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Clinical supervision in nursing: the (un)known phenomenon

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Abstract

To implement a clinical supervision model in nursing, we carry out an exploratory, descriptive and longitudinal study. We aim to publicize the results of its first phase which was focused on the chief nurses' opinion on the clinical supervision on nursing (CSN) phenomenon. Interviews to all chief nurses (18) were conducted. Content analysis was used to data analysis. Themes and categories were found such as perspectives, relevance, conditions to CSN, among others. Results suggested that chief nurses need to improve their knowledge on CSN. However, it was clear what CSN is not or should not be to some of them.

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Keywords: Clinical supervision in nursing; Relevance; Clinical supervisor; Chief nurse

Introduction

The studies on clinical supervision in nursing (CSN) have highlighted the need for more research on its core. Therefore, we decided to carry out an exploratory descriptive and longitudinal study with several phases with the purpose to develop and implement a clinical supervision model in nursing (Cruz, 2011).

The research took place in the Centro Hospitalar do Médio Ave E.P.E. (Médio Ave Hospital Centre – CHMA) which was comprised by two hospital units, specifically: Santo Tirso Unit and Vila Nova de Famalicão Unit.

Nowadays, we are improving and developing our knowledge on CSN in Portugal but there is still a lot of confusion about what CSN is and about what it should be, not only in Portugal but also in the other countries.

With this article we intend to publicize the results of the first phase of the study focused on the chief nurses' opinion on the CSN phenomenon. We decided to interview all chief nurses from the CHMA. Therefore 18 interviews were made and content analysis was used to data analysis. Several themes and categories were found such as perspectives, relevance, conditions to CSN, among others.

This paper is divided into three main sections: the first one is related to the methodology, in the second one, we present the results and the discussion of the content analysis performed and finally its conclusion.

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1. Methodology and study design – designing the research on CSN

A qualitative approach was used to know the chief nurses' opinion on the CSN phenomenon in the CHMA. This first phase of the study was exploratory and descriptive. We interviewed all 18 chief nurses from the Health Institution with the following aims: To identify the concept of CSN adopted by chief nurses; to identify conditions that promote CSN; to identify the clinical supervisor's profile; to understand the importance of CSN for chief nurses and to understanding the necessity for CSN.

We conducted semi structured interviews to the participants to collect data. All interviews were individual, they took at least 45 minutes, the venue was arranged accordingly to the participants' availability and they were all audio recorded with one exception. Field notes were taken during the interviews.

After each interview, we heard the recording which allowed us to retain a global perspective from the thematic. Then we transcribed the content of the interviews keeping rigorously the participants' discourse. Each interview was designated by the letter /E/ and we labelled each one with a sequential number and added our field notes because it is important to notice non-verbal communication, such as: silence, laugh, gestures and tears, among other aspects. As Graneheim & Lundman (2004) advise, we read the transcribed text of the interviews several times to obtain a sense of the whole and then performed content analysis to treat data. Qualitative indicators emerged, therefore we were able to know the CSN phenomenon in the CHMA from the chief nurses' opinions.

We achieved an analysis model comprised by themes, categories and sometimes subcategories which allowed us to decode the messages produced by the participants. "The manifest content, that is, what the text says, is often presented in categories, while themes are seen as expressions of the latent content, that is, what the text is talking about" (Graneheim & Lundman, 2004, p.111).

Permission from the CHMA to carry this research was obtained. We outlined the voluntary nature of the individuals' participation and we explained the study and the ethical issues that we were going to respect like the participants' anonymity and confidentiality, we also requested their permission to audio record the interviews. As mentioned before, one of the participants did not authorize it, so we wrote down the answers on paper and in the end of the interview we confirmed and validated with him/her what we had written to be sure that there were not biases of the discourse.

2. Analysis and discussion - the (un)known phenomenon

To know deeply the CSN phenomenon on the opinion of the chief nurses of the CHMA, we decided to interview all of them.

2.1 *PARTICIPANTS*

There were 18 participants in this first phase of the study, 7 from Santo Tirso Unit and 11 from Vila Nova de Famalicão Unit; 5 participants were male and 13 female. According to the professional category, this was a heterogeneous group because some participants had the professional category of specialized nurse and not chief nurse. However all of them were exercising administrative/management functions but none had a post-graduation in clinical supervision with one exception.

2.2 *THE (UN)KNOWN PHENOMENON*

After the transcription of the 18 interviews, we performed content analysis to treat data. We used NVivo7 as a resource for this treatment.

Five themes and several categories and subcategories emerged from questioning the same areas to all the participants. From the chief nurses' opinion: 'perspectives on CSN', 'relevance of CSN', 'conditions to CSN', 'clinical nurse supervisor' and 'procedures/sessions of CSN' were considered the core of the CSN phenomenon. We show the themes and the categories emerged from the data analysis in table 1.

Table 1 – Themes and Categories of the (un)known phenomenon

THEMES	CATEGORIES
Perspectives on CSN	Concept
	Model
	Strategies
	Professional category of the clinical supervisor
	Frequency
	Nature of the care
Relevance of CSN	Formative
	Administrative
	Normative
	Restorative
Conditions to CSN	Team characteristics
	Factors
	Clinical Supervisor Role
	Management
	Resources
Clinical nurse supervisor	Skills
	Education
	Origin
Procedures/Sessions on CSN	Time
	Sessions frequency
	Venue
	Type

2.2.1 *Perspectives on CSN*

From the theme 'perspectives on CSN' six categories and several sub categories emerged as shown in table 2.

Table 2 – 'Perspectives on CSN': categories and subcategories

Categories	Subcategories	Meaning unit (some examples)
Concept	In attendance on somebody	"To be with the professional in his/her daily clinical practice." E9
	Life-long learning	"I'm aware that with 20 years of nursing my practice is not the same as the one I had five, two years ago." E15
	Assessment/control	"It´s an assessment from all the parameters (…) in all areas, quality, quantity." E3
	Complexity/difficulty to define	"Definitions are always much more complicated. In a definition we have to say in few words lots of things." E15
	Professional growth/development	"For the person grow and development in an issue that is not as developed as it should be, we help to improve it." E12; "I see CSN as a way to professional growth and development." E18
	What is not or should not be	"It´s not an assessment." E1; "It´s not a control from others work" E15; "I don´t see it with a punishment function." E18
	Process	"It's all this process that it is done. It's not completely scientific; it's a little bit of our experience."E1;
	Care quality	"The CSN aims will end in better health care." E2; "It´s excellence in care."E14;
	Solve problems/situations	"It's a way to help to carry on with situations, to solve them." E1
	Safety	"Not to occur any error because it happens, (…). With CSN errors can be reduced and a lot; more safety for patients, for professionals, for all." E17
Model	Absence	"We don´t have anything."E1; "No, it doesn't exist (…) I don't know any institution where it exists." E2
	Beginners integration	"It was more for orientation and integration of the beginners." E8; "What we do is for integration and it's

		based on our experience." E11
	Self-proposal	"The rules I propose when they reach to the unit." E11
Strategies	To attend	"People never feel alone."E16
	Admonish	"When I saw that someone was doing something wrong, I admonish and talked to the person individually." E12; "It works like a traffic policeman, when we drive a 160 km/h if we see the policeman we go to 120Km/h, with the nurse is the same, if the chief nurse pass by, he/she will pay more attention."E14
	Support	"Initially there is a lot of support."E16
	Assertiveness	"I try to be assertive."E13
	Audit	"Sometimes, I do audits to know how things are going, to be able to see if each nurse is doing in the right way."E6
	Gossip	"It's important to know sometimes, not always, to listen to the people (…) peers know what happens (…) I know them all and I know what they are capable to do." E17
	Responsibility delegation	"I have them divided according into the specialities, each speciality has a leader and periodically there are reunions to see what is right and what is wrong."E13
	Aims/goals	"We could have teams organized with the perspective to achieve aims."E9
	Teach	"Teach in a positive way; in a way they felt helped and not criticized." E8
	Motivation	"Because I like to motivate the team."E14; "I give all the incentives to people develop in the area."E16
	Protocols	"We try to have protocols (…) people know the procedures they need to have."E14
	Monitoring/observation	"Supervision is done in several ways here and everywhere, here is through the direct observation of the care that nurses provide to the patients."E17
	Being positive	"Supervisors must see things in a positive way. Let´s change the difficulties into opportunities; let's try this to do something."E16
	Punishment/Public exposition/ Public shame	"With some people, public shame could have a positive effect on his/her exercise."E9; "Supervision, it has to be made through fighting, as we say, works a lot of the times."E10
	Group knowledge	"I know each one and all the team."E4; "For me it's fundamental to know my colleagues (…) to know their professional *curriculum*."E15
	Reflection	"Reflection, I think that is a good, an excellent strategy of supervision." E5
	Positive feedback	Positive feedback is a usual practice not only related to the care they provide but also related to other indicators. This is to empower the team."E9
	Secret/spying	"To a X or Y activity we could have a supervisor without the knowledge of the supervisee." E9; "I could be evaluating a nurse who is doing things badly without his/her knowledge."E13
	Select/choose	"I try to distribute people in rotation (…) I try that every nurse know every patient."E7
Professional category of the clinical supervisor	Nurse	"From nurse to nurse, when a beginner arrives."E1;
	Chief Nurse	"Supervision is made by chief nurse in every unit."E2; "I [chief nurse] do this role [clinical supervisor]."E5
	Nurse Supervisor	"We have a nurse supervisor; from our professional career, it should be one of his/her functions, as the name says."E2; "It's the nurse supervisor function."E17
Frequency	Daily	"I think it is daily, I'm here with my colleagues, isn´t it? As I am here every day I think it's a daily observation." E1; "We argue this every day, we have an hour which is calm."E3
Nature of the care	Dependent	"Perhaps, it ranges from unit to unit and from speciality because the needs are different (…) I recognize that work with children in paediatrics it's different from working here. There are different concerns and different stress."E3; "I think that in specific units, like paediatrics, I think it should be tighter."E4
	Independent	"I think it's independent from the specialities (…) clinical supervision should be equal in the areas."E1

The literature review is consensual that there is no wide consensus on the concept of CSN (Cruz, 2008). "Clinical supervision has various interpretations and there is still confusion in the profession about what the term actually means" (Winstanley, 2000, p.5). There are lots of definitions as White & Winstanley (2010) state: "Indeed, NHS (National Health Service) Evidence at the Health Information Resources, lists some 7362 references to clinical supervision" (p.75). We verified that only few participants of our study referred this complexity and difficulty related to the concept; nevertheless they stated some insights into it.

Several participants defined CSN focusing in the assessment/control of the professionals. Some of them have an opposite opinion. Therefore, we verified different conceptualizations of this concept.

Kilcullen (2007) states that: "The term supervision came from industry, the role of the supervisor in industry was to get the work done, according to define policies and procedures" (p.1030). This vision of supervision as an assessment/control and sometimes as a punishment has a deep negative impact in nurses who are in clinical practice and perhaps this is one of the causes of the resistance to CSN implementation.

In the CSN definition there were some participants that emphasize aspects like: In attendance on somebody; life-long learning; professional growth and development; solve problems/situations; process; quality care and safety which we can find in the literature. McLeod *et al*. (1997 cit in Ping 2008) refer that clinical supervision to be effective "(…) needs to be a planned teaching and supervision session to develop independent practioner with problem-solving skills, self-directed learning ability, autonomy and life-long capability" (p.29). Some authors, such as Butterworth & Faugier (1992) defined clinical supervision emphasizing that the process should promote opportunities to development. The document "Vision for the Future" from the National Health Service Management Executive (1993) defined it as: "A formal process of professional support and learning which enables individual practioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations. It is central to the process of learning and to scope of the expansion of practice and should be seen as a means of encouraging self-assessment and analytical and reflective skills" (p.15). This definition highlights supervision as a formal process, so it can be done *ad hoc*, it involves commitment from the health institution and points out the professional responsibility and safety. The NHS (2011c) about clinical supervision states: "In essence it can be described as a professional conversation to facilitate reflective learning, through a non-judgmental process, which is separate from appraisal" (p.7). To synthesise we could state that there are CSN definitions that are focused on the aims and the purpose of it; others that emphasize the process and the relationship between supervisor and supervisee and others that are focused on the supervisee and the opportunity to reflect (Lynch; Happel & Sharrock, 2008).

There are many CSN definitions as there are many CSN models, however our study documents that in the CHMA they did not have any model and the majority of the participants did not have any knowledge about it. Nevertheless some of them highlighted the program for beginners' integration as a CSN model and one participant referred to a CSN model as the one which was comprised by his/her rules. The NHS (2009) states: "Within the literature there are numerous models of supervision. Choice of model is a matter of personal preference but all encompass aspects of personal and professional support, education, development and training with quality assurance/patient safety function" (p.7). A CSN model should be conceptualized by the actors in the process and should be created in a flexible way to be able to answer the nurses' needs *in loco*.

The participants pointed several CSN strategies although some of them are unusual and illicit. The NHS (2011b) in the document, Policy C16- Clinical Supervision for Nurses about what CSN is not, alerts: "A disciplinary channel; a route to make complaints; an opportunity to criticize other than team members; time to arrange off duty and shifts, hours of work; 'time out' to chat about things in general or gossip" (p.9) In this sense, strategies as 'gossip', 'punishment/public exposition/public shame' and 'secret/spying' should be prohibited in CSN because the supervisory relationship must be raised in trust which is not compatible with those strategies. From the other strategies, we highlighted 'reflection' because as the NHS (2011a) refers: "Reflection is more than an elaborate name given to the normal thinking process it is a conscious effort to explore situations and events learn from them with the idea that you can then put this learning into practice" (p.22). The reflexive practice and CSN are linked because "the interface between reflective practice and clinical supervision becomes evident when considering the numerous definitions of clinical supervision, all of which are underpinned by the belief that it is about learning from practice" (Clouder & Sellars, 2004, p.263).

When we asked the participants about who was or should be the clinical supervisor, their answers were different. The majority stated that the clinical nurse supervisor was or should be the chief nurse. Some of them believe it should be the nurse if the context was related to the beginners' integration. Few participants referred the nurse supervisor as the person to perform this role. It is important to clarify that in Portugal we have the professional category of 'Nurse Supervisor', who is a hierarchical superior whose functions are related to management and not directly to clinical practice. The NHS (2011a) states about this issue: "Hierarchical-your clinical supervisor is likely to be in a higher-grade post but it is not always the case. In more senior positions it is common for practioners to be supervised by others of equal status. A good supervisor is there to guide you not to tell you what to do" (p.19-20). It

is expectable that supervisees do not want to discuss and reflect their practice with someone who can judge their progress in terms of career, especially nowadays when the offer is higher than the demand.

The participants' opinion about the frequency of CSN was that it should be daily and some of them referred the morning shift to do it. Perhaps this is a consequence of their timetable as chief nurses.

From some participants' point of view, there was no association between the nature of the care and CSN while from others it was exactly the opposite, especially in paediatrics, probably because this population is more susceptible to error than any other. "Paediatric patients are more vulnerable to drug administration errors due to a lack of appropriate drug dosages and strengths for use in this group of patients" (Chua, Chua & Omar, 2010, p.603). Patient safety is one of the nurses' concerns especially the ones who work in a paediatric environment. "Nurses play a role in improving the safety of children within their care. The role of the nurse is much wider than simply reporting patient safety incidents or near misses; it includes taking preventative actions, sharing experiences, learning from mistakes, and helping to devise solutions" (Gonzales, 2010, p.561).

2.2.2 *Relevance on CSN*

From the theme 'relevance on CSN', four categories and several subcategories emerged as shown in table 3.

Table 3 – 'Relevance on CSN': categories and subcategories

Categories	Subcategories	Meaning unit (some examples)
Formative	Growth/development	"To be able to help them to grow professionally." E5
	Behavioral changes	"Changing behaviors for sure (…) [clinical supervision] will modify behaviors." E2;
	Decision-making/reflection	"We do things as a routine; sometimes without reflection (…) clinical supervision always implies reflection." E6
Administrative	Control	"With the aim to assess." E1; [Clinical supervision] will act as a policeman, that's the expression." E2
	Management	"Better organization in the unit."E5; "It is required to put the unit to work." E12
Normative	Achieve aims	"To achieve aims. Unit aims and even people aims and profession goals." E1
	Care quality/excellence in care	"For quality." E1, E2; "Better quality of our care." E4, E8
	Social Recognition	"It also gives more credibility to the profession." E1
	Job satisfaction	"More satisfied nurses" E16; "It's going to give satisfaction." E17
	Standardization	"Uniform performance in the units." E1; "Standardize care in all units." E2;
Restorative	Communication/relationship	"Improves the team relationship." E6; "Better communication in the team." E16
	Motivation	"To some units, clinical supervision would be a way of motivation." E2
	Stress	"Less stressed nurses." E16

The theme 'relevance on CSN' has several categories such as: formative, administrative, normative and restorative. About the clinical supervision importance, McColgan & Rice (2012) highlighted that: "Supervision is important as it makes reflective practice a reality. This reflective practice can be considered in three ways:

- Restorative (support) – concerned with how the nurses responds emotionally to the stresses of working in a caring environment. To develop autonomy and self-esteem as a professional.
- Normative (accountability) – concerned with how the nurse maintains and ensures effectiveness in practice. The nurse is enabled to identify areas for development.
- Formative (learning) – concerned with developing the knowledge, skills and attitudes of the nurse problem solving and divergent thinking using a reflective model" (p.37).

Brunero & Stein-Parbury (2008), in their literature review made about the effectiveness of clinical supervision, categorized the terms accordingly to the functions of Proctor's model to describe the results showed by the research done. In our study we found similarities such as: "Normative (professional accountability) - improving practice and job satisfaction; Formative (skill and knowledge development) – Professional development, gaining knowledge, competence, knowledge; Restorative (colleague/social support) – increased interest; relief of thoughts and feelings" (p.88).

Formative, normative and restorative functions are components of CSN and it is crucial not to throw confusion into the administrative clinical supervision. Tromski-Klingshirn & Davis (2007) stated: "Administrative clinical supervision addresses managerial tasks such as overseeing case records; implementing policies and procedures regarding the continuity of care, quality assurance and accountability; hiring, firing, and reprimand clinical staff; and completing employee performance evaluations" (p.295).

2.2.3 *Conditions to CSN*

From the theme 'conditions to CSN' five categories and several subcategories emerged as shown in table 4.

Table 4 – 'Conditions to CSN': categories and subcategories

Categories	Subcategories	Meaning unit (some examples)
Team characteristics	Professional conduct	"When the chief nurse is not present, we notice that things don't go so well." E4;
	Team constitution	"The lack of human resources complicates a lot. " E4; The higher is the group more difficult it is." E13
Factors	Academics	"Having research and publicize the research in a massive way that pass to the population, I think it would be a way to motivate people." E7
	Environmental	"Nowadays everybody is bewildered (…) it's demotivation, it's anarchy. Each one makes what he/she wants." E10; "Make them to reflect. Make them think if the procedure is right or not, try one way and another." E5
Clinical supervisor	Role	"There had to be an initial preparation for the role (…) teams have to accept this role as something positive." E2
	Profile	"Perhaps, in an initial phase would be a punitive figure." E5
Management	Unit Management	"It is related to the unit management (…) so, rules, rules, rules. Clinical supervision is about to know all the rules, unit guidelines." E17
	Top Management	"Top management has been more confrontational and blocking than facilitator." E16
Resources	Financial	"[The program X] is a big call for nurses to this unit (…) we have the team much more satisfied (…) there are nurses who wan 1000€ in a morning." E9
	Physical	"Another thing that sometimes interferes is the physical conditions." E4
	Informatics	"Software X helps a lot (…) the professionals are going to feel almost forced to accomplish strictly (…) if they don´t is going to be recorded [in the software]." E17
	Materials	"Environment temperature – who is feeling hot and under a spotlight (…) it's annoying, no one can do good face." E11

The participants emphasized aspects related to the professional conduct and/or the team constitution that can or cannot promote conditions to CSN. Academics and environmental factors can or not promote CSN. Although participants did not explore this issue further, they referred aspects like the *ad hoc* and conversely reflection and even the need for research and its publication in this area to motivate staff. Koivu, Hyrkäs & Saarinen (2011) state: "Misinterpretation can lead to failure to recognise the need for clinical supervision (Bush 2005) or to *ad hoc* implementation of clinical supervision and the use of models that do not correspond to the realities of the nursing environment (Clearly & Freedman 2005) or the real nature of clinical supervision (Davey *et al* 2006)" (p70).

The participants pointed out supervisors' role and profile as a condition to CSN. The NHS (2011a) states: "Supervisors are experienced practioners who possess certain skills and attributes that enable them to undertake the role and they will have had training at the commencement of their supervisory activities" (p.9).

Unit and top management were crucial as conditions to CSN. "The nurse manager has a key role in facilitating clinical supervision through the provision of protected time and an appropriate environment for clinical supervision to take place. To help nurses managers to achieve this, health care organizations should include clinical supervision in their corporate agenda or business plans (Gilmore 2001) and in the job descriptions of the nurses (Green & Crisp, 2005)" (Koivu, Hyrkäs & Saarinen, 2011, p.77).

Nowadays we are facing financial constraints as well as lack of resources, therefore in our participants' opinion this had an impact on clinical supervision. "There are both organizational and personal barriers to the uptake of

clinical supervision. Organizational barriers result from political and professional conflicts, lack of understanding, constraints on nurses' time and limited resources of health care" (Koivu, Hyrkäs & Saarinen, 2011, p.70).

2.2.4 *Clinical nurse supervisor*

From the theme 'clinical nurse supervisor' several categories and subcategories emerged as shown in table 5.

Table 5 – 'Clinical nurse supervisor': categories and subcategories

Categories	Subcategories	Meaning unit (some examples)
Skills	Open mind	"With an open mind." E11
	Acceptance by the chief nurse	"The group recognizes [his/her] as my replacement." E18
	Acceptance by peers	"Well accepted by all nurses." E8
	Ambition	"To have the perspective to grow in the career." E11
	Assertiveness	"To know how to deal with the professionals (…) skills to avoid offending." E17
	Self-criticism	"To know my potentialities, to identify where I am really good and where I need to improve." E16
	Calm/patience	"Calm (…) patience." E4; "To be able to give calm to others in a stressful situation." E5
	Camouflage/Spying	"To be able to captivate, to err, to go to their side [nurses' side]." E5
	Communication/active listen	"Being aware of the people and talk to them."E4; "To communicate is complicated." E5
	Trust	"Trust spirit is fundamental to improve care." E18
	Dedication/ availability	"Be available." E15; "A dedicated person." E17
	Experience	"With professional experience, with life experience." E12
	Impartiality	"Especially a fair person." E3
	Leadership	"With a leader profile (…) to be able to lead." E2; "With skills of management." E14
	Model	"Himself/herself should be a model in what is going to supervise." E9
	Motivation	"To be able to motivate for change." E2
	Observation	"It has to have an observation spirit (…) he/she must to know how to observe." E6
	Orientation	"You need to know how to guide them and help them." E17
	Expertise	"To be an expert in X or Y issue." E9
	Insight	"It should have expertise to be able to know each group and inside each group." E2
	Persuasion	"With persuasion ability." E2
	Power	"A person who has more power (…) power helps." E14
	Teacher	"Personal characteristics to be able to teach." E15
	Evidence based practice	"Always searching for things ahead (…) shared interests and knowledge." E7
	Proximity	"Closeness not intimacy, but close." E3
	Relationship/Cooperation	"To have a good relationship." E17
	Respect	"Being respected as a supervisor." E5
	Coach	"Skills as a coach." E16
Education	Specialization	"With a specialization, it should be important." E15
	Management	"Education in the management area." E7
	Pedagogy	"It should have knowledge in pedagogy." E1
	Psychology	"In psychology." E2
	CSN	"Should have knowledge in CSN (theoretical and practical) (…) it should be important to have education in CSN." E1
Origin	From Inside the Unit	"From my group, my unit." E4; "It must be from the unit." E5
	From outside the Unit	"Perhaps there are advantages to be outside the unit." E1
	Unconcerned	"Inside or outside the unit? It can be anyone." E3

Given the extent of the subcategories found, we are not going to discuss them even because of the existence of skills that are documented by the CSN literature. However, participants referred as a skill 'acceptance by the chief

nurse' and 'camouflage/spying' which should be pointed out because of their nature. In CSN context, spying is not licit. Nurses have the right to know that they have a supervisor; that they are supervisees; and that they are in a supervision process because they should be an active part of it. Therefore, camouflage/spying is not a strategy to be used. As mentioned before, the supervisory relationship should be based on trust. About the acceptance by the chief nurse, in some circumstances, this fact could lead to silence from the supervisees because of the confusion of roles that might be inherent in the situation.

Some participants pointed out that the supervisor should have education in CSN and they highlighted that they should have knowledge and experience on CSN to be a supervisor.

2.2.5 *Procedures/sessions on CSN*

From the theme 'procedures/sessions on CSN', several categories and subcategories emerged as shown in table 6.

Table 6 – 'Procedures/sessions on CSN': categories and subcategories

Categories	Subcategories	Meaning unit (some examples)
Time	Out of professional time	"If it's [CSN] for the chief nurses, I think it should be volunteer time." E12
	In professional time	"In professional time." E6; E9; E11; E18
Venue	Outside the unit	"In a reunion office, in the library, in the education department but always outside the unit." E2; "Outside the unit." E6
	Inside the unit	Inside the unit (…) because people are in their environment and it should be easier to talk and to remember situations." E1; "Inside the unit." E4; E5; E12
	Indifferent	"I think it is indifferent." E3
Frequency	According the aims	"Depends on what we want to achieve." E12
	Weekly	"Initially, once a week." E16
	Fortnight/monthly	"Initially, I think monthly." E3; "In this unit I will say monthly." E5; E18; "Fortnight, monthly." E14
	Quarterly	"Here, quarterly, to reflect in some issues which are not so well." E2
Type	According the needs/issues	"It depends." E8; "There are issues which are extremely beneficial to discuss in a group and others should be individually." E9
	Unknown	"I don't have experience to say." E11
	Group	"In a group I think it is easier." E1; "With the team." E2
	Homologous unit	"If it is a corresponding unit I think it is worthwhile". E1

The majority of the participants highlighted that the time spent in CSN sessions should be accounted for professional time and the venue should be in the unit. Nevertheless some participants think the venue should be outside the unit and one thinks it is indifferent.

There were different opinions about the frequency of the sessions as well as its type. The NHS (2009) referred that the frequency of the "(…) supervisions sessions should take place: maximum 2 monthly; minimum 3 monthly. However, individual groups may agree to sessions taking place on a more frequent basis" (p.9). The NHS (2011b) also refers that supervisor and supervisee meet each other monthly.

3. Conclusion

The core of the phase presented in this article was essentially exploratory and descriptive and focused on the chief nurses' opinion on the CSN phenomenon. Our study pointed out that chief nurses need to improve their knowledge on CSN to be able to cooperate for its demystification and implementation. In Portugal, the adoption of CSN as a quality strategy should be a reality in health care institutions. Unfortunately, institutions are aware of this but far from providing CS to nurses perhaps because of the financial constraints. Further research, which link effects of CSN and financial issues, should be done urgently to be able to document if CSN could bring simultaneously cost savings and more quality and safety to health care.

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4. References

Brunero, S. & Saint – Parbury, J. (2008). The effectiveness of clinical supervision in nursing: an evidence based literature review. *Australian Journal of Advanced Nursing, 25 (3)*, 86-94

Butterworth, T & Faugier, J. (1992). Clinical supervision and mentorship in nursing. London: Chapman and Hall

Chua, S.; Chua, H. & Omar, A. (2010). Drug administration errors in pediatric wards: a direct observation approach. *European Journal of Pediatrics, 169*, 603-611

Clouder, L. & Sellars, J. (2004). Reflective practice and clinical supervision: an interprofessional perspective. *Journal of Advanced Nursing, 46, (3),* 262-269

Cruz, S. (2008). A supervisão clínica em enfermagem como estratégia de qualidade no contexto da enfermagem avançada. *Servir, 56, (5),* pp.112-118

Cruz, S. (2011). Clinical supervision in nursing: effective pathway to quality. *Procedia Social and Behavioral Sciences, 29*, pp.286-291

Gonzales, K. (2010). Medication administration errors and the paediatric population: a systematic search of the literature. *Journal of Pediatric Nursing, 25*, 555-565

Graneheim, U. & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*, pp.105-112

Kilcullen, N. (2007). An analysis of the experiences of clinical supervision on Registered Nurses undertaking MSc/graduate diploma in renal and urological nursing and on their clinical supervisors. *Journal of Clinical Nursing, 16,* 1029-1038

Koivu, A.; Hyrkäs, K. & Saarinen, P. (2011). Who attends clinical supervision? The uptake of clinical supervision by hospital nurses. *Journal of Nursing Management, 19*, 69-79

Lynch, L.; Happel, B. & Sharrock, J. (2008). Clinical supervision: an exploration of its origins and definitions. *International Journal of Psychiatric Nursing Research, 13, (2)*, 1-19

McColgan, K. & Rice, C. (2012). An online training resource for clinical supervision. *Nursing Standard, 26, (24)*, pp.35-39

NHS (2009). Clinical supervision policy. Leicestershire County and Rutland: NHS Primary Care Trust

NHS (2011a). Clinical supervision for health professionals. Surrey Community Health: NHS Surrey

NHS (2011b). Policy: C16 – Clinical supervision for nurses. West London Mental Health: NHS Trust

NHS (2011c). Clinical supervision policy version 2:1. Plymouth: NHS Plymouth

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

Ping (2008). Roles and models of clinical supervision. *Singapore Nursing Journal, 35, (2),* 26-32

Tromski-Klingshirn, D. & Davis, T. (2007). Supervisees' perceptions of their clinical supervision: a study of the dual role of clinical and administrative supervisor. *Counselor Education & Supervision, 46*, pp.294-304

White, E. & Winstanley, J. (2010). A randomized controlled trial of clinical supervision: selected findings from a novel Australian attempt to establish the evidence base for casual relationship with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. *Journal of Research in Nursing, 15*, 151-167

Winstanley, J. (2000). Manchester Clinical Supervision Scale: user guide. Australia: Julie Winstanley