SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCE
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EXPLORING THE CONCEPT OF CLINICAL SUPERVISION AMONG NURSE SUPERVISEES:
A STUDY AT THE 37 MILITARY HOSPITAL.

BY

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL NURSING DEGREE

JULY, 2019
DECLARATION

This is to certify that this thesis is the results of a research undertaken by Diana Bosomtwe towards the Award of master of Philosophy Degree in Nursing at the School of Nursing and Midwifery, University of Ghana.

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ABSTRACT

Clinical Supervision (CS) is considered as a form of professional support and learning activity that takes place between a supervisor and a supervisee. CS helps nurses to adapt to their new roles, improve their skills, knowledge and improve their decision making abilities. Although a large amount of theoretical literature exists in the areas of CS, little research has been conducted in the area of nurse supervisee’s perception about the concept.

Some nurse supervisees complain about the level of support received from the experienced nurses in developing their professional competencies. The supervisees perceive the actions of supervisors at the unit level as being more managerial than supportive in nature. The study sought to explore the perception, function, stages and elements of Clinical supervision among nurse supervisees working at the 37 Military Hospital. A qualitative exploratory design was employed for the study. Purposive sampling techniques was used to recruit eleven (11) participants. Thematic content analysis was used to analyse the data.

The findings of the study indicated that nurse supervisees have varied perception of the CS process. The participants acknowledged that the stages of CS implemented by the various supervisors was not structured and formalized. However successful implementation of CS guarantees the provision of quality health care service and the standardization of nursing procedures and activities. The supervisee held the view that supervisor must be guided by an institutional protocol and consider their learning needs and deficiencies during the CS process.

Keywords: Clinical Supervision, nurse supervisee, concept
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God richly bless you all.
DEDICATION

I dedicate this work to all my family and friends for the support.
LIST OF ABBREVIATIONS

CS: Clinical Supervision

DDNS: Deputy Director Nursing Services

NMTC-37MH: Nursing and Midwifery Training College- 37 Military Hospital

NO: Nursing Officer

PNO: Principal Nursing Officer

SN: Staff Nurse

SNO: Senior Nursing Officer

VIP: Very Important Personality
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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Clinical supervision (CS) was originally developed within the context of counselling and mental health with its root from psychoanalytical theory in the year 1920 (Bernard & Goodyear, 2009; Brunero & Stein-Parbury, 2008; Cruz, Carvalho, & Sousa, 2013). The concept has steadily been adopted and incorporated into general nursing practice (Cross, Moore, Sampson, Kitch, & Ockerby, 2012; Dawber, 2013; Bailey, Blake, Schriver, Cubaka, & Thomas, T. Martin Hilber, 2016) as a means of professional support for nurse trainees and qualified personnel (Evans & Marcroft, 2002; Martin, Copley, & Tyack, 2014). According to Openshaw (2012) CS improves the skills and knowledge of the individual nurse to practice independently. In view of this, health regulatory bodies in the developed countries recommend that all nurses should access relevant, meaningful and sustained CS activities irrespective of their work roles and demands (Australian College of Mental Health Nursing, 2011). This assertion is supported by Brunero and Lamont (2012) and Parker, Giles, Lantry and McMillan (2014) that, CS provides an opportunity for the nurse to experience support from the other senior nurses and share individual professional experiences. During the CS session, nurses come to the realization that, ‘they are not alone’ in the emotions and sensitivities associated with practice. The support system provides understanding and validation for some of these emotions and perceptions experienced (Parker et al., 2014)

Generally, qualified nurses go through a transitional period ranging from the first twelve (12) to twenty-four (24) months of initial practice and is reported to be the most
In a study conducted by Parker et al. (2014) and Wong (2018), the graduate nurses interviewed, reported a feeling of stress due to the level of expectation exhibited by senior nurses. Most senior nurses did not consider their gradual assumption to duty but expected them to be ready for the job from the day of employment. According to Benner’s Stages of Clinical Competence, the qualified staff nurse, transitions from the stage of a novice to the level of an advanced beginner. The advanced beginners generally, demonstrate minimal acceptable performance based on previous knowledge (Benner, 1982) acquired during training and rotation. Therefore, senior nurses need to appreciate the qualified nurse’s level of efficiency and skilfulness in some aspects of the professional practice and the need for occasional support to perfect the professional skills.

It is however, believed that, having supportive senior colleagues facilitate adequate adaptation to the professional roles and integration within the work environment (Kelly & Ahern, 2009; Suresh, Matthews, & Coyne, 2013; Phillips et al, 2014) is significant. One of the documented support activity utilized by senior nurses to improve the competency base of advance beginners is CS ((CWDC), 2007; Jones, 2006; Parker et al., 2014). CS basically involves a continual process of exchange of professional knowledge and skills amongst the experienced and unexperienced personnel, with the aim of supporting the latter through practice and invariably improve clients’ safety, quality of care and maintenance of the professional standards (Bernard & Goodyear, 2014; Graaff & Francke, 2012; Skills For Care & (CWDC), 2007; NMC, 2006). It is worth noting that, the critical aspect of CS lies in its potential to render continuous education and skill development (Cassedy, 2010; RICO, 2010)
Some of the benefits expected during the CS session includes an increased performance and knowledge level, awareness of one’s work environment and improved decision-making abilities (Johansson, 2015). Also, the supervision process offers a safe and supportive opportunity to engage in critical reflection, raise issues of professional concern, explore challenges, and discover new ways of handling both the profession and oneself (Blishen, 2016; Brunero & Stein-Parbury 2008; Butterworth, Louise, Christine, & Majda 2008). Through constructive criticisms, feedback and advice, the personnel are challenged to be innovative and skillful at work (Fowler, 2012). These exchanges are expected to occur within a supportive, conducive and non-judgmental environment (Graaff & Francke, 2012).

Researchers, both qualitative and quantitative, have been particularly interested in highlighting the effectiveness and outcomes of CS (Blishen, 2016; Daly & Muirhead, 2015; Martin, 2014; Brunero, 2012; Openshaw, 2012; Fowlers, 2011; Cummins, 2009; Brunero & Stein-Parbury 2008; Butterworth, Louise, Christine, & Majda 2008). Several studies revealed that the expectations of CS are far-reaching and include increased level of proficiency, professional skills, support and the acquisition of knowledge. In spite of these positive intention and expectations, differences in the understanding and conceptualization of CS among supervisees who are beneficiaries of the process could avert the achievements of this intended purpose (Bush, 2005; Minot, 1987/2009). Varying perceptions, attitudes and experiences of CS in the organization equally hamper efforts to engage in the process to its successful termination (Daly & Muirhead, 2015). Fowler (2013) equally argued that, despite the existence of CS in the domain of nursing, there seems to be a level of unawareness of its existence, purpose or process among personnel. Study findings suggest that for CS to attain its intended purpose within the clinical setting, it is then important to explore the viewpoint of the recipient (supervisee) of the entire process; what it is, how it is performed and its impact to nursing practice (Pack, 2012).
This study aims at contributing to the knowledge base of nursing by exploring the perception of nurse supervisee on the Clinical supervision process. An insight into the supervisee’s perception will guide the implementation of the support activity at the unit level. The study is guided by the Integrated Model of Clinical Supervision developed by Philip Rich.

1.2 Problem Statement

Most junior nurses within their first three (3) years of full-time practice have been viewed as limited in their capacity to move seamlessly from the educational to the practice sector. Several reports have indicated that about fifty (50) percent of junior qualified and licensed nurses are not “work ready” and find it difficult to fit within the workforce (Australian government Department of Health [AG, DOH], 2013). However, these nurses form the core of the nursing workforce and are expected to take up full responsibility and perform all assigned task when employed. There is the need to institute formal support systems that will help the newly employed junior nurse to enhance their knowledge, skills and fully take up responsibilities (Wolff, 2010). The adaptation and utilization of the Clinical Supervision (CS) process has been found to enhance practical learning experiences and provide a support base for most nurses (Teasdale, Brocklehurst & Thom, 2008). It has also proven to serve as a tool used by senior staff to officially recognize a new employee’s abilities and maintain a clear association between knowledge, competency and motivation (Openshaw, 2012).

The implementation of CS in the area of General Nursing has been a struggle because, many nurse practitioners especially, the supervisees are unclear as to what it is, preventing the achievement of its intended goal (Driscoll, 2000; Bush, 2005; Minot, 2009). In a study conducted by Daly and Muirhead (2015) to assess the effectiveness of supervision, one of the pointers affecting supervision was the varied views and experiences.
Participants suggested that in order to restructure supervision, supervisee current perceptions must be explored in an open manner. There is anecdotal evidence that most newly employed nurses at the 37 Military Hospital complain about the level of support received from the experienced nurses in developing their professional competencies. The supervisees perceive the actions of supervisors at the unit level as being more managerial than supportive in nature and seem not to understand the entire CS process. Cross, Moore and Ockerby (2010) acknowledged that nurses were uncertain about CS’s purpose and perceived it in a negative light, relating it to performance management. There is a consensus from research that the starting point for improving CS is understanding what it is and what sets it apart from other supportive activities (Daly & Muirhead; 2015; Lennox, Skinner, & Foureur, 2008; Mills, Francis & Bonner, 2005).

In the area of General Nursing research, the perceptions of nurses on CS mostly from the supervisors’ view have being explored extensively (Pack, 2012; Fowler, 2011; Cross, Moore, & Ockerby, 2010; Williams & Irvine, 2009; Dehghani, 2016; Manning, 2016; Johansson, 2015). Studies that seek to explore the views of the nurse supervisee focuses on the impact of CS in the clinical area. Within the African and Ghanaian context, few studies have been carried out to investigate the impact of supervision in the nursing profession and among nurse trainees (Adjei, Sarpong, Attafuah, Amertil, & Akosah, 2018; Awuah-Peasah, 2013). The limited published data on the perception of nurse supervisee on the entire CS process, especially, in the African and Ghanaian context hinders a better understanding of the supervisee’s unique concerns with this all important supportive activity. Therefore, this study aims at bridging the gap by exploring the concept of Clinical Supervision from the viewpoint of the nurse supervisee since they are the recipient of the supportive activity.
1.3 Purpose of the study

The purpose of the study was to explore the perception of nurse supervisees on the clinical supervision process.

1.4 Objective of the Study

- Find out the nurse supervisee’s perception of clinical supervision process.
- Identify the functions of clinical supervision in the professional life of the nurse supervisee.
- Describe the stages of clinical supervision experienced by the nurse supervisee.
- Determine the primary elements of the clinical supervision process.

1.5 Research Question

The following research questions were outlined to guide the researcher in the study:

- What is the nurse supervisee’s perception of clinical supervision process?
- What are the functions of clinical supervision in the professional life of the nurse supervisee?
- What are the stages of clinical supervision experienced by the nurse supervisee?
- What are the primary elements of clinical supervision?

1.6 Significance of the Study

The findings from the study will contribute significantly to the body of knowledge on clinical supervision (CS) in nursing practice, education and research. It will provide an insight into how the nurse supervisee perceives the entire clinical supervision. The findings will also provide nurse managers with more insight on how the nurse supervisee perceive the process to help shape its adaptation and implementation as a clinical learning and enhancement tool within the nursing profession.
1.7 Operational Definition

**Clinical Supervision:** This is a supportive activity that assists the junior nurse to develop the knowledge and skill through a professional relationship with an experienced senior nurse.

**Concept:** The ideas, meaning and notions that nurse supervisees ascribe to clinical supervision.

**Nurse Supervisee:** General nurse who are diploma holders, working at the ward for a period of one to three years after initial employment.

1.8 Summary

This chapter focused on the introductory aspect of the study on exploring the concept of clinical supervision (CS) amongst nurse supervisees. CS is an adopted supportive activity that helps nurture and improves the skills and knowledge of an individual nurse to practice independently. Generally, CS assists the inexperienced nurse to advance in skills and integrate into the new work environment. In spite of the far-reaching benefits of this supportive activity, varied perceptions and experiences turn to affect the full attainment of the benefits. This study seeks to explore how the nurse supervisees who are beneficiaries of the activity perceive the concept, its function, stages and elements. A qualitative exploratory descriptive design was employed for the study. Also a semi-structured interview guide developed from the constructs of the Integrated Model of Clinical Supervision was used to collect the data.
CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter reviews existing literature on Clinical Supervision (CS). The main topics discussed include the conceptual model (Integrated Model on Clinical Supervision) guiding the study, the perception of the nurse supervisee on the concept of clinical supervision, function of clinical supervision in the professional life of the nurse supervisee, the stages of clinical supervision and the primary elements of clinical supervision.

A review of theoretical and empirical articles and books was conducted by a systematic search of published articles from the following databases JSTOR, PubMed, Medline, Cumulative Index of Nursing and Allied Health Literature (CINAHL), EBSCO host, Education Resources Information Centre (ERIC), Science Direct, Sage Research Online, Taylor and Francis Online, Google Scholar. The keywords used in searching for information for this review included “clinical supervision”, “clinical supervision in nursing”, “functions of clinical supervision”, “process of supervision”, “elements of supervision”, “nurses experience and clinical supervision”, “qualified nurse and supervision” and “the benefits of supervision”.

2.1 Justification for the Choice of Model

Various models of clinical supervision emerged in the course of literature review. These models were influenced by disciplines such as, psychology, psychotherapy and social work. The models of CS have been classified into the functions of clinical supervision, the process of clinical supervision and the nature of the supervisory relationship.

The Functional Interactive model developed by Proctor (1986) highlights the role and function of the supervisor and the relationship between the supervisor and the
supervisee during the CS process. It however, does not consider the process and elements of supervision and is suitable for studies that seek to assess the functions of CS.

The developmental model by Stoltenberg and Delworth (1987) emphasizes the various developmental stages of the supervisee’s skills and knowledge. The model also illustrates how the clinical supervisor can support at each stage of the developmental process. This model of supervision is suitable for studies that assess the supervisee’s level of development and strategies for effective supervision.

For the purpose of this study, the Integrated Model of Clinical Supervision: Function, Form and Content by Phil Rich (1993) was adopted because it is a comprehensive model which blends all the constructs in the earlier stated models and helps to identify the basic requirements of clinical supervision. The Integrated Model of Supervision is a comprehensive model which addresses the functions, stages, and primary elements of supervision and will help in answering the outlined research questions for this study. The model was developed by Phil Rich (1993), a social worker after a review of the clinical supervision literature across the disciplines of social work, counselling, clinical psychology, psychotherapy, and human service management.

2.2 Conceptual Framework

In this study, the researcher adapted the Integrated Model of Clinical Supervision (Rich, 1993) which is in the field of social work. “The integrated model is an amalgamation of existing models of supervision drawn from related fields of supervisory thoughts within the human service” (Rich, 1993). The model describes the entire clinical supervision (CS) process in terms of it function, form and content. There are three (3) major constructs of the model; Functions of Supervision; Stages or Cycle of Supervision and the Primary elements of Supervision.
Table 2.1: Integrated Model of Clinical Supervision

<table>
<thead>
<tr>
<th>FUNCTION</th>
<th>FORM</th>
<th>CONTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Functions of Supervision</td>
<td>6 Stage Cycle of Supervision</td>
<td>6 Primary Elements of Supervision</td>
</tr>
<tr>
<td>Facilitation</td>
<td>Relationship Building</td>
<td>Facilitative Environment</td>
</tr>
<tr>
<td>Staff Development</td>
<td>Planning</td>
<td>Supervisory relationship</td>
</tr>
<tr>
<td>Staff Socialization</td>
<td>Observation</td>
<td>Structural Elements</td>
</tr>
<tr>
<td>Service Delivery</td>
<td>Analysis</td>
<td>Supervisory Skills</td>
</tr>
<tr>
<td></td>
<td>Conference</td>
<td>Provision of Learning Experience</td>
</tr>
<tr>
<td></td>
<td>Follow-up</td>
<td>Supervisory Role</td>
</tr>
</tbody>
</table>

(Rich, 1993)

However, the research adapted the model and modified it to include the construct of perception to assess how the supervisee perceive the CS process. Some of the sub-themes of the main constructs which were not relevant to the study were omitted.

2.2.1 Function of Supervision

According to Rich (1993), the functions of clinical supervision are to advance the personal skills of the worker, ensure the execution of task in accordance to management values, expectation and standards. In the model there are four sub-themes; facilitation, staff development, staff socialization and service delivery which are related to the supportive and educational roles of supervision.

The facilitation function fosters an organizational environment that develops the skills, personal and professional relationship, goals and strategies. The aim of this function is to increase workers effectiveness and competence. It encompasses the development and maintenance of a work culture that empowers workers to take initiative, be creative, and have a personal responsibility towards work and relation with others. The facilitation function has four prominent areas; Team Building, Role and Goal Clarification, Problem Solving, and Confidence building.
The Staff Development function discloses efforts adopted by the experienced supervisor to develop a learning culture that enables the supervisee to grow and develop the needed knowledge and skills. The key areas in this function are professional skills development, professional knowledge enhancement, reinforcement of behavioural based learning and the development of self-awareness in relation to the supervisee's feelings, values, beliefs, strengths and learning needs.

The Staff Socialization function helps the supervisee to do away with undesirable professional attitudes and values. Staff socialization helps to modify and induct the supervisee into the desired organizational and professional values, ethics, standards and behaviours. The key areas in this function are: the reframing of past experience in terms of the new work context; the development of the supervisees commitment to professional and agency standards; the orientation and integration of the supervisee into the profession and agency; the mentoring and monitoring of supervisees’ attitudes and behaviour.

The Service Delivery, which is the last function aims at enabling quality of service delivery by the supervisee meeting or exceeding agency and professional standards. This function involves the evaluation of client service, the continuous improvement of services, professional modelling and direct involvement in service delivery by the supervisor, and the protection of clients. The study applied this section of the model to identify the function of CS in the professional life of the supervisee.

### 2.2.2 Stages of Supervision

Rich (1993) described the supervisory process as interrelated and cyclical in nature although the stages are presented in a linear fashion. The stages outlined in the model are; Relationship Building, Planning, Observation, Conference and Follow up. The primary purpose of the relationship building stage is to develop a purposeful supervisor-supervisee relationship. At this stage, the supervisor needs to initiate a professional relationship with
the supervisee. Activities such as orientation of new employees, clarification of roles, socialization of employee to the norms and values of the organization are carried out. The supervisor must be mindful of establishing effective communication with the supervisee which will affect the level of trust established.

The second stage of the process is planning of clinical work and staff development. It is the preparatory phase and involves a lot of discussion and negotiation. During this stage, strengths and weakness are identified; expectations of both the supervisor and supervisee are clarified; goals are developed and set in relation to clinical work and professional development. At the third stage, the supervisor observes clinical abilities of the supervisee’s practice. Areas of observation include interpersonal skills, clinical skills, case management skills, the client worker relationship, and achievement of standards.

The fourth stage of the CS process is the supervisory conference. The supervisory conference or meeting is between the supervisor and the supervisee. It is considered the crucial factor for the on-going supervision and communication. At the meeting, questions are raised, problems are managed, and feedback is given based on discussion and observation. It is also a forum in which best practice is modelled by the supervisor.

The final stage is the Follow-up; where future supervisory activities are planned which commence with a new cycle or process of clinical supervision. This stage may involve the implementation of agreed actions, goal setting, reinforcement of standards and plans in relation to future supervisory interventions. The dimension of the stages was explored in this study to bring to bear the experiences of the supervisee on how CS is conducted in the clinical area.

2.2.3 Primary Element of CS

According to Rich (1993), the effective utilization of the cycle of supervision is dependent on some basic elements of the supervisory process. The Facilitative environment
proposed by this model encourages professional and personal development of the supervisee. The supervisor needs to create an environment that is safe, nurturing, open, and interactive. This will provide a solid foundation for the mutual respect, trust and understanding of the supervisory relationship. The structural element, which is the second, provides the base upon which the supervision is built. It involves goal setting, clarification of roles and expectations, consistency in supervisory behaviour, appropriate feedback and constructive critique and debate between the supervisor and supervisee. The third element is the supervisory skills. The skills needed include technical, professional, interpersonal, analytical, explanatory and interpretive. The supervisor provides some learning experiences within the environment created. The learning activities involve the use of adult learning, tutorial, modelling, guidance, and experimentation and shared experience by the supervisor. The final element is the supervisory roles which involves the roles undertaken during the supervisory process. These roles include that of counsellor, teacher, consultant, colleague, mentor and evaluator. In this study, the researcher describes two of the primary elements; facilitative environment and supervisory relationship and it influence on the CS process.

2.3 Related Literature Review

2.3.1 The Perception of Clinical Supervision

Clinical supervision (CS) is an important support activity within the field of nursing. It provides the opportunity for nurses to learn from the experienced personnel and be better placed to contribute their quota towards the provision of safe professional practice and quality health care (Amsrud et al., 2015; Australian Association of Social Workers, 2012; Snowdon et al. 2015). The CS concept has been incorporated in both nursing and midwifery disciplines as well as dominated in varied fields and professions like psychotherapy, psychology and social work (Carpenter, Webb, & Bostock, 2013; Gallagher, 2006; Davey,
Desousa, Robinson & Murrells, 2006; Sloan, 2006; Mullarkey, Keeley & Playle, 2001; Winstanley & White, 2003).

There is a growing interest for health professionals to engage in CS as it constitutes a standard practice within the health care setting as cited in the report of Health Workforce Austrialia (2013b). The American Psychological Association (2014) defines supervision as “a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, extends over time, with the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession” (p. 5).

The concept of CS originated from psycho-analytical therapy training in the 1920 (Lynch, Happell, & Sharrock, 2008) and its emergence in nursing literature is traced backed in the 1970 (Yegdich & Cushing, 1998). Research evidence around the 1980s and 1990s reveal a difficulty in defining the concept of CS (Butterworth & Faugier, 1992). Within current nursing literature, there is equally a plethora of definitions to the concept (clinical supervision) by scholars, academicians and researchers. However, there seem to be no single definition been adopted (Lynch, Hancox, Happell and Biondo, 2008).

In a systematic review of empiric literature in related studies, Dawson, Phillips and Leggat (2013) equally concluded that the concept was not clearly defined. On the contrary, Jones (2006) espouses that, the diversity in the definition and views of the concept in nursing are acceptable due to the varied ideas and approaches employed during supervision.

In this review of literature, several definitions of clinical supervision have been highlighted in an attempt to provide a comprehensive understanding of the concept. Quinn (2000) and North Ireland Practice and Education Council for Nursing and Midwifery
(NIPEC, 2007) explained CS as a structured and formal activity set to provide professional support to individual nurses and practitioners in order to develop their knowledge, competence, assumption of responsibility and enhance service-user protection, quality and safety in complex clinical situations. It can be deduced from this definition that, maintenance of a balance between safety and timely provision of quality health care to patient or client as well as the professional growth of practitioners, through learning opportunities are top priorities in the area of clinical supervision.

In various studies conducted by Launer (2010) and Hancox and Lynch (2002) CS is described as a day-to-day discussion on clinical cases and their management, as well as any issue that may arise, in order to provide support, promote self-awareness, professional development and growth among supervisee(s) within the context of their professional environment. Kavansah et al (2002: 247) as cited in Cassedy (2010) also defined CS as a working alliance or partnership between professionals to provide personal support and encouragement that will influence the outcome and standard of clinical practice. Similarly, Hyrkas (2005) in his study referred to clinical supervision (CS) as a process in which clinical supervisor supports and assists in the growth of the learners to become competent practitioners. Lyth (2000) emphasized that CS is founded on the support mechanism to enhance knowledge and skills and avenue to share clinical, organizational, developmental and emotional experiences among practicing professionals and practitioners in a secure, confidential environment. In relation to support mechanism as cited by Lyth (2000); Winstanley and White (2003) Habimana, Tuyizere, and Uwajeneza, (2016) in their study noted that, CS offers an empathetic support to improve therapeutic skills, transmission of
knowledge and the facilitation of reflective practice in order to develop their own clinical practice and provide a support system to one another.

In another comprehensive definition according to Milne (2007; p. 440), CS refers to formal provision, (i.e., sanctioned by relevant organization/s) by senior or qualified health practitioners (or similarly experienced staff), of an intensive education (general problem solving capacity; developing capability) and/or training (competence enhancement) that is case-focused and which supports, directs and guides (including restorative and/or normative topics, addressed by means of professional methods, including objective monitoring, feedback and evaluation) the work of junior colleagues (supervisees).

Shulman (2013) and Martin, Copley and Tyacle (2014) also explain the concept (clinical supervision) as a guided intervention where a more experienced and skillful professional guides the practice of a less skilled professional. According to Minot and Adamski, (1989/2009) and White and Roche (2006, p. 214) CS is a process of interaction where an experienced practitioner has the opportunity to assess and evaluate the standard of clinical work of another practitioner. In a study by Cross, Moore, and Ockerby (2010) the nurses used the term “oversight and watching” to describe the supervisory activities of the experience personnel over the inexperienced personnel. This indicates that, through the CS process the supervisor has a responsibility of ensuring that the supervisee is constantly being watched to identify the level of experience and standard of service delivered.

According to Cruz, Carvalho and Sousa (2012) and Falender (2014) most of the definitions of CS focuses on either the aims; objectives; functions; relationship and opportunities or assessment and control mechanism. This is because CS is a practice-focused relationship based on formal, monitoring, supportive, analytical or learning process.
that provides a practical platform for supervisee to learn from experienced, skilled and knowledgeable professionals in the form of in-depth discussion and critical analysis of cases within the clinical environment.

2.3.2 Functions of Clinical Supervision

The pivotal focus of clinical supervision (CS) over the years is aimed at ensuring effective, efficient and improved nursing practices (Van Ooijen, 2000). A significant number of studies in nursing literature have clearly depicted that CS is an important support activity that incorporate and enhance the personal and professional development of supervisees (Alaraco & Tavares, 2010; Fowler, 2013; Openshaw, 2012). For instance, some of the literature reviews by Cruz et al (2012); Jones (2006); Bruijn, Busari and Wolf (2006) have categorized the functions of CS into three dimensions namely educational, supportive and administrative or managerial functions. Also, a study by Corey et al (2014) to examine the goals of CS concluded that there are four cardinal goals of CS namely (a) promotion of supervisee growth and development (b) protection of patient welfare (c) quality work performance through effective supervision and gatekeeper for the profession (d) empowerment of supervisee to carry out their responsibility independently and professionally.

According to Callahan, Almstrom, Swift, Borja, & Heath (2009) the key and most important function of CS is the development of the proficiency of practitioners. The implementation of CS in the clinical setting is centered on the professional development and educational activities. This influences the professional lives of nurses in terms of life-long learning, professional development, nursing experience, increased self-awareness, creation
and innovation. Crecious, Patricia and Faston (2018) further indicated that CS helps in the attainment of additional clinical experience and acquisition of skills.

The issue of professional development of nurses as one of the functions of CS was evident in a comparative study conducted by Abreu and Marrow (2012). The study examined CS in nursing practice among forty five (45) nurses in both Portugal and the United Kingdom countries. In a mixed study, the findings indicated that CS and professional development as well as clinical practice among nurses in these countries had a significant positive relationship.

Abiddin (2008) affirmed that, the entire CS process is concerned with the supervisee’s professional growth and skill development. The skills acquired equip the supervisee to be confident enough to handle the professional challenges encountered. This clearly implies that adequate time during clinical supervision, understanding of related clinical issues and increased commitment contributed to their professional development and experience in the nursing practice. Evidence from studies such as Rajeswaran (2017); Stringer et al. (2016) Lyberg, Amsrud and Severinsson, (2015); Memarian, Vanaki and Baraz, (2015) also reported that CS helped bridge academic theory and practice as well as development of professional skills. In other words, assist synthesise classroom theory with the complexity of practice. This clearly implies that adequate time during clinical supervision, understanding of related clinical issues and increased commitment contributed to their professional development and experience in the nursing practice.

Another function of CS is the facilitative role. In a systematic review of empirical data by Fowler (2000) it was highlighted that CS facilitated the professional enhancement of the supervisee. Also a qualitative study by Butterworth et al (2008) depicted that CS helps in developing the professional by increasing confidence, decreasing professional isolation
and improve relationships among nurses at the workplace. Further findings in related studies by Cummins (2009) and Bedward and Daniels (2005) also concluded that implementation of effective CS process reduces professional isolation among staff nurses.

Amongst the findings of a quantitative study conducted to evaluate CS and the development of student nurses competencies was the point that increased CS sessions leads to the development of a positive professional identity and improvement in the decision making abilities of the student nurse (Severinsson & Sand, 2010). Wong, Wong and Ishiyama (2012) in categorizing the several competences related themes of CS found role clarification as prominent among the themes because the supervisors explained and provided adequate information on individual roles and expectations. Similarly the results of a longitudinal study conducted among female nurses in Finland to examine revealed that increased CS sessions resulted in good mastery skills, professional efficacy, well-being and high commitment among the nurses. (Koiva, 2013).

Brunero and Stein-Parbury (2008) conducted an evidence-based literature review on the effectiveness of clinical supervision in nursing. The outcome of the study revealed that the role of CS was made evident as it contributed to professional standard practice and accountability by nurses in their execution on their daily activities and also increased their skills and knowledge acquisition tremendously which is an educative activity. The authors also articulated that out of the interactive functions of clinical supervision that was found in the study, restorative function (that is, social support from peers held reduce stress, burnout, coping strategies and improved relationship and trust among nurses) was very dominant relative to the other two functions. In a nutshell, restorative role of CS is to promote nurses’ health and well-being which has a nexus to the normative goal of promote professional accountability and compliance with standard practice to improve upon the quality of patient
care which is derived from the educative activity of continuous learning, experience, professional development and personal growth among individual nurses in the area of developmental function of clinical supervision.

Another function of CS is staff socialization to help the supervisee to accept the norms and standards practices of the profession. The socialization function of CS assist the supervisee to conform to set standards, rules or practices to achieve a desired goal. In a qualitative study conducted by Ana and Antonio (2014) to assess the role of supervision in professional development of social workers in North-Eastern Romania. The findings highlighted the importance of orienting staff to the work environment. According to the participants it gave a deep and better understanding of the organizational culture and environment. The need for supervisors to assist supervisees to be adequately informed on the existing culture of an organization was emphasized in a conference paper delivered by Openshaw (2012). This would ensure professional accountability and practice among staff nurses.

In other words, strict compliance to lay down procedures, standards and rules in the implementation of clinical supervision would have a significant positive influence on the professional practice and accountability of nurses as well as improved patient care delivery and job satisfaction at large. In addition, the function of CS contribute to nurses professional practice in areas of learning from each other, offering support, recognizing how colleagues perceive them as fellow workers, and moderate concerns and anxiety related to their work (Jones, 2003). This aids in providing professional support needed to mature on the job and reduce isolation and anxiety among nurses.

To attest to the socialization function of CS on the professional life of nurse’s Berggren and Severinsson (2000) investigated the influence of CS on registered nurses. Out
of a sample of fifteen registered nurses, interviewed the participants revealed that effective CS significantly affected the moral reasoning and decision making among registered nurses. The study further indicated that moral sensitivity and decision made was in accordance to standardized clinical supervision practice to improve on patient care delivery. In addition, other studies (Butterworth, Bell, Jackson, & Pajnkihar, 2008; Martino, Ball, Nich, Frankforter, & Carroll, 2008; Roche, Todd, & O'Connor, 2007) indicated a positive links between clinical supervision, professional development and high retention rate.

In relation to the benefit of CS on patient it was identified that overall delivery of quality service and safeguard of patient care were improved as a result of CS (Driscoll, 2007). In support with improvement in the type of care delivered, a study by Driscou (2000) also found that patients experienced a certain type of care from nurses who engaged in clinical supervision. The study findings also indicated that such nurses appeared more confident, knowledgeable, interested in their patients, go the extra mile for patients and have an open and honest approach to clinical cases of their patients.

In a related survey study in Northern Ireland, Kelly et al. (2001b) equally identified a positive improvement in the standard of care of patients from nurses who engaged in CS. Also there was evidence of personal and professional development and the acquisition of skills and knowledge among nurses as well as reduced isolation and increase confidence among the participants. In relation to improved nursing care and job satisfaction, Hashish (2012) investigated the effect of CS on quality of care and job satisfaction. The study revealed that nurses’ experience of CS played a contributing role in their execution of clinical work by following standard clinical practice. This positively affected the delivery service offered to patients and had a positive attitude to their job (job satisfaction).
2.3.3 Stages of clinical supervision

A significant number of studies in nursing literature have clearly depicted that clinical supervision (CS) is an important support activity that incorporate and enhance the personal and professional development of supervisees (Alaraco & Tavares, 2010; Fowler, 2013; Openshaw, 2012). Therefore, attainment of these goals by supervisees rest on the stages or steps used by qualified and experienced supervisors during supervision (Moura & Mesquita, 2010). The stages of Clinical Supervision (CS) outline how the entire process needs to be carried out to achieve the expected outcome. The stages include relationship building, planning, observation, conference and follow-up.

Literature reveals that the major problem of CS has to do with its full implementation (Pillay & Mtshali, 2008). The stages or cycle of the process is not adequately explained in literature, there seem to be varied ways or approaches to conducting the process. According to Fowler (2001) and Daly and Muirhead (2015) there is no single or specific steps in accomplishing the CS process. There seem to be some confusion about how different the CS process is from other supportive activities. However, there are specific variables that must be considered by the supervisor when adapting any of the method or steps in supervising. This includes the organizational culture, clinical environment, staff ratio and the needs of the supervisee (Fowler, 2011) to enable a better planned CS process.

The first stage of the CS process is relationship building. This plays a vital role in the successful implementation and completion or termination of the process. The existing relationship between the supervisor and supervisee strongly influence the outcome of CS and how the supervisee perceives the process either negatively or positively (Inmman & Ledany, 2008). In a related study conducted in three universities in Cyprus to assess student nurses’ satisfaction of the CS and the learning environment, the study concluded that the
supervisory relationship stage was the most influential stage in the entire CS process (Dimitriadou, Papastavrou, Efstatthiou, & Theodorou, 2015).

During the initial phase of the CS process the supervisors need to orientate the supervisees to the work environment, staff, protocols and procedures to help in familiarization of the clinical setting. This helps in building mutual respect and trust among the players thus, setting stage for the entire CS process (Phillips et al, 2014; CPA, 2009). During the orientation phase, the supervisee is informed of their roles and responsibilities. The supervisor draws the line between the protection of both the client and the integrity of the profession and the development of the competence of the supervisee (Falender, 2014; Salera- Vieira, 2009). This helps to defuse the tension between the supervisor and supervisee and helps the latter to better appreciate the feedback given during the CS process.

The level of trust amongst the supervisor and supervisee can be improved when the supervisees have named or specific supervisors. The supervisees’ acceptance of the supervisory team influences the entire CS process and the expected outcome. According to the findings of the quantitative study conducted by Dimitriadou et al. (2015), student nurses who were assigned specific supervisors during their clinical practice reported to be more satisfied with the supervisory relationship and learning environment. There was a positive relation between the level of satisfaction with the supervisor and the clinical learning environment.

The relationship established influences how well the CS was executed and how the supervisee accepted the feedback offered by the supervisor (Fowler, 2011) and how well the supervisee was socialized and engaged in the work environment (Phillips, Kenney, Esterman et al, 2014). The supervisors should be aware that the relationship established at the initial stage is strongly connected to the outcome of the CS process (Inman & Ladany,
Therefore, supervisors should endeavour to develop good relationships with the supervisees to promote enhanced outcomes.

The second stage of the CS process involves planning of the CS activity or process. This should be done by the supervisor and supervisee along a structured guideline. The supervisors must plan the entire CS process with the supervisee and agree on learning activities that would promote skill enhancement and retention of professional knowledge (Harton, 2007). Planning the entire process with the supervisee, encourages confidence and commitment by the two parties to the entire process and a successful outcome.

Amongst the findings of a qualitative study conducted by Williams and Irvine (2009) to explore how the supervisors facilitate the CS process it was concluded that, most clinical supervisors performed CS without a plan or structured guideline and do adopt ad hoc approach to the entire activity. This is supported by the findings of Cleary and Freeman (2005) that most supervisors in the clinical setting have verbally accepted CS to the execution of the process. The study concluded that the informal supervision conducted by supervisors does not conform to the established guidelines of the formal nature of CS.

The informal or ad hoc implementation of the CS process could be attributed to factors such as the busy schedules of the supervisor, work load on the ward and the junior staff being seen and treated as workers who have a task to accomplish (Chuan & Barnett, 2012; Pillay & Mtshali, 2009). Clinical supervisors need to be properly trained on the application of CS at the unit level (Williams & Irvine, 2009). The lack of training and planning affects the full appreciation of the process and its implementation in the clinical setting (Johansson, 2015). There is the need for more research into the content of CS to help supervisors to be abreast with the content of the process which will improve the implementation (Dawson et al, 2013).
The third stage of the CS process is observation. In a systematic review of studies by, Alarcao and Tavares (2010), Rocha (2013) and a paper by Center for Substance Abuse Treatment (2009), direct observation forms part of the CS process in the health service. Supervisors’ usage of direct observation of supervisee in the clinical setting helped to ascertain how nurses transmit the theoretical knowledge to the real-life situation in the clinical context. The study also stressed that direct observation is relevant due to effective monitoring of supervisees’ skills, competence and performance level respectively.

Furthermore, Rothgeb (2008), Rocha (2013) and Kaphagawani and Useh (2017) also identified observation as tool to identify the deficiencies of the supervisees. The study suggested that supervisors after observing the supervisees should demonstrate the appropriate skill to the supervisees. Demonstration is an approach used by facilitators during the learning process of CS. This strategy allows supervisors to epitomize or illustrate a phenomenon to supervisees with the aim of teaching and explaining the concept or the procedure. This creates a pictorial representation of the situation to learners which allows acquisition of knowledge and first-hand skills within the workplace. Some reviews have postulated demonstration as the second most widely used approach in the nursing profession.

Additionally, Larrosa (2000) and Grilo (2011) suggested introspection of self-reflection analysis to enhance supervise identity. This is attainable through self-supervision strategy or metacognitive strategy. The authors articulated that supervisors use this strategy to allow supervisees to demonstrate critical reasoning in their practices and related scientific evidence through underlying professional practice and to the implementation of self-guided changes.

Another stage of CS that focuses on critical description and in-depth analysis of observations in a form of discussion between supervisors and supervisee is conferencing as
case study analysis strategy. Winstanley and White (2011) affirm that reflexive dialogue between supervisors and supervisee during post observational conference enables supervisees to think critically on how to provide their skills which influences the quality and significant care to patients. It also provides an opportunity for the supervisor to better understand the observed behaviour or actions of the supervisees. In the clinical nursing supervision area, it is essential that the supervisor develops activities that enhance in the critical-reflexive abilities of the supervisees.

According to Alarco and Tavares (2010), case study analysis strategy used by clinical supervisors seeks to provide a reflective learning as well as skills empowerment among student nurses. The authors clearly indicated that case study analysis is mostly effective in group sessions which allows varied views, insight and interaction between the supervisor and a group of supervisees to promote experiences exchange. In support with Alarco and Tavares (2010) assertion, Parton and Binding (2009) claimed that case study analysis is one of the most effective method during clinical sessions. Thus, utilization of case study analysis by supervisors significantly impact on skills development as a result of reflection, discussions and sharing of experience by all members.

A critical type of analysis strategy used by supervisors is the critical and reflective practice analysis which is crucial to nurses’ professional practice and supervision processes. Evidence of this strategy was found by a study undertaken by Lehti and Paunonen-Ilmonen (2001). The research concluded that usage of effective critical and reflective practice analysis strategy by supervisors allows for restructuring of interpretations and practices that create the avenue to understand professional issues and its related solutions. Again, it promotes self-autonomy and enhancement in the quality of professional nursing practices. It was concluded that this strategy used by supervisors provides opportunity for supervisees to engage in interpersonal reflective process on nursing practices to enable them identify
clinical problems, set goals and strategies as well as decision-making based on practical evidence as suggested by Henderson (2014), Te Pou, (2009), Winstanley and White (2003) in their studies.

In Portugal, Pinto, Joao, Santos, and Enfermagem (2017) examined the relevance of indicators of clinical supervision strategies in nursing. Out of a sample size of 316 nurses who were supervisors in the hospital context, findings revealed that clinical supervision strategies, especially, the reflexive processes, as well as to methods directed to action and demonstration were of relevance. The study further suggested that reflexive processes and demonstrations are relevant indicators because it is an important step in the structuring and evaluation of supervision processes which contributes to the improvement of quality and safety of care.

Clynes and Raftery (2008), Ping (2008) and Martin, Copley and Tyack (2014) in their respective studies identified feedback as a one of the stages employed by supervisors during CS sessions. The above authors emphasized that feedback employed by supervisors would promote self-awareness and professional development of supervisee during clinical sessions as well as encourage reflective practices. It was also suggested that the form of feedback can either take place in groups or one-on-one basis that provides a useful insight about the current performance of supervisee which helped to ascertain their actual strength and weakness so as to take corrective actions by supervisors. The feedback should be specific, clear, balanced with both positive and constructive elements and non-threatening and abusive (Cox & Araoz, 2009). Studies indicate that there are some supervisors who harbour the concern that feedback can damage the supervisory relationship and try to avoid using this method (Falender, 2014). The supervisor offers little inputs and is hesitant to reflect or challenge the supervisee.
In addition to findings of Brunero and Stein-Parbury (2008), Vieira (2014) also highlighted feedback having a strong link with support tactics, that is, feedback by supervisors are usually accompanied by support. The support strategy aids in offering assistance and stress-relief to supervisees during the session. The study concluded that support strategy utilized by supervisors significantly increased the confidence level, sense of security and control of emotions among supervisee which is instrumental to their professional practice.

In conclusion, it is clear that supervisors who are also seen as facilitators during CS sessions need to create and deploy significant or relevant methods that would help impact the needed knowledge, skill-set and professional behaviours required by supervisees in the nursing field. Out of the above empirical reviews the following CS stages were mostly cited by authors within the nursing literature namely, relationship building, planning, direct observation, feedback (individual or group feedback), reflexive dialogue, demonstration, case study analysis, support strategy, self-reflection analysis strategy, critical and reflective practice analysis strategy. Therefore, all these forms of approaches can be interactive strategies when utilized effectively by clinical supervisors and would contribute to the attainment of the desired goal in the implementation of clinical supervision.

2.4 Elements of Clinical Supervision (CS)

Amsrud et al. (2015) postulated that clinical supervision is the pathway to intensify clinical experience; however, it can be influenced by several contextual variables. Within the context of literature, studies (Ayers et al., 2014; Butterworth et al., 2008; Cutcliffe, 2011; Dawson et al., 2013b; Edwards et al., 2005; Kavanagh et al., 2008; Kuipers, Pager, Bell, Hall, & Kendall, 2013; Nabolsi et al. 2012) have indicated that lengthy supervision session, choice of professional and experienced supervisor, clinical learning environment, effective supervision training influence the entire CS process.
Communication skill is one of the major elements for effective CS. However, it is often the most difficult skills for most health care supervisors. The ideas and messages transmitted to subordinates should be done with clarity and professionalism, since they serve as a liaison between the administration and the employees. For instance, employees will communicate their concerns through the supervisor, and the supervisor communicates the goals and policies established by senior administration to the subordinates. Finally, the supervisor must maintain a satisfactory working relationships and coordination amongst the departments when dealing with employee grievances to reach the overall objectives and goals of the institution.

van Ooijen (2013) similarly, identified some qualities of good supervisors which includes the ability to develop relationships, being open and not pretending to be more or less experienced or knowledgeable than he or she is. Supervisors need to have good skills in questioning, active listening, and the ability to focus and elicit enough information from the supervisee and note the point of need. The CQC (2013) also stated that supervisors should adopt a facilitative and supportive approach where you lead by example, but when there are concerns regarding the competence or conduct of a supervisee, they must act appropriately. Supervisors must also keep their own professional development up to date and have their own supervisor. Wherever possible, the supervisor should not assign line management responsibility for the supervisee due to the risk of clinical supervision becoming an appraisal function with the supervisee acting as subordinate, and the supervisor behaving in a managerial way (Sloan, 2005).

2.5 Summary of Literature Review

Generally, clinical supervision (CS) is seen as a process that benefit both nurses, patients (purely patient-related clinical issues) and health workers. Despite the significant benefits of CS to stakeholders, there has been growing concern about the possible barriers
to effective implementation of clinical supervision. It is worth noting that, effective clinical supervision has resulted in significant benefits experienced by numerous stakeholders (such as patient, supervisors and supervisee or nursing trainees) in the health sector. From the above discussion, it is evident that clinical training of today’s nurses cannot be fully accomplished without the implementation of clinical supervision to achieve its total practicality. Thus, enable junior nurses (supervisees) to gain rich clinical experiences and better ways to handle clinical cases and outcomes whiles executing their responsibility in a confident and professional manner as health workers.
CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter outlines the process through which the entire study was conducted. It also explains the choice and justification of research approach and design, target population, sample size and sampling technique, tools and methods for data collection, data analysis and ethical considerations that were observed in the conduct of this study.

3.1 Research Design

A qualitative exploratory descriptive design was employed for this study as it provided a means for exploring and understanding the meaning individuals give to a social phenomenon (Creswell, 2009). This method relies heavily on subjective opinions of participants and is usually framed with the use of words rather than numbers and relies on the fact that, knowledge about humans cannot be generated without describing the human experience as it is lived and defined by the actors themselves (Polit, Beck, & Hungler, 2003). Likewise, it also provides an in-depth understanding of the phenomenon and experience from the participant’s perspectives in sequential manner which enrich the study findings (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Clarke, 2010; Smith & Osborn, 2003). The results of qualitative methods are more descriptive, and inferences can be drawn quite easily from the data obtained from the study participants in their own language and viewpoint.

This method was ideal because, it allowed the researcher to have a deeper understanding of the personal meaning Staff Nurses (SNs) give to the concept of clinical supervision. It also allowed the researcher the opportunity to thoroughly investigate the full nature of the phenomenon rather than simply observing and explaining the phenomenon.
3.2 Research Setting

The setting for the study was the 37 Military Hospital which is the only military-based public Teaching hospital in Ghana located in Ayawaso East sub-locality in the Accra metropolis. It is situated 4 kilometres from the Accra International Airport on the main Airport-Accra Central road (Independence Avenue Road). The hospital’s mission is dedicated towards the maintenance, promotion and rehabilitation of the health of people leaving within the Accra Metropolis and beyond. The roles of the 37 Military Hospital are to promote and maintain health and prevent disease; care for and treat those disabled by sickness or injury; form the necessary peacetime nucleus from which the medical services could expand in emergency and war; provide medical services to both the military and civilian populace in Ghana.

Currently, nearly 70% of all inpatients of the hospital fall within the civilian population. Additionally, the hospital serves as the Government Emergency Response Health facility and therefore, becomes the center of action in the event of major disasters in the country. The hospital is a five hundred (500) bedded facility but can make provisions for six hundred and fifty (650) patients during emergencies (37 Military Hospital Records, 2019). The 37 Military Hospital, like most tertiary hospitals, has several sub-units and departments working in unison under the control and direction of the Medical Director referred to as the Commanding Officer (CO) to deliver effective healthcare. The hospital has fourteen (14) departments, which consists of the Medical, Surgical, Paediatrics, Obstetrics and Gynaecology, Public Health, the Ear Nose and Throat (ENT), Eye, Dialysis, Haematology, Anaesthesia, Operation Theatres and ICU, X-ray and diagnostics Department and the Department of Morbid Anatomy and the Nursing and Midwifery Training School. It also has eleven (11) wards; divided into three (3) surgical wards, three (3) medical wards, two (2) special wards (for Very Important Personalities), one (1) paediatric and two (2)
obstetrics and gynaecology ward respectively. The hospital provides a 24-hour service.

The hospital has a total of three hundred and fifty-nine (359) nursing staff made up of both civilians and military persons who are mostly products of the Nursing and Midwifery Training College of the hospital. However, the hospital employs qualified nurses from other recognized Nursing Training Schools in Ghana. The calibre of nurses within the hospital ranges from the experienced to the newly qualified ones with various specialty qualifications. (37 Military Hospital, Human Resource Division, 2019).

The researcher chose this setting because, it is one of the clinical learning facilities used in training and supervision of student nurses. The facility has a significant number of experienced senior nurses and supervisors who provide professional support to both novice and advance beginners in the nursing profession. Another reason of choosing this facility was its proximity to the researcher.

3.3 Target Population

Polit, Beck and Hungler (2003) defined the target population as the entire group of cases, people and events in which a researcher is interested. For this study, the target population was all Staff Nurses (SN) who were fully employed and working at the 37 Military Hospital.

3.3.1 Inclusion Criteria

The criteria for inclusion in this study are that:

- The participant must be a Staff Nurse (SN)
- The participant must have completed a diploma in nursing programme from a recognized Nursing Training School.
- The participant must be a full-time employee of the 37 Military Hospital for a least one (1) to at most three (3) years (a period of 1 – 3 years) after initial employment.
The participant must be a Registered General Nurse (RGN) certified by the Nursing and Midwifery Council (NMC), Ghana.

3.3.2 Exclusion Criteria

The criteria for exclusion in this study include:

- Staff Nurses (SNs) doing their rotation
- Staff nurses with more than three (3) years working experience on the ward or less than a year.
- Nurses with degrees and advanced certificates.

3.4 Sampling Size and Sampling Technique

According to Polit and Beck (2003), sampling is the process the researcher goes through to select a section of the population to represent the voices of the entire population. In most qualitative studies, the sample size is not determined but based on the informational needs of the researcher. A guiding principle of data saturation is mostly adapted in qualitative studies because the sample size cannot be determined (Mason, 2010; Polit, Beck, & Hungler, 2003). In this study it was estimated that thirteen (13) to fifteen (15) participants would be engaged for this study. However, at the end of interviewing the eleventh (11th) participant, the researcher realized that most of the information shared by the participants were along the same lines and no new information was identified indicating that saturation had been achieved. Therefore, adding on more participants will not result in any additional views, perspectives or information to the phenomenon being under study (Dworkin, 2012).

A non-probability purposive sampling was used to recruit the participants who could provide in-depth and detailed information about the concept under investigation (Kilcullen, 2007; Patton, 2002). Purposive sampling or judgmental sampling is based on the belief that researchers’ knowledge about the population can be used to hand-pick sample
members (Polit & Beck, 2003). The researcher purposively selected interested Staff Nurses (SN) from the list of employed Registered General Nurses (RGN) of the rank of SN working in the hospital provided by the Chief Ward Master of the 37 Military Hospital using the inclusion criteria. The SNs were allowed to indicate their availability, willingness to participate, and their ability to communicate views, experiences and opinions in an articulated, expressive, and reflective manner (Patton, 2002) after the entire process had been explained to them.

3.5 Research Tool

A semi-structured interview guide with open ended questions was used to conduct an in-depth one-on-one interview to facilitate the collection of data. This helped elicit the needed information to answer the research questions (Cohen, 2007). In-depth interviews are personal interviews that are carried out with one participant at a time to ensure privacy. It is purely a conversational and interactive method and invites opportunities to get detailed information from the study participants (Dworkin, 2012). The research tool was designed by the researcher with the aid of the constructs of the Integrated Model and relevant information from existing literature. It was also modelled in line with the objectives of the study. Section A focused on the demographic and professional background of participants. Section B elicited information about the perception of the concept of Clinical Supervision (CS). Section C identified the functions of CS, Section D centred on the stages of CS and Section E identified the primary elements of CS.

In order to ensure the quality of the data, the research tool was pre-tested with two (2) staff nurses with similar characteristics at La General Hospital in the Accra metropolis. This assisted the researcher to identify how much time it will take to administer the research tool, the sequence of the questions and how the participants react to the set of questions as
well as levels of ambiguity (Polit & Beck, 2003) The outcome of the pre-testing exercise was used to refine the interview guide in order to elicit appropriate response for the study.

3.6 Data Collection

Prior to the study, formal permission was sought by the researcher from the Commanding Officer, Hospital Matron and the Human Resource Officer of the 37 Military Hospital to select the study participants. This was aided by the introductory letter and Ethical Clearance Certificates. The Chief Ward Master and the ward in-charges provided the researcher with the list of all Staff Nurses working at the 37 Military hospital. With the approval, the researcher identified and contacted the prospective participants to arrange an initial meeting in the Chief Ward Master’s office. On the agreed day, all the prospective participants and the researcher met to discuss the relevance of the study. This was to ensure that participants had a better appreciation of the study and identify those who were willing to participate and respond appropriately to the interview questions.

Those who met the inclusion criteria and expressed their willingness to participate were given the information sheet for further clarification and the consent form to sign. Their contacts were taken and allowed to decide the interview days. The first participant agreed to be interviewed on the ward but this interview, had to be rescheduled because of the interruptions from colleagues and ward activities during the process. In view of that, the other participants agreed on conducting the interview outside their work schedule and ward environment to reduce interruptions. A convenient place within the hospital environment was chosen for the meeting as well as the date and time based on the preference of the participants. The data collection process started on the 1 February 2019 and lasted for a period of nine (9) weeks.
Each interview session took a conversational form to ensure that the participants were relaxed and comfortable. The researcher established rapport with each participant by generally talking about their ward experiences and the profession; this was aimed at breaking the ice and relaxing the study participants. Participants were given the chance to glance through the interview guide, ask questions to clear any doubt and stimulate their thoughts for the interview. The researcher encouraged the participants to express themselves freely. Probing questions were used to help participants contribute meaningfully to the discussion. All interviews were audio taped and recorded with the participants’ consent to enhance the capturing of accurate and credible information. Field notes were taken from observations made during each interview session to form part of the full report and reflect the entire discussions held with the participant. At the end of each session, the researcher played back the recorded interview to each participant to ensure that all important data had been collected and the recording was a representation of their views and thoughts. Each participant was interviewed for at least forty (40) minutes and at most sixty (60) minutes. Participants were thanked for their co-operation.

The researcher then listened to the entire interview repeatedly to identity key phrases and keywords and made reflections on the entire process considering the non-verbal cues of the participants, the entire conversation and how it impacted on the session. The data gathered was then transcribed verbatim and activities of the day were summarized after which modification and adjustments were made to enhance the subsequent interviews.

3.7 Data Analysis

Thematic content analysis was used to analyse the data and to identify themes that emerged in relation to the construct of the adapted model for the study. This technique allows for a rich, thorough and multifaceted description of the data available. It helps to provide response to the research question being posed, through a painstaking process of data
familiarization, coding, theme development and revision Clarke and Braun (2013). The six-step approach as described by Braun and Clark (2006) was used. The first step was to listen to the audio recordings severally to get a better understanding and appreciation of the content. The data was transcribed verbatim as it helped the researcher to be immersed in the data, clarify ambiguities and become more sensitized to the data. After which the researcher read and re-read the transcripts and noted the interesting and salient ideas. The raw narration which was transcribed was presented to the SN (s) to check for true and fair representation of their views.

The data on the transcripts were examined line by line and deductively assigned codes which captured the meaning and content of each sentence; this helped to reduce of the data. The assigned codes were based on the constructs in the integrated model of supervision. The transcripts were read several times to identify similar phrases and patterns of responses to aid in coding the data. Appropriate follow-ups were made to the participants for clarity until saturation was attained. Identified patterns and similar phrases were categorized and isolated into sub-themes manually. The sub-themes were thereafter, categorized to generate more generalized themes based on the consistency and relatedness in the summarized data.

The researcher, after a few days, then re-read the original transcripts without looking at the codes, and subthemes generated initially, then reviewed the initial categorization and compared it with the first categorization to confirm the codes and subthemes under the themes. This process was done severally until the researcher was satisfied that all the themes and subthemes generally, reflected the interview transcripts. The researcher then organized the themes, subthemes and the supporting quotations manually, and these constituted the major themes of this study upon which inferences and discussions were made and a detailed report was written.
3.8 Data Management

Data management is about preserving the sanctity and completeness of the information collected from the participants. The researcher ensured that the interviews were conducted in an enclosed area. After every interview section, the researcher played back the audio recording to the participants to ensure that information collected was accurate and a fair representation of the participant’s thoughts and views. All the information obtained from participants during the interview sections were assigned pseudonyms, this was to guarantee anonymity. All documents including individual consent forms, demographic data, field notes and all other relevant materials concerning the study were appropriately filed and kept under lock and key. The audio recordings and transcripts have been labelled, stored electronically and kept safely by the researcher. The information will be accessible to only the researcher and her supervisory team. The data will be destroyed after a period of five (5) years.

3.9 Rigour of the Research

In order to create the true value of the study, the researcher adopted the qualitative research rigour criteria as identified by Lincoln and Guba (2000). It includes credibility, transferability, dependability and confirmability.

Credibility comprises of activities that increase the confidence, truthfulness of the results and findings of the study (Polit & Beck, 2010; Speziale, Streubert & Carpenter, 2007). It ensures that the research methodology adopted measures what is intended to measure (Shenton, 2004). The researcher ensured credibility by selecting the appropriate research methodology and design. The researcher also read extensively on current literature to develop the right interview guide which elicited accurate answers to the research questions. The researcher ensured a prolonged engagement with the participants throughout the data collection process, to establish rapport and trust. It helped the researcher to know
more about the staff and to get an in-depth understanding of the organizational culture (Polit & Beck, 2010). Again, triangulation was done by adopting several tactics such as prolonged engagements of participants, member checking and audit trail.

The researcher maintained a frequent debriefing session with the research supervisor regarding the research methodology and the data collection procedure. The supervisor listened to the recorded interview and juxtaposed it to the interview guide. This assisted the researcher to identify gaps in the work and make necessary corrections. The researcher also presented the work to colleagues and peers who reviewed the work and made necessary contributions that enriched the work. Member checking was also employed to enhance the credibility of the study. The preliminary research findings and interpretations were presented to the participants to ensure that they truly reflected their views and experiences (Polit & Beck, 2010) before conclusions were drawn.

The second criterion in establishing the rigour of the study was dependability. According to Graneheim and Lundman (2004), the dependability of a study is the extent to which judgments about similarities and differences of content are consistent with time. To ensure dependability in this study, all respondents were interviewed using the same interview guide with a similar process which when repeated with similar participants yielded similar findings. A detailed description and recording of all stages and methods in the research process have been provided to offer readers the opportunity to follow the guidelines to replicate the study.

The third measure used to ensure trustworthiness of the study was transferability. Transferability, according to Creswell (2014), broadly refers to the likelihood that the findings of the study have implications for others in similar circumstances. This is also called fitness; transferability determines whether findings can suitably fit well in or are transferable to related conditions. To accomplish transferability in this study, a vivid
description of the setting, methodology, and the characteristics of the participants have been provided.

The final step in ensuring rigour of the study was confirmability. Confirmability in research is the degree to which the results could be confirmed or substantiated by others. It is to ensure that the meanings of the data collected are not changed by the prejudices, knowledge, and experiences of the researcher (Kusi, 2012). The researcher ensured confirmability by reflexivity and bracketing her experiences, knowledge, biases and views. Reflexivity, according to Jootun and McGhee (2009), is an invaluable tool that increases the rigour of a research process by promoting the understanding of the phenomenon under study and the researcher’s role. Whereas, bracketing is an active process in which the researcher becomes aware of his or her own biases, beliefs, assumptions and experiences that may influence the research process (Clancy 2013). The researcher is a general nurse who has been practicing for the past thirteen (13) years. She is currently in the senior staff category which qualifies her to be a supervisor to any of the staff nurses. Therefore, to ensure confirmability of this study, the researcher developed the interview guide based on the literature reviewed and the constructs of the integrated model of supervision. The researcher during the interview sessions did not discuss her professional life but asked probing questions based on the interview guide to elicit answers from participants that answered the research questions. Participants had no idea about the researcher’s professional ranking to influence their response.

3.10 Ethical Consideration

Ethics is a set of moral values that is aimed at doing good and preventing any form of harm to participants of a study (Creswell, 2014). Cohen, Manion and Morrison (2004) stressed on the fact that ethical consideration revolves around the rights of participants which must be observed in the event of any research process. The researcher has a
responsibility of protecting the study participants from any form of harm, respect their views, develop a level of trust, guard against any misconduct and promote the integrity of the study (Creswell, 2009; Israel & Hay, 2006). The guiding principles for ethical consideration include autonomy, confidentiality, beneficence, non-maleficence and justice.

Prior to the conduct of this study, the researcher submitted the study proposal to the Institutional Review Board (IRB) at Noguchi Memorial Institute for Medical Research, University of Ghana to assess how the researcher intended to respect the rights of the participants and prevent the participants from exposure to any form of physical, psychological, social and legal risk. A copy of the study proposal was also submitted to the Institutional Review Board (IRB) at the 37 Military Hospital who gave the institutional clearance and the authorization to select the study participants. Upon receipt of the ethical clearance certificates, the researcher presented the certificates and an introductory letter from the School of Nursing and Midwifery (SoNM) to the Commanding Officer, Matron and the Human Resource Officer of the 37 Military Hospital. This was to introduce the researcher, seek formal permission and approval for the selection of the study site and the participants.

The participant(s) rights to make personal choices was respected throughout the process. In order to ensure the full adherence to the principle of autonomy, the researcher met all the prospective participants (Staff Nurses) and had a verbal briefing about the purpose, procedure and the benefits of the study and allowed participants to ask relevant questions to clear doubts. Staff Nurses who agreed to participate and met the inclusion criteria for the study were given the Comprehensive Information Sheet (see Appendix B) which explained the risks and benefits of the study to peruse for three (3) days and decide on their participation. The participants who agreed to partake in the study were given the
consent form to sign. Voluntary participation was adhered to without any form of coercion or pressure on the part of the researcher. The right of the participant(s) to withdraw from the research process without any form of intimidation from the researcher was emphasized and adhered to throughout the process. Two (2) of the participants withdrew from the study.

Again, the participant(s) right to privacy and confidentiality was ensured by protecting all information provided by participants, not making it accessible to others not related to the research. During the interview the researcher and participants agreed on the venue and did not allow anyone to sit in. The actual names of the participant(s) were omitted instead, pseudo name(s) were assigned and used in the work (Chapter 4) in order to ensure anonymity. The researcher did not discuss the demographic data of the participants with any participant, nurse or the ward in-charges. Likewise, participant(s) were assured that information obtained would be used solely for academic purpose. Only the researcher and the supervisor had access to the information collected. The audio recordings and transcribed data were stored electronically with a password known to the researcher alone. Field notes and all forms signed by the participants were kept under lock and key.

During the interview sections, the researcher did not expose the participants to any form of harm or injury through acts of commission or omission. No physical or psychological harm was caused to the participants whilst taking part in this study. Participants were not taken out of their wards or unit during working hours; neither did the researcher impose any day or venue. Participants decided when and where they wanted to have the interview. The researcher explained to all participants their right to refuse to answer any of the questions if it had the tendency of causing any emotional disturbance.

The researcher ensured fairness, equality and impartiality towards all the participants. The choice of participants for this study was not based on any special
qualification apart from the fact that they were staff nurses working at the 37 Military Hospital and volunteered to participate in the study. The same set of interview questions was used for all the participants. After each interview session, participants were appreciated for their time and inputs; snacks were provided for refreshment.
CHAPTER FOUR

FINDINGS OF THE STUDY

4.0 Introduction

This chapter describes the findings of the data generated from the study participants at the 37 Military Hospital. The study findings have been organized according to the constructs of the Integrated Model of Supervision (Rich, 1993) through thematic content analysis. This chapter further describes the demographic information of the eleven (11) participants; the results have been presented in the form of themes and sub-themes and supported with verbatim quotation from participants.

4.1 Demographic Characteristics of Participants

Demographic characteristics describe the profile of the study participants. Characteristics obtained included gender, age, institution attended, nursing rank, status of employment, year of employment, years of working experience and their current unit or ward within the hospital. A total of eleven (11) Staff Nurses (SNs) were interviewed for the study. Six (6) of the participants were females and five (5) males. The age range of the participant was between twenty-five (25) to thirty-nine (38) years with a modal age of twenty-eight (28) years. Participants had all successfully graduated from recognized Nursing Training Institutions in Ghana; eight (8) of them were products of the Nursing and Midwifery Training College of the 37 Military Hospital and three (3) from other Nursing Training Colleges in Ghana. Participants were all licensed and had valid professional identification numbers (PIN) from the Nursing and Midwifery Council (NMC) of Ghana. The work experiences of the participants range from one (1) to three (3) years and their year of employment was from February 2016 to January 2018 which was their initial employment after School. Five (5) of the participants were working at the surgical wards.
four (4) at the medical wards and two (2) at the paediatric wards. Pseudonym was assigned to each participant to ensure anonymity. The demographic data of the participants are illustrated in Table 4.1.

<table>
<thead>
<tr>
<th>Pseudo name</th>
<th>Gender</th>
<th>Age (years)</th>
<th>Nursing College Attended</th>
<th>Nursing Rank</th>
<th>Year of employment/ Status</th>
<th>Years of work experience</th>
<th>Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN1</td>
<td>Male</td>
<td>28</td>
<td>NMTC, Sekondi</td>
<td>Staff Nurse</td>
<td>Feb. 2017 Full time</td>
<td>2 years</td>
<td>Paediatric</td>
</tr>
<tr>
<td>SN2</td>
<td>Female</td>
<td>26</td>
<td>NMTC 37 MH</td>
<td>Staff Nurse</td>
<td>Feb. 2017 Full time</td>
<td>1 ½ years</td>
<td>Paediatric</td>
</tr>
<tr>
<td>SN3</td>
<td>Female</td>
<td>27</td>
<td>NTC Bawku</td>
<td>Staff Nurse</td>
<td>Jan. 2018 Full time</td>
<td>1 year</td>
<td>Surgical</td>
</tr>
<tr>
<td>SN4</td>
<td>Male</td>
<td>28</td>
<td>NMTC 37 MH</td>
<td>Staff Nurse</td>
<td>Feb 2016 Full time</td>
<td>3 years</td>
<td>Surgical (VIP)</td>
</tr>
<tr>
<td>SN5</td>
<td>Female</td>
<td>39</td>
<td>NMTC 37 MH</td>
<td>Staff Nurse</td>
<td>Feb 2016 Full time</td>
<td>3 years</td>
<td>Surgical/ Orthopaedics</td>
</tr>
<tr>
<td>SN6</td>
<td>Male</td>
<td>26</td>
<td>NMTC 37 MH</td>
<td>Staff Nurse</td>
<td>Feb. 2017 Full time</td>
<td>1 ½ years</td>
<td>Medical</td>
</tr>
<tr>
<td>SN7</td>
<td>Female</td>
<td>25</td>
<td>NMTC Korle-bu</td>
<td>Staff Nurse</td>
<td>Jan. 2018 Full time</td>
<td>1 year</td>
<td>Medical (VIP)</td>
</tr>
<tr>
<td>SN8</td>
<td>Female</td>
<td>25</td>
<td>NMTC 37 MH</td>
<td>Staff Nurse</td>
<td>Jan 2018 Full time</td>
<td>1 year</td>
<td>Medical</td>
</tr>
<tr>
<td>SN9</td>
<td>Female</td>
<td>27</td>
<td>NMTC 37 MH</td>
<td>Staff Nurse</td>
<td>Feb 2016 Full time</td>
<td>3 years</td>
<td>Surgical</td>
</tr>
<tr>
<td>SN10</td>
<td>Male</td>
<td>28</td>
<td>NMTC 37 MH</td>
<td>Staff Nurse</td>
<td>2017 Full time</td>
<td>2 years</td>
<td>Surgical</td>
</tr>
<tr>
<td>SN11</td>
<td>Male</td>
<td>28</td>
<td>NMTC 37 MH</td>
<td>Staff Nurse</td>
<td>Jan 2018 Full time</td>
<td>1 year</td>
<td>Medical (Isolation)</td>
</tr>
</tbody>
</table>

NOTE: Field Data 2019

4.2 Organization of Themes and Sub-themes

Six (6) main themes with its corresponding sub-themes were identified from the data. Four (4) of the main themes were identified based on the constructs of the adapted version of the Integrated Model of Clinical Supervision (Rich, 1993). The themes included; (1) Perception of CS (2) Functions of CS (3) Stages of Supervision (4) Elements of Supervision. Two (2) other themes emerged from the data namely: (1) Strategies of Supervision and (2) Measures of enhancing CS. Details of the themes and sub-themes are presented in Table 4.2.
4.3 Perception of Clinical Supervision

The first research question was aimed at explaining how the nurse supervisees working at the 37 Military Hospital perceive the concept of clinical supervision (CS). In answering the first research question, five (5) sub-themes emerged. The sub-themes were supervising, monitoring and evaluation, directing, helping and alliance. Participants viewed CS as an essential intervention that will help the supervisee to acquire additional knowledge, enhance the professional skills and minimize or eliminate any form of maltreatment to the patients.
4.3.1 Supervising

Majority of participants irrespective of their years of experience indicated that clinical supervision is a process by which the senior nurse who is more skilful, supervises the junior nurses on the ward. Participants recognized the role of the senior nurses as superiors and leaders with the responsibility of ensuring that the junior staff performs their assigned task and duties diligently. Comments generated from the participants to support the above are the following:

“Well ... in my view I think, clinical supervision is when a senior most staff with some sort of skill supervises and ensures that the junior most is doing the right thing whiles carrying out some particular task on the ward.” (SN1)

“I think clinical supervision is a process whereby our senior colleague supervises us the young nurses on the ward.” (SN7)

“Clinical supervision is actually some kind of a process whereby your superiors take charge of what you are doing and supervise you based on the hospital’s protocol and the standards of the hospital and probably Nursing and Midwifery council.” (SN2)

Participants held the view that through supervision senior nursing staff ensures that the actions of the junior nurse positively benefit the patient on the ward.

“To me, supervision is complete when a senior nurse, leader or superior supervise the junior ones to carry out their nursing duties effectively for the betterment of the patient in the ward.” (SN3)

“Supervision in my own context or my understanding is when you as a superior or in-charge supervise the staff nurse do things right, not to harm the patient on the ward or do things which will endanger the patient.” (SN4)

4.3.2 Monitoring and evaluation

The participants explained clinical supervision along the lines of monitoring and evaluation of the quality of professional skills and services offered by the nurse supervisees and the educational knowledge possessed after completion of nursing education to bridge the theory and practice gap. In explaining CS, the participants stressed the point that senior
nurses must constantly monitor how well the nurse supervisee performs in accomplishing assigned tasks with the aim of perfecting their professional skills. Staff nurse SN6 retorted that:

“Clinical supervision is when someone is still being monitored to grow his skills in the particular field that he has chosen to work and also to be corrected as and when there is the need to. Monitoring as I would explain, is when someone takes personal interest in your actions, watches what you do to see whether you are doing it right or wrong.” (SN6)

Some participants explained CS as a process of monitoring and comparing the theoretical and practical knowledge of the newly employed nurse with the accepted standards of the profession. Participants felt that after evaluation, the senior nurses has a responsibility to assist the junior nurse to develop the needed professional skill to help bridge the theory and practice gap. Comments generated from the participants are:

“….. clinical supervision is a kind of process of monitoring and comparing what the new nurse has studied in Nursing Training College (NTC) and what is being practiced at the practical field. Whether it conforms to the standards or otherwise so that amendment can be made…..” (SN10)

“... it also helps to assess what the person has learnt from school and how he or she is implementing whatever he has learnt on the ward, irrespective of how long the person has completed schooling and practicing.” (SN7)

4.3.3 Directing

Participants explained clinical supervision as a directive process, where a senior nurse assigns responsibility, gives instructions, controls and guides the supervisees in their line of work. The aim is to identify how well the junior nurse has performed the assigned responsibility and correct them accordingly.

“... clinical supervision is basically about directing and controlling how people work, you assigned duties to them, asses how they are able to carry out the task you have given them based on the instructions given and making the necessary corrections as and when it is needed.” (SN8)
Participants indicated that CS directs and guides the newly employed nurse to learn the practical aspects of the nursing profession and better understand the nursing activities. SN11 had this to say:

“It directs and guides newly employed nurses who are in the ward to learn the practical aspect of the day to day nursing activities. They are guided to understand what to do on every shift and why we are doing them on the ward.” (SN11)

4.3.4 Helping

One participant explained CS as a process where the senior nurse helps the junior nurse to perform procedures to improve the care given to the patient. The participant stated that through supervision the senior staff notices the deficiencies of the junior staff and rectifies them accordingly. SN5 recounted that:

“Supervision in the clinical area is when somebody older than you in the profession decides to help you. When you are doing a procedure that person will be there to observe what you are doing whether you are doing it right or wrong…. I think that, through supervisions, corrections are made, you get to find faults, and we correct each other.” (SN5)

4.3.5 Alliance

Generally, all the participants agreed that the clinical supervision process is a relationship or an alliance between two groups of nursing professionals; the senior colleagues who are more skilful and experienced and the junior colleagues who are less experienced and less skilful. Participants had this to say:

“Clinical supervision is an alliance, not necessary between a subordinate and an employer or something. I think the alliance could be between just an immediate in-charge and then let's say the subordinate, amongst two subordinates with one being more skilful and experienced than the other or between the ward in charge who is the senior staff and the subordinates.” (SN9)

“It should be between a senior staff and a junior staff or with a more skilled staff and someone with a deficiency related to a particular task.” (SN1)
4.4 Functions of Clinical supervision

The second research question aimed at identifying the roles that clinical supervision plays in the working life of practicing nurses. In analysing the data, the main theme “function of clinical supervision” and four (4) sub-themes in relation to the constructs of the adapted model emerged. This theme generally, explains the clinical impact or influence of CS on the nurse supervisee’s professional life. The sub-themes included facilitation, staff development, staff socialization and service delivery.

The facilitation function comprised of activities that develop competencies, promote team building, role clarification, problem solving and innovative thinking. Participants agreed that the aim of the facilitative function was to increase effectiveness and competence amongst the junior nurses. The participants recounted how the ward in-charges explained the roles and responsibilities of nurses on daily basis during handing and taking over sessions and ward meetings. Participants who had worked for a period of two (2) to three (3) years narrated how the supervisors allowed junior nurses some level of autonomy in resolving minor challenges during various shifts. Some participants enumerated instance where supervisors sort views on issues pertaining to the ward and case management from the junior staff.

All the participants recognized the role of CS in the development of professional knowledge and skills. Participants described the various ward activities that were initiated by supervisors to motivate the culture of learning. The activities included the weekly ward conferences, presentations and reading of assignments. Some participants stated that staff supervision helps to develop a positive employee behaviour and shapes supervisees attitude to work.

Generally, all the participants were engaged in some socialization activities when employed in the hospital and identified it as one of the function of CS. Participants who
were working at the special (VIP) wards had intensive orientation and were assigned to senior nurses for a period to orient them to the ward environment and introduced them to their roles and responsibilities. Participants who were products of the NMTC- 37MH also stated how the orientation received during the school days came in handy when they were employed. Participants agreed that the orientation helped to integrate new nurses into the work environment, be abreast with the institution’s values, ethics, standards and behaviours.

Participants stressed on the provision of quality healthcare service delivery as one of CS function. Generally, all the participants expressed the view that CS is aimed at ensuring quality service delivery which is equivalent to the accepted professional standards. Participants recounted several instances of how supervision received from senior colleagues made rich contributions to their professional life and helped provide quality service and guaranteed clients’ safety.

4.4.1 Facilitation

The facilitation function centred on the educative activities that influences the newly qualified nurses’ professional development, life-long learning, creativity, self-awareness and skill development. Participants indicated that CS encourage the development of confidence and the proficiency of staff nurses in the accomplishment of professional assigned duties. The level of confidence and proficiency shown by the nurse supervisees are considered when supervisors are assigning specific duties on the ward. Most participants also acknowledged the fact that patients on the ward assess the nurses’ competencies and confidence when they are been attended to.

4.4.1.1 Confidence building and Competence

All the participants especially, those working at the special ward (VIP) wards asserted that CS helps the supervisee to become confident and competent in carrying out
procedures on patients. CS also helps to acquire more experience from the corrections received.

“Through the supervision received you become very competent and confident when performing your task. For you know what you are about, you go to the patient with some boldness, you are able to work from your heart with a smile and everything goes well.” (SN7)

“With the clinical supervision, the role it plays in one’s professional life is; help boost your confidence level, because it’s like, as and when you are being watched and corrected, you begin to gain more experience which makes you confident.” (SN4)

Several participants also felt that CS helps the ward in-charges to identify the nurse’s levels of efficiency and job capabilities. For instance, SN2 put it this way:

“... it helps the ward in-charge to also know the kind of people they have, as in the workers level of efficiency because, when you supervise maybe nurse A and you supervise nurse B, you’ll know how efficient both of them are and you know who to assign a particular task to. So, it’s also helps the wards in-charge to also assign duties”. (SN2)

A statement made by a participant describe how supervisors select nurses for specific duties based on their skills and capabilities:

“For instance, within the hospital we are assigned to go for medical cover outside the hospital, staff nurses especially. The Chief ward master constantly selects some people because they are capable. So, he expects those people to use their skills learnt to handle the situation like minor condition you should render such standard care because you have been supervised.” (SN11)

Additionally, participants buttressed the point that, the level of competency exhibited by the nurse during service delivery helps to win the confidence of the patients. The patients tend to trust the nurses and always prefer their service. Participants recounted it this way:

“... and if your confidence level is high, the patients will know and will trust you and if you are doing a procedure and you are not sure, it will show, the patient will see it because of this sometimes the patients even kind of discriminate among the nurses. If she wants somebody to maybe fix or remove something, the patient
can even say 'ooh please I want that nurse to come and do this for me.’” (SN10)

“Because of the quality of supervision received, I can say am very competent. Now when am assigned a procedure like wound dressing, I take up that responsibility with all courage and once I’m able to execute it very well, I win the confidence of the patient I am taking care of.” (SN5)

4.4.1.2 Role Clarification

The participants who were products of NMTC-37MH and had some level of military orientation stressed on the role clarification aspect of the facilitative function. Participants stated that the CS process helps the supervisee to be well informed on their roles; follow the orders of the supervisor. Participants believed that if human beings are not reminded of their roles and put in check there is the tendency of having things done haphazardly.

“The main purpose of the clinical supervision is to be sure that staff nurse or let say junior staffs know their roles and task, follow the orders of their superiors, just doing the right thing. Because it is believed that as humans as we are, if we are not supervised and informed, things will be done haphazardly. So, the main thing is to ensure that the staff nurse knows the responsibilities and right thing is being done. I mean orders are strictly followed.” (SN2)

“Supervision helps the staff nurse to know his role on the ward. The supervisor shares the day’s tasks, and everyone carries it out as expected because, at the end of the shift you will document what you have done and hand over to your colleagues, Simple!” (SN11)

Some participants explained that through supervision the staff nurse becomes aware of the organizational mission and vision and the departmental goals. The supervisor informs the staff nurses of their role in achieving the stated mission. SN8 had this to say:

“... for every institution it has, its missions and visions and when you are employed your supervisor educates and explains them to you. You are also informed on how your actions are supposed to help achieve them. Your supervisor keeps reminding you to maintain the standard of the facility. For instance, you hear the in-charge saying “eei” this is a military institution ooh do things right!” (SN8)

Some of the participants underscored how CS helps staff nurse to be conversant with patients’ details and procedures carried out on daily basis. Participants stated that,
supervisors on the various wards expect staff nurses to deliver information about their patient with ease during staff meetings. For instance, SN1 asserted that:

“Clinical supervision helps in understanding the type of patient on your ward, their disease conditions and the kind of task that the staff needs to perform. During morning meetings, handing and taking over sessions, our supervisors expect us to know and discuss the patient and their conditions off head as well as the procedures we have carried out.” (SN1)

4.4.1.3 Problem solving

Some of the participants who had practiced for a period of two (2) to three (3) years revealed that due to the years of practice and experience gained through supervision they have gradually gained the trust of their in-charges and are allowed to manage challenges that are encountered during their shift. The in-charges also assigned student nurses to the senior most staff nurse to monitor their activities when they come for their clinical attachment. Two participants had this to say:

“... for instance on my ward, when am on duty with other staff nurses, my supervisor allows me to quickly go and intervene when there is a problem with the patient because she sees me to be older and more experienced than the others because of my years of service and the supervision received.” (SN9)

“When student nurses come for their clinicals, the in-charge hands them over to me because am the senior most staff nurse. DDNS will ask me to prepare their timetable, identify their weakness, teach them and handle all their problems.” (SN5)

4.4.1.4 Team building

Majority of the participants narrated how positive team spirit allows nurses with different levels of experience and skills to come together, share ideas on issues and find innovative ways of accomplishing tasks. Participants were happy about how teamwork easily facilitates the progression of work. SN7 asserted that:

“The team spirit makes work easy for us here because when there is a problem the in-charge allows everybody; senior or junior to share our opinions. You bring your ideas, I also bring my idea then we all share, weigh the options and together
choose the best and we are able to work for the free flow of services on the ward.”
(SN7)

Participants who had three years’ work experience also expressed their appreciation about the support system and how supervisors respect and solicit opinions of junior nurses which encourage them to give off their best. SN9 acknowledged that:

“Our supervisor listens to us. When you come to work you have the support of everyone, you work together, and you go home motivated. Exactly, you put in your best because your views are respected. You don't have issues going the extra mile to do something out of your job description.” (SN9)

4.4.2 Staff Development

All the participants acknowledged the vital role clinical supervision plays in their professional development. The staff development function of CS provides opportunities for the staff to nurture their professional skills in areas pertaining to their clinical work. Participants in the study admitted that CS assisted in the development of their professional knowledge and skills. Some participants confirmed that the entire CS process constantly reinforced the learning culture amongst the newly qualified nurses. Other participants equally attested to how CS helps nurse supervisees to adjust and adapt to positive behaviours at the workplace.

4.4.2.1 Development of professional knowledge and skills

Majority of the participants stated that the main purpose of CS is to help the supervisee to develop the knowledge and skills by learning from the experienced nurses. Expressions captured from two participants are the following:

“The main purpose of clinical supervision is to help us to develop our skills well and to learn more on the ward to gain adequate knowledge....” (SN6)

“... so, it helps us to also gain the practical skills. You know the senior nurses are more experience and have worked for long so they can impact the experience to us.” (SN1)
Similarly, other participants mentioned that CS offers staff nurses the opportunity to learn from the experienced nurses some practical skills which were not taught in school. SN4 had this to say:

“I think the clinical supervision will help the staff nurse to develop certain skill, practical skill that was not learnt during the school days. It gives the staff an opportunity to learn more from the experience hands and build on the school and book knowledge to better the practical skills.” (SN4)

4.4.2.2 Learning Activities

Majority of the study participants described various ward activities that were initiated by the supervisors to promote the culture of learning. Some of the activities comprised of weekly ward conferences and presentations, reading of assignments and demonstration sections. Participants indicated that as part of the learning activities, there is a learning policy of assigning unfamiliar health related topics to the junior staff as reading assignments. SN9 asserted that:

“... as part of the learning activities on my ward, it is a policy that when your shift in-charge asks you a question about a condition or a procedure and you are unable to answer, she gives it to the you and everybody around as reading assignment and she expects you to brief her on what you read the next day.” (SN9)

Some participants were of the view that, staff nurses needed to read more to broaden their professional knowledge and understanding of new information and procedures they come across in their line of duty. It also helps give accurate answers to patients on the ward. Participants views expressed are the following:

“As a staff nurse you need to read, when you read it also helps you to broaden your knowledge to learn more, because your supervisor may say something that you don’t know or you have not heard about. But when you go home and read more on that topic, it broadens your knowledge and understanding, and you are able to appreciate what they said or did.” (SN7)

“... When doing a procedure, the patient can ask you ‘madam nurse please this thing that you are doing, why are you doing this? So, because your patient will ask questions you push yourself to know more and read so you explain it to the person.” (SN3)
Additionally, participants on all the wards inferred about the morning presentations that have been instituted to help nurses brainstorm on some of the common diagnosis and management of patients on the ward. The supervisor assigns individual nurses to lead the discussion or presentations. Participants had this to say:

“On the ward, each morning after handing over, the in-charge brings up a topic mostly it’s on the common diagnosis and condition on the ward and the nursing management of that condition. Sometimes she assigns someone to prepare or selects one person on the spot to lead the discussion. We brainstorm on some of the conditions we have on the ward and discuss how best to handle such situation before the shift begins.” (SN3)

“Yes, on my ward we have morning presentation. So, they give topics based on the conditions on the ward and people present. I have been given a topic to read on but the day for the presentation, I’m yet to be told, I haven't been able to present it but I'm prepared for it.” (SN11)

4.4.2.3 Developing positive attitudes and behaviour

The positive attitudes and behaviour exhibited by the supervisors during supervision sessions is most likely to influence the professional development of the supervisees over time. Several participants agreed that through the constant interaction with the supervisor, supervisees develop positive attitudes. Participants who had three (3) years’ work experience narrated how their association with supervisors had motivated a positive change in their attitude towards work and other colleagues. Expressions captured from some participants are the following:

“One of the function or role of supervision (pause) is reforms the staff nurse. Personally it has changed my attitude to work. When I was assigned to my ward, I realized that all the seniors from N.O and above who supervised me were hardworking and always on working, can you sit? Hmm no! So even when I wanted to lazy around I couldn’t because, the seniors exhibited a good work attitude which gradually change mine.” (SN4)

“through constant supervision, I have learnt how to talk to the junior staff on the ward. I learnt that from my supervisors. They are friendly when you do something and it’s even serious, she will get closer to you and address it without shouting. The way she will talk to you; you wouldn’t feel too bad and embarrassed; but you will learn.” (SN5)
“When I was a student through to rotation, I always thought nurses of the rank of PNO just give instructions and stay in the offices writing notes. This changed when I was posted to my current ward. I saw my PNO changing diapers, bathing patients, tube feeding the patient. So we all had to also work like her or even better. So, on my ward we have all learnt from her and we are hardworking, we do everything for the patient.” (SN10)

4.4.3 Staff Socialization

Participants who were trained in NMTC-37MH asserted that they were socialized and integrated into the hospital’s environment whilst they were students. This was because, the hospital served as their affiliate facility for clinical practice. They were orientated from first year on the institutional ethics to help every student integrate with ease and this experience came in handy when they were finally employed to work in the hospital. SN5 acknowledged that:

“... it helps in socialization of new staff as every facility has its own protocols and norms that must be followed. For example, I was trained here and I never had the chance of doing clinical outside but I did it here and whilst here as a student from first year, I remember sister taught us norms; to respond yes sir, yes mum to my senior. I also learnt the chain of command, who to report to and by the time I completed school I had already fit into the setting. Unfortunately, or fortunately I was also employed here after school which made life easy.” (SN5)

Participants who were trained outside NMTC-37MH equally agreed that one of the functions of CS is to help newly employed personnel acclimatize with their new work environment and know the culture and norms of the institution most especially, in a military setting like this. SN3 expressed that:

“Yes, it helps you the new staff to be able to socialize, to relate well in the new facility that you find yourself and get use to the company’s culture and norms like the military greetings, responses, standards and the ranks. You need to learn to show respect to everyone because, you never know who you will meet in your line of work or call someone by the wrong rank hmm, and they will report you to supervisor.” (SN3)
Some of the participants held the view that socialization creates a better work setting and relationship. It also gets the staff working accordingly to the preserved institutional standards:

“when the staff are well socialized; I think it create a better relationship, create a better working setting, gets everybody doing what he or she is supposed to do and maintain the standards and at the end of the day. Like soldier will say you either improve the standards or maintain it, you don’t lower it.” (SN9)

One of the study participants indicated that when an individual is employed, the supervisor needs to educate the staff on the facility’s mission, vision and goals.

“When you are employed, your supervisor educates you on the mission and whatever vision the hospital is operating with, maybe to be the leading institution providing health care. He or she explains how you can help achieve that and you end up working towards that goal or mission. So, once you are providing the quality of care to people, you are also working towards the hospitals goal and then it is also improving on people lives as well.” (SN8)

4.4.4 Service Delivery

Participants generally agreed that the main function of CS is to assist the nurse to provide quality service. The supervision provided guides the nurse to do proper assessment, diagnosis and management of client’s problems which leads to proper service delivery and early recovery of patient. Participants had this to say:

“In my view I think clinical supervision will help to come out with; like provide quality service to our clients on the ward. Yes, we are supervised to ensure that the right thing is done, the right problems are identified and then the right procedures are carried out for our patients. It means we are going to get a right or a good outcome which will help in our patients in recovering fast from their illness.” (SN1)

“It also helps to improve upon the quality of services we give because, if you are supervising people, they get to know how to always do the right thing to enhance the quality of your services delivered to the general public.” (SN8)
Majority of the participants concluded that, when staff nurses provide standard treatment to the patients, it leads to promote clients’ satisfaction, increased revenue and referrals which improves the image of the facility. SN4 had this to say:

“Sure, because when standard treatment and quality service is provided and the person is satisfied, this is a form of customer satisfaction. The clients are satisfied and with that, it's brings more clients to the hospital and boost the revenue level. For example some people even come all the way from other regions just because somebody told them ‘when I went to this hospital, I went to do this operation and the nurses they did this and this and this and now I’m walking and am better so go there.” (SN4)

Participants in the study indicated that, during supervision, staff nurses must be cautious of the need to accept correction and prompting to avoid any form of mistake and harm to clients in the line of duty. Participants were aware of the legal implications of rendering unprofessional service to the clients and the institutional measures introduced to curb any form of error. SN9 recounted that:

“... during supervision you need to accept instant correction and prompting so that you avoid those errors and wrongful action against the patient that will bring about legal and may get you wanting because here I mean in 37 hospital every mistake is investigated by command. They will call you to the board of inquiry to answer, you will sweat.” (SN9)

4.5 Stages of Clinical Supervision

This section is aimed at describing the stages of CS experience by the nurse supervisee. The stages of supervision according to the Integrated Model has six (6) sub-themes that describe the cyclical nature of supervision. However, five (5) of the sub-themes emerged from the data collected from participants. It comprised of relationship building, planning, observation, conference and follow-up.
4.5.1 Relationship Building

Relationship building is the first stage of the CS process. It comprises series of activities that are carried out on the first meeting day between the supervisor and the supervisee. During this stage it is expected that the nurse supervisee is oriented to the entire work environment, be socialized to the norms and protocols of the facility establish effective communication and develop trust and intimacy among the supervisor and the supervisee. It also creates the opportunity for the supervisor and supervisee to understand each other’s roles and responsibilities. These activities help to integrate the nurse supervisee within the work environment and develop a meaningful supervisor-supervisee relationship. The sub-themes that were identified during this stage were orientation of new employees, establishing relationship, establishing communication and role clarification.

4.5.1.1 Orientation of new employees

Participants stated that on the first day of employment, the nurse supervisees are assigned to a senior staff who has been on the ward for a while to orient them. The SN is also informed of their roles and responsibility. Participants enumerated the areas of orientation and how it aided the smooth transition into the various ward.

“... DDNS assigned me to another nurse, another senior colleague nurse to take me round the ward to know every corner of the ward because you can’t just enter into someone’s ward and start to work. So, the person took me round the ward and taught me a whole lot of things I have to know, were items are picked, type of room and the patients who are admitted there, type of documentation and the staff around.” (SN7)

“Normally, what they do is not too different from how we were oriented during school days. When you come to the ward for the first time, they will introduce you to the nursing staff and then take you round the ward to orient yourself with the place, where to get items, the various office, and schedule for ward procedures. That was how I was oriented ....” (SN2)

“Okay, so from the very first day when you come to the ward, you are oriented around and then you are assigned to a senior staff or any other person who has been on the ward for long, to take you through the responsibilities and the task you are supposed to do on the ward.”(SN8)
4.5.1.2 Relationship building

Majority of the participants were quite pleased with the initial interaction with their supervisors. According to the participants the interactions created an opportunity for the supervisee to be introduced and build a meaningful relationship with the supervisors. Participants stated that as part of the relationship building, the senior nurse or nurse supervisor gives the nurse supervisee the opportunity to introduce themselves on the first day. Participants acknowledged that:

“My first day, the in-charge welcomed me nicely to the ward. We had a lengthy discussion, some of the questions she asked me: my name, age, where I lived, where I complete school (and let me try to remember) ... when I completed school and my main motive for employment. These questions gave me the opportunity to introduce myself.” (SN7).

“Yes! So, in order to build an effective relationship and communicate well you have to know each other. Like the first day I came to this ward, the senior nurse welcomed me, gave me a seat and asked me to introduce myself.” (SN2)

Although majority of the participants spoke highly of their in-charges during the orientation phase, one participant shared her experienced of how the opening comments of the ward in-charge almost affected her; as the supervisor sounded upset and unwelcoming.

“Hmmm, the first day I went to work, first, I went to the WO and he was like, the senior nurse was not there so they asked me to start work. But later in the day when I met her, she said she doesn’t know me because, they didn’t bring me to her office, and I was not introduced to her. So, I have to come, and she’ll talk to me and also interview me to assess whether I can really work, because for her, she doesn’t just pick anybody to work at the surgical department. I was hurt by that statement.” (SN3)

Majority of the participants were, however, not happy with the general relationship that exists between supervisors and supervisees on the ward.

“The general relationship that exists between supervisors and supervisee, hmm I wouldn’t say it’s all that good and I wouldn’t say it’s all that bad. Its 50, 50.” (SN2)
“As for the relationship it’s not that cordial, and you cannot say is that bad to (laughs).” (SN3)

Several of the participants were of the view that the personality of the supervisor influences the type of relationship that is built and admitted that some of the supervisors were approachable while others constantly wore straight faces making them unapproachable. SN6 had this to say:

“As for the relationship, it depends on the individuals involved because there are some people that are very nice and down to earth, always smiling even if they are your supervisor or not you like their company. Others too always with a straight face so you can’t go to them and that’s who they are, and you can’t change it.” (SN6)

Participants lamented on how some supervisors intimidate the junior nurses because of the rank differences. This behaviour according to participants makes it difficult for the junior nurses to approach them on any issue. SN2 stated that:

“As for the relationship, it always brings about some kind of pressure. There are some supervisors that I would say, will put that kind of fear in you, that kind of superior inferior barrier. Hey am your supervisor, am a Senior Nursing Officers (SNO) or Principal Nursing Officers (PNO) you are a junior nurse, a SN. When it happens that way, the supervisee is not able to even go to them for help or have a discussion.” (SN2)

Most of the participants had sustained that nurses of the same rank had a cordial relationship as compared with nurse of different ranks. SN10 deliberated that:

“... between senior staff and junior staff, the relationship is not all that good, I think the relationship between staff of the same nursing rank, is much closer and better than staff of different nursing ranks. For instance, PNO and a staff nurse, the relationship is not that close. But staff nurse and senior staff nurse, staff nurse and staff nurse that one the relationship is very, very close.” (SN10)

On the other hand, participants who had limited number of senior nurses like the SNO, PNO on their staff strength appeared to experience healthy and more cordial working relationship. SN9 recount that:
“On my ward the relationship is very cordial; we don’t experience bad working relationship. This is because the rank difference is not that much, we have more of the Staff Nurse to the NOs, on the ward with three (3) SNOs, so at the end of the day we find each other cooperating I mean suitable to work with.” (SN9)

Generally, all the participants confirmed that staff who consistently work on the same shift turn to have a good relationship and communicate effectively. For instance, participants expressed that:

“The relationship is more cordial between those you have frequently worked with on your shift. If you are for morning or afternoon or night, those you consistently work with, it looks like they are those people you build much cordial relationship. You are free to talk to them about anything that is bothering you and they are also free to talk to you too.” (SN8)

“You know because we run shifts, you get use to your team members, you flow and understand each other. So, you realize you have a better relationship with them than the other nurses.” (SN3)

Some of the participants had observed that the level of knowledge and competency of their supervisors influence the relationship that exists among supervisors and supervisees. The skilful and knowledgeable supervisors are more welcoming than the unskilled supervisors. Participants asserted that supervisors who are not skilful, are quite unfriendly and unapproachable. SN2 and SN4 stated that:

Some of the supervisors are not friendly because they don’t have the necessary skill. If you ask a question the response they give is mostly not friendly. I think they do that so that you may not gather the courage again to ask them any questions the next time or even get closer.” (SN2)

“Even on my ward you realize that the very experience and knowledgeable nurses are always nice, they chat with you, ask you questions about the work; oh! they are nice. But the ones who lack the experience don’t want to create the chance for you to have a conversation. Maybe they fear you will ask a question they can’t answer.” (SN4)
4.5.1.2 Establishing communication

Communication is an important tool in maintaining effective working relationship. Effective communication enables exchange and dissemination of information among the workforce of an institution. Majority of the participants confirmed that personal interactions with the ward in-charges during the orientation period afforded them the opportunity to know much about the facility and establish rapport. Participants were adequately informed about the chain of command, the flow of information and the systems of information within the hospital and advised to follow the standards of protocol for communication within the ward and the hospital. Participants insisted that, the initial relationship created between the supervisor and supervisees affected the effectiveness of communication on the ward.

All the participants described the standard protocols of communication and chain of command within the hospital which is religiously adhered to by all personnel. SN8 described that:

“Communication is effective in the hospital. Information is relayed from the top to the bottom, I mean from the seniors before the information is relayed to you. If you also want to report something you tell your immediate senior person then it goes to the top.”

The study revealed that there is free flow of information in the various ward. Participants referred to the mini meetings that are organized at the end of each shift to allow the staff to acquire relevant and adequate information and discuss issues of concern. For instance, SN6 says that:

“Yes, it’s kind of okay because most often, when we finish handing over like when shift hand over to the next shift, there is this thing to 5, 15 minutes that the senior most probably gives out any information and then ask if there’s anyone, if anyone has a comment or anyone has an issue or anyone has a concern that he wants to raise that needs the attention of the senior ones. So, at that level, at least there’s an information platform for everybody to express himself, they don’t really frown on you expressing yourself, not at all. There’s that free flow of information.”
Participants iterated that the initial encounter between the supervisor and supervisees affect communication. When the relationship is unhealthy, the supervisee lacks confidence and courage to approach the supervisor. SN1 recounted that:

“Like I said earlier on, it’ll still depend on the individual and the earlier encounter of that individual. If the approach was that friendly, it builds a very good communication and encourages that kind of cordial relationship between the supervisor and the supervisee. But if it’s otherwise, it means there’ll be poor communication because the supervisee will lack confidence to or that courage to approach the supervisor the next.”

Majority of the participants complained about the supervisors’ skills, tone and approach in communicating information. The participants observed that most of the supervisors like to scream and insult instead of talking to the staff nurses. Also, participants suggested that supervisors need to be more professional when assigning duties. Participants acknowledge that:

“Hmmm, you know the communication aspect, the supervisor if I should say lack the skills of effective communication. One supervisor will tell you something in a nicer way, you find another person coming with another approach either screaming or insulting you in the process.” (SN9)

“The effective communication skill is the problem; if you have to assign a responsibility to me, tell me directly and it should be in a tone and a manner, not necessarily like friends, like a professional supervisor. But don’t sound like you are ordering or something. It should be that cool, the person should understand that this is my job for the day; not as if you are being ordered [‘today you will do this whether you like it or not’ – In Twi].” (SN8)

4.5.1.3 Clarifying roles and responsibilities

As part of the relationship building stage, the supervisor interacts with the supervisees and discuss the work ethics, protocols of the ward and the responsibilities towards the patients and the job in details. For instance, SN3 stated that:

“... my supervisor sat me down and told me all I needed to know about my roles and my responsibilities. She explained that I have a responsibility to make my patient comfortable at every time. She said, when you report to work, first you take
up, you make the beds, you do your damp dusting, change those with soiled dressing, and then after that you will be assigned the day’s task. After that you make sure that you document everything on the system or the patient chart until it’s time for you to hand over and you go.”

The supervisors also informed the nurse supervisees about their expectations and whom to take orders from while on duty. SN4 recounted that:

“My supervisors I mean the NOs, SNOs and even the PNO all taught me what I had to do as a staff nurse. I was told that I will always have to take orders from the shift in-charge. They also told me to always come to work early and expect me to be hard working and be ready to learn and they will also be ready to teach me.”

4.5.2 Planning Stage

All the participants who worked at the medical, surgical, paediatric and orthopaedic wards (i.e. the general wards) expressed some doubt about the nature and form of planning that is conducted during supervision. Participants revealed that none of the supervisors or in-charges officially informed them (i.e. Nurse Supervisee) about the CS process, the duration, category of nurses to seek assistance from or even the names of their supervisor. Participants acknowledged that:

“Okay, with where I’m working, I have seen that some senior nurse staff with the supervisees, but I doubt if it is official. We are not told officially that this is your supervisor or even what the process entails.” (SN10)

“When I came to the ward it was only the in-charge who talked to me and told me she would be observing me. She didn’t really assign me to anyone to supervise me, she didn’t tell me what she will be observing and for how long. When I have a problem, I talk to any nurse who is around to help sometimes I even go to the ward assistant for help.” (SN5)

“Am not sure if I am supervised or not (laughs); because sometimes the in-charge will ask just anybody, sometimes a nurse assistant to come around to check what you are doing.” (SN11)

However, participants who worked on the special wards (Surgical and Medical VIP ward) shared varied opinions. These participants acknowledged that, due to the special
nature of their assigned wards, all junior nurses are assigned supervisors who are of the rank of Nursing Officers (NO) for a period of one month. Participants for example recounted that:

“I have received adequate supervision from day one that I was assigned to this ward; because I will say my ward is a bit different from other wards. So, from day one you are assigned a supervisor who is of the rank of NO, you run the same shift for close to a month, so, you do things well.” (SN4)

“After orientation, my in-charge called a senior nurse and assigned her to supervise me for a month.” (SN7)

Majority of the participants believed that supervisors did not consider the professional needs of the supervisees during the planning stage because, their supervisor never had a formal session to discuss their professional needs. Participants wished the supervisors would identify their capabilities and weaknesses and develop a plan of action to address their knowledge and skill deficiencies. Participants admitted that:

“When you start working, nobody sits you down, nobody asks you about your strengths and weaknesses. You are not taken through any form of systematic planning to address it and even meet you maybe after two weeks to ask, how are you adjusting in the ward? How are things going? Are you okay? Do you have professional issues that needs to be handled? Then they give you a form of feedback so, that it will help you. There’s nothing like that.” (SN6)

“For example, when I came earlier, I had a problem with the monitors, but nobody really took interest in teaching me; the supervisor expects me to know how to use it” (SN11)

“So far am disappointed, there hasn’t been any formal meeting to discuss my strengths and weakness, am a year old on the ward.” (SN8)

Generally, all the participants maintained the nurse supervisees should do a self-assessment of his or her abilities or deficiencies in carrying out the procedure and seek for help from senior nurses. SN1 who is a nurse supervisee in ward B had this to say:

“Well, the process of supervision I have experienced ever since I started working depends on the kind of task that needs to be carried out. Like myself, if am given a task to perform I assess myself if I can do it. If I think I’m not sure or I don’t have
that knowledge about, it means I have to gather courage and ask the next senior most colleague; oh Sister am not comfortable with this procedure, how is this procedure carried out please can you supervise me.”

Participants averred that there is no plan or supervision schedule for the nurse supervisees to follow. For instance, SN2 claimed that:

“...there is no specific plan, like this is your supervision schedule to follow or this is your supervision week. There is nothing like that”

On the contrary, participants working at the VIP ward had formal discussions with their supervisors to identify their strengths and weakness. An action plan was developed by the supervisors to address the identified deficiencies. Participants in the VIP wards had this to say:

“... my supervisor who was a nursing officer also took over. We discussed the procedures I was comfortable with and the ones I had difficulty. I had forgotten a lot of things that I learnt in school and even whiles I was doing my rotation probably injection giving and things like that. She informed me that we will be running the same shift for a month so I will get the opportunity to learn. She gave me reading assignment, care plan and did a lot of demonstration.” (SN7)

“... My in-charge informed me of the some of the nursing procedure done on the ward and ask if I could do them even under supervision. She allowed me to tell her the procedures I can do and the ones I can’t do. She then assigned me to one of the SNO on the ward to assist me for some time. Hmm like a month or more.” (SN4)

Some of the study participants complained of how senior nurses assign task to junior nurses without first examining the capabilities of the personnel and the ability to carry them out successfully. Participants had also observed that, when tasks are assigned, some of the supervisors will hardly follow-up to assess the outcome of the procedure. Below are some comments from the participants:

“Actually for us from day one what I have realize is that, maybe you come in the morning the senior most will be like “Okay you take this task for today; if you can do it or not she will not ask, sometimes she will not even follow you to see if you can do it.”(SN7)
“My first day, we were working as a group, the seniors that I was working with told me to do wound dressing, they didn’t ask if I could do it or not. They didn’t tell me how they expect me to do it; just go and do the dressing. So, I had to ask them, Sir, what is your protocol for wound dressing here? Before he stopped me and said I should observe the old nurses” (SN 10)

Furthermore, participants narrated how nurse supervisees pretend to be knowledgeable about assigned tasks. SN5 acknowledged that:

“... There are some things that really you don’t know but you have to pretend you know so that it doesn't look like you are dump, or you are lazy.”

4.5.3 Observation Stage

During the observational stage, the supervisor assesses the supervisee within the clinical setting to detect the practical skill, nurse patient relationship and adherence to standard practice. Majority of the participants agreed that through observation the supervisor can confirm the capabilities of the staff nurses and identify any challenge.

Generally, all the participants felt that during the initial period of employment, supervisors secretly observed the practical skills of the staff nurse on daily basis to confirm the initial impression and level of proficiency.

“My very first day, I didn’t know I was being observed by one senior staff, the only thing he said to me in the morning was, my face looks responsible, when sharing the responsibilities for the day, I was given all these tasks handing over, the wound dressing and some other peculiar things on the ward; I was like, my very first day on the ward and everything on me, why? So, I carried out whatever responsibility I was given throughout the day. And at the end of the handing over, all that the lady said was, 'you’ve really marched our expectations, what we expected from you, you have really worked towards it. I was like, what was she expecting? She was like, when the senior man was leaving, he said your face looked responsible so, I should give you this, this and this duty and truly you’ve been able to carry them out.” (SN8)

“Sometimes they wouldn’t let you know someone is really observing you to give a report. But then, you’ll be assigned certain tasks to do and you realize as at the end of the day by their comments that they were really observing you.” (SN6)
Participants indicated that on the first day of work, most of the senior nurses prefer to initially assign a task and observe the skills of the junior nurse for competencies. SN2 who is in the paediatric ward has this to say:

“Some senior nurses when they are working with junior nurse for the first time, they like to observe your skills. They assign you a procedure like wound dressing and just observe to see whether you are doing the right thing, or you are not doing the right thing.”

During the observation process, supervisors possess questions to the SN to assess the level of understanding of the procedures. SNs can be asked to fully explain the procedure. SN10, a nurse in the surgical ward asserted that:

“Usually they do observation, as you are working, they are observing and sometimes they ask you to explain why you are using this or that and the method. I think maybe they want to find out if you understand the procedure.”

Participant also stated that some of the senior nurse prefers to observe the activities of the nurse supervisee even when the supervisor is assured of the nurse’s ability to carry out the task.

“... and also, maybe you assured her you can do the procedure but because they have doubt about you, you are new on the ward or something, they’ll come and stand by you and make sure that you do the right thing” (SN3)

“Sometimes they know that you can do the procedure, yet they will come there to monitor, no matter how well you are doing the procedure they will wait to see that you are doing the right thing.” (SN4).

4.5.4 Conference Stage

The supervisory conference or meeting is the primary vehicle for on-going supervision and communication. It comprises of the post-observational conference and the feedback mechanisms. During this forum, work related questions are raised, problems are managed, and feedback is given based on discussions and observations. Most participants
were not aware of any post-observational conference but mentioned that the facility had instituted morning meetings and monthly ward meetings to discuss work related issues.

Participants believed that the feedback mechanism adopted by the supervisors was not structured and mostly informal. Participants revealed that mostly, supervisees had to make personal contacts with the supervisors to receive any feedback on tasks assigned. Majority of the participants held the conviction that supervisors were highly interested in giving negative feedbacks.

4.5.4.1 Post – observational conference

Generally, the participants were not aware of any post-observational conference to discuss issues about supervision. However, participants mentioned the morning meetings and monthly ward meetings as the forms of supervisory meetings that are organized in the units. For instance, the participants recounted that:

“They have not taken us through any form of conference of that sort; (giggles) even the supervision is not formal. But we have ward meeting maybe that can be a form of conference." (SN5)

“We don’t have individual conference, its mostly the general one like the morning meetings and ward meeting or durbar that is organized once a month.” (SN3)

“Every morning, the morning staff have a meeting to discuss general issues on the ward and we organize the ward durbars once a month which is compulsory for all nurses on the ward.” (SN11)

Some of the participants stated that individual meetings with supervisors are not a common practice on the ward. It is mostly organized when an individual has been reported, has done something wrong or needs to fill the appraisal form. SN9, a staff nurse at the surgical ward acknowledged that:

“Apart from the ward meetings, we hardly have one on one meetings with the in-charges. The in-charge occasionally calls for a meeting with individual staff; when they have done something wrong, or you have been reported for wrong-doing or you are filling your appraisal form.”

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All the participants indicated that the ward meeting and monthly durbars give the staff the opportunity to discuss professional issues and concerns. The ward in-charges bring up issues related to current management of patients’ condition, malpractices and misconducts and opportunities are offered to all staff present to suggest ways to address the concerns raised. Participants recounted that:

“During the ward meeting the agenda is mostly on nursing management of certain conditions, any issue of malpractice or misconduct and staff welfare.” (SN1)

“At morning meetings, we pick the folders of critically ill patients and discuss their condition and the current management. We are allowed to suggest how best we can improve upon the nursing care we give them.” (SN7)

“Also, the in-charge will give the staff the platform to bring up any issue of concern; it can be about the work, the requirements or a procedure so a solution is found.” (SN10)

4.5.4.2 Feedback System

On the issue of feedback, participants complained of how it was conducted, it was however, blamed on the fact that the entire supervision process was not well structured and quite informal in nature. SN8, a staff nurse in the medical ward stated that:

“The feedback system; once there hasn’t been any formal way or form of supervision, so far I don’t know how the formal feedback system will be like.” (SN8)

Some of the participants felt the feedback system adapted by supervisors were not structured because the supervisors do not consider how encouraging the environment is before talking to the supervisee. SN2, who is a staff nurse at the paediatric ward acknowledged that:

“I can't tell if the feedback system is structured because the supervision itself “aah”. Everybody at any time anywhere on the ward will give you some form of informal feedback. Like someone is passing and you are doing a procedure the person can shout “eei” is that how to do it? The senior nurse does not care who is there, how the patient will feel and even you the staff nurse.”
Some participants complained about the comments made by the senior nurses when one tries to explain his or her difficulty in carrying out assigned tasks. SN11, a staff nurse at the medical ward lamented that:

“When you tell the senior nurse, oh sister I am not good at this procedure; they go like, staff nurse you should know, or staff nurse you should know this. So, there are some things that really you don’t know but you have to pretend.”

Participants who had worked for three (3) years explained how SNs use the trial and error method to carry out tasks with the hope of getting it right. For instance, SN9, who is at the surgical ward has this to say:

“So sometimes you have to push, you have to try, you make a mistake not a mistake that may kill somebody anyway, you go ahead to make the mistake and then hope you get the right at the end.”

Participants revealed that sometimes the nurse supervisee secretly asks for assistance from other colleagues to teach instead of the supervisor in carrying out unfamiliar task. SN8, who is at the medical ward reported that:

‘... sometimes you secretly ask Sister xxx, [how do we do it – In Twi?]’. Then the person will direct you. Typical example; one day, a colleague staff nurse was asked to set a tray to nebulize the patient and she was like [‘what is that? I don’t know how to do it?’ –In Twi] she came complaining to me she cannot ask the supervisor because of the negative comments she will receive. Then I was like, it’s okay just calm down, and I explained everything to her, and she was like [just this?] – In Twi] before she could do it.”

Participants also attributed the lack of feedback to the fact that the senior staff sees the completion of a procedure as a job well done which will attract some payment. Supervisors turn to be concerned about getting the work done and discharging the patient on time. SN9, a staff nurse on the surgical ward recounted that:

“Well I think, it's just because maybe they think it's your job, you are paid to do it, so, you are doing your job. We don't need to give you a feedback. You must come to work, you are at work, you are assigned to do this, you do it, you close, you go
home. That is what I think; I don't think anybody else is thinking about that aspect of giving a feedback. They are concern about getting the job done; getting the patient discharged without any problems and it's a routine, that's how it's always been.”

Most of the participants also stated that individual nurse supervisee will have to sometimes contact the supervisor to receive some feedback on assigned task. SN2, a staff nurse at the paediatric unit acknowledged that:

“**Unless you the supervisee, you go to ask them “okay mum when I was doing the procedure you said this. How was I supposed to go about it?” With that one, I think everybody on this ward is good at it. They’ll sit you down and teach you, if only you ask.”**

Participants who were working at the VIP wards also shared a similar concern although they indicated that some of the supervisors will occasional call the staff and give feedback on tasks assigned. SN7, a staff nurse in the medical VIP ward, asserted that:

“**Most of the time, the supervisee needs to go back to the in-charge for any form of feedback but not always. There are some supervisors who will occasionally call you afterwards and give you the feedback.”**

The general observation of participants was that supervisors were quick to give negative feedback as to the positive ones. According to the study participants, supervisors will always make reference to the wrong actions. For instances, participants recounted that:

“**The supervisors mostly give negative feedback when you do the right thing nothing is said but make one mistake, they’ll begin to hammer on it always, but the good things that you’ve done, that one, and it’ll not be seen.” (SN2)**

“**On the part of the supervisor; if the supervisor should find out that a junior or a supervisee has done something wrong, the approach to which the supervisor will comment is bad. You see them shouting sometimes in front of the patient and the relative.” (SN7)**

“**Me I’ve never gotten a positive feedback. They like to give negative feedback I remember the first day I went to the ward, we were dressing wound of the patient and I was with the senior lady, so she asked me to relax small then the DDNS came and said “you, why are you sitting down”? Trying to explain, she doesn’t want to**
One of the participants who worked at the medical ward held the view that, negative feedback was more important than the positive because, it helps the nurse to learn and correct their mistakes. The participant also stressed that the negative work attitude if not checked has the tendency of hurting or killing patients.

“Yes, the in-charges like giving negative feedback, I don't want to say more important but they are more hmm, more important than the positive one because the negative attitude of the staff are the ones that can actually hurt someone, can kill someone, so you getting feedback on the negative one seem more crucial than getting feedback on the positive one even though the positive one could encourage someone to do more. The negative ones seem more important than positive feedback because you learn and correct it” (SN11)

Despite the misgivings participants had about the feedback received from the supervisors, participants agreed that supervision process cannot be successful without effective feedback system. SN2, a staff nurse in the paediatric ward insisted that:

“… because supervision is a learning tool, it becomes successful only when there is a feedback. So, once there is a feedback after every supervision session you will know that a good job has been done.”

4.5.5 Follow up Stage

The final stage of the CS process is Follow-up, in this stage future supervisory activities are planned which commence a new cycle of the process. Generally, all the participants stated that, because the entire CS process is not planned and fully implemented, they cannot fathom when its ends or begins. Participants had this to say:

“… we cannot tell if the process has ended or not because no one official informs us of a supervision plan and the duration. Like I said earlier no one plans the supervision with you, you don’t know the goal and method, so how will you know it has ended or a new one is starting (laughs).” (SN6)
“I think supervisors don’t go through the full cycle or the process, I think its ends somewhere I cannot tell. At least if we know the hospitals policy on supervision we can tell if it is completed or not.” (SN11)

Also, participants who work at the VIP ward and have been assigned supervisors equally expressed that cannot fathom the whole process thus, cannot tell the point at which the process is terminated. Comments expressed by participants are as follows:

“I don’t remember being told that my supervision period is over, I think after a month I realized I was not running the same shift with sister, but I didn’t ask why. Maybe it has ended.” (SN4)

“... with the supervision, nobody has told me it over so, I think the supervision is still ongoing, but I don’t know my current supervisor?” (SN7)

However, the participants revealed that, some supervisor were always willing to commence a new stage of the CS process depending on eagerness of the junior staff to learn, type of ward one finds him or herself in, type of procedure or tasks that needed to be accomplished and where the staff nurse was trained. Generally, the nurse supervisees need to be eager and yearning to ask questions to attract more supervision cycles form the senior nurses. Participants acknowledged that:

“If you the young one or staff nurse, you are not eager or you are not yearning to ask questions and consult the senior one, it’s not automatic that they will come to you and supervise you to do this or that. They will leave you and you will just be walking around.” (SN2)

“They supervise you alright but for them to actually come willingly and teach you that do it this way, it's very difficult. Especially, if you the staff nurse you are not the type who is active and ask questions, but if you are active, they willingly follow you and teach you.” (SN11)

“As for the experienced nurses, they are there so you the junior will have to go to them; tell them your weakness and you will be surprised how they will teach you and supervise you. If you don’t follow or go to them, you will not learn.” (SN5)
4.6  Primary Elements of Clinical Supervision

The primary elements of CS identified in the study were the facilitative environment, supervisory relationship and supervisory role. Participants argued that it is significant to create facilitative environments during the CS process to provide solid foundation for mutual respect and trust. Generally, all the participants indicated that the supervisors paid less attention to the environment in which the supervision takes place. The learning environments at the wards were not safe, nurturing, and interactive enough. Most of the participants highlighted the importance of promoting a mutually beneficial relationship between the supervisor and supervisee. Participants suggested that supervisors should worked on the communication skill to improve professional relationships between them and the nurse supervisees.

4.6.1 Facilitative Environment

Majority of the participants agreed that supervisors should create favourable and serene environments within the ward to promote effective learning during the supervision process. Participants suggested that supervisors should identify enclosed areas such as the nursing station or nursing office to reduce interruptions or interferences from other nursing staff during supervision. Staff nurse (SN1), who is the paediatric unit had this to say:

“I think there should be an enclosed place within the ward for the supervision to take place. The supervisor can use the nurses’ station or office to reduce interference from nurses.”

A participant who works at the VIP ward in her statement stressed the need for the ward to be serene to aid learning during supervision:

“The supervisor before starting the supervision process must make sure environment on the ward is serene for us to learn because you can’t learn in on a ward where everything is scattered and noisy.” (SN7)
Another participant who works at the medical ward confirmed that nurse supervisees would prefer to work in a more relaxed environment:

“Of course, the ward should be favourable because, no one would want to be in a tensed situation every day; if the environment is relaxed at least it would enhance learning.” (SN6)

All participants complained about how most supervisors were fond off correcting the supervisee in the presence of the patient and other ward staff which turns to affect their level of confidence. For instance, SN1, a staff nurse in the paediatric ward acknowledged that:

“It is not very right at all to point out the mistakes of a supervisee in the middle of the ward or in front of everybody; in front of students’ nurses and medical students, patients and patients’ relative with this the patient lose confidence in you the staff.”

A participant who worked at the VIP ward shared a similar concern:

“Hmm, sometimes you get to the nurses’ station and you find your supervisor discussing your mistakes with her colleagues, sometimes with the student nurses and orderlies sitting there and they will be laughing.” (SN4)

Majority of the participants preferred that the correction is done in the presence of just the supervisor and supervisees. The supervisors should avoid making public unhealthy comments. Staff nurse SN2, who is in the paediatric ward expressed that:

“I think the correction should be done aside but just between the supervisor and the supervisee. And even if the supervisors are more than one, maybe two or three who are working professionally not friends who have gathered and are talking and passing unhealthy comments taking glances at you.”

Majority of the participants stated that some utterances of supervisors sounded abusive rather than corrective which affected the learning environment negatively. Staff nurse SN1 in the paediatric ward recounted that:
“... the kind of words used on the supervisee will encourage the supervisee to learn and be willing to learn; instead of using abusive words, supervisor must use more friendly words.”

Participants stressed that such abusive and unhealthy utterances deter the supervisees from taking up difficult tasks. Staff nurse SN5, working in the surgical/orthopaedic ward expressed that:

“maybe the supervisor assigns you to try to set a line, you don’t get it, the senior nurse will come and angrily go like 'that is the line over there, this is the visible vein, you couldn’t get it' I would never want to try again because of the comment passed.”

One participant shared an experience:

“There is one senior nurse on my ward if you make a mistake, she will insult you. She goes like I gave you this task and you are still there; then the way she will shout on you. So, for that particular person, if every staff nurse is to work with that person, I don’t think you can even ask her any question if you even have doubts, you can’t ask her.” (SN10)

Some participants encouraged supervisors to identify better ways of correcting the staff nurses and avoid shouting. For instance, SN8, a staff nurse in the medical ward recounted that:

“When you come and the person has made any mistake, find a nice way of approaching the person and try to correct the person. Most of the senior nurses will be shouting. For instance, one day, one of the staff was asked to remove a patient’s catheter and then I don’t know whether she forgot or not. She left the catheter on the bed, when the in-charge got there, she started shouting [‘‘Eeii’’ a nurse and you are doing this, what will the patient’s relatives do?’ – In Twi ‘is that how you do things in your house? Is that how you were taught? Which school did you attend?’ – In Twi].”

4.6.2 Supervisory Relationship

The relationship between the supervisor and the supervisee should be mutually beneficial, promoting and maintaining strong professional ties. Majority of the participants
emphasised the need for supervisors to maintain a professional relationship with supervisees. SN6, a staff nurse in the medical ward, acknowledged that:

“The supervisors must make sure they have a perfect professional relationship with their supervisee to the point that the junior nurse can freely come to them to discuss any problem.”

According to the participants, the relationship established determines how receptive the supervisee would be to the correction. A staff nurse (SN2) at the paediatric unit asserted that:

“So, for the relationship building is very necessary because it affects how you will supervise me and how I will also accept your corrections.”

Participants further revealed that some supervisees intentionally avoid the company of certain senior nurses because of how the nurses interact with junior staff.

“If you are the type that scolds the junior nurses and maybe if I do the wrong thing and you try to scold me in front of other nurses and embarrass me, when I see you I will use the other door so we don’t meet (laughs). Even when I am doing a procedure and you are coming around; I’ll make sure that I leave there.” (SN3)

“When the supervisor uses abusive words and is always shouting, you realize that such people do the junior nurses don’t like their company even though that person maybe good and experience.” (SN9)

Another factor that affects the supervisory relationship is the knowledge, skills and willingness of the supervisor to teach the supervisee. The participants stated that, most supervisees would establish healthy and better relationships with skilled supervisors who are willing to impact knowledge, skills and attitudes. Participants expressed that:

“The relationships with your supervisors depend greatly on the competency of that supervisor and the knowledge level of that supervisor and yes the willingness to teach.” (SN1)

“The relationship depends on how the experienced and knowledgeable supervisor shows readiness to teach. On the ward, you see that most of the staff nurses like to
associate with the nurses who like to teach because even though they are working they are learning.” (SN9)

Participants who were trained in 37 NMTC raised concerns about how the school a nurse was trained in, affects the level of supervision received. These participants expressed worry about how the senior nurses perceived that successful trainees of 37MH can do without supervision. Participants felt they should equally be supervised just like their colleagues from other schools. Participants retorted that:

“I would say, I have not really enjoyed that supervision as I would have wished to. The reason being that, having trained here, they see you during your clinical period and they feel that, after you have completed and you have passed your licensure, all is well, you can even manage a ward.” (SN6)

“Yeah, personally it boils down to the fact that I was trained here. You are expected to get some kind of confidence, to know everything when you are employed. But you see the in-charges assisting the new nurses who trained outside. For us, noo! So, I will say that, nobody really supervised me, I was left alone to do things on my own” (SN9)

“... some too, they assume that maybe once you have completed school from here, once you are coming from here, they see that ooh you are familiar, once we know you, we believe that you can deliver so, literally, they don’t supervise.” (SN10)

While majority of participants who were trained in NMTC -37 MH complained about the quality of supervision received, those who were trained outside confirmed that they were supervised from the first day of employment. For instance, SN7, a staff nurse in the medical VIP acknowledged that:

“The very day I got to my ward the DDNS sent me to her office, she asked where I was trained and if I had ever worked in the hospital. I told her I came over occasionally for my clinical while I was in school. She told me I needed to be well oriented and supervised for a month so I can work well.” (SN7)
4.7 Emerging Themes

4.7.1 Strategies of supervision

Participants in answering the stages of supervision made reference to three (3) strategies that supervisors adopt namely, observation, demonstration and delegation. Majority of the participants stated that most of the supervisors on the ward observed the initial skills and knowledge of the newly employed nurse to determine the proficiency level. Through the observation the supervisors can determine the individuals’ capabilities. Generally, all the participants mentioned demonstration as one strategy that clinical supervisors used in teaching the nurses some practical skills. Participants confirmed that the supervisors either demonstrates the procedure at the nurses’ station prior to assigning the supervisees the tasks or the supervisor demonstrates the procedure out on a patient for the supervisee to observe and learn; after which the supervisees can perform under supervision. Participants also revealed that because of the busy nature of the ward and the volume of work that must be completed in a day, the supervisor also delegate tasks to the supervisees. The supervisors give clear instructions on how to accomplish certain tasks. However, participants complained that supervision is ineffective when supervisors adapt the delegation strategy.

4.7.1.1 Demonstration

The study revealed that majority of the supervisors on the ward use demonstration session to teach the junior nurses’ practical skills before the carrying it out in the patients. Staff nurse SN5 at the surgical/orthopaedic ward recounted that:

“Sometimes before you go to the patient’s bedside to carry out a procedure or something; let’s say you are going in for a line, you set your tray or trolley, the supervisor checks whether you have picked everything. The supervisor will then demonstrate how you will perform that task and she will also give you the run down that this and this is what you’re going to do before you go to the patient.”
Participant stated that sometimes the supervisor allows the SN to observe while specific procedures are been performed on the patient. The SN is later supervised to perform the exact procedure observed. Participants acknowledged that:

“... if the supervisor is also going to carry out certain procedures that he or she thinks might be useful to the supervisee, he or she will call the supervisee to come around, the supervisor will demonstrate the activity and then the supervisee will have the opportunity to do it under supervision.” (SN 11)

“Yes, sometimes they demonstrate, like how to use the perfusor. The senior nurse will pick any kind of IV fluids and call the supervisee that “come, let me show you how this is being done. So, you start from here, you enter the figures here and do your calculations and those ones then you start here, you stop here”. So that one is demonstration; sometimes it’s the demonstration that is being used too.” (SN1)

4.7.1.2 Delegation

Participants revealed that because the ward is busy and the volume of work is heavy, most supervisors look out for SNs with the appropriate skills and competencies and delegate some of the duties. The supervisor prior to delegating to the SN gives clear instructions on how the task should be performed and whom to report to. SN1 a staff nurse in the paediatric ward affirmed that:

“One of these strategies is that errhm. You see the ward is busy and we have a lot of work to do. So, they will ask the supervisee to carry out minor task and tell you, because the place is busy, you go and carry out these minor ones. When you get here, this is how you are supposed to do it. But in case you get there and you are unable to do as I’ve said, come back for more explanation.”

Participants were of the view that supervision is ineffective when tasks are delegated because the supervisor has confidence in the SN that he or she will complete the tasks. Some supervisors don’t follow up to assess how well the tasks have been performed. SN10 a staff nurse in the surgical ward acknowledged that:

“If they delegate, the supervision level is low because, they (supervisor) have the confident that you can. So, they are just waiting for you to finish and give them feedback, they will not pass by to confirm what you have done.”

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4.7.2 **Measures to improve Clinical Supervision**

Measures suggested by participants to improve clinical supervision at the unit level included the development of a clear standardized institutional guidelines on clinical supervision, which will guide supervisors in its implementation. Participants also suggested that educational programmes must be organized either internally or externally to upgrade the supervisors and enhance supervisory skills.

4.7.2.1 **Clear institutional guidelines on clinical supervision**

All the participants were of the view that the hospital must have a standardized and clear guidelines or protocols on clinical supervision. Participants stated that the hospital should make it a mandatory activity and enforce the implementation of the guidelines on every ward. Participants reiterated that:

“I think it can be improved, if the hospital come up with a laid down procedure or if there are protocols to follow, which will apply to all wards so, there will be a standard that all supervisors will follow.” (SN2)

“Because there is no standard guideline, every wards supervision is different at least we observed that during rotation, so the hospital should develop one so that every ward will practice the same thing.” (SN10)

Some participants suggested that the Nursing Administration should make CS a compulsory learning activity on the ward and draft a protocol on the steps which should be pasted in the ward for quick reference. SN6, a staff nurse in the medical ward asserted that:

“... the Nursing Administration must make supervision compulsory on every ward. They must draft and give the in-charges the standard protocol so, they follow and if possible, paste it in the wards so, we all know the steps and refer to it.”

4.7.2.2 **Educational Programmes to Enhance Supervisory Skills**

Participants suggested that educational programmes must be organized either internally or externally to train and re-train the supervisors to enhance the supervisory skills and professional knowledge. Participants reiterated that:
“The supervisors should go for in-service training or workshops and any other form of training or they should leave the work, go to school, study for a while and come back as better supervisors and impact whatever they have learnt.” (SN1)

“The hospital should organize a quarterly training sections for all supervisors to re-train the old one and remind them of their roles and responsibilities as well as how to communicate with the junior staff and possibly strategies of supervision.” (SN9)

Some participants emphasized the need for supervisors to identify courses on supervision and attend. SN4, who works at the surgical VIP ward stated that:

“The senior nurses; they don’t like to go to school, I suggest since they are the supervisors, they identify courses that teach supervision and go and learn and come and teach the younger ones.”

Participants further emphasized that attending workshops will provide the supervisors with the opportunity to learn and be abreast with the new trends in nursing practice. He said:

“Supervisors must go for workshops and know what is trending; the new changes in the standards of practice, because there are some of the wards, in-charges don’t go for workshops. They don’t know the current things that are going on, yet they are also not in school so how will they know the things and teach us.” (SN3)

4.8 Summary of Key Findings

The study focused on exploring the concept of Clinical Supervision among nurse supervisees working at the 37 Military hospital. The perceptions of eleven participants were obtained using a semi-structured interview guide, and their responses were analysed by the thematic content analysis approach. The key findings of the study are as follows:

- The participant had varied views and perceptions about the CS process. Clinical Supervision was perceived as a process of supervising, monitoring and evaluation, directing, helping and alliance. Participants viewed CS as an essential intervention
that will help the supervisee to acquire additional knowledge and enhance the professional skills.

- Supervisors adopt three (3) strategies for supervision namely: observation, demonstration and delegation. However, participants raised concerns about how the entire process was planned and conducted. CS process was not guided by an institutional policy or guideline to ensure uniformity. Participants suggested the process must be well structured.

- The participants stressed that the successful implementation of the CS process is dependent on the supervisory relationship and the environment in which the activity is conducted. The participants also suggested that the supervisors must be educated on the stages of CS and provide with an institutional guideline to direct the successful implementation of this important supportive activity.
CHAPTER FIVE
DISCUSSION OF FINDINGS

5.0 Introduction

This chapter draws a relation between the existing literature and the findings of this study. The chapter discusses the findings from the study participants in conjunction with the study objectives and the constructs of the adapted model.

5.1 Perception of Clinical supervision

In exploring the perception of nurse supervisee on the concept of Clinical Supervision (CS) the findings of this study suggested that participants had a positive perception of the concept. The participants in their narration suggested that CS is an important learning activity that helps in shaping the professional life of the nurse and contributes immensely to the quality of service delivered. This finding is consistent with the assertion made by the North Ireland Practice and Education Council for Nursing and Midwifery ((NIPEC), 2007) and White and Winstanley, (2014) that, CS provides professional support to individual nurses and develops their knowledge, competence, and enhances quality of service delivered.

In explaining the concept of CS, participants of this study gave varied definitions which support the assertions made by researchers about the diverse operationalization and conceptualization of the concept (Butterworth, Bell, Jackson & Pajnkihar, 2008; Lynch, Happell & Sharrock, 2008; Lyth, 2000 ;White and Winstanley, 2010; Buus and Gonge, 2009). On the contrary, Jones (2006) held the view that, varied definitions of CS was necessary because it indicates the diversity of the concept in terms of ideas, disciplines and specialties. In this study, the participants did not highlight the structured and formal nature of CS as indicated in several literature (NIPEC, 2007; Milne, 2007; Winstanley and White,
This could be attributed to the difference in the approach or styles adopted by different supervisors in the different ward settings.

The study findings of Cruz, Carvalho and Sousa (2012) therefore, concluded that most of the definition of CS given by nurses was based on the aim, function, objective, relationship or control mechanism. This was evident in the themes that emerged from participants explanation of the concept. The themes included supervising, monitoring and evaluation, directing, helping and alliance. Which portrays the diversity in the subject matter of clinical supervision.

Majority of the participants explained CS as a supervisory process where the senior nurse ensures that the junior nurse carries out their assigned tasks diligently. The participants emphasized that the supervisor does not only supervise but guarantees that the tasks supervised conforms to the accepted standards and protocol and protect the patients. Participants used words such as “overseeing” and “take charge of” to describe the act of supervising. This relates to the terms used by nurses in a qualitative study conducted by Cross, Moore and Ockerby (2010) to describe the supervisory activity. According to Bennet (2007) the word “oversees” is used to describe the legal implications of CS where the supervisor supervises or oversees the activities of a personnel who is not authorized by law to perform. This explanation is not supported by this study because all the participants interviewed had valid Professional Identification Numbers (PIN) from the Nursing Regulatory body of Ghana and are authorized to perform the activities of General Nursing.

In explaining the CS concept participants perceived the supervisor as skilful, senior person, senior colleague, a leader or a superior who had a responsibility of maintaining a balance between the junior staff activities, the safety and timely provision of patient care. This is in accordance with the definition stated by the NIPEC (2007) and CSAT (2007).
Similarly, Bernard and Goodyear (2009) noted that the focus of supervision is the safety of the client and supervisee development which the supervisor must achieve at the end of the process. This assertion made by the study participants is in support of the other half of Bennet (2007) definition which stated that the supervisor has a sole responsibility towards the supervisee and the patient. This implies that every supervisor must be more knowledgeable and skilful than the supervisee and be able to identify errors in practice and address it immediately.

Some of the participants of this study also described CS as a process of monitoring and evaluating the theoretical and practical knowledge of the new nurse with the accepted standards of the profession. Minot and Adamski (1989/2009) and Roche (2006) also stated that through the interactive process the supervisor needs to assess and monitor the work of the supervisee. Participants of this study stressed the need for supervisors to assess how well supervisees applied the acquired knowledge to work and the support needed to enhance the professional skill. In a study by Staun, Bergstrom and Wadensten (2010) to evaluate patient-based learning strategy in clinical supervision of nursing students, the study revealed the need for supervisors to monitor how the supervisees integrate the knowledge and practice. The use of reflective skills by the supervisees to merge the theoretical knowledge acquired in training to the practical skills learnt as indicated by Staun, Bergstrom and Wadensten (2010) was not mentioned in this study. This implies that supervisees have not being exposed to the use of reflective skills during the CS process. Supervisors must be encouraged to identify different strategies of monitoring the theory and practice gap of the nurse supervisee.

Some study participants perceived the CS process to be directive in nature; where the supervisor assigns duties, instructs, controls and guides the actions of the junior nurse. This explanation is consistent with Milne (2007), Shulman (2013) and Martin, Copley and
Tyacle (2014) definitions of CS, where the process entails provision of guiding interventions to assist less skilled professionals to follow through. The supervisor according to the National Association of Social Worker (NASW, 2013) guideline is responsible for the development of the competencies and skills of the supervisee. The supervisor, therefore, needs to provide the direction and guidance throughout the supervisory process. On the contrary, Fowler (2011) and Openshaw (2012) were of the view that even though the supervisor has a responsibility towards the supervisee, the supervisor needs to be aware that the act of supervision is to challenge the supervisee to think out of their current way of performance and identify challenging and new ways. It is also a process of preparing the supervisee for more challenging and independent tasks therefore, the supervisor should not give directions and instructions but work together with the supervisee, give advice and allow the supervisee to do more reflection on previous actions. Hyrkas (2005) referred to CS as an act of supporting and helping in the growth of the learners to become competent. Some of the participants in this study agreed with the Hyrkas (2005) as CS helping the supervisee to perfect the existing skills and acquire new ones to improve upon their competencies.

Lastly, some participant perceived CS as a professional relationship or alliance that exist between the supervisor and supervisee at the workplace. The participants indicated that the alliance could be between personnel of the same or different nursing rank. According to participants the emphasis in selecting a supervisor should be on skills of the personnel and not about a superior and a subordinate. This assertion is consistent with literature (Kavansah et al 2000; 247; NASW, 2013; Bernard and Goodyear, 2013), which suggests that the relationship is developed between a less experienced learner and an experienced learner. Thus, the relationship is developed over a period and with the potential of enhancing the proficiencies of supervisee.
The American Psychological Association (2014) and Australian College of Mental Health Nursing (ACMHN, 2011) have set out some parameters to guide the process of supervision which are that; the supervisor should be more skillful, experienced and well-informed. This was vital in the selection of supervisors among the study participants who work at the general wards. However, the participants who worked at the special wards (VIP) were assigned specific supervisors and confirmed that these supervisors were more experienced, well informed and skillful in the nursing practice.

In summary, the above findings from the study highlights the fact that even though most nurse supervisees have a positive perception of the CS process, there was no clarity on the definition of the concept as participants presented varied views. The explanations provided did indicate that the process was unstructured but was based on the aim, function, and objective or relationship aspect of the concept.

5.2 Function of Clinical Supervision on the Professional Life

The findings of the study revealed that participants had experienced the entire functions outlined in the conceptual framework adopted for the study. Participants explained the clinical impact of clinical supervision in their lived professional experience.

The central focus of clinical supervision (CS) is to facilitate and reduce the level of dependency of the nurse at the unit level. This was iterated by participants in explaining the facilitation function of clinical supervision. Participants stated that CS helps to build nurses’ level of confidence and competence to enhance performance of assigned duties. This assertion supports the findings of Callahan et al. (2009) that the key and most important function of CS is to develop the proficiencies of practitioners at all levels. Fowler (2000) also maintained that CS enables the supervisee to perform better on the job, enhanced professional support improves the supervisee’s confidence. The findings of this study
revealed that, the experienced and skilful nurses monitor the activities of the supervisee to identify errors and omissions in practice and assist to perfect the needed skills which invariably, improves the competence level of nurse supervisee (Staun, Bergstrom and Wadensten 2010). It can be deduced that CS plays a vital role in shaping the level of proficiency of every nurse supervisee which helps to improve generally nurse supervisee’s confidence to practice with minimal support or guidance.

This study also revealed that the level of confidence and competence exhibited by a nurse determines the level of trust and willingness of the patient under one’s care. Also, supervisors consider the skills and capabilities of the supervisees before assigning responsibilities. The findings of a study by Driscoll (2007) and Lu White and Barriball (2006) confirm the assertion made by the participants that, nurses who have experienced clinical supervision appear more confident, knowledgeable and interested in their patients. This is in accordance with the findings of a related study conducted in Rwanda where it was evident that level of professionalism amongst student nurses leads to an increase in patients trust and increases the student nurse’s opportunity to practice (Habimana, Tuyizere, and Uwajeneza, 2016). In support with confidence building and increase in competence, Paterson (2004), White and Winstanley (2012) and Magure, Grellier and Clayton (2017) maintained that increased level of confidence among professional nurse can be realized through effective CS practice.

Participants also revealed that effective CS helps the supervisees to identify their roles and responsibilities in achieving the organizational mission and vision. The supervisors had a role of explaining the institutional policies to guide the actions of the nurse (Winstanley and White, 2003). The supervisor shares and reminds personnel of their scope of work and respective tasks to ensure orderliness at the workplace. This is evident in a case study conducted by Cross, Moore and Sampson (2012) to examine the role of CS for two
outreach nurses in Australia. Role clarification was one of the themes that emerged in the study. The participants of the case study agreed that supervision help them to differentiate between their roles and others and set various professional boundaries to manage the work schedule on the ward. They agreed that having well defined roles help to relinquish task to other staff and get things done on time in relation to organizational structure. However, the findings of a study conducted by Parker et al. (2014) revealed that even though the roles and responsibilities of the new nurse is explained, they (New Nurse) were not informed about what other nurses expected from them. Also, in a cross-sectional survey conducted amongst student nurses in Sweden, the study findings suggested that the roles of the head preceptors and the supervisees must be explained to improve communication.

The findings of this study indicated that participants who have been supervised to practice for more than a year were satisfied with the level of autonomy enjoyed at the ward. Participants revealed that the supervisor over time turn to trust and impose some confidence in some of the nurse supervisee to manage minor situations and issues at the workplace. The supervision received overtime equips the supervisee to meet up with the new challenges (Abiddin, 2008) as evident in the findings of a longitudinal study, among female hospital nurses at Kuopio University hospital in Finland (Koiva, 2013). The findings revealed, good mastery skills, professional efficacy, well-being and high commitment among the nurses who are supervised over a long period. According to Falender and Shafranske (2014) effective supervision is when there is deployment and some form of autonomy as indicated by the study participants. The level of trust according to participants in this study is developed through the constant interaction with the supervisor, the learning experiences acquired and the supervisee proficiency. These factors enhance the decision-making ability and professional growth of the nurse and enabled him to take up new challenges and responsibilities (Severinsson & Sand, 2010). The CS process gradually prepares the
supervisee for independent practice (Openshaw, 2012) as highlighted by the participants. The study revealed that as part of the preparation of the nurse supervisee to gradually assume supervisory roles and practice independently, nurses who have worked for more than a year need to be allowed some level of autonomy to practice and take decisions with minimal direction.

The staff development function of CS provides opportunity for the nurse supervisee to nurture professional skills. Participants in this study admitted that CS provides learning opportunities and assist the nurse supervisee to develop the practical skills as emphasized by Bradley, Ladany and Hendricks(2010) and Brunero and Stein-Parbury (2008). The participants stated that during the CS session, the nurse supervisee learns from the rich experience of the supervisor. It also enables the supervisee to learn some new practical skills which were not acquired in school and improve upon the professional knowledge and skills that are needed to practice effectively (Abiddin, 2008). The study also established that in order to maximize efficiency at the workplace, the nurse supervisee needs to build new skills to enhance the existing skills (Crecious, Patricia & Faston, 2018; Caras & Sandu, 2014)

In a qualitative study conducted in North-Eastern Romania to identify the role of supervision in professional development of social workers, one of the major findings was that, the whole CS process creates learning opportunities for the supervisees (Caras & Sandu, 2014). This point was equally outlined by the participants in this study. The participants of the study stated that supervisors at the unit level, established learning policies that motivated the supervisees to learn. For instance, the supervisors assigned nursing related topics to the nurse supervisee to read and later given the opportunity to present at the scheduled morning conferences. The study participants viewed this practice as an effective way of facilitating learning and skill development. Also, studies by Johansson (2015) Ernestzen, Bitzer and Grimmer-Somers (2009) respectively students and staff
acknowledges CS as an educational tool and highlighted the importance of the debriefing session, patient management discussions and assessment in their professional development. The participants of this study had a positive attitude towards the various strategies adopted by the supervisors and indicated that these activities created the opportunity for nurses to be abreast with new information, to confidently explain outcomes of procedure to patients, to brainstorm and share opinions on better ways of managing the patients and improved their presentation skills. This indicates that there is a positive relationship between CS and professional development (Abreu & Marrow, 2012; Cross, Moore and Ockerby, 2010).

The finding also complements that of Habimana, Tuyizere, and Uwajeneza (2016) who indicated that CS process significantly motivates the nurse trainee to learn to enhance their professional attitude and identity. The clinical supervisor is expected to exhibit positive attitudes and work behavior as role models to the supervisee (Abiddin, 2009). Role modeling as a learning tool influences the supervisee’s skill development (Tanggard & Jacobsen, 2012; Adtienne & Bob, 2009; Donaldson & Carter, 2005). The study further found that majority of participants in the study had observed positive personal and professional behaviour of supervisors which changed their initial perception held about senior nurses. Observing the positive work attitudes of their supervisors have also changed their general attitude to work and improved their communication skills toward patients and other staff. This was corroborated by a related study by Curry, Cortland and Graham (2011); the medical students reported observing some positive attitudes from their senior medical doctors which had a positive impact on their professional grooming. The medical students observed the cordial respect shown to each staff, calm and comforting communication skills and great teamwork. It indicates that there is a high tendency for most young practitioners to model their professional lives by what is constantly observed from their senior colleagues from training through to practice.
Another function of clinical supervision is staff socialization. Staff socialization helps the nurse supervisee to adjust and have a sense of belonging amongst the ward team (Crosse, Moore, Sampson et al. 2012). In line with studies conducted to explore the experience of newly employed graduate nurses’ transition to the ward environment, most of the nurses described their initial adaptation to the work environment as stressful and demanding (Park, 2010; Patterson, Boley, Bernell and Rhoads, 2010; Edwards, Hawker and Carrier, 2011; Beecroft, Doney and Wenten, 2007). The employed nurse needs to adjust their personal life to the new work culture and environment. These finding were no different from the findings of this study. In this study the participants stressed on the importance of initial orientation and recounted how it had helped individual nurses to adjust, fit and feel belonged among the staff on the ward. According to the participants, the initial orientation received helped to integrate the newly employed personnel into the organization. Participants were oriented to the ward environment; the staff, various protocols and procedures to help them familiarize themselves to the work environment (Phillips, Kenny, Esterman & Smith, 2014). The supervisors explained the work culture, ethics and organizational norms to the participants. The participants also stated that staff socialization creates a better work setting and a cordial relationship amongst personnel.

5.3 Form: Stages of Clinical supervision

The stages of Clinical Supervision (CS) entails the steps or method employed by the supervisor during the supervision sessions. In this study, the participants acknowledged that CS process was conducted at the unit level however, expressed some doubt about the nature and form of supervision received from senior nurses at their ward. Participants could not indicate if the CS experienced was either a formal process or cyclical in nature. The study also revealed that the initiation of the CS process is dependent on eagerness of the nurse supervisee to learn, willingness of the supervisor to teach, type of ward one finds him or
herself in, type of procedure or tasks that should be accomplished, and where the staff nurse was trained. This assertion support literature that the major problems of CS have to do with its full implementation (Pillay & Mtshali, 2008) as the stages or cycle are varied and not adequately explained (Fowler, 2011; Daly & Muirhead, 2015). This affects the effectiveness of the process as identified in a quantitative study conducted in Australia to evaluate the effectiveness of CS amongst physiotherapist working in a public hospital. The findings of the study indicated a general uncertainty about the CS process, as more than half of the participants rated the supervision received as ineffective. The participants recommended an improvement in the process.

Amongst the findings of this qualitative study, the participants revealed that none of the supervisors or in-charges officially informed them about the CS process, the duration, category of nurses to seek assistance from or even the names of their supervisors, which affirms the findings of the qualitative study conducted by Williams and Irvine (2009) and Cleary and Freeman (2005) that, most clinical supervisors performed their roles in CS without a structured guideline and do adopt an ad hoc approach to CS. This is supported by the findings that most supervisors in the clinical setting have verbally accepted CS and believe they are implementing the process. It is concluded that the informal supervision conducted by supervisors does not conform to the established definition of the formal nature of CS and recommend that there should be a general protocol or guideline to direct supervisors during the supervision sessions as suggested by the study participants.

Most of the nursing training schools in Ghana are affiliated to specific health facilities where the student nurses receive clinical experience. Some successful trainees have the opportunity of being employed to work in some of these health facilities. It is however, expected that the nurse who is employed to work in a health facility that serviced as a Clinical training site should be better equipped to deliver with little or no supervision.
issue was highlighted by the participants who were trained in NMTC-37MH. The participants confirmed the perception held by most senior nurses that the school one attended affects the level of supervision received. Participants felt they should equally be supervised as done for their colleagues from other nursing schools. This perception needs to be further explored both qualitatively and quantitatively to assess if the level of supervision is dependent on the training institution attended and clinical facility used for practical learning.

The study findings support the statements made by Chuan and Barnett (2012) and Pillay and Mtshali (2009) that the informal or ad hoc implementation of the CS process could be attributed to factors such as the busy schedules of the supervisors, workload on the ward and the junior staff being seen and treated as workers who have a task to accomplish. The participants working on the general ward indicated that there was no form of structure for the CS session. The workload of the nurses is overwhelming, and the senior nurses were mostly concerned about the patients and how to get them to recover and be discharged early. Some of the study participants also indicated that the senior nurses saw them as colleagues and co-workers and therefore, expected them to carry out all assigned tasks with little or no error and thus, were not adequately supervised. On the contrary, the study participants who worked on the special wards had specific supervisors because the ward is known to admit very few patients who are quite prominent in society. In view of this, the supervisors need to monitor and correct all inactions of the nurse supervisee and this is in support of the point highlighted by Fowler (2011) that CS is implemented depends on the staff ratio, type of clinical area and culture of the organization.

The relationship established from the onset of the CS process helps to develop a meaningful supervisor-supervisee connection. Statements of participants of this study were equally in agreement with the assertion made by the student nurses in three universities in
Cyprus that the supervisory relationship was the most influential factor in the clinical learning environment (Dimitriadou et al., 2015). However, majority of the participants of this study enumerated factors such as the personality of the supervisor, rank difference, skill and knowledge of the supervisor affecting the relationship between supervisors and supervisee.

The importance of orientation was emphasized by the participants. The findings revealed that it helped the nurse supervisee to integrate into the ward environment, be well informed about the standards and norms of the facility as well as the accepted roles and responsibilities (CPA, 2009; Phillips, Kenney, Esterman et al, 2014). According to Tobias, Ives and Graham (2016) most nurses’ perception of CS is influenced by the level of trust established between the supervisor and the supervisee. This was evident in a statement made by one of the study participants who was affected by the initial negative comments passed by the supervisor during the early stage of the process. The participant expressed the preference to solicit help from the peers than the supervisor (Parkers et al, 2014).

The findings of this study are consisted with literature in relation to the use of observation during CS sessions. Participants of this study reported that most supervisors use direct observation of supervisee in the clinical setting to ascertain how nurses transmit the theoretical knowledge into the real-life situation at the clinical context. The study also stressed that direct observation is relevant due to effective monitoring of supervisee skills, competence and performance level respectively (Alarcao & Tavares, 2010; Rocha; 2013).

In support with Alarco and Tavares (2010) and Parton and Binding (2009) assertions, the participants of this study claimed that one of the effective methods utilized by the supervisor during the session is the case study analysis. In other words, utilization of
case study analysis by supervisors significantly impact on skills development through reflection, discussions and sharing of experience by all members.

Feedback is one of the methods employed by supervisors during CS sessions and informs the supervisee of the progress and emphasizes the areas that need more attention. In this study, the participants stated that individual nurse supervisee will have to sometimes contact the supervisor to receive some feedback on assigned tasks. Cox and Araoz, (2009) proposed that feedbacks should be timely, well structure and non-threatening or abusive in nature. The general observation of the participants was that supervisors were quick to give negative feedback as to the positive ones and were always making references to wrong actions committed. This act as was reported by participants, do negatively affects the self-awareness and professional development (Clynes & Raftery, 200; Ping, 2008; Martin, Copley & Tyack, 2014). Despite the misgivings participants had about feedback received from supervisors, participants agreed that supervision process cannot be successful without effective feedback system.

The final stage of the CS process according to Rich (1993) is the follow-up stage where future supervisory activities are planned based on the outcome of the process. The follow-up stage also initiates a new cycle of the CS process. The participants of the study could not relate to this stage. The participants stressed the point that since the entire process was not well structure and formalized, it was difficulty to indicate the point at which a cycle had ended or began. This buttress the earlier point made about the need for the adaptation of specific guidelines to direct the implementation of the CS process.

5.4  Elements of Clinical Supervision

The primary elements of CS identified in the study were the facilitative environment and the supervisory relationship. Participants stressed on the need to create facilitative environment during the CS process which provides a solid foundation for the mutual respect
and trust. This point was also highlighted in a study conducted in Rwanda amongst student nurses (Habimana, Tuyizere & Uwajeneza, 2016). The student nurses were of the view that the clinical environment was vital to the achievement of the clinical learning outcomes. The environment plays a role in enhancing the competence of the nurse and provides a support bases for the supervisee (Winstanely & White, 2003). Generally, all the participants in this study indicated that the supervisors paid less attention to the environment in which the supervision takes place. The learning environments at the wards were not safe, nurturing, and interactive enough as emphasized in the findings of Adjei, et al (2018). The study revealed that when the learning or clinical environment is unsupportive it reflects on the type of relationship that will exist between the supervisor and the supervisee. Majority of the participants of this study agreed on the need for supervisor to create a favorable and serene environment within the ward that promotes learning during the supervision process. All participants complained about how most supervisors were fond off correcting the supervisee in the presence of the patient and other ward staff which turns to affect their level of confidence. Participants suggested the supervisors should identity an enclosed place like the nursing station or nursing office to reduce the interference from other nursing staff.

In a qualitative study conducted in Canada and United State of America to identify factors that helps or hinders effective CS, fifty six (56%) percent of the respondent stated that their supervisors provided a safe and trusting environment. Thirty six (36%) of the respondent were pleased with how the supervisors treated them with much respect. However, majority stated that the supervisors were rigid, controlling, intimidating, insulting and judgmental (Wong, Wong & Ishiyama, 2012). The findings were similar to the statements made by some participants of this study. The participants complained about the tone and approach in communicating issues. The supervisors like to scream and insult instead of talk to the supervisee when something goes wrong. This attitude undermines the
confidence of the supervisee making supervisees unwilling to get closer to supervisors and try new procedures (Scott et al., 2008; Duchscher, 2008). Supervisors need to cautious in their utterances and work at promoting a mutually beneficial relationship between the supervisor and supervisee. van Ooijen (2013) advocates that a good supervisor should develop a positive relationship, be open and not pretend. Supervisors need to have good skills in questioning, active listening, and the ability to focus and elicit enough information from the supervisee and note the point of need. The CQC (2013) also stated that supervisors should adopt a facilitative and supportive approach where you lead by example, but when there are concerns regarding the competence or conduct of a supervisee, they must act appropriately.

5.5 Emerging Themes

In analysing the data collected other constructs not contained in the integrated model of supervision additional findings emerged. This included the strategies adopted by the supervisors during the supervision process and measures to improve the entire CS process. Participants in answering the stages of supervision made reference to three (3) strategies that supervisor adopt namely: observation, demonstration and delegation. Majority of the participants viewed the act of observation as a strategy than part of the stages of conducting CS.

The participants affirmed that most supervisors utilize demonstration as a strategy in teach the supervisee some practical skills. Also, because of the busy nature of the ward and the volume of work that needs to be completed in a day, supervisor also to delegate task to SNs. The supervisor gives clear instructions on how to carry out the task. However, participants complained that supervision is low when the supervisor adapts the delegation strategy.
The participants acknowledged the importance of CS in developing the skills and knowledge of the younger generation of nurses and stressed the need to find ways of improving this important supportive activity. Measures suggested by participants to improve CS at the unit level included the development of a clear standardized institutional guideline on clinical supervision, which will guide supervisors in its implementation. Participants also suggested that educational programmes must be organized either internally or externally to upgrade the supervisors and enhance supervisory skills.

5.6 Summary of Discussion.

In summary the study identified that there is no common perception or explanation for Clinical Supervision (CS). The nurse supervisees interviewed had varied perception of the CS process but in unison acknowledged the importance of CS in the development of every nurse’s professional knowledge and skill. CS therefore creates the opportunity and avenue for the less experienced staff to learn from the experienced staff. CS also serves a guarantee for the provision of quality health care service and the standardization of nursing procedures and activities.

The participants acknowledged that the stages of CS implemented by the various supervisors were not structured and formalized. This is because the participants could not relate to all the stages of CS as indicated in the literature. Most supervisors according to the participants do not have a standard guideline to direct the implementation. The issue of supervisors not planning the entire process with the supervisee was emphasized. The supervisee held the view that supervisor must be guided by an institutional protocol and consider their learning needs and deficiencies during the process.

The study identified the first stage of the CS process as the most important stage. According to the participants the general relationship between the supervisors and
supervisees was influenced by the rank variations, willingness to teach, the competence level and the personality of the supervisor. This makes it difficult for supervisee to approach the supervisor but restore to their peers for assistance.

Supervisors need to maintain a cordial relationship with the supervisee to enhance the successful implementation of the CS process. Also, the environment in which the supervision is conducted must be conducive and not intimidating. From the study, when the facilitating environment is not conducive it affects the confidence level of the supervisee as well as the relationship and level of trust on the part of the patient.

All the findings identified from the study were in line with findings of previous studies conducted in different countries and different professional fields. On the whole, the conceptual framework adopted from Philip Rich (1993) guided the study and aided the researcher to answer the research questions. However, external to the conceptual framework, the study yielded two additional themes which were not part of the dimensions of the integrated model of clinical supervision. These themes included strategies adopted by supervisors during supervision and measures to improve the implementation of the CS process.
CHAPTER SIX

SUMMARY, IMPLICATION, LIMITATION, CONCLUSION AND RECOMMENDATION

6.0 Introduction

This chapter presents the summary of the study, implications of the research findings to nursing practice, administration, education and research. The chapter further explains the insight the researcher gained from the study, limitations of the study, conclusions and recommendation.

6.1 Summary of the Study

In this study, the researcher sought to explore the concept of Clinical Supervision among nurse supervisees working at the 37 Military hospital. An exploratory qualitative approach to research was adopted. Clinical supervision was perceived as a supportive activity that helps in developing the clinical competencies and knowledge of the nurse supervisee.

Philip Rich Integrated Model of clinical supervision was adapted and guided the formulation of the research objectives for the study. This conceptual framework explained the function, stages and elements of clinical. The literature discovered that there is the need for further studies in the area of clinical supervision, especially on how the supervisee perceive the entire process. A semi-structured interview guide with open-ended questions based on the dimensions of the conceptual framework and the objectives of the study were designed to elicit responses from the participants. The purpose and objectives of the study were explained to participants and information sheets were given to participants for further clarification on the research. Participants who met the inclusion criteria and consented to be part of the study were recruited and consent forms were signed.
Participation in the study was purely voluntary without any coercion. An agreed day, time and place were scheduled with each participant. Interviews were conducted with their permission to record the interview sessions and all the major happenings of the day were recorded in a field diary. Thematic content analysis was used to analyse the data. Transcripts were read and re-read to make meaning and to generate codes to identify the sub-themes under the main themes provided by the conceptual framework. Quotations to support the information provided were also identified. The transcripts, demographic data and audio recordings were kept safe electronically. The four main themes that guided the study were the Concept of CS, Functions of CS, Stages of CS, and Primary Elements of CS. Furthermore, two emerging themes were identified from the data, which were the Strategies adopted during the stages of CS and the Measurers to improve the CS process.

6.2. Implications for Nursing

6.2.1. Practice

From the study, it is evident that effective clinical supervision is vital in the development of the professional skills of the nurse supervisee. Therefore, there is the need for a guideline to assist supervisors in the full implementation of this supportive activity. Nurse supervisee also need to show the eagerness to learn and a positive attitude towards the experienced nurse and accept the feedback given at the end of each session.

In order to ensure the full participation of the supervisee, it would be appropriate if the supervisors engage the supervisees in the planning stage to identify the deficiencies and plan strategies to improve the skill and competencies of the supervisee. Also, the supervisors must work at maintaining a cordial relationship with the supervisees and give constructive feedback to encourage the spirit of learning.

The environment in which supervision is conducted must be conducive enough to support learning. The supervisors must consider having a room dedicated to holding
meetings and conference to discuss the issues identified during the observation phase. Further research must be done to explore the conduct of clinical supervisors during clinical supervision.

6.2.2 Education

Both supervisors and supervisee must be educated on the stages involved in the successful implementation of CS. These educational programs can be organized internally to upgrade the supervisory skill of the supervisor and enlighten the supervisee to know their role and responsibility in the successful implementation of this activity.

6.2.3 Administration

It is necessary for all nursing administrators to make Clinical supervision a compulsory learning activity on the ward and develop a standardized and clear guideline to enforce its implementation. The nurse supervisee must also be assigned a specific supervisor and be informed about the duration of the supervision. Both the supervisor and supervisee must know clearly their roles and responsibilities in ensuring the success of the activity. This will help eliminate the idea that clinical supervision is an extra duty by clinical supervisors.

6.2.4 Research

This study explored the concept of clinical supervision among the nurse supervisees at the 37 Military hospital. However, further studies must be done to explore the conduct of clinical supervisors during clinical supervision. Another study could compare the perception of both supervisors and supervisee on the concept in the urban and rural setting. Also, a study can be conducted to explore the perception that the level of supervision to a newly qualified nurse is dependent on the training institution attended and clinical facility used for practical learning.
6.3 Limitations

The qualitative design used for the study makes it difficult to generalize the findings of the study to the entire nurse supervisee populace within Ghana. Secondly, the findings are unique to the selected setting and the population sample used. Also, the study focused on only nurse supervisees with one to three-year work experience.

6.4 Insights Gained

This study has enabled the researcher to gain a lot of understanding into the research process right from identifying a problem and developing a proposal through to the end of the entire process. Additionally, the use of a model as a basis for conducting any study was very insightful as it helped in setting the objectives, reviewing literature, and discussion of findings. The researcher has also learnt a lot in analyzing and reporting qualitative data. The researcher equally has learnt a lot on the subject studied and this has been an eye-opening experience.

6.5 Conclusion

In conclusion, the study employed the qualitative exploratory descriptive design to explore the concept of CS among nurse supervisees. A total of eleven study participants who were staff nurses (SNs) and fully employed for a period of one to three years were involved in the study. The study sought to explore the concept, functions, stages and primary elements of the CS process. Strategies adopted during the implementation of CS and measure to improve the process were also examined. The Integrated Model of clinical supervision was very appropriate in exploring and describing the nurse supervisee views about CS process because it considered the entire sections of the process; its function, stages and primary elements.

The findings of the study indicated that nurse supervisee had adequate knowledge of CS and could relate to its function and impact on the professional life of every nurse. It
was also identified from the study that the stages of conducting supervision should be reviewed and a standardized approach adopted by all supervisors. This will bring about uniformity in the implementation and encourage more supervisors to participate and implement this important support activity which will improve the competency of all general nurses.

6.6  **Recommendations.**

The following recommendations were made based on the findings of the study:

- The health care facility must make clinical supervision a mandatory professional activity for all practicing nurses to improve upon the competency and knowledge.
- A clear standardized institutional guideline on clinical supervision process must be developed by the facility and monitor the implementation of the guidelines.
- The various health care facilities must ensure that each nurse supervisee is assign a specific supervisor to assist in the professional development of the nursing staff.
- Educational programmes must be organized either internally or externally to upgrade and enhance supervisory skills of nurse managers.
- Further research must be done to explore the conduct of clinical supervisors during clinical supervision. Another study could compare the perception of both supervisors and supervisee on the concept in the urban and rural setting.
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APPENDICES

APPENDIX A: INTERVIEW GUIDE

Demographic Data
Gender:
Age:
Nursing School attended:
Nursing Rank:
Year of employment:
Years of work experience:
Current Ward:

Section A: Perception of the Concept of Clinical Supervision

<table>
<thead>
<tr>
<th>Questions</th>
<th>Field Notes</th>
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<tbody>
<tr>
<td>1. How would you describe clinical supervision?</td>
<td></td>
</tr>
<tr>
<td>2. What category of nurses, in your view qualifies to be supervisors?</td>
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Section B: Functions of Clinical Supervision

<table>
<thead>
<tr>
<th>Questions</th>
<th>Field Notes</th>
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<tbody>
<tr>
<td>1. What are the functions and roles of Clinical supervision in the professional life of a SN?</td>
<td></td>
</tr>
<tr>
<td>2. How do these function and roles impact:</td>
<td></td>
</tr>
<tr>
<td>a. Nursing Practice</td>
<td></td>
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<tr>
<td>b. Service delivery</td>
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<tr>
<td>c. Staff development</td>
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Section C: Stages of Clinical Supervision

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<th>Questions</th>
<th>Field Notes</th>
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<tbody>
<tr>
<td>1. Briefly describe the stages of clinical supervision you have experienced throughout your years of working.</td>
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<tr>
<td>2. How do you perceive the entire process in terms of:</td>
<td></td>
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<tr>
<td>a. Relationship building amongst junior and senior staff</td>
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<tr>
<td>b. Effective Communication</td>
<td></td>
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<tr>
<td>c. Feedback</td>
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<tr>
<td>d. Goal attainment</td>
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<tr>
<td>3. How do you view the entire process and its effectiveness?</td>
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Section D: Primary Elements of Clinical Supervision

<table>
<thead>
<tr>
<th>Questions</th>
<th>Field Notes</th>
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<tbody>
<tr>
<td>1. What are the core elements of clinical supervision?</td>
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<td>2. How do these element impact or affect the</td>
<td></td>
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<td>a. Supervisee</td>
<td></td>
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<tr>
<td>b. Supervisor</td>
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<td>c. Nursing practice</td>
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Thank you.
APPENDIX B: CONSENT FORM

Title: Exploring the Concept of Clinical Supervision among Nurse Supervisees: a study at the 37 Military Hospital.

Principal Investigator: Diana Bosomtwe-Duker

Address: University of Ghana
    College of Health Sciences
    School of Nursing and Midwifery
    Legon
Phone: 024 498 1960
Email: dbosomtwe.db@gmail.com

General Information about Research

You are kindly requested to participate in the research study that is to explore the concept of clinical supervision among nurse supervisees at the 37 Military Hospital. Participants to be recruited will be Staff Nurses (SNs) with less than three (3) years working experience who are fully employed and working at the 37 Military Hospital. After reading this general information, if you agree to participate in the study, you would be interviewed to recount the experience you have had with supervision. The researcher would ask you questions in English and would redirect you whenever you are out of context. You are also to take note that the interview will be conducted at your own time and convenience and may last for forty (40) to sixty (60) minutes. The entire interview will be recorded based on your agreement. Kindly note that your participation in this research study is strictly voluntary and you can decide to opt out at any given period if you feel uncomfortable to continue.

Possible Risk and Discomforts
No physical, social or psychological risk or discomfort is anticipated from your participation in this research.

Possible Benefits
It is expected that the outcomes of this research will provide nurse managers and unit heads with an insight to shape the adaptation and implementation of clinical supervision as a clinical learning and enhancement tool for junior nurses.

Confidentiality
Your participation will be treated confidentially, and all data and recordings about you will be protected to the best of our ability. You will not be named in any report and during data analysis; all names will be replaced with alphabets. Personal identifiers and identifiable quotes will not be included in any publications arising from the research. All data collected from the research participants would be used purposely for academic reasons, including publications. Some staff of the School of Nursing and Midwifery, Graduate School, Legon and members of the professional nursing bodies may sometimes look at your research records, but you are assured that they will not be able to tell who said what. All data and
recordings will be stored by the researcher and later destroyed by deletion of the electronic files, shedding and secure destruction of paper files, five (5) years after the completion of the research. Whenever there is the need to use the data in the near future, permission will be sought from an ethics committee.

**Compensation**

Participants will not be paid for partaking in the research but will be appreciated with a bottle of water and a soft drink of your choice.

**Additional Cost**

You will not incur any financial cost for participating in this research.

**Voluntary Participation and Right to Leave the Research**

Your participation in the research is voluntarily. If you wish to end participation at any point prior to completion of the research, you simply need to tell the researcher. Any contribution made can be withdrawn at any point of the study based on your request.

**Contact of Additional Information**

If you have any concerns or issues regarding this research, kindly contact the following people

1. Diana Bosomtwe- Duker (Principal Investigator) – 024 498 1960
2. Dr. Adelaide Ansah Ofei (Faculty/ Supervisor) – School of Nursing and Midwifery, University of Ghana. 020 465 3065

**Your rights as a Participant**

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your right as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.
VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title (Exploring the Concept of Clinical Supervision among Nurse Supervisees: a study at the 37 Military Hospital) has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

………………………                                        ……………………………………………

Date                                                                     Name and signature or mark of volunteer

I certify that the nature and purpose, the potential benefits and possible risks associated with participating in this research have been explained to the above individual.

……………………….                                  ……………………………………………..

Date                                                               Name Signature of Person who obtained consent
APPENDIX C: ETHICAL CLEARANCE
APPENDIX D: INTRODUCTORY LETTER

UNIVERSITY OF GHANA
SCHOOL OF NURSING

Ref. No.: SONG/A/12

October 16, 2018

The Chairman
NMIMR - LRB
P.O. Box LG 581
Univ. of Ghana
Legon.

Dear Sir/Madam,

Dear Sir/Madam,

LETTER OF INTRODUCTION

This is to introduce to you Diana Boosomwe-Okur, an MPhil second year student of the School of Nursing and Midwifery.

The Scientific Review Committee of the School has approved the thesis topic: “Exploring the Concepts of Clinical Supervision amongst Nurse Supervisors: A Study at the 37 Military Hospital”.

I hope that the Institutional Review Board will consider the proposal to enable her collect data.

Counting on your usual co-operation.

Thank you.

Yours faithfully,

Dr. Adelake M. Asafo-Okye
Head, Dept. of Research, Education & Administration

COLLEGE OF HEALTH SCIENCES

* Tel: 0306 288 855 855 831 511 * Email: info@ugspace.ug.edu.gh * Website: www.ugspace.ug.edu.gh