



Interpersonal communication in clinical supervision: A qualitative study with nursing educators

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ABSTRACT

Aim: To explore how communication is conceived and enacted by nursing supervising educators in clinical education and to identify processes, barriers and strategies influencing its effectiveness.

Background: Communication is a key component of effective clinical supervision, shaping learning, motivation and safety in nursing education; however, limited evidence addresses how supervising educators conceptualize and practice communication in clinical settings.

Design: Qualitative descriptive study.

Methods: Semi-structured interviews were conducted with 23 supervising educators from Portugal. Data were analyzed using reflexive thematic analysis, drawing on Peplau's Interpersonal Relations Theory, Proctor's model of the three functions of supervision and the Person-Centered Practice Framework.

Results: Five interrelated categories characterized supervisory communication: core communication processes, pedagogical value, enabling conditions, barriers and optimization strategies. Across categories, communication operated as an integrated relational-functional-contextual process, requiring adaptability, reflection and mutual understanding.

Conclusions: Communication is the central mechanism through which supervision promotes meaningful learning and professional development. Strengthening communicative competence among supervising educators may enhance feedback quality, student engagement and the overall learning environment in clinical placements. Institutional investment in communication training and supportive conditions is essential to sustain effective supervision and ensure person-centered educational practice.

1. Introduction

Clinical supervision constitutes a cornerstone of nursing education,

functioning as a primary pedagogical space through which students integrate theoretical knowledge with professional practice, develop clinical reasoning and internalize professional values and standards

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(Ryu et al., 2025). Within this relationship, communication is the mechanism through which supervising educators and students negotiate expectations and learning goals, build trust, provide formative feedback, regulate emotions in demanding clinical contexts and support safe practice (Javornická et al., 2024). When communication is person-centered, reflective and responsive to context, it can foster engagement, confidence and learning; when fragmented, overly directive, or constrained by organizational barriers, it may undermine participation and learning outcomes (Shahzeydi et al., 2024).

To situate the present study, we synthesize recent peer-reviewed empirical research and reviews on clinical supervision and preceptorship in nursing education, prioritizing literature that addresses communicative processes (e.g., feedback, goal-setting, reflective dialogue) and the conditions shaping supervisory encounters (Gill-Meeley et al., 2025; Ryu et al., 2025). Across studies of students' experiences, perceived supervisor availability, empathy and feedback quality are consistently associated with satisfaction with clinical learning and self-efficacy (Atashi et al., 2024; Löfmark et al., 2012). Research focusing on specific communicative practices has further described the value of structured feedback approaches and deliberate opportunities for reflection (Allen and Molloy, 2017; Javornická et al., 2024). At the same time, workload, limited time and evaluative pressure are repeatedly reported as constraints that shape how supervisory communication is enacted in practice (Ryu et al., 2025; Shahzeydi et al., 2024).

Nevertheless, the literature leaves key questions insufficiently addressed. First, reviews highlight heterogeneity in how clinical supervision is defined and operationalized across settings, complicating comparison and obscuring what "effective" supervision looks like in day-to-day practice (Gill-Meeley et al., 2025). Second, much of the evidence adopts a student-centered or skills-focused lens, examining discrete behaviors rather than communication as a dynamic process integrating relational, pedagogical and organizational dimensions (Allen et al., 2017; Javornická et al., 2024). Third, although implementation-oriented work emphasizes the importance of culture, resources and institutional support, fewer studies foreground how supervising educators themselves conceptualize and adapt communication across supervision phases under real-world constraints (Benny et al., 2023; Ryu et al., 2025). Addressing these gaps is necessary to move beyond prescriptive descriptions toward grounded, context-sensitive understandings of supervisory communication.

This study aimed to explore how communication is conceived and enacted by nursing supervising educators in clinical education, with attention to core processes, barriers and adaptive strategies that may shape its effectiveness. The study addressed three research questions: How do supervising educators define and prioritize communication within their supervisory role?, What relational, functional and contextual conditions enable or constrain effective communication? and What strategies do supervising educators use to optimize communication when facing structural or interpersonal challenges?

To support interpretation without predetermining findings, the analysis was informed by theoretical perspectives that foreground communication in supervision. Peplau's Interpersonal Relations Theory frames communication as the medium through which educational relationships develop across phases of orientation, working and resolution (Peplau, 1988). Proctor's triadic model articulates formative, restorative and normative functions of supervision, each reliant on purposeful and empathic communication (Proctor, 1986). The Person-Centered Practice Framework situates these interactions within broader organizational and cultural contexts, highlighting how learning climates, power dynamics and institutional values shape person-centered processes in practice (McCance and McCormack, 2025).

2. Materials and methods

2.1. Study design

This qualitative study used semi-structured individual interviews to examine communication in clinical nursing supervision from the perspective of clinical supervisors. The design was theoretically informed by Peplau's Theory of Interpersonal Relations (Peplau, 1988), Proctor's three-function model of supervision (Proctor, 1986) and the Person-Centered Practice Framework (McCance and McCormack, 2025).

2.2. Researcher characteristics and reflexivity

The team comprised four investigators with expertise in nursing education, clinical supervision and qualitative research. Three were PhD candidates in Nursing with experience in clinical teaching/supervision; one senior PhD-prepared researcher provided methodological oversight. Interviews were conducted by the first and second authors, both nurse educators and clinical supervisors trained in qualitative interviewing and reflexive thematic analysis (Braun and Clarke, 2021, 2025). Reflexivity was sustained through reflexive journaling, analytic memoing and regular team meetings focused on assumptions, alternative readings and decisions recorded in an audit trail (Braun and Clarke, 2025; Tracy, 2010). To avoid a theory-constrained reading, analysis began with data-near open coding and memos capturing competing interpretations; theory was integrated primarily during theme refinement, including purposeful attention to contradictions and negative cases (Braun and Clarke, 2021, 2025).

2.3. Participant selection and sampling

Purposive criterion-based sampling recruited information-rich clinical supervisors aligned with the research question (Creswell and Creswell, 2018; Palinkas et al., 2015; Robinson, 2014). Inclusion criteria were: (1) current role as clinical supervisor in nursing placements; (2) ≥ 3 years of supervision experience; (3) consent to participate and be audio-recorded; (4) informed consent capacity. Participants were approached via institutional email through academic and healthcare institutions in Northern/Central Portugal.

Sample size ($n = 23$) was set using information power and monitored during data collection/analysis through attention to diminishing informational yield, considering code and meaning saturation (Guest et al., 2006; Hennink et al., 2017; Malterud et al., 2016; Vasileiou et al., 2018). All invited eligible participants participated; there were no refusals or dropouts.

2.4. Data collection

The interview guide was developed from the study frameworks and followed methodological recommendations for semi-structured guides, ensuring alignment between objectives, prompts and analysis (Kallio et al., 2016). Domains covered: participant characterization; perceived relevance of communication in supervision (mapped to Peplau's phases and Proctor's functions); experienced communication difficulties; strategies used and perceived effects, elicited through concrete supervisory episodes.

Interviews occurred March–July 2025 in participant-selected private settings (workplace office/meeting room/university facilities). Before each interview, the interviewer re-stated study procedures, confidentiality, voluntary participation and obtained written consent and recording permission. Interviews lasted 40–75 min. Only the participant and interviewer were present; no repeat interviews were conducted. Field notes captured context and initial analytic reflections.

Audio was transcribed verbatim by the first author, with random transcript checks by the senior researcher. Transcripts were not returned to participants; accuracy was supported by transcript–audio verification

and integration of field notes during analysis (Nowell et al., 2017).

2.5. Setting and context

Participants worked in hospital settings (n = 15, 65.2 %), primary healthcare (n = 5, 21.7 %), or exclusive academic teaching roles (n = 3, 13.0 %). Most were from Northern Portugal (n = 19, 82.6 %), with the remainder from Central Portugal (n = 4, 17.4 %). Contextual factors (e. g., workload, shift patterns, multiprofessional coordination) were considered during interpretation (Ryu et al., 2025).

2.6. Data analysis

Thematic analysis was conducted following Braun and Clarke's (2025) contemporary guidelines for qualitative research, ensuring transparency, explicit theoretical choices and consistent linkage between objectives, methods and interpretation. The analytical process involved:

Familiarization: Repeated reading of transcripts, selective audio review and integration of field notes.

Coding: Reflexive, interpretative coding of meaningfully patterned segments on communication processes, enabling conditions, barriers and strategies. Coding was undertaken by the first and second authors; analytic meetings and memoing were used to interrogate assumptions and refine code meanings and boundaries, rather than to pursue inter-coder agreement.

Theme development: Codes were clustered into candidate themes/subthemes through iterative comparison; early development prioritised data-near patterns, with theoretical frameworks informing later interpretative refinement.

Review and refinement: Themes were checked against extracts and the full dataset, including attention to contradictory material/negative cases.

Definition and naming: Themes were defined and named to capture their analytic contribution.

Data were analyzed manually using reflexive thematic analysis (Braun and Clarke, 2021, 2025). The strategy combined inductive openness in early coding with later theoretical interpretation through Peplau, Proctor and the Person-Centered Practice Framework (McCance and McCormack, 2025; Peplau, 1988; Proctor, 1986). An audit trail and a "data-to-theme" table (excerpt → code → subtheme/theme → interpretive note → theory link, where applicable) documented analytic decisions and traceability (Lincoln and Guba, 1985; Nowell et al., 2017).

The analytical framework was structured into five categories: Core communication processes, Pedagogical value of the supervisory relationship, Essential conditions for effective communication, Barriers and challenges and Strategies for optimization (Braun and Clarke, 2025; McCance and McCormack, 2025; Peplau, 1988; Proctor, 1986).

A Sankey diagram was produced to support visual synthesis of thematic links and relative prominence across categories, complementing the narrative results (Braun and Clarke, 2025).

Ethical considerations

The study received ethical approval from XXXX. All participants provided written informed consent after receiving detailed information about the study purpose, voluntary participation, right to withdraw, confidentiality measures and data management procedures. Data were pseudonymized (E1–E23), securely stored and accessed only by the research team. Audio recordings and transcripts were stored securely with access restricted to the research team. All data were handled in accordance with the General Data Protection Regulation (GDPR) and with the ethical principles of the Declaration of Helsinki (World Medical Association, 2013).

1. Rigor and trustworthiness

Trustworthiness was ensured through explicit procedural links to quality criteria: credibility via sustained engagement with the corpus, memoing and negative case analysis; dependability via an audit trail documenting sampling, data collection, coding iterations and theme development; transferability via contextual and sample description; confirmability via transparent data-to-theme linkage (Table 1) and reflexive documentation (Lincoln and Guba, 1985; Nowell et al., 2017; Tracy, 2010). Reporting followed COREQ (Tong et al., 2007) alongside contemporary qualitative reporting principles that require explicit methodological and interpretative choices (Braun and Clarke, 2025).

4. Results

4.1. Participant characteristics

Twenty-three supervising educators participated in the study. Participants' ages ranged from 29 to 54 years (mean 40.1), with an average of 17.9 years of professional experience and 9.7 years of supervisory experience. Most participants worked in hospital settings (n = 15; 65.2 %), followed by primary health care (n = 5; 21.7 %) and exclusive academic teaching (n = 3; 13.0 %). Most held a master's degree (n = 16; 69.6 %), four held a PhD (17.4 %) and three a bachelor's degree (13.0 %). Seventeen participants (73.9 %) had specific training in clinical supervision. This experienced and heterogeneous group provided rich, contextually grounded insights into communication in clinical education.

Five interrelated categories described supervisory communication: (1) core communication processes; (2) pedagogical value; (3) essential conditions; (4) barriers; and (5) optimization strategies. Across categories, participants framed communication as relational, functional and context dependent.

4.2. Category 1 – Core communication processes

Participants described communication as the central process that initiates and sustains the supervisory relationship across the placement. Communication was consistently framed as the starting point for aligning goals, clarifying roles and establishing trust, with early interactions shaping how subsequent learning conversations unfolded. As one educator emphasized: "Clearly defined objectives from the outset. Explicit 'rules of the game' that everyone understands [...]" (E12).

Within this foundational work, active listening emerged as a core practice through which supervising educators created openness, recognized uncertainty and calibrated their guidance to what students were ready to articulate. Listening was described not only as hearing content, but also attending to pauses, hesitations and emotional cues, including nonverbal signals. Participants linked this attentive stance to trust-building and to more accurate understanding of students' needs: "[...] silence, allowing the student to speak, truly listening to them [...]" (E13) and "[...] active listening, not only to the verbal message but also to the reading of facial expressions [...]" (E22).

Communication was also portrayed as multimodal and adaptive. In addition to face-to-face dialogue, educators reported using digital channels (e.g., Teams, email, messaging) to maintain accessibility, continuity and timely clarification when in-person contact was constrained by workflow (E5). Overall, core processes combined early alignment (expectations/goals), attuned listening (verbal and nonverbal) and flexible channel use to sustain relational connection and learning direction.

direction.

4.3. Category 2 – pedagogical value of the supervisory relationship

Communication was repeatedly positioned as the primary

pedagogical instrument of supervision, enabling learning, motivation and reflective development while supporting emotional safety and professional accountability. Participants described formative functions such as guidance, feedback and scaffolding of competence progression, often emphasizing feedback as a continuous process rather than a single event. For example, educators highlighted: “[...] *constructive feedback [...] continuous improvement of practice [...]*” (E10).

Communication was also described as restorative in that it supported emotional regulation, reduced anxiety and strengthened students’ confidence to engage with complex clinical realities. Participants associated empathic and assertive dialogue with a trusting and safe environment that supports autonomy: “[...] *an environment of trust and safety [...] development of autonomy.*” (E14). In parallel, communication was seen as normative by reinforcing safe practice standards and ensuring timely awareness of relevant events in the clinical environment. Educators explicitly linked effective communication to safety: “[...] *both for students and for patients [...]*” (E19).

Taken together, participants framed communication as simultaneously relational (trust/safety), functional (feedback/guidance) and ethically oriented (standards/safety), positioning it as the mechanism through which supervision becomes educationally meaningful.

4.4. Category 3 – essential conditions for effective communication

Participants emphasized that effective supervisory communication depends on conditions that are relational, environmental and organizational. At the environmental level, protected time and appropriate space were described as prerequisites for dialogue that is reflective rather than purely transactional. Quiet environments and privacy were repeatedly identified as necessary for sensitive conversations and honest disclosure: “[...] *a quiet and reserved environment, with dedicated moments for communication [...]*” (E15).

Relationally, educators stressed clarity, assertiveness and tailoring language to students’ needs. Communication was expected to be: “[...] *clear, simple and objective [...]*” (E9), while remaining individualized to what students required at a given moment (E17). Participants also highlighted the importance of mutual availability—time, presence and openness—as a condition for sustained supervisory dialogue (E20, E23).

At the organizational interface, several participants described alignment between educational institutions and clinical services as essential for coherence in expectations, feedback and roles. They emphasized the value of shared understanding among school, supervising educator and student to support consistency across the placement (E11). Overall, conditions for effective communication were presented as more than individual competence: they included time, privacy, relational availability and institutional coordination.

4.5. Category 4 – barriers and challenges to communication

Participants reported multiple constraints that disrupted supervisory communication and reduced opportunities for reflection and learning. The most frequently cited barriers were workload pressure, limited time, interruptions and lack of privacy—factors that pushed communication toward rapid exchanges rather than structured dialogue. Educators described: “[...] *lack of time and availability, as well as the difficulty of finding an adequate space [...]*” (E10) and argued that clinical areas were not always suitable for in-depth communication: “[...] *it is not always possible to have a restricted space free of interruptions [...] the ward should not be the privileged place for communication [...]*” (E22).

Emotional dynamics also shaped the supervisory dialogue. Fear of evaluation, anxiety about being judged and early insecurity were described as inhibiting disclosure and limiting students’ willingness to ask questions or reveal uncertainty. As one educator noted: “[...] *nervousness, the fear of ‘being tested’, makes communication harder [...]*” (E3).

Participants additionally described mismatches in communication

styles, generational differences and variable student motivation as barriers to reciprocity and engagement (E20, E8). Finally, institutional and interprofessional misalignment—unclear role mediation, competing priorities and difficulties coordinating with tutors—were described as weakening coherence and continuity in supervision (E4, E9). In combination, these barriers were experienced as constraining both the relational flow of supervision and the functional work of guiding learning.

4.6. Category 5 – strategies for communication optimization

Participants described communication optimization as an intentional, context-sensitive effort to preserve relational depth and pedagogical clarity despite constraints. A central strategy involved structuring feedback to maintain motivation and transparency, often beginning with strengths before addressing areas for improvement. One participant described: “[...] *providing constructive feedback, starting by highlighting the student’s positive aspects before addressing areas for improvement [...]*” (E10). Participants also reported setting goals collaboratively and revisiting them to sustain direction and shared accountability (E17).

A second strategy focused on early expectation negotiation. Educators described initial diagnostic conversations to clarify objectives, roles and mutual expectations, reducing misunderstandings later in the placement (E11, E12). Alongside this, participants highlighted deliberate emotional support as a communicative strategy—listening without judgment, creating psychological safety and allowing space for students to articulate concerns: “[...] *creating a ‘safe space’, listening more than speaking and giving the student time and room to express themselves [...]*” (E12).

Participants also described pragmatic adaptations to maintain continuity: using multiple channels (Teams, email, messaging) when time or physical proximity limited contact and employing supervision tools (e.g., observation grids, development plans) to structure preparation and evaluation (E5, E23). Reflective practices—briefing/debriefing and case-based discussion—were used to deepen reasoning and connect experience with learning goals: “[...] *structured briefing–debriefing [...]*” (E12) and “[...] *reflective analysis of cases [...] hypothetical scenarios [...] fostering critical thinking [...]*” (E1). Finally, tailoring communication style and language to each student was presented as a marker of professionalism and person-centered supervision, including checking understanding and adjusting complexity to students’ needs (E10, E14).

Collectively, these strategies show supervising educators working across relational (safety/empathy), functional (goals/feedback/guidance) and contextual (time/tools/channels) dimensions to sustain supervision as a coherent educational process.

4.7. Summary of findings

Across all categories, communication emerged as the core mechanism of supervision, enabling learning, emotional regulation and professional accountability. Effective communication was not perceived as a single skill but as an integrated process involving relational, functional and contextual dimensions. Supervising educators viewed communication as both a pedagogical and moral responsibility, essential to creating safe, meaningful and person-centered learning environments in clinical education.

To visually synthesize the interrelations among the five main categories, a Sankey diagram was developed (Fig. 1). The diagram illustrates the dynamic flow of communication in clinical supervision, showing how facilitating and constraining conditions influence core communication processes, pedagogical functions and resulting outcomes. The width of each flow represents the relative recurrence and strength of themes across interviews, integrating relational, functional and contextual dimensions of supervision.

The Sankey diagram visualizes the pathways from facilitating and

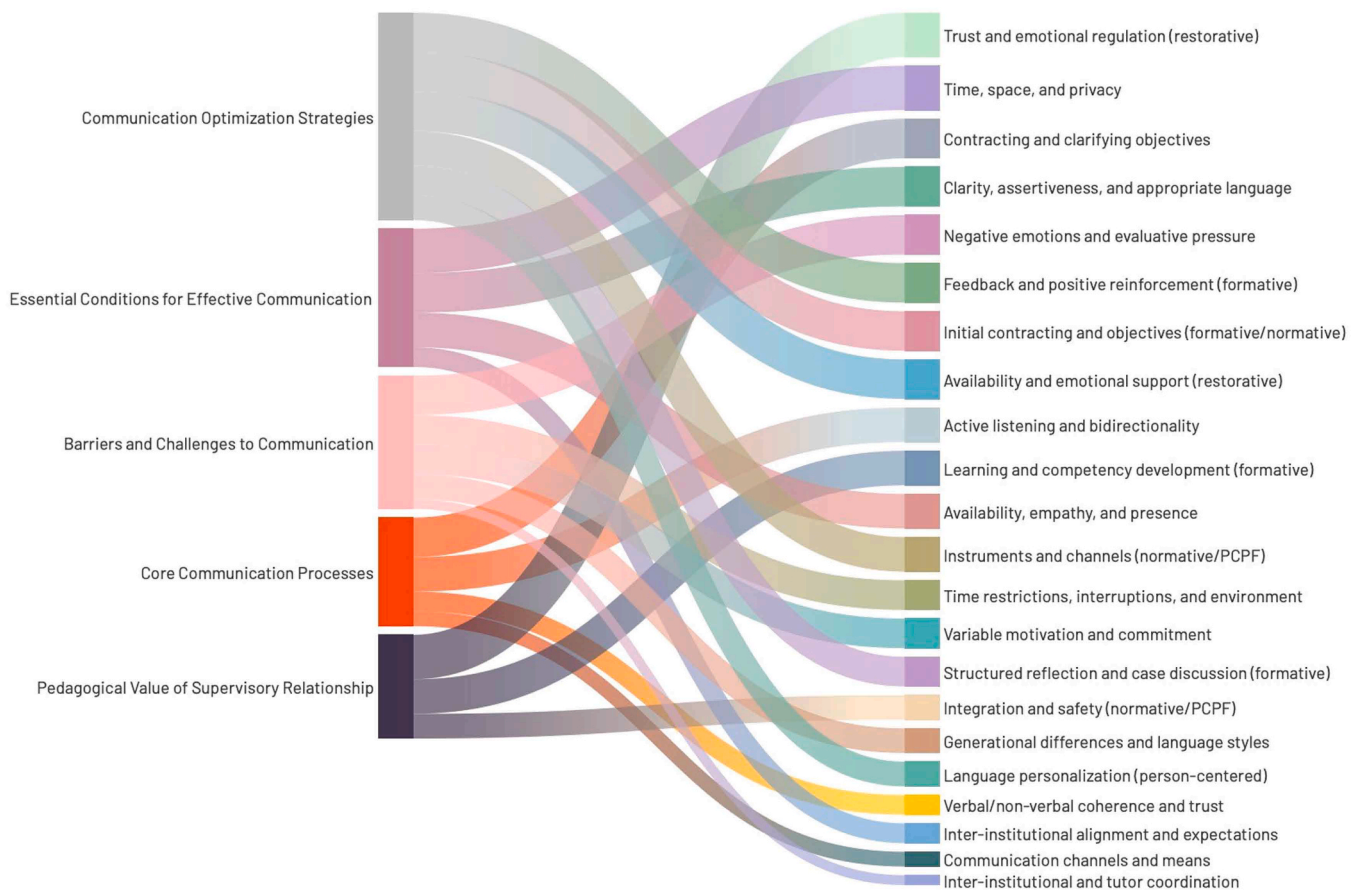


Fig. 1. Conceptual flow of supervisory communication in nursing education.

constraining conditions to communication processes, adaptive strategies and supervisory functions (formative, restorative, normative), culminating in learning, motivation and professional integration outcomes.

5. Discussion

This study explored how supervising educators conceive and enact communication in clinical education and identified five interrelated categories that portray communication as an integrated relational–functional–contextual process. Across accounts, communication-initiated supervision through early expectation-setting and goal negotiation, sustained the supervisory relationship through trust, empathy, authenticity and emotional attunement and enabled learning and safe practice through guidance, feedback and standard-setting. In this sense, supervision was described less as a sequence of tasks and more as a communicative practice where educational, emotional and accountability aims are continually coordinated (Peplau, 1988; Proctor, 1986). Participants emphasized that this process requires continual reflection and mutual adjustment across supervision phases.

Supervising educators positioned communication as the “infra-structure” of supervision because it defines the working alliance and the conditions under which learners can engage with challenge. Early conversations were portrayed as decisive: they clarify roles, set expectations and establish a tone of openness that later supports difficult feedback and reflective dialogue. This emphasis converges with psychological safety research showing that learners participate more actively in learning conversations when they can disclose uncertainty and ask questions without disproportionate relational or evaluative consequences (Butler and Lyman, 2025; Lyman and Mendon, 2021). Our findings extend this literature by showing how educators operationalize psychological safety through concrete communicative

choices—listening practices, pacing and explicit checking of understanding—rather than treating safety as a background climate.

Participants also described supervisory communication as adaptive rather than standardized. Educators shifted between communicative purposes (coaching, feedback, emotional support and accountability) and between modalities (face-to-face and digital channels) to maintain continuity in volatile clinical environments. This aligns with evidence that “clinical supervision” is defined and enacted heterogeneously across nursing contexts and that this heterogeneity can create ambiguity about what supervision entails in practice (Zonneveld et al., 2025). A distinctive contribution of this study is that it makes the adaptive work visible: educators described communication as ongoing negotiation, not a single agreement made at the start of placement.

With respect to the pedagogical value of communication, participants’ accounts map closely onto Proctor’s triadic model and illustrate how formative, restorative and normative functions are enacted through interaction (Proctor, 1986). Formatively, educators described communication as the principal tool for structuring learning through guidance, collaborative goal setting and iterative feedback, consistent with findings that supervisory support and feedback quality are linked with positive clinical learning experiences and confidence (Atashi et al., 2024). Restoratively, communication was used to contain anxiety and foster confidence, echoing work highlighting the importance of psychological safety for engagement and learning (Butler and Lyman, 2025; Lyman and Mendon, 2021). Normatively, educators connected clear communication to safe practice and accountability, while also noting that evaluative pressures can inhibit openness, a tension also described in studies of supervision where feedback is intertwined with assessment (Shahzeydi et al., 2024).

Context emerged as a strong explanatory layer across categories and helps interpret why communication sometimes falls short of prescriptive

ideals. Participants emphasized that protected time, privacy and environmental calm are prerequisites for reflective supervisory dialogue; when these are absent, communication becomes brief, reactive and task-focused. This convergence with implementation-focused evidence is important: scoping work shows that logistical constraints of nursing work (e.g., shift patterns and limited control over time) and managerial or cultural support shape whether clinical supervision can be implemented as intended (Ryu et al., 2025). In our data, these factors were experienced as communicative constraints that reduce opportunities for reflection, increase interruptions and delay difficult conversations.

A related contextual issue concerned alignment between academic institutions and clinical services. Participants portrayed misalignment in objectives, roles and assessment expectations as a source of communicative “noise” that undermines coherence and perceived fairness in supervision. This aligns with evidence that lack of definitional consensus and incomplete reporting of supervision practices contribute to ambiguity and inconsistent uptake of supervision as professional support (Zonneveld et al., 2025). The present findings add that alignment is not merely administrative; it is communicative infrastructure that stabilizes goal-setting and feedback, clarifies accountability and reduces contradictory messages to learners.

Participants described purposeful strategies to optimize communication despite constraints. Common approaches included establishing objectives early, using structured feedback that balances affirmation with clear developmental guidance and embedding reflection through briefing/debriefing and case discussion, consistent with pedagogical recommendations that emphasize dialogic and reflective supervision (Javornická et al., 2024). Educators also described using multiple communication channels to maintain availability, which appears pragmatic in time-pressured settings; however, this raises boundary and fragmentation risks if institutional norms are unclear. These findings suggest that communication optimization requires both individual skill and system-level support to protect time, ensure privacy and normalize reflective dialogue as legitimate work.

Synthesizing across categories, the findings support a model where relational qualities enable functional educational work, and both are conditioned by context. This integration is consistent with person-centered perspectives that position culture and organizational conditions as determinants of interaction quality and learning climates (McCance and McCormack, 2025; Slater et al., 2017). The study illustrates how communication operates as the mechanism linking supervisory intentions to enacted supervision under real-world constraints. A key nuance relative to many student-centered accounts is that educators emphasized anticipatory framing of feedback and ongoing renegotiation of expectations as deliberate strategies to protect engagement over time.

Several strengths support the credibility of these findings, including the inclusion of experienced educators working across hospital, primary care and academic contexts and the emphasis on supervisors’ perspectives, which are less frequently examined than learner-centered accounts. At the same time, important limitations should be acknowledged. As a qualitative study, transferability depends on the extent to which supervision structures, workloads and organizational cultures are comparable across settings. In addition, participants’ retrospective accounts may be shaped by recall and social desirability, particularly when describing emotionally charged supervisory encounters. Because the study did not directly observe supervisory communication, it cannot determine how reported strategies are enacted in real-time interactions, how they evolve across placement phases, or how they are perceived and interpreted by learners.

Future research should build on these findings with multiperspective designs that include supervising educators, students and academic tutors, enabling analysis of convergence and divergence in how communication is intended, experienced and interpreted. Longitudinal and observational studies could examine how psychological safety and feedback engagement evolve across placement phases and in contexts of evaluative pressure. Intervention studies should test whether

structured protected time, access to private spaces and clearer role agreements improve the quality of supervisory dialogue and the consistency of learning goals, while evaluating how digital channels can support continuity without undermining confidentiality or reflective depth.

6. Conclusion

This study demonstrates that communication constitutes the core mechanism of effective clinical supervision, integrating relational, pedagogical and contextual dimensions. By centering supervisors’ lived experiences, we revealed communication not as a discrete skill but as a dynamic, theoretically informed practice that requires individual competence, relational attunement and organizational support. Strengthening communication through targeted training and structural investment is essential to realize person-centered, psychologically safe clinical learning environments. Future research should examine dyadic communication patterns and evaluate interventions designed to enhance supervisory communication competence across diverse educational contexts.

Ethics and Integrity Statements

Ethics approval statement: Approved by the Ethics Committee of the Northern School of Health of Portuguese Red Cross, Report No. 010/2025, Code 2025.010.

Patient consent statement: Patient consent was not required for this study, as it did not involve patients. Written informed consent was obtained from all participating nurse educators.

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Permission to reproduce material

Not applicable.

Clinical trial registration

Not applicable.

Declaration of Competing Interest

The authors hereby declare that they have no conflicts of interest regarding the research, authorship, and/or publication of this manuscript. No financial, personal, or institutional relationships have inappropriately influenced, or could be perceived to have influenced, the work reported in this paper.

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Data availability statement

The datasets generated and analyzed during the current study are not publicly available due to ethical and confidentiality restrictions.

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