A Model of Shared Supervision in Nurse-Family Partnership: A Descriptive Case Study

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Background

Nurse-Family Partnership® (NFP) is a home visitation program where young women and adolescent girls are enrolled early in pregnancy with visits continuing until the child's second birthday (Olds et al., 2013). In Ontario, public health nurses who have completed the NFP nurse education deliver this program through regular, intensive, and mutually planned visits with first-time mothers living in situations of socioeconomic disadvantage (Olds, 2006). NFP program goals include improving: 1) pregnancy outcomes; 2) child health and development; and 3) parents' health and economic self-sufficiency (Olds, 2006). In the United States, NFP has been established as an effective intervention with over four decades of robust evidence, including three randomized controlled trials, which has resulted in the program being implemented at scale in 42 states.

Given the robust evidence from the United States for the effectiveness of the NFP program in positively improving a range of maternal and child health outcomes, efforts were initiated to bring NFP to Canada. It was positioned as a public health strategy to promote healthy behaviours in pregnancy, prevent child maltreatment, improve children's health and development, and to improve the lives of parents and their children living in disadvantaged circumstances. However, as baseline health and social services differ in the United States compared to other countries, the Prevention Research Center for Family and Child Health at the University of Colorado Anschutz Medical Campus requires that countries with a long-term goal of implementing NFP agree to follow a four-phase framework for international evaluation of the intervention (Table 1).

Table 1. ***NFP International Implementation: Four-Phase Framework***

Phase	Description
Phase One: Adaptation	Examine the adaptations needed to deliver the NFP program in local contexts while ensuring fidelity to the NFP model.
Phase Two: Feasibility and acceptability through pilot testing and evaluation	Conduct a pilot test of the adapted NFP program to inform what additional adaptations may be needed to ensure the feasibility and acceptability of the adapted NFP program.
Phase Three: Randomized controlled trial	Consider expansion of the testing and evaluation work by conducting a randomized controlled trial.
Phase Four: Continued refinement and expansion	Once the evaluation of the randomized controlled trial findings has been completed and the outcomes found to be of public health significance, the implementing agency may decide to further refine and expand the adapted NFP program in their society.

Adapted from: Prevention Research Center (2023)

A summary of how the four-phase process for international evaluation and implementation unfolded in Canada is summarized in Table 2. Adaptation of NFP materials for the Canadian context is an ongoing collaboration between NFP nursing practice leads in Ontario and British Columbia (BC), public health management, front-line public health nurses and nurse researchers to integrate feedback from those with clinical experience delivering NFP, with existing best practices and research evidence. The original pilot study (2008-2012) to establish the feasibility of delivering NFP and the acceptability of this program to clients, public health nurses, and community stakeholders was conducted in collaboration with the City of Hamilton Public Health Services. From 2016-2018, an additional study to develop, pilot, and evaluate a Canadian Model of NFP Education (CaNE project) was conducted in collaboration with four Ontario public health units (Niagara Region Public Health & Emergency Services, Toronto Public Health, York Region, and Middlesex London Health Unit).

Table 2. ***Timeline for adaptation, piloting, and evaluation of NFP in Canada***

Years	Evaluation Component	Activities
2008-11	Phase 1: Adaptation	Adapt NFP guidelines to include Canadian standards of evidence and update content
2008-12	Phase 2a: Feasibility study	Pilot study testing procedures for the recruitment and retention of pregnant and parenting young women and evaluation of instruments for collecting clinical and interview data from participants
2008-12	Phase 2b: Acceptability study	A qualitative case study exploring the acceptability of NFP to clients, their families, public health nurses and community stakeholders
2011-ongoing	Phase 3a: Ongoing adaptation to program materials	Updating and revisions of the NFP Canadian visit-to-visit guidelines Development, piloting, and evaluation of a Canadian model of NFP Education (CaNE project) (2016-2018)
2011-14	Phase 3b: Preparation for randomized controlled trial- public health nurse/ supervisor education	Hiring of public health nurses and supervisors; complete nurse education
2013-2022	Phase 3c: Large scale randomized controlled trial in British Columbia (BC Healthy Connections Project) (Catherine et al., 2016)	Eligible pregnant women enrolled in randomized controlled trial comparing NFP to existing services
2013-2020	Phase 3d: Process evaluation (Jack et al., 2015) Healthy Foundations Study (Gonzalez et al., 2018)	Two adjunctive studies to the randomized controlled trial implemented in BC
2022-ongoing	Phase 4: Continued refinement and expansion of program	Continued integration of NFP into existing public health programming in BC health authorities and Ontario public health units, as well as expansion to new Ontario sites. Expansion of program to Nova Scotia.

Team Composition and Supervision in NFP

The NFP international program (2019b) has outlined 14 core model elements that provide implementing agencies with guidance and criteria for client enrollment, intervention delivery, home visiting guidance, team composition, nurse and supervisor education, quality improvement processes, and supervision standards.

Guided by these core model elements, a typical NFP team consists of a full-time NFP supervisor leading a team of no more than eight full-time NFP public health nurses and a team administrator. In agencies where a smaller team is required to meet community needs, the guidance provided by the NFP International Program (2019a) is that the minimum team size is four NFP nurses, receiving support from a part-time supervisor. The supervisory activities that public health nurses engage in, facilitated by the NFP team supervisor, are summarized in Table 3.

Table 3. NFP Program Requirements for Nurse Supervision

1.	***Weekly reflective supervision*** (1 hour in length) with each full-time public health nurse (and on a pro-rated basis for nurses working part-time in NFP).
2.	Twice a month: ***case conference meetings*** to discuss team challenges, conduct joint case reviews, and review data reports.
3.	Twice a month: ***team meetings*** to address administrative issues such as program implementation issues and team building.
4.	***Accompanied home visits*** with each public health nurse every four months, allowing the supervisor to observe the nurse-client interaction and then subsequently facilitate a reflection with the nurse that promotes the development of the nurse's clinical practice.
5.	***NFP education/learning activities***, including coordinating nurse attendance at core NFP education, identifying individual/team learning needs, and creating structured time or learning activities to address these needs.

In addition to the above responsibilities, many NFP supervisors are also responsible for program planning and implementation, representing NFP at community tables and meetings, and managing administrative functions (including hiring, conducting performance appraisals, staffing, planning and budgeting responsibilities).

INSIGHTS INTO NFP SUPERVISION IN CANADA

Public health nurses' experiences with and supervisors' perceptions of the NFP model of supervision were explored in both the initial pilot study to determine the acceptability of delivering NFP through public health in Canada and in the BCHCP process evaluation. In public health organizations where NFP supervisors are valued and supported in their roles by senior management, a workplace culture is created where these

supervisors can successfully implement the multifaceted NFP supervision model (Jack et al., 2020). Across NFP programs, there is consensus that the NFP model of supervision is essential for providing them with the support and structure needed for their home visiting practice with families experiencing social and economic disadvantage (Jack et al., 2012; Jack et al., 2020). In the BCHCP process evaluation, both nurses and supervisors agreed that engagement in regular, high-quality reflective supervision was an essential component of the NFP program that promotes nurses' professional growth and is a valued tool for preventing compassion fatigue.

In the Canadian NFP pilot and BCHCP process evaluation studies, NFP teams achieved a high level of success in conducting the required number of team meetings and case conferences (Jack et al., 2012; Jack et al., 2020). Generally, public health nurses participated in weekly reflective supervision on a consistent basis (Jack et al., 2012; Jack et al., 2020). It was noted that the quality of the reflective supervision experience is influenced by individual, relational and procedural characteristics (Jack et al., 2020). The establishment of a nurse-supervisor relationship where deep and honest reflection can occur is considered foundational to the reflective supervision process (Jack et al., 2020). NFP public health nurses identified that both the supervisor and nurse need to experience psychological safety within the relationship, and trust that the sharing of emotions and experiences will be met with non-judgmental and non-punitive responses (Jack et al., 2020). However, some NFP nurses did express that it can be difficult to honestly engage in the process of reflective supervision when their supervisor is also the individual responsible for their performance appraisal (Dmytryshyn et al., 2015). When supervisors or managers have multiple roles and are required to simultaneously provide reflective, clinical, and administrative supervision, this creates a context where the goals of reflective supervision may be comprised. This occurs because reflective supervision is relational and needs to occur within a context where staff feel safe to be vulnerable while reflecting on how their beliefs, emotions and experiences influence their interactions with clients, without fear of judgment or recrimination that their experiences will influence an appraisal of their performance (Hause & LeMoine, 2022).

Findings from the BCHCP process evaluation (Jack et al., 2020) suggest that a range of contextual factors may influence an NFP team's capacity to maintain fidelity to the core model elements related to supervision. In a large geographical health region, nurses may not be physically situated in the same office as their immediate supervisor. Furthermore, travel constraints or weather barriers may limit flexibility to schedule or complete the required supervisor accompanied home visits. NFP implementing agencies with small NFP teams or part-time NFP nurses have limited flexibility in scheduling their individual reflective supervision or to participate in all team meetings, education sessions, or case conferences. Supervisors managing multiple responsibilities also reported that they re-scheduled supervisory sessions due to competing agency demands. Finally, while public health nurses appreciated the scheduled supervisory sessions, they noted there were times when they would have appreciated the flexibility to have an "unscheduled" session with their supervisor to reflect and explore their feelings towards an emerging or current challenging clinical situation (Dmytryshyn et al., 2015). During these periods of times, nurses often turned to their NFP nurse colleagues to engage in a process of "peer" debriefing (Dmytryshyn et al., 2015).

THE PROPOSED MODEL OF SHARED SUPERVISION IN NFP

To respond to some of these identified challenges in providing reflective supervision an opportunity to pilot and evaluate an alternative model of nurse supervision in NFP was identified during the CaNE pilot project. The typical NFP supervision model assigns one NFP supervisor to complete all NFP supervision responsibilities in addition to any other leadership obligations from the agency. Typically, this individual provides administrative, clinical, and reflective supervision to the NFP nurses on the team. In the proposed adaptation, two distinct supervisory roles were developed:

1. An ***NFP Program Manager,*** responsible for administrative supervision and oversight of program implementation and delivery. The NFP Program Manager was also responsible for providing overall leadership to the NFP program, participating in required provincial NFP meetings, as well as other non-NFP management roles, including regular human resource duties.

2. A ***NFP Team Lead***, a public health nurse who was responsible for reflective and clinical supervision with the team of nurses. For the NFP Team Lead, half of the position was dedicated to supervisory responsibilities and the remaining half was reserved for regular NFP public health nursing practice (i.e., delivering the program to half the regular caseload of NFP clients).

Given this novel approach to NFP supervision, it was important to evaluate the proposed model and outcomes to ensure continued fidelity to the NFP core model elements.

Therefore, the purpose of this study was to describe this unique model of shared supervision as implemented within one NFP program, situated within an Ontario public health unit. Understanding how this model of supervision was operationalized, as well as nurses' and supervisors' experiences of working within this model were also explored. Within the context of this study, a secondary objective was to also explore how NFP was integrated into the local existing home visitation program. and public health programming.

The findings from this study will provide guidance to Niagara Region Public Health & Emergency Services about the benefits and challenges associated with this model and guide future decisions about the sustainability of this model. The findings from this study, will also provide insights and guidance to other NFP implementing agencies across Canada and in other countries about the potential for implementing a novel approach to supervision as well as recommendations for integrating NFP into existing public health programming.

Research Design

A single, descriptive case study (Yin, 2014) was conducted to answer three research questions:

1. What are the characteristics of a shared model of NFP supervision as implemented by the Family Health Division, Niagara Region Public Health & Emergency Services?

2. What are the experiences of implementing and delivering the NFP program within the context of this shared model of supervision?

   The conduct of this case study also provided the team with an opportunity to answer a broader question of interest related to NFP-program integration into existing public health services:

3. How has the Family Health Division at Niagara Region Public Health & Emergency Services integrated the NFP home visitation program with their existing Healthy Babies Healthy Children (HBHC) program?

A case study research design involves the description, exploration, or explanation of a unique condition within its real-life context (Yin, 2014). It is a particularly useful method for investigating complex social interactions, when investigators have minimal control over variables, and when boundaries between the phenomenon under study and the context in which it is situated are not clearly delineated (Yin, 2014). In this study, the case under evaluation was a description of a model of shared supervision in NFP. This case was bounded by both time (2018-2019) and location (Family Health Division, Niagara Region Public Health & Emergency Services). Embedded within this case study, elements related to program implementation were also explored and described.

CONTEXT AND SAMPLE

This case study was conducted within the context of the Family Health division at Niagara Region Public Health & Emergency Services as this was the only public health unit with an NFP site in Canada piloting this novel approach to supervision.

In a case study, it is essential to include individuals who can provide a rich, comprehensive description of the phenomenon under study. Therefore, all the NFP public health nurses including the NFP Team Lead (n=5) and NFP Program Manager delivering NFP in the Niagara region were invited to participate and to offer their descriptions of how this model of supervision was developed and implemented by the local NFP team. To enrich the exploration of the advantages and challenges of adopting this novel model of supervision, as well as integrating NFP into an existing public health program, snowball sampling was employed to identify other public health stakeholders (n=8) to participate in the study.

DATA COLLECTION AND ANALYSIS

Participants' perceptions of their experiences with the adapted model of NFP supervision were explored in one-to-one, in-depth semi-structured interviews. NFP team members were invited to participate in two interviews. The focus of the first interview was to learn about their roles and responsibilities within the program, understand the process of implementing this shared model of supervision, and explore any perceived advantages or disadvantages to its use. The second interview continued to explore their experiences of working within the shared supervision model over time. The stakeholder interviews included questions about their roles and responsibilities with respect to NFP, and their perceptions of how NFP has been implemented and integrated into existing health unit program policies, and procedures.

All interview data were transcribed verbatim with identifying information removed. An analytical process for rapid turn-around in health service research was utilized. This involved the primary analyst reading all transcripts first in their entirety. Then a data synthesis template was developed, using domains from the interview guide. Information from each transcript was synthesized within a template, including the extraction of powerful quotes. Verbatim data or quotes extracted directly from a transcript are typically selected when the analyst perceives that the direct words of a participant particularly exemplify the concept being described. Findings across domains were then summarized.

To describe the frequency of supervisory activities facilitated by the NFP Team Lead with the NFP public health nurses between September 2018 and November 2019, de-identified data from a program database were also extracted and analyzed using descriptive statistics. The following data were extracted: number of accompanied home visits/public health nurse, date and length of time of reflective supervision sessions/ public health nurse; and the number of team meetings, case conferences, or education sessions (including date, length of time, and number of attendees) conducted during this time period.

Findings

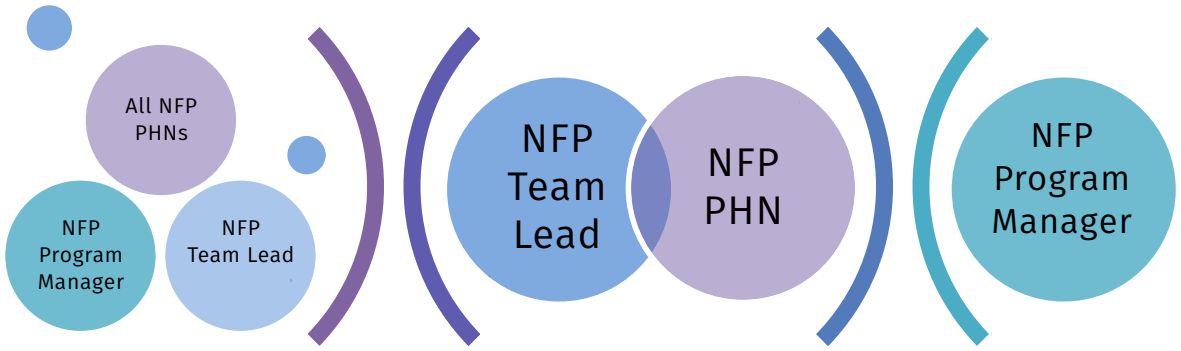
A total of 17 semi-structured interviews were conducted between June and November 2019. The Program Manager, Team Lead, and two NFP public health nurses were each interviewed twice (n=8 interviews); a third public health nurse who joined the team after study initiation completed a single interview (n=1). Eight stakeholders from the public health unit and external to the NFP program, including public health nurses from the Family Health Division, a Program Manager and an administrative staff member, each completed a single interview.

Between September 2018 and November 2019, a total of 170 reflective supervision sessions between the NFP Team Lead and NFP public health nurses were completed, averaging 60 minutes in length. Participating public health nurses engaged in an average of 43 reflective supervision sessions (range 31-49 sessions). The Team Lead observed 10 public health nurse facilitated home visits (i.e., an accompanied home visit) (range 2-5 accompanied home visits per public health nurse). This reflects an average of 2.5 accompanied home visits per public health nurse over a 15-month period. During this same period, the Team Lead coordinated or facilitated 20 team meetings, 15 case conferences, and 14 education or training sessions. Data were not collected on the number of reflective supervision sessions provided by the Program Manager for the NFP Team Lead.

CHARACTERISTICS OF THE NFP SHARED SUPERVISION MODEL

With respect to the provision or receipt of supervision, each NFP team member described the responsibilities associated with the public health nurse, Team Lead, or Program Manager roles (Figure 1).

Figure 1. ***Roles and Responsibilities within the NFP Shared Supervision Model***



NFP TEAM MEMBERS

Participate in NFP education session, team meetings, case conferences

Provide support to each member of the team, as required

PHN TEAM LEAD & NFP PHN

Meet individually for regular reflective supervision (weekly)

Participate in accompanied home visits

Plan and facilitate team meetings & case conferences

Determine together when NFP concerns should be escalated to NFP Program Manager

Carry NFP client caseload; NFP Team Lead carries reduced client caseload

NFP PROGRAM MANAGER

Provide overall leadership to NFP program

Provide reflective supervision to NFP Team Lead

Provide regular support to NFP Team Lead

Complete performance appraisals (or address performance concerns) with PHNs and Team Lead

Participate in required provincial NFP meetings

Manage non-NFP management responsibilities

ACCEPTABILITY OF A SHARED SUPERVISION MODEL

The shared model is highly acceptable to all NFP team members in Niagara Region Public Health & Emergency Services. External to the NFP team, but internal to the health unit, this model was described as a highly desirable supervisory process by other nursing staff, including practicing nurses, nursing managers, and senior decision makers. There was consensus that this model provided nurses with a foundation of support that then increased their confidence to provide high-quality home visitation services for pregnant clients as well as those clients who were new parents.

Within the context of the NFP team, this shared supervision model provided efficiency and flexibility for team members. Of greatest importance to the team, was that the Team Lead was readily available to the public health nurses at the times when their reflective supervisory needs were greatest. Similarly, this model provided an opportunity for the Team Lead to engage in reflective supervision with the Program Manager. Overall, NFP nurses expressed feelings of safety and comfort in being able to connect with and engage in supervision with a Team Lead. Being able to share, discuss, and reflect on their personal feelings and reactions to their work with families enrolled in NFP with a Team Lead was identified as emotionally safer with an individual who was not responsible for evaluating their performance or work quality, and who did not hold the title of "manager." Nurses hypothesized that with a more traditional model of supervision there could be circumstances where a nurse may fear a punitive response from a manager if they risked sharing their emotions and reflections about their clinical practice. As one NFP public health nurse explained:

> *"I feel very comfortable talking to [Team Lead]. I can see the benefit of saying to the Team Lead, "I was uncomfortable about this [practice issue] and this is the decision I made, what do you think?" Where I wouldn't be comfortable saying this to a manager. So, I see a huge benefit [to this model of supervision]. Not that I would expect the manager to say, "Oh, you shouldn't have done that" because that is not who she is or how she manages staff, but I think it's just the label, she's your manager.*

All NFP team members were asked to summarize the benefits and challenges of working within the shared supervision model. Participants listed multiple benefits of this model (Table 4). Only one challenge was discussed in the interviews, however it was related to the program as a whole and not specific to the shared supervision model. It was noted that within the NFP program, documentation and charting processes are complex, and duplicative in some cases. Given the documentation burden placed on nurses, it was noted that scheduling all NFP-related supervision activities can be "tricky."

Beyond the benefits to the immediate NFP team, nurses and home visitors working in other areas of public health (external to NFP) showed an interest in and a desire to engage in reflective supervision using a shared supervision model. It was noted that within this health unit, reflective practice sessions were subsequently organized with family home visitors and integrated into existing Healthy Babies Healthy Children program based on the shared supervision model.

ATTRIBUTES OF A SHARED SUPERVISION MODEL

The establishment of relationships, characterized by trust, among all team members is at the core of this shared supervision model. For the shared supervision model to be successfully implemented within an NFP program, the NFP Team Lead and Program Manager must have a strong professional working relationship characterized by trust, regular communication, and rapport.

Table 4. ***Benefits of NFP Model of Shared Supervision***

The NFP model of shared supervision promotes....	....through
Emotional safety	Nurses' increased comfort to reflect on practice challenges or concerns without fear or judgment Nurses' perceived sense of increased equality within the power dynamics in the relationship between Team Lead and public health nurse
Accessibility to supervision and support when required	Shared office space which provides nurses with increased opportunities to access or connect informally with Team Lead when needed (outside of scheduled 1:1 sessions) Engaging with a Team Lead who has fewer responsibilities external to the NFP program, which increases their availability for both scheduled and unscheduled supervisory sessions The availability of a Program Manager, when the Team Lead is unavailable, which across the team increases options for support
Provision of credible, NFP-specific practice guidance	Consultation with a Team Lead who maintains an NFP client caseload, which thus ensures that they have expertise in and an understanding of program model elements, program content, and common challenges experienced by nurses when home visiting. Engagement with a Team Lead who is able to provide "real-world" guidance on how to apply the visit-to-visit guidelines or use facilitators with clients
Increased quality of all forms of supervision	Clear division of responsibilities for both Team Lead and Program Manager, which provides increased time for each individual to focus on providing high quality clinical and reflective supervision or administrative supervision, rather than dividing time across all activities.
Team cohesion	Role modeling of the parallel process, whereby Program Manager provides a critical space for reflective supervision for the Team Lead, who in turn provides supervision to the nurses Reduction in hierarchy between different roles

Public health nurses reported higher levels of comfort in reflective supervision when it occurred with someone they trust regardless of their position (Team Lead or Program Manager) and recognized that reflective supervision is not safe with management when the supervisor is not trusted. The nurses also indicated that they are more likely to share sensitive information with the Team Lead. However, they would be equally comfortable engaging in reflective supervision with the Program Manager.

In this model of shared supervision, the Team Lead maintains a small caseload of NFP clients. For the nurses on the team, this meant that with respect to providing clinical supervision, the Team Lead was perceived as a highly credible practice expert. As one nurse shared,

> *"The Team Lead has her own clientele that she visits as well, which I think has to stay because she gets it [the NFP program] – she understands. Being out on the streets herself, she understands the issues that are affecting our clients.*

Working with a Team Lead with extensive professional practice knowledge and experience was highly valued during the conduct of the required accompanied home visits. Nurses summarized that given the Team Lead's knowledge of the program, she was: 1) comfortable in a home visit setting and able to effortlessly engage with clients and their infants; and 2) able to provide valuable feedback on the nursing process and skills observed in a home visit. The presence of a Team Lead, compared to a Program Manager, during an accompanied home visit influenced nurses' confidence levels. Overall, nurses perceived that the Team Lead was there to participate, observe and reflect on the home visit, whereas if a Program Manager was present, they often felt that visit foci would be for the Program Manager to observe and evaluate their practice. With the removal of the perceived hierarchy between front-line nursing staff and management, the nurses expressed that the accompanied home visits then became truly an opportunity to receive and then reflect on the feedback shared with them to increase their skills. In contrast, they perceived that any accompanied visit with a manager would require them to carefully select a "good choice" for a visit, and that they might experience increased anxiety, feeling that their performance was being observed and evaluated.

Both the NFP Team Lead and Program Manager were described as having high levels of relational intelligence. An individual who possesses relational intelligence is someone who exhibits emotional and ethical intelligence and who can understand and critically reflect on their own and others' emotions, values, interests, and demands to make decisions (Pless & Maak, 2005). Across all interviews, public health nurses described the Team Lead's skill in providing both reflective and clinical supervision. As one nurse shared:

> *"I've called [the Team Lead] after a visit where I just felt it didn't go the way I wanted it to go. So, a couple of things happened. She supported me by making me feel better and also discussed what I can do next time.*

Within the context of Niagara Region Public Health & Emergency Services, there was consensus that the high level of acceptability of this model was influenced by the specific attributes of the individuals selected to be in the Team Lead and Program Manager roles. In general, participants identified that for this model to be successfully implemented in other NFP contexts, it is critical for the Team Lead and Program Manager to have open communication and a respectful relationship, with frequent opportunities for connection and consultation. A clear message across interviews was around the importance of selecting the "right" person for this role, regardless of seniority within the agency. It was identified that a Team Lead should be an individual who is knowledgeable about the NFP program, highly skilled in coaching, motivational interviewing,

and active listening, and who is able to create a cohesive team that can work together in a positive atmosphere. Participants recommended that a Team Lead exhibit the following attributes: trustworthy, kind, compassionate, and non-judgmental.

INTEGRATION OF THE NFP PROGRAM INTO HEALTHY BABIES HEALTHY CHILDREN

In this case study, participants also reflected on their perceptions and experiences around the introduction of the NFP program within their public health unit and the program's integration into the established Healthy Babies Healthy Children program. When NFP was first introduced, it was acknowledged that some public health nurses and family home visitors feared that their positions in the Healthy Babies Healthy Children program would be eliminated. Participants acknowledged though that health unit management was successful at reassuring them that their jobs would not be "at-risk" with the introduction of this new program. It was also noted that with the establishment of an NFP team, separate from the Healthy Babies Healthy Children Team, that this initially created challenges for the consistent sharing of information. As a result, opportunities for joint meetings with both the NFP and Healthy Babies Healthy Children Team members in attendance were established.

There was also recognition that NFP is a program that requires public health nurses to be provided with additional, extensive training to develop specialized knowledge and skills. This additional education is necessary to ensure that they can conduct comprehensive assessments of family health and well-being and then to develop tailored plans of care to meet the needs of the pregnant individuals or new parents and their infants on their caseloads. Additionally, as a licensed program, there are limits to what information and program materials can be shared with individuals external to the NFP team. Finally, given that NFP nurses carry a smaller caseload of clients (e.g., < 20 clients) relative to nurses on the Healthy Babies Healthy Children team and the flexibility to visit clients more frequently, nurses on this team had relatively more time (compared to HBHC nurses) to develop a strong, long-term therapeutic relationship with their clients and to adequately identify and address their needs. However, these differences between program structure, staffing and focus resulted in some derisiveness or feelings of "jealousy" within the Division. Participants perceived that some nurses external to the NFP team felt that NFP nurses received more opportunities for professional development, had higher quality (and more) resources to share or use during home visits, and were able to engage in collaborative, non-hierarchical relationships with their supervisors. However, one public health nurse (external to NFP) noted that there was value to working side-by-side with the NFP team in that current research and evidence on best practices could be readily shared between teams.

Advantages to adding the NFP program within the existing suite of Healthy Babies Healthy Children services were also noted. By identifying and recruiting NFP nurses from the existing pool of Healthy Babies Healthy Children nurses, an NFP team composed of individuals familiar with health unit policies and referral procedures, with pre-existing partnerships with community partners, and skills in home visiting could be established. Through the development of seamless intake and referral processes, it was also noted that when a potential client did not meet the NFP program eligibility criteria, then the NFP and Healthy Babies Healthy Children teams were able to connect and discuss how the individual could be referred to the Healthy Babies Healthy Children program. Exposure to the NFP program model, eligibility criteria, structures, and activities also inspired senior decision makers, Healthy Babies Healthy Children managers and nurses to think about how the this provincially mandated blended home visitation program could be further strengthened. As one participant stated, "I think NFP has been a catalyst to think about the quality of our home visiting services across the board." Of critical note, the NFP shared supervision model prompted a similar development within the local Healthy Babies Healthy Children program with the establishment of a Nurse Home Visiting

Lead position, an individual who could provide reflective and clinical supervision to Healthy Babies Healthy Children public health nurses and family visitors. As one stakeholder, external to NFP summarized:

> *"Our Healthy Babies Healthy Children program has changed because NFP has been here. [For example], we are now able to implement a Home Visiting Lead position. If the plug was pulled on NFP those nurses will never practice the same again – they would probably be loud advocates for some of the supports and resources they received in NFP. So yes, having NFP here makes an impact…there are just practice things that happen that can't help but to rub off onto Healthy Babies, especially when you have shared management, and when it's part of our Healthy Babies team.*

Discussion

In this case study, conducted in one Ontario public health unit, a model of NFP shared supervision was found to be acceptable to public health nurses, managers, and other health unit staff. In this alternate model of supervision, an experienced NFP public health nurse assumed a Team Lead position to provide reflective and clinical supervision to their peers while also retaining a reduced caseload of clients. The NFP Program Manager maintained all administrative supervisory responsibilities for the team, provided supervision and support to the Team Lead and managed all other organizational leadership requirements.

This model of shared supervision provided a critical mechanism to minimize the power and privilege differentials that are typically present in traditional supervision models between staff and managers. In receiving supervision from a Team Lead, public health nurses with emergent needs for support reported having timely access to a supervisor with more availability and flexibility to meet. While expressing significant regard and respect for the Program Manager's clinical expertise, the public health nurses valued that their consultations with a Team Lead experienced in NFP program delivery resulted in the receipt of information that was grounded in nursing practice, reflected a deep understanding of the "real-world" challenges of delivering NFP, and was deemed to be highly credible. The opportunity for a public health nurse to assume a Team Lead role within the program, also becomes an opportunity not only for career-growth, but where the individual in this role is working to the full scope of nursing practice, and in particular, is utilizing skills related to interprofessional communication, promoting team functioning, engaging in collaborative leadership, and addressing interprofessional conflict resolution (Community Health Nurses of Canada, 2019). Given the intensive relational work required of reflective supervisory processes, the scaffolded nature of this model also ensured that appropriate supports are in place for the Team Lead, through opportunities to engage in their own reflective supervision with the Program Manager. No participants in this case study identified any relative disadvantages of the model of shared NFP supervision compared to the traditional NFP model of supervision.

It is critical to note that within this health unit, the positive response to the implementation of this shared model of supervision is closely linked to the selection of a Team Lead who participants perceived was a good "fit" for the role. Additionally, it was described, that there was team acceptance of the model because the Team Lead was perceived to be a trusted and credible team member, who also had a strong professional working relationship characterized by trust and strong rapport with the Program Manager.

RECOMMENDATIONS

Given the consensus that the novel model of supervision provided relative advantage over the traditional model of supervision with no obvious disadvantages, it is recommended that Niagara Region Public Health & Emergency Services sustain this shared supervision model in both the NFP and Healthy Babies Healthy Children programs. However, given that each of these home visiting programs rely on the use of a single, skilled, and credible team member to fulfill the Team Lead role, it is imperative that teams engage in strategies for succession planning for the role. The provision of ongoing professional development opportunities for the Team Lead and Program Manager are also important to advance their skills in further supporting the delivery of safe and effective reflective supervision. At both local and provincial levels, the next step will be to continue to evaluate the benefits and challenges of the shared supervision model and measure the effectiveness of this strategy to positively influence both nursing workforce and client outcomes. We would also recommend that, for other existing or new NFP sites in Canada or internationally, that this shared model of NFP supervision be included as a permissible variation in the International NFP Core Model Element Guidance Document (2019) for Element 12: *Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular reflective supervision*. Additional information for implementing this supervision model should include: 1) guidance for clearly defining and differentiating between the roles of the Team Lead and Program Manager/Supervisor; 2) information on the attributes and characteristics valued within the Team Lead role, to ensure that hiring criteria and practices are adapted to find an ideal candidate for the role; and that 3) mechanisms are instituted to ensure that ongoing and regular communication channels are established and maintained between the public health nurses, Team Lead and Program Manager. Revisions to this core model element would be further strengthened by the inclusion of more detailed guidance outlining the scope of responsibilities to be assumed by an NFP Supervisor. While the current guidance outlines the requirement for a nurse to supervisor ratio of 8:1, information is lacking on the maximum number of individuals that should be directly reporting to the supervisor or the amount of additional program coordinator or administrative work that can be combined with the role. Finally, within the NFP Core Model Element Guidance Document, under the section of "Variations and Challenges Across Countries" for Element 12, we would recommend adding some notes that within agencies where nurses are unionized, that discussions may be required to clearly define the role scope, select a role title that reflects the scope of practice (and avoid the perception that this is a management or administrative level role).

Conclusion

In the NFP program, structured supervisory support is provided to all public health nurses to sustain the emotional well-being of staff as they work with families experiencing social and economic disadvantage and to strengthen the therapeutic alliances between nurses and clients, with the goal of promoting optimal client outcomes. The robust NFP model of supervision includes multiple supportive elements including the requirement that a supervisor facilitate case conferences, team meetings, accompanied home visits, education activities and weekly 1:1 reflective supervision. To minimize power differentials within the highly relational context of reflective supervision, a model of shared supervision provides an opportunity for an NFP Program Manager to assume oversight for administrative and some clinical supervisory responsibilities, while allocating the reflective supervisory sessions to a Team Lead, another public health nurse home visitor, respected by their peers and who holds credible knowledge about program delivery. Findings from this case study confirm the acceptability of this model for a range of stakeholders.

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