process of an intervention developed for NHVs to identify and respond to IPV among women on their caseloads, within the existing NFP program. From 2011-2015, this NFP IPV intervention was evaluated with a 15-site cluster RCT in the US. Within this trial, seven NFP implementing agencies received the NFP IPV education and were responsible for implementing the novel IPV intervention into their daily home visiting practices. As part of this larger trial, qualitative study components were added to increase our understanding of several procedural issues, including implementation of the intervention. This study will describe NFP supervisors' experience of implementation, identify the roles and responsibilities they assumed, recommend strategies to help support supervisors facilitate the implementation process for new NFP innovations, and elucidate challenges supervisors experienced with the introduction

of the IPV intervention. The findings from this qualitative study will subsequently inform recommendations for scale up of the IPV intervention to other states in the US, and lend application to other countries such as Canada, Northern Ireland, Norway and Australia, currently adapting the IPV intervention for integration into their NFP home visitation programs.

Research Questions

The overarching research questions for this study were: 1) what are NFP supervisors' roles and responsibilities related to the implementation of an IPV intervention by NHVs to identify and respond to IPV in home visitation? and; 2) what are the strategies that could best support NFP supervisors in the facilitation of their roles and responsibilities for the implementation of the IPV intervention or future NFP innovation?

Chapter 2: Methods

Evaluation of the IPV Intervention

The effectiveness of the NFP program augmented with the IPV intervention, compared to the standard program, was evaluated to determine if this intervention would improve overall maternal quality of life at 24 months post partum (Jack et al., 2019). Fifteen US-based NFP agencies participated in a cluster RCT, with seven sites randomized to the intervention arm and eight sites randomized as control sites. A qualitative process evaluation was embedded in the trial which included data collection from managers, supervisors, and NHVs at the seven NFP intervention sites. The overall purpose of the process evaluation was explore and describe NFP teams' experiences of implementing and delivering this novel practice augmentation, as well as to identify individual, team, contextual, and intervention factors that may have influenced the successful uptake of the intervention into practice. The research conducted for this master's thesis was a critical component of this NFP process evaluation and focused on exploring supervisors' roles and responsibilities with respect to supporting the uptake of the IPV intervention by their agencies. Inclusion criteria for the process evaluation component included English speaking NHVs, supervisors and managers who completed the IPV intervention educational curriculum and were trained to execute or supervise the implementation of the IPV intervention into practice, completed consent for the parent study, and active employment at an intervention site.

Study Design

The principles of interpretive description guided the conduct of this applied qualitative health research study (Thorne, 2016). Interpretive description is a qualitative method that has

been developed and informed by a range of qualitative designs originating in the social sciences (Thorne, 2016). Interpretive description differs in its flexibility when compared to traditional qualitative approaches, encouraging researchers to use disciplinary logic to avoid making research questions fit a specific rule structure (Thorne, 2016). The motivation of interpretive description is to create meaning for applied fields (such as nursing) by providing an organizing logic, with epistemological underpinnings of the applied disciplines (Thorne, 2015). This approach supports the most relevant and highest quality research so applied fields benefit from important qualitative insights. Interpretive description has been selected for this study based on its pragmatic philosophy and support of applied questions for the generation of nursing knowledge that is useful.

To develop a comprehensive understanding of NFP supervisor roles involved in the implementation process of the IPV intervention, it was important to triangulate data from multiple perspectives. The data used in this study included two data sources: 1) secondary data from NHV focus groups (phase 1 data collection) and; 2) primary data collected from supervisors and managers using semi-structured interviews (phase 2 data collection). Collection of data from these independent data sources occurred at two different time points and will be described further below.

Approval to perform this study was received from the Hamilton Integrated Research Ethics Board, McMaster University, and approvals granted from organization and site-specific institutional review boards (See Appendix C, Figure C1). Ethics and review board requirements were fulfilled with obtained consent from supervisors, managers, and nurse home visitors prior to participation in the qualitative component of the parent clinical IPV intervention trial. All participants were given the option to freely withdraw from interviews at any time.

Phase 1: Secondary Analysis of Data from NFP Nurse Home Visitors

Sample and Data Collection. Over the course of the trial (2011-2015), all NFP NHVs (n=64) who were employed at any point during this time period at the seven intervention sites, who completed the NFP IPV education program and were employed in the NFP program at the time of the qualitative data collection, were invited to participate in the process evaluation. As part of the broader process evaluation, focus groups were held with NHVs from the seven intervention sites at two points in time: 1) 12 months following completion of the IPV education (conducted between April 2012 and February 2013) and; 2) following collection of final outcome data from women enrolled in the cluster RCT (conducted between September 2015 and September 2016). The purpose of the first focus groups was to explore NHVs' perceptions of the IPV education and their early experiences implementing the NFP IPV clinical pathway. The goal of the second focus groups was to explore NHVs' general experiences of identifying and responding to IPV in their home visitation practice and to document individual, intervention, team or contextual factors influencing uptake of the intervention in their home visitation. Secondary analysis was completed using focus group data from the second time point (2015 and 2016) only.

A total of 35 of 40 eligible NHVs participated in the first series of focus groups (87.5% participation rate), and 35 of 36 eligible NHVs shared their experiences in the second (97.2% participation rate). As a result of staff turnover and reduction in NFP team sizes across the seven sites, 22 NHVs participated in both focus group interviews; 13 NHVs were participants in only the first focus group and 11 NHVs, who were hired later in the trial, were participants in only the final focus group. Nurse home visitors were all females and all were registered nurses, worked an average of 2.25 years for the NFP with a total of 14.42 years nursing experience, and 71% of

NHVs who participated had a baccalaureate degree as the highest level of education completed (Table 1).

Table 1

Nurse Home Visitor Participant Demographics for Focus Groups

Description	Value
Average # of years working in NFP program	2.25 years
Average # of years nursing experience	14.42 years
Female Gender	100%
Baccalaureate degree as highest level of education	71%
Registered Nurses	100%

Focus groups were facilitated by Dr. Susan Jack (co-principal investigator, a content expert in the areas of home visitation, family domestic violence, family health and public health nursing practice. The focus groups lasted from 120-150 minutes in length (see interview guide, Appendix D, Figure D1) and were conducted on site at each of the participating NFP agencies. The purpose of the first focus group was to explore participants' experiences of completing the NFP education; the second focus group explored their experiences of delivering the IPV intervention to women enrolled in the program, as well as an exploration of individual, relational, team, and contextual factors that influenced overall implementation of the intervention within their implementing agency and clinical practice. Supervisors were excluded from participating in focus groups to allow for NHVs to freely discuss their experiences. Interview data were recorded in duplicate, and transcribed verbatim, removing all identifying information, into a word processing document for analysis.

Phase 2: Primary Data from NFP Semi-Structured Interviews

Sample and Data Collection. All supervisors and managers who were involved in the IPV intervention implementation process were invited to participate in the interviews post implementation of the IPV intervention (n=14). A total of 11 of 12 eligible supervisors (91.6% participation rate) and all eligible managers (n=2) shared their experiences for the adoption of the IPV intervention. These two managers completed the IPV education and provided support to supervisors. Supervisors and managers were all female, worked for the NFP for an average of 6.83 years and of those years, on average, occupied a supervisor position for 5 years. The highest level of education for 54% of supervisors and managers was a baccalaureate degree, and 46% completed a master's degree program (Table 2).

Table 2

Demographics of NFP Supervisors and Managers (n=13) Participating in 2016 Interviews

Description	Value
Average # of years working in NFP program	6.83 years
Average # of years nursing experience	5.00 years
Female Gender	100%
Baccalaureate degree as highest level of education	54%
Masters degree as highest level of education	46%

The interview guide was created by Dr. Susan Jack; a content expert with extensive qualitative experience with the NFP program and the IPV intervention and reviewed by the author (Appendix D, Figure D2). I facilitated all telephone interviews using the interview guide between March 21st and April 8th, 2016, and interviews were between 60-90 minutes in duration. Open-ended questions were used to foster the spontaneous exploration of information and generate discussion (Ryan et al., 2009). To mitigate group dynamics and influence, reduce bias, and increase quality (Palmerino, 2006), questions were conducted one-on-one. Interviews were

recorded in duplicate and transcribed into a word processing document by a contracted transcription service and all participant identifying information was removed.

Data Analysis

Primary Interview Data

Transcript files, created in Microsoft® Word® for Office 365, were analyzed one interview at a time using conventional content analysis, with the goal to describe phenomena for which limited research on the phenomena exists (Hsieh & Shannon, 2005). Utilizing this approach, preconceived categories were not considered; rather, categories were identified from within the data by inductive content examination (Kondracki et al., 2002). Analysis involved initial immersion within both the transcript and respective audio file data for each interview to gain a sense of the whole (Tesch, 1990), followed by repetitive reading of transcription data (line by line) with focus applied to each word to derive data codes by constant comparison (Miles & Huberman, 1994). Although data were assessed line by line, flexibility was incorporated to capture the essence of a code beyond each line as needed, ensuring that patterns could be logically derived from a complete thought, rather than subscribing to a rigid process for the sake of the process alone (Thorne et al., 2004). Codes were created in Microsoft® Excel® for Office 365, merged to represent data categories based on shared linkages (Hsieh & Shannon, 2005), and categories were arranged into broader related groupings called clusters (Coffey & Atkinson, 1996; Patton, 2002). To avoid diluting code meaning, literature review findings were considered; however, a purposeful and reflexive process was enacted to facilitate a natural abstraction of code meaning, preventing a clinging to prior assumptions, and relying on intellectual inquiry (Thorne et al., 2004). Intellectual inquiry involved a disciplined exploration

of possibilities, posing questions such as: Why is this here? Why not something else? What is its meaning? (Thorne et al., 2004).

Secondary Focus Group Data

Similar to primary data analysis, secondary transcript data from NFP focus groups with NHVs were reviewed line by line using a conventional content analysis approach (Hsieh & Shannon, 2005), allowing for the inductive capture of categories by constant comparison (Miles & Huberman, 1994). Both primary and secondary data analyses categories were compared to understand themes of divergence and convergence. It is important to note the initial goal of the NHV focus groups was to have an understanding of the NHV experience during the implementation of the IPV intervention, and the interview guide was not designed to directly target and explore supervisor roles.

Rigor

Utilizing the quality approach of trustworthiness by Lincoln and Guba (1985), the associated components of credibility, dependability, confirmability, and transferability were considered and integrated in this study's design and analysis. The generation of knowledge through more than one data source becomes the check and balance for one another (Thorne, 2016), and provides corroborating evidence (Lincoln & Guba, 1985; Patton, 1990; Miles & Huberman, 1994). Primary and secondary data sources were used to triangulate data in this study from more than one perspective, that is, to understand the experiences of the implementation process from NHVs' and supervisors' perspectives as well as gain insight into supervisor roles and responsibilities, thus establishing credibility and dependability through corroboration (Lincoln & Guba, 1985; Miles and Huberman, 1994, Patton 1990). Triangulation

has been incorporated by utilizing different data sources (supervisors, managers and NHVs) and data types (interviews and focus groups) for this study (Krefting 1991).

Thorne et al. (2004) assert for interpretive description studies, credibility is a product of how "analytic decisions are presented and contextualized within the larger picture" (p. 15), as well, how complexities encountered within the analytic process are conveyed with transparency, and findings are presented with a degree of tentativeness (Emden & Sandelowski, 1999). Complexities and tensions encountered during the decision-making process of the analysis were identified and recorded.

This study was focused on developing a rich understanding of supervisor experiences, roles and responsibilities, with the pragmatic goal of developing meaningful recommendations aimed to improve support structures for supervisors implementing novel innovations into established home visiting practice. The Integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) framework (Harvey & Kitson 2015) was utilized to gain insight into the implementation process, enable guidance for an applied translation of this study's findings, and assist in the development of NFP National Service Office (NSO) recommendations to support supervisors during the implementation process of the IPV intervention. Additionally, *lean team management* philosophy and principles, as applied to the home visiting setting (Miller, 2012), were leveraged to identify quality improvement strategies for the implementation process of the IPV intervention. The lean team management approach draws on many methods including quality management, Six Sigma, employee involvement or self-directed work teams, re-engineering as well as lean management (Miller, 2012).

Chapter 3: Results

IPV Intervention, RCT and Demographic Overview

The NFP IPV intervention (developed by Jack et al., 2012) provided each participating NFP team with: 1) education about how to recognize and respond to IPV; 2) a manualized intervention, along with a clinical pathway to guide clinical decision making; 3) an organizational checklist to support implementation of the intervention into the agency; 4) supervisor guidelines for reflective supervision and; 5) expert coaching.

In a cluster RCT (2011-2015), the effectiveness of the NFP program augmented with the IPV intervention, compared to the standard program, was evaluated to determine if this intervention would improve overall maternal quality of life at 24 months postpartum (Jack et al., 2019). In this trial, 15 NFP agencies in the US participated, with seven sites randomized to the intervention arm and the remaining 8 sites randomized as control sites (Jack et al., 2019). The findings of this study reflect the experiences of 11/12 supervisors (91.6%), 2/2 managers (100%) and 46/64 NHVs (72%), who completed the NFP IPV education program and participated in the implementation process of the IPV intervention and who were employed in one of the seven sites that participated in the intervention arm of the trial.

The findings for this study have been structured relative to the overall objectives and will be presented in alignment with two broad categories: 1) NFP supervisor functions (domains, roles and responsibilities) during the implementation of a new intervention designed to support nurses identify and respond to clients' experiences of IPV within an established nurse home visiting program and; 2) factors influencing the provision of supervision to NHVs engaged in

adopting this new innovation and supporting women experiencing abuse. Additionally, recommendations as suggested by NFP supervisors will be presented.

Primary Data Analysis

The Language of NFP Supervision

Within our discussions of the work of NFP supervisors, the participants identified and richly described multiple roles and responsibilities they assumed within the NFP team and the unique (yet sometimes overlapping) functions of each role. To capture and synthesize their descriptions, I categorized their work into domains, roles and sub-roles. Domains are descriptions of supervision used to classify a collection of associated functions called *roles* and *sub-roles* which also have a collection of associated functions called *responsibilities*. Domain categories were named using an abstract noun, describing the concept of supervision they represented (e.g., clinical supervision). Roles and sub-roles described the supervisor (the person) with respect to the collection of work they executed and use concrete nouns (e.g., planner) to describe their specific function. Sub-roles, as a related collection, described one parent role. Sub-roles were not utilized for every role, instead sub-roles were only used if a single role had multiple functions. The term "responsibilities" was used to identify the individual tasks a supervisor completed and were related to a specific supervisory role or sub-role. Responsibilities were described using verbs, to capture the specific actions completed by supervisors.

From the literature search, it was understood that there are seven broad concepts of supervision: supportive, personal well-being, reflective, administrative, clinical, education and mediation. Given the definitions presented above, these broad concepts have been defined by this study as "domains" of supervision and will be referred to as such from here on forward.

Additionally, domains, as they specifically relate to the IPV intervention, will be described further to follow.

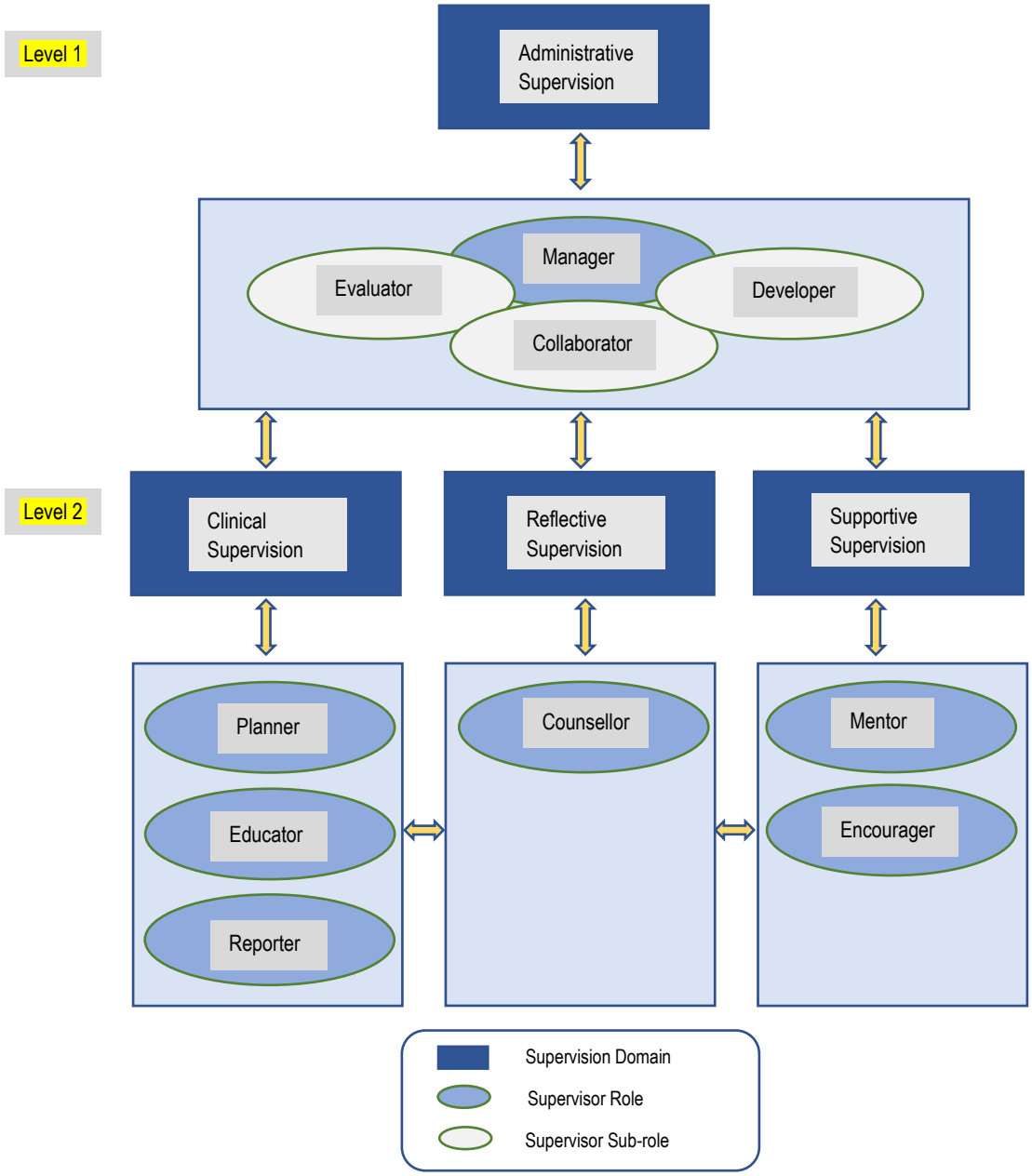
NFP Supervision Framework

An NFP supervision framework (Figure 1) was contextualized from the ground up representing supervisor functions facilitated for the implementation process of the IPV intervention. First, responsibilities identified from coding were assembled based on relatability and together formed a supervisor role or sub-role. Subsequently, and similarly, related roles (with respect to function) were assembled into a single domain. In total, four domains, seven roles, three sub-roles, and numerous responsibilities (see Appendix E, Table E1) have been identified that supervisors enacted during the implementation process of the IPV intervention. The classification of domains, roles, and sub-roles are represented in this framework. Domains were conceptualized as the broadest level of supervisor function, followed by a refinement of function using the concepts of roles and sub-roles. The domains of this supervision framework have been described as administrative, clinical, reflective, and supportive. Supervisor roles were characterized as manager, planner, educator, counsellor, mentor, and encourager. The role of manager was further represented by the sub-roles of evaluator, collaborator, and developer. Each domain, their respective roles, sub-roles and responsibilities will be described in more detail to follow.

From the primary data analysis, an important concept emerged that distinguished supervision by two separate approaches and resulted in a hierarchical classification of supervision in the NFP supervision framework. In one supervision approach, supervisors enacted roles and responsibilities that served in direct support of the IPV intervention's

Figure 1

NFP Supervision Framework for the Implementation Process of the IPV Intervention



Note. Level 1 in this figure refers to the supervision domain, roles, and sub-roles focused in oversight of level 2 domains and roles. Domains and roles from level 2 informed the actions of the level 1 domain and associated roles, and sub-roles.

implementation. This form of supervision was called level 2 supervision. The second approach, called level 1 supervision, functioned in oversight of level 2 supervision: evaluating implementation progress, leveraging networks to identify solutions, and developing tools and resources to improve the quality of implementation. Level 1 functions required information from level 2 functions to be able to improve implementation quality, therefore, level 1 is considered to be informed by level 2 supervision functions. The combined functions of level 1 and level 2 formulated the *implementation process* of NFP supervision for the IPV intervention. It is important to note that implementation of the IPV intervention is not the same as the implementation process. While implementation involved the direct adoption of the IPV intervention into NHV practice, the implementation process involved both supervisor functions of oversight and direct implementation (level 1 and level 2 supervision), ensuring that not only was the IPV intervention implemented, but it was implemented well. Bi-directional arrows between domains, roles, and their sub-roles of levels 1 and 2 in Figure 1, demonstrate the fluid nature of this framework, and while there was a primary association of roles and sub-roles with a specific domain, they were not exclusive. Additionally, the bi-directional arrows represent the influence of domains, roles and sub-roles on each other as non-linear, and functioning as an interconnected system.

NFP Supervision Domains and Associated Roles and Responsibilities

Domains were the broadest classification of supervision in the NFP supervision framework and were categorized by primary data analysis to include: 1) administrative 2) clinical 3) reflective and; 4) supportive supervision. Domains and their related functions were further characterized with respect to their approach to supervision, as level 1 or level 2 as part of the presented NFP supervision framework (Figure 1). In this context, the domain of

administrative supervision and associated functions were classified as a level 1 approach (in oversight), while the remaining domains of clinical, reflective, and supportive supervision were classified as a level 2 (direct) approaches.

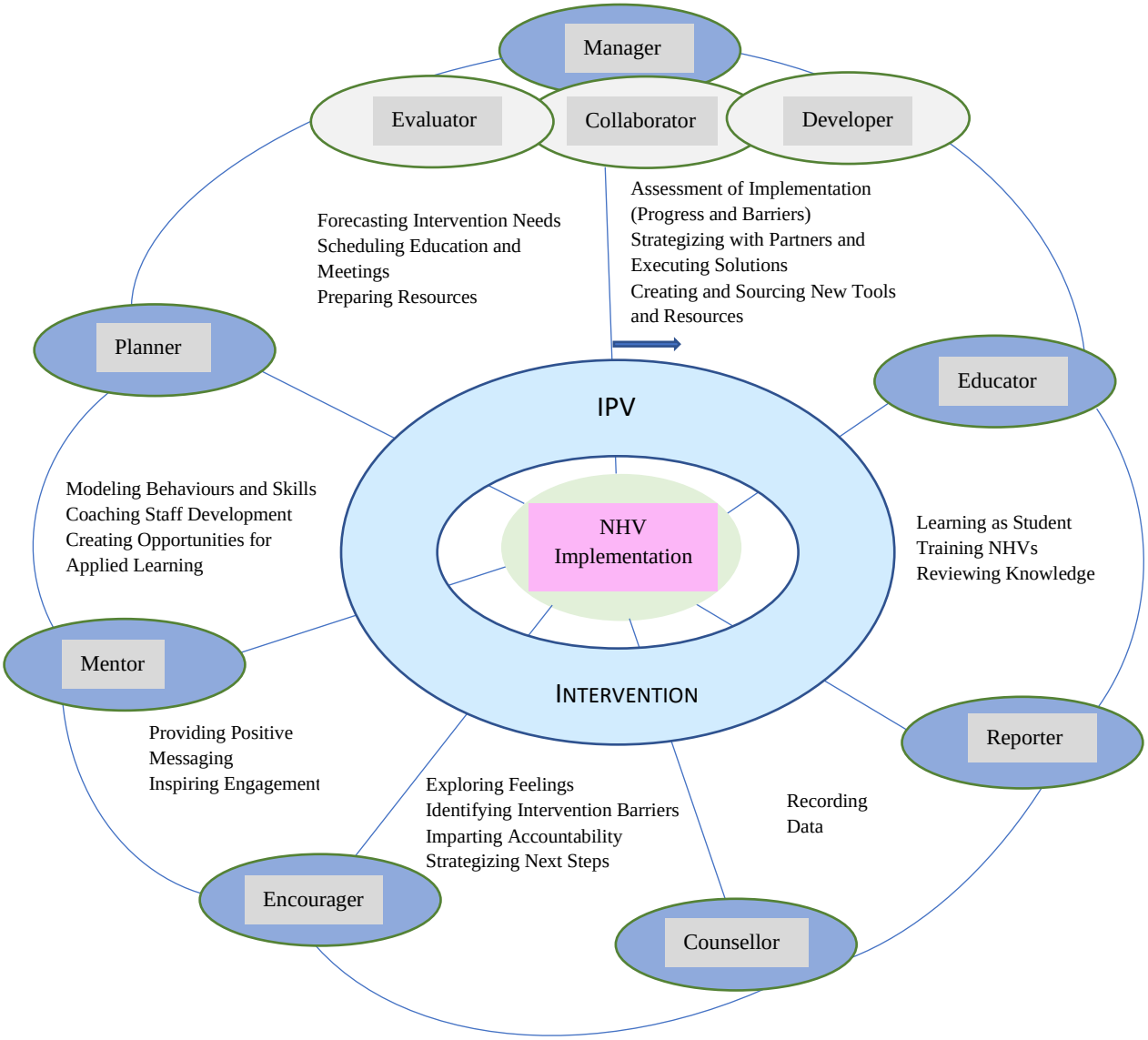
An overview of each role, sub-role, and their respective responsibilities are represented in Figure 2. In this model, the functions of supervisor roles and responsibilities are represented working in concert with one another to influence the implementation of the IPV intervention by NHVs for translation to mothers in their home environment. Nurse home visitors are placed centrally in relation to the IPV intervention, demonstrating their critical involvement working with women to create safe environments for discussions of their experiences of abuse and surrounded by the supervisor's guiding action to support application of the IPV pathway by NHVs in practice. In-depth descriptions surrounding each supervisor function in relation to the implementation process will be presented in the sections to follow.

Administrative Supervision. As a level 1 approach to supervision, administrative supervision and associated roles, sub-roles and responsibilities performed by NFP supervisors, functioned in oversight of level 2 clinical, reflective, and supportive supervision domains (see Figure 1). Within the administrative supervision domain, supervisors enacted the role of manager, and manager sub-roles of evaluator collaborator, and developer, to assess, appraise, and create solutions to challenges and gaps encountered and informed from level 2 supervisor functions of the implementation process.

Manager Role, Sub-Roles, and Responsibilities. The manager role and evaluator, collaborator, and developer sub-roles relied on feedback from level 2 functions to inform understanding of how well the implementation of the IPV intervention was progressing and

Figure 2

NFP Supervisor Roles, Sub-roles and Responsibilities Guiding IPV Intervention Implementation



Note. The blue arrow indicates where the reader should begin reading this diagram, starting with the role of manager and associated text above the blue arrow, then proceeding in a clock-wise direction to review each role and their respective responsibilities.

assist with whether action was needed (in the form of responsibilities) for challenges not anticipated, as a response. It is important to note that the supervisor's *role* of manager should not be confused with the NFP *title* of manager, which is a formal position within the NFP organizational structure and a human resource classification. Supervisors did not have a formal title of manager for the implementation process. The supervisor, however, did have responsibilities that related specifically to the implementation of the IPV intervention that were best characterized by the word manager in reference to the role, and to date, this role relates only to the implementation of the IPV intervention. To explain the overarching role of manager, the sub-roles and responsibilities of evaluator, collaborator and developer will be described in more detail.

Supervisors in the sub-role of evaluator assessed the experiences of NHVs and the progress of IPV intervention implementation. Supervisors assessed NHV and client safety, the impressions and impact of the IPV training, how much time was being added to NHV work, whether the clinical pathway was being implemented as intended, and identified barriers to implementation. Often the three sub-roles would work in concert with each other (but not always necessarily): the evaluator sub-role would assess, the collaborator sub-role would work further on the issue with an individual or team to identify solutions, and the developer sub-role would help with the development of new tools or resources.

Completing an assessment of safety was a responsibility all supervisors facilitated in the evaluator sub-role. The IPV intervention was intended to assist young, first-time mothers in their home environment by identifying and responding to IPV exposure. The very nature of NHV work, therefore, required consideration of issues involving safety and risk. Supervisors would assess how safe it was for the NHV to continue if there was a potential threat of violence,

making sure communication lines stayed open. As supervisors assessed safety, they collaborated with the NHV to understand specific issues and developed an emergency plan in response, demonstrating evaluator, collaborator, and developer sub-roles working in partnership of the overarching manager role. The work contribution of all three sub-roles improved safety for NHVs.

Time allocated to the implementation of the IPV intervention was assessed by most supervisors in the evaluator sub-role, identifying how time was best used. Most supervisors discussed the impact of time on the NHV for documentation, feeling NHVs were overburdened with the amount of documentation they had and NHVs felt it took them away from the time they had directly with their clients. One supervisor discussed how they were cautious to prevent "losing" a client because the IPV intervention was adding another layer of assessment on an already assessment-heavy approach in the home, and delivery of the IPV assessments needed timing adjustments due to being too much in a short period of time for the client:

> And because our agency is a trauma and home care agency…they've [NFP] also added in a trauma assessment that we need to do. So sometimes it's just too much...too much stuff in a short period of time and...and everyone kind of thinks, "Well, you know, this is just one more piece of paper, you know?" …so we had to kind of soften that approach with the client for fear that we would lose them. So... the timing of the introduction of some of these things like the videos and the [IPV facilitators]...and discussions was very sensitive, so...so we had to do some changes.

This supervisor introduced flexibility into the schedule for NHVs delivering the IPV intervention, by extending timelines for completion of intervention elements, and in turn created a more natural flow to the intervention for the client by relaxing deadlines of when IPV

intervention assessments needed to be completed. This example demonstrates the essence of level 1 supervision. The supervisor and NHVs could have continued to delivered the IPV intervention as intended based on the visit-to-visit guidelines for the intervention, however, an important decision was made to modify visit delivery to fit a more organic approach with the client, and potentially prevented the client from leaving the program. This choice by the supervisor resulted in an improvement to the IPV intervention by retaining the client in the program through the adoption of flexibility. The IPV intervention may have continued to proceed with level 2 supervisor functions only (focused on direct implementation), but as a result of this oversight and design of a response from level 1 supervision functions, the experience of the client was positively impacted.

In the evaluator sub-role, supervisor responsibilities involved assessing how well the team was adhering to the IPV clinical pathway as it was designed for implementation. The reporter role responsibilities informed the evaluator sub-role assessment. Details about the intervention completion was entered by NHVs into an electronic log and reviewed by supervisors within the reporter role. All supervisors relied on completion of checklists to know what was completed by NHVs; some making their own additional checklists to keep NHVs on track. For example, one supervisor was exceptional in her approach by developing her own excel spreadsheet tracker to identify what visit each NHV had completed so she could have a targeted discussion with her NHVs during reflective supervision sessions. As part of the developer sub-role, more than half of supervisors went above the expectation of activity log entry and developed their own tools to have a better awareness of where the nurse withing the IPV clinical pathway and some supervisors used only what the IPV intervention provided. For the supervisor developed a comprehensive tracking tool, this may have had a positive impact on

the ability of this supervisor to assess the IPV intervention uptake with her targeted question approach, perhaps understanding and identifying barriers better, and impacting her timely response to challenges. In general, the independent creation of checklists and tools by supervisors may have contributed to differences in implementation and IPV intervention uptake. Developing additional checklists and the tracking tool is another demonstration of the impact of level 1 supervision, overseeing the intervention through assessment and responding to barriers to support implementation.

The assessment of the IPV intervention's progress by supervisors in the evaluator sub-role was often followed by responsibilities from the role of collaborator and developer. Supervisors in the collaborator role networked with internal and external stakeholders, as well as community partners, to source solutions to challenges assessed and identified during implementation. Some challenges met for example involved the inability to get the client alone to assess IPV, NHVs needing assistance to create a comprehensive safety plan for the client upon disclosure, when and how to report to child protective services, and identifying resources in coordination with client need. Some supervisors took advantage of the clinical consultant resource that was available to them in their collaborator sub-role when they encountered challenging issues and needed guiding strategies to assist. Reaching out the clinical consultant, this supervisor describes her desire to understand how other sites are managing challenges and looking for supportive solutions:

> Having the researcher's guidance, as well as being able to have those conferences, teleconferences with them and saying: "hey this is what it is…this is what we are running into." "How can we address this?" "Are other people running into this challenge?" "Has this been reported elsewhere?"

Some discussed how challenges were particularly prevalent at the onset of implementation, and this became a time when they greatly valued and relied upon the support of the NFP clinical consultant. There were, however, different levels of outreach to the clinical consultant, some supervisors utilized this resource outside of the scheduled monthly check-in meetings as needed, and others did not.

Informed by the educator role, some supervisors utilized the evaluator sub-role to assess gaps in the education curriculum and sourced educational opportunities, such as conferences, for IPV-related NHV learning opportunities: "We make sure that we go to conferences, I send my nurses to conferences. Anything…anytime that I can around violence and trauma." One supervisor used the collaborator sub-role to form networks with external local community resources, such as a psychologist, and would invite partners to team meetings to expand IPV learning opportunities for NHVs. Finally, most supervisors assessed whether the NHVs required additional review of the provided education curriculum to solidify skills and learning and would facilitate additional learning in team meetings.

Understanding the experience of NHVs and their clients during implementation of the IPV intervention was important indicator for supervisors of how well the uptake of the IPV intervention was progressing. The experiences were largely informed by the roles of counsellor and mentor, as the supervisor engaged in reflection and review of IPV intervention delivery to clients and IPV curriculum understanding. Assessed by the evaluator sub-role, all supervisors determined whether the NHV was positively moving forward with implementation or if there were challenges that required attention. The example presented demonstrates the supervisor assessing the impact of the IPV intervention on NHV practice, determining the intervention to have a positive influence on NHV comfort level: feeling less fearful, more prepared, able to set

better boundaries, know what to do if there was an IPV disclosure, and provide information that was more consistent.

> I think the most significant impact that it [the IPV intervention] had…is that it did change … what we did, what we delivered, as part of the model. And I think the most significant part of that was the comfort that I saw the team have in, you know, when this [IPV] would come up, not being afraid of it...you know, a little bit of fear...you know, "What to do?" "Am I going to do it right?" but ...I did see an improvement in people's ability to set better boundaries. I mean, it had a...it had a far-reaching effect, you know, outside of just IPV. But I'd say the most significant impact was the nurse's comfort level. You know, in...in feeling prepared...when they had a disclosure, they had...they knew what to do next. Or they at least had, you know, an idea...a path...you know, what to do, and that...that was very significant. And, I'm sure the...the information they provided was more consistent.

In summary, the manager role involved supervisor responsibilities associated with assessment, networking with partners (internal and external), and creating new resources represented by the sub-roles of evaluator, collaborator, and developer respectively. Collectively, the manager role and its three sub-roles form the administrative domain of supervision, functioned in oversight as a level 1 supervision approach, and was informed by level 2 supervision functions (domains, roles, and responsibilities). As a result of oversight, the IPV intervention had enhancements made by supervisors that likely had a positive impact on how the intervention was delivered by NHVs and received by NFP clients.

Clinical Supervision. The domain of clinical supervision and associated roles of planner, educator, and reporter functioned in direct support (not in oversight) of the IPV intervention implementation and, therefore, was classified as a level 2 approach to supervision. Responsibilities related to each role facilitated the detailed work of supervisors associated with scheduling, training, and reporting IPV intervention expectations for implementation. The clinical supervision domain was where the large majority of IPV intervention work associated with the IPV clinical pathway was completed by NHVs. It is important to note, however, that this single domain represents only one of four domains of the entire implementation process for supervisors. The domain of clinical supervision is the front-end of the implementation process and required NFP supervisors to operationalize details surrounding the "who, what, where when and how" of the IPV intervention. This type of supervision was especially time-consuming, where supervisors concentrated extensive planning and training efforts to make sure that NHVs were fully prepared to administer the components of the IPV intervention, and confirmed the correct information was being documented and collected.

Planner. Supervisors focused on planning how the IPV intervention would be introduced and integrated into the existing NFP program structures at their local site. This involved completion of a site-readiness assessment, creating schedules for education and meetings, and preparing resource materials in advance. Supervisors considered the impact to their current program delivery and considered plans for the NHV to enable adoption into practice. One supervisor commented on accommodations she made to the NHV schedule:

> I made allowances. You [the nurse] may have clients that are not seen every two weeks this month because we have this training… we are really flexible around that because, especially in the beginning, we need to do that.

Another supervisor discussed the commitment to her role as planner to be able to prepare her NHVs for delivery of the IPV intervention as intended:

> I spend probably more time planning than anything and then I just do my best. I think it is just careful planning knowing the time sensitiveness to it, that she [the nurse] is prepared enough to do a good job and do it consistently with what the model is.

There appeared to be varying degrees of planning from supervisors, with only one supervisor discussing the great amount of time she spent on planning. This supervisor was unique in the way she specialized her role as planner to incorporate both pre-planning and planning; stating that she would book time in her own schedule (pre-planning) to be able to have time that was dedicated solely to planning for the IPV intervention's implementation.

All supervisors discussed scheduling time and preparing resources for the intervention. Supervisors created training schedules for nurses to complete the IPV education modules during their work hours. The planner role required extensive coordination efforts by the supervisor to confirm a date and location that was mutually convenient for the team and the educator. Common to the role of planner, was ensuring that IPV resource materials including brochures, checklists, tracking sheets, binders, facilitators, and laminated IPV clinical pathway sheets were available for NHVs to use in practice. In some sites, supervisors worked to make this process easy for NHVs, creating a dedicated residence for resource materials, such as a filing cabinet area, where the nurse could reliably go to find these materials.

Educator. Responsibilities of the educator role required supervisors to first learn about related tools and the training curriculum for the IPV intervention prior to any training for NHVs. Most supervisors facilitated the first and third phases of IPV education with NHVs; however,

some supervisors placed the responsibility on the NHV to complete the modules themselves through self-study. Supervisors ensured that the expected training sessions with experts were scheduled and completed with NHVs. Most supervisors discussed expectations for the IPV intervention were made clear during the training, and the clinical pathway for the IPV intervention's delivery was introduced as a guiding reference to implementation. One supervisor discussed specifically how NHV expectations were broken down to the visit-to-visit level, indicating that the nurse understood what assessments were to be completed relative to the client visit number. This supervisor presented NHVs demonstrating understanding of expectations based on their use a new language related to the IPV curriculum and the IPV clinical pathway visit guidelines:

> It's also just kind of having the language. Like…[nurse speaking to another nurse] "have you completed the beginning the way she had it on the clinical IPV…pathway…it was listed as P4?" … We know what that means for us is…doing the clinical IPV assessment and the universal assessment of safety.

The educator role did not stop after the initial IPV education was complete; supervisors continued to review the IPV education components as needed by nurses. Supervisors discussed showcasing IPV tools, related forms, and reviewing the clinical pathway expectations during team meetings and reflective supervision sessions. This supervisor discussed the importance of reviewing the original education curriculum with NHVs to solidify skills:

> You know, people can get off track with what they thought they remembered, especially depending on when they came into the program and how many competing things are going on. I've found that we have to review quite a bit more when there's a lot of

> learning going on at one time. It's [the IPV intervention] just like DANCE [The Dyadic Assessment of Naturalistic Caregiver-Child Experiences - an initiative of the NFP program]. I mean, we integrated DANCE last year but we still…bring it up as part of our case conference because if we don't…we're going to lose a lot of that skill.

Reporter. Once trained, NHVs would visit their clients with the expectation they would apply the elements of the IPV clinical pathway to their home visits. As NHVs performed visits, less than half of supervisors discussed their role of reporter, ensuring that NHVs would document completed IPV intervention activities on specific NFP (paper) forms and updated electronic data logs about what IPV assessments had been performed during implementation. From the interview data, it appeared that only one site adopted an electronic model of form completion for client assessments, the remaining sites seemed to have paper. Supervisors monitored and maintained the *efforts to outcomes* log as part of their reporter role, to track form completion and ensured that targets for documentation were met and followed-up with NHVs if documentation was missing to understand why. One supervisor described dedicating special days to review NHV logs and documentation that required completion for the IPV intervention:

> We reviewed a lot and we would go back in time and take time to just make sure that they [nurses] went back through their travel charts and they actually put [it] on the log…Because it was research, I mean, it was very important that they [nurses] keep track of that information. So…we would include points in time where it would be like, okay…today is a review day to go back through and make sure that your logs are up to date with those pieces, those facilitator pieces.

Another supervisor appeared to take the reporter role to the next level, creating time to review documentation completed for every NHV visit completed:

> Making sure the intervention logs were completed as thoroughly as possible…It's kind of a lot of oversight of paperwork and management…We still keep checklists, you know that we do at our pregnancy…visit, our infancy visit and our toddler visit, or if there's a client-initiated disclosure or nurse indicator-based disclosure that those check lists stay in the client's record. I definitely review my nurses' documentation for every visit so I'm …able to stay on top of it.

This was the same supervisor, identified in the manager role section, responsible for developing an excel-based tracking tool to keep informed of nursing visits completed. Understanding where each NHV was in the IPV clinical pathway enabled this supervisor to have a focused assessment of the implementation's progress and facilitated NHV accountability to the IPV intervention.

Reflective Supervision. The reflective supervision domain supervision provided an opportunity for supervisors and NHVs to pause, reflect, and to check-in with one another during the delivery of the IPV intervention. The focus of the reflective supervision type was for the supervisor to gain an understanding of challenges from the perspective of NHVs, to model motivational interviewing skills, identify barriers to IPV intervention delivery by NHVs, to reinforce elements of IPV training and to strategize steps for the next home visit together. This type of supervision was also focused on the detail, with supervisors and NHVs reviewing case scenarios and associated feelings in greater depth. Reflective supervision required a dedicated window of time for supervisors to formally meet with NHVs in one-on-one sessions, where they facilitated information exchange, exploration, and professional development with NHVs.

Sessions were conducted with the expectation that the NHV and supervisor would openly immerse themselves in client and NHV experiences, commit themselves to a growth mindset and determine strategies for the next home visit to enable the execution of the IPV intervention's goals with the client.

Counsellor. Supervisors, in the role of counsellor, formally met weekly with their NHVs for required sessions as part of the IPV intervention that occurred as a function of the reflective supervision domain. In the counsellor role, supervisors took the opportunity to explore the feelings of NHVs surrounding the IPV intervention and assess how the delivery of the IPV intervention clinical pathway elements was progressing in their practice with clients. Supervisors provided an open environment, free of judgement, where the nurse could work through some of her feelings about the intervention to better understand herself and identify improvements that could be made for an enriched client experience. Supervisors modelled behaviours as a parallel process strategy, engaging in a motivational interview style with NHVs to demonstrate how NHVs could use this skill with their own clients. One supervisor discussed reflective supervision sessions and the responsibilities of the counsellor role as: "…Asking a lot of open-ended questions; kind of doing discovery with them [nurses]. If they [nurses] have a client that they're having… some concerns about." Articulating her counsellor role at a deeper level, another supervisor described how reflection involved not just asking questions, but also required understanding the root of NHV behaviour:

> Really just asking…about the situation, like, what's going on with that particular client, especially if I know there's a challenge or there's some sort of violence going on [and not just] physical. It's a lot of threats; it's a lot of subtle, passive-aggressive type things…but I think it's just asking questions about what's going on and then …find[ing] something

> that the nurse isn't really fulfilling … the whole aspect of assessing that client and, you know, and give it the time that it needs then, you know just kind of reflecting on that [with the nurse]. Like, what…what's behind that? Where's the discomfort?

The safe and open environment created by supervisors enabled NHVs to have an awareness of their own biases which could have prevented the client from moving forward within the IPV intervention:

> I'd say the biggest challenge is that if they [nurses] haven't been in a situation like that themselves, they tend to get frustrated. That there's a sense [on behalf of the nurse] of: "Gosh, you know, like, how many times is it going to take?" Or, "This guy is such a deadbeat!" …and I love it when they say stuff like that because at least they feel like it is a safe place to say it. Because, you know, that isn't how we should be thinking.

Supervisors described the role of counsellor in the reflective supervision sessions as guiding and as a facilitator for the NHV's own discovery, instead of trying to solve the issue for her. This part of the counsellor role was described as most challenging from one supervisor, where the supervisor wanted to offer solutions or assistance but, intentionally, held back for the NHV to discover this on her own. Furthermore, supervisors depicted their counsellor role as a partnership with the nurse during these sessions, often defaulting to the NHV as an expert and learning equally from the NHV during reflective supervision sessions. One supervisor articulated the depth of understanding for her counsellor role, conveying how she felt her responsibility was to go beyond simply exploring NHV feelings and make sure that the sessions were productive for the benefit of the client and impart NHV accountability:

> We [supervisors] have to be real careful with our words and…and what we say and how we handle it [client challenges with nurses] because they [clients] may…not leave this person [the IPV perpetrator] and, you know… is [it] their [client] goal or your [nurse] goal? But that's the hardest part is, you know, helping them [nurses] to see that without [the supervisor] coming across as uncaring or unkind, you know, like letting them [nurses] vent but also holding them accountable [to the goals of the IPV intervention].

The responsibility of accountability associated with the counsellor role, was demonstrated by some supervisors by making sure the intervention was being delivered as it should be and understanding challenges to implementation. In this example, the supervisor discusses how she felt responsible to ensure the NHV was fulfilling the expectations of the intervention completely, while simultaneously balancing respect for NHV judgement and despite feeling awkward at this juncture:

> I think it's really a supervisor's role to make sure that the clients are getting [the IPV intervention]…the nurses are going there. And then, also understanding…you know, it's a fine balance between understanding, you know, they're [nurses] in the home; they're [nurses are] an expert on this family, I'm not. You know, and…respecting…their [nurse's] judgement. But it…that's kind of the awkward role of a supervisor is you have to really kind of reflect on it sometimes in terms of if you feel like action should be taken or assessment should be done and…the nurse is not really…it feels like, you know, she kind of blowing that off a little bit. And so there's always that risk, you know, of clients missing out because the nurse isn't comfortable enough. So that's one responsibility in terms of supervision is to, you know, gently remind and…explore with them [nurses] when they have cases like this, that it is their [nurse's] responsibility…and how that can

> be achieved… how can we get there? That's probably the hardest one, I'd say that you know, just reminding people that, especially in the… in the study like, we are part of an intervention group: this has to be done.

Supervisors in the counsellor role explored NHV feelings during the integration of the IPV intervention and gained understanding of NHV fears. Some supervisors explored fears relating to a NHV's safety in client scenarios such as in isolated environments: "[Home city] is very rural. Our nurses travel sometimes 30 miles to get to a family. So…it can be… either more intimidating for, not just the client having issues…but with the nurses going out into the home." Depending on the nature of the safety risk, an assessment was made (mostly in-person as a joint-visit) by the supervisor, determining whether the NHV would be able to continue seeing the client.

Only a few supervisors in the counsellor role discussed receiving IPV disclosure from their own NHVs as recipients during reflective supervision sessions. In these instances, disclosure from NHVs occurred due to the open and trusting environment offered by supervisors, where nurses felt comfortable enough to share even their own experiences of IPV. Exploring feelings with the supervisor's open questioning style enabled NHV to better understand the impact of their feelings may have in relation to their client due to their own IPV trauma. The offering of formal organization Employee Assistance Program (EAP) supports to NHVs was mentioned by one supervisor.

Strategizing "next steps" was a responsibility of the supervisor in the counsellor role, responding to information and feelings shared by the NHV during reflective supervision sessions. Strategizing included developing a plan with the NHV to facilitate during the next visit

with the client. One supervisor discussed how she empowered the NHV to use her nursing expertise, anchored strategy development by revisiting the IPV curriculum and asked open ended questions (demonstrating motivational interviewing skills), while considering safety:

> Just…going back to that…the good things… that you have a curriculum to refer to. To say: "Okay in this scenario…what [do] you think you could have done differently?" "How do you think you could have handled that?" You know, just going over different things that we could have used…or if you think something is going on, go with your gut. Do a power of control wheel and see what happens and how she responds to that…So, you know, having them be the expert with their clients…and try to ask them how they think they can approach the situation you know, 'cause what might work for one client might not work for the next…and also knowing the safety is our priority. So always refer them back to the curriculum again.

Supportive Supervision. The functions of the domain of supportive supervision focused on keeping the momentum going for adoption of the IPV intervention by NHVs. Where the domain of clinical supervision was at the front-end of the implementation process and reflective supervision followed, supportive supervision picked up from where clinical and reflective supervision left off, reinforcing IPV curriculum understanding with NHVs and encouraging positivity. Nurse-family partnership supervisors demonstrated supportive supervision by their ability to build strong relationships with NHVs, focused on developing individual strengths, and maintaining optimism within the NHV team to "keep going". Supervisor roles of mentor and encourager were informal and ad hoc. Accessibility was a key component to this domain, supervisors in the mentor and encourager roles took advantage of every opportunity for NHV development, whether it was a "drop-in" to the office, as a situation presented in a team meeting,

or accompanying a nurse to the client's home, the drive was to assist professional NHV growth outside of scheduled and formalized time with the NHV. The supervisor worked to build a culture where the nurse felt validated, encouraged, and empowered, contributing to the intervention's positive uptake into practice by NHVs.

Encourager. Supervisors expressed historically adopting a new innovation into practice, often was met with resistance from NHVs. From supervisor interviews, it was understood the IPV intervention was implemented during a period of time when a number of other new initiatives were being rolled out by the NFP National Service Office (NSO). This constant state of change to the program requirements was identified as stressful for many NHVs. Adding an IPV intervention that was perceived as more work by NHVs to an already overwhelming work schedule and having NHV "buy-in" was perceived as potentially challenging, requiring NHVs to manage competing priorities. For this reason, supervisors were considerate in their approach toward NHVs and utilised the role of encourager from the onset of IPV intervention implementation, to bring positivity to the new experience for NHVs who may have been overburdened by continuous change. Supervisors carried optimism about the intervention from an authentic place, believing the IPV curriculum would greatly benefit NHV practice and help support NHV to navigate the challenges of violence already encountered in client homes. Supervisors focused on the perceived benefits of the intervention and created a positive environment fostering NHV engagement. In this example, the supervisor provided reassurance to NHVs and focused on their competencies to add value to the initiative:

> Well this group [I] remember, that was, like, up in arms about [nurses to supervisor]: "We are not mental health professionals!" "We're not, you know." It's like [supervisor to nurses] "Okay, we're not but you know what, what are we?" "We're nurses". "We

> listen, we plan, you know, we're assessing, we're implementing." "Like we're doing this all the time, you know, we…we are capable." So it's like changing the mindset.

Inspiring nurse engagement was a responsibility of the supervisor in the encourager role, asking NHVs to bring case scenarios and challenges to team meetings for further discussion. Supervisors worked to make it as easy as possible for NHVs by having all resource materials ready for use, to save time for NHVs and to show support for them. This supervisor discusses the importance of keeping morale going, understanding the workload of their NHVs to be heavy, and wanting to support nurses by making access to resources as easy as possible:

> We want to do our best to maintain morale and we want to make it as good an experience as possible 'cause when you're in it, it is so challenging and again you are trying to learn this new interventions and you're trying to maintain your caseload and you know, again, the training took us out of the field for awhile so…and trying to catch up. It was very challenging so we tried to do what we could [provide resources] to make it easier for the nurses.

Mentor. Supervisors in the role of mentor were responsible for demonstrating behaviours and skills for the NHV to facilitate professional development and focused on individual NHV strengths. Supervisors modeled empathy, care, and respect, carrying on from where the counsellor role left off in reflective supervision as part of a parallel process strategy, to demonstrate these behaviours so NHVs could also employ them with their clients. Supervisors in the mentor role expanded beyond reflective supervision sessions, taking advantage of every opportunity to further coach and reinforce skills learned such a motivational interviewing. Supervisors challenged IPV learning of NHVs, facilitated IPV skill development, and helped

NHVs see their impact with the client during home visits. Differences existed between supervisors, however, with how well these responsibilities were executed. One supervisor utilized a passive, minimalist approach to the mentor role, and simply listened to the NHV:

> My door will be open and like, when a …nurse, like yesterday, like I have a chair right by the door. Like she came in and I [supervisor to nurse] go: "How's it going [nurse] you wanna have a seat?" "Yeah sure [nurse to supervisor]." So, like then she [the nurse] talks for like half and hour about, she didn't need any advice, she just needed to say, oh my god you can't believe this.

While this approach may have been of benefit for the NHV by enabling her own discovery and understanding of a situation, some supervisors actively engaged NHVs to actively assist in professional skill development as part of the mentor role. In this example, the supervisor was coaching the NHV about the importance of not only listening and asking questions of the client, but the NHV also needs to be "moving" (demonstrating a motivational interview technique) the client to the next step of the IPV intervention:

> "You know [supervisor to nurse], every time you listen to what she's [the client] saying, even if you've heard it ten times, it's helping, believe it or not." But you know, also to help them [nurses] figure out, using their skills, you know, how to move them [clients] to a different place or, at least try. Like…[it]isn't just about asking open-ended questions; it's about moving someone to another place.

A responsibility collectively shared by supervisors in the mentor role was the informal offering of their time to support NHVs with any challenges they may have been experiencing with the IPV intervention. Supervisors made themselves available and accessible in a variety of

ways: they accompanied NHVs for client home visits to become a second pair of eyes for difficult situations and they made themselves available by phone call, by text, or by office drop-in whenever the nurse needed additional support. Supervisors took these opportunities to keep the momentum of the IPV intervention moving forward, to apply the acquired IPV education curriculum, and for nurses to feel supported until they felt comfortable with the pathway and with the challenges they met. In this example, the supervisor discusses making herself available to the NHV by text, despite having competing work, to make sure she could respond to the NHV in a timely manner to help coach her through a client home visit and later follow-up with her during reflective supervision sessions:

> [supervisor about her nurse] …she knew I had several conference calls and meetings today but I told her: "If you get yourself in a situation and you're not sure, text me." I said, "That way I can…read a text and I can still be on a call." My goal with her is to just kind of hear what she says about what happened, what does she think this girl needs, what resources does she think she can provide and kind of just go through it like that and just…and that'll be on the forefront with this client, you know, over the next…every time we meet one on one.

Another supervisor describes the trusting relationship that existed between the NHV and the supervisor, demonstrated by the level of comfort the NHV had to stop by or call at anytime when needed:

> The nurses knew they just kind of come in at any point. Like not just during weekly supervision, but they could, you know, call if there were out in the field or if they needed

> anything to talk about, you know, a client may [not] have disclosed but the nurse might be having some feelings, like some red flags.

Supervisor Roles and Chronology

There was a loose chronology related to supervisor roles; however, most overlapped in the context of time and utilization. In general, supervisor roles were regarded to function as an integrated, interwoven system, with roles informing the action of other roles at any point in time. The supervisory role of planner, however, was the most concrete exception, with planning forming the first step for the supervisor relative to the integration of the IPV intervention. The supervisor's educator role subsequently followed the planner role and the roles of reporter, counsellor and mentor occurred in concert, or independently, once the NHV had acquired the IPV training and was directly delivering the IPV intervention. The roles of planner and educator, although present at the front-end of the intervention, did continue for the entire implementation of the IPV intervention: planning meetings, reviewing the IPV education curriculum with nurses and, facilitating new IPV-related education opportunities. The role of encourager functioned jointly with all level 2 roles at any point in time with the exception of planner where there was no interaction, and had little function with respect to informing the level 1 manager role and sub-roles of evaluator, collaborator, and developer. All other level 2 roles: planner, educator, reporter, counsellor and mentor did, however, have a function to inform the level 1 role of manager and its sub-roles and at any time.

Supervisor Experiences During the Implementation Process

The implementation of a new IPV intervention facilitated by supervisors into an NFP program that had already been established, was not without challenges. Supervisors described

five main experiences impacting the uptake of the intervention by NHVs: 1) Competing Priorities; 2) Feeling Overwhelmed; 3) Excessive and Inorganic Documentation 4) Expert Access and; 4) Fear and Safety.

Competing Priorities. Many supervisors discussed that during NFP NSO often introduced multiple new NFP innovations all at the same time, each requiring NHV training. Supervisors and NHVs described feeling overwhelmed as a result. For most innovations, the NFP NSO would provide an initial training or educational session. However, these NSO provided sessions were not sustained over the long term, and this meant that as supervisors hired new NHVs into their sites, they then were responsible for replicating the training and providing an orientation to the NHV on all of the new innovations, which during this time period included: 1) The Dyadic Assessment of Naturalistic Caregiver-child Experiences (DANCE); 2) Strengths and Risks Framework (STAR) and; 3) The IPV Intervention. With respect to providing an orientation to the IPV intervention, one notable stressor was that the nurse training had to be completed early in their onboarding period and before they completed a 4th home visit with a new client (the visit when the first IPV assessment would be initiated). They felt the introduction of these new NFP initiatives piled up on each other and, that there was not enough time to comprehensively implement them as needed, leading to the loss of important information. One supervisor described her feelings of the roll-out of multiple changes to the NFP program, expressing there to be too many and poorly introduced: “There’s been so many interventions or so many changes to the model, or a new form, a new process…that the national service office rolls out and they’ve rolled them out in such an ineffective manner.” Another supervisor discussed how it was overwhelming for NHVs to have so much to learn while also trying to establish a client caseload:

> We have the STAR framework. Now we have E guidelines…and then we have to do IPV. It's a lot. And then plus, you're [nurses] trying to build your case load, and you're [nurses] trying to learn all the NFP theories and principals and all of that. It's a lot.

Feeling Overwhelmed. Supervisors expressed that they observed many NHVs feeling overwhelmed during the implementation of the IPV intervention. This state of feeling overwhelmed appeared to have overlap with the challenge of competing priorities for NHVs as described above. Establishing the IPV intervention into an already busy NFP program, having to learn more than one new intervention at a time, and trying to keep up with other NFP quality improvement updates such as form changes and switching to electronic medical records (EMR) became overwhelming for NHVs. One supervisor added depth to the understanding of how NHVs experience overwhelmed feelings, discussing how over time, nurses were observed to demonstrate a "residual effect" from the continuous changes, with NHVs not as accepting of change over time:

> I'd just say it's a lot of information and that it feels overwhelming. So, very overwhelming to the staff [nurses]. And I'm really sensitive to that because what I've also learned is that this change stuff is residual; there's a residual effect…and so it's...it's almost like we live with Post Traumatic Stress Disorder because the reactions that I'll get from people...and I totally get it, like, I...there are moments when I will, a sense of, like, I don't know what the word is, will come over me and it...all it is, is just...it's a sense of overwhelmed-ness. So...I say it takes a lot of time; the [IPV] modules are time intensive and so...you have to be really careful when you integrate something and that your team is ready and that you're going to be totally focused on it and not trying to compete with you know, two or three other things.

Supervisors witnessed NHVs getting off-track, relative to which facilitators had been used and during which visit, requiring supervisors to consistently review what had been completed with NHVs.

Excessive and Inorganic Documentation. Supervisors described the charting of information relative to the IPV intervention to be too time consuming for NHVs and charting one visit with a client could take over an hour long. Finding time for NHVs to dedicate to charting was difficult. One supervisor discussed there being an impracticality to the intervention, with too many steps, too much paper and incorporating many facilitators (e.g. the power and control wheel) as part of the assessments. Additionally, supervisors felt there was a discrepancy between what NHVs actually completed in the visit, compared to what was documented; the NHV completed far more in the visit than documented.

In addition to supervisors observing time as a challenge to comprehensively complete documentation, one supervisor discussed the nature of the intervention as having a negative impact on the nurse-client relationship due to IPV documentation. The supervisor discovered that NHVs viewed their interaction with a client involving IPV discovery as a conversation with the client, however, in practice the NHV's ability to converse was affected by the need to incorporate documentation elements of the intervention into her conversation, and made it less conversational and relational.

Expert Access. Supervisors experienced value in having access to an expert during the implementation of the IPV intervention, to be able to ask questions and to have a person to go to if they needed extra support. The value of an expert was seen by most supervisors to be more at

the beginning of the implementation of the IPV intervention, when there are many questions and more support needed, rather than later in the intervention.

Fear and Safety. Supervisors described NHV safety and feelings of fear as a challenge while integrating the IPV intervention into nursing practice. When it was known that abuse was taking place in the home, NHVs at times became fearful of the abuser. Supervisors noted that these fears tended to amplify when the home of the client was situated in a remote or rural location. Isolated homes, long driveways, poor cell phone reception and in combination with the socio-demographic challenges within the home, were found intimidating for NHVs and challenging for the supervisor to navigate. Supervisors generated safety plans with NHVs prior to re-entry into the home. Additionally, many rural homes had guns in the home for hunting, compounding the fear that a gun in the home could be used to harm either the client or the nurse.

Supervisor Recommendations

Education. The IPV educational curriculum was welcomed as a valuable new resource by the NFP teams and fulfilled an educational gap as supervisors expressed that many NHVs lacked the resources or the tools to respond to IPV. Supervisors considered the NHVs' perceptions of the education curriculum to be comprehensive and that the tools for the IPV intervention were useful. Supervisors expressed that the IPV intervention education enabled NHVs with an improved level of IPV awareness, improved IPV understanding and improved capacity to respond to IPV; feeling more prepared and knowing what to do if they had a disclosure. According to supervisors, education prior to the IPV intervention was limited, with one-time training sessions offered and the expectation to administer associated interventions. Recommendations for education was to continue with the IPV intervention education, in its

comprehensive form, and to continue with the face-to-face format for all NFP sites. One supervisor felt so strongly for it to be maintained as face-to-face that she thought it would be better not to offer the education at all, as there could be more harm than good, if it wasn't face-to-face or if the site was not prepared for it:

> I think otherwise what I think is a potentially a really impactful intervention is going to get watered down, potentially be harmful, or…or ineffective. I feel like it's an effective intervention and everyone should have it. I think it's sad when I think about sites that don't have it. But only if they are prepared for it…But if it's all going to be distance learning I say just scrap the idea, it's not even worth it… Like that to me is the most important, is the face-to-face time, to be able to process, ask questions.

Another supervisor discussed the significance of face-to-face education, feeling that other NFP initiatives such as STAR, which was individual-based, had less merit in the eyes of NHVs because it was an online education module rather than a module completed in person. Although supervisors thoroughly supported the IPV education intervention overall, they felt that there were some enhancements that could be made. Suggestions included infusing more interactive modules into the curriculum to try to reach NHVs with different learning styles, assistance with understanding the laws of their own jurisdiction, a video that could be supplied that the NHV could watch with the client about IPV and effects on children, and providing more tools that assist to address non-physical dangers in the client's relationship instead of being weighted to the physical.

Supervisors frequently discussed an appreciation to have been first trained on the IPV intervention education curriculum prior to their NHVs and, expressed they felt more prepared to

assist NHVs as point people with areas they may find some struggle during their training. This was an area they valued and thought important to maintain if bringing the intervention to other sites. Supervisors felt they could benefit from more training than what was provided by the IPV intervention education curriculum, suggesting: trauma-informed care addressing adverse childhood experiences and maternal mental health, what local community resources need to be identified (e.g., shelters and authorities), and more training how to best support their NHVs and what their NHVs are going through.

Expert Access. Supervisors valued the opportunity to access a clinical consultant during the implementation process. With respect to other sites adopting the IPV intervention, there were variations on what kind of an expert they would recommend, however, most suggestions were to continue to have a clinical consultant, who has experience with both the NFP (processes) and IPV. Regardless, supervisors recommended the clinical consultant have a deep understanding of the IPV intervention's expectations, the curriculum, NFP background and goals, as well as reflective supervision. Further to this, supervisors discussed the importance of an expert to be accessible, approachable, and responsive. One supervisor discussed that she under-utilized expert support due to time-constraints and not having regular meetings scheduled. Another supervisor felt in addition to having a consultant like their current consultant, a nurse consultant that worked per region, would be helpful to have a follow-up with each site and support each site with tracking e.g., learning modules. On the other hand, one supervisor did not like the idea of having a nurse consultant as an expert. This supervisor felt that the nursing consultant is pulled in so many directions that there is not enough dedicated time for a nursing consultant to offer each site and discussed that a nationally dedicated group to the IPV intervention would be of greater benefit, in particular, to have consistency with the education

across the sites. In this example, a supervisor discusses the need for standardization in the form of a single clinical consultant when administrating the IPV educational curriculum to all staff, due to one site's interpretation differing from another's with respect to the curriculum:

> Being able to have a point person just so all the sites are carrying it out the same and being in fidelity to the clinical pathway. Because again there were I think even with our… when we came out with our new… it's not new, but our revised NFP curriculum, some sites' interpretation how to carry it out was different because they had not gone to NFP training for some time and it wasn't until we networked… they networked with us … we told them we just went to training and we were told this is the idea of how to carry out the curriculum as they were trying to present the curriculum how we did it in the past with packets and different things of that nature.

Standardization. There were variations in the use of the supervisor manual. Some supervisors discussed it as useful and employed its use for reflective practice if having a difficult time to answer questions, for training and keeping on track to maintain fidelity to the intervention expectations, and to assist with motivational interview skills; to be able to ask questions in a variety of ways. Approximately half of the supervisors found the supervisor manual useful, while the other half did not make use of the manual. Some used the manual more at the beginning of the IPV intervention implementation when they needed more support and found it helpful as a guide. Conversely, others did not find the guide useful. One supervisor discussed not using it very often, only when a new NHV was in training and used it as an occasional resource rather than a continuous guide. Another stated rather than using the manual she started "winging it" because of her own previous home visiting nursing experience and would consult the manual only in tough situations if needing more assistance. A third supervisor

discussed referencing the material to confirm she was offering the correct guidance to her home NHVs but only used it a couple of times. A fourth supervisor felt the manual was a good idea but not useful in its current state. Other supervisors felt the IPV facilitators and the curriculum were more useful than the supervisor guide itself and used both as a guide more often than the manual.

Supervisors discussed a variety of developed IPV intervention strategies that kept them on track. Supervisors explained that the NFP designed visit-to-visit guidelines helped them keep NHVs on track and, helped guide what to do and when for the IPV intervention. Checklists were helpful, although, not all were standardized and, many supervisors disclosed that they developed their own checklists to help keep them on track. Particularly valued was the checklist associated with the visit-to-visit guidelines to help home visiting nurses stay on track with the intervention. There was some overlap of how sites used guidelines, checklists and facilitators, however, there general was a lack of consensus about how supervisors tracked implementation progress. Additionally, there was a discrepancy between sites with respect to at least one site having migrated to electronic documentation and adopting the use of computers for NHVs, while other sites continued to use traditional paper-based methods. Several supervisors discussed that the clinical pathway was a tool that kept the intervention on track. Although supervisors did not have clear recommendations for standardization, it is clear from this discussion standardization for the implementation process could be improved.

Networking and Sharing Resources. The implementation of the IPV intervention at seven of the 15 NFP sites did not facilitate the collaboration between supervisors due to the requirements related to confidentiality for the RCT. One supervisor felt that for larger sites, where there was more than one supervisor, this made the process easier due to a built-in support

network that smaller sites did not have. Having more than one supervisor facilitated greater exchange of ideas and strategies, as well they could help each other out in their roles and responsibilities. Supervisors collectively recommended for the implementation of the IPV intervention at other future sites have a formalized opportunity to network and share resources with one another. The opportunity to have other supervisors as soundboards, learn from them, ask questions of one another, understand what is working well, sharing techniques, resources and scenarios was how supervisors expressed they would feel supported during the implementation of the IPV intervention.

Secondary Analysis of Nurse Home Visitor Focus Groups

From the focus group interview data, NHVs described their supervisors as assuming all seven roles: 1) Planner; 2) Educator; 3) Reporter; 4) Counsellor; 5) Encourager; 6) Mentor and; 7) Manager. With respect to the sub-roles in association with the manager role, NHVs discussed the evaluator and collaborator sub-roles but did not discuss the developer role of supervisors. Some roles were mentioned by NHVs in more depth than others during focus groups interviews. In particular, NHVs most often discussed the mentor role, with findings representing six of the seve NFP sites. Similarly, NHVs discussed the role of manager from six of seven NFP sites. Considering the role of manager to have support from three sub-roles and situated in overseeing the entire IPV implementation, it was not surprising that this role would be one of the most discussed. Nurse home visitors discussed more responsibilities relating to the role of mentor for supervisors than for responsibilities related to the manager role, perhaps, demonstrating its perceived importance among NHVs. After the role of mentor and manager, NHVs most often discussed the role of counsellor in three of the seven sites. This was not surprising given the relatedness of responsibilities between these two roles. Nurse home visitors referred least to the

roles of encourager, planner, and educator, with mention of only 1 or 2 responsibilities and represented by only 1-2 NFP sites. From this analysis, no new information came forward from NHV focus group to support roles that had not already been conceptualized; interviews reinforced the roles and responsibilities established by supervisors.

Mentor Role

Nurse home visitors verified the role of mentor also as a supportive function, discussing this role with respect to supervisors making themselves available and accessible for NHVs during the implementation of the IPV intervention. Several NHVs discussed supervisors as easily reachable by phone, and at any time that they were needed. One NHV described needing a supervisor to help her with an IPV disclosure she had with a client, another talked about brainstorming ideas and experiences with her supervisor in multiple formats: on the phone, in case conferences with other nurses, and 1-on-1 discussions. Nurse home visitors described the support received from supervisors in the mentor role as offering to join NHVs for a joint visit in the home, calling and facilitating a conversation about what could be going on in the home, and directly asking NHVs: "What can I do for you?" This example demonstrates the NHVs perception of the supervisor as dependable and available to help facilitate next steps with the NHV upon IPV disclosure from a client:

> I've had, two times, with the two disclosures, I've had to call her [supervisor] after the visit and ask "what do I do?" [Laughs]. And, you know, just her [supervisor] being available. And then her [supervisor] like walking, like, us [nurses] walking together through it, like what we should do.

The testimony from nurses is consistent with the supervisor's own description of the mentor role's responsibilities (see Appendix E, Table E1), where supervisors created opportunities of applied learning for the IPV intervention by making themselves accessible outside of a formalized meeting structure and reinforcing the information acquired from the IPV education curriculum. Supervisors in the role of mentor was also discussed by NHVs with respect to building on individual NHV strengths demonstrated within her practice, and coaching skill development such as demonstrating with NHVs how to use motivational interviewing skills.

Manager Role

Nurse home visitors frequently discussed the actions of the supervisor that aligned with the collaborator sub-role responsibilities of the manager role. Specifically, NHVs appeared to value the assistance of supervisors who had connections established to source community resources needed for client disclosure. Furthermore, NHVs found it important that supervisors helped them not only identify resources in the community but also keep resources up to date, conveying any changes to service with them since they did not have time to manage resources themselves.

Nurse home visitors appreciated the role of manager relative to supervisor's involvement with safety, how supervisors prioritized safety, and implemented strategies to support NHVs during the implementation of the IPV intervention. One NHV discussed how she personally felt valued by her supervisor's prioritization of her safety, instead of having a supervisor's motivation dominated solely by the success of the numbers related to the IPV intervention:

> And what I think is great, and is what makes this particular site so amazing is the fact that [supervisor] doesn't just focus on…we have to keep this number up. Our safety comes

> first, and I think that sometimes that gets lost in the translation for some supervisors. They get very adamant about you have to have this number, you can't drop that, keep that client whatever possible. But in this fact, she's that grounding that says, hey, what you're doing is not okay. And it is okay for you to drop this client for your safety, because what happens to you, to your family?

Counsellor Role

Nurse home visitors discussed supervisor responsibilities in the role of counsellor, how they assisted NHVs by providing an environment for debriefing, offerings of reassurance, brainstorming ideas, and developing strategies. One NHV described the supervisor's ability to calm her down and facilitate an exploration of feelings related to an IPV encounter with a client:

> My supervisor would just to be like calming me down because you get so, you're so upset that this person [IPV perpetrator] has hurt your client and you're so angry. And then you [nurses] start to, especially something happens, the blame game [toward self]. Did I miss it? Did I not do enough? Did I, oh my god, how could I miss that? You know? How did I not see that? Or I knew that guy wasn't—you know, you had a feeling but it's that kind of guilt, you take it personally.

Another nurse described feeling like she could "spill her guts" to the supervisor about what was happening in the client's home because of a feeling of openness, not feeling judged, and trust for the supervisor.

Planner, Educator and Encourager Roles

Supervisor responsibilities related to the roles of planner, educator, and encourager roles, were not described to the degree that the other roles above were. Nurse home visitors, however,

did confirm the responsibilities of the supervisor in the planner role to include setting the agenda for the team meetings, reviewing IPV curriculum as part of the educator role and making nurse feel successful as part of the encourager role.

In summary, secondary analysis findings from NHV focus groups supported the roles and responsibilities of supervisors characterized by primary analysis. There was no new contribution to primary analysis findings from the secondary analysis with seven roles and two sub-roles similarly represented, however, there was one sub-role (developer) and several responsibilities from the primary analysis that were not represented by secondary analysis, suggesting there may be findings from NHVs that have not been captured.

Chapter 4: Discussion

Within the cluster RCT, conducted to evaluate the effectiveness of the NFP IPV intervention in reducing women's experiences of violence and improving their overall quality of life, a process evaluation was embedded to document how this novel practice innovation was implemented and delivered by NFP teams (Jack et al., 2019). As part of that process evaluation, this purpose of this study component was to explore and describe the roles, responsibilities, and experiences of NFP supervisors facilitating the implementation process for the uptake of the IPV intervention by nurses into home visiting practice. To accomplish this task, supervisors provided leadership by assuming the roles of planner, educator, reporter, counsellor, encourager, mentor, manager, evaluator, collaborator and developer roles, sub-roles, and assuming responsibilities representing administrative, clinical, reflective and supportive domains of NFP supervision.

The process to implement a new innovation required supervisors to assume a complex system of interconnected roles and responsibilities that functioned in both the oversight and direct adoption of the IPV intervention. It is important to understand the functions of NFP supervisors to: 1) identify strategies to support supervisors with the innovation process of new innovation; 2) to ensure the responsibilities of supervisors are correctly aligned and; 3) to compare supervision functions between innovations and programs for advancement of supervision research in the field of home visitation.

This study has provided an in-depth examination of NFP supervisor functions and experiences specific to supporting the adoption of the IPV intervention within NHV teams and has led to development of an NFP supervision framework that conceptualizes the relationship between domains roles and responsibilities assumed by NFP supervisors. New understanding

from this study includes: 1) NFP supervision domains, roles and associated responsibilities are comparatively represented in the literature, and yet, a clear definition of functions and their relationship is greatly needed for meaningful comparisons of supervision and; 2) NFP supervision for the implementation process of the IPV intervention uptake has an associated hierarchy to its organization and, therefore, associated power structures could exist that require examination.

Supervision as a System

The functions of NFP supervisors were complex, with multiple responsibilities, sub-roles, and roles represented by overarching domains. These supervisor functions were relational, interactive, and interconnected, operating as a network with one another. The conceptualization of NFP supervision was equally complex, particularly due to the lack of clarity associated with current described supervision models and concepts. The functions of supervision were not clearly defined in home visiting research; a variety of descriptors were used without knowing how they relationally fit together, and this made comparisons between research studies (including this one) and disciplines (nursing and social work) particularly difficult. This confusion prompted the need to step back from simply describing NFP supervisor functions and shifted to defining and classifying functional categories. A language of supervision including domains, roles, sub-roles, and responsibilities was developed from this study to characterize the relationship of defined supervisor functions and conceptualized as the framework of NFP supervision (Figure 1).

Understanding both functions and their relationship was critical to characterizing NFP supervision beyond a mere description of completed linear tasks, and instead, authentically

represented NFP supervision as the relational, multi-faceted classification system it was. This is important in order to recognize the depth of facility by NFP supervisors, offer adequate supervisor support, and for the NFP Research Team to ascribe understanding to innovation success or failure, not only for the IPV intervention but for the future adoption of any NFP innovation. Considering the broader impact, this study has made a first step to initiating the conversation of supervision in home visiting research, by providing a language for communication and a framework of supervisor functions, enabling comparisons of the supervisor's implementation process between program innovations. Having the ability to analyze supervisor functions and communicate with a common language will contribute to further advancement by applying understandings of supervision within the field of home visitation. Additionally, understanding supervisor functions related to the implementation process can offer comparisons not only in the field of home visiting nursing but potentially as it applies to home visiting in other disciplines such as social work.

Supervision Hierarchy within the NFP Supervision Framework

NFP supervision emerged to have two levels of supervision, level 1 which was situated in oversight of all other supervision domains, roles, sub-roles and responsibilities, and level 2 with a direct supervisory function for the implementation process of the IPV intervention. Level 1 comprised the administrative supervision domain, involving the key supervisor role of manager, and further described by the sub-roles of evaluator, collaborator, and developer. Level 1 supervision was informed by level 2 supervision functions of the NFP supervision framework (Figure 1), and operated executively by assessing the IPV intervention, formulating collaborative responses, and developing new tools and solutions as challenges were encountered. Essentially, the implementation of the IPV intervention's clinical pathway could have progressed from start

to finish with only level 2 supervision functions, however, likely the results would have been far less acceptable (e.g. not assessing or addressing safety concerns) or successful (assessing adherence challenges to the IPV clinical pathway and responding). The level 1 functions of supervisors evaluated how well the IPV intervention was progressing, identified barriers to uptake, and designed meaningful solutions in response to met challenges. These functions attributed to the positive adoption of the IPV intervention into NHV practice and contributed to its implementation as intended by NFP Research Team. There appeared, however, to be different levels of facilitation experience from supervisors that had the potential to enhance the execution of level 1 functions. For the reason level 1 functions could impact the IPV intervention and improve the implementation of the IPV intervention, a greater level of attention by NFP Research Team could be given to confirm support for the execution of level 1 functions.

The classification of NFP supervision as a framework has identified NFP supervision to have an associated hierarchy with two levels of supervision, and how well level 1 functions are executed, is understood to likely have an impact on the quality of the IPV intervention. As a result, level 1 functions could be reviewed by the NFP Research Team to ensure that accountability for the IPV intervention's success is appropriately assigned to the right person, and consider whether this obligation should be assumed by an alternate leader within the NFP organization. Additionally, it should be explored whether there is a negative impact to supervisors facilitating level 1 functions. For instance, supervisors may be challenged to engage in both the exploration of a NHV's experience and feelings during implementation and be responsible to ensure there is adherence to the IPV clinical pathway.

NFP Supervision and Current Literature Comparisons

Within home visitation literature pertaining to supervision, seven broad domains of supervision were identified: 1) supportive (Gillet et al., 2013; Nathans et al., 2019; Pohl & Galletta, 2017; Kadushin, 1976); 2) clinical (Acheson & Gall, 1997; Baglow, 2009; Bogo & McKnight, 2005; Clifford et al., 2005; Eisner, 1982; Girling et al., 2009; Glickman, 1980; Goldhammer, 1969; Grauel, 2002; Jack, Busser et al., 2012; Proctor, 1987; Waskett, 2009; Wheatley, 1999); 3) reflective (Andrews, 2016; Beam et al., 2010; Eggbeer et al., 2007; Jack, Busser et al. 2012; MAIMH, 2020; Shahmoon-Shanok, 2009; Tomlin, Hines et al., 2016; Watson, Bailey et al., 2016; Weatherston, Kaplan-Estrin et al., 2009; Zero to Three, 2020); 4) administrative; (MI-AIMH, 2018, Grauel, 2002, Kadushin, 1976, Radley & Stanley 2018); 5) education (Kadushin, 1976; Radley & Stanley, 2018); 6) personal wellbeing (Radley & Stanley, 2018) and; 7) mediation (Schulman, 1982). These broad categories described supervision in the literature but, have not classified or adequately defined the supervision in the field of home visiting. For the purposes of having a meaningful discussion and comparing NFP supervision to the literature's findings, I had defined these broad concepts of supervision as domains in the results section (Chapter 3) and will continue to use this classification. Due to lack of formalized definitions and classification of supervision in home visitation research, I will attend to comparing supervision predominantly at its broadest domain level.

Comparing NFP supervision domains with domains of home visiting literature on supervision reveal a direct alignment of this study's four classified supervision domains: administrative, clinical, reflective, and supportive. Domains not represented by NFP supervision include education and mediation. In this study, education has been addressed, not as a domain of NFP supervision, but rather as the supervisor's role of educator. While education was certainly an important component of the IPV intervention, it was conceptualized to have a better "fit"

associated with the domain of clinical supervision rather than as a single domain on its own. Education was not a broad function relative to the IPV intervention; it was discrete and was represented better with the actions of the supervisor, categorizing it as the concrete noun of educator rather than as a broad abstract concept such as clinical supervision (its parent domain). Although education may not have been represented as a single domain, education as a role was certainly a component of the NFP supervision framework and represented more specifically as a role.

The domain of mediation was also not represented by NFP supervision system, its intent focused on mediating communication efforts between staff members and the systems involved to bring resolve (Shulman, 1982). This is an interesting find because not only is mediation not represented as a domain, it is not represented as a role, sub-role, or responsibility within NFP supervision. This could be explained by either: the supervisor interview questions may not have been specific enough to capture every domain, or the functions of the mediation domain were not facilitated by supervisors for the purposes of implementing the IPV intervention. The nature of NHV work, i.e. to address IPV experienced by young mothers and their children, and the safety challenges encountered by NHVs, would suggest that an explanation supporting the former to be more likely. Regardless, this is an important discovery and is worth consideration by NFP Research Team to ensure there is a viable communication strategy facilitated by supervisors to escalate issues experienced on the front-lines for appropriate response and policy review.

In examination of Radley and Stanley's (2018) understanding of personal well-being, this concept (representing a domain of supervision) appears to be inaccurate. Personal well-being has a greater level of refinement compared to the other domains and likely would be better represented by the broad concept or domain of reflective supervision than as a domain on its

own. Nurse-family partnership supervisors, for example, would explore the experiences of NHVs during reflective supervision sessions, creating an opportunity for NHVs to voice concerns and express their feelings. The function of personal well-being is for supervisors to emotionally support home visitors (Radley & Stanley, 2018). This refined function would be better represented by the domain of reflective supervision and represented as a responsibility.

When domains are presented in previous literature the domains are mostly presented in isolation and thus not represented as they are in this study, a "system" of supervision. For example, reflective supervision is extensively described by Zero to Three and MI-AIMH researchers (Eggbeer et al, 2007; MI-AIMH 1986; MI-AIMH 2016; MI-AIMH 2018; Parlakian, 2001; Shahmoon-Shanok, 2009; Tomlin & Heller, 2016; Watson & Heller, 2016; Weatherston & Barron, 2009; Weatherston et al, 2010), however, there is little communication of how reflective supervision relate to the other 5 domains of supervision, except overlapping somewhat with administrative supervision; the relationship remains unclear. One exception to this is with clinical supervision which seems to incorporate several other domains of supervision: education (Clifford et al., 2005; Goldhammer, 1969, Eisner, 1982; Glickman, 1980; Acheson & Gail, 1997), administrative (Proctor, 1987; Sloan & Watson, 2002), reflective (Clifford et al., 2005; Proctor, 1987), and supportive (Clifford et al., 2005; Proctor, 1987). Similar to other domains, literature associated with the clinical supervision domain does not clearly define this relationship and how functions work together. The supervision literature simply has not captured information in this way and has only described non-characterized functions of supervision, without an emphasis on analysis. This study appears to be novel to have characterized supervision as a system, defined its functions from broad to specific, and described their functional relationship to one another.

It is difficult to compare roles, sub-roles, and responsibilities of each domain from the general supervision literature with NFP supervision because these functions have not been defined, only described. Understanding NFP supervisor roles and sub-roles as they compare to the literature is facilitated more by extrapolation than by transparent assessment. Comparing by extrapolation, roles, and sub-roles unique to the NFP appear to be collaborator, encourager, planner, and reporter. These role and sub-role comparisons, without having clear functional definitions, may not be truly representative of the general literature. One explanation that could support these roles and sub-roles as unique to NFP, is the assignment of collaborator, encourager, planner, or reporter associated responsibilities may have been to an alternate member of the organization such as a manager, facilitator, team lead, nurse, or researcher, and the supervisor is was not directly accountable. Another explanation for unique NFP roles and sub-roles could be related to the uniqueness of the IPV intervention itself, and other innovations may not have required these specific functions. It is apparent from this study, further research is needed in the field of supervision and home visitation to better define supervisor functions and their relationship, to assist with meaningful comparisons and to advance development, particularly for the implementation process of new innovations. Defining and comparing are essential steps to elucidate an applied direction for research teams engaged in innovation implementation.

Study Strengths and Limitations

Trustworthiness

In qualitative research, the quality of a study is related to the trustworthiness of the inquiry process. Lincoln and Guba (1985) have established criteria of trustworthiness in

qualitative studies to include credibility, dependability, confirmability, and transferability. I will address each criterion and discuss strategies that were employed to establish rigor.

Credibility. According to Krefting (1991), critical strategies required to establish research quality and credibility include the concepts of reflexivity and triangulation. Reflexivity was attended by capturing my own perceptions and experiences related to home visitation, supervision, implementation, and program management in a personal journal beginning with the design of interview questions and was continued throughout the research process. As result, I was able to reflect and analyze my own understanding of these concepts and identify potential areas of bias. This awareness enabled an embedded process of self-checking and evaluation of bias as I progressed through the research phases (e.g. data collection and analysis), ensuring that my understanding of the data was from a place of truth, and in direct representation of the supervisor population. Triangulation was established by using different data sources and data types (Jack et al., 2015). Interview data was collected from NFP supervisors and a NFP manager. Focus group data was gathered from NFP NHVs. Convergence and divergence of themes was examined between data sets (Jack et al., 2015). Researcher credibility (Jack et al., 2015) is acknowledged for the data collection of this study, I have an intimate understanding of supervision, implementation, and home visitation in the field of nursing. Additionally, the interview guide was developed by an NFP clinical expert, who had extensive qualitative experience with the NFP program and the IPV intervention. Furthermore, the NFP expert had prolonged exposure to participant groups during IPV intervention implementation and facilitated a variety of IPV intervention-related experiences with all participants (Krefting, 1991). Interviewing technique (Krefting, 1991) used for this study incorporated an interview guide that

was developed and used universally for each participant group, interview questions were re-framed with participant responses validated (Jack et al., 2015).

Dependability. This criterion relates to the consistency of research's findings (Guba, 1981). A complete description of methods has been provided in this study for the collection and analysis of participant data and an audit trail of findings has been compiled as part of the inquiry process (Guba, 1981). Transcript data was coded and re-coded at separate time points as part of the analysis (Krefting, 1991). Triangulation was used as a dependability strategy (Guba, 1981) through the review of several different NFP data sources including published research pertaining to the IPV intervention, IPV manuals and related documents, interview transcripts and audio files from different participant sources (supervisors, NHVs, and manager), as well as different forms of data collection (interviews and focus groups).

Confirmability. Maintaining an audit trail throughout the research process is an essential element to the confirmability criterion and(?) associated trustworthiness (Guba, 1981). For this study, a written audit trail raw data was developed detailing perceptions, tensions and decisions made during the analysis of data sources. The designation of categories was captured as part of the audit trail, with supporting memos of interpretations and inferences made (Lincoln & Guba, 1985). Triangulation and reflexivity (Krefting, 1991) were additional strategies used to demonstrate confirmability of this study and described in the credibility section above.

Transferability. The applicability of research results (Krefting, 1991) from this study to the general NFP population has limitations. While several NFP sites participated and represent different geographical locations, the number of sites represented to offer the perspective of supervisors overall is small and cannot be expected to represent the experience of all supervisors

with different sized teams, geographies, and alternate programming models (eg. in other countries).

Secondary Data

Nurse home visitor focus group data could be a limiting factor for this study because the focus group interview questions were not designed for the primary purpose of exploring the supervisor role, and was intended to understand the perspective of the NHV during the IPV implementation. There was discussion about supervisors, however, that supported the functions they facilitated during the implementation process by NHVs.

Implications and Recommendations of Support for NFP Supervisors

The process of implementing the IPV intervention for NFP supervisors was complex and executed as an interconnected, cooperative relationship of domains, roles, sub-roles, and responsibilities. Recommendations to support NFP supervisors for the implementation of the IPV intervention, and future adoption of new NFP innovations into practice have been identified and are assembled into two main categories: 1) Commitment to the Implementation Process and; 2) Supervisor Education. Table 3 outlines recommendations and supportive elements of the implementation process, and each will be explained in detail to follow.

Table 3

Recommendations and Supportive Elements for the IPV Intervention Implementation Process

Recommendations	Supportive Elements

NFP Research Team and NSO Commitment to the Implementation Process	**Generate a Transparent Process**
	· Create process maps for the implementation process of the IPV intervention
	  · Define the implementation process
	  · Identify stages
	  · Identify steps
	  · Identify responsibilities
	  · Assign a version code to each map
	· Create a manual of implementation guidelines
	
	Improve Standardization
	· Identify and collect key performance indicators
	· Update standard work documents to reflect supervisor roles, responsibilities, and domains
	
	Mentorship
	· Determine the mentorship team for innovation facilitation
	· Identify experienced supervisor or facilitator (eg. nurse consultant) for supervisor mentorship
	· Determine skill building opportunities for supervisor (e.g. networking)
	· Schedule reflective supervision sessions with supervisor and experienced facilitator
	
	Embed a Quality Improvement Strategy
	· Identify the individual (e.g. nurse consultant) or team responsible for quality improvement
	· Identify resource gaps and respond
	· Examine supervisor roles and responsibilities, assess suitability
	· Define a communication process between NHVs and NFP Research Team to address challenges
	· Develop and disseminate standardized resources where gaps exit
	· Revisit and update process maps, policies, and documents with new versions as appropriate
	· Review supervisor roles and responsibilities, assess suitability
	· Evaluate progress with respect to clinical pathway and process adherence
	· Facilitate networking opportunities for supervisors
	
	Consider NFP Competing Priorities
	· Improve communication between NFP NSO and supervisors to determine current team workload
	· Strategize timing for launch of new NFP program enhancements

NFP Supervisor Education	**NFP Research Team Expert Led Training** · Introduce the NFP supervision framework, language of supervision, process maps and standardized work, key performance indicators · Train supervisors on IPV intervention curriculum, clinical pathway, guidelines, forms, check lists and related resources · Train supervisors on any new software, technology, or data collection strategies · Review supporting resources (e.g. best practice guidelines, theory, frameworks, and articles) · Present quality improvement strategy for the implementation process **Formal Education** · Learn communication skills and team building skills · Attend IPV-related conferences · Reflective supervision competency development · Attend an implementation science course

Commitment to the Implementation Process

Implementation direction from the NFP Research Team is a fundamental responsibility to ensure the IPV intervention, or future innovation, is assumed into practice as it was intended. Supervisors and NHVs of the NFP want to be successful with the implementation process and improve the NFP program for the benefit of young vulnerable mothers and children experiencing IPV. Committing to strategies for supervisors to make sure they are set-up with the implementation process supports to succeed, will be a critical function of the NFP Research Team. Essential recommendations to support supervisors with the implementation process of the IPV intervention and future innovations include: 1) generating a transparent process; 2) improving standardization; 3) providing mentorship; 4) embedding a quality improvement strategy; 5) considering NFP's competing priorities and; 6) facilitating supervisor educational opportunities.

The focus of implementation science is to support the systematic integration of research into healthcare practice (Nilsen, 2015) to respond to gaps between what currently exists and what would be an improvement for patient care (Casey et al., 2017). Implementation science frameworks are descriptive and suggest factors thought to enhance implementation outcomes (Nilsen, 2015). The field of implementation science is pragmatic and utilizes a multi-professional approach (Nilsen, 2015). While helpful, implementation frameworks are often criticized to do little to address the process itself (Casey et al., 2017; Nilsen, 2015). For these reasons, I will first describe, then pair the implementation process as described by Harvey and Kitson (2015) with lean team management strategy to offer suggestions focused on improving process quality (Miller, 2012) and advance the opportunity for IPV intervention implementation success.

Innovation Implementation and Quality Improvement Guiding Frameworks.

The Promoting Action on Research Implementation in Health Services Framework. As an implementation framework used in over 40 research studies, the PARiHS framework has been selected by researchers and healthcare providers to provide direction for adopting new innovations into practice (Harvey & Kitson, 2015). The facilitation process (or implementation process) of an innovation is considered the active ingredient of implementation (Harvey & Kitson, 2016). The PARiHS framework has been developed to serve as a heuristic tool for knowledge translation (Kitson et al., 2008). Its original version describes successful implementation (SI) of evidence into practice through consideration of the key elements: 1) the quality and the type of evidence (E); 2) the context (C) for evidence implementation and; 3) how the evidence is facilitated (F) into practice (Kitson et al., 2008). The concept of successful implementation is summarized by the equation: SI=*f*(E,C,F) where "*f*"denotes "function of" (Kitson et al., 2008).

The original PARiHS framework has since been revised as the i-PARiHS framework, where "i" refers to "integrated" in its title and the equation has changed to: $SI=Fac^{n}(I + R + C)$ where "Fac^{n}" relates to the construct "facilitation", "I" indicates the construct of "innovation" and replaces the former (E) evidence, "R" represents a new construct "recipient", and "C" remains the "context" for the innovation (Harvey & Kitson, 2016). The reasoning behind the framework modification, is relative to the iterative understandings acquired from the actual use of the framework in the disseminated research using the original PARiHS framework (Harvey & Kitson, 2015). Evidence has been switched out of the equation with innovation taking its place as an attempt to better represent how explicit evidence is utilized pragmatically, with local (or tacit) practical knowledge also incorporated with the evidence in its application, thereby

generating the innovation (Harvey & Kitson, 2016). Recipients were newly included as a construct to address researcher feedback that individuals or teams shaped by the intervention, also have a contributing effect on how the innovation is received, and can support or resist the intervention (Harvey & Kitson, 2016).

Authors Harvey and Kitson (2016) determined that facilitation should have a different positioning relative to its impact on successful integration, and therefore, facilitation was separated from the other constructs, signifying facilitation as the construct that "activates implementation through assessing and responding to characteristics of the innovation and the recipients (both as individuals and in teams) within their contextual setting" (p.6). Further to this, Harvey and Kitson (2016) assert that successful implementation is dependent upon "the ability of the facilitator and the facilitation process to enable recipients within their particular context to adopt and apply the innovation by tailoring their intervention appropriately" (p.6). I will apply the i-PARiHS framework (Harvey & Kitson, 2015) as a tool to assist with understanding the stages of the implementation process and provide guidance around support for supervisors as *novice facilitators.* Please note the terms: *facilitation* process by Harvey and Kitson (2015) and *implementation* process by this study are interchangeable and characterize the same concept.

Lean Team Management Philosophy in Healthcare. Lean team management has its roots in the Toyota Production System, it is focused on organizational process, and has been adapted to improve healthcare delivery both in hospital and for home health (Miller, 2012). Lean management principles in healthcare can be summarized as: 1) continuously striving for improvement; 2) experimenting with scientific methods (like evidence based practice implementation) to daily work practices; 3) respecting health care providers and their expertise;

4) eliminating waste to reduce cost and improve client experiences; 4) blaming the process not the people, encouraging organizations to become experts in their processes; 5) fostering a culture of teamwork; 6) promoting joy in the workplace and; 7) creating interruption free flow of care and eliminating time waste (Miller, 2012). Lean has been used to improve care processes in health care by using value stream mapping (Ng et al., 2010), process mapping (Cima et al., 2011; Reznick et al., 2014), standardized work (Vats et al., 2011), a team approach to problem solving (Yusof et al., 2012), defining and displaying measures, and analyzing variances (Miller, 2012). The scope of this study is focused on the implementation process for NFP supervisors. Identified lean methods to shape recommendations for NFP Research Team commitment and support NFP supervisors include: process mapping, standardized work, displaying measures, and analyzing variances for an embedded quality improvement within the implementation process.

Generate a Transparent Process. Maintaining fidelity to the IPV intervention was an expectation of supervisors and NHVs by the NFP Research Team. For supervisors and NHVs to be accountable to the IPV intervention, they need to clearly understand what the expectations are, and they need to know what they are each specifically accountable for. Resources were developed to help inform supervisors and NHVs about the IPV intervention and help guide the implementation process and included: a clinical pathway, an IPV training curriculum for NHVs, an IPV intervention: enhanced curriculum manual, and an IPV supervisor implementation manual. The supervisor's manual was a document that did not provide the guidance needed relative to the breadth and depth of a supervisor's roles and responsibilities. Within the *IPV intervention: NFP curriculum enhanced manual* there were descriptions of nursing competencies, but competencies were not outlined for supervisors. The IPV intervention manual was helpful for NHVs to understand their responsibilities and roles, however, did not explain

roles and responsibilities for supervisors. Essentially, supervisors had to extrapolate their roles and responsibilities from the those outlined for NHVs, leaving room for a subjective interpretation between supervisors and sites. Additionally, it was not clear how responsibilities of the NHV and supervisor coordinated with one another within the implementation process as "recipient" users (Harvey & Kitson, 2015).

Supervisors need two implementation process-related documents for the IPV intervention detailing: 1) a break-down of all implementation elements for recipients and; 2) an improved supervision manual to assist with the implementation process. When there is ambiguity in a process and the ownership of the process is not clearly understood, process maps are a tool used in home visitation to help create a visual picture and clearly represent a process' steps (Miller, 2012). Process mapping, also known as value stream mapping, is most often performed by management teams with the goal to optimize and define the workflow of a process; recipient users will know what they are doing by understanding the process' steps and who is responsible (Miller, 2012). Process maps detail the work that will be carried out by a specific team or individual and can be presented as a macro (high-level overview) or micro view (detailed version) of the process (Miller, 2012). A macro map for instance, would detail the entire implementation process associated with the IPV intervention and a micro map would focus on a single core process of implementation (e.g. education).

Define the Implementation Process. Prior to this study's completion, the resources developed for the IPV intervention focused directly on implementation itself by NHVs, not the implementation process, and while NHV responsibilities were generously addressed, defined supervisor responsibilities were exceptionally lean. Both supervisor and NHV responsibilities need to be combined, to better define the implementation process, and to clearly identify

accountability for recipients. It is recommended that a process map for the implementation process be created. This map would clarify responsibilities aligned with the IPV intervention and assign them to a specific recipient, thereby, presenting a transparent process for the implementation team. Initially, it is recommended the NFP Research Team take responsibility for developing the first version of an implementation process map, and the experienced facilitator (or mentor- to be described below) be responsible for its updating ongoing. To do this, the IPV intervention's implementation process would need to be broken down into stages and steps for which responsibilities and recipients could be assigned. Six existing resources are suggested for consideration in the generation of an implementation process map for the IPV intervention: 1) Harvey and Kitson's (2015) i-PARiHS framework; 2) NFP supervision framework (Figure 1); 3) IPV intervention manual (detailing NHV responsibilities); 4) IPV intervention clinical pathway; 5) IPV supervisor implementation manual and; 6) NFP supervisor associated role and sub-role responsibilities (Appendix E, Table E1).

Identify Stages. According to Harvey and Kitson's i-PARiHS framework (2015) the facilitation (or implementation) process for new innovations consist of four key stages: 1) *clarify and engage*, where a team is assembled to brainstorm and develop the innovation in relation to context; 2) *assess and measure* occurs to determine recipient acceptance of the innovation and how it will be measured; 3) *action and implementation* involves the execution of the innovation by utilizing successive cycles of the plan, do, study, act (PDSA) strategy, combined with evaluation and iterative improvements for each cycle and; 4) *review and share* is when team members reflect on the innovation, report findings and build networks through engaged scholarship. These 4 stages could serve as a scaffold of the implementation process for the IPV intervention or future NFP innovations and will be described further.

Identify Steps. From the four stages from Harvey and Kitson's i-PARiHS framework (2015), the action and implementation stage (stage 3) of the implementation process can be applied most with respect to the work of NFP supervisors and NHVs for the IPV intervention, therefore, will be focused upon for the purposes of this discussion but all stages, steps, and recipients would require identification. All four supervision domains, seven roles and three sub-roles articulated in this study occupy the action and implementation stage. Supervisor roles and sub-roles from the NFP supervision framework (Figure 1) could specifically be used to develop the steps involving supervisors for the action and implementation stage of the implementation process: planning, educating, reporting, managing, evaluating, collaborating, developing, counselling, encouraging and mentoring. To clarify, however, supervisor roles and sub-roles could be used to identify steps, but not necessarily become the steps. Like steps in any process, there should be a flow, and the priority would be to make sure steps having an associated chronology with one step following the other in time. Identified steps require a logical ordering within each stage. In addition to using supervisor roles to characterize steps, the IPV clinical pathway, IPV supervisor implementation manual, and the 5 *NHV competencies* (developed in the IPV intervention manual) could be leveraged to develop steps within the action and implementation stage.

Identify Responsibilities. Once steps are identified for each stage, responsibilities can be identified and assigned to each recipient. For the IPV intervention, this study has already captured responsibilities identified by supervisors during the implementation process in (Appendix E, Table E1) and could be used to guide the identification of supervisor responsibilities for each step within the action and implementation stage. Responsibilities for NHVs could be articulated from the IPV intervention manual. Any additional recipients should

have their specific steps and responsibilities identified for this stage as well. Essentially there should be an "owner" assigned for each responsibility (Miller, 2012). The responsibilities and owner for each responsibility can be mapped diagrammatically as a linear flow within each step, and for each stage of the implementation process. Once a process map is finalized, a version code can be attached to the map and with each change made to the process, the process map should be updated, and a subsequent version code should be assigned to the map.

Having a transparent process is helpful so that owners of responsibilities know what they are accountable for and feel confident to either execute or question where they may need for additional clarification. When recipient users are working from the same document, they understand not only their own specific roles, they understand the roles of all recipients and how they fit together as a bigger picture. Understanding the bigger picture provides meaning for an individual and for teams, giving a sense of purpose to the daily work, innovation, or program being adopted. Further to this, a sense of purpose can result in a satisfying work environment, less stress, and higher employee retention. A clear process could also positively impact the quality and accomplishment of innovation goals. Additionally, when there is a clear process work can be analyzed, teams can identify when there is an imbalance in responsibility, and workflow can be optimized to improve both time management and the sharing of responsibility (Miller, 2012).

Implementation Process Manual for Supervisors. A manual currently exists for the IPV intervention to support supervisors; however, supervisors require more supportive guidance than the manual provides. In the previous section, the generation of an implementation process map was recommended. A process map provides an outline of who does what responsibilities within a particular order but, does not detail the "how" responsibilities should be implemented. The

implementation process manual for supervisors should be an extension of the process map, providing depth of explanation to the implementation process, detailing supervisor roles and responsibilities in relation to steps and stages. Supervisor domains could also be identified in this document, using the language of NFP supervision, promoting consistency, and understanding of supervisor functions for the IPV intervention.

The *IPV intervention: NFP curriculum enhancement manual* was written to attend specifically to how the IPV intervention should be implemented by NHVs and already does well to identify the roles and responsibilities for NHVs during the implementation process. Once a process map is generated for the implementation process of the IPV intervention, this document may need only minor modification due to the depth roles and responsibilities have already been described for NHVs. Additionally, a clear identification of what are the NHV roles and what are the associated responsibilities for each NHV role, may be a useful exercise to provide consistent understanding of NHV functions for all NFP sites. Essentially, all recipients for the implementation process should not only be identified and included in the IPV intervention process maps, but a manual for each recipient should be provided detailing roles and responsibilities.

Improve Standardization. Differences existed in the depth that supervisors adopted their roles and responsibilities between sites that participated in the IPV intervention arm of the RCT. Naturally, there will variation when adopting a new innovation based on a supervisor's level of experience with implementation and their associated skill set; however, divergence in the facilitation process can be minimized by improving standardization where possible. The NFP Research Team has already generated documents and sourced tools for the IPV intervention that create some standardization for the implementation process. The intention would not be to

change many of these resources, but rather, augment what already exists. The exception for this would be with providing updates to the *IPV intervention: NFP curriculum enhancement manual* and supervisor's implementation manual. Creating process maps, also previously described, would serve to augment existing tools and resources. Other resources recommended to enhance standardization will be described to follow with the intention that standardization will help support supervisors in the same way across all sites and eliminate any guesswork or uncertainty.

During the delivery of the IPV intervention, supervisors experienced gaps in the process and responded by creating their own checklists and trackers so they could maintain adherence to the clinical pathway. New tools were created independently by supervisors and there were variations from one site to the next. Variance in process performed by supervisors equate to a problem (Miller, 2012). When a gap exists in the process, it is likely that other sites are experiencing the same challenges, and once identified, should be responded to by developing standardized resources and approaches for all sites to use in the same way. This would be part of a quality improvement strategy and a way to improve standardization for all sites (will be discussed further to follow). In addition to developing standardized resources where gaps exist, other methods of standardization could include monitoring key performance indicators, such as client retention (Miller, 2012) or client disclosure for example. Key performance indicators could have periodic review by supervisors, NHVs, and experienced facilitators or the NFP Research Team. Collecting the same key metrics across sites would foster an opportunity for discussion where differences exist between IPV intervention sites during implementation, help teams understand how they are performing, and assist with strategies on how they can improve.

Organizations generally have standard work documents describing the roles and responsibilities of each position's title e.g. manager or supervisor. Updating NFP standard work

documents for NHVs and supervisors relative to the IPV intervention, may not require a full update. The two implementation manuals (the curriculum enhancement manual designed for NHVs and the suggested implementation process manual for supervisors) would be sufficient to refer to in the standard work document for the IPV intervention element. Depending on the other recipients involved in the implementation process, additional manuals may need to be developed for their specific roles and responsibilities and their work referred to in respective standard work documents.

This study has described a language of supervision to include domains, roles, and responsibilities and discussed the importance of maintaining the language of supervision to compare and analyse supervisor functions across NFP sites to maintain consistency for the implementation process of the IPV intervention and future NFP innovations. The implementation manuals for NHVs and supervisors would be an opportunity for the NFP to maintain the language of supervision and enhance standardization for innovation implementation across sites. The language of supervision would facilitate directed comparisons of supervisor functions between sites and help to understand any differences in IPV intervention uptake.

Mentorship. The implementation of the IPV intervention occurred within the context of an RCT and adoption was limited to seven sites in the intervention arm of the trial. Mentorship support for IPV intervention uptake was provided by a one clinical consultant from the NFP Research Team and no programmatic or organizational support was received by supervisors from the NFP nurse consultants. Typically, the NFP nurse consultants would provide extensive support to supervisors and NFP teams under conditions where sites are required to adopt an NFP-sanctioned innovation. The single clinical consultant was accessible to supervisors in mentorship via teleconference after the initial training was complete for monthly scheduled

meetings and as needed by the supervisor. While some supervisors did utilize this remote support structure as needed, others only participated in the required monthly meetings. Consequently, NFP supervisors were likely under-supported for the implementation process of the IPV intervention and needed more mentorship, more often. Although the clinical consultant was accessible, the remote monthly meetings (when confirmed or supported by the supervisor) via teleconference for supervisors was not enough to mentor and support the daily responsibilities they performed. Furthermore, without a formalized structure outside of the scheduled monthly meeting, variations in clinical consultant engagement were present and may have contributed to a better uptake of the intervention for some sites over others. Variation in process from one supervisor to the next requires assessment and the introduction of standardization in the form of change process, supplies, tools, or human performance to prevent associated system waste such as loss of time and finances (Miller, 2012).

Referring to the i-PARiHS framework, facilitators of an intervention can be a team or an individual, and are represented by three levels: novice, experienced, or expert (Harvey & Kitson, 2016). Harvey and Kitson (2016) recommend that facilitators should have a "buddy" relationship, and a novice facilitator should be paired with a more experienced facilitator as a source of support offering guidance. With respect to adoption of the IPV intervention, the NFP supervisors in this study were novice, individual facilitators, with responsibilities focused at the local organizational level. As highlighted in Table 1, when faced with the responsibility of adopting a new innovation, novice facilitators should focus on: 1) the evidence surrounding the innovation; 2) understanding the recipient's culture, motivation and readiness for change; 3) the impact of the innovation at the local site and broader organizational level and; 4) planning, implementing, and measuring the innovation as change agent to previous program practice.

Table 4

Facilitation Levels for the NFP IPV Intervention Context

Experience	Facilitation Area of Focus
Novice facilitator	Working under the supervision of an experienced facilitator Focus on: What the IPV intervention is; what evidence informs the intervention and how to assess and apply it Readiness to change for adopting the IPV intervention at a local, NFP site, level What motivates individual NHVs and NHV teams and how NHV teams work effectively What the context is; what impact does the NFP site's context have on the IPV intervention's implementation at a local, NFP site, and NFP organizational level Planning, implementing, measuring and embedding change related to the IPV intervention
Experienced facilitator	Working under the supervision of an expert IPV innovation facilitator Focus on: In depth understanding and knowledge of the NFP organization or organizations the NFP are working with Awareness of competing tensions (internal and external to NFP) and how to manage these in relation to implementing the IPV intervention In depth understanding of NHV individual and team motivation, NHV team dynamics and productivity Experienced and knowledgeable in local NFP site-context evaluation Able to assess system-wide IPV-related activities and influence IPV-related actions Aware of wider contextual issues (e.g. IPV-related laws, regulations, policies, reports) and confident in terms of negotiating boundaries and political tensions as they relate to the IPV intervention.
Expert facilitator	Expert facilitator operating as a guide and mentor to other IPV intervention facilitators Focus on: Coordinating and supporting NFP-IPV networks of experienced and novice facilitators Working with health systems to improve IPV intervention implementation success Working across academic, service and other organizational boundaries to integrate IPV intervention facilitation and research activity Developing and testing theories of implementation, innovation and facilitation Evaluating IPV intervention implementation and facilitation interventions to generate new knowledge Refining and improving IPV intervention learning materials and IPV intervention mentoring processes Running IPV intervention workshops and advanced master classes on IPV intervention facilitation approaches

Note. Adapted from "PARIHS Revisited: From Heuristic to Integrated Framework for the Successful Implementation of Knowledge into Practice," by G. Harvey and A. Kitson, 2016, *Implementation Science, 11,* p.8.

Over time, individual NFP supervisors or clinical consultants that they report to might identify them as experienced and expert facilitators, thus, changing the focus of their roles.

The implementation of the IPV intervention required a high level of accountability from NFP supervisors, and this work represented only a portion of their total workload. The NFP Research Team will need to consider integrating a more supportive form of mentorship for NFP

supervisors, as novice facilitators, while adapting new innovations to practice with their NHV team. Mentorship support would include pairing NFP supervisors with more experienced mentors such as a nurse or clinical consultant. This mentorship is suggested to occur at frequent intervals and ideally in-person, to enable the development of new facilitation skills for the novice facilitator and help them move to an experienced level of innovation facilitation. Considering the complexity of the IPV intervention and degree of accountability for the supervisor, the experience also of the NFP supervisor (not just NHVs) during implementation is critically important and, therefore, the experienced facilitator should engage in a parallel process of reflective supervision with the NFP supervisor. This engagement will not only assist NFP supervisors to feel supported in their many roles, but it will also inform the quality improvement strategy for the IPV intervention or for any new innovation being implemented (to be discussed in the next section). Ideally, experienced supervisors should also have mentorship, from an expert level consultant, creating a team-based approach to mentorship and supporting supervisors or facilitators at all levels.

In summary, mentorship recommendations for the NFP Research Team include: 1) determine the levels of mentorship required for the innovation (see Table 4) and create a mentorship team or identify individual facilitators for each NFP site; 2) pair supervisors with an experienced facilitator who will directly support them for innovation implementation and; 3) enable reflective supervision sessions between experienced facilitators and supervisors to uphold the parallel process of reflective supervision to benefit supervisors. Supervisor mentorship from an experienced facilitator will provide improved consistency for innovation implementation for all sites, develop a competent facilitation team, and reduce the stress associated with a heavy accountability for supervisors, as novice facilitators, during implementation.

Embed a Quality Improvement Strategy. Supervisors took it upon themselves (as part of their developer sub-role) to develop their own tools, checklists, and trackers to assist with the implementation process of the IPV intervention. This was an unstructured effort by supervisors and in response to the needs or gaps exposed during the active implementation of the IPV intervention. Resources were developed as needed by supervisors, independently, and without coordinated organizational support. The NFP Research Team would be encouraged to integrate a quality improvement strategy for the IPV intervention and new NFP innovations, responding to this need of sites to develop new resources while newly adapting innovations to practice. With this strategy, one resource, tool, or process could be developed for all sites to use to answer a particular challenge, thereby, improving standardization across all sites and providing equal access and opportunity for implementation success. Identifying an individual or team responsible for quality improvement for the IPV intervention or future innovation for each site, and all sites, would be a recommended step in this strategy.

The IPV intervention required supervisors to adopt a multitude of roles and responsibilities for which the level of associated complexity was largely unknown. As demonstrated by this study, there was a hierarchy to supervisor roles in relation to the IPV intervention's implementation process, which required the supervisor to endorse roles and responsibilities that they may not have had to engage prior to the IPV intervention. To clarify, I pose the question: Should the manager role and associated responsibilities belong to the NFP supervisor, or to a more qualified designate such as the NFP organizational position of manager or a more experienced facilitator? Equally, Should the accountability of level 1 roles and responsibilities as part of the administrative supervision domain (see Figure 1), be assumed by the NFP supervisor or be assigned to an alternative NFP organizational position? Perhaps there

is a conflict of interest for the supervisor in occupying both a counselling role and a manager role, or there may be identified barriers for the supervisor facilitating both roles. As part of a quality monitoring process, it is recommended that the NFP Research Team examine supervisor roles and responsibilities and assess whether they are properly aligned to the most suitable employee.

Comparing supervision domains between the NFP and the literature identifies a potential area for future development, specifically in relation to the mediating supervision domain. The mediating supervision domain was an area of supervision that was not represented by roles or responsibilities of NFP supervisors. Within the mediating supervision domain, supervisors are responsible for communicating front-line concerns with leadership teams to address system-level challenges (Baglow, 2009). The very nature of NHV work involving the assessment of intimate partner violence in homes has an associated potential of risk to safety for both the NHV and the client. For this reason, it is recommended as part of a quality improvement strategy to have a communication process (linked to NFP policy) designed by the NFP Research Team, outlining how to escalate issues involving safety or risk to safety. Furthermore, the NFP Research Team should provide a schedule for communication exchange with supervisors, or experienced facilitators, to review all other (non-urgent) front-line challenges during implementation of the IPV intervention.

As part of the quality improvement strategy, the responsible quality individual or team will need to review standardized documents and update all resources, maps, policies, protocols, manuals etc. periodically during the implementation process of the IPV intervention, to accurately reflect changes and improvements to the implementation process. Version codes should be assigned to all documents and updated as new versions are added.

Scheduled and structured opportunities between the supervisor, experienced facilitator and appointed quality improvement individual or team would be helpful to formally review the progress of the implementation process relative to clinical pathway and process map adherence. Supervisors stated a higher amount of support was required in the beginning of the implementation process; likely more challenges would present themselves at initiation of the implementation process. It would be recommended; therefore, that more frequent interaction take place between the supervisor, an experienced facilitator and quality improvement representative(s) at the front-end of the implementation process.

Finally, novice NFP supervisors to the implementation process should have exposure to skill development as part of their journey toward experienced facilitator. As suggested by Harvey and Kitson (2015), this would include exposure to other networks such as the NFP Research Team, local and regional stakeholders, and academic influencers.

Consider NFP Competing Priorities. The roll-out of new innovations, education, and documentation (forms) has been described as overwhelming for supervisors and NHVs, with their occurrence often concurrently with other NFP program expectations. Considering the lLean principle of respecting for employees as the experts (Miller, 2012), one of the supervisor's own recommendations was for NFP NSO to stagger the launch or strategically introduce program enhancements as able. This would certainly be a reasonable and feasible request. Ideally, supervisors would be consulted with respect to the timing of planned improvements, especially for complex innovations such as the IPV intervention. Involving supervisors in some of the decision making around the timing of innovation implementation can help them and their NHVs be better prepared, alleviate some of the stressors in their daily work, and provide a collaborative work environment where they feel valued.

NFP Supervisor Education

NFP Research Team Led Training. The IPV intervention curriculum training consisted of one facilitated half-day training session for NFP supervisors, one structured on-site NHV training session, a scheduled monthly meeting via teleconference, and limitless "as needed" tele-conference sessions with an (expert) clinical consultant, initiated by the supervisor. Additionally, the NFP supervisor had access to an IPV implementation manual designed to assist completion of the site-readiness assessment and checklist, to ensure expectations of training NHVs were met, and to offer reflective supervision guidelines to help supervisors respond to potential NHV scenarios during reflective supervision sessions. Supervisors greatly appreciated completing the IPV intervention education prior to their NHVs, so they could be better prepared to support their NHVs while they were being trained. The education was considered comprehensive and highly valued by all supervisors and NHVs. No change, therefore, would be recommended to the IPV intervention education curriculum materials.

While supervisors may have understood the IPV intervention well, supervisors did not receive training on the implementation process itself. The recommendation is for supervisors to receive additional expert led education (see Table 4), introducing the NFP language of supervision and the NFP supervision framework (Figure 1), supervisor roles and responsibilities (Figure 2), IPV intervention process maps, standard work as a supervisor IPV intervention implementation process manual and curriculum enhancement manual, key performance indicators (how to collect and display), and the quality improvement strategy for implementation. Further to this, supervisors should be trained on any new software or technology required to facilitate the IPV intervention. Finally, any associated policies developed for the IPV intervention should be reviewed with supervisors.

Supervisor education is recommended to incorporate local or national guidelines for implementation of evidence. In Ontario, Canada, for example, The Registered Nurses' Association of Ontario has developed a toolkit of how to implement best practice guidelines, and the assessment of barriers and facilitators are an identified step in the implementation process (Registered Nurses' Association of Ontario, 2012). Leveraging existing guidelines would help anchor supervisors in their assessment skill development for example, essential for level 1 supervision.

Formal Education. Communication is a key element that is integral to all of the NFP supervisory roles and sub-roles. The ability to convey information in a meaningful, transparent and respectful way would be a formidable skill for supervisors to learn and would be a skill worth mentoring to NHVs, similar to how motivational interviewing skills are mentored.

Mining for IPV-related resources was a responsibility of supervisors to respond to the local needs of NFP families and NHVs supporting families. The development of IPV-linked networks could be established by sending supervisors to local academic conferences involving IPV or domestic abuse themes and would support supervisors by expanding their connections and resource options.

NFP supervisors engaged in weekly reflective supervision sessions with their NHVs and were accountable in the role of counsellor to understand NHV feelings and experiences associated with the delivery of the IPV intervention, to identify barriers to implementation and help NHVs strategize prospectively. Supervisors would benefit from education to support reflective supervision competency development. Zero to Three is an organization the NFP has utilized to develop previous reflective supervision strategies. As part of their learning centre,

Zero to Three offers onsite reflective supervision sessions, webinars, and training for supervisors to observe and practice associated key skills (Zero to Three, 2020).

Successful implementation of the IPV intervention was the purpose and goal behind the 10 roles and sub-roles of NFP supervisors. As facilitators of the implementation process, supervisors would benefit from an implementation science, or research action course, to understand methods that motivate the uptake of clinical-based interventions into practice (Bleich & Jones-Schenk, 2019). This would advance supervisor competencies for successful implementation and would supportively assist the transition of NFP supervisors from novice facilitators to experienced.

Conclusion

The NFP supervision framework developed through this analysis is represented by a language of supervision defined as domains, roles, and sub-roles, and is enacted by NFP supervisors to facilitate the implementation process of the IPV intervention. A language of supervision has been developed in the context of the NFP program, however, in the field of home visitation research involving the functions of supervisors, terms to clearly define supervision in this context are lacking and the NFP supervision framework developed here could be useful as a first step to lucidly define supervision and remove ambiguity. Utilizing the same language of supervision in this field will enable direct comparisons of supervision between innovations and programs, fostering the identification of meaningful implementation strategies in home visiting. The NFP supervision framework of supervision characterizes four domains, seven roles, and three sub-roles facilitated as a interconnected system by supervisors during the adoption of the IPV intervention into NFP practice and embodies two levels of supervision, one functioning in

oversight and the other associated with direct implementation. This understanding signifies a hierarchy to be correlated with NFP supervision and should be reviewed to determine whether IPV intervention responsibilities are correctly aligned. The NFP supervisor domains, roles and sub-roles, as well as associated responsibilities, exemplifies a complex system that supervisors are accountable to facilitate. Recommendations to support supervisors include an enriched commitment by the NFP Research Team to clearly characterize and standardize the IPV intervention implementation process, assist with mentorship, ensure quality improvement, and facilitate greater collaboration with supervisors. Finally, improving informal and formal education opportunities would assist supervisors in the development of competencies in the areas of communication, reflective supervision, networking, and implementation science.

References

Acheson, K. A., & Gall, M. D. (1997). *Techniques in the clinical supervision of teachers* (4th ed.). Longman.

Alhusen, J. L., Ray, E., Sharps. P. W., & Bullock, L. (2015) Intimate partner violence during pregnancy: Maternal and neonatal outcomes. *Journal of Women's Health, 24*(1), 100-106. https://doi.org/10.1089/jwh.2014.4872

Andrews, L. (2016). Family Nurse Partnership: Why supervision matters. *Nursing Times, 112*(3-4), 12-14.

Andrews, L., & Oxley, A. (2015). Supervision in FNP: A reflection on practice. *International Journal of Birth and Parent Education, 3*(2), 25-28.

Austin, J. (2020, June 23). *Supporting public health nurses to work with vulnerable and at risk Children and families: Informing the development of a specialist management role.* [Unpublished doctoral dissertation]. The School of Social Work, Trinity Clooege Dublin. https://www.tcd.ie/swsp/assets/pdf/Dissertations%20CPW/Austin,%20Jackie%20secure.pdf

Austin, J., & Holt, S. (2017). Responding to the support needs of front-line public health nurses who work with vulnerable families and children: A qualitative study. *Journal of Contemporary Nurse, 53*(5), 524-535. http://dx.doi.org/10.1080/10376178.2017.1330661

Baglow, L. (2009). Social work supervision and its role in enabling a community visitor program that promotes and protects the rights of children. *Australian Social Work, 62*(3), 353-368. https://doi.org/10.1080/03124070902964632

Beam, R. J., O'Brien, R. A., & Neal, M. (2010). Reflective practice enhances public health nurse implementation of nurse-family partnership. *Public Health Nursing, 27*(2), 131-139.

https://doi.org/10.1111/j.1525-1446.2010.00836.x

Bertacchi, J., & Coplon, J. (1989). The professional use of self in prevention. *Zero to Three Journal, 9*(4), 1–7.

Bleich, M. R., & Jones-Schenk, J. (2019). Implementation science as a leadership and doctor of nursing practice competency. *Journal of Continuing Education in Nursing, 50*(11), 491-492. http://doi.org/10.3928/00220124-20191015-03

Blishen, M. (2016). Why we need supervision. *Kai Taiki Nursing New Zealand, 22*(2), 30-31.

Bogo, M., & McKnight, K. (2005). Clinical supervision in social work: A review of the literature. *The Clinical Social Worker, 24*, 49-67.

Bond, M., & Holland, S. (1998). *Skills of clinical supervision for nurses*. Open University Press.

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. http://doi.org/10.1111/j.1447-0349.2009.00612.x

Campbell, J. C. (2002). Health consequences of intimate partner violence. *Lancet, 359*, 1331-1336. http://doi.org/10.1016/S0140-6736(02)08336-8

Campbell, J. C. (2008). The intersection of intimate partner violence against women and hiv/aids: A review. *International Journal of Injury Control and Safety Promotion, 15*(4), 221-31. http://doi.org/10.1080/17457300802423224

Casey, M., O'Leary, D. O., & Coghlan, D. (2017). Unpacking action research and implementation science: Implications for nursing. *Journal of Advanced Nursing, 75*(5), 1051-1058. https://doi.org/10.1111/jan.13494

Center for Evidence Based Management. (2014, July). *Critical appraisal of a cross-sectional study (survey)*. Center for Evidence Based Management.

https://cebma.org/wp-content/uploads/Critical-Appraisal-Questions-for-a-Cross-Sectional-Study-July-2014-1.pdf

Cha, S., & Masho, S. W. (2014). Intimate partner violence and utilization of prenatal care in the United States. *Journal of Interpersonal Violence, 29*(5), 911-927. http://doi.org/10.1177/0886260513505711

Chu, S. Y., Goodwin, M. M., & D'Angelo, D. V. (2010). Physical violence against U.S. women around the time of pregnancy, 2004-2007. *American Journal of Preventative Medicine, 38*(3), 317-322. https://doi.org/10.1016/j.amepre.2009.11.013

Cima, R. R., Brown, M. J., Hebl, J. R., Moore, R., Rogers, J. C., Kollengode, A., Amustutz, G. J., Weisbrod, C. A., Narr, B. J., & Deschamps, C. (2011). Use of Lean and Six Sigma methodology to improve operating room efficiency in a high-volume tertiary-care academic medical center. *Journal of the American College of Surgeons, 213*(1), 83-92. https://doi.org/10.1016/j.jamcollsurg.2011.02.009

Clifford, J. R., Macy, M. G., Albi, L. D., Bricker, D. D., & Rhan, N. L. (2005). A model of clinical supervision for preservice professionals in early intervention and early childhood special education. *Topics in Early Childhood Special Education, 25*(3), 167-176. https://doi.org/10.1177/02711214050250030401

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. Sage.

Coffee-Borden, B., & Paulsell, D. (2010). *Supporting home visitors in evidence-based programs: Experiences of EBHV grantees*. Mathematica Policy Research. http://doi.org/10.1186/1748-5908-8-60

Davys, A., & Beddoe, L. (2009). The reflective learning model: Supervision of social work

students. *Social Work Education: The International Journal, 28*(8), 919-933. https://doi.org/10.1080/02615470902748662

Department of Health. (1993). *A vision for the future: The nursing, midwifery and health visiting contribution to health and health care*. National Health Service.

Devries, K. M., Kishor, S., Johnson, H., Stockl, H., Bacchus, L. J., Garcia-Moreno, C., & Watt, C. (2010). Intimate partner violence during pregnancy: Analysis of prevalence data from 19 countries. *Reproductive Health Matters, 18*(36), 158-170. http://doi.org/10.1016/S0968-8080(10)36533-5

Dewald, P. (1987). *Learning process in psychoanalytic supervision: Complexities and challenges*. International Universities Press.

Dmytryshyn, A., Jack, S. M., Ballantyne, M., Wahoush, O., & MacMillan, H. L. (2015). Long-term home visiting with vulnerable young mothers: An interpretive description of the impact on public health nurses. *BMC Nursing 14*(1), 1-14. http://doi.org/10.1186/s12912-015-0061-2

Eckenrode, J., Ganzel, B., Henderson C. R., Jr., Smith, E., Olds, D. L. Powers, J. L., Cole, R., Kitzman, H., & Sidora, K. (2000). Preventing child abuse and neglect with a program of nurse home visitation. *The Journal of the American Medical Association, 284*(11), 1385-1391. http://doi.org/10.1001/jama.284.11.1385

Eckenrode, J., Campa, M. I., Morris, P. A., Henderson, C. R., Jr., Bolger, K. E., Kitzman, H., & Olds, D. L. (2016). The prevention of child maltreatment through the Nurse Family Partnership program: Mediating effects in a long-term follow-up study. *Child Maltreatment, 22*(2), 1-8. https://doi.org/10.1177/1077559516685185

Eggbeer, L., Mann, T. L., & Seibel, N. L. (2007). Reflective supervision: Past, present, and future. *Zero to Three, 28*(2), 5-9.

Eisner, E. W. (1982). An artistic approach to supervision. In T. J. Sergiovanni (Ed.), *Supervision of teaching (1982 Yearbook)* (pp. 53-66). Association for Supervision and Curriculum Development.

Ekstein, R., & Wallerstein, R. S. (1972). *The teaching and learning of psychotherapy* (2nd ed.). International Universities Press.

Elster, A. B., & McAnarney, E. R. (1980). Medical and psychological risks of pregnancy and childbearing during adolescence. *Pediatric Annals, 9*(3), 89-94.

Emden, C., & Sandelowski, M. (1999). The good, the bad and the relative, part two: Goodness and the criterion problem in qualitative research. *International Journal of Nursing Practice*, 5(1), 2-7. https://doi.org/10.1046/j.1440-172x.1999.00139.x

Erera, I. P., & Lazar, A. (1994). The administrative and educational functions in supervision: Indications of incompatibility. *The Clinical Supervisor, 12*(2), 39-56. https://doi.org/10.1300/J001v12n02_04

Feder, G., & MacMillan, H. L. (2011). Intimate partner violence. L. Goldman & A. Shafer (Eds.), *Goldman's Cecil Medicine* (pp. 1571-1574). Saunders. https://doi.org/10.1016/B978-1-4377-1604-7.00249-9

Feinchel, E. (2020, June 23). Zero to Three classics: 7 articles on infant/toddler development. ERIC. https://eric.ed.gov/?id=ED352159

Fincham, J. E. (2008). Response rates and responsiveness for surveys, standards, and the journal. *American Journal of Pharmaceutical Education, 72*(2), 1-3.

Furstenburg, F. F., Jr., Brooks-Gunn, J., & Morgan, S. P. (1987). Adolescent mothers later in

life. *Family Planning Perspectives, 19*(4), 142-151. https://doi.org/10.1017/CBO9780511752810

Ghaye, T. (2005). *Developing the reflective healthcare team*. Blackwell Publishing Ltd. http://doi.org/10.1002/9780470774694

Gibbs, J. (2001). Maintaining frontline workers in child protection: A case for refocusing supervision. *Child Abuse Review, 10*(5), 323-335. http://doi.org/10.1002/car.707

Gilbert, T. (2001). Reflective practice and clinical supervision: Meticulous rituals of the confessional. *Journal of Advanced Nursing, 36*(2), 199-205. https://doi.org/10.1046/j.1365-2648.2001.01960.x

Gilkerson. L., & Kopel, C. C. (2005). Relationship-based systems change Illinois' model for promoting social-emotional development in Part C early intervention. Infants & Young Children, 18(4), 349-365.

Gillet, N., Colombat, P., Michinov. E., Pronost, A., & Fouquereau, E. (2013). Procedural justice, supervisor autonomy support, work satisfaction, organizational identification and job performance: The mediating role of need satisfaction and perceived organizational support. *Journal of Advanced Nursing, 69*(11), 2560-2571. https://doi.org/10.1111/jan.12144

Girling, A., Leese, C., & Maynard L. (2009). How clinical supervision can improve hospice care for children. *Nursing Management, 16*(7), 20-23. http://doi.org/10.7748/nm2009.11.16.7.20.c7350

Glickman, C. D. (1980). The developmental approach to supervision. *Educational Leadership, 38*(2), 178–180.

Goldhammer, R. (1969). *Clinical supervision, special methods for the supervision of teachers*.

Holt, Rinehart & Winston.

Grauel, T. (2002). Professional oversight: The neglected histories of supervision. In M. McMahon & W. Patton (Eds.), *Supervision in the helping professions: A practical approach* (pp. 3-15). Prentice Hall.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Resources Information Center Annual Review Paper*, *29*, 75-91. https://doi.org/10.1007/BF02766777

Hair, H. J. (2013). The purpose and duration of supervision, and the training and discipline of supervisors: What social workers say they need to provide effective services. *The British Journal of Social Work*, *43*, 1562-1588https://doi.org/10.1093/bjsw/bcs071

Harden, B. J., Denmark, N., & Saul, D. (2010). Understanding the needs of staff in head start programs: The characteristics, perceptions, and experiences of home visitors. *Children and Youth Services Review*, *32*(3), 371-379. https://doi.org/10.1016/j.childyouth.2009.10.008

Harvey, G., & Kitson, A. (2015). PARIHS re-visited: Introducing i-PARIHS. In: Harvey G & Kitson A. (Eds.), *Implementing evidence-based practice in health care: A facilitation guide* (pp 25-46). Routledge.

Harvey, G., & Kitson, A. (2016). PARIHS revisited: From heuristic to integrated framework for the successful implementation of knowledge into practice. *Implementation Science*, *11*(33), 1-13. http://doi.org/10.1186/s13012-016-0398-2

Heise L, Moore K, & Toubia, N. (1995). *Sexual coercion and reproductive health: A focus on research*. Population Council.

Horwath., J., & Morrison, T. (1999). *Effective staff training in social care: From theory to practice.* Routledge.

Hsieh, H., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. http://doi.org/10.1177/1049732305276687

Jack, S. (2010). *Supervision of paraprofessional and lay home visitors providing services to women, children and families*. Maternal Child Health, Community Programs Directorate, Health Canada.

Jack, S. M., Busser, D., Sheehan, D., Gonzalez, A., Zwygers & MacMillan, H. L. (2012). Adaptation and implementation of the Nurse-Family Partnership in Canada. *Canadian Journal of Public Health, 103*(1), 42-48. https://doi.org/10.1007/BF03404459

Jack, S. M., Ford-Gilboe, M., Wathen, C. N., Davidov, D. M., McNaughton, D. B., Coben, J. H., Olds, D. L., MacMillan, H. L., & NFP IPV Research Team. (2012). Development of a nurse home visitation intervention for intimate partner violence. *BMC Health Services Research, 12*(50), 1-14. https://doi.org/10.1186/1472-6963-12-50

Jack, S. M., Sheehan, D., Gonzales, A., MacMillan, H. L., Catherine, N., & Waddell, C. (2015). British Columbia Healthy Connections project process evaluation: A mixed methods protocol to describe the implementation and delivery of the Nurse-Family Partnership in Canada. *BMC Nursing, 14*, 47. https://doi.org/10.1186/s12912-015-0097-3

Jack, S. M., Ford-Gilboe, M., Davidov, D., MacMillan, H. L., & NFP IPV Research Team. (2016). Identification and assessment of intimate partner violence in nurse home visitation. *Journal of Clinical Nursing, 26*, 2215-2228. https://doi.org/10.1111/jocn.13392

Jack, S. M., Boyle, M., McKee, C., Ford-Gilboe, M., Wathen, C. N., Scribano, P., Davidov, D., McNaughton, D., O'Brien, R., Johnston, C., Gasbarro, M., Tanaka, M., Kimber, M., Coben, J., Olds, D. L., & MacMillan, H. L. (2019). Effect of addition of an intimate partner violence intervention to a nurse home visitation program on maternal quality of life: A randomized clinical trial. *The Journal of the American Medical Association, 321*(16), 1576-1585. http://doi.org/10.1001/jama.2019.3211

Jasper, M. (2003). *Beginning reflective practice*: *Foundations in nursing and health care*. Nelson Thornes Ltd.

Johnston, B., Coole, C., Feakes, R., Whitworth, G., Tyrell, T., & Hardy, B. (2016). Exploring the barriers and facilitators of implementing research into practice. *British Journal of Community Nursing, 21*(8), 392-398. https://doi.org/10.12968/bjcn.2016.21.8.392

Kadushin, A. (1976). *Supervision in social work.* (5th ed.). Columbia University Press.

Killion, J., & Todnem, G. (1991). A process for personal theory building. *Educational Leadership*, 48(7), 14-16.

Kingston, D., Heaman, M., Urquia, M., O'Campo, P., Janssen, P., Thiessen, K., & Smylie. J. (2016). Correlates of abuse around the time of pregnancy: Results from a national survey of Canadian women. *Maternal and Child Health Journal, 20*(4), 778-789. https://doi.org/10.1007/s10995-015-1908-6

Kitson, A. L., Rycroft-Malone, J., Harvey, G., McCormack, B., Seers, K., & Titchen, A. (2008). Evaluating the successful implementation of evidence into practice using the PARIHS framework: Theoretical and practical challenges. *Implementation Science, 3(1),* 1-12. http://doi.org/10.1186/1748-5908-3-1

Kitzman, H., Olds, D. L., Henderson, C. R., Jr., Hanks, C., Cole, R., Tatelbaum, R., McConnochie, K. M., Sidora, K., Luckey, D. W., Shaver, D., Engelhardt, K., & Barnard, K. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries and repeated childbearing: A randomized controlled trial. *Journal of the American Medical Association, 278*(8), 644-652.

Kitzman, H. J., Olds, D. L., Cole, R. E., Hanks, C. A., Anson, E. A., Arcoleo, K. J., Luckey, D. W., Knudston, M. D., Henderson, C. R., Jr., & Holmberg, J. R. (2010). Enduring effects of prenatal and infancy home visiting by nurses on children: Follow-up of a randomized trial among children at age 12 years. *Archives of Pediatrics & Adolescent Medicine, 164*(5), 412-441. http://doi.org/10.1001/archpediatrics.2010.76

Kleiser, H., & Cox, D. L. (2008). The integration of clinical and managerial supervision: A critical literature review. *British Journal of Occupational Therapy, 71*(1), 2-12. http://doi.org/10.1177/030802260807100102

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. International Universities Press.

Kondracki, N., Wellman, N. S., & Amudson, D. R. (2002). Content analysis: Review of methods and their applications in nutrition education. *Journal of Nutrition Education and Behavior, 34*(4), 224-230. https://doi.org/10.1016/S1499-4046(06)60097-3

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy, 45*, 214-222. https://doi.org/10.5014/ajot.45.3.214

Lawrence, A. (2004). *Principles of child protection.* Open University Press.

Lee, E., Esaki, N., Kim, J., Greene, R., Kirkland, K., & Mithcell-Herzfeld, S. (2013).

Organizational climate and burnout among home visitors: Testing mediating effects of empowerment. *Children and Youth Services Review, 35*(4), 94-602. https://doi.org/10.1016/j.childyouth.2013.01.011

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

MacMillan, H. L., Wathen, C. N., Barlow, J., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. 2008). Interventions to prevent child maltreatment and associated impairment. *Lancet, 373*, 250-266. http://doi.org/10.1016/S0140-6736(08)61708-0

Michigan Association for Infant Mental Health. (2016). *Competency guidelines.* Michigan Association for Infant Mental Health. https://mi-aimh.org/store/mi-aimh-endorsement-competencies-20022011-revised/

Michigan Association for Infant Mental Health. (2018). *Best practice guidelines for reflective supervision/consultation.* Michigan Association for Infant Mental Health. https://mi-aimh.org/reflective-supervision/best-practice-and-consultant-competencies/

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: A source book of new methods* (2nd ed.). Sage.

Moore, J. (1995). Child protection: Supervision in social service departments. In J. Pritchard (Ed.), *Good practice in supervision: Statutory and voluntary organizations* (pp. 55- 70). Jessica Kingsley.

Morrison, T. (1996). Partnership and collaboration: Rhetoric and reality. *Child Abuse and Neglect, 20*, 127-140. https://doi.org/10.1016/0145-2134(95)00124-7

Morse, J. M., & Field, P. A. (1995). *Qualitative research methods for health professionals* (2nd ed.). Sage.

Miller, L. M. (2012). *The VON team guide how to create the exceptional client & customer*

experience through Lean team management. Miller Management Press.

Nathans, L., Gill, S., Molloy, S., & Greenberg, M. (2019). Home visitor readiness, job support, and job satisfaction across three home visiting programs: A retrospective analysis. Children and *Youth Services Review*, *106*, 104388. https://doi.org/10.1016/j.childyouth.2019.104388

National Centre for Injury Prevention and Control. (2014). *National data on intimate partner violence, sexual violence and stalking: Fact sheet, 2014*. Violence Prevention. https://www.cdc.gov/violenceprevention/pdf/nisvs-fact-sheet-2014.pdf

National Centre for Injury Prevention and Control. (2015). *Intimate partner violence surveillance uniform definitions and recommended data elements*. Preventing Intimate Partner Violence. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html

National Centre for Injury Prevention and Control. (2017). *National intimate partner and sexual violence survey-survey report*. Summary and Special Reports. https://www.cdc.gov/violenceprevention/datasources/nisvs/summaryreports.html

National Centre for Injury Prevention and Control. (2019, February 26). *How big is the problem?* Preventing Intimate Partner Violence. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html

Ng, D., Vail, G., Thomas, S., & Schmidt, N. (2010). Applying the Lean principles of the Toyota Production System to reduce wait times in the emergency department. *Canadian Journal of Emergency Medicine, 12*(1), 50-57. https://doi.org/10.1017/S1481803500012021

Nichols, H. M., Swanberg, J. F., & Bright, C. L. (2016). How does supervisor support influence

turnover intent among frontline hospital workers? The mediating role of affective commitment. *The Health Care Manager, 35*(3), 266-279. http://doi.org/10.1097/HCM.0000000000000119

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

Olds, D. L. (2006). The nurse-family partnership: An evidence based preventive intervention. *Infant Mental Health Journal, 27*(1), 5-25. https://doi.org/10.1002/imhj.20077

Olds, D. L. (2007). The Nurse-Family Partnership: Foundations in Attachment theory and epidemiology. In L. J. Berlin, Y. Ziv, L. Amaya-Jackson, & M. T. Greenberg (Eds.), *Enhancing early attachments, theory, research, intervention and policy* (pp. 217-249). The Guilford Press.

Olds, D. (2010). The Nurse-Family Partnership. In R. Haskins & W. S. Barnett (Eds.), *Investing in young children: New directions in federal preschool and early childhood policy* (pp. 69-78). Brookings Institution.

Olds, D. L., Henderson, C. R., Jr., Chamberlin, R. & Tatelbaum, R., (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics, 78*(1), 65-78.

Olds, D. L., Henderson, C. R., Jr., Tatelbaum, T., & Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics, 77*(1), 16-28.

Olds, D. L., Henderson, C. R., Jr., & Kitzman, H. (1994). Does prenatal and infancy nurse home visitation have enduring effects on qualities of parental caregiving and child health at 25 to 50 months of life? *Pediatrics, 93*(1), 89-98.

Olds, D. L., Eckenrode, J., Henderson, C. R., Jr., Kitzman, H., Powers, J., Cole, R., Sidora, K.,

Morris, P., Pettitt, L. M., & Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized controlled trial. *Journal of the American Medical Association, 278*(8), 637-643.

Olds, D. L., Henderson, C. R., Jr., Cole, R., Eckenrode, J., Kitzman. H., Luckey, D., Pettitt, L., Sidora, K., Morris, P., & Powers, J. (1998). Long-term effects of nurse home visitation on children's criminal and antisocial behavior: Fifteen-year follow-up of a randomized controlled trial. *Journal of the American Medical Association, 280*(14), 1238-1244. https://doi.org/10.1001/jama.280.14.1238

Olds, D. L., Robinson, J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson C. R., Ng, R. K., Sheff, K. L., Korfmacher, J., Hiatt, S., & Talmi, A. (2002). Home visiting by paraprofessionals and by nurses: A randomized controlled trial. *Pediatrics, 110*(3), 486-496. https://doi.org/10.1542/peds.110.3.486

Olds, D. L., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D. W., Henderson, C. R., Hanks, C., Bondy, J., & Holmberg, J. (2004). Effects of nurse home-visiting on maternal life course and child development: Age 6 follow-up results of a randomized trial. *Pediatrics, 114*(6), 1550-1559. https://doi.org/10.1542/peds.2004-0962

Olds. D. L., Sadler, L., & Kitzman, H. (2007). Programs for patents of infants and toddlers: Recent evidence from randomized trials. *Journal of Child Psychology and Psychiatry, 483* (34), 355-391. https://doi.org/10.1111/j.1469-7610.2006.01702.x

Olds, D. L., Donelan-McCall, N., O'Brien, R., MacMillan, H., Jack, S., Jenkins, T., Dunlap, W. P., III, O'Fallon, M., Yost, E., Thorland, B., Pinto, F., Gasbarro, M., Baca, P., Melnick, A., & Beeber, L. Improving the Nurse-Family Partnership in community practice. *Pediatrics, 132*(Suppl2), S110-S117. https://doi.org/10.1542/peds.2013-1021I

Olds, D. L., Kitzman, H., Knudtson, M., Anson, E., Smith, J. A., & Cole, R. (2014). Effect of home visiting by nurses on maternal and child mortality. *Journal of the American Medical Association Pediatrics, 168*(9), 800-806. https://10.1001/jamapediatrics.2014.472

O'Rourke, P. (2011). The significance of reflective supervision for infant mental health work. *Infant Mental Health Journal, 32*(2), 165–173. https://doi.org/10.1002/imhj.20290

Overpeck, M. D., Brenner, R. A., Trumble, A. C., Trifiletti, L. B., & Berendes, H. W. (1998). Risk factors for infant homicide in the United States. *New England Journal of Medicine, 17*, 1211-1241. http://doi.org/10.1056/NEJM199810223391706

Palmerino, M. B. (2006, November). *One-on-ones put the quality in qualitative*. The Center for Strategy Research, Inc. https://www.csr-bos.com/wp-content/uploads/2017/09/Quirks-One-on-One-Interviews.pdf

Parlakian, R. (2001). *Look, listen, and learn: Reflective supervision and relationship based-work*. Zero to Three Center for Program Excellence.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Sage.

Patton, M. Q. (2002). *Qualitative evaluation and research methods* (3rd ed.). Sage.

Pave, J., Alvarez, J., Baumrind, N., Induni, M., & Kimerling, R. (2007). Intimate partner violence and housing instability. *American Journal of Preventative Medicine, 32*(2), 143-146. https://dx.doi.org/10.4135/9781849209618

Perlmutter, F. D., Netting, E., & Bailey, D. (2001). Managerial tensions: Personal insecurity vs personal responsibility. *Administration in Social Work, 25*(1), 1-16. https://doi.org/10.1300/J147v25n01_01

Perrewe P. L., Treadway, D. C., & Hall, A. T. (2003). The work/family interface: Conflict,

family-friendly policies, and employee well-being, in health and safety. In D. A. Hoffman & L.E. Tetrick (Eds), *Health and safety in organizations: A multilevel perspective* (pp. 285-286). Jossey-Bass. https://doi.org/10.1016/S1479-3555(05)05002-X

Pluye, P., Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., Griffiths, F., Boardman, F., Gagnon, M. P., & Rousseau, M. C. (2011). *Proposal: A mixed methods appraisal tool for systematic mixed studies reviews.* McGill University. http://www.mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/84371689/MMAT%202011%20criteria%20and%20tutorial%202011-06-29updated2014.08.21.pdf

Pohl, S., & Galletta, M. (2017). The role of supervisor emotional support on individual job satisfaction: A multilevel analysis. *Applied Nursing Research, 33*, 61-66. https://doi.org/10.1016/j.apnr.2016.10.004

Pollock, A., Campbell, P., Deery, R., Fleming, M., Rankin, J., Sloan, G., & Cheyne, H. (2017). A systematic review of evidence relating to clinical supervision for nurses, midwives, and allied health professionals. *Journal of Advanced Nursing, 73*(8), 1825-1837. https://doi.org/10.1111/jan.13253

Prevention Research Centre for Family and Child Health. (2017, June 2). Nurse-Family Partnership® (NFP) International Guidance Document – Revised Set of NFP Core Model Elements. [NFP Internal 88-page Document]. Unpublished, Department of Pediatrics, University of Colorado, Aurora, CO.

Proctor, B. (1987). Supervision: A co-operative exercise in accountability. In M. Marken & My. Payne (Eds.), *Enabling and ensuring* (pp. 21-23). National Youth Bureau and Council for Education and Training in Youth and Community Work.

Radley, M., & Stanley, L. (2018). Hands on versus empty: Supervision experiences of frontline

child welfare workers. *Children and Youth Services Review, 91*, 128-136. http://doi.org/10.1016/j.childyouth.2018.05.037

Raghavan, C., Rajah, V., Gentile, K., Collado, L., & Kavanagh, A. M. (2009). Community violence, social support networks, ethnic group differences, and male perpetration of intimate partner violence. *Journal Interpersonal Violence, 24*(10), 1615-1632. https://doi.org/10.1177/0886260509331489

Rapp, C., & Poertner, J. (1992). *Social administration: A client-centred approach*. Longman.

Rand T. M., Mahoney, J. T., & Mahoney, F. C. (1990). Management effectiveness analysis: Technical considerations. Management Research Group.

Registered Nurses' Association of Ontario. (2005). Woman abuse: Screening, identification and initial response guideline supplement. International Affairs and Best Practice Guidelines. http://rnao.ca/sites/rnao-ca/files/BPG_Women_Abuse_Supplement_Only.pdf

Registered Nurses' Association of Ontario. (2012). *Toolkit: Implementation best practice guidelines, second edition.* International Affairs and Best Practice Guidelines. https://rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

Reznick, D., Niazov, L., Holizna, E., Siperstein, A. (2014). Applying industrial process improvement techniques to increase efficiency in a surgical practice. Surgery, 156(4), 752-8. http://doi.org/10.1016/j.surg.2014.06.059

Rooney, J. A., & Gottlieb B. H. (2007). Development and initial validation of a measure of supportive and unsupportive managerial behaviors. *Journal of Vocational Behavior, 71*, 186-203.

https://doi.org/10.1016/j.jvb.2007.03.006

Ryan, F., Coughlan, M., & Cronin, P. (2009). Interviewing in qualitative research: The one-to-one interview. *International Journal of Therapy and Rehabilitation, 16*(6), 309-314. https://doi.org/10.12968/ijtr.2009.16.6.42433

Saltzman, L. E., Johnson, C. H., Gilbert, B. C., & Goodwin, M. M. (2003). Physical abuse around the time of pregnancy: An examination of prevalence and risk factors in 16 states. *Maternal Child Health Journal, 7*(1), 96-98.

Sarnat, J. E. (1992). Supervision in relationship: Resolving the teach-treat controversy in psychoanalytic supervision. *Psychoanalytic Psychology, 9*(3), 387–403. https://doi.org/10.1037/h0079388

Searles, H. F. (1955). The informational value of supervisor's emotional experiences. *Psychiatry, 18*, 135–146. https://doi.org/10.1080/00332747.2015.1069638

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action*. Basic Books. https://doi.org/10.1080/07377366.1986.10401080

Schultz, D., Jones. S. S., Pinder, W. M., Wiprovnick, A. E., Groth, E. C., Shanty, L. M., & Duggan, A. (2018). Effective home visiting training: Key principles and findings to guide training developers and evaluators. *Maternal and Child Health Journal, 22*(11), 1563-1567. http://doi.org/10.1007/s10995-018-2554-6

Scribano, P. V., Stevens, J., & Kaizar, E. (2012). The effects of intimate partner violence before, during and after pregnancy in nurse visited first time mothers. *Journal of Maternal Child Health, 17*(2), 307-318. https://doi.org/10.1007/s10995-012-0986-y

Shahmoon-Shanok, R. (2009). What is reflective supervision? In S. S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision* (pp. 7–20). Zero to Three.

Schulman, L. (1982). *Skills of supervision and staff management*. F. E. Peacock Publishers.

Shulman, L. (1993). *Interactional Supervision*. NASW Press.

Sloan, G., & Watson, H. (2002). Clinical supervision models for nursing: Structure research and limitations. *Nursing Standard, 17*(4), 41-46. http://doi.org/10.7748/ns2002.10.17.4.41.c3279

Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. Falmer.

Thorne, S., Kirkham, S. R., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3*(1), 1-11. https://doi.org/10.1177/160940690400300101

Thorne, S. (2015). Interpretive description. In C. T. Beck (Ed.), *Routledge international handbook of qualitative nursing research* (pp. 295-306). Taylor and Francis.

Thorne, S. (2016). *Interpretive description: Qualitative research for applied practice* (2nd ed.). Routledge.

Tomlin, A., Weatherston, D., & Pavkov, T. (2014). Critical components of reflective supervision responses from expert supervisors from the field. *Infant Mental Health Journal, 35*(1), 70–80. http://doi.org/10.1002/imhj.21420

Tomlin, A. M., & Heller, S. S. (2016). Measurement development in reflective supervision: History, methods, and next steps. *Zero to Three, 37*(2), 4–13.

Tomlin, A. M., Hines, E., & Sturm, L. (2016). Reflection in home visiting: The what, why, and beginning step to how. *Infant Mental Health Journal, 36*(6), 617-627. http://doi.org/10.1002/imhj.21610

Tsui, M. S. (1997). Empirical research on social work supervision. *Journal of Social Service Research, 23*(2), 39-54. https://doi.org/10.1300/J079v23n02_03

Vats, A., Goin, K. H., & Fortenberry, J. D. (2011). Lean analysis of a pediatric intensive care unit physician group rounding process to identify inefficiencies and opportunities for improvement. *Pediatric Critical Care Medicine, 12*(4), 415-21. http://doi.org/10.1097/PCC.0b013e3181fe2e3c

Virmani, E. A., & Ontai, L. L. (2010). Supervision and training in child care: Does reflective supervision foster caregiver insightfulness? *Infant Mental Health Journal, 31*(1), 16–32. https://doi.org/10.1002/imhj.20240

Wallerstein, R. (1981). *Becoming a psychoanalyst: A study of psychoanalytic supervision.* International Universities Press.

Waskett, C. (2009). An integrated approach to introducing and maintaining supervision: The 4S model. *Nursing Times, 105*(17), 24-26.

Wathen, C. N., Jamieson, E., MacMillan, H. L. (2008). Who is identified by screening for intimate partner violence? *Women's Health Issues, 18*(6), 423-432. https://doi.org/10.1016/j.whi.2008.08.003

Watson, C., Gatti, S. N., Cox, M., Harrison, M., & Hennes, J. (2014). Reflective supervision and its impact on early childhood intervention. *Advances in Early Childhood and Day Care, 18*(1), 1–26. http://doi.org/10.1108/S0270402120140000018001

Watson, A., & Heller, S. S. (2016). Measurement development in reflective supervision. *Zero to Three Journal, 37*(2), 4-12.

Watson, C. L., Bailey, A. E., & Storm, K. J. (2016). Building capacity in reflective practice: A tiered model of statewide supports for local home-visiting programs. *Infant Mental Health Journal, 37*(6), 640-652. https://doi.org/10.1002/imhj.21609

Weatherston, D. J., & Barron, C. (2009). What does a reflective supervisory relationship look

like? In S. Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision* (pp. 61–80). Zero to Three.

Weatherston, D. J., Kaplan-Estrin, M., & Goldberg, S. (2009). Strengthening and recognizing knowledge, skills, and reflective practice: The Michigan Association for Infant Mental Health competency guidelines and endorsement process. *Infant Mental Health Journal, 30*(6), 648–663. https://doi.org/10.1002/imhj.20234

Weatherston, D., Weigand, R. F., & Weigand, B. (2010). Reflective supervision supporting reflection as a cornerstone for competency. *Zero to Three Journal, 31*(2), 22-30.

Weaver, S. H., & Lindgren, T. (2016). Administrative supervisors: A qualitative exploration of their perceived role. *The Journal of Nursing Administration, 40*(2), 167-172. https://doi.org/10.1097/NAQ.0000000000000126

Wheatley, M. (1999). Implementing clinical supervision. *Nursing Management, 6*(3), 28-32.

World Health Organization. (2012). *Understanding and addressing violence against women*. Sexual and Reproductive Health. https://www.who.int/reproductivehealth/publications/violence/rhr12_36/en/

World Health Organization. (2017). *Violence against women, key facts.* http://www.who.int/news-room/fact-sheets/detail/violence-against-women

Yerushalmi, H. (1994). A call for change in emphasis in psychoanalytic supervision. *Psychotherapy: Theory, Research, Practice, Training, 31*(1), 137-145.

Yusof, M. M., Khodambashi, S., & Mokhtar, A. M. (2012). Evaluation of the clinical process in a critical care information system using the Lean method: A case study. *BMC Medical Informatics and Decision Making, 12*(1), 150. http://doi.org/10.1186/1472-6947-12-150

Zero to Three. (2020, June 29). *Reflective supervision*. Zero to Three Early Connections Last a Lifetime. https://www.zerotothree.org/resources/407-reflective-supervision

Appendix A

Figure A1

Database Search Strategy for Literature Review

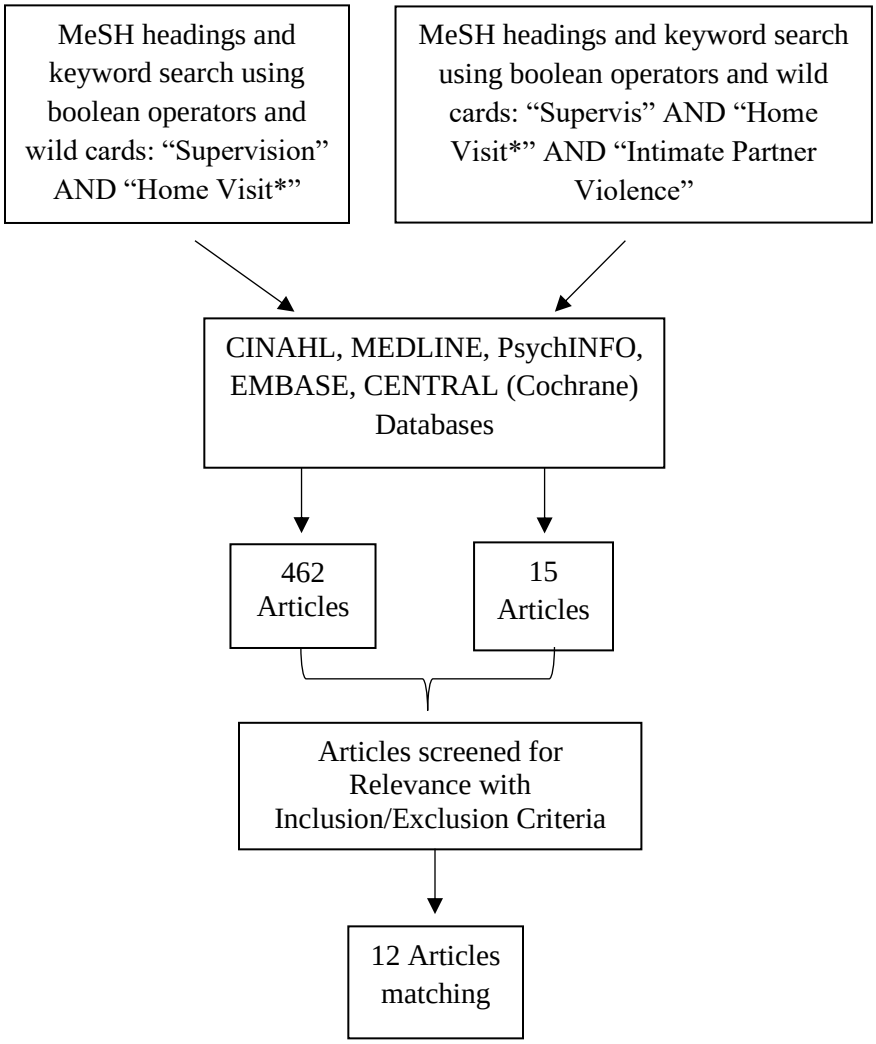


Table A1

Conceptual Literature Search Results

Study #	Title	Authors, Source & Year of Publication
1	"Hands on" versus "empty": Supervision experiences of frontline child welfare workers.	Radey, M., & Stanley L. **Source:** Children and Youth Services Review **Year:** 2018
2	An integrated approach to introducing and maintaining supervision: The 4S model.	Waskett, C. **Source:** Nursing Times **Year:** 2009
3	Clinical supervision using the 4S model 1: Considering the structure and setting it up.	Waskett, C. **Source:** Nursing Times **Year:** 2010
4	Implementing clinical supervision.	Wheatley, M. **Source:** Nursing Management **Year:** 1999
5	How clinical supervision can improve hospice care for children.	Girling, A., Leese, C., & Maynard L. **Source:** Nursing Management **Year:** 2009
6	Reflection in home visiting: The what, why, and beginning step to how.	Tomlin, A. M., Hines, E., & Sturm, L. **Source:** Infant Mental Health Journal **Year:** 2016
7	Managerial tensions: Personal insecurity vs personal responsibility.	Perlmutter, F. D., Netting, E., & Bailey, D. **Source:** Administration in Social Work **Year**: 2001
8	Social work supervision and its role in enabling a community visitor program that promotes and protects the rights of children.	Baglow, L. **Source:** Australian Social Work **Year:** 2009
9	Effective home visiting training: Key principles and findings to guide training developers and evaluators.	Schultz, D., Jones, S. S., Pinder, W. M., Wiprovnick, A. E., Groth, E. C., Shanty, L. M., & Duggan, A. **Source:** Maternal and Child Health Journal **Year:** 2018

Table A2

Empirical Literature Search Results

Study #	Title	Authors, Journal & Year of Publication	Study Category
1	Procedural justice, supervisor autonomy support, work satisfaction, organizational identification and job performance: The mediating role of need satisfaction and perceived organizational support.	Gillet, N., Colombat, P., Michinov. E., Pronost, A., & Fouquereau, E. **Source:** Journal of Advanced Nursing **Year:** 2013	Cross-sectional
2	The role of supervisor emotional support on individual job satisfaction: A multilevel analysis.	Pohl, S., & Galletta, M. **Source:** Applied Nursing Research **Year:** 2017	Cross-Sectional
3	Building capacity in reflective practice: A tiered model of statewide supports for local home-visiting programs.	Watson, C. L., Bailey, A. E., & Storm, K. J. **Source:** Infant Mental Health Journal **Year:** 2016	Mixed Methods
4	*A systematic review of evidence relating to clinical supervision for nurses, midwives, and allied health professionals.	Pollock, A., Campbell, P., Deery, R., Fleming, M., Rankin, J., Sloan, G., & Cheyne, H. **Source:** Journal of Advanced Nursing **Year:** 2017	Systematic Review

* Manual Search: Google Scholar

Appendix B

Table B1

Critical Appraisal #1 (Cross-sectional Study)

Name of Study	Procedural justice, supervisor autonomy support, work satisfaction, organizational identification and job performance: the mediating role of need satisfaction and perceived organizational support.
Authors	Gillet, N., Colombat,P., Michinov, E., Pronost, A.M., & Fouquereau, E.
Year of Publication	2013
Source	Journal of Advanced Nursing
Aim of Study	The aim was to determine if there was any linkage, by testing a model, for the relationships between procedural justice, supervisor autonomy support, need satisfaction, organizational support, work satisfaction, organizational identification and job performance.
Did the study address a clearly focused question / issue?	Yes. In lieu of questions, hypotheses were used to present the relationships the authors intend to measure. The language that is used in the hypotheses makes the understanding for the reader difficult. It is not explicit in its presentation, rather it is implicit by needing to read into the context and gain more depth. The word "mediate" in the written hypotheses makes it difficult to understand the relationships being presented. For example, in hypothesis #1, the relationship between need satisfaction to supervisor autonomy support and work satisfaction is difficult to understand. Specifically, it is unclear how need satisfaction would mediate this relationship, how need satisfaction would "bring about" autonomy supervisor support and thereby effect a positive or negative relationship with job satisfaction. Implicitly understood for this hypothesis however, is that when needs are met for an employee and supervisors support staff with some latitude in their autonomy, this positively impacts job satisfaction for the employee (nurse).
Is the research method (study design) appropriate for answering the research question?	Yes, a cross-sectional, correlational design is appropriate for testing the relationships as presented in this model. Continuous variables are used.
Is the method of selection of the subjects (employees, teams, divisions, organizations) clearly described?	Yes, a convenience sample was used, method of sampling from 47 units within the province is clearly described in the study.
Could the way the sample was obtained introduce (selection) bias?	Yes, some subgroups may not be represented and therefore results may not be transferrable to the population.
Was the sample of subjects representative with regard to the population to which the findings will be referred?	Due to the nature of sampling being a convenience sample, some groups may not be represented in the sample and result findings may not, therefore, be completely transferrable to the population of interest.

Was the sample size based on pre-study considerations of statistical power?	There was no discussion in the study of statistical power or effect size. No discussion how sample size of 500 was decided and how this size represents the population. No other studies sited relative to sample size modelling. No pilot study to determine. A sample of 500 nurses were used for this study, with 323 returned surveys.
Was a satisfactory response rate achieved?	Yes. The response rate was 64.6%. According to Fincham, 2008, representativeness from a survey needs at least a 60% response rate. The response rate at 64.6% is on the lower end of acceptable but is acceptable.
Are the measurements (questionnaires) likely to be valid and reliable?	By nature of a convenience sample and the nature of a cross-sectional survey representing only a snap-shot in time, there would be risk of sample bias and bias related to the cross-sectional study design. This risk may impact internal validity relative to measured findings and impact external validity to the population of interest. Findings do provide useful information but, would need to be utilized with caution. Further testing would be recommended.
Was the statistical significance assessed?	Yes. Statistical significance was assessed with the use of chai square values, Chronbach's alpha coefficients (internal validity), and p values for result findings. Results were significant.
Are confidence intervals given for the main results?	No.
Could there be confounding factors that haven't been accounted for?	Cross-sectional studies are a snap-shot in time and measure specifically what is occurring at a specific point in time. For this reason, cross-sectional design results and presented implications do need to be perceived with caution as causal relationships between variables can be difficult to establish. The findings could be further validated with other study designs such as a longitudinal or experimental study.
Can the results be applied to your organization?	Yes, the results can be applied, however, with some caution. A pilot program would be suggested.

Adapted from Center for Evidence Based Management (July, 2014), Critical Appraisal Checklist for Cross-Sectional Study.

Table B2

Critical Appraisal #2 (Cross-Sectional Study)

Name of Study	The role of supervisor emotional support on individual job satisfaction: A multilevel analysis.
Authors	Pohl, S., & Galletta, M.
Year of Publication	2016
Source	Applied Nursing Research
Aim of Study	The aim was to look at the role of the supervisor as a moderator for emotional support and the relationship between support, work engagement and job satisfaction.
Did the study address a clearly focused question / issue?	Yes. 3 Hypotheses were organized and stated in explicitly the relationship between continuous variables. Additionally, a model was offered for a clear understanding of variable relationships and stated hypotheses.
Is the research method (study design) appropriate for answering the research question?	Yes. A cross-sectional study is an appropriate design to test relationships between the described variables of supervisor support, job satisfactions and work engagement.
Is the method of selection of the subjects (employees, teams, divisions, organizations) clearly described?	No. It is not understood how the 39 units and nurses from these units were selected for this study. No sampling method is detailed. Participant consent was assumed obtained by nurse participation in the survey. Ethics was approved for this study. Participation was voluntary and anonymous. Nurses were contacted prior to their participation to describe the purpose of the study.
Could the way the sample was obtained introduce (selection) bias?	Yes, however, it is unclear how since the sampling methodology is not described.
Was the sample of subjects representative with regard to the population to which the findings will be referred?	No details are presented, it is not understood how nurses were selected. This presents an issue for determining the level of representation to the external population.
Was the sample size based on pre-study considerations of statistical power?	No discussion of sample power or effect size was stated. It is unclear how the sample size of 459 nurses was calculated and how the nurses selected represent the population. No other sources were presented with similar effect size, no pilot studies mentioned.
Was a satisfactory response rate achieved?	Yes. A response rate of 70.1% is satisfactory, with the goal being at least 60% for a survey design (Fincham, 2008). No response rate bias has therefore been reduced.
Are the measurements (questionnaires) likely to be valid and reliable?	Acceptable cronbach alpha coefficients were used to measure internal validity of the model and were greater than 0.70. Factor validity was supported when

	testing the measurement model. Internal results would be considered valid and reliable.
Was the statistical significance assessed?	Yes. Statistically significant p values were obtained for all measurements $p<0.05$ and $p<0.001$.
Are confidence intervals given for the main results?	No.
Could there be confounding factors that haven't been accounted for?	Yes. As it is unclear how the sample was selected, there may be confounding based on sample selection bias. The nature of the cross-sectional study representing only one select point in time also creates bias relative to interpreting causal relationships between variables.
Can the results be applied to your organization?	Yes. Statistically significant findings have been presented, however, study findings and generalization to the population would require use with caution. A pilot study would be recommended.

Adapted from Center for Evidence Based Management (July, 2014), Critical Appraisal Checklist for Cross-Sectional Study.

Table B3

Critical Appraisal #3 (Mixed Methods Study)

Mixed Method Study Components	Methodological Quality Criteria	Response	Comments
Study Name	Building capacity in reflective practice: a tiered model of statewide supports for local home-visiting programs	-	-
Authors	Watson, C.L., Bailey, A.E., & Storm, K.J.	-	-
Year	2016	-	-
Screening Questions for all types.	Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?	Yes	There are clear qualitative and quantitative questions. It is not clear for the reader how any of the questions are mixed methods questions.
	Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).	Yes	Results from a custom posttest measure, from standardized surveys, and expert led interview questions addressed the original 3 positioned research questions.
Qualitative	Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?	Yes	Interviews at the beginning and end of evaluation period with supervisors, administrators, and consultants.
	Is the process for analyzing qualitative data relevant to address the research question (objective)?	Yes	Yes, however, there is no clear understanding in the methodology how qualitative and quantitative data are synthesized in tandem to support a mixed methods interpretation.
	Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?	Yes	Findings have direct relevance to the context.
	Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?	No	There is no discussion around influence.

Quantitative Descriptive	Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?	Yes	Yes, however, no discussion is given around sample power and, therefore, sample size is not justified.
	Is the sample representative of the population understudy?	Unclear	Inclusion and exclusion criteria are not outlined. Further information was not offered about why an eligible participant chose not to participate in the study.
	Are measurements appropriate (clear origin, or validity known, or standard instrument)?	Yes	Variables are implicitly defined. Study could benefit from clear definitions. Measurements are relevant to questions and variables presented and measure what they were intended for.
	Is there an acceptable response rate (60% or above)?	Yes	
Mixed Methods	Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?	Unknown	No rationale is given for study design. It is implicitly understood by the study design that the authors want to measure both qualitative and quantitative metric for their sample population, it also makes sense the tools that they selected, however the study employs a clear qualitative component, a clear quantitative component, but not a clear mixed methods component.
	Is the integration of qualitative and quantitative data (or results) relevant to address the research question (objective)?	No	When the integration of the qualitative and quantitative component takes place is not understood. No explanation of how integrated nor integration participants.
	Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results)?	No	No consideration discussed.

Adapted from Pluye, P., Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., Griffiths, F., Boardman, F., Gagnon, M.P., & Rousseau, M.C. (2011). Proposal: A mixed methods appraisal tool for systematic mixed studies reviews.

Table B4

Critical Appraisal #4 (Systemic Review)

Systematic Review Questions	Answers		
	Yes	Can't Tell	No
Study Name: A systematic review of evidence relating to clinical supervision for nurses midwives and allied health professionals Authors: Pollock, A., Campbell, P., Deery, R., Fleming, M., Rankin, J., Sloan, G., & Cheyne, H. Year: 2016			
1. Did the review address a clearly focused issue? Was there enough information on: • The population studied • The intervention given • The outcomes considered	• Clear issue presented. Midwife population detailed. • intervention given and explained.	• Not clear that outcomes were considered.	•Little information on nursing and allied health professional population.
2. Did the authors look for the appropriate sort of papers? The 'best sort of studies' would • Address the review's question • Have an appropriate study design	• All study designs were used but in alignment with contingent design used. • Utilized a framework for systematic review approach and generated 2 syntheses • Quality of reviews assessed with ROBIS tool for synthesis 1		
3. Do you think the important, relevant studies were included? Look for • Which bibliographic databases were used • Follow up from reference lists • Personal contact with experts • Search for unpublished as well as published studies • Search for non-English language studies	• MEDLINE, CINAHL, EMBASE, AMED, CDSR, DARE, CENTRAL, and HTA dateabases used. • Contact with experts		• No manual search from reference list • English sources only • Published studies only
4. Did the review's authors do enough to assess the quality of the included studies? The authors need to consider the rigour of the studies they have identified. Lack of rigour may affect the studies results.	• Quality of reviews assessed with ROBIS tool synthesis 2 and may have included study designs at high risk of bias for synthesis 1		• Quality of primary studies not assessed for
5. If the results of the review have been combined, was it reasonable to do so? Consider whether • The results were similar from study to study • The results of all the included studies are clearly displayed	• Results of the review are appropriately presented as two distinct syntheses, with clear outcomes articulated.		• narrative display and one table but not a comprehensive summary table-reader forced to

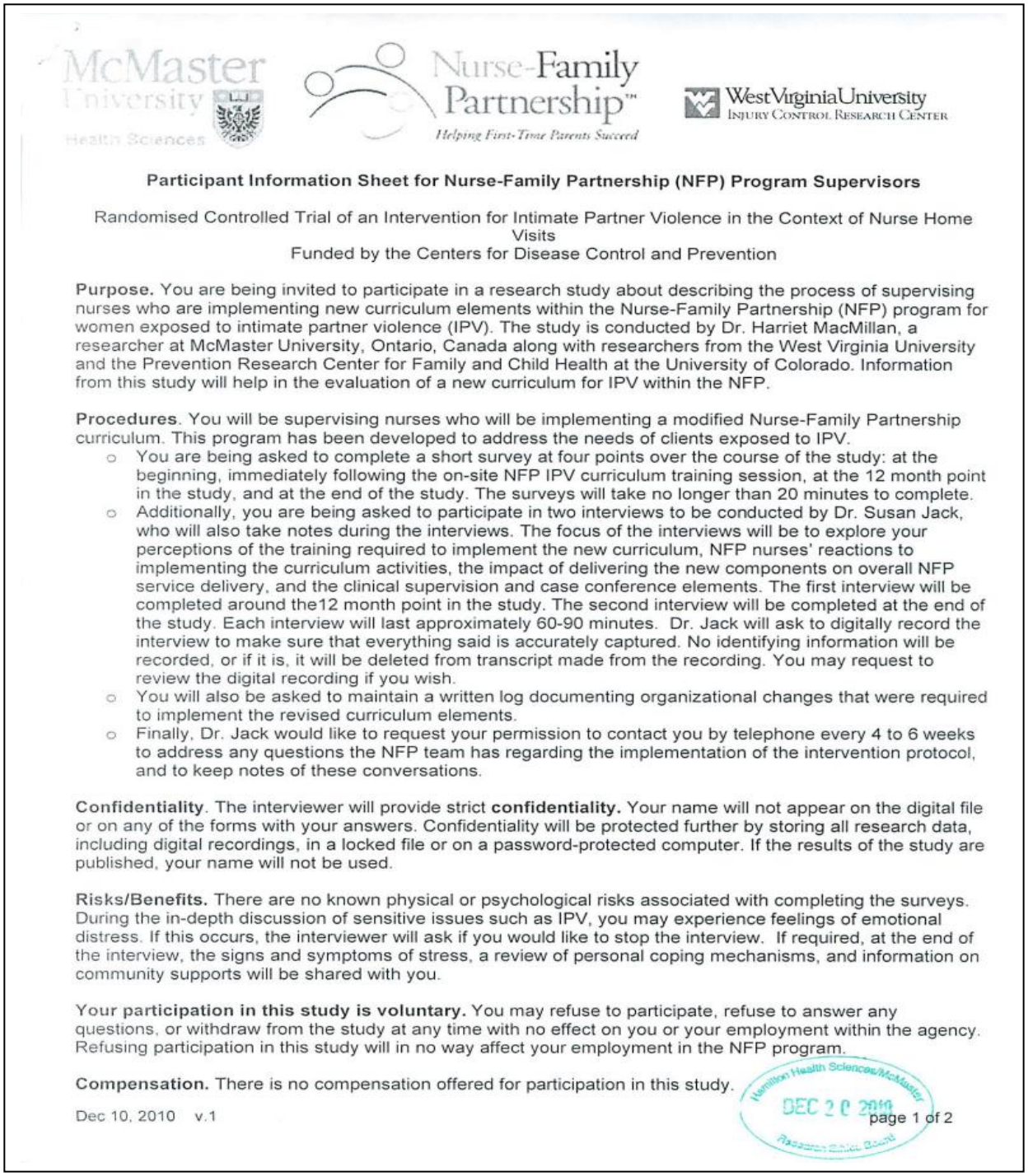
• The results of the different studies are similar • The reasons for any variations are discussed	• similar results with general agreement for synthesis 1 • variation in synthesis 2 was discussed and met the purpose of study design.		weave through pages of information
6. What is the overall result of the review? Consider • If you are clear about the reviews 'bottom line' results • What these are (numerically if appropriate) • How were the results expressed (NNT, odds ratio, etc)	• Clear bottom line for synthesis 1 and 2. Synthesis 1- the evidence demonstrates a lack of agreement regarding how clinical supervision is characterized. Synthesis 2- from 19 primary studies there is a lack of consistency and great variation of employed interventions for clinical supervision		
7. How precise are the results? Are the results presented with confidence intervals?	• Robust methodology used to evaluate quality of review (ROBIS tool) for synthesis 1 and in alignment with design.	• difficult to determine given contingent design – No assessment of heterogeneity, No CI	• Without quality screening of primary studies for synthesis 2, high publication bias may have skewed findings.
8. Can the results be applied to the local population? Consider whether • The patients covered by the review could be sufficiently different from your population to cause concern • Your local setting is likely to differ much from that of the review	Synthesis 1 can be applied to the local context.	Synthesis 2 may be informed by bias and would not be reliable to apply to local context.	
9. Were all important outcomes considered?	Yes		
10. Are the benefits worth the harms and costs? Even if this is not addressed by the review, what do you think?	Yes. It is understood that the current evidence around clinical supervision is of low quality and poor. This informs future research and practice.		

Critical Appraisal Checklist for a Systematic Review as adapted by Dept. of General Practice, University of Glasgow. Adapted from: Critical Appraisal Skills Programme (CASP), Public Health Resource Unit, Institute of Health Science, Oxford and Oxman, A. D., Cook, D. J. & Guyatt, G. H. (1994). *Journal of the American Medical Association, 272*, 1367-1371.

Appendix C

Figure C1

IPV Intervention Consent



McMaster University Health Sciences

Nurse-Family Partnership™
Helping First-Time Parents Succeed

West Virginia University
Injury Control Research Center

Participant Information Sheet for Nurse-Family Partnership (NFP) Program Supervisors

Randomised Controlled Trial of an Intervention for Intimate Partner Violence in the Context of Nurse Home Visits
Funded by the Centers for Disease Control and Prevention

Purpose. You are being invited to participate in a research study about describing the process of supervising nurses who are implementing new curriculum elements within the Nurse-Family Partnership (NFP) program for women exposed to intimate partner violence (IPV). The study is conducted by Dr. Harriet MacMillan, a researcher at McMaster University, Ontario, Canada along with researchers from the West Virginia University and the Prevention Research Center for Family and Child Health at the University of Colorado. Information from this study will help in the evaluation of a new curriculum for IPV within the NFP.

Procedures. You will be supervising nurses who will be implementing a modified Nurse-Family Partnership curriculum. This program has been developed to address the needs of clients exposed to IPV.

- You are being asked to complete a short survey at four points over the course of the study: at the beginning, immediately following the on-site NFP IPV curriculum training session, at the 12 month point in the study, and at the end of the study. The surveys will take no longer than 20 minutes to complete.
- Additionally, you are being asked to participate in two interviews to be conducted by Dr. Susan Jack, who will also take notes during the interviews. The focus of the interviews will be to explore your perceptions of the training required to implement the new curriculum, NFP nurses' reactions to implementing the curriculum activities, the impact of delivering the new components on overall NFP service delivery, and the clinical supervision and case conference elements. The first interview will be completed around the12 month point in the study. The second interview will be completed at the end of the study. Each interview will last approximately 60-90 minutes. Dr. Jack will ask to digitally record the interview to make sure that everything said is accurately captured. No identifying information will be recorded, or if it is, it will be deleted from transcript made from the recording. You may request to review the digital recording if you wish.
- You will also be asked to maintain a written log documenting organizational changes that were required to implement the revised curriculum elements.
- Finally, Dr. Jack would like to request your permission to contact you by telephone every 4 to 6 weeks to address any questions the NFP team has regarding the implementation of the intervention protocol, and to keep notes of these conversations.

Confidentiality. The interviewer will provide strict **confidentiality.** Your name will not appear on the digital file or on any of the forms with your answers. Confidentiality will be protected further by storing all research data, including digital recordings, in a locked file or on a password-protected computer. If the results of the study are published, your name will not be used.

Risks/Benefits. There are no known physical or psychological risks associated with completing the surveys. During the in-depth discussion of sensitive issues such as IPV, you may experience feelings of emotional distress. If this occurs, the interviewer will ask if you would like to stop the interview. If required, at the end of the interview, the signs and symptoms of stress, a review of personal coping mechanisms, and information on community supports will be shared with you.

Your participation in this study is voluntary. You may refuse to participate, refuse to answer any questions, or withdraw from the study at any time with no effect on you or your employment within the agency. Refusing participation in this study will in no way affect your employment in the NFP program.

Compensation. There is no compensation offered for participation in this study.

Hamilton Health Sciences/McMaster DEC 2 0 2010 Research Ethics Board

Dec 10, 2010 v.1

page 1 of 2

Dr. Harriet MacMillan can be contacted confidentially at: (toll free) 1-866 403-3084 or by e-mail at macmilnh@mcmaster.ca.

If you have any questions about your rights as a research participant or the conduct of the study you may contact the Office of the Hamilton Health Sciences/Faculty of Health Sciences REB Chair at 905 521-2100, Ext. 42013.

You will receive a signed copy of this form.

Thank you very much for considering participation.

Consent

I fully understand the nature of this consent as explained to me by _____ and agree to participate in this study.

_____ _____ _____
Signature of Participant Print Name & Date

I, the undersigned, have fully explained the study to the person named above.

_____ _____ _____
Signature of Person Obtaining Consent Print Name & Date

_____ _____ _____
Signature of Principal Investigator Print Name & Date

McMaster University Health Sciences

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Helping First-Time Parents Succeed

West Virginia University
Injury Control Research Center

Participant Information Sheet for Nurse-Family Partnership (NFP) Program Nurses

Randomised Controlled Trial of an Intervention for Intimate Partner Violence in the Context of Nurse Home Visits
Funded by the Centers for Disease Control and Prevention

Purpose. You are being invited to participate in a research study about describing the process of implementing new curriculum elements within the Nurse-Family Partnership (NFP) program for women exposed to intimate partner violence (IPV). The study is conducted by Dr. Harriet MacMillan, a researcher at McMaster University, Ontario, Canada along with researchers from the West Virginia University and the Prevention Research Center for Family and Child Health at the University of Colorado. Information from this study will help in the evaluation of a new curriculum for IPV within the NFP.

Procedures. You will be delivering a modified NFP curriculum. This program has been developed to address the needs of clients exposed to IPV. You are being asked to complete a short survey at four points over the course of the study: at the beginning, immediately following the on-site NFP IPV curriculum training session, at the 12 month point in the study, and at the end of the study. The surveys will take no longer than 20 minutes to complete.

Also, you are being asked to provide your ideas, opinions and feelings regarding the process of delivering the new curriculum in a group setting of your colleagues. The group will be led by a trained moderator (Dr. Susan Jack). A research assistant will also attend to take notes of the meeting. The group will meet twice and each session will last approximately 90-120 minutes. The group meeting will be conducted during your regular working hours. The researcher will ask to digitally record the meeting to make sure that everything said by the group is accurately captured. No identifying information will be recorded, or if it is, it will be deleted from transcripts made from the recordings. You may request to review the digital recording if you wish.
Lastly, you will be asked to maintain and complete a written log to document the training activities completed and the new curriculum elements implemented.

Confidentiality. The moderator will provide strict **confidentiality.** Your name will not appear on the digital file or on any of the forms with your answers. Confidentiality will be protected further by storing all research data, including digital recordings, in a locked file or on a password-protected computer. If the results of the study are published, your name will not be used.

Risks/Benefits. There are no known physical or psychological risks associated with completing the surveys. During the in-depth discussion of sensitive issues such as IPV, participants may experience feelings of emotional distress. If this occurs, the moderator will ask the participant if she would like to leave the group. At the conclusion of the group discussion, the signs and symptoms of stress, a review of personal coping mechanisms, and information on community supports will be shared with each participant.

Your participation in this study is voluntary. You may refuse to participate, refuse to answer any questions, or withdraw from the study at any time with no effect on you or your employment within the agency. Refusing participation in this study will in no way affect your involvement in the NFP program.

Compensation. During the group meeting, which will occur during working hours, a meal will be provided.

Dr. Harriet MacMillan, the Project Director, can be contacted confidentially at: (toll free) 1.866 403.3084 or by e-mail at macmilnh@mcmaster.ca.

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McMaster University Health Sciences

Nurse-Family Partnership™
Helping First-Time Parents Succeed

West Virginia University
Injury Control Research Center

If you have any questions about your rights as a research participant or the conduct of the study you may contact the Office of the Hamilton Health Sciences/Faculty of Health Sciences REB Chair at 905 521-2100, Ext. 42013.

You will receive a signed copy of this form.

Thank you very much for considering participation.

Consent

I fully understand the nature of this consent and agree to participate in this study.

Signature of Participant	Print Name & Date

I, the undersigned, have fully explained the study to the person named above.

Signature of Person Obtaining Consent	Print Name & Date
Signature of Principal Investigator	Print Name & Date

Appendix D

Figure D1

IPV Intervention Interview Guide for Focus Groups

Nurse-Family Partnership Intimate Partner Violence Intervention

Intervention Sites (Final Focus Groups)

The NFP Intimate Partner Violence intervention was developed specifically for NFP nurse home visitors to identify and respond to disclosures of NFP among socially and economically disadvantaged pregnant women and first-time mothers. The goals of the intervention, outlined in the NFP IPV clinical pathway, are to support nurse home visitors to:

1. Identify women exposed to, or at-risk, of exposure to IPV
2. Complete in-depth clinical assessments to identify the types and frequency of IPV exposure
3. Respond empathically to disclosures of abuse
4. To conduct risk assessments and tailored safety planning
5. To ascertain a women's stage of readiness to address safety for herself and her child and then tailor interventions to that stage – focused on safety, awareness of IPV, self-efficacy and social support.

The overall goal of implementing this intervention was to reduce maternal and child exposure to IPV and to increase maternal quality of life.

In this final focus group, I would like to learn about your experiences in using the NFP IPV clinical pathway in your home visiting work and how this intervention has influenced the delivery of your nursing care. I would also be interested in hearing your perceptions of how your clients have responded to this new approach to assessing for and responding to IPV.

I. General Impact

- **a.** In your experience, what has been the most significant impact that implementing the NFP IPV intervention has had on your nursing practice?
  - **i.** What impact overall did this intervention have on your delivery overall of the NFP program?
  - **ii.** For women who were enrolled in the RCT, very few of them received the full dose of the intervention. What barriers or challenges existed that limited your capacity to implement the NFP IPV Clinical Pathway with Fidelity?
- **b.** How has the IPV work impacted you professionally as a nurse?
  - **i.** Do you have greater competence or confidence to assess and identify IPV?
  - **ii.** Do you have greater competence or confidence to respond to disclosures of IPV?

c. How did asking about and addressing IPV impact the nurse-client relationship?

II. Identification of IPV

The clinical pathway outlines three different ways in which a nurse home visitor might create opportunities to learn about a client's exposure to IPV: a) universal assessment of safety, b) indicator-based assessment; and c) client-initiated disclosure.

a. How was your nursing practice influenced by the introduction of these new strategies for identifying IPV?
b. What were the positive outcomes related to using these identification strategies?
c. What were challenges you experienced in implementing these strategies?
d. What nursing strategies do you use to conduct IPV assessments when the partner or father are in the home?
e. What solutions were implemented to address these challenges?
f. How did your clients respond to a) the universal assessment of safety; b) the indicator-based assessment?

III. Clinical IPV Assessment
IV.

Instead of conducting a Relationship Assessment during the first- visit, the IPV pathway recommended conducting an in-depth clinical assessment following the Universal Assessment of Safety, an indicator-based assessment or when a client self-disclosed a situation of violence.

a. How was your nursing practice influenced by the introduction of the Clinical IPV Assessment?
b. What were the positive outcomes related to using conducting the Clinical IPV Assessment?
c. What were challenges you experienced in conducting this assessment?
d. What solutions were implemented to address these challenges?
e. How did your clients respond to the Clinical IPV Assessment?

V. Empathic Response to a Disclosure of IPV

a. What have been your client's responses once they disclose their IPV experiences to you?

VI. Risk Assessment

a. How was your nursing practice influenced by the introduction of the Danger Assessment?
b. What were the positive outcomes related to using the Danger Assessment?
c. What were challenges you experienced in conducting the Danger Assessment? On the implementation logs – only about 25% of women nurses identified as abuse had the Danger Assessment?

d. How did your clients respond to the Danger Assessment process, scoring and follow-up –e.g. tailoring safety plans to their level of danger?

VII. Tailored Assessment

An important component of the NFP IPV intervention was to use a range of tools (e.g. Mothers Stories of Strength and Survival, Making Changes in My Life) to ascertain what "stage" a client is in – in terms of her readiness to change or address safety- so that you could tailor your nursing interventions to her level of readiness and to meet her needs.

a. How did you implement this part of the intervention?
b. What worked? Why?
c. What didn't work? Why?

VIII. SASS Tailored Intervention

A number of facilitators were developed for you to use to help clients reflect on safety planning, increase their awareness of the impact of IPV on their health and their child's health, to enhance maternal self-efficacy and to increase a client's use of social supports to assist with issues related to violence exposure.

a. How did you implement this part of the intervention?
b. What worked? Why?
c. What didn't work? Why?

IX. Uptake and Implementation of Intervention

a. What strategies promoted the uptake and implementation of the intervention?
b. What strategies supported delivery of the intervention with fidelity to the clinical pathway?
c. Has the education and tools you were provided resulted in a sustained change in your practice in how you identify and respond to IPV?
    i. If yes – how has this practice change been sustained?
    ii. If no- what is required to sustain the practice change?

X. Supervision

a. What role can supervisors play in supporting nurse home visitors in their work with families experiencing violence?
b. What challenges associated with working with families experiencing violence are raised during reflection supervision?
    i. What responses/strategies have been supportive?
    ii. What additional strategies could be employed?

XI. What advice would you give to other NFP nurses who will have the opportunity to learn about and then implement the IPV intervention?

XII. What advice would you give to the NFP National Service Organization about the best way to introduce the IPV intervention, into NFP practice?

Figure D2

IPV Intervention Interview Guide for Supervisors

Nurse-Family Partnership Intimate Partner Violence Intervention

Intervention Sites

Interview Guide – NFP Supervisors

Introduction

Hello, my name is Cynthia Stone and I am a Masters of Nursing student working with Dr. Susan Jack on the Nurse-Family Partnership Intimate Partner Violence process evaluation. Thank you for taking time to speak with me today. The interview today will last approximately 60 minutes - 90 minutes.

This interview is part of a program of research to evaluate both the outcomes and process associated with the NFP Intimate Partner Violence Intervention. The overall purpose of this interview is to understand *how* supervisors supported the implementation and uptake of the NFP IPV clinical pathway into practice, as well as to explore your role in supporting nurse home visitors in their work with women and children exposed to violence. We are most interested in learning about your personal experiences working in the program, including the successes and challenges you have encountered throughout this process, and how you have addressed challenges. There are no right or wrong answers. Your participation is completely voluntary and we can stop the interview at anytime. The information you share about your work in the NFP program will also remain confidential and will not be shared with anyone on your team, your employer or individuals at the NFP National Service Office. Instead, the data from the interviews will be synthesized and general broad themes will be summarized and shared back to all of the NFP sites and stakeholders.

The NFP Intimate Partner Violence intervention was developed specifically for NFP nurse home visitors to identify and respond to disclosures of intimate partner violence among socially and economically disadvantaged pregnant women and first time mothers. The goals of the intervention, outlined in the NFP IPV clinical pathway (*send a copy of the pathway at the time of scheduling the interview)*, are to support nurse home visitors to:

6. Identify women exposed to, or at-risk, of exposure to IPV

7. Complete in-depth clinical assessments to identify the types and frequency of IPV exposure
8. Respond empathically to disclosures of abuse
9. To conduct risk assessments and tailored safety planning
10. To ascertain a women's stage of readiness to address safety for herself and her child and then tailor interventions to that stage – focused on safety, awareness of IPV, self-efficacy and social support.

The overall goal of implementing this intervention was to reduce maternal and child exposure to IPV and to increase maternal quality of life.

In this final interview, I would like to learn about your experiences in supporting nurse home visitors to implement and deliver the NFP IPV intervention

XIII. General Impact

a. In your experience, what has been the most significant impact that implementing the NFP IPV intervention has had on the delivery of the NFP program in your agency?

b. In achieving the goal of identifying women who are exposed to abuse and then responding to meet their needs, how does the NFP IPV intervention (all components) compare to other alternatives that have been tried before?

c. What advantages does this intervention have compared to other IPV programs or interventions?

d. How has the IPV impacted you professionally as a nurse supervisor?

XIV. Implementation

Please describe your role (as a supervisor) in implementing the NFP IPV intervention into the home visitation work of your team related to the following activities:

i. Supporting completion of the NFP IPV Education modules

ii. Integration and delivery of the NFP IPV Intervention as part of nursing practice

iii. Role in clinical supervision.

iv. Role in reflective supervision.

XV. Identification of IPV

The clinical pathway outlines three different ways in which a nurse home visitor might create opportunities to learn about a client's exposure to IPV: a) universal assessment of safety, b) indicator-based assessment; and c) client-initiated disclosure. All of these are followed by the completion of the Clinical IPV Assessment.

g. What impact did integration of these new identification and assessment procedures have on the delivery of the NFP program by nurses and for clients?

XVI. SASS Tailored Intervention

A number of facilitators were developed for nurses to use to help clients reflect on safety planning, increase their awareness of the impact of IPV on their health and their child's health, to enhance maternal self-efficacy and to increase a client's use of social supports to assist with issues related to violence exposure.

d. How did you implement this part of the intervention?
e. What worked? Why?
f. What didn't work? Why?
g. What changes (if any) would you make to improve implementation?

XVII. Uptake and Implementation of Intervention

a. What strategies did you develop and implement to integrate the NFP IPV clinical pathway into existing NFP visit-to-visit guidelines? Do you have any tools or checklists that you developed that you could share with us?
b. [Adaptability]. What strategies supported delivery of the intervention with fidelity to the clinical pathway? In your estimation, were nurses able to implement this intervention with fidelity to the clinical pathway? Why or why not? What changes or alterations did you have to make to the intervention to ensure that it would work in your agency? Please describe.
c. What challenges emerged related to integrating the NFP IPV clinical pathway into nurse home visitor practice?
d. Has the education and tools you were provided resulted in a sustained change in your practice in how you support nurses working with families experiencing IPV?
    i. If yes – how has this practice change been sustained?
    ii. If no- what is required to sustain the practice change?

XVIII. Supervision

i. During the period of the study, how did you use the Supervisor Implementation Manual?
ii. If it was not used, explore why.
iii. If it was used, explore what additional content needs to be added to the manual.
iv. In addition to the IPV education received by nurses and supervisors, what supervisor specific education is required related to the issue of IPV?

b. What challenges associated with working with families experiencing violence are raised during reflection supervision?
    i. What responses/strategies have been supportive?
    ii. What additional strategies could be employed?
    iii. How could the guidelines for reflective supervision be improved?
c. A clinical consultant (Dr. Susan Jack) was available to you and your team on an "as needed" basis to provide support in addressing issues related to intervention implementation or to consult on clinical issues.
    i. Did your team take advantage of this support? Why or why not?

ii. If the NFP IPV intervention is integrated at a national level – how important would it be to have access to a clinical consultant? Why? Who should provide the clinical consultations (e.g. NFP Nursing consultant, contracted consultant with IPV expertise)?

XIX. What advice would you give to other NFP supervisors who will have the opportunity to learn about and then implement the IPV intervention?

XX. If the NFP IPV education and clinical pathway is updated to include recommendations from the sites that participated in the RCT, would you recommend that this NFP IPV Education and intervention be made available to all NFP sites across the US? Why or why not?

XXI. What advice would you give to the NFP National Service Organization about the best way to introduce a new innovation, such as the IPV intervention, into NFP practice?

XXII. Is there any other information about your experience with the NFP IPV intervention and education that you would like to share with our research team?

Appendix E

Table E1

NFP Supervisor Roles and Responsibilities for the IPV Intervention Implementation Process

Supervision Type: Administrative
Role: Manager Sub-roles: Evaluator, Collaborator, and Developer
Responsibilities: ***1) Assessment of Implementation Progress and Barriers*** ***a) Education*** -Assessing IPV education curriculum and IPV resources with NHVs: impressions, impact, value and gaps. Identifying additional educational needs for NHVs. -Assessing how the IPV intervention, tools, and resources are being utilized and interpreted by the NHV. -Evaluating the depth of IPV intervention delivery and interaction with the client by the NHV. -Reviewing community resources with NHVs and identifying gaps ***b) IPV intervention Experiences*** -Understanding NHV experience of the IPV intervention during implementation and obtaining feedback -Assessing what has worked well, and what challenges were encountered during the integration of the IPV intervention for NHVs and supervisors. ***c) Safety*** -Identifying challenges to NHV or client safety. ***d) Time Allocation*** -Assessing whether time allotted for the IPV intervention was adequate for IPV training, to maintain clinical pathway fidelity, and to carry out expected supervisor and NHV roles/responsibilities. ***e) Adherence to the Clinical Pathway*** -Assessing fulfillment of clinical pathway elements -Assessing completion of IPV intervention logs and documentation to determine clarity of expectation and level of completion. ***f) NHV Retention*** -Assessing barriers to NHV retention ***2) Strategizing with Partners and Executing Solutions*** -Networking with internal and external stakeholders (NHVs, clinical consultants, community partners) to review difficult challenges as they are encountered during delivery of the IPV intervention to identify responses. -Transferring formal power from supervisor to NHV where appropriate e.g. time and schedule management, visit prioritization. -Brainstorming strategies with NHVs to maintain fidelity to the IPV intervention clinical pathway. -Committing to prioritizing safety of NHV and client during IPV intervention implementation; creating strategies for risk mitigation. ***3) Creating and Sourcing New Tools and Resources*** -Generating new documentation resources for tracking, fidelity maintenance and reporting. -Facilitating a forum for IPV information exchange and engagement between NHVs and community partners (eg. inviting clinical psychologist or social work to team meetings) to identify new useful resources. -Sourcing new IPV learning opportunities for NHVs e.g. conferences or courses responding to educational gaps.
Supervisor Type: Clinical
Role: Planner

Responsibilities:

1) ***Forcasting Intervention Needs***
   -Blocking time to assess and identify site needs (e.g. readiness check-list completion) for integration of the IPV intervention.
   -Considering impact to current program delivery and plan for transition to incorporate the IPV intervention.

2) ***Scheduling Education and Meetings***
   -Designing a comprehensive schedule for NHV education sessions, team and reflective supervision meetings.
   -Arranging ad-hoc meetings as deemed necessary with NHVs and partners.

3) ***Preparing Resources***
   -Ensuring brochures, check lists and binders are available and replenished for NHVs to take to home visits.
   -Providing laminated copies of reference materials e.g. clinical pathway.
   -Creating a space (eg. filing cabinet) where physical resource materials will reside.
   -Reserving training facilities for IPV education sessions with supervisors and experts.
   -Organizing NHVs to plan the education modules into their schedule.
   -Maintaining current IPV information and resources; updating as appropriate, educating and distributing updates to NHVs.

Role: Educator

Responsibilities:

1) ***Learning as a Student***
   -Participating in self-directed and/or expert-led IPV education curriculum.

2) ***Training Nurse Home Visitors***
   -Teaching IPV educational resources to NHVs: modules, tools, forms, check lists and clinical pathway or facilitating self-directed learning.
   -Clarifying IPV intervention expectations, NHV roles and responsibilities (e.g. assessment to complete relative to visit number, how to complete/log documentation, and clinical pathway adherence).
   -Facilitating IPV education delivery from experts with NHVs (e.g. arranging facilities for training and scheduling
   -Incorporating various learning styles (e.g. videos, interactive sessions, visuals).
   -Reviewing IPV education by NHV has been completed in full.

3) ***Reviewing Knowledge***
   -Re-visiting IPV education, resources, and expectations as applicable during team meetings and reflective supervision sessions to encourage application of learning and NHV integration of IPV intervention materials into practice.
   -Showcasing IPV resources (e.g. power and control wheel) during NHV team meetings to reinforce learning.

Role: Reporter

Responsibilities:

1) ***Recording Data***
   -Ensuring completion of forms, assessments, checklists, and data entry logs related to the IPV intervention.
   -Tracking the location of the NHV (i.e. visit number) within the IPV clinical pathway;

Supervisor Type: Reflective

Role: Counsellor

Responsibilities:

1) ***Exploring Feelings***
-Creating a safe environment, free of judgement, during reflective supervision sessions for NHVs to express their feelings (e.g. compassion fatigue) and help understand gut-reactions and biases.
-Facilitating emotional discovery and self-awareness with open-ended style questioning. Exploring root causes.
-Employing motivational interviewing skills during reflective supervision sessions to show how to these skills can be used with their clients.
-Identifying NHV level of comfort for delivery of the IPV intervention in the client's home.
-Assisting NHVs to understand feelings and biases that can interfere with delivery of the IPV intervention.
-Ensuring sessions are productive and purposeful rather than listening solely to help NHVs vent.
-Identifying and addressing (if led by NHVs) any feelings, or experiences of NHVs' own trauma related to IPV that NHVs would like to discuss.
-Offering organizational supported options (eg. Employee Assistance Program services) as needed to NHVs.
-Understanding fears of NHVs.

2) ***Identifying IPV Intervention Barriers***
-Discovering challenges encountered by NHVs impeding the delivery of the IPV intervention (e.g. getting the client alone).
-Assisting with NHVs understanding and acceptance for the position of the client (seeing from the client's perspective).

3) ***Imparting Accountability***
-Reviewing IPV intervention expectations and responsibilities.
-Discussing unmet expectations with NHVs e.g. documentation, assessments, resource utilization.

4) ***Strategizing Next Steps***
-Reviewing IPV resources, assessments, and tools that could be used in the home with the client.
-Reviewing what has worked historically.
-Formulating a plan with the NHV for the next visit.
-Implementing safety precautions and protocols for NHV or client or both.

Supervisor Type: Supportive

Role: Encourager

Responsibilities:

1) ***Providing Positive Messaging***
-Being a role model for NHVs; demonstrating a positive attitude about the IPV intervention and focusing on the benefits of the intervention.
-Helping NHVs see what they are doing well for the client.
-Encouraging NHVs to do their best and presenting as "cheerleader" for NHVs until they become more comfortable with the IPV intervention.

2) ***Inspiring Engagement***
-Empowering NHVs to bring challenging issues to team meetings to discuss with their peers.

Role: Mentor

Responsibilities:

5) Modeling Behaviours and Skills

-Demonstrating a creative mindset for brainstorming solutions.
-Modeling positive behaviours such as respect, care and empathy with NHVs to show how these behaviours can be utilized with their clients.
-Assisting the nurse to move to the next level with the client in lieu of identifying only using motivational interviewing skills.

6) Coaching Staff Development

-Facilitating time management skills/ helping NHVs prioritize responsibilities.
-Providing guidance on how to implement the intervention when encountering challenges to pathway fidelity
-Helping NHVs see their capacity (e.g. identifying what they already know and have done well).
-Building on identified NHV strengths.
-Prioritizing individual and client safety.
-Showcasing complicated case scenarios from reflective supervision sessions in team meetings to brainstorm solutions and next steps with the NHV team members.
-Generating awareness of community IPV resources.

7) Creating Opportunities for Applied Learning

-Scheduling extra time as needed to meet and review client situations or concerns.
-Enabling a culture where NHVs feel comfortable to drop-in as needed and discuss issues.
-Identifying ad hoc opportunities to solidify IPV curriculum skills
-Offering accessibility by providing communication channels of support such as texting.

Table E2

Descriptions of NFP Supervision Concepts for the IPV Intervention Implementation Process

Supervision Concept	Description
NFP Supervision Framework	A model representing NFP supervisor functions while implementing the IPV intervention into daily practice by NHVs. This model comprises 2 main categories called domains and roles, and captures NFP supervision as a hierarchy of 2 levels. Level 1 (the highest level) is operationalized by the administrative supervision domain and its related work roles and, level 2 by clinical, reflective and supportive domains and their related roles. Level 1 refers to supervision domains and roles that function in the oversight of level 2 domains and roles.
Domain	The broadest category of the NFP supervision framework describing a single role or collection of related supervisor roles and sub-roles.
Roles	A category of the NFP supervision framework describing a collection of related work responsibilities and represented by an overarching domain category. This category is more refined than a domain.
Sub-roles	A sub-category of roles of the NFP supervision framework that further describes a single parent role function.
Responsibilities	A category of supervision associated with roles of the NFP supervision framework, identifying individual tasks completed by supervisors during implementation of the IPV intervention.
Administrative Supervision (Level 1 Domain)	One of 4 domains represented in the NFP supervision framework and, positioned at a level 1 function with respect to operation. This supervision domain (with its related role of manager and sub-roles of evaluator, collaborator and developer) is informed by level 2 clinical, reflective and supportive domains and their related roles. This executive level 1 domain functions in the oversight of level 2 domains, using assessment and evaluative methods to create strategy and responsive solutions ensuring fidelity of IPV intervention's clinical pathway is maintained.
Clinical Supervision (Level 2 Domain)	One of 3 level 2 domains of the NFP supervision framework, representing the "action" type work of the supervisor for implementation of the IPV intervention by the NHV team. This domain comprises 3 supervisor roles of planner, educator, and reporter. Level 2 domains inform the executive function of level 1 domains.
Reflective Supervision (Level 2 Domain)	One of 3 level 2 domains of the NFP supervision framework, describing the counsellor role of the NFP supervisor, engaged in understanding experiences of NHVs and their clients during the delivery of the IPV intervention. Level 2 domains inform the executive function of level 1 domains.
Supportive Supervision (Level 2 Domain)	One of 3 level 2 domains of the NFP supervision framework, responsible for keeping the IPV intervention going and maintaining implementation

	momentum by employing the roles of mentor and encourager. These roles enable positive reinforcement and solidification of NHV training and competency development. Level 2 domains inform the executive function of level 1 domains.
Manager	One of 7 roles of the NFP supervision framework. A role belonging to the administrative supervision domain of the NFP supervision framework that should not be confused with the NFP organizational position title of manager. This role comprises three sub-roles in relation to its function including: evaluator, collaborator, and developer. This role occupies a position of oversight for all other roles and associated responsibilities and, is accountable for the success of the IPV intervention by using assessment, appraisal, and a strategic response.
Planner	One of 7 roles of the NFP supervision framework. A role belonging to the clinical supervision domain of the NFP supervision framework, responsible for forecasting a site's needs relative to the IPV intervention, scheduling NHV training and meetings, and preparing IPV intervention resources.
Educator	One of 7 roles of the NFP supervision framework. A role belonging to the clinical supervision domain of the NFP supervision framework involving all aspects of IPV intervention curriculum training including: learning, teaching, and reviewing.
Reporter	One of 7 roles of the NFP supervision framework. A role belonging to the clinical supervision domain of the NFP supervision framework where documentation and log entries are reviewed ensuring that all is completed as expected.
Counsellor	One of 7 roles of the NFP supervision framework. A role belonging to the reflective supervision domain of the NFP supervision framework, focused on understanding the feelings and experiences of NHVs and their clients while implementing the IPV intervention. This role is formalized, with weekly scheduled reflective supervision sessions, to review NHV progress delivering the IPV intervention and facilitating solutions to challenges that arise prior to the next visit.
Mentor	One of 7 roles of the NFP supervision framework. A role belonging to the supportive supervision domain of the NFP supervision framework, overlaps with the counsellor role in the lens of listening and coaching by the supervisor. The mentor role is differentiated however, in that it is not a formalized role, and picks up from the counsellor role with an ongoing informal exchange whenever needed by the NHV. The goal of this role is to support NHV growth and development outside of reflective supervision sessions, while modelling skills and behaviours to facilitate improved client support.
Encourager	One of 7 roles of the NFP supervision framework. A role belonging to the supportive supervision domain of the NFP supervision framework serving as the positive attitude behind the roll-out of the new IPV intervention to NHVs, identifying NHV's personal strengths in the nurse-client relationship, and inspiring NHVs to lead team building opportunities. Similar to the mentor role, the encourager role is an ongoing, informal role. Supervisors in this role operate with the goal to invoke a motivation and engagement.

Evaluator	One of 3 sub-roles of the parent manager role, belonging to the administrative supervision domain of the NFP supervision framework functioning in the assessment and appraisal of each Level 2 supervision domain and associated roles and responsibilities. The output from the evaluator sub-role often becomes the input for the actions of the collaborator and developer sister sub-roles.
Collaborator	One of 3 sub-roles of the parent manager role, belonging to the administrative supervision domain of the NFP supervision framework and closely tied with the sister roles of evaluator and developer. This sub-role involves taking information from the assessments performed by the evaluator role and working with partners to identify strategies and solutions to presented challenges.
Developer	One of 3 sub-roles of the parent manager role, belonging to the administrative supervision domain of the NFP supervision framework, working in tandem with evaluator and collaborator sister sub-roles. In this sub-role, information is acquired from the evaluator and collaborator sub-roles, supervisors envision change needed to better the IPV intervention and design new tools, ideas, opportunities, and recommendations to improve the intervention.