

**SCHOOL OF PUBLIC HEALTH
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA**



**ASSESSMENT OF FACTORS INFLUENCING THE QUALITY OF CLINICAL
SUPERVISION OF NURSING AND MIDWIFERY STUDENTS AT THE 37
MILITARY HOSPITAL**

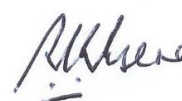
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**THIS DISSERTATION IS SUBMITTED TO THE UNIVERSITY OF GHANA,
LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE
AWARD OF MASTER OF PUBLIC HEALTH DEGREE**

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DECLARATION

I, Miriam Tuowulle Aryere, hereby declare that apart from references to other people's work, which have been duly acknowledged, this work is the result of my own independent work. I further declare that this dissertation, either in whole or in part has not been submitted to any University to the best of my knowledge for the award of any degree.



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DEDICATION

I dedicate this dissertation to my loving husband Dr. Francis Bitasimi Bilson and my three wonderful children, Nikimi, Tilaar and Nimormi.

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Many people and institutions contributed immensely to the completion of this dissertation.

My first appreciation goes to the Almighty God for granting me wisdom and strength throughout the development of this dissertation.

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ABSTRACT

Background: Nursing and Midwifery is a practice-based profession that is built on theoretical knowledge gained through comprehensive nursing and midwifery education. This is done with the overall goal of equipping nurses and midwives with professional clinical competencies ready to deliver safe, quality nursing and midwifery care. The most effective way of integrating both theory and practice in nursing and midwifery to build the skills, knowledge and attitudes of nurses and midwives is through clinical supervision. Poor working relations between hospitals and health training institutions and the preceptorship model of practical supervision across the country have been identified as some of the many factors that limit clinical practice to only the acquisition of clinical skills.

Objective: The objective of this dissertation was to examine the factors that influence the quality of clinical supervision among nursing and midwifery students at the 37 Military Hospital, in the Greater Accra region of Ghana.

Methodology: The study adopted a cross-sectional design. A mixed method (qualitative and quantitative) approach was used to collect data for the study. A sample size of 200 Nursing and Midwifery students were selected using simple random sampling technique to respond to a structured questionnaire in the quantitative study. The qualitative data was collected through Key Informant Interviews (KII) with five clinicians and eight tutor supervisors who were selected using purposive sampling technique. Quantitative data was analysed using Stata version 15. Descriptive, bivariate and multiple logistic regression analysis were carried out to determine the factors influencing the quality of clinical supervision. The qualitative data was also analysed using content analysis and the transcripts read through to allow themes to emerge.

Qualitative Results: The study showed that clinician and tutor supervisors held different views of what constituted quality clinical supervision. Quality clinical supervision was

conceived as 1) clinicians or staff working with students posted to wards, 2) students being supervised by quality assurance nurses and in-charges in wards and 3) tutor and clinical supervisors putting measures in place to adequately supervise nursing and midwifery students. The study also revealed three main modes of clinical supervision namely; Objective-Based Supervision, Facility-Based supervision, and Preceptor-Based Supervision. Factors identified as influencing clinical supervision were pre-clinical student orientation, lack of training for supervisors, absence of a standard guideline for student clinical supervision, inadequate logistics for students to work with, time constraints and heavy workload schedules for tutor supervisors.

Quantitative Results: Overall, only 19% of the nursing students experienced high quality clinical supervision at the 37 Military hospital. The study found that marital status, religion, program of study, how close a respondent's residence is to the hospital of attachment, whether the respondent's institution choose hospital for them, issues of accommodation, negative attitude of clinical staff towards respondents, issues of sexual harassment during clinical attachment, whether senior staff over rely on respondents work, whether enough time is given by the clinical supervisor to teach respondents, whether tutor supervisors visit respondents at the hospital to conduct supervision, when respondents buy their own clinical materials, whether respondents are emotionally stressed during clinical practice, whether respondents are aware of any standard guidelines for supervision, the interaction between respondents and their tutor supervisors as well as clinical supervisors have significant influence on the quality of clinical supervision of nursing and midwifery student at the 37 Military hospital from the nursing and midwifery students perspective.

Conclusion: There should be a standard for supervising students in the country to ensure uniformity in nursing and midwifery training. The provision of standard guidelines for clinical supervision will address factors affecting tutor and clinician supervisors as well as

those of the students. Enhanced efforts should be made by the various stakeholders like the Ministry of Health, Ghana Health Service and Nursing and Midwifery Council of Ghana, who are responsible for the training of nurses and midwives. When these factors are properly addressed, there would be improvement in the quality of clinical supervision of student nurses and midwives in Ghana.

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LIST OF ABBREVIATIONS

| | |
|-----------------|---|
| CCHN..... | College of Community Health Nursing |
| CPD..... | Continuous Professional Development |
| DDNS..... | District Director of Nursing Services |
| GHS..... | Ghana Health Service |
| MOH..... | Ministry of Health |
| NAC..... | Nurse Assistant Clinical |
| NAP..... | Nurse Assistant Prevent |
| N&MC..... | Nursing and Midwifery Council of Ghana |
| NMTC..... | Nursing and Midwifery Training Colleges |
| RCN..... | Registered Community Nursing |
| RGN..... | Registered General Nursing |
| RM..... | Registered Midwifery |
| RMN..... | Registered Mental Nursing |
| 37 MH-IRB | 37 Military Hospital-Institutional Review Board |

DEFINITION OF TERMS

Clinical Attachment: A period when a nurse is attached to a particular department of a hospital with an assigned supervisor.

Clinical supervision: it is a formal and disciplined working alliance that is generally between a more experienced nurse/midwife who is the supervisor and a less experienced nurse/midwife who is the supervisee with the aim of improving the supervisee's work with clients.

Clinical supervisor: A registered professional nurse or midwife working in a clinical setting who supports and develops nurses and midwives who are placed there.

Clinician: A registered nurse who has received special training and can perform many of the duties of a physician.

Nursing/Midwifery tutor: A nurse/midwife who formally teaches at a Nursing or Midwifery school and prepares student nurses/midwives for entry into practice position. They also provide continuing education to licensed nursing/midwifery staff.

Preceptorship: It involves the pairing of an experienced teacher with a less experienced learner with the goal of achieving selected learning objectives.

Quality Supervision: It is a measure of excellence or a state of being free from defects, deficiencies and significant variations regarding supervision.

Student Nurse/Midwife: Any person enrolled in an approved nursing or midwifery education program that leads to certification and licensing to practice nursing or midwifery.

Supervision: It is the act or function of overseeing an activity or somebody.

Tutor supervisor: A registered professional nurse or midwife with a qualification in nursing/midwifery education and teaches in a Nursing or Midwifery Training Institution.

CHAPTER ONE

INTRODUCTION

1.0. Background to the study

Nursing and Midwifery are health professions which provide care to individuals and their families. A person would have to go through formal training for a period of time and sit a licensing examination before he/she qualifies to practice as a nurse or midwife. The training involves the combination of complex knowledge and theories which is done in the classroom and practice sessions which are done in a skills laboratory and in a health facility. The theoretical component of the training is very essential but the practical component is seen as the most important and takes a greater percentage of the entire training process. The reason being that it is the point at which the student nurse and midwife must apply the knowledge he/she has acquired to the real life situation thereby enabling him/her to gain confidence, independence and skill. The importance of clinical practice for nursing and midwifery students therefore cannot be over-emphasized.

Gaberson and Oermann (2010) state that, clinical teaching is the most important component of nursing/midwifery education and thus a compulsory aspect of the nursing and midwifery curricula. In South Africa, clinical teaching must make up 70% of the nursing and midwifery curricula, according to a proposed model of clinical education (Nursing Education Stakeholders Group, 2012). In Ghana, the training of nursing and midwifery students for the diploma programme and the degree takes three and four full years respectively. A student nurse and midwife must have mandatory 1,632 hours of clinical training which makes up 60% of the curricula for training. (N&MC Ghana, 2015).

Clinical supervision is the means by which student nurses and midwives are mentored during practical sessions. Mabuda, Potgieter and Alberts (2008) state that the aim of clinical

supervision is to enable student nurses and midwives learn to apply theory to the real-life situations. They further added that supervision of these students in their clinical practice helps them to integrate the theoretical knowledge and practical skills. According to the South African Nursing Council Regulation (2018), student nurses or midwives must make a minimum of a mandatory 4000 hours of supervised experience during the clinical practicum. The overall goal of quality clinical supervision is equipping student nurses and midwives with professional clinical competencies ready to deliver safe, quality nursing and midwifery care (Nabolsi, Zumot, Wardam, & Abu-Moghli, 2012).

The team responsible for the supervision of student nurses and midwives are clinical tutors and registered nurses or midwives who are professional staff. Clinical tutors are responsible for sending the students to the health facilities and expected to do clinical visits to offer support and take feedback. The clinical supervisors or preceptors on the other hand, are designated employees in the clinical placement facility and are responsible for clinical teaching of any student nurse or midwife placed in the facility.

Quality supervision in clinical practice is very important in nursing and midwifery education. The Business Dictionary defines quality as “a measure of excellence or a state of being free from defects, deficiencies and significant variations. It is brought about by strict and consistent commitment to certain standards that achieve uniformity of a product in order to satisfy specific customer or user requirements”. By inference, quality clinical supervision is said to be achieved when nursing and midwifery practices are free from defects, deficiencies and significant variation and when there is strict and consistent commitment to maintain certain standards and achieve uniformity by key players.

Quality supervision strives on certain factors according to Landmark (2003) for the development of competence and skill in student supervision. These factors are didactics, role

functions and organizational framework. Didactic factors described included: integration of theory and practice; reflection on clinical situations; clarification of supervision aims and student evaluation. Role function factors were described as: feelings of security and awareness in supervision, differentiation between student and supervisor roles and the meaning attached to being a role model. Organizational framework factors included nursing faculty and clinical field expectations. The absence of these factors poses challenges to the nursing and midwifery clinical supervision.

Globally, about 25% of nursing and midwifery students withdraw from the nursing/midwifery programme before qualifying as a nurse or midwife (Tseng, Wang, & Weng, 2013). This is because the combination of nursing and midwifery education and clinical practice is considered a demanding process for some trainee students (Asirifi *et al.*, 2017). More specifically, fulfilling their student role effectively as against unfriendly study schedule (Papastavrou, Lambrinou, Tsangari, & Saarikoski, 2010), insufficient time (Helgesen, Gregersen, Karine, & Roos, 2016), inadequate study and clinical materials (Mwale & Kalawa, 2016), and lack of coherent training and support, make nursing/midwifery education and clinical practice challenging (Bengtsson & Carlson, 2015).

Additionally, human resource management insufficiency (fewer student nurses/midwives and more patients) is recognized to be related to nurse/midwife practice error during clinical practice (Farsi, Dehghan-nayeri, Negarandeh, & Broomand, 2010). This may widen the gap between theory and practice (Bukaliya, 2012) which consequently leads to graduate nurses and midwives who are not qualified to be employed in clinical areas (Allari & Farag, 2017).

Evidence from Tanzania demonstrates that nursing and midwifery students are often overwhelmed with workload in over-crowded hospitals and clinics (Niles *et al.*, 2017), inadequately compensated for their support during clinical practice (Mullan & Frehywot,

2007), and demoralized by a lack of continuing professional development opportunities within the hospital (Ssenyonga & Seremba, 2007). Furthermore, it is estimated that 34% of clinical trainees such as nurses and midwives are challenged with accommodation deficit in Nigeria (Ayandiran, Irinoye, Faronbi, & Mtshali, 2013) and 19% are said to have withdrawn from training due to complex curricula and challenging course content (Ayandiran et al., 2013).

In Ghana, available information suggests that lack of close supervision of nursing and midwifery students on clinical placement by clinical staff is a major barrier to the acquisition of clinical skills (Asirifi, Mill, Myrick, & Richardson, 2013). Additionally, the increasing number of nursing and midwifery institutions, and limited number of nursing and midwifery tutors during practice also hamper the progress in clinical industrial attachment (Anne, 2014). Bam and colleagues (2014), identified stressors such as fear of making mistakes, attitude of clinical team, theory practice gap, lack of teaching and lack of interest in learners in the clinical setting as factors hampering clinical supervision. Also poor working relations between hospitals and health training institutions in many regions (Agyapong, Osei, & Mcloughlin, 2016), inadequate preceptor preparation (Avén & Jacobson, 2011), and inadequate faculty supervision (Asirifi et al., 2017) have been reported as creating an unstable clinical environment for students.

Clinical supervision is therefore very crucial in nursing and midwifery training. It is important that all nursing and midwifery students receive the highest degree of clinical supervision so as to attain clinical competence, proficiency and independence (White & Winstanley, 2009, 2014). Given this, the researcher intends to explore nursing students' experiences regarding clinical supervision and the roles played by clinical supervisors.

The 37 Military Hospital is a state of the art referral facility in Ghana with a bed capacity of 533. The facility has a total number 442 nurses and midwives. Every year, the hospital receives about 1200 students from 52 public, private and mission nursing and midwifery training institutions for clinical attachments. A study assessing the factors influencing the quality of clinical supervision of nursing and midwifery students in the facility would add to knowledge that would improve clinical supervision in the aforementioned facility and other health facilities in the country.

1.1. Problem Statement

Nursing and Midwifery education has advanced on many fronts but there has been little progress in clinical nursing and midwifery training and clinical based attachment (Esmaeili et al., 2014). The According to N&MC (2015) a minimum number of contact hours have been set for nursing and midwifery trainees for both theoretical and clinical sessions in Ghana. However, with regards to the clinical sessions, most student nurses/midwives have very little practical teaching from both their tutor and clinician supervisors.

Several studies have identified that the lack of close supervision of students are due to shortages of nursing/midwifery staff, inadequate collaboration between clinical staff and academia (Asirifi et al., 2017; Gardener, 2014) and inadequate or scarce clinical placement sites, often as a consequence of increased numbers of students (Gardener, 2014; Brunero, 2008). Also, the clinical environment is characterized by various challenges such as unpredictability, limited resources and overcrowding of students; however, it is rich in learning opportunities (de Swardt, van Rensburg, & Oosthuizen, 2017).

Additionally, studies have shown reduction in traditional clinical placement opportunities related to health system changes (Gardner, 2014) and competition with other health disciplines for the same practice settings as major challenges facing clinical nursing and

midwifery education (Gardener, 2014; (Brunero, 2008). However in low resource countries such as Ghana, these issues are compounded by serious shortage of qualified faculty and clinical supervisors (Bell et al., 2013).

In Ghana, poor working relations between hospitals and health training institutions in many regions have been identified (Asirifi et al., 2017). Additionally, inadequate preceptor preparations, and inadequate faculty supervisions have been recorded (Atakro & Gross, 2016; Asirifi et al., 2017). Moreover, the role of nursing and midwifery preceptors in Ghana have not been defined or recognized and accountability for student learning is diffused among staff nurses and midwives (Asirifi et al., 2013).

Consequently, it is reported that, there is a widening gap between theory and practice. Also, nursing and midwifery training is being compromised as the quality of nurses/midwives turned out is being questioned in recent times because of poor quality of care to patients and their families (Amoah, 2017).

Data to guide decision making and policy formulation on the challenges of clinical supervision of nursing/midwifery students in Ghana are limited (Bam et al., 2014). This is because few studies have investigated the challenges of nursing and midwifery education and students' clinical practice in Ghana (Asirifi et al., 2017). Hence, this current study seeks to assess the factors influencing the quality of clinical supervision of nursing/midwifery students at the 37 Military hospital, in order to fill the dearth of literature and provide data for decision making.

1.2. Justification of the study

This study is important for several reasons and to different stakeholders. First, the study has significance for health policy formulation. Health authorities ranging from government agencies such as the Ministry of Health, Nurses and Midwifery Council, Nursing Training

Colleges and Hospitals where nurses undertake their clinical practice can adopt the findings of the study in creating a conducive clinical practice environment for nursing students. In relation to the challenges students face, the authorities can take targeted steps in ameliorating the challenges in order to ensure an effective clinical experience for students. Similarly, these authorities can, with a better understanding of the factors affecting clinical supervision, take the right steps to ensure excellence is achieved regarding clinical supervision in Ghana.

In the absence of studies that investigate the factors that affect the quality of clinical supervision of nursing/midwifery students, standards in the nursing /midwifery profession would deteriorate as policy formulators and implementers will be misinformed.

Clinical supervisors and tutors stand to benefit from the study as they can become better informed on issues like the factors affecting clinical supervision as well as the modes of supervision in existence. Finally, student nurses and society as a whole will be better informed on the challenges facing nursing/midwifery students, clinical supervisors and academic tutors in clinical practice in Ghana.

Most studies on nursing and midwifery education and clinical supervision have focused on the success of the nursing and midwifery education program with limited emphases on the challenges facing nursing and midwifery preceptorship and clinical based practice of nursing/midwifery students. To fill the gap in literature, the current study systematically explores the factors influencing clinical supervision and challenges facing nursing and midwifery students.

1.3. Objectives of the study

The objectives of the study have been grouped into general and specific as shown below.

1.3.1. General Objective

The general objective of the study was to assess factors influencing the quality of clinical supervision of nursing and midwifery students at the 37 Military Hospital, Accra.

1.3.2. Specific Objectives

The specific objectives were:

1. To determine the quality of clinical supervision of nursing and midwifery students at the 37 Military hospital.
2. To determine factors influencing quality of clinical supervision from nursing and midwifery students' perspective.
3. To explore clinical and tutor supervisors' perceptions of quality of clinical supervision of nursing and midwifery students.
4. To explore factors influencing quality of clinical supervision from supervisors' perspective.

1.3.3. Research Questions

The specific questions were:

1. What is the quality of clinical supervision of nursing and midwifery students at the 37 Military hospital?
2. What factors influence the quality of clinical supervision from nursing and midwifery students' perspective?
3. How do clinical and tutor supervisors perceive the quality of clinical supervision of nursing and midwifery students?
4. Which factors influence quality of clinical supervision from supervisors' perspective?

1.4. Organization of the Study

The study was organized into six chapters. Chapter one covered the background of the study and statement of the problem. It then progressed to the study's objectives and research questions, after which the justification came. The organization of the study then concludes the chapter.

Chapter two undertakes a review of relevant literature on clinical supervision. It covers items such as a definition and introduction, clinical supervision models, the role of effective supervisors, the role of supervisees and their relationship with their supervisor, challenges encountered by nursing students during clinical practice, challenges encountered by health tutors during clinical supervision, challenges encountered by clinical staff during clinical supervision, clinical placement and preceptorship, and the conceptual framework. Chapter three covers the study's methodology. Some elements covered in the methodology include the study design, study population as well as sample size, sampling techniques and data collection strategies. Data management and analyses, as well as ethical procedures and safety protocols are also covered.

Chapter four presents the findings of the study. The demographic characteristics of respondents is presented first, followed by supervisors' concept of quality clinical supervision, the mode of supervision, factors affecting supervision, and the challenges students face during clinical attachment. Chapter five undertakes a discussion of the study's findings; whilst chapter six presents a summary of the study's findings, conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.0. Introduction

The chapter undertakes a review of relevant literature on clinical supervision. It covers items such as a definition and introduction, clinical supervision models, the role of effective supervisors, the role of supervisees and their relationship with their supervisor, challenges encountered by nursing students during clinical practice, challenges encountered by health tutors during clinical supervision, challenges encountered by clinical staff during clinical supervision, clinical placement and preceptorship, and the conceptual framework.

2.1. Quality of clinical supervision

The concept of quality of care has been applied to different activities in the health care environment (Mosadeghrad, 2012). Mosadeghrad (2012) showed the view that for an individual, quality healthcare may be measured by the pleasantness of the healthcare provider, for another, it may be measured by being able to acquire certain services and medications of their own choice whether it is necessary in the particular health concern or not.

Donabedian (1990) defined healthcare quality as the application of medical science and technology in a manner that maximizes its benefit to health without correspondingly increasing the risk showing three dimensions as; structure, process, and outcome. The outcome is the quality of healthcare. The structure - is the setting in which healthcare is provided and received, especially describing the healthcare provider (whether physician, nurse etc.) and their skills and attributes, the health facility and its characteristics including total number of staff, equipment available and facilities and the organization and funding of

the healthcare system. Donabedian (1990) explains that the process - is the interaction between the patient and healthcare provider whereas the outcome - is the status of the patient after accessing care, which could either be cure, morbidity or mortality.

Studies have examined the effects of clinical supervision on the quality of care: examining the results of team supervision (Hyrkäs, & Paunonen-Ilmonen, 2001). Hyrkäs and Paunonen-Ilmonen (2001) described how the concept of clinical supervision relates to the quality of care and identified 'knowledge, change and 'I and we as providers of quality' (p.492). These researchers concluded that clinical supervision had effects on the quality of care and it could be considered a quality improving intervention in nursing practice. Consequently, Kilminster and Jolly (2000) demonstrated the need for more structured and methodologically sound programmes of research into supervision in practice settings so that detailed models of effective supervision could be developed and thereby inform practice.

2.2. Clinical supervision

A study argues that the knowledge of the different conceptions of clinical supervision gives proof that team supervision is a challenge for supervisors (Hyrkäs, & Paunonen-Ilmonen, 2001). Clinical supervision has been considered as a formal professional process that facilitates the development of knowledge, skills, and accountability, promoting the quality of care and safety of clients (Department of Health, 1993). Clinical supervision has been considered as an interpersonal process where skilled practitioners or supervisors assist less skilled practitioners in their professional growth (Van Ooijen, 2000), and personal development (Darley, 1995). Consequently, clinical supervision can be considered as a practice-focused relationship involving one individual or group of practitioners reflecting on practice and guided by a skilled supervisor (Fowler, 1999; Kohner, 1994; UKCC, 1996).

Supervision is considered an indispensable part of effective healthcare systems (Kadushin 2002), and part of professional training for mental health professionals (Milne et al., 2011; Watkins, 2011). Milne (2009) provides at least three reasons why it is important to have an in-depth understanding of supervision. The first is that effective supervision may lead to the enhancement of professional competencies. Secondly supervision can provide greater support for evidence-based treatment models, and thirdly, effective supervision can lead to a reduction in unnecessary interventions.

Roles of clinical supervisors

Supervisors should focus their attention on reflective training, with the goal of stimulating, challenging and helping supervisees develop and acquire the skills necessary to excel in their professions (Moura & Mesquita, 2010). It is imperative that clinical supervisors possess certain key skills, training, as well as teaching and pedagogical knowledge, and should employ the appropriate strategies and methodologies suitable to the training and development needs of supervisees (Alarcão & Tavares, 2010; Moura & Mesquita, 2010; Sá-Chaves, 2000).

Benefits of Supervision

Supervision has several benefits including improved patient care outcomes (Callahan et al., 2009, Watkins, 2011), as well as acting as a tool for quality assurance (Schoenwald et al., 2009). Clinical supervision is a continuous supportive learning process for clinicians to develop, improve, and keep track of re-mediate professional functioning (Bernard & Goodyear, 2014).

Purpose of Supervision

The main purpose of clinical supervision is to reduce non-purposeful activity and increase intentional acts which enhance clinicians' competencies, improve quality control and promote better patient outcomes (Milne, 2009). Supervision can be provided in various ways including one-on-one supervision, small group supervision, peer-based consultation, and

facilitated team-based consultation. Supervision can also include presentations using case discussion, video review or live presentation/ demonstration (Todd & Storm, 2002).

Fowler (1996) has hinted some of the roles of supervision as being helping supervisees better perform at their jobs and providing informed and enhanced interactions such as professional support, role development, boosting confidence, encouraging intra and inter-personal networking, and providing greater job control and satisfaction with the aim of improving clinical outcomes.

Types of Clinical Supervision

Clinical supervision can occur in quite a number of ways. One such way is when one clinical supervisor oversees one supervisee, and this is generally referred to as individual clinical supervision. Individual clinical supervision is generally considered as the most dominant form of supervision in nursing (Duarri & Kendrick, 1999). Other forms of supervision discussed in the literature include the group and triad forms of supervision (Price & Chalker, 2000; Sloan et al., 2000). In the group supervision model, a clinical supervisor takes charge of a number of supervisees ranging between four and six. This appears to be the preferred model of supervision in Scandinavian countries (Arvidsson et al., 2001). In the triad format, a supervisor normally supervises two supervisees (Sloan et al., 2000).

Other types of supervision described are process orientated supervision (which involves pre-orientation of nursing and midwifery students on learning outcomes and practice process (Brunero, 2008), clinical nursing supervision (which ensures the supervision of students on the practical experience of clinical practice) (Bos et al., 2015), and psychotherapeutic supervision (which involves the emotional and psychological guidance of students throughout the clinical supervision process (Keefe et al., 2014).

2.3. Clinical Supervision Models

Quite a number of models exist for clinical supervision. One such model is Proctor's three-function model.

2.3.1. Proctor's Three-Function Model

This model was developed by Proctor (1987). As Proctor (1987) indicated, both [supervisor and supervisee] carry some degree of responsibility for the development of the student or worker (the formative task). Both carry some share of the responsibility for the ongoing monitoring and evaluating of the student or worker and at certain times – at the end of the course or the point of promotion, for instance – either may carry responsibility for assessment (the normative task). Each carries a share of the responsibility for ensuring that the student or worker is adequately refreshed and re-creative (the restorative functions).

Within nursing supervision, the formative function pertains to skills development and enhancing supervisees' knowledge. The normative aspect concerns itself with managerial issues covering matters such as the maintenance of professional standards (Cutcliffe & Proctor, 1998), while the restorative function is concerned with providing support in fighting the stressors associated with the nursing profession (Jones, 1996). This model has been employed in a number of nursing contexts such as mental health nursing (Cottrell, 2001), practice nursing (Styles and Gibson, 1999), occupational health nursing (Bainbridge et al., 2001), as well as medical and surgical nursing (Bowles & Young, 1999).

2.3.2. Heron's Intervention Analysis Framework

Heron's (1989) six-category intervention analysis framework has led researchers to develop a model for clinical supervision (Johns & Butcher, 1993; Chambers & Long, 1995; Fowler, 1996; Cutcliffe & Epling, 1997; Driscoll, 2000). Heron's framework was initially developed to aid in understanding interpersonal relations in delivering interventions within a helping

context. Chambers (1990) has indicated that since 1975, Heron's framework has been instrumental in aiding mental health nurses to enhance their interaction with patients.

Heron (1989) noted that an interpersonal relationship develops between practitioners and their clients. A practitioner refers to anyone providing professional services to clients. The client is the person who chooses to patronize the services provided by the practitioner in meeting his peculiar needs. The six categories of Heron's intervention analysis framework are prescriptive, informative, confronting, cathartic, catalytic and supportive. Authoritative interventions cover the type of interactions which allow the practitioner some form of control over the relationship. It includes the prescriptive, informative and confronting categories. Facilitative interventions pertain to those which allow the center of control to remain with the client; and include the cathartic, catalytic and supportive categories. Authoritative interventions cannot be said to be more, or less important, than facilitative ones. Instead, the importance of an intervention is determined by the practitioner's role, the client's peculiar needs, and the content or focus of the intervention.

Prescriptive interventions include actions such as providing advice and offering suggestions, as well as directing the behavior of clients. Being informative concerns offering information or instruction, while being confronting covers challenging people's behavior, attitudes or beliefs. Cathartic interventions include activities which allow for the release of strong emotions and tension such as grief, fear and anger. Catalytic interventions include encouraging people to engage in further self-exploration, self-directed living, learning and problem solving. To be supportive encompasses validating or confirming the worth and value of clients' personal qualities, attitudes or actions (Heron, 1990).

2.3.3. Cognitive Therapy Supervision

Supervision provided under the cognitive therapy model is similar to the actual therapy process as it seeks to be focused, structured, educational and collaborative. It is also generally accepted that the supervisor-supervisee activity is influenced by factors such as the core beliefs of the parties, their fundamental assumptions, and automatic thoughts. Supervision sessions are organized along similar lines as those of cognitive therapy sessions; and include strategies such as being structured by an agenda with the goal of making linkages across sessions, summarizing previous session content, and reviewing prior learning from previous sessions.

Clinical supervisors aim to assist supervisees apply cognitive therapy to the highest standards possible, develop their assessment, conceptualization and treatment skills (Paolo, 1998), in addition to exploring their own reactions to the therapeutic process (Feasey, 2002). The agenda for a supervision session could include personal updates, agenda setting, linking to previous sessions, reviewing previously supervised cases, checking on homework assignments, discussing agenda items, giving new homework, summary from clinical supervisors, and feedback from supervisees (Liese and Beck, 1997).

Padesky (1996) highlights the differences between supervision modes and the focus of supervision. A supervision mode refers to the methods in which supervisee learn and discover knowledge for themselves. Examples of these include case discussions, role play, observing clinical supervisors and learning from relevant literature. Supervision focus on the other hand pertains to the mastery of new skills, conceptualizing clinical problems or gaining a better understanding of the client-therapist relationship. Sometimes during the supervisory process, a supervisor may discern that a supervisee holds certain assumptions about clients, the therapy process, or the supervisor himself, which affects how the supervisee applies cognitive

therapy or compromises his/her self-care or influences the therapeutic change process in a negative way. Since cognitive therapy supervision is a collaborative process (Safran and Segal, 1996), supervisors must negotiate with supervisees for their peculiar observations to be placed on the agenda.

2.3.4. Other Supervision Models in Nursing

Nicklin (1997) talks about the Practice-Centered Supervision Model which classifies clinical supervision into Managerial, Educational and Supportive categorizations. In this model, Nicklin presents the nursing process in a supervision cycle consisting of practice analysis, problem identification, objective setting, planning, implementation/action and evaluation. Nicklin (1997) also incorporates counseling skills into his model, thus hitting on the importance of the interpersonal angle to supervision.

Rogers and Topping-Morris (1997) came up with the Problem-Focused model for clinical supervision. They indicate that with this model, clinical supervisors can focus on addressing the clinical problems supervisees find most challenging. They also suggest that the model can be used in solving problems occurring within the supervisory relationship, as well as improving ineffective care plans, enhancing supervisees' comprehension of clinical issues they have no experience with.

Problem-oriented clinical supervision is therefore a collaborative process which allows for the adoption of problem-solving strategies in providing a better understanding of clinical problems identified by supervisees and providing solutions to these problems. In recent times, a solution-focused clinical supervision model has been developed by Driscoll (2000). This model allows both clinical supervisors and supervisees to find proactive solutions to problems instead of focusing on the causes of the problems.

2.4. The Role of Effective Supervisors

Supervisors are supposed to perform certain functions in the supervisory process. The traditional function of supervisors was ensuring that work was done according to standard (Fowler, 1996). Hawkins and Shohet (1989) and Proctor (1988) indicate that supervisors have three tasks. The first is the administration or normative task, which covers the managerial aspect of the supervisor's role, and concerns on-going monitoring and quality (Berger & Bushholz, 1993; Carroll, 1996). The education or formative task encompasses the process of skill development and the capacity to think back on past experiences. Finally, the support or restorative task encompasses the helping function provided by supervisors.

Hawkins and Shohet (1989) indicate that supervision can constitute an integral component of caring for oneself and promoting reflection. Researchers have pointed to supervision as being important in staying open as well as being committed to learning (Berger & Bushholz, 1993; Carroll, 1996; Department of Health, 1993; Fowler, 1999). Other researchers also hint at supervision as being important in maintaining self-awareness (Ekstein & Wallenstein, 1972; Rogers, 1957). This implies that supervisors need to be teachers and innovators (Goldhammer et al., 1980; Van Ooijen, 2000).

Ekstein and Wallenstein (1972) identify some of the approach supervisors can employ in their role as including openness to feelings, experiences and reward, which encourage supervisees and recognize their efforts. With time, supervisors should become more capable in their role more skilled at providing support to other practitioners (Berger & Bushholz, 1993; Page & Wosket, 1994). Carroll (1996) also mentions some of the generic tasks of counselling supervision as including consulting, evaluating (Pierce, 2004; Van Ooijen, 2000) and monitoring professional or ethical issues as well as emotional awareness and self-evaluation. Holloway (1995) suggests other tasks as including instructing, advising and

sharing. Supervisors should also be skilled in record-keeping (Neufeldt, 2004), procedures and relevant inter-professional relationships and fully participate in the supervisory relationship (Carroll, 1996).

Butterworth and Faugier (1992) indicate that supervisors need to be trained in the art of supervision as an important part of their professional development. Rogers (1997) argues that a clinical supervisor should be a role model. Page and Wosket (1994) stated that a clinical supervisor should establish a safe confidential environment for student trainees. Fowler (1999) also said a clinical supervisor must provide clear feedback and be aware of organizational and personal constraints. Furthermore, some of the skills required by supervisors as suggested by Holloway (1995), include (1) communication skills (2) supportive skills (3) general skills; and (4) specialist skills. Effective supervisors are also respectful and honest (Carroll, 1996); empathic, non-sexist and non-authoritarian (Holloway, 1995) and genuine (Page & Wosket, 1994).

Effective supervisors should also direct their attention to client welfare (Fowler, 1999). Carroll (1996) identifies a good supervisor as being a good teacher, who employs innovative teaching and learning methods and can adapt to the needs of individual supervisees. Similarly, Berger and Bushholz (1993) indicate that teachers should have a flexible working relationship with supervisees, flexibly switching between the roles of teacher, monitor, evaluator, model, mentor and counselor.

2.5. The Role of Supervisees and their Relationship with their Supervisor

Before supervision begins, there is the need for discussions between supervisors and supervisees regarding expectations, as the lack of such a discussion could lead to frustration for both parties (Holloway, 1995; Van Ooijen, 2000). Van Ooijen (2000) further indicates that preparation is essential, and that supervisees should be clear regarding what they want

from the supervision activity. Anderson and Swim (1995) and White (1990) said that during therapy sessions, supervisees need to tell their stories in ways which make it easy thinking about their problems and finding solutions to them.

Supervisees should develop and maintain trust, as well as managing ethical and legal issues associated with the supervisory process (Neufeldt, 2004). They should be prepared for all sessions with the necessary documents, tapes, and case or process recordings. Supervisees should adopt the attitude of adult learners and be willing to read and review any material provided by the supervisors. Furthermore, they are responsible for learning about practice settings and reporting for all supervision appointments on time (Pierce, 2004).

There should be a general agreement between supervisors and supervisees regarding the content of the supervision, and Swain (1995) suggests that this agreement should cover (1) what should be covered and not covered in the session, (2) the means for setting the agenda, with the understanding that supervisee will initiate other matters that need to be included. Length of supervision varies as well, and the allocated time for the supervision could be utilized based on factors such as the volume of work, experience of supervisees, and the work setting (UKPPG, 2004). At least fifty minutes is considered optimum for individual supervision, while UKPPG proposes a minimum of forty-five minutes and a maximum of one and a half hours. The time in-between supervisions should not be more than eight weeks; and the record of all sessions should be kept, reviewed and evaluated at subsequent sessions (UKPPG, 2004).

Wright (1992) indicates that clinical supervision should see supervisors and supervisees brainstorming on occurrences and why they occurred, how they were handled, and how they could have been handled better, or differently. The supervisory relationship serves as the basis for analyzing other relationships and is a medium through which learning occurs

(Brown & Bourne, 1996). Swain (1995) considers supervision within the systems approach to be a dynamic process, with Simms (1993) indicating that supervisors and supervisees negotiate regarding power structures within that dynamic process.

Holloway (1995) talks of three essential elements, namely (1) the interpersonal structure of the relationship which covers dynamics such as power and involvement; (2) phases of the relationship which encompass relational development peculiar to the participant; and (3) a supervisory contract which covers expectations for the tasks and functions of supervision. Furlong and Maynard (1995) also propose three other important phases of the relationship, which they term as the beginning phase, the mature phase and the terminating phase.

2.6. Student factors (socio-demographic characteristics of nursing/midwifery students) and clinical practice

Kilminster and Jolly (2000) suggest that the supervision relationship is probably the single most important factor for the effectiveness of supervision, more important than the supervisory methods used - feedback is essential and must be clear. These researchers argue that it is important that the trainee has some control over and input into the supervisory process. On the issue of time, these analysts found that finding sufficient time for supervision could be a problem noting that trainee behaviours and attitudes towards supervision require more investigation - some behaviour are detrimental both to patient care and learning. The student factors considered in this study included their socio-demographic characteristics: age, sex, educational status, religion, ethnicity, among others.

Less than a decade ago, helping students learn to care for patients at the clinical level was part of the role of the sister/in-charge nurse at the clinic (Smith & Gray, 2001). Recently, even though changes has been made on who teaches student nurses/midwives on clinical practice, the trend and content remains similar but gradually evolving (Papastavrou et al.,

2016). The evolving process of nursing/midwifery and clinical education requires that both students and teachers continuously update themselves (Samarakoon et al., 2013).

However, in this environment, recruitment and retention of skilled nursing and midwifery staff to meet growing needs has become difficult (Annear et al., 2014), considering that several challenges exist to the success of nursing and midwifery education and clinical practice among nursing/midwifery students (Nelson et al., 2010). For instance, a major evaluation report from experts identified problems similar to those reported in other countries, like linking theory to practice (Bukaliya, 2012), poor acquisition of skills and problems in the supervision of clinical practice (Papastavrou et al., 2010).

Additionally, the decrease in the number of hospital beds, especially in developing countries in parallel with the increase in the number of nursing/midwifery students has created a challenge in terms of providing the best possible learning facilities under given conditions in hospitals (Helgesen et al., 2016).

In addition, clinical education and the clinical area can be stressful for students and negatively affect their emotions (Bam et al., 2014). In one study, it was perceived that negative clinical experiences affect students' self-confidence and readiness to practice (Allari & Farag, 2017). Similarly, previous studies in Taiwan reported that perceptions of satisfaction and stress from clinical experiences were the main influences on the nursing/midwifery students to choose nursing and midwifery as their career (Tseng et al., 2013).

Apart from that, majority of nursing/midwifery students on clinical placement are not provided with decent accommodation and are required to acquire their own accommodation (Faronbi et al, 2017). Meanwhile, data available show that challenges with place of stay are direct determinants of nursing/midwifery students ability to gainfully acquire clinical skills

for practice (Allari & Farag, 2017). Again, while most students on internship are expected to learn from clinical based doctors, students complain about the lack of time of the ward doctors available for supervision and even about being rather exploited for non-medical activities (Celebi et al., 2012). Most student nurses/midwives in Ghana are educated in training colleges, which are often, but not necessarily, affiliated to teaching hospitals (Bell et al., 2013).

2.7. Clinical staff and health tutor supervisors' perception of clinical supervision

The importance of academically preparing students for their clinical practice including the ability to integrate theory into a clinical setting and to secure time for reflection, to promote learning and confidence, has been highlighted in several studies (Helgesen et al., 2016; Oulton, 2005; Kaffenberger & Mason, 2007). This is because the quality of nursing and midwifery services is highly dependent on the preparedness of nursing/midwifery students (Faronbi et al., 2017).

Clinical supervision is an important component of the preparation process that enables student nurses/midwives to discuss patient care in a safe, supportive environment (Brunero, 2008). However clinical learning takes place in the complex social context of the clinical environment that is defined in several ways (Papastavrou et al., 2010), including periodic tutor visits and supervision of students on clinical placement (Carlson & Bengtsson, 2015).

Though nursing and midwifery tutorship and supervision are considered relevant to nursing and midwifery education (Kaffenberger & Mason, 2007), some studies suggest that this exercise is not without challenges to nursing and midwifery tutors whose responsibility it is to visit and supervise students on clinical placement (Smith & Gray, 2001). In fact, preliminary data indicate that major challenges facing tutor-student clinical supervision include limited logistics (Ajani & Moez, 2011), means and cost of traveling (Samarakoon et

al., 2013) and low tutor to student ratio (Bengtsson & Carlson, 2015). The shortage of supportive and prepared skilled faculty members in clinical training, is currently an issue locally and globally (Allari & Farag, 2017).

Studies conducted by Mwale and Kalawa (2016) put the challenges of tutors ability to supervise clinically placed nursing and midwifery students more clearly. In it, they argued that the acquisition of practical knowledge and competence from clinical placement is hugely determined by the availability of tutors to assess the quality of training at the clinic setting. Similarly, studies conducted in both Malawi indicate challenges including lack of cooperation from clinical staff and limited government support on clinical placement of students (Mwale & Kalawa, 2016; Samarakoon et al., 2013).

In other settings, educators/tutors name workload as the most important reason for inadequacies in teaching and disorganized surface supervision of students on internship (Celebi et al., 2012). Therefore, the nursing and midwifery education sector has had to rethink the knowledge and skills it provides and how it teaches patient interaction to its students (Helgesen et al., 2016). This is particularly important because effective evaluation of clinical practice provides insight for the development of effective teaching strategies to enhance the integration of theory-practice (Sharif & Masoumi, 2005).

Clinical education is important in terms of having students acquire actual experience on patients and practice the skills they have learnt (Caliskan, Ozturk, Baykara, Korkut, & Karadag, 2012). Fifty percent of nursing and midwifery education in different countries consists of clinical practice where the students are under the supervision of registered nurses and midwives (Helgesen et al., 2016). The mentoring role of staff nurses and midwives has become increasingly central to these clinical supervision processes (de Swardt et al., 2017).

As such they make a significant contribution to educational process within practice settings, including coordinating student assessments and learning (Warne et al., 2010). Registered student nurses/midwives assuming the role of clinical preceptors for nursing/midwifery students is common in nursing and midwifery literature (Au, Lo, Cheong, Wang, & Van, 2016; Landeen et al., 2016; Papastavrou et al., 2016). The clinical preceptor role entails guiding and supervising nursing/midwifery students to implement the theory of nursing and midwifery in real practice in the clinical setting (Annear et al., 2014). Additionally, the preceptors also function as role models, teaching practical nursing and midwifery skills as well as critical and reflective thinking (Escartín *et al.*, 2015).

Clinical supervision provides the opportunity for nursing/midwifery students to experience the realities of patient care (Mwale & Kalawa, 2016). It offers nursing/midwifery students the opportunity to directly implement content learnt in classroom to practice (Bengtsson & Carlson, 2015). More specifically, clinical practice facilitates the development of nursing/midwifery students' professional identity through the establishment of effective interpersonal relationships different patients and conditions (Nelson *et al.*, 2010).

This notwithstanding, clinical staff and clinical based supervisors of nursing/midwifery students are faced with several challenges (Farsi et al., 2010). Supervision challenges among clinical staff are known in literature to be influenced by new challenges and demands in health care such as population ageing (Allari & Farag, 2017), technology growth, increased level of patient knowledge (Asirifi *et al.*, 2017), and evidence based practice in nursing and midwifery (Löfmark & Mamhidir, 2010). For example, the ability of clinical staff preparation include the clinical learning environment, clinical educator competence and technical skills of nursing and midwifery staff with regards to using emerging technologies (Bam *et al.*, 2014). In addition, changing disease and illness patterns, new and sophisticated medical

technologies and an ever widening range of health care settings are also cited in literature as challenges for clinical based supervisors (Andrews *et al.*, 2005).

2.8. Clinical placement and preceptorship

The concept of preceptorship refers to a short-term relationship between a nursing or midwifery student on clinical placement and an experienced nurse (Asirifi *et al.*, 2017). Broadly, clinical preceptorship is considered in two categories, including formative preceptorship and summative preceptorship (Atakro & Gross, 2016). While formative preceptorship involves preceptors, faculty, and students working together in establishing clear objectives, implementation procedures, and evaluation measures in the preceptorship teaching experience (Allari & Farag, 2017), evaluative preceptorship involves collaboratively evaluating the clinical experience of both students, clinical supervisors and faculty during and after clinical practice of nursing and midwifery students (Haugland *et al.*, 2018). Formative preceptorship can also be considered as defining the respective roles of the supervisor and supervisee, joint goal-setting, observation of the supervisee, and evaluation process (Milne, 2007).

Ghana has adopted the preceptorship model of supervision of student nurses/midwives at the clinical area. However, this concept is not without challenges (Atakro & Gross, 2016). Challenges of preceptorship model of practical supervision include the fact that preceptors limit clinical practice to only the acquisition of clinical skills (Escartín *et al.*, 2015). The same findings were revealed in other studies which establish preceptors' experiences of a theory-practice gap, and the challenges of bridging the gap (Elbaş *et al.*, 2010). Notwithstanding, some researchers postulated that the ability of preceptorship to improve communication and clinical skills, and effectively socialise nursing and midwifery students to the professional role makes it a success (Nabolsi *et al.*, 2012).

Despite the fact that clinical preceptorship is gaining recognition as a sustainable way to integrate theory into practice (Pichlhöfer et al., 2013), it is yet to be adopted by most countries as a mandatory requirement for the training of nurses and midwives (Escartín et al., 2015). Meanwhile, clinical preceptorship during clinical placement is known to improve knowledge acquisition among nursing/midwifery students (Kyei et al., 2015).

2.9. Conceptual Framework on Quality of Clinical Supervision

Figure 2.1 below depicts the conceptual framework of the study developed based on different concepts based on literature (Donabedian, 1990; Price & Chalker, 2000; Sloan *et al.*, 2000). For the quantitative study, the conceptual framework was developed based on a modified form of the Donabedian's (1990) model of quality of care. The original framework was for quality of care but has been modified to reflect quality of supervision. The researcher considered this suitable as quality of clinical supervision ultimately leads to quality of care.

The framework shows that the interaction between the structure and process factors would lead to the outcome factor, which in this study was quality of clinical supervision. This means that the students' assessment of the quality of clinical supervision (as the outcome) will manifest at the process level, where there is the interaction between the clinical and tutor supervisors and the students. This will also be associated with the availability of the variables in the structure level and the students' own factors (socio-demographic characteristics).

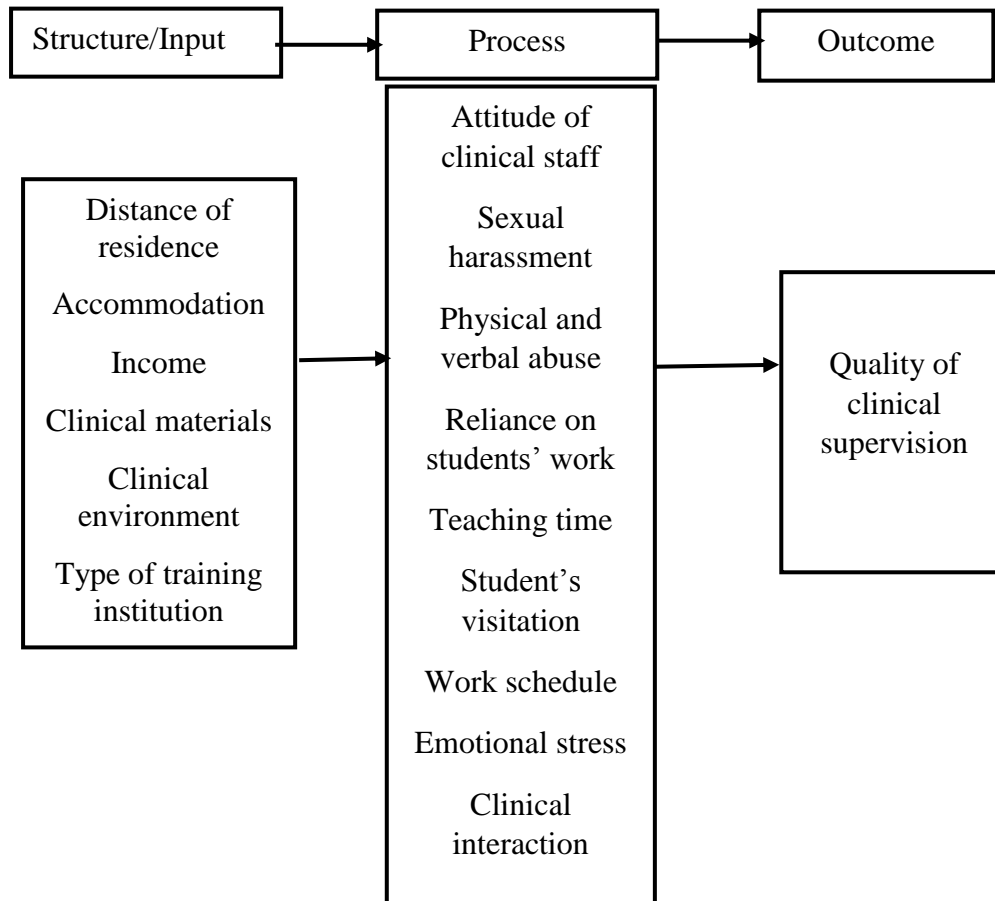


Figure 2.1: Conceptual Framework on Quality of Clinical Supervision (modified from Donabedian's (1990) model of quality of care).

2.10. Summary of the Chapter

The chapter has presented an evaluation of existing literature on the concepts related to the field of study. Based on the literature, the conceptual framework was also developed and presented. The next chapter presents the methods that were applied to collect data for analysis.

CHAPTER THREE

METHODS

3.0. Introduction

This chapter provides a detail description of the dissertation methodology of this study. The issues discussed include the dissertation design, study area, study variables, study population, sample size, sampling procedure, data collection techniques and tools, quality control, pre-data collection stage, data processing and analysis, statistical methods, ethical considerations, descriptions of subjects, potential risks and benefits to participants and data usage and storage.

3.2. Study design

This study applied a cross-sectional design in the selection study. It was aimed at exploring and describing tutor supervisors, clinical supervisors and student's nurses'/midwives challenges regarding clinical supervision. The research designs utilized a mix method approach that is, both quantitative and qualitative methods to explore the factors influencing the quality of clinical supervision. A mixed method is advantageous over a single method because it gives a broader understanding of the dissertation question and makes up for the short comings of using a single method of study. Another advantage of the mixed method is the possibility of triangulation, that is, the use of several means (methods and data sources) to examine the same phenomenon.

The study used the qualitative method to assess challenges among clinical and tutor supervisors during clinical supervision. It involved Key Informant Interviews (KII) using an interview guide, with 5 selected clinicians from the 37 Military hospital and 8 tutors from selected Nursing and Midwifery Training Colleges whose students had their clinical attachment at the 37 Military hospital. The quantitative method assessed the challenges of

200 nursing and midwifery students using structured questionnaires that were administered to the nursing and midwifery students who had their clinical attachment at the 37 Military hospital.

3.3. Study setting

The study was carried out in the 37 Military Hospital located in the Greater Accra region of Ghana. The 37 Military Hospital is a specialist hospital located on the main road between Kotoka International Airport and Central Accra and receives several referral cases from other hospitals across the country. It is the largest military hospital in the Republic of Ghana (Addae, 2004). The name of the hospital is mostly used to refer to the community in which it resides. The name 37 was because it was the 37th military hospital to be built in the British colony of West Africa. The hospital was originally established in 1941 by a British military officer, General Giffard and is currently under the supervision of the Ministry of Defence.

The hospital has five main departments namely Medical, Surgical, Paediatric, Obstetrics & Gynaecology and Public health. It also has 15 wards under these departments with names like Opoku ward, Easmon ward, Tamakloe ward, Yaa Asantewaa ward, Anoff ward, Simango ward and Nkrumah ward among others. The hospital runs a 24-hour accident and emergency services and thus has 4 emergency units which are; Trauma and surgical unit, Medical emergency unit, Gynaecology emergency unit, and Paediatric emergency unit. The 15 wards have a bed capacity of 533 whiles the emergency units have a bed capacity of 94. The hospital also has a Public health unit, ultramodern laboratory and diagnostic units. The hospital also offers Outpatient Department (OPD) services. Specialist services rendered include; Urology, Neurology, Obstetrics & Gynaecology, Dermatology, Radiology, Dental, Ophthalmic and Ear, Nose and Throat (ENT) services.

Overall, there are 442 nurses and midwives of civilian and military rankings, 18 are District Directors of Nursing Services (DDNS), 47 and 18 are Principal Nursing Officers (PNO) and Principal Midwifery Officers (PMO) respectively, 113 are Senior Nursing Officers (SNO) and 88 are Nursing Officers (NO).

A total of 35 public nursing training institutions and 17 mission and private nursing training institutions rely on the 37 Military hospital for clinical training of their nursing and midwifery students. In the first quarter of 2018, 831 nursing and midwifery students were on clinical attachment at the 37 Military hospital and 400 were on attachment in the second quarter (37 Military Hospital, 2017).

3.4. Study population

There were three (3) target populations in this study. These were the clinical supervisors who supervised nursing and midwifery students on attachment in the various departments of the 37 Military hospital, tutor supervisors who sent their nursing and midwifery students to the 37 Military hospital for clinical attachment and followed up to supervise them and all student nurses and midwives who were on attachment at the 37 Military hospital from the period of April to June 2018.

3.5 Inclusion criteria

The criteria used to select the participants into the study included:

All Student nurses and midwives in training in any of the four diploma programmes (RGN, RMN, RCN, RM) who were at the 37 Military hospital for attachment in the second quarter of the year and were from NMTC 37 Military, NMTC Koforidua, NMTC Tamale, NMTC SDA Kwadaso, NTC HO, NMTC Sunyani, SON Legon and CCHN Winneba.

Tutor supervisors from NMTC 37 Military, NMTC Koforidua, NMTC Tamale, NMTC SDA Kwadaso, NTC HO, NMTC Sunyani, SON Legon and CCHN Winneba who have carried or are currently carrying out clinical supervision at the 37 Military hospital.

District Director of Nursing Services, Principal Nursing and Midwifery Officers, Senior Nursing and Midwifery Officers and Nursing and Midwifery Officers who are clinical staff of 37 Military hospital and have previously supervised or are currently supervising nursing/midwifery students on clinical attachment.

3.5.1 Exclusion criteria

The criteria used to exclude participants from the study included:

All Student nurses and midwives in training in any of the four diploma programmes (RGN, RMN, RCN, RM) who were at the 37 Military hospital for attachment in the second quarter of the year and were from NMTC 37 Military, NMTC Koforidua, NMTC Tamale, NMTC SDA Kwadaso, NTC HO, NMTC Sunyani, SON Legon and CCHN Winneba but did not consent to participate in the study or were not feeling well at the time of the data collection so could not participate in the study.

Clinical supervisors from the 37 military hospital and tutor supervisors from NMTC 37 Military, NMTC Koforidua, NMTC Tamale, NMTC SDA Kwadaso, NTC HO, NMTC Sunyani, SON Legon and CCHN Winneba who are currently or have previously supervised nursing and midwifery students at the hospital but did not consent to participate in the study.

3.6 Sample size calculation

The study used Yamane' formula for finite population in calculating the sample size. If the population size is known, under the Yamane equation, there is no need for mean and standard deviation. The Yamane approach is given by:

$$n_Y = N/(1+Ne^2),$$

Where,

N=population size, and

e = alpha level, thus e = 0.05 if the confidence interval is 95%.

Calculation was as follows:

$$n_Y = \frac{400}{1+400(0.05^2)}$$

$$n_Y = 200$$

ny=minimum required sample size = 200

From the formula therefore, two hundred (200) students were sampled for the quantitative aspect from eight selected Nursing and Midwifery Training Institutions.

3.7. Sampling methods

Appropriate sampling methods were applied to select the research participants for both the quantitative and qualitative studies. These have been explained below.

3.7.1. Quantitative Sampling Method

A simple random sampling technique was adopted to sample the student nurse and midwife participants for the study. Firstly, eight (8) Nursing and Midwifery training institutions which had their students doing clinical attachment at the 37 military hospital were selected using simple random sampling technique out of the twenty-nine (29) institutions provided by the In-service coordinating unit of the hospital for the second quarter of the year. The eight institutions were selected because it gave a sufficient sample size needed to achieve the study objective within the timeframe. These institutions were: NMTC 37 Military, NMTC Koforidua, NMTC Tamale, NMTC SDA Kwadaso, NTC HO, NMTC Sunyani, SON Legon and CCHN Winneba.

In order to ensure representativeness, the study participants from each of the eight health training institutions were sampled according to the proportion of the students represented at

the 37 military during the second quarter of the year. That is, institutions with higher number of students who did their attachment at the hospital had more samples selected and those with lower numbers had fewer samples selected. In all, 60 participants were selected from NMTC 37 Military, 20 participants each from NMTC Koforidua, NMTC Tamale and CCHN Winneba, 18 participants from NMTC SDA Kwadaso, 9 participants from NTC HO, 8 participants from NMTC Sunyani and 45 participants from SON Legon.

In the 8 institutions, the list of student nurses and midwives who did their clinical attachment during the second quarter of the year at the 37 Military hospital was acquired and used as a sampling frame. Numbers were assigned to the individuals on the list. Excel was used to generate random numbers based on the numbers presented. Any number which was selected, the corresponding name was contacted. However, any student who refused to consent was replaced with similar procedure.

3.7.2. Qualitative Method

Purposive sampling technique was used to select 5 clinical supervisors from the 5 departments of the 37 Military hospital namely; Medical, Surgical, Obstetrics and Gynaecology, Paediatric and Public health. Using purposive sampling technique 8 tutor supervisors were also selected from the 8 Nursing and Midwifery Training Institutions that were previously selected randomly. The purpose was to find out how the tutor supervisors were able to supervise their own students on clinical attachment.

3.8. Study Variables

The variables measured in the quantitative study were grouped into dependent and independent as shown below.

3.8.1. Dependent variable

The outcome variable for this study was quality of clinical supervision of nursing and midwifery students. Quality denotes how clinical supervision is free from defects, deficiencies and significant variations.

3.8.2. Independent variables

The independent variables were the student (socio-demographic characteristics) factors, structure and process factors as shown below.

Student (socio-demographic characteristics) factors: Age, sex, educational status, religion, ethnicity.

Structure factors: distance of residence for students, accommodation, income, clinical materials, clinical environment and type of training institution.

Process factors: attitude of clinical staff, issues of sexual harassment, physical and verbal abuse, reliance on students' work, teaching time, visitation of students during clinical attachment by tutors, work schedule of students and emotional stress of students.

3.9. Data Collection Methods

Data collection for the study commenced in July 2017 and ended in August 2017. This took place within a duration of four (4) weeks after receiving ethical clearance from the 37 Military Hospital's Institutional Review Board (37 MH-IRB). How the quantitative and qualitative data were gathered have been explained below.

3.9.1. Quantitative Method

A structured questionnaire was designed and administered to a total of 200 nursing and midwifery students who were on clinical attachment at the 37 Military Hospital in the quantitative study. The questionnaire was divided into sections. Section A captured

information on the student (socio-demographic characteristics) factors such as age, gender, religion, educational status, marital status, religion, ethnicity, among others. Section B collected data relating to structure factors such as distance of residence for students, accommodation, income, clinical materials, clinical environment and type of training institution. Section C collected data on the process factors, including attitude of clinical staff, issues of sexual harassment, physical and verbal abuse, reliance on students' work, teaching time, visitation of students during clinical attachment by tutors, work schedule of students and emotional stress of students.

The questionnaires were administered by the researcher and research assistant using the interviewer-administered approach after the purpose of the study had been explained to the participants and a written informed consent had been sought. The questionnaire had close-ended items for participants to either a yes or a no and another section for rating the level of interaction with supervisors by ticking high, moderate or low. There was one open ended question which allowed participants to express their opinion. Each questionnaire was administered within a duration of 50 minutes at a designated location which was convenient for the participants within normal working hours.

3.9.2. Qualitative Method

In all, thirteen (13) Key Informant Interviews were conducted during the qualitative study. The participants were 5 clinical supervisors and 8 tutor supervisors. Each of the five (5) clinical supervisors was drawn from the Medical, Surgical, Paediatric, Public health and Obstetric and Gynaecological departments of the 37 Military Hospital. On the other hand, the eight (8) tutor supervisors were selected correspondingly from the 8 randomly selected Nursing and Midwifery Training Institutions. The criteria for selecting them were based on

their ability to give expertise information on nursing and midwifery practical training and on factors influencing the quality of clinical supervision.

A Key Informant Interview (KII) guide was used to conduct interviews for 5 clinical supervisors and 8 tutor supervisors using a face-to-face interview. The interviews with participants lasted for about 30 minutes in most cases. The interviews were held at locations convenient to the participants and were recorded with a voice recorder. A note book with a pen was used to write certain aspect of the interview that could not be captured on the recorder like body and hand gestures. The tutor and clinical supervisors were interviewed in-depth because they were identified as key persons in Nursing and Midwifery training and experts on the issues of clinical supervision of student nurses and midwives.

3.10. Data Processing and Analysis

Suitable analytical strategies were adopted to analyse both the quantitative and qualitative data. These have been explained below.

3.10.1. Quantitative Data Analysis

The information provided by the participants for each of the questionnaires was coded and keyed into Microsoft excels for data management and later imported into Stata version 15.0 for analysis. Data was transferred to Stata 15.0 (Stata Corp, College Station, Texas, USA) for cleaning, merging and analysis. Cleaning of the data was done by running frequencies of the variables. This checked inconsistently coded data. Inconsistently coded data were double checked with raw data. The distribution of each variable was examined to gain understanding of the characteristics of the study population. To recode any variable, commands such as “tab” followed by variable name were done in Stata to understand the nature (the codes assigned to each sublevel) of the various variables. Descriptive analysis was run to determine

proportions for categorical variables, e.g. sex. Graphs and tables were used where necessary to present the report to allow for easy understanding.

To determine the association between dependent (quality of clinical supervision) and independent variables, firstly bivariate analysis between each of the independent variables and the dependent variable of interest were conducted using Chi square. This was followed by a multivariate analysis to assess the strength of the association. The multivariate analysis was based on ordinal logistic regression models (since the outcome variable, quality of care is an ordered variable: high, moderate, low) to control for potential confounding effects of the independent variables. A confidence interval of 95% was used to show significant relations between the dependent and the independent variables.

3.10.2. Qualitative Data Analysis

Content analysis was applied to theoretically analyse the qualitative data (Mayring, 2004). Mayring (2004) explains that the goal of content analysis is the systematic examination of communicative material. The Key Informant Interviews (KII), which were recorded using a phone and a voice recorder with the permission of the participants were transcribed verbatim after the recordings were coded and played many times to ensure that spoken words were captured as they should, especially with the nursing and midwifery terminologies. Transcription was done in Microsoft word and read through several times to ensure no important data was left out. Additionally, the recorded interviews and field notes were used to verify the transcription. Four major themes were identified, and sub-themes were derived from these major themes. Codes were used to identify the interviewees wherever they are quoted. CS means clinical supervisor. TS means tutor supervisor.

3.11. Quality control

The study was conducted in accordance with the procedure specified in the proposal approved by the 37 Military Hospital Institutional Review Board (37 MH-IRB), which required that all ethical issues including privacy, anonymity and confidentiality of respondents were addressed. The training of field assistants covered the following key areas; objectives and importance of the study, probing techniques, data collection procedures, and filling of questionnaires. Demonstration and role playing were also used throughout the training. The researcher together with two field assistants collected the data. An average of 30 minutes was spent interviewing each participant in both the quantitative and qualitative studies.

3.12. Pretesting of Instruments

The questionnaire was pretested at the Korle-Bu Teaching Hospital located in Accra because it has similar characteristics as the 37 Military Hospital. The pretesting sought to assess the flow of questions, presence of sensitive questions and appropriateness of categorization of variables.

3.13. Ethical considerations

The dignity, rights, safety and well-being of participants must be the primary consideration in any dissertation (Davies, 2005). Ethical considerations included securing ethical clearance, consenting processes, risks/benefits of the study and issues of anonymity, privacy and confidentiality. These have been explained below.

Ethical clearance

Ethical clearance was obtained from 37 Military Hospital Institutional Review Board (37 MH-IRB) on dissertation on human subjects.

Consent form

Permission was sought from the participants before they participated in the study. Participants were told the purpose of the study and who their researchers were. Information on risk, benefits, anonymity, privacy and confidentiality were explained to enable them to make informed decisions as to whether or not to participate. Participants who agree to participate were made to sign the consent form which captured the explanation above (see appendix A for the participants' consent form).

Privacy

The privacy of the participants was ensured throughout the study. Research assistants were trained adequately on data collection and given instruction to go according to the questions on the questionnaire to avoid intrusion into participants' privacy. In the analysis and report writing, the data was reported in the aggregate and no one was able to trace the information back to the respondents.

Right to refuse

Participation in this study was voluntary. Participants were not under any obligation to respond to questions or participate in the study if they did not want to. Participants were made to understand; they were at liberty to withdraw from the study at any point in time even after giving initial consent. They were however encouraged to participate.

Risks and benefits

The study did not cause any potential risk to the participants. The study is expected however, to provide evidence which may be used to institute reforms for the benefit of clinical supervision of nursing and midwifery students in the study setting and beyond.

Compensation

There was no compensation or reward in monetary terms for participants who took part in the study. The participants bore no cost in participating in this study.

Anonymity and confidentiality

Participants were assured that any information given during the study was going to be used for the purpose of research. They were further assured that any information given would not be disclosed but treated with utmost confidentiality and no other person will know the name of participants granting interviews besides the researchers.

Data storage, usage and security

Data collected was saved to a computer with password that was known only to the principal researcher and supervisor. All filled out questionnaires were also stored in shelves of a cupboard and kept under key always. The data will be stored for five years and all records will be destroyed in an environmentally friendly manner when the five-year period elapses.

Conflict of interest

The researcher declared to the participants that there was no conflict of interest in the conduct of the study.

Funding

The study was solely funded by the researchers with no support from any external funding organisation.

3.12. Summary of the Chapter

The chapter has explained the strategies adopted in the conduct of the study, which took place at the 37 Military Hospital in the Greater Accra Region. The subsequent chapter presents the results obtained from the analysis.

CHAPTER FOUR

RESULTS

4.0. Introduction

This chapter presents the analysis of data collected during field work. The chapter is divided into two main sections with each having sub-sections. The first section presents the quantitative results while the second section presents the qualitative results. The first section presents the demographic data of respondents, after which respondents' views on the study variables are presented. Univariate, bivariate analysis (chi squared test) of the variables is presented as well as logistic regression.

4.1. Quantitative results

This section presents the results obtained from the analysis of the quantitative data.

4.1.1. Socio-Demographic characteristics of respondents

Table 4.1 presents results of the socio-demographic characteristics of the 200 respondents surveyed in the study. Majority, 172 (85.9%) of the respondents were females. More than half, 145 (79.0%) of the respondents were in the age group (18-25) years followed by 39 (17.0%) for age group (26-30). More than two thirds, 178 (88.9%) of the respondents were single while 22 (11.1%) were married. Majority 184 (92.0%) of the respondents were Christians. Most 196 (98.5%) of the respondents were from public training institutions. More than half 116 (58.0%) were third year students while the least 1 (0.5%) was a first year student. Similarly, more than half 106 (53.5%) of the respondents were registered general nursing students.

Table 4.1: Socio-demographic characteristics of respondents

| Variable | Frequency (N=200) | Percent (%) |
|-----------------------------|-------------------|-------------|
| Sex | | |
| Male | 28 | 14.1 |
| Female | 172 | 85.9 |
| Age group (years) | | |
| 18-25 | 145 | 79.0 |
| 26-30 | 39 | 17.0 |
| 31-35 | 16 | 4.0 |
| Marital status | | |
| Single | 178 | 88.9 |
| Married | 22 | 11.1 |
| Religion | | |
| Christian | 184 | 92.0 |
| Muslim | 15 | 7.5 |
| Others | 1 | 0.5 |
| Type of school | | |
| Private | 196 | 98.5 |
| Public | 4 | 1.5 |
| Years of studentship | | |
| 1 st year | 1 | 0.5 |
| 2 nd year | 37 | 18.5 |
| 3 rd year | 116 | 58.0 |
| Others | 46 | 23.0 |
| Program of study | | |
| RGN | 106 | 53.5 |
| RM | 67 | 33.8 |
| RMN | 6 | 3.1 |
| RCN | 19 | 9.6 |

4.2. Quality of clinical supervision of nursing and midwifery students

Figure 4.1 shows the quality of clinical supervision of nursing and midwifery students as rated by the respondents. Overall, only 19% of the respondents experienced high quality clinical supervision.

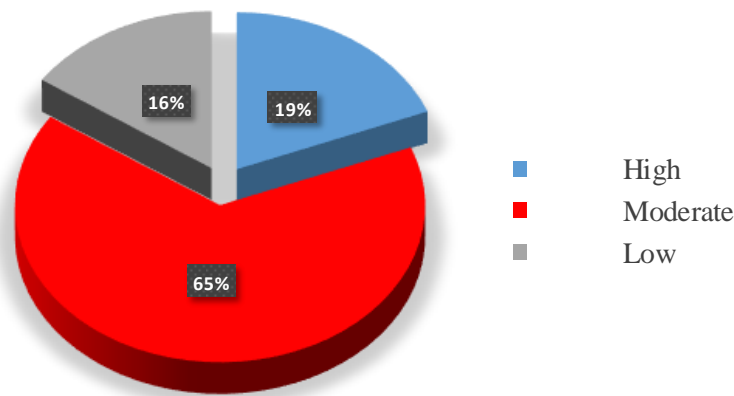


Figure 4.1: Overall quality of clinical supervision rated by the respondents

4.2a. Assessment of factors influencing quality of clinical supervision from nursing and midwifery students' perspective

Respondents were asked to respond to statements in relation to factors that could influence quality of clinical supervision. These are based on the structural and process factors of nursing supervision. This is presented in table 4.2a below. Most 131 (65.1%) of the respondents stated their residence is not close to the hospital of attachment. More than half 108 (54.3%) of the respondents had some source of income or financial support while more than half 129 (64.8%) stated their institution choose the hospital of attachment for them. Most 162 (81.8%) of them agreed they do face challenges during

clinical practice. Majority 106 (52.8%) face accommodation challenge while 142 (71.7%) face financial challenge during clinical attachment.

More than half 132 (66.7%) of the respondents stated the clinical staff have negative attitude towards them. Similarly, a significant number 27 (13.6%) reported they face issues of sexual harassment during clinical attachment. Additionally, close to half 89 (47.1%) face physical or verbal abuse from their clinical supervisors. Further, more than one third 86 (43.9%) stated their senior staff over rely on their work. More than one quarter therefore reported poor knowledge acquisition during clinical attachment. The results are shown in table 4.2a.

Table 4.2a: Assessment of factors influencing quality of clinical supervision from nursing and midwifery students' perspective

| Variable | Frequency (N=200) | Percent (%) |
|--|-------------------|-------------|
| Residence is close to hospital of attachment? | | |
| Yes | 69 | 34.9 |
| No | 131 | 65.1 |
| Do you have any source of income or financial support? | | |
| Yes | 108 | 54.3 |
| No | 92 | 45.7 |
| Does your institution choose hospitals for you? | | |
| Yes | 129 | 64.8 |
| No | 71 | 35.2 |
| Do you face challenges during your clinical practice? | | |
| Yes | 162 | 81.8 |
| No | 38 | 18.2 |
| Is accommodation a challenge during clinical | | |

| | | |
|---|-----|------|
| attachment? | | |
| Yes | 94 | 47.2 |
| No | 106 | 52.8 |
| Is finance a challenge during clinical attachment? | | |
| Yes | 142 | 71.7 |
| No | 58 | 28.3 |
| Do clinical staff have negative attitude towards students? | | |
| Yes | 132 | 66.7 |
| No | 68 | 33.3 |
| Do you face issues of sexual harassment during clinical attachment? | | |
| Yes | 27 | 13.6 |
| No | 173 | 86.4 |
| Do you face physical or verbal abuse from clinical supervisors? | | |
| Yes | 89 | 47.1 |
| No | 111 | 52.9 |
| Senior staff over rely on students work? | | |
| Yes | 86 | 43.9 |
| No | 114 | 56.1 |
| Is there poor knowledge acquisition during clinical attachment? | | |
| Yes | 53 | 26.6 |
| No | 147 | 73.4 |

4.2b. Assessment of factors influencing quality of clinical supervision from nursing and midwifery students' perspective

Table 4.2b presents the continuation of the assessment of the factors that could influence quality of clinical supervision. Majority 156 (80.4%) of the respondents stated their

clinical supervisors have limited time to teach them. Additionally, more than three third reported their tutor supervisors do not visit them at the hospital to conduct supervision. Close to half 91 (46.2%) of the respondents stated they were given the most stressful work schedule. Additionally, 92 (46.9%) disclosed that they buy their own clinical materials. About one third of the respondents also agreed that the challenges during clinical practice are more than the benefits.

However, most 169 (85.8%) of the respondents agreed that the ward is a good learning environment. Majority 131 (66.5%) stated they get emotional stress during clinical practice and only 74 (38.1%) are aware of any student/standard guidelines for supervisors. Most, 134 (67.7%) of the respondents rate the level of interaction with their tutor supervisors as moderate, only 22 (10.6%) rate the interaction as high. Similarly, 125 (62.5%) rate the interaction with their clinical supervisors as moderate while more than one fourth 53 (26.5%) rated the interaction as low.

Table 4.2b: Assessment of factors influencing quality of clinical supervision from nursing and midwifery students' perspective

| Variable | Frequency (N=200) | Percent (%) |
|---|-------------------|-------------|
| Clinical supervisors have limited time to teach students? | | |
| Yes | 156 | 80.4 |
| No | 44 | 19.6 |
| Tutors don't visit students at the hospital to conduct supervision? | | |
| Yes | 85 | 42.9 |
| No | 115 | 57.1 |
| Students are given the most stressful work schedule? | | |
| Yes | 91 | 46.2 |

| | | |
|--|-----|------|
| No | 109 | 53.8 |
| Students are asked to buy their own clinical materials? | | |
| Yes | 92 | 46.9 |
| No | 108 | 53.1 |
| Are the challenges during clinical practice more than the benefits? | | |
| Yes | 67 | 33.8 |
| No | 133 | 66.2 |
| Can the ward be regarded as a good learning environment? | | |
| Yes | 169 | 85.8 |
| No | 31 | 14.2 |
| Do you get emotionally stressed during clinical practice? | | |
| Yes | 131 | 66.5 |
| No | 69 | 33.5 |
| Are you aware of any student/standard guidelines for your supervisors? | | |
| Yes | 74 | 38.1 |
| No | 126 | 61.9 |
| How would you rate the level of interaction with your tutor supervisor? | | |
| High | 21 | 10.6 |
| Moderate | 134 | 67.7 |
| Low | 45 | 21.7 |
| How would you rate the level of interaction with your clinical supervisor? | | |
| High | 22 | 11.0 |
| Moderate | 125 | 62.5 |
| Low | 53 | 26.5 |

4.3. Chi-Square Tests: Relationship between socio-demographic factors and quality of clinical supervision

The relationship between socio-demographic factors and quality of clinical supervision is presented in Table 4.3 below. Overall, there are statistically significant relationships between the quality of clinical supervision and sex ($\chi^2=8.13$, $p < 0.05$), marital status ($\chi^2=8.91$, $p < 0.05$), and years of studentship ($\chi^2=37.62$, $p < 0.05$) of the respondents. Among the sex group, males 32.1% experienced lower quality clinical supervision compared to their female 11.8% counterparts. Among the married, none of the respondents experienced high quality clinical supervision while more than one fourth (31.8%) reported low quality of clinical supervision. Similarly, among those who were in third year, 73.3% experienced moderate quality of clinical supervision while only 17.2% reported high quality clinical supervision. There is no significant ($p > 0.05$) relationship observed between the age (in years), religion, type of school and the programme of study by the respondents.

Table 4.3: Chi-Square Tests: Relationship between socio-demographic factors and quality of clinical supervision

| Variable | Quality of clinical supervision on clinical practice | | | χ^2 | <i>p</i> -value |
|-------------------|--|-------------------|--------------|----------|-----------------|
| | High N (%) | Moderate N (%) | Low N (%) | | |
| Sex | | | | 8.13 | 0.017* |
| Male | 5 (17.9) | 14 (50.0) | 9 (32.1) | | |
| Female | 33 (19.4) | 117 (68.8) | 20 (11.8) | | |
| Age group (years) | | | | 4.59 | 0.332 |
| 18-25 | 22 (16.3) | 93 (68.9) | 20 (14.8) | | |
| 26-30 | 5 (17.2) | 16 (55.2) | 8 (27.6) | | |
| 31-35 | 0 (0.0) | 5 (71.4) | 2 (28.6) | | |

| | | | | | |
|----------------------|-----------|------------|-----------|-------|--------|
| Marital status | | | | 8.91 | 0.012* |
| Single | 38 (21.6) | 114 (64.8) | 24 (13.6) | | |
| Married | 0 (0.0) | 15 (68.2) | 7 (31.8) | | |
| Religion | | | | | |
| Christian | 38 (20.7) | 120 (65.2) | 26 (14.1) | 6.95 | 0.139 |
| Muslim | 0 (0.0) | 10 (66.7) | 5 (33.3) | | |
| Others | 0 (0.0) | 1 (100.0) | 0 (0.0) | | |
| Type of school | | | | 0.80 | 0.671 |
| Private | 37 (18.9) | 128 (65.3) | 31 (15.8) | | |
| Private | 1 (33.3) | 2 (66.7) | 0 (0.0) | | |
| Years of studentship | | | | 37.62 | 0.000* |
| 1 st year | 1 (100.0) | 0 (0.0) | 0 (0.0) | | |
| 2 nd year | 14 (37.8) | 10 (27.1) | 13 (35.1) | | |
| 3 rd year | 20 (17.2) | 85 (73.3) | 11 (9.5) | | |
| Others | 3 (6.5) | 36 (78.3) | 7 (15.2) | | |
| Program of study | | | | 14.37 | 0.073 |
| RGN | 13 (12.3) | 70 (66.0) | 23 (21.7) | | |
| RM | 19 (28.4) | 41 (61.2) | 7 (10.5) | | |
| RMN | 0 (0.0) | 6 (100.0) | 0 (0.0) | | |
| RGN | 4 (21.1) | 14 (73.7) | 1 (5.3) | | |

*Statistically significant associations between quality of clinical supervision and exposure variables ($p < 0.05$).

4.4a. Chi-Square Tests: Relationship between quality of clinical supervision and the structural and process factors of nursing/midwifery supervision

Table 4a presents the relationship between quality of clinical supervision and the structural and process factors of nursing/midwifery supervision. There are significant associations between quality of clinical supervision and how close a respondent's residence is to the hospital of attachment ($\chi^2 = 11.88$, $p < 0.05$), whether the respondent's institution choose hospital for them ($\chi^2 = 39.34$, $p < 0.05$), issues of accommodation ($\chi^2 = 13.88$, $p < 0.05$),

negative attitude of clinical staff towards respondents ($\chi^2=24.11$, $p < 0.05$), issues of sexual harassment during clinical attachment ($\chi^2=15.15$, $p < 0.05$) and whether senior staff over rely on respondents work ($\chi^2=8.15$, $p < 0.05$).

Table 4.4a: Chi-Square Tests: Relationship between quality of clinical supervision and the structural and process factors of nursing/midwifery supervision

| Variable | Quality of clinical supervision on clinical practice | | | χ^2 | p-value |
|--|--|-------------------|--------------|----------|---------|
| | High N (%) | Moderate N (%) | Low N (%) | | |
| Residence is close to hospital of attachment? | | | | | |
| Yes | 11 (15.9) | 55 (79.7) | 3 (4.4) | 11.88 | 0.003* |
| No | 25 (19.4) | 76 (58.9) | 28 (21.7) | | |
| Does your institution choose hospitals for you? | | | | | |
| Yes | 10 (7.8) | 89 (69.0) | 30 (23.3) | 39.34 | 0.000* |
| No | 28 (40.0) | 41 (58.6) | 1 (1.4) | | |
| Do you face challenges during your clinical practice? | | | | | |
| Yes | 29 (17.9) | 102(63.0) | 31 (19.1) | 8.32 | 0.016* |
| No | 9 (25.0) | 27 (75.0) | 0 (0.0) | | |
| Is accommodation a challenge during clinical attachment? | | | | | |
| Yes | 14 (14.9) | 56 (59.6) | 24 (25.5) | 13.88 | 0.001* |
| No | 24 (22.9) | 74 (70.5) | 7 (6.7) | | |
| Is finance a challenge during clinical attachment? | | | | | |
| Yes | 30 (21.1) | 93 (65.5) | 19 (13.4) | 2.65 | 0.266 |
| No | 8 (14.3) | 36 (64.3) | 12 (21.4) | | |
| Do clinical staff have negative | | | | | |
| | | | | 24.11 | 0.000* |

| | | | | | |
|---|-----------|------------|-----------|-------|--------|
| attitude towards students? | | | | | |
| Yes | 14 (10.6) | 89 (67.4) | 29 (22.0) | | |
| No | 23 (34.9) | 41 (62.1) | 2 (3.0) | | |
| Do you face issues of sexual harassment during clinical attachment? | | | | 15.15 | 0.001* |
| Yes | 3 (11.1) | 13 (48.2) | 11 (40.7) | | |
| No | 35 (20.4) | 117 (68.0) | 20 (11.6) | | |
| Do you face physical or verbal abuse from clinical supervisors? | | | | | |
| Yes | 12 (13.5) | 58 (65.2) | 19 (21.4) | 5.48 | 0.064 |
| No | 23 (23.0) | 66 (66.0) | 11 (11.0) | | |
| Senior staff over rely on students work? | | | | 8.15 | 0.017* |
| Yes | 9 (10.5) | 65 (75.6) | 12 (14.0) | | |
| No | 28 (25.5) | 64 (58.2) | 18 (16.4) | | |

*Statistically significant associations between quality of clinical supervision and exposure variables ($p < 0.05$).

4.4b. Chi-Square Tests: Relationship between quality of clinical supervision and the structural and process factors of nursing supervision

Table 4.4b presents the continuation of the relationship between quality of clinical supervision and the structural and process factors of nursing supervision. There are significant relationships between quality of clinical supervision and whether enough time is given by the clinical supervisor to teach respondents ($\chi^2 = 9.22$, $p < 0.05$), whether tutor supervisors visit respondents at the hospital to conduct supervision ($\chi^2 = 23.2$, $p < 0.05$), when respondents buy their own clinical materials ($\chi^2 = 22.61$, $p < 0.05$), whether respondents are emotionally stressed during clinical practice ($\chi^2 = 22.76$, $p < 0.05$), whether respondents are aware of any standard guidelines for supervision ($\chi^2 = 11.67$, $p < 0.05$), the interaction

between respondents and their tutor supervisors ($\chi^2 = 56.21$, $p < 0.05$) as well as clinical supervisors ($\chi^2 = 120.24$, $p < 0.05$).

Table 4.4b: Chi-Square Tests: Relationship between quality of clinical supervision and the structural and process factors of nursing supervision

| Variable | Quality of clinical supervision on clinical practice | | | χ^2 | p-value |
|---|--|-------------------|--------------|----------|---------|
| | High N (%) | Moderate N (%) | Low N (%) | | |
| Clinical supervisors have limited time to teach students? | | | | | |
| Yes | 24 (15.4) | 103 (66.0) | 29 (18.6) | 9.22 | 0.010* |
| No | 13 (34.2) | 23 (60.5) | 2 (5.3) | | |
| Tutors don't visit students at the hospital to conduct supervision? | | | | | |
| Yes | 10 (11.8) | 50 (58.8) | 25 (29.4) | 23.20 | 0.000* |
| No | 28 (24.8) | 79 (69.9) | 6 (5.3) | | |
| Students are given the most stressful work schedule? | | | | | |
| Yes | 13 (14.3) | 64 (70.3) | 14 (15.4) | 2.44 | 0.295 |
| No | 24 (22.6) | 65 (61.3) | 17 (16.0) | | |
| Students are asked to buy their own clinical materials? | | | | | |
| Yes | 21 (22.8) | 46 (50.0) | 25 (27.2) | 22.61 | 0.000* |
| No | 15 (14.4) | 83 (79.8) | 6 (5.8) | | |
| Can the ward be regarded as a good learning environment? | | | | | |
| Yes | 32 (18.9) | 110 (65.1) | 27 (16.0) | 0.12 | 0.940 |
| No | 6 (21.4) | 18 (64.3) | 4 (14.3) | | |
| Do you get emotionally stressed during clinical practice? | | | | | |
| | | | | 22.76 | 0.000* |

| | | | | | |
|--|-----------|------------|-----------|--------|--------|
| Yes | 15 (11.5) | 87 (66.4) | 29 (22.1) | | |
| No | 23 (34.9) | 41 (62.1) | 2 (3.0) | | |
| Are you aware of any student/standard guidelines for your supervisors? | | | | 11.67 | 0.003* |
| Yes | 21 (28.4) | 49 (66.2) | 4 (5.4) | | |
| No | 16 (13.3) | 81 (67.5) | 23 (19.2) | | |
| How would you rate the level of interaction with your tutor supervisor? | | | | 56.21 | 0.000* |
| High | 12 (57.1) | 9 (42.9) | 0 (0.0) | | |
| Moderate | 22 (16.4) | 100 (74.6) | 12 (9.0) | | |
| Low | 2 (4.7) | 22 (51.2) | 19 (44.2) | | |
| How would you rate the level of interaction with your clinical supervisor? | | | | 120.24 | 0.000* |
| High | 17 (77.3) | 5 (22.7) | 0 (0.0) | | |
| Moderate | 17 (13.6) | 104 (83.2) | 4 (3.2) | | |
| Low | 4 (7.6) | 22 (41.5) | 27 (50.9) | | |

Statistically significant associations between quality of clinical supervision and exposure variables ($p < 0.05$).

4.5: Logistic regression: Relationship between demographic characteristics and quality of clinical supervision

Table 4.5 presents the multiple logistic regression of the relationship between demographic characteristics and quality of clinical supervision. After adjusting for the confounding effects of age, sex, type of school and years of studentship, there is strong evidence that marital status ($p < 0.05$), religion ($p < 0.05$) and the program of study ($p < 0.05$) of the participants had significant influence on the quality of clinical supervision.

Table 4.5: Logistic regression: Relationship between demographic characteristics and quality of clinical supervision

| Exposure variable | Adjusted analysis | | |
|--------------------------|-------------------|----------------|---------|
| | Coefficient (k) | (95% CI) | p-value |
| Age group (years) | | | |
| 18-25 | 1 | | 0.859 |
| 26-30 | -0.06 | (-1.11, 0.99) | |
| 31-35 | 0.45 | (-1.31, 1.15) | |
| Marital status | | | |
| Single | 1 | | 0.002* |
| Married | -1.56 | (-2.53, -0.59) | |
| Religion | | | |
| Christian | 1 | | 0.040* |
| Muslim | 1.38 | (0.30, 2.45) | |
| Others | 0.91 | (-3.06, 4.88) | |
| Type of school | | | |
| Private | 1 | | 0.621 |
| Private | -0.57 | (-2.82, 1.68) | |
| Program of study | | | |
| RGN | 1 | | 0.026* |
| RM | -1.00 | (-1.68, -0.32) | |
| RMN | -0.62 | (-2.88, 1.65) | |
| RGN | -1.25 | (-2.28, -0.22) | |

*Statistically significant associations between quality of clinical supervision and exposure variables ($p < 0.05$).

4.6: Logistic regression: Relationship between quality of clinical supervision and the structural and process factors of nursing supervision

Table 4.6 presents the multiple logistic regression of the relationship between quality of clinical supervision and the structural and process factors of nursing supervision. After adjusting for the confounding effects of staying close to hospital of attachment, financial challenges during clinical attachment, negative attitudes of clinical staff, physical and verbal abuse, over reliance on students work and stressful work schedule for respondents, there is strong evidence that choosing of hospital of attachment by respondents institution ($k = -1.96$; 95 % CI = [-3.11, -0.82]; $p < 0.05$), accommodation challenges ($k = -1.05$; 95 % CI = [-2.01, -0.08]; $p < 0.05$), sexual harassment during clinical attachment ($k = -1.56$; 95 % CI = [-2.91, -0.20]; $p < 0.05$), limited time in teaching respondents ($k = -1.56$; 95 % CI = [-2.79, -0.34]; $p < 0.05$), visitation by tutor supervisors during clinical attachment ($k = -1.09$; 95 % CI = [-2.08, -0.09]; $p < 0.05$), the ward environment ($k = -1.40$; 95 % CI = [-2.71, -0.10]; $p < 0.05$), level of interaction between clinical ($p < 0.05$) and tutor supervisors ($p < 0.05$) have significant influence on the quality of clinical supervision.

Table 4.6: Logistic regression: Relationship between quality of clinical supervision and the structural and process factors of nursing supervision

| Variable | Coefficient(k) | (95% CI) | <i>p</i> -value |
|--|----------------|----------------|-----------------|
| Residence is close to hospital of attachment? | | | |
| Yes | 1 | | |
| No | 0.55 | (-0.41, 1.52) | 0.260 |
| Does your institution choose hospitals for you? | | | |
| Yes | 1 | | |
| No | -1.96 | (-3.11, -0.82) | 0.001* |
| Is accommodation a challenge during clinical attachment? | | | |

| | | | |
|--|-------|----------------|--------|
| Yes | 1 | | |
| No | -1.05 | (-2.01, -0.08) | 0.033* |
| Is finance a challenge during clinical attachment? | | | |
| Yes | 1 | | |
| No | 0.91 | (-0.20, 2.01) | 0.109 |
| Do you face issues of sexual harassment during clinical attachment? | | | |
| Yes | 1 | | |
| No | -1.56 | (-2.91, -0.20) | 0.025* |
| Clinical supervisors have limited time to teach students | | | |
| Yes | 1 | | |
| No | -1.56 | (-2.79, -0.34) | 0.012* |
| Tutors don't visit students at the hospital to conduct supervision? | | | |
| Yes | 1 | | |
| No | -1.09 | (-2.08, -0.09) | 0.032* |
| Can the ward be regarded as a good learning environment? | | | |
| Yes | 1 | | |
| No | -1.40 | (-2.71, -0.10) | 0.035* |
| How would you rate the level of interaction with your tutor supervisor? | | | |
| High | 1 | | 0.003* |
| Moderate | 1.68 | (-0.14, 3.50) | |
| Low | 3.12 | (0.91, 5.34) | |
| How would you rate the level of interaction with your clinical supervisor? | | | |
| High | 1 | | 0.008* |
| Moderate | 2.14 | (-0.09, 4.37) | |
| Low | 3.55 | (1.07, 6.04) | |

*Statistically significant associations between quality of clinical supervision and exposure variables ($p < 0.05$).

4.7. Qualitative results

This section presents the results/findings obtained from the analysis of the qualitative data.

The presentation is based on the different themes that emerged from the interview data.

4.7.1. Clinical and tutor supervisors' perceptions of quality of clinical supervision of nursing and midwifery students

The clinical and tutor supervisors held varying views regarding what constituted quality clinical supervision. These have been presented below.

4.7.2. Clinical and tutor supervisors' understanding of the concept of clinical supervision

To ensure that the students achieved the best of skills during their clinical training or attachment, there is always the need to ascertain whether the supervisors themselves understood what the concept of clinical supervision is all about. When asked to briefly explain what they understood by quality clinical supervision, different views and understanding were presented by the participants. On the part of the clinical supervisors, the following explanations were provided:

“is like students coming to the clinical area to learn what they have been taught in class, like people being there to teach them the practical form of what they have learnt in the theoretical thing they have learnt. That’s how I understand it.” (CS-2).

“Quality in this way is anything that will bring about good results and therefore if you’re to supervise, we want the outcome to be positive. Then one will say that the measures that you put in place, if it works then the result will show. The thing they needed results from the patients those that you’re managing; if those managing are doing the right thing the patients are likely to bring it out getting their care rendered effectively.” (CS-4).

To sum up, the major themes found from among the clinicians' response to their conception of quality clinical supervision were: (1) clinicians or staff working with students posted to wards, (2) students being supervised by quality assurance nurses and in-charges in wards, and (3) putting measures in place to adequately supervise students.

For tutor supervisors, similar conceptions of quality clinical supervision were held among them. One tutor supervisor stated her concept of quality clinical supervision as being:

“Quality clinical supervision is something that we as tutors and the head institutions need to embark on when our students are at field doing their practical, being it internal or after their end of semester; they go to their clinical field for. So, we go there and then we make sure that we monitor and then supervise. Where we take part wherever they are fallen short, we also make our input. At times we also go there and then carry out some activities that they need to do. So quality supervision is just going to make sure that the clinical that they undergo; whatever they are being taught in the classroom they are also practicing the same thing on the ward.” (TS-1).

The themes found from tutor supervisors’ responses on quality clinical supervision pertained to (1) supervision which benefits not only students but clients as well, (2) support provided to students in the clinical field by way of personnel and logistics, and (3) getting a qualified nurse/midwives to give the best supervision or guidance to students during their clinical experience.

From the foregoing, it became evident that clinicians and tutor supervisors held alternating views regarding what constitutes quality clinical supervision. Some conceptualized quality from the angle of the actual clinical experience, while others considered it in terms of nurses and other qualified staff being around to supervise students in doing their work in the ward and correcting them when they made mistakes or went down the wrong path. Yet, others viewed quality supervision in terms of logistics available for students to effectively function during their clinical experience. Consequently, it was apparent that no universal or harmonized conception of quality clinical supervision existed among clinicians and tutor supervisors who supervised nursing and midwifery students during their clinical experience at the 37 Military Hospital.

4.8. Mode of Supervision of Students in Clinical Facilities

A few innovative and unique modes of supervision were employed in the wards in supervising students on clinical practice. From the data, three main themes came up concerning the modes of clinical supervision. The modes as indicated by the supervisors are discussed below.

4.8.1. Objective-Based Supervision

One key mode of supervision that was indicated by interviewees was objective-based supervision. With this kind of supervision, supervisors request from students, at the inception of their clinical practice, what their objectives for the clinical period were. Based on these objectives, supervisors would supervise the students in such a manner as to make them learn the things they want to learn, which they had expressed as their objectives. Any student who does not have objective(s) is requested to furnish the supervisor with one. Interviewees showed how this was done:

“My ward; this is personalizing some of the things; because I have taught before, I know problems of students, so when they come, is like I’m interested in what they come to learn. First and foremost, I ask them for their objectives. Some do bring, others don’t. If you don’t bring, I’ll not attend to you, you’ll go back for it. Then I look on the objective; that is what I use to direct what they learn” (CS-5).

This form of supervision is novel in that it incorporates students in the supervision activity and forces them to take some responsibility for their own professional development. Consequently, it builds a sort of partnership between the supervisor and students in shaping the content of the learning and supervisory activity, and how it ultimately unfolds.

4.8.1. Facility-Based Supervision

In this mode of supervision, students are received into the wards through in-service coordinators. At the wards, there are note books, which serve as attendance registers for students. Students’ schedules are then planned to fit into the wards’ demands. When students report to the wards, they sign the attendance register; after which they are assigned tasks based on the type of work available for that day:

“Okay, over the years what we do is, as they come in through the in-service coordinator, on the ward we have a notebook or attendance book for students and we plan their schedules to fit the wards demand. So today, morning shift if I know a particular day morning shift I would have two students, once they come and our attendance is not signed or is signed, you check through the attendance sheet, we

assign tasks to them depending on their objectives to be achieved and then the shift in-charge, every shift has an in-charge, is responsible for seeing through the students. So, whatever the student has; and at the end of the day before they even dispense or after handing over, they come to ask and the in-charges we try to tease out they have learnt. “Today what did you learn, you came to work today what have you learnt”? and you can correct all the things that are not right or teach them afresh or whatever they’ve learnt we’ll get to know if that is exactly what a nurse had to be equipped with”. (CS-2).

Consequently, for this mode, shift supervisors are responsible for ensuring that students undertake all tasks assigned to them for each day. At the end of the shift, shift supervisors or ‘In-Charges’ interrogate students on what they had learnt for the day. Wrong knowledge is corrected, and right ones reinforced, with students taught anew if necessary, in order to enable them to acquire correct information. Thus, the supervision in this mode is undertaken based on the schedule of the facility, thus making it facility-based supervision.

4.8.3. Preceptor-Based Supervision

Another mode of supervision was the one undertaken by preceptors. Preceptors are specially trained and designated nurses or health staff with primary responsibility for supervising students during their clinical period. The preceptors are responsible for drawing up supervision schedules and carrying out any activity necessary to make the supervision successful. How this role was being performed was espoused by interviewees:

“On our ward, the preceptors distribute them first and then later on we have preceptors on the wards, individual wards. We have the main preceptor and then the individual preceptors on the ward. So we assign the students to the preceptors on each ward and then when the preceptor comes, he’s come to supervise the students, how they are faring and then he carries a task like “let’s do vital signs” so we see how the students does the vital signs including the preceptor and the preceptor corrects them wherever they go wrong” (CS-5).

Thus, it was explained that the supervision activity is undertaken under the direction and control of the Preceptor.

4.9. Factors influencing quality of clinical supervision from supervisors' perspective

From the responses given, it was noted that quite several factors affected clinical supervision of students. This means that the analysis showed that in addition to the laid down regulations and guidelines or the designed modes of clinical supervision, there were other factors that could influence the delivery of quality clinical supervision from the perspectives of the clinical and tutor supervisors. These factors have been discussed below.

4.9.1. Pre-Clinical Student Orientation

Prior to students going to their various postings or facilities they would undertake their clinical sessions, they are given orientation on the various dynamics surrounding their work in the facilities. Based on the year students are in, i.e. 1st year, 2nd year, etc., specific sets of objectives are developed for their education in school, and these are used in orienting students prior to undertaking the clinical practice. During this orientation, students are also taught what to look out for and the various things they would be supervised on. The quality of this preparation determines how prepared students are for their clinical practice, and by extension, supervision. Thus, good pre-clinical orientation ensures that the supervision is smooth and less cumbersome for both supervisors and students alike.

4.9.2. Lack of Supervisor Training

Training is a key factor in determining how work gets undertaken. It was revealed from the analysis that some of the supervisors indicated that they had not received training on how to undertake clinical supervision. Only a few indicated that they have received some form of in-service training. The extent to which majority of supervisors had not received training, could affect how they conducted their supervision. The lack of training therefore, was a factor that affected how clinical supervision was undertaken.

4.9.3. Lack of Standard Guidelines

Respondents indicated that no standard guidelines existed on clinical supervision. Supervision as it occurs now was facility-based. The implication is that there is no uniformity in how supervision is undertaken. The absence of standard guidelines on supervision is therefore, a factor that affects how supervision is undertaken in the country.

4.9.4. Logistics

The findings of the study showed that logistics was not a significant factor, which could affect how clinical and tutors supervised the students. Whereas the clinicians mostly talked about logistics in terms of how students wasted hospital supplies such as gloves, the tutor supervisors, however, hinted that the unavailability or lack of logistics was affecting how students learnt in the wards, which in effect impacted on how they supervised students:

“Logistics like I said sometimes it’s inadequate. You go and then the student is performing a procedure and in the demo room, you have the ideal setup; you have everything. But the student goes to the ward and some of the things are not there so the student will learn it half and half, and it affects their learning abilities.” (TS-6).

From this response, it was evident that students were taught in school what should pertain in real life. Similarly, they got the chance to practice same in the Demonstration Rooms or “demo room” in their schools. When they go to the wards/hospitals for clinical however, a lack of logistics had an impact on how nurses could work, thereby making them improvise in order to get their work done. This disconnect between theory and practice would impact on what students learn in the wards, which in turn affects how supervisors do their work as they must find a way to supervise students in order to bridge that gap and make their learning meaningful.

4.9.5. Time Constraints and Heavy Workload

It is important to emphasise that the workload of supervisors would in one way or the other influence the quality of the clinical supervision provided to students by the supervisors. The

study found that workload was also a major factor, which could affect how supervision was done, especially for the tutors:

“It affects because when the students are on vacation, that’s when you mark. You prepare for the next semester. Sometimes you want to take your leave, and then in-between your leave you should still make time to go for clinical supervision. And when you go, you cannot just go and walk about, you have to help the student, let the student feel your presence. You have to be involved with the student. So, you become more worked out and then you have to go back to work and complete your assignment for that particular period. Combining it is not easy.” (TS-8).

Combining the supervision activity with academic work therefore, tended to affect tutors in how they supervised students in hospitals and fulfilled their academic duties at work (in the Nurses Training Colleges). Making time to undertake the heavy schedules brought about by a high workload therefore, affected how supervision occurred, especially for tutors. Large student numbers have also contributed to the issue of heavy work load for both clinicians and tutors.

4.10. Summary of the chapter

This chapter has presented analysis of the results of the quantitative study as well as the key themes that emerged from the analysis of the qualitative data. Different variables and factors, which influence the quality of clinical supervision from the point of view of nursing and midwifery students on one hand and the clinical and tutor supervisors have been outlined. The next chapter is where the findings identified in this study are related to current literature so as to establish relationship or otherwise.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0. Introduction

This study found that several factors impacted clinical supervision of nursing and midwifery students. It is important to state what respondents in this study mentioned as factors influencing clinical supervision were conceptualized as challenges in other literature.

5.1. Quality of clinical supervision of nursing and midwifery students

The findings showed that only 19% of the nursing/midwifery students experienced high quality clinical supervision. This may be as result of the numerous challenges that come with nursing and midwifery supervision as identified in both the qualitative and quantitative phases of this study. These are discussed below.

5.2. Factors influencing quality of clinical supervision from nursing and midwifery students' perspective

The study grouped the factors that influence the quality of clinical supervision from the nursing and midwifery students' perspective into two: socio-demographic factors and structural and process factors of nursing supervision. These are discussed into details in the sections below.

5.2.1. Socio-demographic factors influencing quality of clinical supervision

Our results showed statistically significant relationships between the quality of clinical supervision and sex, marital status and years of studentship of the respondents in the bivariate analysis while marital status, religion and program of study still remain major factors in the multiple logistic regression. The effect of the sex of the respondents may be felt more in this

current study as a result of the larger number of the female respondents compared to their male counterparts.

Additionally, the married respondents experienced lower quality of clinical supervision compared to respondents who were single. This may be because of the sort of care and respect they are exposed to at their home, which they might have been expecting in similar measure at the clinical setting since they are considered 'more' adults than those who are single in the study context. In terms of the program of study, it is obvious that if a mental health nurse is attached to a ward where most of the care being rendered is non-mental health cases may feel he or she is not benefiting from the clinical practice.

Previous studies reported similar findings (Gemuhay et al, 2018; Shaheen et al, 2016). For instance, a cross-sectional study carried out to determine factors affecting performance in clinical practice among pre-service diploma nursing students in Northern Tanzania found a significant association between quality of clinical supervision and gender (Gemuhay et al, 2018). It was noted that male nursing students significantly reported lower quality as compared to the females. This is not different from our current finding. Similarly, the current study shows no significant relationship between quality of clinical supervision and the age of the respondents. This agrees with a study by Gemuhay et al. (2018).

5.2.2. Structural and process factors influencing quality of clinical supervision

The study showed several structural and process factors that influence the quality of nursing/midwifery supervision. These include how close a respondent's residence is to the hospital of attachment, whether the respondent's institution choose hospital for them, issues of accommodation, negative attitude of clinical staff towards respondents, issues of sexual harassment during clinical attachment, whether senior staff over rely on respondents work, whether enough time is given by the clinical supervisor to teach respondents, whether tutor

supervisors visit respondents at the hospital to conduct supervision, when respondents buy their own clinical materials, whether respondents are emotionally stressed during clinical practice, whether respondents are aware of any standard guidelines for supervision, the interaction between respondents and their tutor supervisors as well as clinical supervisors.

The current findings are consistent with several studies carried out to determine the factors that influence quality of nursing and midwifery supervision (Allari & Farag, 2017; Helgesen et al., 2016; Tseng et al., 2013; Bukaliya, 2012; Celebi et al., 2012; Papastavrou et al., 2010). For instance, the earlier studies identified several factors including challenges linking theory to practice (Bukaliya, 2012), stress from clinical experiences (Tseng et al., 2013), lack of time available for supervision (Celebi et al., 2012), uncondusive clinical environment (Shaheen et al, 2016), poor acquisition of skills and problems in the supervision of clinical practice (Papastavrou et al., 2010), and poor learning conditions for students (Helgesen et al., 2016). Mwale and Kalawa (2016) also stated inadequate study and clinical materials as a challenge student nurse and midwives were confronted with. Moreover, our study confirms earlier study by Dlama et al (2013) where high levels of stress, poor interpersonal relationship and inadequate clinical time were identified as major barriers to quality of clinical supervision.

5.3. Factors influencing quality of clinical supervision from supervisors' perspective

The qualitative study found factors which included lack of readiness of students for supervision, lack of or poor orientation, lack of supervisor training, lack of standard guidelines for clinical supervision, logistical constrain as well as time constrain and heavy workload. The current findings agree with several similar studies conducted in other jurisdictions. According to Ajani and Moez (2011) the major challenges facing tutor-student clinical supervision is limited logistics while Samarakoon et al. (2013) and Bengtsson &

Carlson (2015) identified means and cost of traveling and inadequate tutors to student population as major challenges hindering quality clinical supervision of nursing and midwifery students. Additionally, our study confirms similar study by Celebi *et al.* (2012) where supervisor workload was found as the major factor influencing clinical supervision.

Further, the lack of proper training for supervisors as well as inadequate faculty supervisions found in this study have been reported elsewhere as well (Atakro & Gross, 2016; Asirifi *et al.*, 2017). For instance, study by Bweupe, Ngoma, and Sianchapa (2018) where Clinical Supervision of Midwifery Students at the University Teaching Hospital School of Nursing and Midwifery in Lusaka, Zambia showed high percentage of the clinical supervisors (89.5%) without training in clinical supervision and most respondents had moderate knowledge on clinical supervision of students and therefore could not exhibit adequate supervision skills.

5.5. Summary of the chapter

This chapter has presented analysis of the findings of the study and how they were either confirming or disproving current literature. The analysis was done on the basis of the main objectives of the study on the factors, which influence the quality of clinical supervision from the point of view of nursing and midwifery students on one hand and the clinical and tutor supervisors have been outlined. The next chapter is the summary, conclusions and recommendations of the study.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.0. Introduction

This chapter presents the summary, conclusions and recommendations of the key findings of the study. There are about six sections contained in this chapter.

6.1. Summary of the study

The aim of this study was to assess factors influencing the quality of clinical supervision of nursing and midwifery students at the 37 Military hospital, Accra. While a quantitative method was applied to collect data from 200 nursing and midwifery students, qualitative research method was applied to collect data from five clinicians and eight tutor supervisors, which helped in getting both the statistical and non-statistical results for analysis. Overall, only 19% of the nursing/midwifery students experienced high quality clinical supervision at the 37 Military hospital.

Generally, the study found that marital status, religion, program of study, how close a respondent's residence is to the hospital of attachment, whether the respondent's institution choose hospital for them, issues of accommodation, negative attitude of clinical staff towards respondents, issues of sexual harassment during clinical attachment, whether senior staff over rely on respondents work, whether enough time is given by the clinical supervisor to teach respondents, whether tutor supervisors visit respondents at the hospital to conduct supervision, when respondents buy their own clinical materials, whether respondents are emotionally stressed during clinical practice, whether respondents are aware of any standard guidelines for supervision, the interaction between respondents and their tutor supervisors as well as clinical supervisors had significant influence on the quality of clinical supervision of

nursing and midwifery students at the 37 Military Hospital from the nursing and midwifery students perspective. Additionally, major challenges facing quality clinical supervision from the perspectives of the tutor and clinical supervisors include student's orientation prior to supervision, lack of supervisor training, lack of standard guidelines for clinical supervision, logistical constrain as well as time constrain and heavy workload.

Based on the key finding of the study, the study argues that clinical supervision is a key factor that affects the quality of nurses/midwives churned out from nursing/midwifery training institutions. Enhanced attention is therefore required to ensure it is effectively undertaken in order to ensure quality outcomes. Concerted efforts are then required among the nursing training colleges, hospitals and supervisors in ensuring only the highest quality supervision is undertaken. This will also ensure that student nurses have access to the best training possible, to become well-trained professionals equipped to contribute in creating a healthy and stronger Ghana.

6.2. Conclusions of the study

This section presents the conclusions of the study based on the specific objectives. These assisted in identifying the key factors influencing clinical supervision of students such as student's readiness for supervision as a result of orientation, lack of supervisor training, lack of standard guidelines for clinical supervision, logistical constrain as well as time constrain and heavy workload. These have been explained below.

6.2.1. Socio-demographic factors influencing quality of clinical supervision

Generally, the study found that marital status, religion and program of study have significant influence on the quality of clinical supervision of nursing and midwifery student at the 37 Military hospital from the nursing and midwifery student's perspective.

6.2.2. Structural and process factors influencing quality of clinical supervision

Overall, the study found that how close a respondent's residence is to the hospital of attachment, whether the respondent's institution choose hospital for them, issues of accommodation, negative attitude of clinical staff towards respondents, issues of sexual harassment during clinical attachment, whether senior staff over rely on respondents work, whether enough time is given by the clinical supervisor to teach respondents, whether tutor supervisors visit respondents at the hospital to conduct supervision, when respondents buy their own clinical materials, whether respondents are emotionally stressed during clinical practice, whether respondents are aware of any standard guidelines for supervision, the interaction between respondents and their tutor supervisors as well as clinical supervisors have significant influence on the quality of clinical supervision of nursing and midwifery student at the 37 military hospital from the nursing and midwifery students perspective.

6.2.2.1. Factors influencing quality of clinical supervision from supervisors' perspective

Some challenges, which were found to affect students during clinical attachment from the perspectives of the tutor and clinical supervisors included student's orientation prior to supervision, lack of training for supervisor, lack of standard guidelines for clinical supervision, logistical constrain as well as time constrain and heavy workload.

6.2.4. Clinician and tutor supervisors' perceptions of quality of clinical supervision

The study showed that clinicians and tutor supervisors held differing views of what constituted quality supervision. Specifically, for clinicians, quality supervision was conceived in terms of 1) clinicians or staff working with students posted to wards, (2) students being supervised by quality assurance nurses and in-charges in wards, and (3) putting measures in place to adequately supervise students, among others. Also, for tutor supervisors, quality supervision was conceptualized, among other things, as including (1) supervision which

benefits not only students but clients as well, (2) support provided to students in the clinical field by way of personnel and logistics, and (3) getting a qualified nurse to give the best supervision or guidance to students during their clinical experience. No consensus therefore existed as to what constituted quality clinical supervision.

Three main modes of student supervision were observed from the study. The first is Objective-Based Supervision, which sees supervisors requesting students to state their objectives for the clinical practice, which supervisors then use in teaching students what they want to learn. The second is facility-based supervision, which sees the facility setting the tone for what students ought to learn and assigning 'In-Charges' to supervise the learning activity. The last is Preceptor-Based Supervision, in which specially designated staffs called preceptors oversee the clinical supervision activity.

6.3. Recommendations

Based on the findings of the study, the following recommendations were made for consideration.

Ministry of Health, Ghana Health Service and Nursing & Midwifery Council

Training on the art and science of clinical supervision is highly recommended. The study's findings show that no proper training regime exists in preparing supervisors for the task at hand. The lack of training translates into situations where supervisors hold different views about what quality clinical supervision is, which ultimately influences how they undertake the supervision activity itself. It is therefore recommended that supervisors be adequately trained on how to supervise students, in order to make them more effective at their jobs. This should be done through the collaborative efforts of the MOH, GHS and N&MC.

Though several challenges were identified as affecting students during their clinical attachment in this study, some of these challenges can be addressed by health authorities. With the issue of accommodation, Government, acting through the Ministry of Health and Ghana Health Service can intervene by putting up structures to provide accommodation for students on clinical attachment.

To tackle the issue of poor attitude of supervisors toward students, the N&MC must organize periodical workshops on attitude, encourage nurses and midwives to attend CPD programmes to update their knowledge skills and attitudes, conduct vibrant supervision exercises and apply sanctions to nurses and midwives who breach standards of the profession. Doing this will help in greatly minimizing some of the challenges students face, thereby making their clinical practice experience a fulfilling one. It will also ultimately ensure that nurses/midwives of high caliber are churned out to provide the much-needed health services Ghanaians expect from their health facilities.

Hospitals and Nursing and Midwifery Training Institutions

Hospitals where students are sent to for clinical attachment/practice, and Nursing and midwifery Training Institutions, should work together to acquire clinical materials and other logistics students need for their clinical practice. This will ensure that students have access to all the right materials they need for their clinical practice; instead of having to buy those logistics themselves, as the case presently is. Ultimately, this would bridge the gap between theory and practice for students.

Nursing and Midwifery Council of Ghana

No standard guidelines exist for clinical supervision. This is a weakness in the system that needs to be corrected. A lack of standard guidelines means there is no coherence in the clinical supervision undertaken in the country. As such, different forms of supervision exist

based on the preferences of supervisors or the hospital students undertake their clinical sessions in. To correct this anomaly, it is recommended that standard guidelines be developed by the Nursing and Midwifery Council, the body mandated by the Health Professions Regulatory Bodies Act 2013 (Act 857) to regulate nursing and midwifery training and practice in the country.

6.4. Limitation to the study

A key limitation to this study pertains to the availability of relevant literature. The nature of the study as an exploratory one implied that not much prior work has been done on the subject matter. Thus, even though there was enough literature on the challenges of clinical supervision, very little literature existed on issues such as the mode of supervision and factors affecting supervision. Consequently, this lack of literature negatively impacted the study regarding how well its finding could be discussed.

6.5. Future Research

Finally, it is recommended that further research should be undertaken on areas not covered in this study; such as the conception of quality supervision from the perspective of nursing and midwifery students who are the direct beneficiaries of the supervision, and the regulator (Nursing and Midwifery Council of Ghana) on whose behalf the supervision is being done.

Also, during the conduct of this study, it became evident from the literature search that not much work had been undertaken on factors influencing clinical supervision of nursing and midwifery students, as well as, a lack of a standard procedure for supervision of nursing and midwifery student. It is highly recommended that adequate research should be undertaken on the aforementioned items in order to make quality data available for informed decision making and improvement in clinical supervision of nursing and midwifery students.

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APPENDICES

Appendix A: Participant Information Sheet

Principal investigator: Miriam Tuowulle Aryere

Academic Supervisor: Dr. Reuben K. Esena

Study title: Assessment of factors influencing the Quality of Clinical Supervision of Nursing and Midwifery Students at 37 Military Hospital.

Introduction

I am part of a team conducting a dissertation on the factors influencing the quality of clinical supervision of nursing and midwifery students. It is purely an academic study which forms part of my work for the award of a Master of Public Health degree. We are pleased to invite you to be part of the study. We request that you read this information sheet which outlines the purpose of the study, the risk and benefits, the time commitment required and the privacy/confidentiality of the participant.

Purpose of the Study

The overall goal of this study is to determine the factors and challenges that influence the quality of clinical supervision of nursing and midwifery students from selected Nursing and Midwifery Training Institutions on clinical attachment at the 37 Military hospital.

Risk and benefits

There are no risks and no financial benefits for taking part in the study.

Time commitment required

The period required for you to answer questions would be 30 minutes. Participant is allowed to stop answering questions whenever he/she wishes and/or skip answering any question that he/she is uncomfortable with.

Privacy/confidentiality

Participants is assured that any information given during the study will not be disclosed to anyone, will be treated with utmost confidentiality and be used solely for the purpose of the dissertation.

Research Right

If participant needs any clarification on the study, he/she contact Mr. Sylvanus Akorsu, IRB Administrator on 0302 769667/0208371969 from Monday to Friday between the hours of 8 am and 1pm.

Contact Person

Participants can freely contact the following research staff below during the study to make comments or ask questions:

Miriam Tuowulle Aryere, Principal researcher - 020-9095506

Dr. Reuben K. Esen, Academic supervisor -0277220276/0543012970

Participant Consent Form

I have been thoroughly briefed on the entire method and significance of the ongoing study, which is being conducted. On my own free will, I consent to be part of the study, based on my understanding of what the study entails. However, by deciding to participate in this study, I am not waiving away any of my legal rights as a participant in the study.

Participant Signature.....

Date.....

Appendix B: Student questionnaire

Quantitative data collection tool

| | | |
|---|----------------------|--|
| THIS SECTION IS TO BE COMPLETED BY INTERVIEWER [for office use] | | |
| Q001 | Questionnaire Number | <input type="text"/> <input type="text"/> <input type="text"/> |
| Q002 | Date of interview |/...../..... dd/mm/yyyy |
| Q003 | Name of Interviewer | |

Section A: Socio-demographic information on respondent

| NO. | QUESTIONS AND FILTERS | CODING CATEGORY | |
|-----|---|---|---|
| Q1 | How old are you? (Age in completed years) | <input type="text"/> <input type="text"/> | |
| Q2 | What is your current marital Status? | Married | 1 |
| | | Single | 2 |
| | | Divorced | 3 |
| | | Widowed | 4 |
| Q3 | Gender of respondent | Male | 1 |
| | | Female | 2 |
| Q4 | What is the highest level of education completed? | Senior High | 1 |
| | | Teacher training | 2 |
| | | University | 3 |
| | | Others,specify..... | 4 |
| Q5 | What is your local dialect? | Ga | 1 |
| | | Twi | 2 |
| | | Ewe | 3 |
| | | Others, specify..... | 4 |
| Q6 | What is your religious denomination? | Christian | 1 |
| | | Muslim | 2 |
| | | Traditional | 3 |
| | | Others, specify..... | 4 |

| | | | |
|----|--|----------------------|---|
| Q7 | Which level are you as a student nurse or midwife? | 1 st Year | 1 |
| | | 2 nd year | 2 |
| | | 3 rd Year | 3 |
| | | Other, specify..... | 4 |
| Q8 | Type of institution | Public | 1 |
| | | Private | 2 |
| | | CHAG | 3 |
| Q9 | Type of programme | RGN | 1 |
| | | RM | 2 |
| | | RMN | 3 |
| | | RCN | 4 |

Section B: Assessment of factors influencing the quality of clinical Supervision from Nursing/Midwifery student's perspective.

| | | | |
|-----|--|-----|---|
| Q10 | Residence is close to the hospital of attachment | Yes | 1 |
| | | No | 2 |
| Q11 | Do you have any source of income or financial support? | Yes | 1 |
| | | No | 2 |
| Q12 | Does your institution choose hospitals for you? | Yes | 1 |
| | | No | 2 |
| Q13 | Do you face challenges during your clinical practice? | Yes | 1 |
| | | No | 2 |
| Q14 | Is accommodation a challenge during clinical attachment? | Yes | 1 |
| | | No | 2 |
| Q15 | Is finance a challenge during clinical attachment? | Yes | 1 |
| | | No | 2 |
| Q16 | Do clinical staff have negative attitude towards students? | Yes | 1 |
| | | No | 2 |

| | | | |
|-----|--|-------------------------|-------------|
| Q17 | Do you face issues of sexual harassment during clinical attachment? | Yes No | 1 2 |
| Q18 | Do you face physical or verbal abuses from clinical supervisors? | Yes No | 1 2 |
| Q19 | Senior staff over rely on students for work | Yes No | 1 2 |
| Q20 | Is there poor knowledge acquisition during clinical practice? | Yes No | 1 2 |
| Q21 | Clinical supervisors have limited time to teach students | Yes No | 1 2 |
| Q22 | Tutors don't visit students at the hospital to conduct supervision. | Yes No | 1 2 |
| Q23 | Students are given the most stressful work schedule | Yes No | 1 2 |
| Q24 | Students are asked to buy their own clinical materials | Yes No | 1 2 |
| Q25 | Are there challenges during clinical practice more than the benefits? | Yes No | 1 2 |
| Q26 | Can the ward be regarded as a good learning environment? | Yes No | 1 2 |
| Q27 | Do you get emotionally stressed during clinical practice | Yes No | 1 2 |
| Q28 | How would you rate the level of interaction with your tutor supervisor? | High Moderate Low | 1 2 3 |
| Q29 | How would you rate the level of interaction with your clinical supervisor? | High Moderate Low | 1 2 3 |
| Q30 | If you are to rate the quality of clinical supervision on | High | 1 |

| | | | |
|-----|--|----------|---|
| | clinical practice, what would it be? | Moderate | 2 |
| | | Low | 3 |
| Q31 | Are you aware of any student/standard guidelines for your supervision? | Yes | 1 |
| | | No | 2 |

Appendix 3: Key Informant Interview (KII) Guide

Perception of the quality of clinical supervision among Tutor Supervisors.

| Main question | Please briefly describe in your own words what you understand by quality clinical supervision. | Field Notes | |
|--------------------|--|-------------|--|
| | | | |
| Follow-up question | <p>What preparations do you make before students are sent to do their clinical attachment area?</p> <p>Ask About the facilities</p> <p>Objectives</p> <p>Materials</p> | | |
| Probe | <p>How do you supervise students who go on clinical supervision?</p> <p>What is the minimum qualification a tutor needs to qualify him/her to undertake clinical supervision?</p> | | |
| Main Question | <p>What is your perception about the quality of students' clinical supervision?</p> <p>What can be done to improve upon the quality of supervision?</p> | | |
| Main question | <p>What are the challenges you face as a tutor supervisor during students' clinical attachment in relation to?</p> <p>Hospital environment: friendly or unfriendly</p> <p>Logistics</p> <p>Time</p> <p>Workload</p> <p>Transport</p> | | |
| Follow-up question | <p>Would you describe the challenges discussed as barriers to clinical supervision?</p> | | |
| Probe | <p>Do you receive feedback from the clinical area on your students' conduct?</p> <p>How do you address issues raised?</p> | | |
| Main question | <p>What is your source of motivation as a tutor supervisor?</p> | | |

| | | | |
|---------------|---|--|--|
| Main question | Is there any existing standard guideline that stipulates how supervision of students should be done? | | |
| Probe | Do you think the existence of a standard guideline can improve the quality of supervision of students and solve the challenges? | | |

Appendix 4: Key Informant Interview (KII) Guide

Perceptions of the quality of Clinical supervision among clinical supervisors.

| | | | |
|--------------------|--|-------------|--|
| Main question | Briefly explain what you understand by quality clinical supervision. | Field Notes | |
| Follow-up question | Do you have preceptors in the hospital? How are students supervised in your ward? | | |
| Probe | What is the minimum qualification of one who is responsible for supervising students? | | |
| Probe | How often do you undergo training to equip you to supervise students on clinical attachment? When was the last time you attended one? Who should be responsible for the training of clinical supervisors? Why? | | |
| Main question | Describe your expectations of students on clinical attachment as a supervisor. | | |
| Main question | What is your perception about the quality of clinical supervision of student? What can be done to improve upon the quality of supervision | | |
| Main question | Please describe the challenges clinical supervisors face when nursing students are on clinical attachment in relation to; Logistics Time Workload Technology | | |
| Probe | Would you describe the challenges discussed as barriers to clinical supervision? | | |
| Main question | How is feedback on the conduct of students relayed to the Nursing Training Schools? | | |
| Main question | What is/are your source(s) of motivation as a clinical supervisor? | | |

| | | | |
|---------------|---|--|--|
| Main question | Is there an existing standard guideline that stipulates how supervision of students should be done? | | |
| Probe | Do you think a standard guideline can improve upon the quality of supervision of students and solve the challenges? | | |