

UNIVERSITY OF KWAZULU NATAL

**AN ANALYSIS OF CLINICAL SUPERVISION
AND SUPPORT FOR BRIDGING PROGRAMME
STUDENTS IN THE CLINICAL SETTINGS IN THE
GREATER DURBAN AREA**

Compiled by:

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**AN ANALYSIS OF CLINICAL SUPERVISION AND
SUPPORT FOR BRIDGING PROGRAMME
STUDENTS IN THE CLINICAL SETTINGS IN THE
GREATER DURBAN AREA**

**A dissertation submitted
to the Department of Nursing at the
University of KwaZulu Natal
in partial fulfilment of the
requirements for the degree of
Masters in Nursing Education**

BY

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DECLARATION

I DECLARE THAT THIS IS MY OWN UNAIDED WORK. IT IS BEING SUBMITTED FOR THE DEGREE OF MASTERS IN NURSING EDUCATION AT THE UNIVERSITY OF KWAZULU NATAL. DURBAN. IT HAS NEVER BEEN SUBMITTED FOR ANY OTHER PURPOSE.

ALL SOURCES USED HAVE BEEN ACKNOWLEDGED BY MEANS OF REFERENCING.

PADMINI PILLAY DATE: FEBRAURY 2005

DEDICATION

**THIS DISSERTATION IS DEDICATED TO MY
HUSBAND GEORGE, AND MY CHILDREN
THIRUSHA, VIRESHAN AND LUSELA FOR ALL
THEIR LOVE, SUPPORT, AND
ENCOURAGEMENT.**

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ABSTRACT

The purpose of the study was to describe the nature of clinical supervision and support provided to bridging programme students in the clinical settings. A descriptive and an exploratory design were most appropriate.

There were one hundred-and-twenty-two participants in the study.

Data was collected by means of a questionnaire and a critical incident report.

The questionnaires included semi-structured questions where the respondents were able to discuss the effects of clinical supervision and teaching behaviours that would enhance learning during clinical accompaniment.

The subjects were the second year students in the bridging programme.

Only those students who consented participated in the study.

The campuses that were used were the Prince Mshyeni College of Nursing, Netcare Nursing Academy and Afrox College of Nursing.

These campuses were conveniently selected because they were in the greater Durban area and were thus easily accessible to the researcher.

Students described the positive and negative experiences they received from the clinical supervisor and the ward staff. Positive experiences included the feelings of confidence, and the gaining of interpersonal skills. Gaining self- confidence as a nurse is an essential aspect of the student nurse's professional development.

The negative experiences were that the students were treated as the normal workforce because of their experience as enrolled nurses.

The challenges of clinical supervision are to help the student to evaluate critically the effect of actions taken, to assist him/her to perform procedures skilfully and to enable him/her to relate to patients in an ethical and caring manner.

The critical incident analysis revealed that the student nurses continued to use informal support networks as well as their supervision sessions to discuss clinical issues.

Respondents reported an enthusiasm for the opportunity to talk meaningfully to a trusted colleague about personal circumstances at work. Such opportunities were particularly welcomed by nurses who wished to reflect upon their own practices with patients, especially when dealing with clinical conditions that were upsetting, or otherwise challenging.

Respondents pointed out that more time would make clinical supervision sessions longer and more effective.

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CHAPTER ONE

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

The challenge of clinical teaching in the words of Irby (2004) is to transform novice students into practicing professionals. The transformation process is designed to help students learn how to collect data, interpret and synthesize findings, evaluate critically the effect of actions taken, perform procedures skilfully, and relate to patients in an ethical and caring manner.

Kuhn cited in Irby (2004) in an attempt to explain the transformation from novice to professional wrote, "Looking at a bubble-chamber photograph, the student sees confused and broken lines, the physicist a record of familiar sub nuclear events. Only after a number of such transformations of vision does the student become an inhabitant of the scientist's world, seeing what the scientist sees and responding as the scientist does." In Saliba (1997) it is stated that for the student to reach the level where she/he functions as a professional there is a need for the assistance and support of a clinical supervisor who is knowledgeable, committed to the facilitation of the learning process and who moves beyond providing academic support, to providing emotional and social support.

The concept of clinical supervision can be traced as far back as the times of Florence Nightingale, where experienced nurses provided guidance to less experienced nurses in their clinical work (Winstanley & White, 2003). Proctor, in Teasdale, Brocklehurst and Thom (2000) asserted that clinical supervision has three main functions: normative, formative and restorative. Explaining these three dimensions further, Proctor (1996) indicated that *normative supervision* is described as a managerial aspect of clinical supervision. This dimension of supervision has a crucial quality control element, promoting and complying with policies and procedures. This aspect of supervision promotes quality care and reduces

risks to patients or clients. *Formative supervision* is concerned with helping student nurses to develop their skills and update their knowledge base. This is achieved through reflection on, and exploration of student's work. *Restorative supervision* sometimes referred to as pastoral support is defined by Winstanley et al (2003) as supportive action, and responses to unload stress and also as a means of maintaining adequate emotional stability during clinical learning. The clinical supervisor gives personal support to help learners cope better with their pressures in the clinical settings.

Literature reveals that the term clinical supervision is a challenging concept because of the multiple interpretations and understandings of this term. According to McCabe (1985) there is no universally agreed upon definition of this concept. This creates a number of problems in the implementation of this phenomenon. Rather than defining this term, some authors provide benefits of clinical supervision. For example, Perry (1991) defines clinical supervision as one strategy used to help students learn to deal with situations and people they will meet in the nursing role, and also to understand the wider context in which their practices take place.

Fawcett and McQueen (1994) view clinical supervision as an instrument used to help students to learn skills they will need as nurses, to practice intelligently and reflectively in a challenging and changing health care system, and to gain an understanding of the principles underlying those skills. Schweer and Gebbie (1976) understand clinical supervision in nursing, as the mode that provides students with the opportunity to translate theoretical knowledge into the learning of a variety of skills required to give patient-centred care. Department of Health in the United Kingdom (1993) also known as the Doll, on the other

hand, conceptualises clinical supervision as a formal process of professional support and learning, which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex clinical situations.

In spite of the differences in the understanding of the concept clinical supervision, Fawcett and McQueen (1994) emphasized that the value of sound clinical teaching practices cannot be questioned, assisting students to develop personally and professionally, as well as developing vital clinical nursing skills. In the “Vision for the Future Document” (2003), clinical supervision is illuminated as central to the process of learning of student nurses. Flagler, Loper-Powers, and Spitzer (1988) and Wood (1982) are of the view that a substantial part of nursing students’ education involves clinical practice, and when students have a positive experience in the practice setting, they are more likely to undergo meaningful learning and be motivated to learn.

Irby (2004) pointed out that clinical supervision is a conceptually sound learning model, which, unfortunately, is flawed by problems of implementation. Some of the more glaring problems include (a) limited emphasis upon problem-solving, (b) lack of clear expectations for student performance, (c) inadequate feedback to students, and (d) inappropriate role models in clinical settings. According to Irby (2004), one of the persistent complaints about learning in clinical settings is the overwhelming work demand placed upon students. This is supported by the study of Zulu (2003) on non-traditional students (bridging programme students), which concludes that in most cases they are utilized as an extra pair of hands in clinical settings. If placed in the units where they were functioning before becoming students, the unit managers allocate them to their old responsibilities with limited

opportunities, if any, to engage in work that will prepare them for their future roles as registered nurses. Their student status is hardly considered, and their clinical supervision is very limited because it is assumed that they are coping. As a result this leaves them with little time to be exposed to the learning expected from students being prepared to become registered nurses. If such an opportunity becomes available, there is little time for thinking and reflecting on their learning experiences because of the busy work environment. They rarely have an opportunity to reflect on their learning, make connections to information or theory learned, and to engage in real problem solving with patients under their care.

Benoliel (1988) suggested that in the clinical setting students need not only have technical and problem solving skills, but also the emotional discipline and support that is essential for providing care in difficult patient care situations. During the learning process, the students need (a) a sense of being cared for while they are learning to care for others, (b) a feeling that they are receiving support and guidance whilst dealing with clinical experiences in which they may perceive themselves to be failures and (c) experiences which provide them with a sense of mastery and growth that enhances professional competence. Clinical teachers should be able to provide this support. Some of the themes that emerged from the study by Smith (2000) about clinical supervision indicated that nurses in the clinical settings feel lonely and unsupported. This study revealed that over and above academic support, the supervisees (students) need emotional or social support from clinical supervisors.

Mogan and Knox (1997), as well as Irby (2004) indicated that there are concerns about clinical teachers as role models in clinical settings. According to these authors, many clinical instructors and clinical staff fail to serve as exemplary role models in a number of ways. For example, during the clinical teaching sessions, the clinical teachers focus on the skill they want to teach the student and the related theory, and fail to attend to the psychosocial needs

of patients and the ethical issues of patient care. To illustrate this, during a clinical teaching session when a patient requires some assistance with an issue not related to what is being taught at that time, the clinical instructor calls another person to attend to it. A session is not stopped momentarily to attend to the patient's needs, which the patient obviously deems urgent. If assistance is not available, the patient is promised that the student will attend to them later, after the session. Covertly, the students learn such behaviour and attitudes from their instructors that what only the nurse regards as a priority at a given time is actually a priority, and the rest will follow. During the teaching sessions, the clinical instructors when interacting with clients, in one way or another teach certain types of behaviour to students.

According to Henderson (1995), role modelling is a powerful teaching technique. Modelling involves demonstrating exemplary professional characteristics. These include the non-cognitive dimensions of professional practice such as showing genuine concern for patients, recognizing one's own limitations, showing respect for others, taking responsibility, and not appearing arrogant. If the attending professionals treat patients with respect and genuine concern, students will do the same. The reverse is also true.

Kramer (1976) asserted that poor clinical supervision has an impact on the quality of graduates produced, and that employees unfortunately find themselves spending a lot of time on graduates by trying to assist them in their period of transformation from students to professionals. It is believed that this could be avoided through good quality clinical supervision, which would prepare students for professional life after graduation. The process of clinical supervision should help students gain self-confidence and self-esteem, which will help them to identify themselves as professionals. Kramer (1976) reported that nurse coordinators attributed a lack of self-confidence as the main cause of the inability of new

graduates to function effectively. Moreover, according to Moeller (1984), the clinical instructor who supervises the student during this 'hands on' practice often bore the burden of being the final gatekeeper to the profession.

Henderson (1995) indicated that clinical supervision involves more than evaluating learning. Effective clinical supervisors *provide structure* for the learning environment, promote problem-solving and critical appraisal skills, objectively observe and offer feedback on student performance, and provide professional support and encouragement. Structuring work and learning environments is a key component of a clinical supervisor's responsibility. This involves clearly articulating expectations, structuring time for learning (as well as work), and providing appropriate practice opportunities. Students are more likely to achieve the intended learning outcomes if they are told clearly what is expected and why. Also, they can better direct their attention towards the important details and skills to be learned when the learning experience is focused. Maintaining focus and clarifying important clinical issues are important clinical teaching functions. Students need practice opportunities for skill and concept development. By matching the problems of patients to the levels of skills students have attained, clinical supervisors direct students toward competence. In learning skills, students need to know what they are to learn. During the early periods of practice, they require brief guidance and help in discovering the critical cues that will allow them to evaluate their performance. The learning process is not complete without feedback and the knowledge of results.

Students need professional support and encouragement to deal with the stresses of the clinical environment and with their own performance anxieties. The professional and

emotional support of concerned clinical teachers can alleviate much of this stress and anxiety.

McKenna (1997) emphasized that generally, clinical teachers receive minimal preparation before undertaking their clinical roles. This author envisaged that the clinical learning of students would be greatly enhanced, if provision were made to provide clinical teachers with a better understanding of the theory and practice of clinical teaching. This author asserted that minimal educational preparation compromises the quality and effectiveness of clinical supervision.

1.2 PROBLEM STATEMENT

The background to this study revealed that the concept itself is a complex term with multiple interpretations. Over and above this, a number of concerns have been highlighted regarding the practice of this phenomenon, the quality of clinical supervision provided, the limited expertise of those regarded as clinical supervisors, the pressures in the workplace where clinical supervision takes place which displaces clinical supervision to the bottom of the agenda, or results in clinical teaching often occurring by chance. McCallion and Baxter (1995) insisted that clinical supervision should not be something that is pushed aside because it is less important. It should be established as a part of normal practice like having a set number of lectures to attend.

Moreover, this study focuses on bridging programme students. These students are regarded as groups of students with special needs because of their dual status as students and employees. Their learning needs are in most cases neglected because they are regarded as

part of the workforce. Clinical supervision is viewed as a burden in some of the units, because it entails time spent outside the actual workforce. Some units prefer to rely on the bridging programme students because they are a better kind of student; they are familiar with the routine and therefore require less assistance/attention from the ward staff. Taking these students away from their daily activities for clinical supervision sessions poses a challenge because this means that the unit is minus a staff member. Work tends to be a priority as opposed to the learning needs of students. The assistance which they require with their learnerships as they prepare to become registered nurses is not regarded as a priority, and this lack compromises their learning, as pointed out by Zulu (2003). Furthermore, when afforded an opportunity to attend a clinical supervision session together with traditional students, they are given less attention than the traditional students. It is assumed that bridging programme students are familiar with the ward procedures and most of what takes place in clinical settings. The clinical staffs tends to forget that being familiar with the practices in the clinical settings is not the crux of the matter and that linking those practices to the theory underpinning practices is essential. It is also acknowledged that some of the bridging programme students have over years of their practice as enrolled nurses developed unacceptable practices. They have to be assisted by clinical supervisors to relinquish these practices. The challenge of this current study is to analyse the phenomenon of clinical supervision in a bridging programme, and the nature of support provided to this special group of nursing students.

1.3 PURPOSE OF THE STUDY

The purpose of this study is to describe the nature of clinical supervision and support provided to bridging programme students in the clinical settings in Greater Durban area.

1.4 RESEARCH OBJECTIVES

1. To analyse and describe preconditions taken into consideration in a bridging programme for clinical supervision to be effective.
2. To analyse the teaching/learning process during clinical supervision in a bridging programme.
3. To describe the type of support provided to bridging programme students when they encounter a critical incident in the clinical setting.
4. To describe and analyse how clinical supervision and support influences the learning outcomes.

1.5 RESEARCH QUESTIONS

- 1.1 What type of agreement do bridging programme students and clinical supervisors enter into in preparation for the clinical supervision process?
- 1.2 What do these agreements entail as a framework, which will guide the clinical supervisory process?
- 2.1 What are the core characteristics of the clinical supervision process?
- 3.1 What type of support is provided to bridging programme students when they encounter critical incidents in the clinical learning environment?
- 4.1 What are the outcomes of support provided to bridging programme students regarding their learning and development?
- 4.2 What are the outcomes of restorative and supportive roles of clinical supervisors?

1.6 SIGNIFICANCE OF THE STUDY

Kramer (1976) pointed out that due to a lack of good preparation for professional practice, employers find themselves spending extensively in trying to assist students to bridge the gap between being students and becoming professionals. The findings in this study might shed some light on the deficiencies existing in clinical supervision, which have led to this problem. It is believed that these could be avoided through good quality clinical supervision, which would prepare students for their professional life after graduation.

The findings of this study can help the clinical tutors and nurse educators to re-orientate their practice to improve their clinical supervision practices.

The findings from this study could provide baseline data for a larger scale study in this area as this study only focuses on three institutions. The study might also make a contribution to nursing research by increasing the body of knowledge concerning the quality of clinical supervision given to nursing students in general.

1.7 CONCEPTUAL FRAMEWORK

This framework is modified from the model, which was developed by Hyrkas (2002) from the literature review on clinical supervision. This model looks at the antecedent factors (preconditions) to be considered for effective clinical supervision to take place, the core of clinical supervision, and the expected outcomes of clinical supervision. (See Figure 1.)

1.7.1 Antecedent factors to be considered for effective clinical supervision

In this framework the concrete *arrangements and resources* such as money, time and place have been considered important preconditions for clinical supervision (Hyrkas, 2002). Lack of resources seems to be the biggest threat to the occurrence of the concept. In the context of this study, nursing education should make provision for all the resources required, appointing suitable qualified clinical supervisors, following a set schedule to ensure that clinical supervision consistently takes place, providing persons (such as hospital matrons) from the clinical settings to liaise with, to ensure that there is communication between the academic institution and clinical settings.

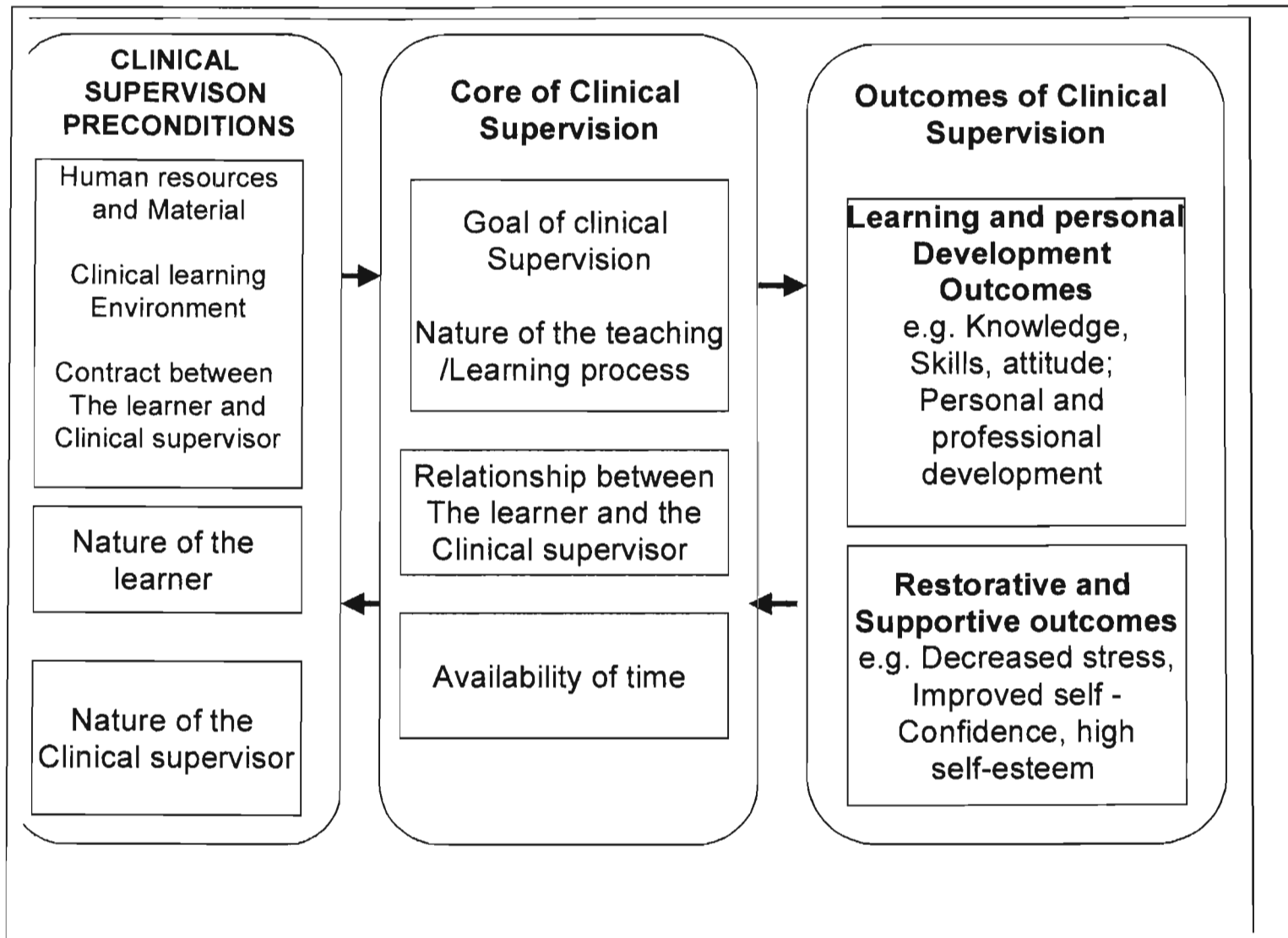


Figure 1
Clinical Supervision Conceptual Framework Adapted from Hyrkas, K (2000)'s Model

There should be an *agreement* between supervisor and student. This is the crux of clinical supervision. The agreement is described as a contract where the practical arrangements (such as the duration of clinical supervision, frequency and place) and the 'play rules' (such as, roles, preparing issues for sessions, confidentiality, evaluation) are agreed (Hyrkas, 2002). This agreement provides a form of boundaries or framework for clinical supervision. Without a formal structure, avoidance behaviours are easily produced and this can create a climate where clinical supervision does not have positive outcomes (Hyrkas, 2002).

The roles and responsibilities of both the *supervisor and the student* should be clearly defined in the contract, and the contract should clearly define the goals to be achieved through clinical supervision (Hyrkas, 2002). The supervisor is defined as a person with practical and professional experience (expertise) and theoretical knowledge that is equal to, or more advanced than that of the student. Ideally, the supervisor is in a non-hierarchical relation to the student. In this framework, the role of the supervisor is described as supportive, in accomplishing, assessing and solving work-related problems with the student, and assisting the student to reflect on practice (Hyrkas, 2002). Lyth, (2000) elaborating on the characteristics of a supervisor stated that the supervisor should be inspiring, have adequate knowledge and skills as a consultant and mentor, possess good qualities of being able to interact and relate with the students (such as sensitivity and listening skills) and be aware of self (knowing his/her strengths and limitations). This author however, emphasis that the important characteristics related to supervisors' characteristics are adequate knowledge, and supervisory and interaction skills (Lyth, 2000).

Supervisors' demographic background characteristics such as gender, age, personality and cultural background are viewed as factors affecting clinical supervision (Hyrkas, 2002). The background of the supervisor is viewed as a factor affecting, for example, the way in which the supervisor sees and understands the student. It is assumed that if the background characteristics differ between student and supervisor, 'blind spots', and even such reactions as ignorance and defensive feelings of guilt and anxiety can develop (Hyrkas, 2002)

According to this framework, certain specific personal characteristics of *students* are important to successful clinical supervision. These can be summarised in terms of demographics, motivation to learn, self-confidence, openness, willingness to acquire feedback, and self-disclosure, which have been identified as characteristics of self-awareness. The motivation factor as a personal characteristic has been considered essential, as it is seen that the outcome of clinical supervision depends ultimately on the student's willingness to invest in clinical supervision.

The *clinical environment* is another precondition for effective clinical supervision. The clinical environment selected for the placement of students should have appropriate learning experiences that will facilitate the development of required competencies from the students (Hyrkas, 2002). There should be a system of continuous support of students in the clinical settings in the absence of an appointed clinical supervisor.

1.7.2 The core of clinical supervision

According to Hyrkas, (2002) the core of the clinical supervision process is described as continuous learning from experience, practice or problem solving, but also as an integration

process of professional experiences, skills and knowledge. The core of clinical supervision includes important issues such as clearly stated goals of each clinical supervision session, teaching-learning process and focus of clinical supervision. The goals are described as individually emphasized, based on the student's specific needs, but also as coherent with the organizations or units activities, development of positive culture and the profession's function (Hyrkas, 2002). The teaching learning process during the clinical supervision process is described as having practice-oriented learning experiences, comprised of everyday experiences and characterised by examinations (assessments) of one's performance in relation to objectives, systems requirements, professional practice, research evidence or otherwise relevant knowledge (Hyrkas, 2002).

Holloway (1995) stated that the relationship between the supervisor and the student is characterised by several attributes such as supporting and facilitating, encouraging, sharing, non-possessiveness, independence, and valuing of the student's knowledge, personal learning style and tempo. Clinical supervisors need to identify individual student needs and learning styles and plan supervision accordingly.

1.7.3 Expected outcomes of clinical supervision

Outcomes are expected in two main areas namely the learning and development of the learner, as well as the restorative and supportive dimensions of clinical supervision.

Regarding *learning and development of a learner*, outcomes expected are related to development of expected competencies (knowledge, skills and attitude) and personal as well as professional development (Hyrkas, 2002). Motivation to learn is viewed as an important outcome of clinical supervision.

Restorative and supportive outcomes for an individual student have been described in terms of decreased anxiety, reduced fears, and reduced stress, less strain, decreased burnout and combating feelings of being drained (Hawkins and Shoheit, 1996). The links between clinical supervision and restorative and supportive outcomes have been described in literature starting with an assumption that work load causes psychological problems, and emotions such as distress, stress, strain and burnout (Hyrkas, 2002). It is claimed that clinical supervision allows learners to become aware of the effects of distress and pressure and teaches them how to deal with these emotions.

1.8 Operational Definition of Terms

Clinical supervision is a process through which the clinical supervisor facilitates the process of growth of a novice (the learner) towards becoming a competent professional. This process has three core functions namely: an *educative function* which enables the development of skills, understanding and abilities, by reflecting on, and exploring the person's work-based learning experience; a *supportive function* providing support to enable the person to deal with what has happened and move on, and a *managerial function* which includes the provision of quality control.

Student. The term student will be used interchangeably with that of learner in this study. This term refers to the second year bridging programme students who are registered at an institution being used in this study with the aim of qualifying as registered nurses.

Clinical supervisor refers to a registered nurse who is employed in a nursing college or teaching hospital in order to teach student nurses in clinical settings.

Bridging programme refers to the official South African Nursing Council's programme for the education and training of enrolled nurses in order to become Registered General Nurses.

Support refers to lending of assistance, to encouraging and to providing the necessities within the clinical setting.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of this review was firstly, to examine the conceptualisation of the term clinical supervision, secondly to provide an outline of clinical supervision models, and thirdly to provide a summary of the empirical literature related to clinical supervision. The following areas are also addressed; the core of clinical supervision benefits of clinical supervision, clinical supervision and the clinical environment and its effect on the nurse, nurses' perceptions of the elements of clinical supervision and who performs clinical supervision. It is important to note that effective approaches to the acquisition of clinical skills in nursing education have been widely debated, both within the education sector and clinical practice arena (Willis, 2004). Changes in approaches to skills development have varied at different points in the history of nurse education. This will be further discussed under conceptualisation of the term clinical supervision.

2.2. Conceptualisation of the term Clinical supervision.

The concept of experienced nurses providing guidance to less experienced nurses in their clinical work has been accepted since the days of Florence Nightingale (Emmerton, 1999) but, according to McCabe (1985), to date, there is no universally agreed upon definition of this concept which thus makes it difficult to implement. According to Butterworth, (1992), Bond and Holland (1998), and Lyth (2000), clinical supervision is an 'umbrella term' and the terms mentor, assessor, and preceptor are all linked to the clinical supervision practice. Further elaborating variation in the understanding of the term 'clinical supervision', Palmer

(2000) indicated that the relation between the terms is described as forming a system that covers the whole career development. Lyth (2000) asserted that the ambiguity of clinical supervision even as an 'umbrella term' has been criticised, based on the argument that the defined attributes for the related terms have not in fact clarified the concept of clinical supervision. The multiple definitions and understandings of this term have led to a lot of confusion around the practice of clinical supervision, as Infante (1996) stated that nursing education has difficulty in identifying what clinical teaching consists of. It is important to note that academic institutions when referring to the clinical supervision of the student by the experienced nurse practitioner use this concept. It is also used in the workplace, referring to the process whereby senior employees assist young employees to develop.

The Royal College of Nursing (1999) asserted that a nurse, new (student) or returning (practicing nurse) to an academic environment that is fast changing requires support in the development of his/her practices. One way of providing support is through the process of clinical supervision. Professionally, clinical supervision is viewed as an aid to nurses in developing their professional standing, their professional competence and their right to registration (Butterworth & Faugier 1992, UKCC, 1995). In this study, the focus is on the process of developing students in the clinical settings.

Some early definitions of the term 'clinical supervision' included it being considered as an interpersonal interaction whereby the supervisor meets with the supervisee, in an effort to make the latter more effective in helping people (Hess, 1980). Loganbill (1982) defined clinical supervision as an intensive, interpersonal focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other

person. These early definitions reflected the psychodynamic origins of clinical supervision when supervision was very structured, and was conducted via an intense therapist-supervisor relationship. The prime duties of the supervisor were to assist the supervisee to work through phenomena encountered in their relationships with their clients, such as feelings of aggression, via the medium of the supervisory relationship, rather than the therapeutic one (Faugier, 1992). Psychodynamic therapists therefore regarded supervision as a fundamental element of preparation and ongoing practice. More simply, Wright (1989) defined clinical supervision as a meeting between two or more people who have a declared interest in examining a piece of work. The work is presented, and they then think together about what occurred and why, what was done and said, and how it was handled.

Clinical supervision was defined as a formal process of professional support and learning which enabled individuals to develop knowledge and competence, assume responsibility for their own practice, and enhance the consumer protection and safety in complex situations (United Kingdom Department of Health 1993). This term therefore refers to a formal meeting between supervisee and supervisor, in which a safe environment is provided for nurses to reflect on clinical events and discuss new clinical ideas and problems.

The Open University (1998) defines clinical supervision as an opportunity to provide time out and an opportunity, in the context of an ongoing professional relationship with an experienced practitioner, to engage in guided reflection on current practice, in ways designed to develop and enhance that practice in the future. Butterworth et al (1996) are of the understanding that clinical supervision is concerned with providing support for practitioners and developing their knowledge skills and values.

Other authors use the terms 'clinical teaching' and 'clinical supervision' interchangeably. Different authors define the term 'clinical teaching' in a variety of ways. McCabe (1985) defines clinical teaching as a process of providing the student with the opportunity to put theory into practice, with the emphasis on knowledge and understanding. It should include the essentials of nursing practice, recognizing and supporting the students in their confrontation with new human experiences in the clinical settings. Reilly and Oermann (1985) however, argue that McCabe's definition provides a narrow and technical perspective of the term clinical teaching.

According to Reilly and Oermann (1985), clinical teaching does not only provide the student nurse with skills for addressing clients' problems, but also provides the student with many essential learning experiences, planned and unplanned. Ewan and White (1991) view clinical teaching as teaching that occurs in the presence of the teacher, the student nurse and the client in a face-to-face situation, with the main objective being to acquire professional competence and values essential for nursing practices. Ewan and White's definition provides us with details of 'who' is involved in the process of clinical supervision and the outcome of that process. It does not entail what takes place during the process of clinical supervision.

Dana (1997) in describing the concept clinical supervision distinguished three categories that the definition of clinical teaching should include; "firstly integration of theory and practice, secondly integrating of basic sciences into nursing practice and thirdly the context in which clinical teaching takes place"(p.20).

According to Brocklehurst (1994) the majority of definitions have a number of common features. They encompass supportive, educational and managerial aspects. Brocklehurst pointed out that (a) the supervision relationship is of fundamental importance, (b) supervision has a number of related aims, ensuring safe practice, developing skills, encouraging personal and professional growth and supporting staff, (c) the process of supervision requires structures and procedures, and (d) supervision is an active process necessitating equal input from supervisor and supervisee.

Shedding some light on the problems surrounding the concept of clinical supervision authors such as Farrington (1995) and Butterworth (1998) argued that a theoretical perspective on the concept of clinical supervision is not possible. The reasons behind these claims are that the characteristics or attributes of the concept differ in various contexts, and depend on a number of factors such as student or target group, purpose of clinical supervision for the group, nature of supervisory relationship, time involvement and a necessity to specify certain areas for examination.

One can conclude by indicating that the above definitions vary, but in essence have a similar meaning, as stated in Brocklehurst (1994,), which is focused upon the provision of empathetic support to improve therapeutic skills, the transmission of knowledge and the facilitation of reflective practice. This process seeks to create an environment in which the participants have an opportunity to evaluate, reflect and develop their own clinical practice and provide a support system for one another.

2.3 Models of Clinical Supervision.

The purpose of this section is to outline the common models in clinical supervision so as to have a general understanding of them. The researcher does not engage in their in-depth analysis because this study is not aimed at developing a clinical supervision model.

According to Leddick (1994) clinical supervision is the construction of individualised learning plans for students working with clients. The systematic manner in which supervision is applied is called a 'model'. A range of models have been developed for example, Proctor's model (1986), Page and Wosket's model (1994), Hawkins and Shohet's model (1989), Johns' model (1997, 1998), Faugier's model (1992), the triadic model, the multicultural model and the model of supervisory relationship. Burrow (1995) pointed out that most of these models are aimed at clinical supervision in mental health practice and, according to Morris (1995), much of the literature towards the understanding of supervision has been produced or developed by schools of psychotherapy. This may suggest the question whether these models are the best choice, and whether they will work similarly when they are exercised in different contexts of clinical supervision. Only five of the above models will be presented in this chapter, Growth and Support Model, (Faugier 1992): Integrative Approach Model (Hawkins and Shohet, 1989), Proctor's three function integrative model of supervision, Severinsson's (2001) model of supervisory relationship and Smith's (2000) model of friendship in clinical supervision.

2.3.1 The Growth and Support Model (Faugier1992)

This model focuses on the student's growth and development. According to this model the role of the supervisor is to facilitate growth, both educationally and personally, in the student

while providing essential support to his/her developing clinical autonomy. The key characteristics underpinning the growth and support model are as follows: generosity, reward, openness, willingness to learn, thoughtfulness and thought-provoking stimuli, humanity, sensitivity, an uncompromising stance, personal interaction, practical experience, orientation, relationship and trust. Faugier's (1992) model places emphasis on development and focuses on developing competence in supervisees (students). The model aims at setting standards for clinical competence through integrating educational and professional systems by linking relevant education to skills and competencies required in clinical practice, and facilitating professional development throughout a practitioner's career.

2.3.2 Integrative approach (Hawkins and Shohet 1989)

Hawkins and Shohet's (1989) model focuses more closely on the process of the supervisory relationships and divides supervision into four main components, namely, supervisor, supervisee (student), and client (patient) and work context. Hawkins and Shohet (1989) separate the process into two interlocking systems: the therapy system, which connects the client and supervisee, and the supervision system, which involves the supervisee and supervisor. Both systems are based on a similar type of agreed contract of time spent together through negotiated shared tasks and goals. According to this model, an agreed contract is often established between the supervisor and the supervisee as to the content of the sessions, which generally remain confidential. The sessions can be held on a one-to-one basis, privately, between one supervisor and one supervisee, or alternatively held as a group session, where one supervisor is identified to lead sessions with several supervisees together.

2.3.3 Proctor's Model of Clinical supervision

Proctor (1996) developed a model that encompasses aspects of personal and professional support, educational and quality assurance function. Proctor's model of supervision consists of the three components: normative, formative and restorative. *Normative* (managerial)- defined as the managerial aspect of clinical supervision, as a crucial quality control element, promoting and complying with policies and procedures, developing standards and contributing to clinical audit. *Formative* (educative)- is defined as an educational characteristic and is linked to skills development, understanding, abilities and developing evidence based nursing practice. This is achieved through reflection on, and exploration of, a student's work. *Restorative* (pastoral support)- is defined as supportive action and responses in order to unload stress, but also to maintain adequate emotional stability and boundaries by developing awareness of the effects of emotional stress, thus enabling practitioners to understand and manage the emotional stress of nursing practice. According to Winstanley et al (2003) elements of these components must be considered integral parts of an evaluation system for the process of clinical supervision.

2.3.4 Model of supervisory relationship.

Severinsson's (2001) model of clinical supervision is one of the newly published models in nursing focusing on the supervisory relationship. The emphasis of clinical supervision is defined as support for the development of the student's job identity, competence, skills and ethics. The first assumption underlying this model is that during clinical supervision, the supervisor transforms knowledge on different levels by inviting a student to begin and participate in dialogue. The dialogue between the clinical supervisor and the student is crucial in order to receive and give confirmation and gain insights. Confirmation is seen to

have a supportive and motivating effect, but also develops closeness promoting functions in relation to patients. Confirmation of how much a student knows by a senior person is important to the student; it boosts his/her esteem and she/he develops confidence in what she/he does. Severinsson's model asserts that knowledge of, and values concerning caring are transformed and learnt during clinical supervision process. The second assumption in this model is that the clinical supervision process is largely a learning process in which growth and development takes place, especially in the form of spiritual and emotional development. This model also brings in the concept of self-awareness. Clinical supervision should promote self-awareness for growth purposes. Severinsson's model (2001) therefore integrates into clinical supervision the three main concepts, which are confirmation, meaning and self-awareness. It clearly emphasises the supervisor's competence and responsibility for establishing the key concepts in the nursing supervision process. The clinical supervisor is viewed as having a leading and crucial role during the clinical supervision process

2.3.5 Model of Friendship in Clinical Supervision

This model was developed primarily for professionals already in clinical practice but is not only limited to them. Smith (2000) was of the view that sometimes new nurses or recruits feel lonely and isolated in the clinical settings, and that they are always rushing, so have little time to form relationships. Friendship is viewed as important at times of rapid cultural change and at turning points in individual lives. This author identified a need for a model of clinical supervision that could address the needs of nurses who were feeling isolated and lonely in practice. Smith (2000) pointed out that a number of models of clinical supervision exist but that they lack in the aspect of friendship. This author felt that a model specifically based on friendship in clinical supervision should be developed. The author was aware of the

view that a friend should not be chosen as a supervisor as situations might arise within supervision that could be affected by that relationship. To address this, Smith (2000) engaged in the process of analysing the ethical foundations of friendship as a base of a model of clinical supervision. By identifying and using ethics to underpin the relationship Smith (2000) hoped to achieve the best of both worlds, giving colleagues a 'friend' to support them, yet one who would be unaffected by the usual dynamics inherent in the term. Smith's model uses a contract between the supervisor and the supervisee. The use of a contract to make explicit the 'rules' of the friendship and what might lead to its termination is the defining difference of this ethical friendship. This contract sets the standards for the continuation and development of the relationship. As the process of supervision progresses, so does the friendship, and it may develop after a period of time into what Aristotle calls a complete friendship.

Aristotle says it is common features of character that draw us together such as shared understanding and values (Smith 2000). This model of friendship might not be ideal in clinical supervision that is aimed at developing students academically, personally and professionally. For an inexperienced supervisor, it might not be easy to draw a line and to set parameters for the relationship. If unable to confine the relationship between set limits, the student or the supervisor might take advantage of the situation, thus compromising learning, which is a primary goal of clinical supervision. In cases where a clinical supervisor is of the opposite gender, this friendship model might cause problems especially as the clinical supervisors are not yet familiar with the model.

To conclude, Butterworth and Faugier (1993) perceive models of supervision as falling into three major categories: firstly those which describe supervision in relation to the main functions of the supervisory relationship and its constituents; secondly, those which describe supervision in relation to the main functions of the role; and thirdly, those developmental models which emphasise the process of the supervisory relationship. Farrington (1995) pointed out the dangers of implementing theoretical models. According to Farrington (1995) clinical supervision easily loses its meaning and connections to professional practice if formal systems are developed with the imposition of rigid models. This author does not, however, take into consideration that the model is a framework, or a guide. The institutions do not necessarily have to use the model as stipulated, but have to extract what works in their context, and come up with a model that meets their needs. The main argument is that there does not appear to be a single model of clinical supervision appropriate for all types of clinical supervision, all levels of staff and all clinical specialities, but that a model implemented in practice should always be tailored to suit specified needs and purposes.

It is important to note that although these models vary considerably in their approach towards clinical supervision, common themes such as supervisor-supervisee-client interaction, support, educational and professional development, equality, mutual respect, shared responsibility and good interpersonal relationships all emerge from these models. Some highlight the importance of entering into an agreement. This agreement might be formal taking the form of a contract. One model emphasized the importance of a friendship aspect during the clinical supervision process, over and above what the clinical supervision process entails.

2.4 Empirical Research on Clinical Supervision

Research by Luker, Carlisle, Riley, Stilwel, Davies & Wilson, (1996) found that nursing students do not have the appropriate skills and abilities to meet the expectations of the employer. Jinks and Paterman (1998) also found that the students felt that they had insufficient clinical skills upon completion of the pre-registration programme. Jowet, Walton, Payne (1992) came to a similar conclusion. A conflict between education and service with regard to the value of practical skills in nursing is identified by Bjork (1995), Elkan and Robinson (1993) and Luker et al (1996). Clinical staff was, for example, found to consider the introduction of basic practical skills training from the beginning of any pre-registration programme. Nurse educationalists, however were found to believe acquisition of interpersonal skills should be addressed at an early stage in the programme. These differences in opinion resulted in students lacking practical competence and feeling awkward in placements. Bjork (1995) also highlighted the value patients place on practical skill, suggesting that education that produces nurses adequately equipped with knowledge but lacking in basic skills, does not meet the needs expressed by the patients studied.

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting requires practitioners to be accountable for their practices from the point of registration (UKCC 1992). In addition, there is also the expectation that students should acquire increased technical skills in order to meet the changing demands of health care. These edicts imply that nurse education needs to consider how technical skills can best be developed.

Reilly and Oerman (1990) state that the acquisition of such skills should be managed by educationalists in co-operation with clinical colleagues.

The development of clinical skills as a joint venture can, however, be seen as being problematic. Time, resources and ideological differences are issues that may impede progress. Knutton and Pover (2004) have had extensive experience of clinical supervision as supervisees, supervisors and trainers, and have experienced supervisory relationships where an inability or unwillingness to maintain honesty has led to dissatisfaction, or discontinuation of supervision. They have also seen relationships develop significantly as a result of honest disclosure.

In creating an honest relationship, Feasy (2002) identifies integrity and honesty of both supervisor and supervisee as irreplaceable in the supervision relationship. Without this, Feasy suggests, difficult issues will not be explored. One of the key tasks of clinical supervision, therefore, is to create and maintain honest relationships in which people can learn.

Honesty then, is important in creating a learning environment and the authors Knutton et al (2004) identify three areas that can hinder supervisory relationships unless they are identified and explored:

- Past relationships
- Multiple roles
- Levels of congruence

Past relationships: It is important for supervisors and supervisees to explore past relationships with one another as these can affect current contracts. Supervisors are often chosen by the supervisees because their practices are respected or their positions aspired to, and frequently, they have greater authority or power in organisations than supervisees. This can lead to difficulties in supervisory relationships because, due to previous power

dynamics, supervisees may feel inhibited and unable to take responsibility for learning which is desirable in supervision.

Multiple roles: the role of the clinical supervisor is ideally the only one clinical supervisors have with supervisees (Bond and Holland 1998), although in complex organizations this is unlikely. Contact in other roles sometimes increases positive feelings and enhances supervisory relationships, but more usually, it produces negative feelings and inhibits the supervision work.

Congruence in current relationships: Congruence is consistency. Jones (2003) suggests that incongruence occurs when there is a mismatch, for example, between what is said and what is done, or what is communicated verbally and non-verbally. People are not aware that they are displaying incongruence. It is important for supervisors and supervisees to explore their feelings and reactions towards each other, because underlying feelings are often displayed unconsciously. (Knutton et al, 2004).

In view of the problems associated with clinical supervision, McKenna (1997) reported that a study was conducted in one of the nursing education institutions. This nursing institution developed a special course for clinical instructors which had the following content; introduction to clinical teaching; roles, models and resources, educational and nursing theories in clinical teaching, the clinical learning cycle, clinical teaching methods, clinical assessment and problems in clinical teaching. The overall results suggested that participants found the content of the course to be useful. The following areas were perceived by participants to be most beneficial; the roles of the clinical teacher, the clinical learning cycle, clinical teaching methods, clinical assessment and problems in clinical teaching. According to the findings in McKenna's study, the least useful were perceived to be models of clinical

teaching, learning styles and the visit to the nursing laboratory. From the standard deviations of the results, for a number of areas including the roles of the clinical teacher, environments for clinical teaching/learning, types of learning, there appeared to be a wide spread of opinion as to the perceived benefit to the individual participant. According to McKenna (1997), this may be partially attributed to the variety of settings from which participants came, and their differing individual requirements. The findings in this study suggested that the role of clinical supervisors can be enhanced through educational programs developed to meet their particular learning needs, providing information on a range of topics encompassing both nursing and educational facets. Such educational programs have the ability to influence the effectiveness and quality of clinical education, and ultimately influence student-learning outcomes in clinical settings. While the educational program outlined in this paper has only been a pilot program requiring some modification, the need to offer educational programs in the area of clinical teaching has been highlighted. With the introduction of other programs such as this, the quality of learning experiences in clinical settings can be expected to be greatly enhanced.

2.5 The Core of Clinical Supervision

The aim of clinical supervision is to help the nurse to get the most out of her career as a nurse. Infante (1975) and Hinchiff (1975) agree that the aims of clinical teaching are to help the students to learn clinical skills which they will need as nurses, and to gain an understanding of the principles underlying these skills, and to help students learn to deal with situations and people who they will meet in their nurse roles. Both of these authors agree that clinical supervision is there to provide supervised practice so that the student can apply factual knowledge and learned skills, in order to resolve real patient problems.

Kirchbaum (1994) adds that clinical teaching should include the ability to set clear learning objectives to help students organize their learning and to ask appropriate questions, to provide specific and timely feedback to students, as well as to convey a positive concerned attitude towards students.

2.6 Benefits of Clinical Supervision

The importance of clinical supervision in clinical practice has been reported to have a potential benefit in nursing (Lyth 2000). Perceived benefits of clinical supervision are improved patient care, stress reduction, increased skills and job satisfaction. (Begat, Berggren, Ellefsen, Severinsson, 2003). The overall goal of clinical supervision is to improve the way in which nurses practise their profession, which, in turn, will lead to improved patient care (Fowler, 1996, Hansebo, 2001).

Clinical Supervision is designed to facilitate professional growth. It offers the chance to learn from experience and provides a source of new ideas and information. It can also help the nurse to identify areas that one wants to explore through training and some further education. Because it is so flexible and is led by the nurse and her needs, clinical supervision can help the nurse to meet the challenges of change. Clinical supervision allows staff, particularly those students returning to an academic environment, to confirm that they are doing the right thing, without fear of ridicule. A good clinical supervisor will acknowledge and extend praise when a nurse does well, and so build confidence. Clinical supervision encourages students to become broader thinkers and to consider what they are doing and why. Clinical supervision encourages students to change long established practices, so that nurses can help patients more effectively. Clinical supervision broadens the perception of

how one goes about one's work. Nurses often feel that they are told quickly enough if their work isn't up to scratch, but that nothing is said when they perform correctly.

Nursing can be emotionally draining. The nurse is in a position where she can form intimate relationships with people who are in pain and distress. It is inevitable that some of that distress will affect the nurse. Clinical supervision provides the opportunity to deal with the strong feelings that nursing work arouses. It also helps one gain a sense of perspective about one's work. The clinical supervisor is there to establish the correct emotional engagement between the nurse and the patient. With regular clinical supervision, one is less likely to carry the emotional weight of the job home.

Kohner (1994) identifies some important benefits of clinical supervision; firstly, it can be a means of improved quality of patient care and can enhance the need for standard setting and clinical audit; secondly, it can improve staff performances through the development of individual accountability; thirdly, it can be viewed as a staff investment, since it acknowledges and affirms the value of nurses and nursing, and lastly, it can be seen as professional development which encourages professional growth through experiential learning, even on a line management approach, Kohner(1994) argues that a positive relationship can develop between nurse (supervisee) and manager (supervisor), which can provide a two-way process of feedback and discussion and thus strengthen and improve the team.

2.7 Clinical Supervision and the Clinical Environment and its Effect on the Nurse

According to Kelly (2002), nurse education mainly takes place in two environments namely the academic institution and the clinical healthcare setting. Butterworth et al (1996) have the

experience of facilitating the introduction of clinical supervision to a wide range of clinical areas, from community teams to in-patient settings. It has been their experience that many well-meaning attempts to introduce supervision to pre-existing teams, seem either to fall at the first hurdle, end in some form of crisis or to slowly 'peter out' over time. During a series of workshops they became interested as to why this should be so. They felt that the more nurses are exposed to the tensions and stresses of patient care from an increasingly autonomous position, the less effective their traditional adopted defensive measures become. It has been argued that health care work can be some of the most stressful and personally costly areas of main employment (Hawkins & Shoheit, 1989).

Many attempts to introduce clinical supervision are unsuccessful, due to stakeholders in the process being uninvolved during the planning, promotion and implementation stages of clinical supervision. Most nurses come to feel that clinical supervision time is a valuable part of their working routine. If a nurse wants to make the best use of this time, s/he needs to pay attention to what happens before, during and after the clinical supervision. Student nurses gain clinical experience in the nursing services as part of the health team. This is in accordance with the South African Nursing Council's (S.A.N.C.) prescription that the student should perform as a member of the health team with certain responsibilities for patient care from the commencement of her training (S. A.N.C., 1985). Reilly and Oermann (1985) described the clinical learning environment as the major contributing factor to the learning of student nurses, because to them, the clinical environment is where the student learns the problem-solving, decision-making and critical-thinking skills necessary for dealing with the uncertainties of clinical practice. Quinn (2000) describes the clinical environment as the type of environment which includes patients or clients and their

significant others, the nursing care delivery system ancillary staff, clinical nursing staff, nurse tutors, student nurses, other professional staff and educational aspects. She views the clinical environment as the most important aspect in nurse training and education because it is in this setting, that the nurse can apply all the principles of nursing care to patients or clients, or groups of clients. All these are aspects that the South African Nursing Council considers before approving nursing schools (S.A.N.C., 1985). The clinical learning environment can either enhance or hinder student nurses' learning and professional development. Reilly and Oermann (1985) defined clinical learning as that which is "characterized by value learning, exhibiting a caring relationship for all concerned, providing for the students freedom within the structure of exploring, questioning and trying out different approaches, accepting differences in others and fostering the development of each individual"(p.77).

2.8 What are the nurses' perceptions of the elements of clinical supervision?

In a study conducted by Fowler (1995) on this subject, it was concluded that the nurses perceive good supervision to be characterised by those who are knowledgeable in the area that they are working in, and by a clinical supervisor who can communicate this knowledge in a comprehensible manner, discuss with the student nurse their previous experience and knowledge, interact with the student, and comment on good practice and not simply criticize weak practice. Wilson (1994) conducted a qualitative study of nursing students' perspectives of learning in a clinical setting, and her findings indicated that nursing students wanted to do no harm to patients; to help patients to integrate theory based knowledge into clinical practice, to learn clinical skills, to look good as students, and to look good as nurses.

2.9 Who should perform clinical supervision?

Managing a ward and also performing clinical supervision might bring about a stressful situation, where the outcome of clinical supervision might end up in a premature collapse. This is strongly supported by McCallion and Baxter (1995) who forecast constant problems such as issues, which nurses would not be willing to raise with their managers, but would rather raise with someone else. Burrow (1995) also argues that if the managerial and supervisory roles are combined within the same individual, it will be difficult to see how a supervisor can switch to a disciplinary function with the student nurse, without seriously affecting the close relationship that supervision tends to build.

Conflict of interest, difficulty in maintaining confidentiality and trust, and limited supervision through constrained interaction are some of the issues, which are put at risk (Kohner1994). Such settings should therefore not be insisted upon. An alternative, which could overcome such problems, as, suggested by McCallion and Baxter (1995) is that a lead person could be identified to implement clinical supervision throughout the organization and if possible, this should be the prime focus of the role. Clinical supervisors are nurses who have been trained to give supervision. They would have had supervision themselves and relevant previous experience in an appropriate nursing environment.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the research approach, research design, research setting, population, sampling technique, process and sample size, data collection process, data collection instruments. Ethical considerations, limitations of the study, as well as validity and reliability are also discussed.

3.2 Research Approach

Moving from the post-positivism worldview, this study employs both a quantitative and a qualitative approach. Post-positivism is consistent with positivism in assuming that the objective world exists, but it assumes that the world might not be readily apprehended and that variable relations or facts might be probabilistic, not deterministic (Gephart, 1999). A quantitative approach was used to address the first four questions in this study and the qualitative approach helped in addressing the fifth question, which was aimed at establishing the nature of support provided to bridging programme students, when they are confronted by a critical incident.

3.3 Research Design

The main objective of this study was to explore and describe the nature of the phenomenon of the clinical supervision and support provided to bridging programme students. Therefore, descriptive and exploratory designs were more appropriate.

According to Polit and Hungler (1995) a descriptive design is appropriate in studies interested in finding out more about the characteristics of a phenomenon and the process by which a phenomenon is being experienced. An exploratory design, on the other hand, addresses questions aimed at establishing the nature of the phenomenon, what is going on, and what factors are related to the phenomenon. Therefore, a combination of designs was used to address the objectives to be achieved in this particular study.

3.4 Research Setting

About five institutions in the Greater Durban area offer Bridging programmes. Only three of these five institutions were used in this study to narrow the scope of the study. The setting for this study was the Prince Mshiyeni Memorial Nursing College situated in the same hospital in Umlazi Durban, The Netcare Nursing Academy attached to the St Augustines Hospital and The Afrox Nursing College situated in Entabeni Hospital in Glenwood, Durban. The former is a provincial hospital and the latter are private hospitals

3.5 Population

The population of this study were students enrolled in their second year in the Bridging programme. The second year students were more appropriate for this study because of the period they had already spent in the programme. The researcher believed that their experiences in the clinical settings could help them contribute a lot to this study. The inclusion criterion was that the students should be in their second year in the programme. This population served as a sampling frame. Currently, the bridging programme at Prince

Mshiyeni Nursing College has about 200 second year students, The Netcare Training Academy has about 100 second year students and The Afrox College of Nursing has about 25. It is important to note that the names of the institutions were not used on the data collection instruments for confidentiality. The total population from these three settings is about 325 second year students. The researcher intended to include students from the two private institutions because the students are mixed from different groups. There is a chance that some of them may be supervised by a clinical supervisor who is not from their group, and that will help the researcher establish whether demographic differences have an influence on the clinical supervision process.

3.6 Sampling Technique, Process and Sample Size

Purposive sampling was used for the selection of the hospitals. Purposive sampling is sometimes referred to as judgemental sampling, and involves the conscious selection by the researcher of certain subjects or elements to be included in the study (Burns & Grove, 1997). The researcher purposively selected those institutions offering Bridging programmes. The students were randomly sampled. Random sampling of the students from the Bridging programme was done. Simple random sampling is the most basic of the probability sampling methods (Burns & Grove, 1997). To achieve simple random sampling elements are selected at random from the sampling frame.

The targeted sample size was 150. The researcher selected every second student from the sampling frame to come up with this size sample. To cater for attrition possibility, the

researcher intended to include 20 more participants to ensure that at least a reasonable number of responses would be obtained from participants. Between the three colleges consent was obtained from the students willing to participate, but 61 students did not complete the questionnaire.

3.7 Data Collection- Methods and Instrument/s

The researcher used questionnaires, documents, and a critical incident to gain more information about the phenomenon under study. A questionnaire used in this study was adapted from the Manchester Clinical Supervision Instrument. According to Winstanley and White (2002) the Manchester Clinical Supervision Instrument is the only internationally validated research instrument to measure clinical supervision. This instrument was accessed from the www.clinicalsupervisionscale.com. The researcher did not have to request permission from the owners of the research instrument because it was already available in the public domain.

On further analysis of the tool, in conjunction with the purpose of the study, the researcher identified the need to remove some items from this instrument and include new ones, in order to ensure that the instrument was able to collect the required data in this study. The data collecting instruments used in this study were divided into three sections. Section A was used to gain information about the demographics of the participants. Section B focused on the clinical supervisor and Section C items aimed at establishing more information about clinical supervision (preconditions of clinical supervision, the core and outcomes of clinical supervision).

The researcher analysed the documents outlining clinical learning objectives/outcomes for the students, and objectives/outcomes of clinical supervision were used to guide the clinical supervisors. It is believed that this would form part of the clinical supervisor's job description. The researcher intended to establish whether each clinical supervision session had any formal objectives to be achieved during the teaching/learning process and to analyse the focus of those objectives (whether they are learner centred, practice-oriented and whether they address the professional development of the learner).

A critical incident questionnaire was used (open ended questionnaire) where participants were asked to detail a recent situation, which they were sufficiently concerned about to have discussed with a clinical supervisor, or with an informal support network. This was a reflection on a situation, detailing the situation, indicating the support system that was approached, the process by which the situation was dealt with, and the evaluation of the support that was offered and recommendations for the future.

3.8 Data collection Process

After obtaining permission from the School of Nursing at the various hospitals, the class teachers were approached in order to gain access to the students. The purpose of the study, as well as its significance was discussed with the students. The students were then requested to participate voluntarily in this study. Tea and lunch breaks were used to collect data. The researcher personally distributed the data collecting instruments and collected the questionnaires when completed. Confidentiality and anonymity was ensured. The researcher

assigned codes (for the type of an institution) and numbers to each questionnaire. In this way it was not possible to link the questionnaire to a respondent.

3.9 Data Analysis

Data was captured and analysed in SPSS version 11.5 (Chicago, Ill). Frequency distributions, as well as the Post hoc Kruskal-Wallis Multiple Comparison Z value tests were performed in Number Cruncher Statistical Systems (NCSS) and Power Analysis and Sample Size (PASS) (Hintze, J (2001). A p-value of <0.05 was considered as statistically significant. Qualitative data was analysed through line-by-line analysis identifying common categories and themes. The categories and themes were further analysed to look for relationships between the identified categories and themes, and conclusions were drawn from there.

3.10 VALIDITY AND RELIABILITY

Validity refers to the extent to which an instrument measures what it is supposed to measure (Polit & Hungler, 1995). Reliability, on the other hand, refers to the extent to which the same results can be obtained if the instrument has been repeated on others (Polit & Hungler, 1995). The researcher in this study used content validity and test retest reliability. **3.10.1**

3.10.1 Content validity

Content validity was conducted by subjecting the instruments to the scrutiny of experts in nursing education and in research, and suggested corrections were made appropriately.

3.10.2 Reliability

The questionnaire was adapted from the Manchester clinical supervision scale therefore test-retest reliability was conducted to measure whether the instruments are able to measure what they are supposed to measure. The questionnaire was administered to a group of about 10 students and then re-administered, after two week's interval. The answers will be checked to see that they are similar on both occasions. The researcher also conducted a pilot study to check the feasibility of the study and to detect problems with the instrument. A small group of students were asked to participate in this trial run, which was a small-scale version of the study. The function of the pilot study was to obtain information for improving the research project. (Polit & Hungler, 1995)

3.11 Ethical Considerations

In this study, permission was sought from the Head of the School of Nursing. Ethical clearance was obtained from the University of KwaZulu-Natal Ethics Committee.

A letter of permission to carry out the research was obtained from the Department of Health (Annexure3), Prince Mshyeni Nursing College (Annexure 3), Netcare Nursing Academy (Annexure3) Afrox Nursing College (Annexure3).

According to Cohen et al (2000), respondents cannot be coerced into completing questionnaires. They may be strongly encouraged, but the decision whether to become involved and when to withdraw from the research is entirely theirs. The purpose and significance of the study was explained to the students and informed consent was obtained

from the respondents. Willingness to participate in the study was considered to be consent. The researcher explained that participation was voluntary and that anonymity and confidentiality was ensured. To ensure anonymity, codes and special numbers were used as explained under data collection process. A covering letter accompanied the questionnaire stating the above, and a letter of consent was provided.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 INTRODUCTION

For ethical reasons, the names of the three hospitals will not be used when presenting the findings. The hospitals, in which the colleges are situated, are called College 1, College2, and College 3. Students who attend these colleges are supervised at different hospitals.

4.2 Data analysis

4.2.1 Statistical methods

To reiterate, data was captured and analysed in SPSS version 11.5 (Chicago, Ill). Frequency distributions were used to analyse the Section A (demographic data, and Clinical Supervision antecedents) and Post hoc Kruskal-Wallis Multiple Comparison Z value tests were performed in NCSS (Hintze, J (2001) to analyse section B (clinical Supervision Scale).

The questionnaire contained 41 individual statements on clinical supervision. These were graded on a Likert scale, and treated quantitatively. The distribution of these responses was highly skewed, thus non-parametric methods were used for description and analysis of the statements. Comparison of the responses to the clinical supervision statements between the three hospitals was achieved by nonparametric Kruskal-Wallis testing, with post-hoc Multiple Comparison Z value tests. Responses were scored (scoring was reversed for the negatively phrased statements) and summed for each individual, and total scores compared between the three hospitals using the same methods as above. Critical incidents and support

given were categorized and compared between the three hospitals using chi-squared tests. A p-value of <0.05 was considered as statistically significant.

4.3 Results

4.3.1 Distribution of participants by hospital

Of the 122 participants in the study, 26.2% (n=32) were from College 1, 15.6% (n=19) were from College 2, and the majority, 58.2% (n=71) were from College 3. This distribution is shown in Figure 2.

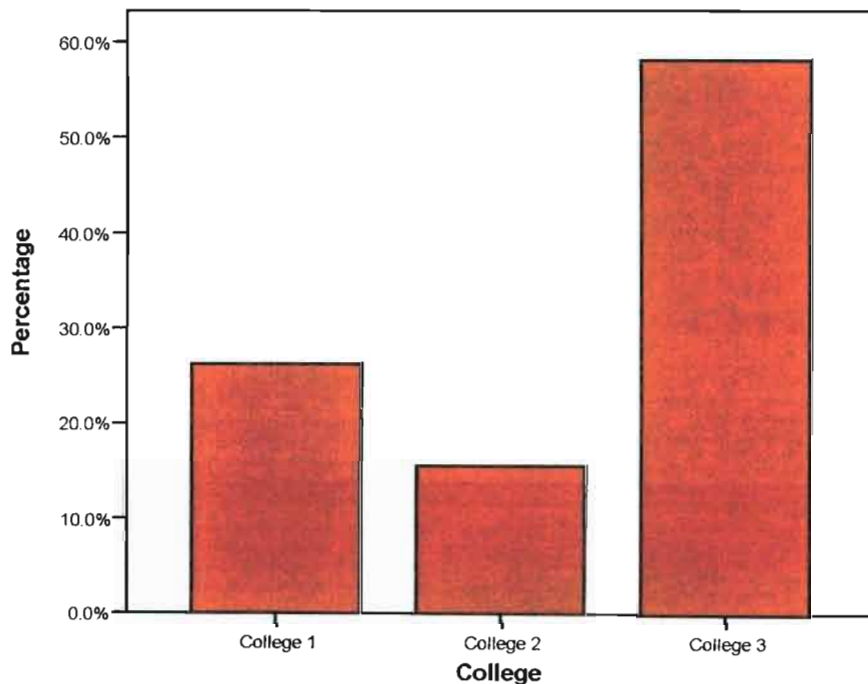


Figure 2: Percentage of respondents in the three different colleges

4.3.2 Antecedents of Clinical Supervision

Only 2% (2) were below 25 years, 58% (51) were aged between 25 and 40 and 40% (35) were above 40 years. The clinical supervisors, on the other hand, were all above 40 years, see figure 3. According to the conceptual framework used in this study, the age difference between the student and the clinical supervisor is an important factor to be considered. If the age difference is too large, it might affect the working relationship between the student and the supervisor. The older clinical supervisor supervising a very young student might not understand some of the young student's behaviour, and be offended, or might feel as if s/he was in a parental role and the student might feel childlike, and a parent-child relationship might be observed.

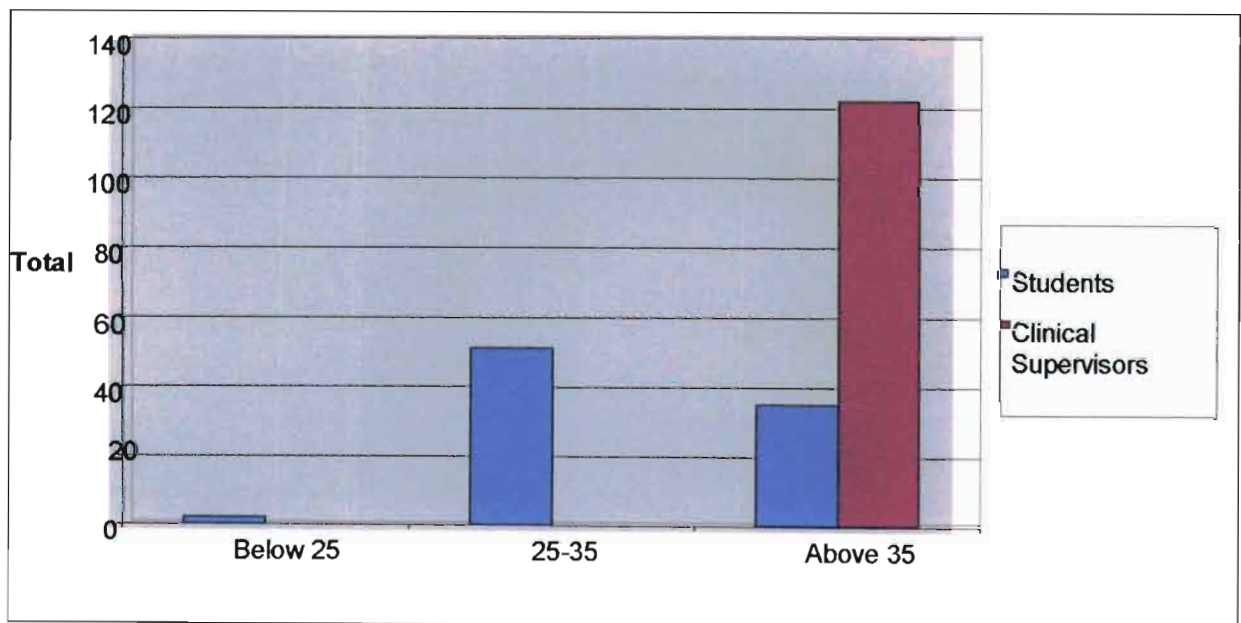


Figure 3: Ages of students versus the ages of clinical supervisors

All the clinical supervisors were females and about 16% (19) of the participants were males and 84% (103) were females. According to the framework in this study, gender is one of the

factors affecting clinical supervision. This framework states that differences in demographics may have an influence on how students view clinical supervisors and vice versa. Defensive feelings and dominating authoritative behaviour might be displayed during the working relationships.

About 73% (89) of the clinical supervisors were qualified as nurse educators, and about 27% (33) were not registered as nurse educators. The conceptual framework used in this study supports the idea that a clinical supervisor is a person with knowledge, expertise and theoretical knowledge at a higher level than that of students. The use of clinical supervisors without a nursing education qualification may be justified, in that their knowledge level may be higher than that of students and they may be more experienced than students. However, according to the South African Nursing Council policy, the clinical supervisors should be qualified nurse educators who are licensed to practice as nurse educators.

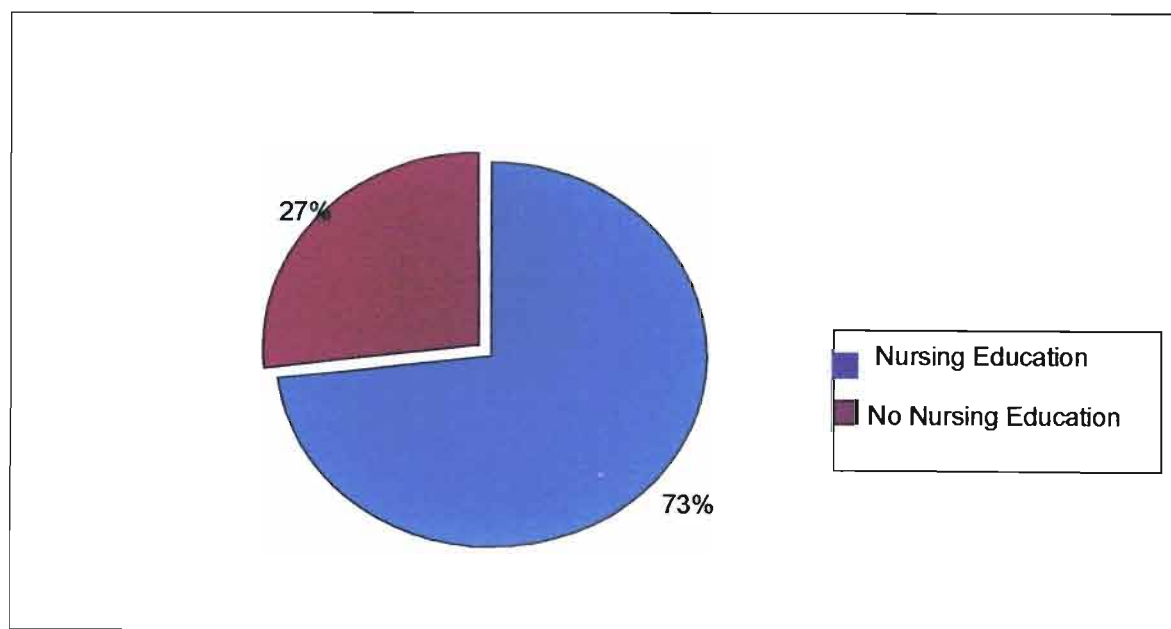


Figure 4: Clinical Supervisor's Qualifications

Although the participants stated that there was no formal contract between them and the supervisor, they indicated that the first session with the supervisor was used to detail the goals of clinical supervision, the roles and expectations from both parties (the student and the clinical supervisor). In a way, there was a verbal contract. About 73% of the participants had a meeting with the supervisor where what is supposed to be contained in a formal contract was discussed. About 22% had no formal session where roles and expectations were discussed, and 5% did not respond to this statement.

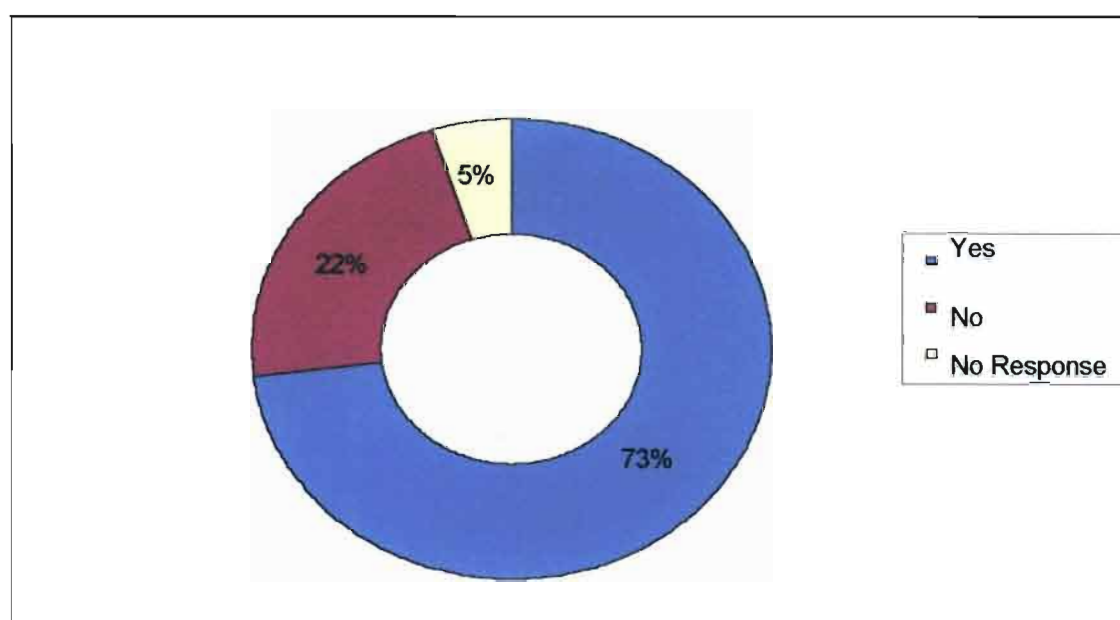


Figure 5: Contract between Students and Clinical Supervisor

Regarding the content of the contract, out of the total number of participants, about 56% (114) indicated that the goals of clinical supervision were stated, out of 100% participants about 31% (64) were informed of the role of the clinical supervisor, about 11% (25) of the total number of participants knew about the role of the students and 2% (5) of the total participants had knowledge of the relationship between the supervisor and the student (See

Figure 6). These areas should form part of the contract that exists between the clinical supervisor and the student, and the two parties should be informed of the content of the contract, as indicated in the conceptual framework used in this study

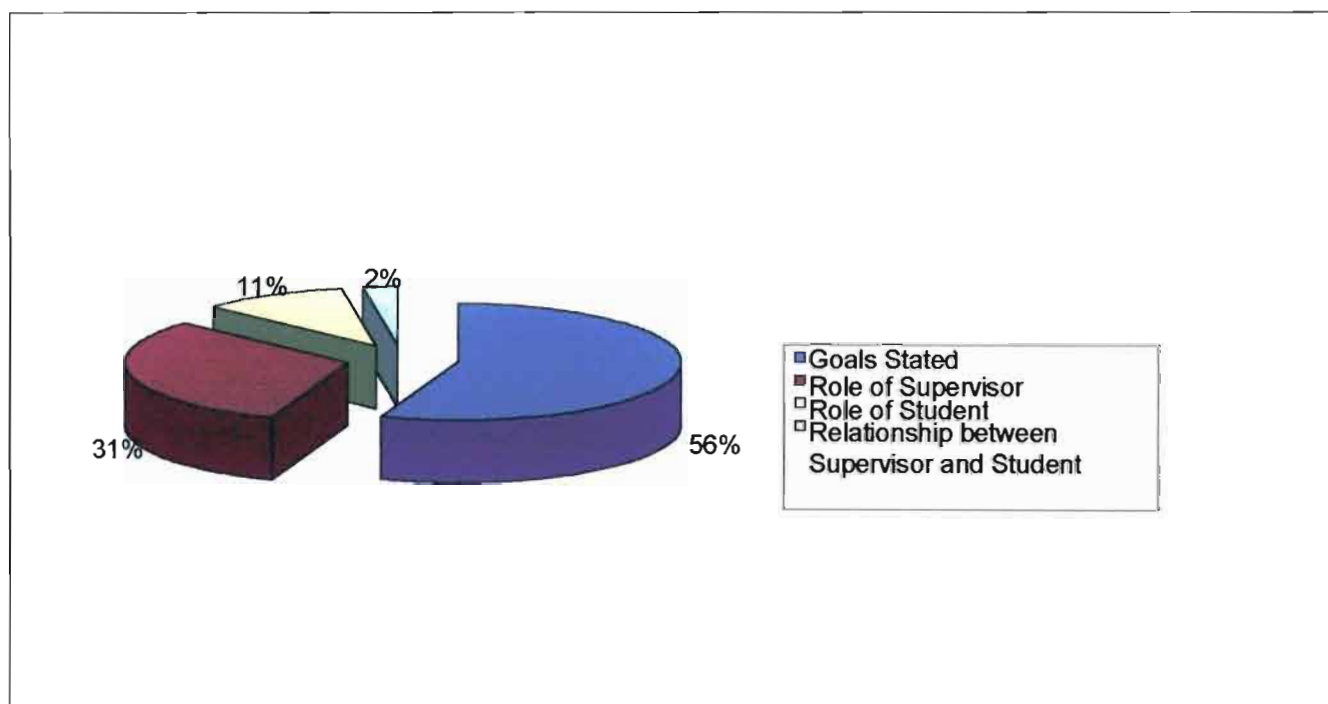


Figure 6: Contents of a Contract

The conceptual framework used in this study indicates that the availability and adequacy of clinical learning experiences is one of the preconditions for successful clinical supervision and learning. About 13% (16) of the participants agreed that the clinical learning environment had adequate learning experiences, and 80% (98) of the participants indicated that the experiences were not adequate. About 7% of the participants pointed out that those learning experiences were irrelevant. According to the conceptual framework used in this study, inadequate and irrelevant learning experiences limit learners from developing required clinical competencies.

4.3.3 Core of Clinical Supervision

About 61% (71) of the participants indicated that clinical sessions took less than 15 minutes, 21% (26) stated that the length of their clinical learning sessions ranged between 15 to 30 minutes and 18% (22) had clinical learning sessions which were longer than 30 minutes (See Figure 7).

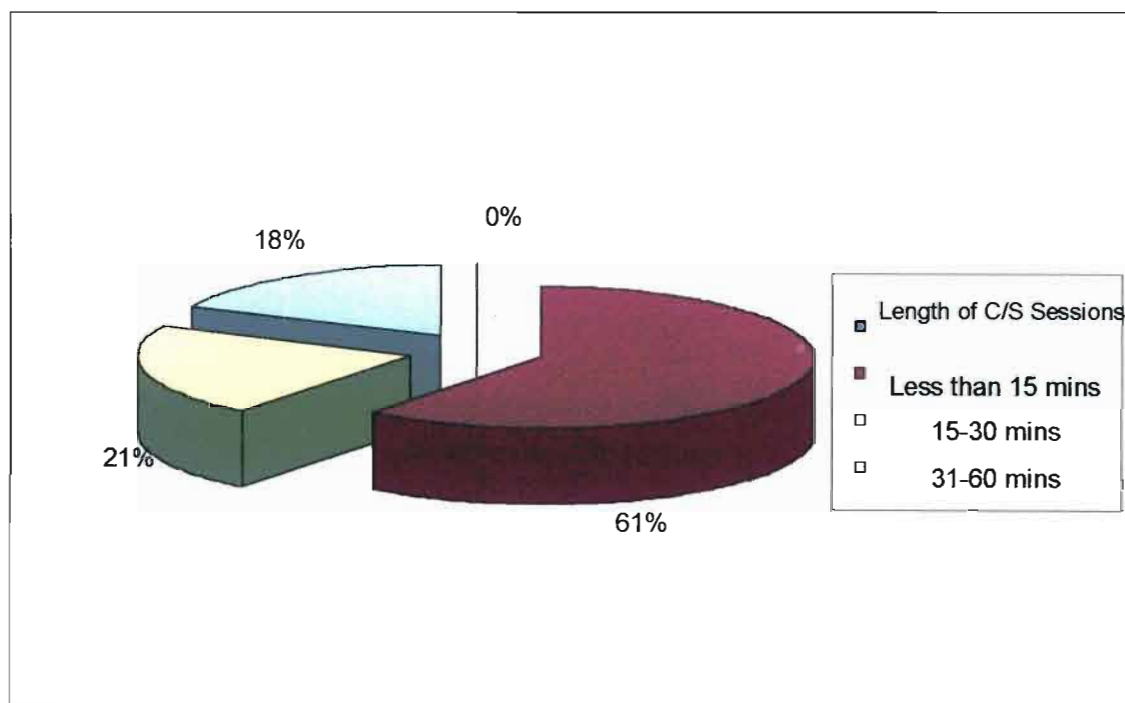


Figure7: Length of Clinical Supervision Sessions

None of the participants had clinical supervision sessions daily. About 49% (60) had sessions weekly and 51% (62) had sessions fortnightly, as in figure 8.

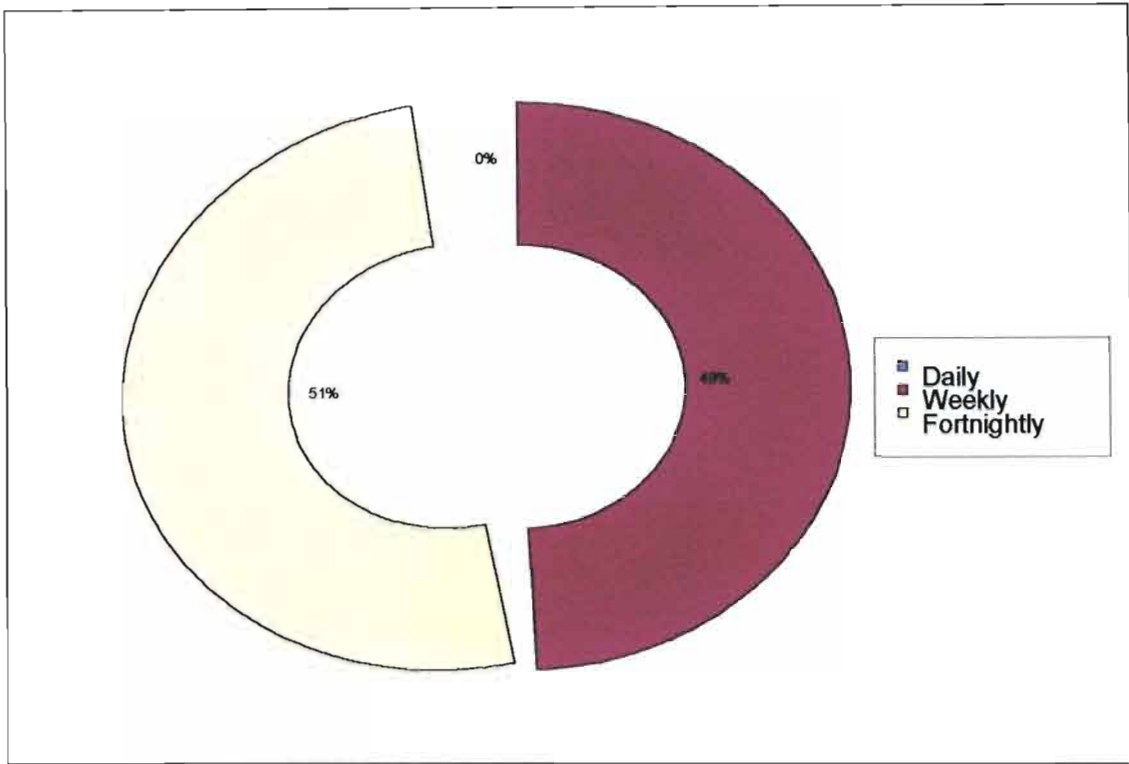


Figure 8: Frequency of clinical supervision sessions

About 95% of the participants had a copy of learning objectives, and about 3% reported that they did not have a copy. About 2% of the participants did not respond to this question as indicated in Figure 9.

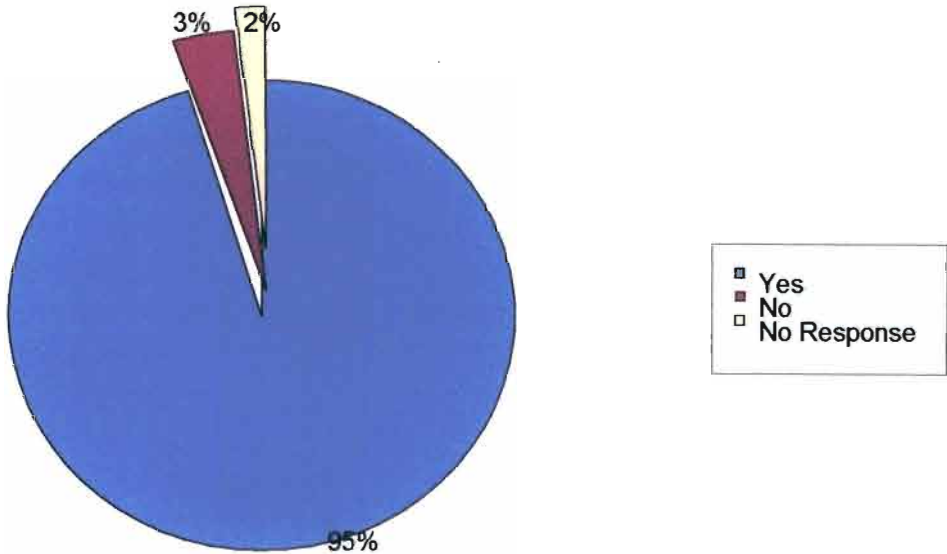


Figure 9: Students with copies of learning Contracts

✓
Responding to the statement about the support in the unit, 66% (80) got support from peers, 32% (39) got support from the unit staff, and no participants had support from the hospital coordinator, 3% did not respond to this statement, as indicated in Figure 10.

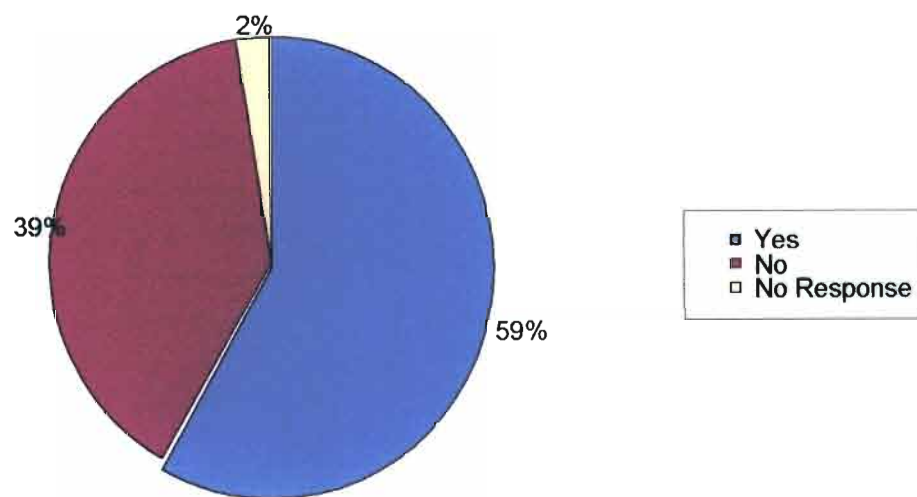


Figure 10: Support in the clinical settings

4.3.4 Comparison of responses to clinical supervision statements by hospitals / colleges

Annexure 1 shows the results of the comparison of median responses to the individual statements on clinical supervision between the three colleges. Original scoring was used in these comparisons and the accompanying plots (Figures 11-36).

It can be seen in Annexure 1 that the responses of 25 of the 41 statements differed significantly between the three hospitals / colleges. In order to interpret the analysis and

evaluate which hospital / college scored the highest or lowest, box and whisker plots of the responses to the significant statements are shown in figures 11 to 36. The higher the disagreement with a statement, the lower the score on the y-axis.

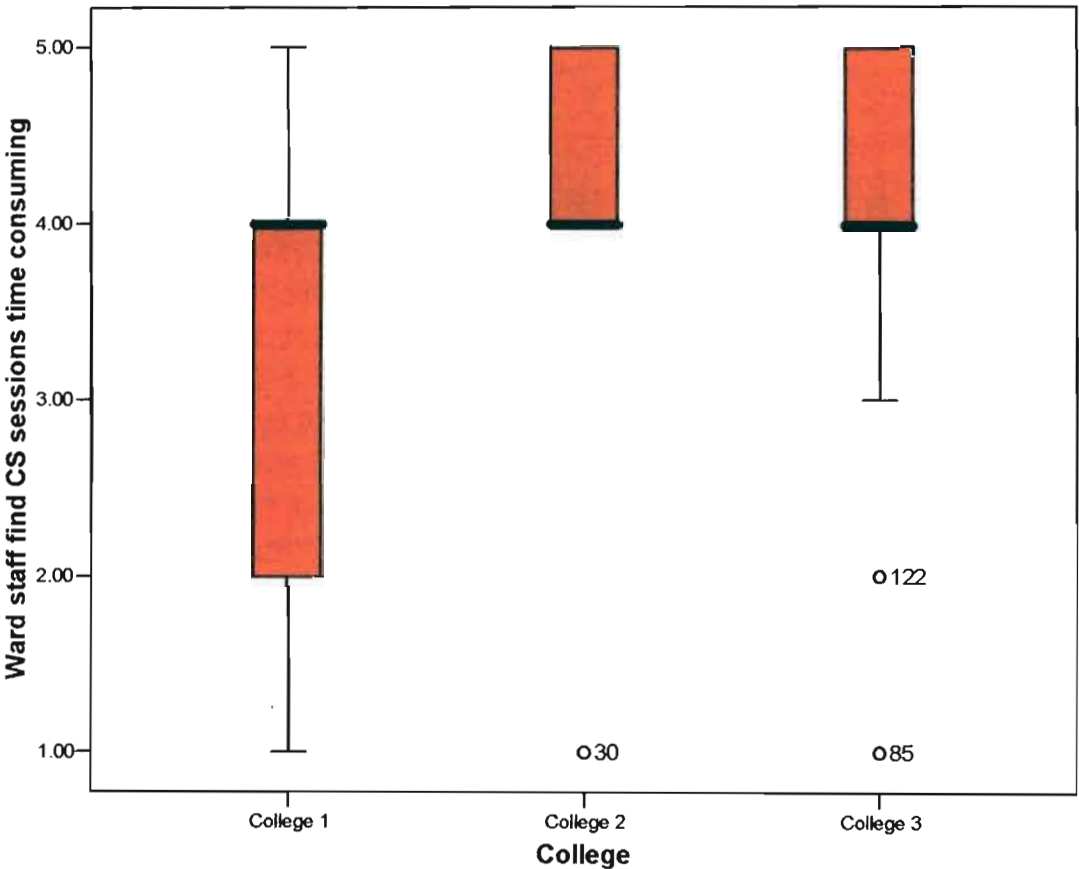


Figure 11: Boxplot of statement1 by College/hospitals

Figure 11 shows that College 1 responses were significantly lower (tended to disagree more) than the responses from the other two colleges in response to the statement that ward staff find clinical supervision time consuming

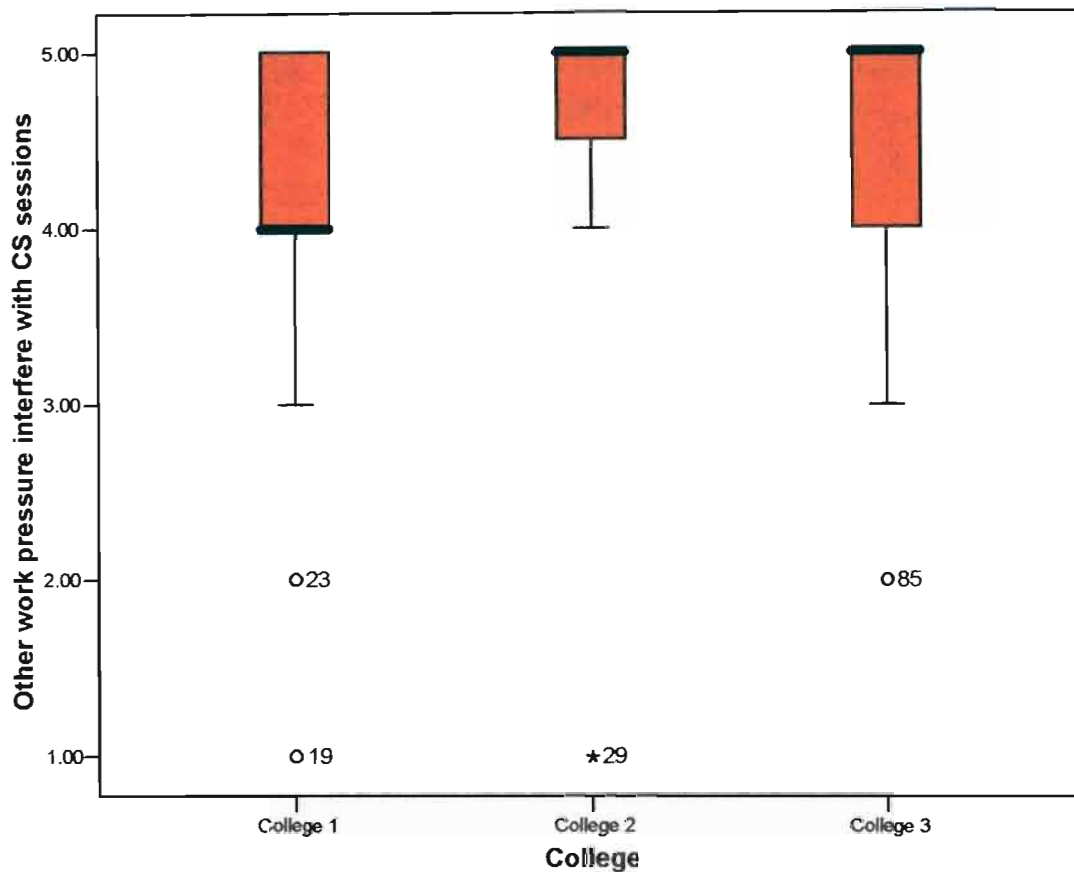


Figure 12: Boxplot for statement 2 by hospital / college group

Figure 12 shows that the responses to the issue of other work pressures interfering with clinical supervision were significantly lower (disagreed more) for College 1, than for the other two colleges.

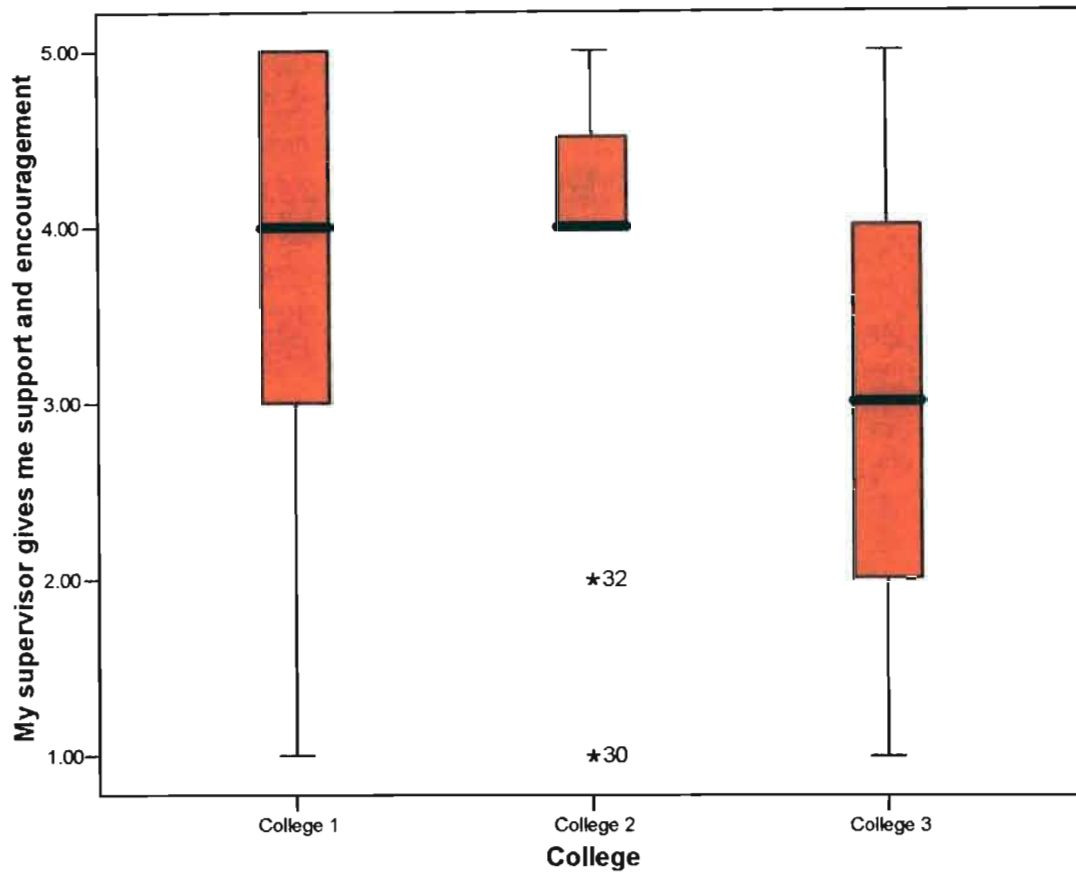


Figure 13: boxplot of statement 8 by hospital/college group

In response to the statement, 'my supervisor gives me support and encouragement', there was a significant difference in responses between College 3 and College 2. Figure 3 shows that College 3 respondents gave lower responses (disagreed more) than College 2 respondents.

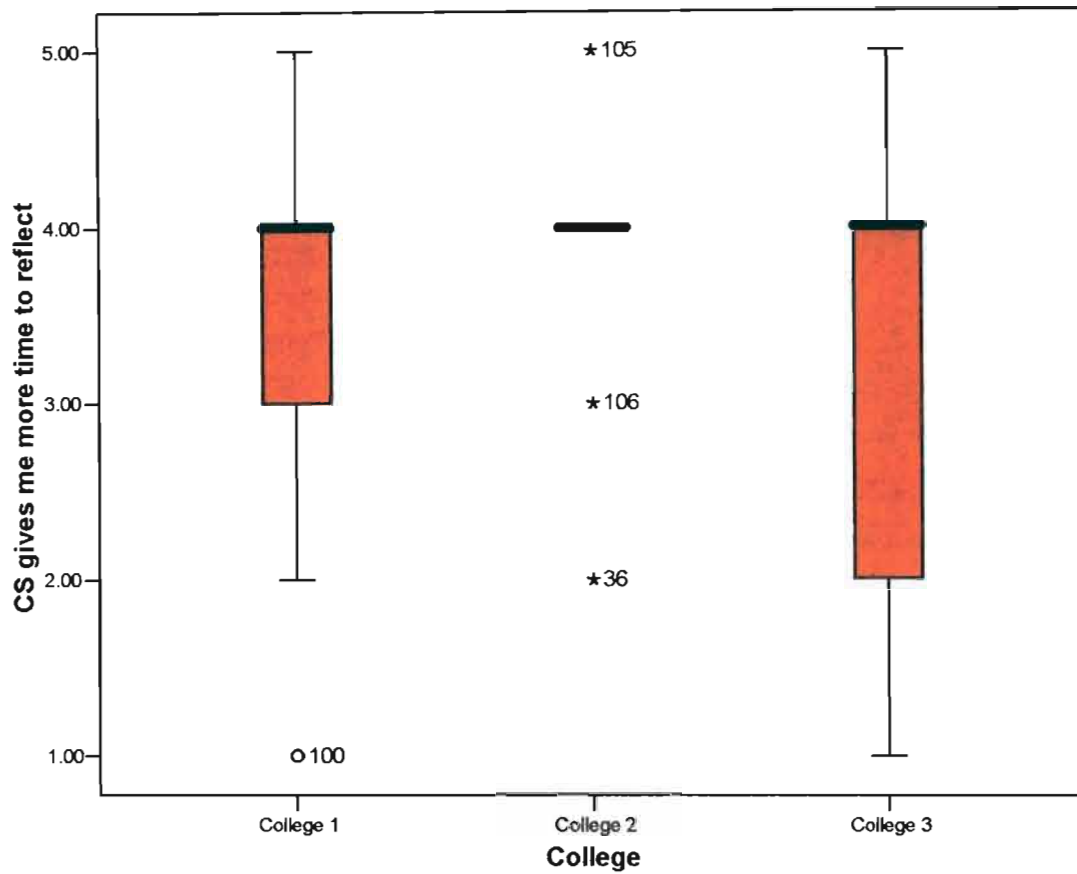


Figure 14: boxplot of statement 11 by hospital/college

Figure 14 shows that responses to the statement that clinical supervision afforded students more time to reflect were lower in College 3 than in College 2 (tended to disagree more).

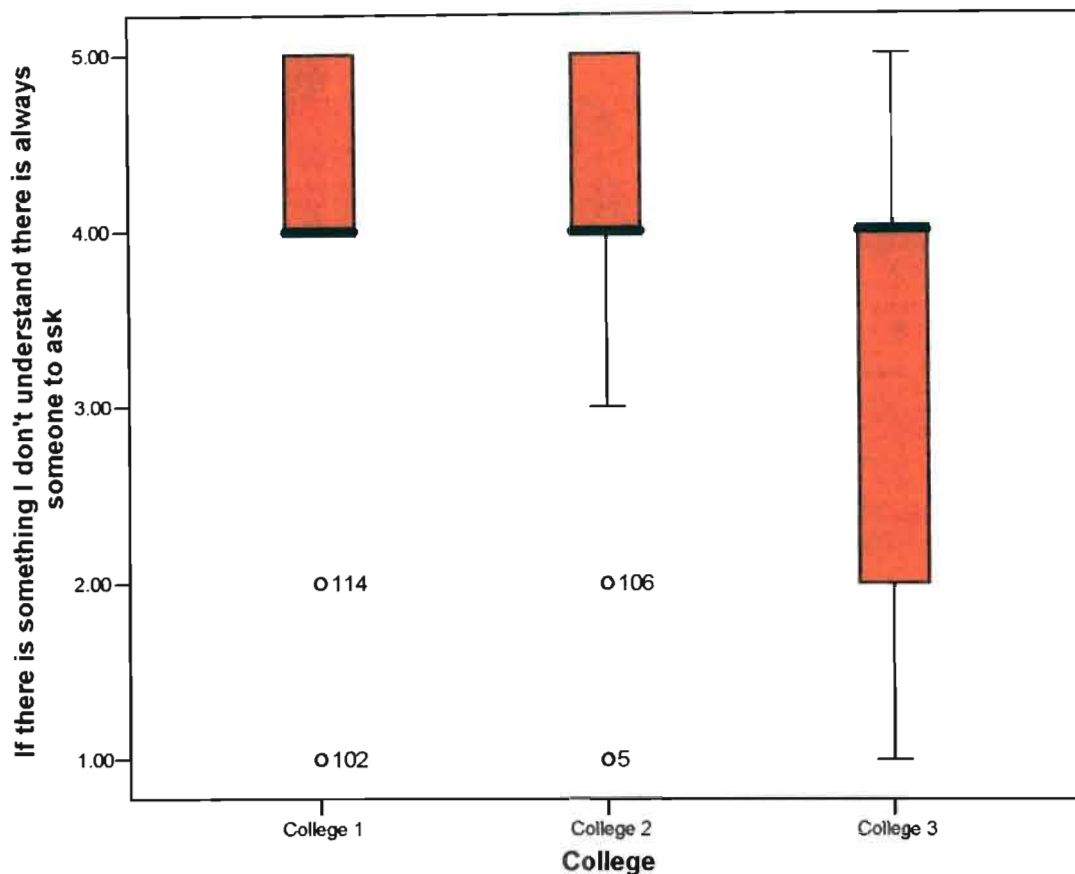


Figure 15: boxplot of statement 13 by hospital/college

The responses to the statement, 'If there is something the students do not understand there is always someone to ask', were significantly different between College 1 and College 3.

Figure 15 shows that College 3 respondents gave lower responses than College 1 respondents.

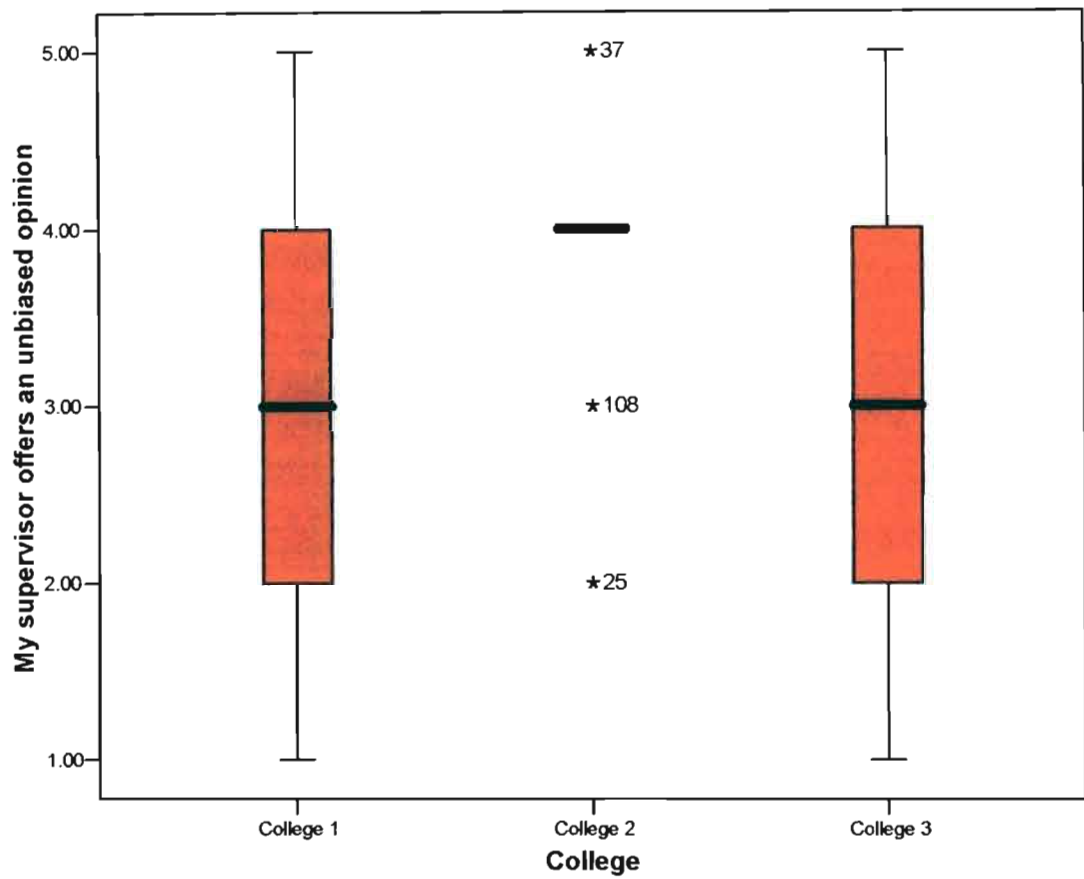


Figure16: boxplot of statement 14 by hospital/college

Figure 16 shows that College respondents gave lower (disagreed more) responses to the statement that the supervisors offer an unbiased opinion than College 2 respondents.

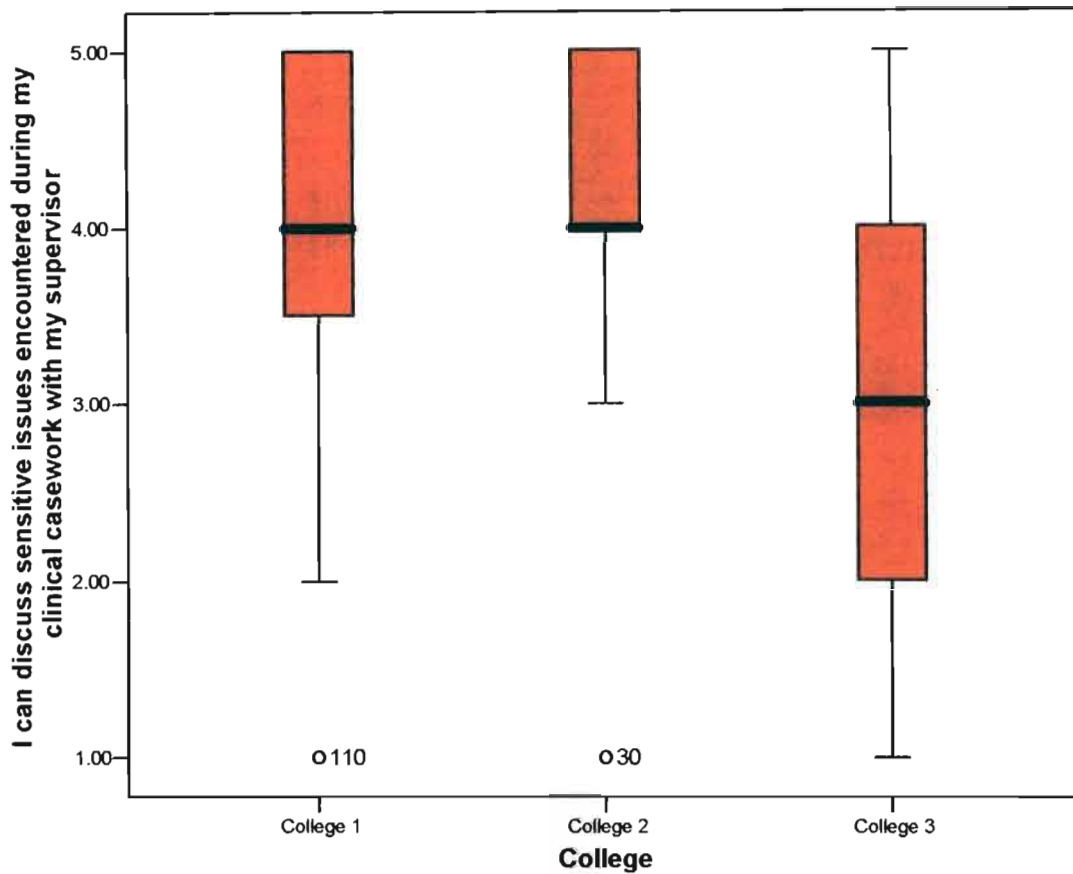


Figure 17: boxplot of statement 15 by hospital/college

College 3 respondents disagreed more with the statement that they could discuss sensitive issues encountered during clinical casework with their supervisor than College 2's respondents (Figure 17).

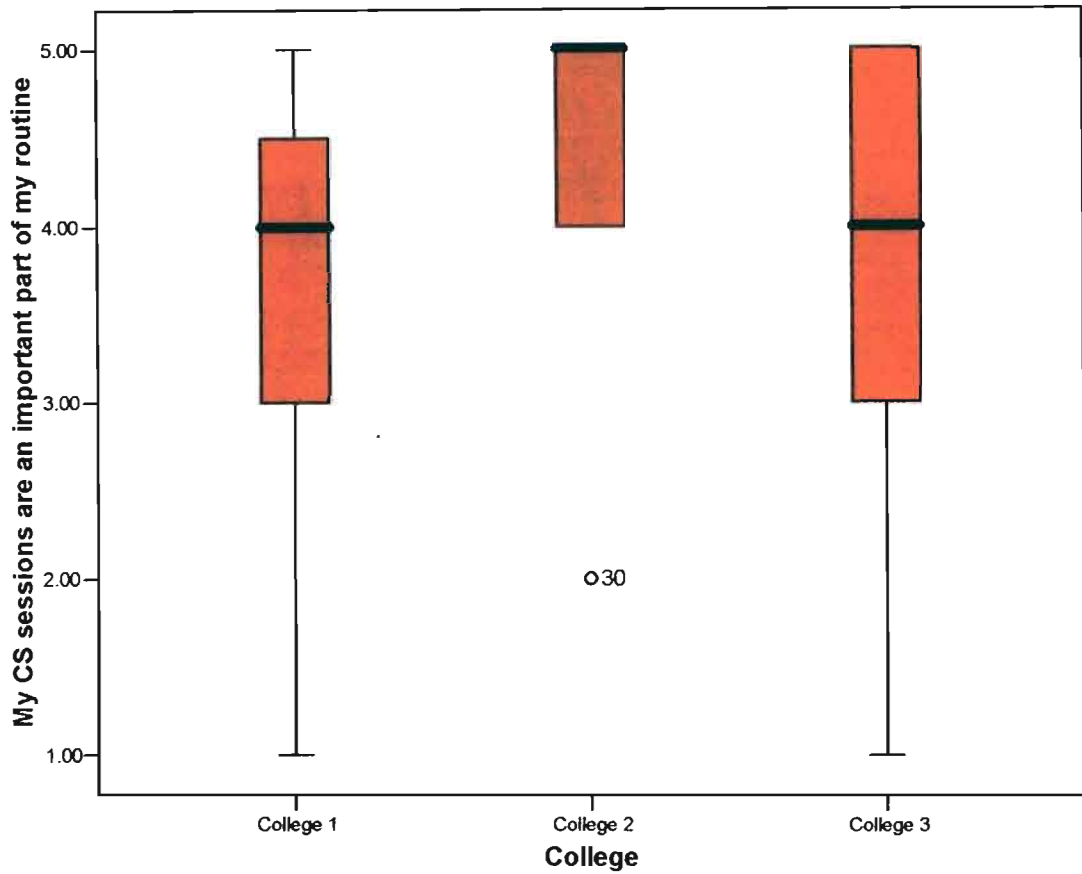


Figure 18: boxplot of statement 17 by hospital/college

College 2 responses to clinical supervision sessions being an important part of work routine were significantly higher (agreed more) than both the other two colleges (Figure 18).

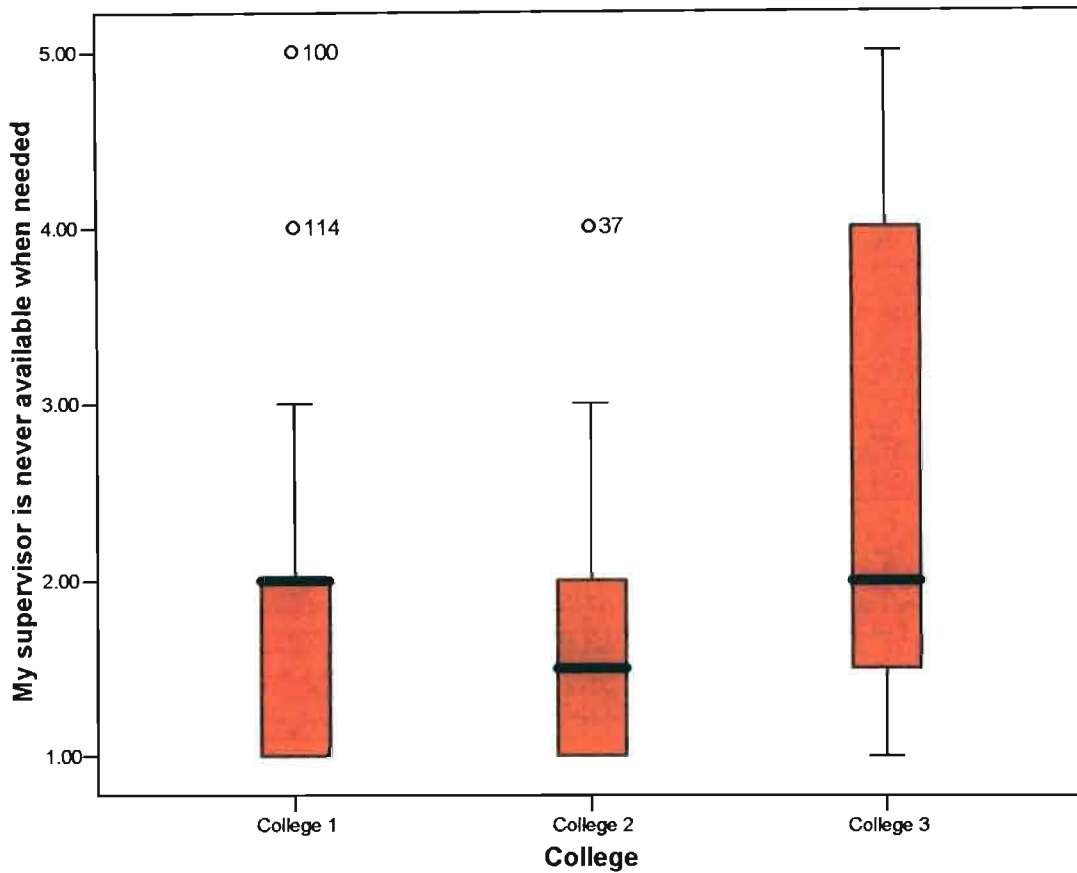


Figure 19: boxplot of statement 18 by hospital/college

For the statement that the supervisor was never available when the students needed help, which was negatively phrased, College 3 respondents tended to agree more than College 2 respondents (Figure 19).

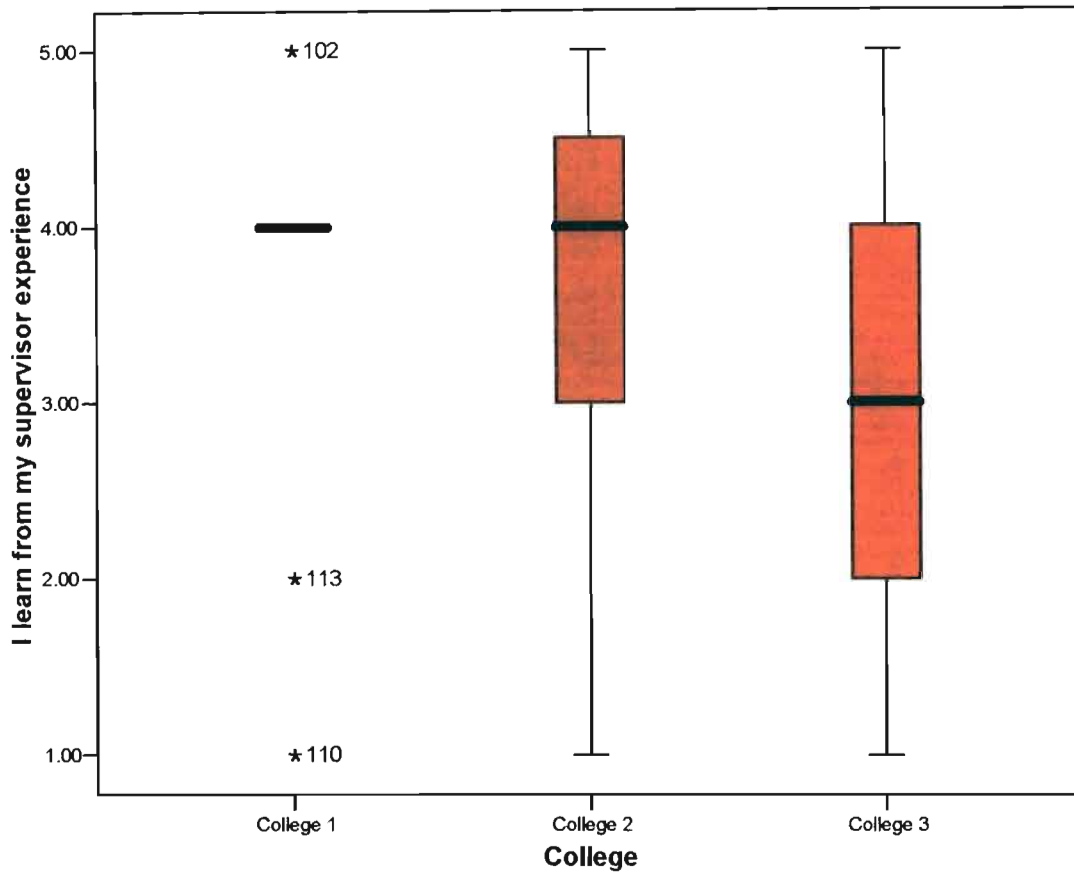


Figure 20: boxplot of statement 19 by hospital/college

Although College 3 respondents scored lower than the other two colleges for the statement that they learn from their supervisor's experiences, there was no statistically significant difference between any of the individual hospitals (Figure 20).

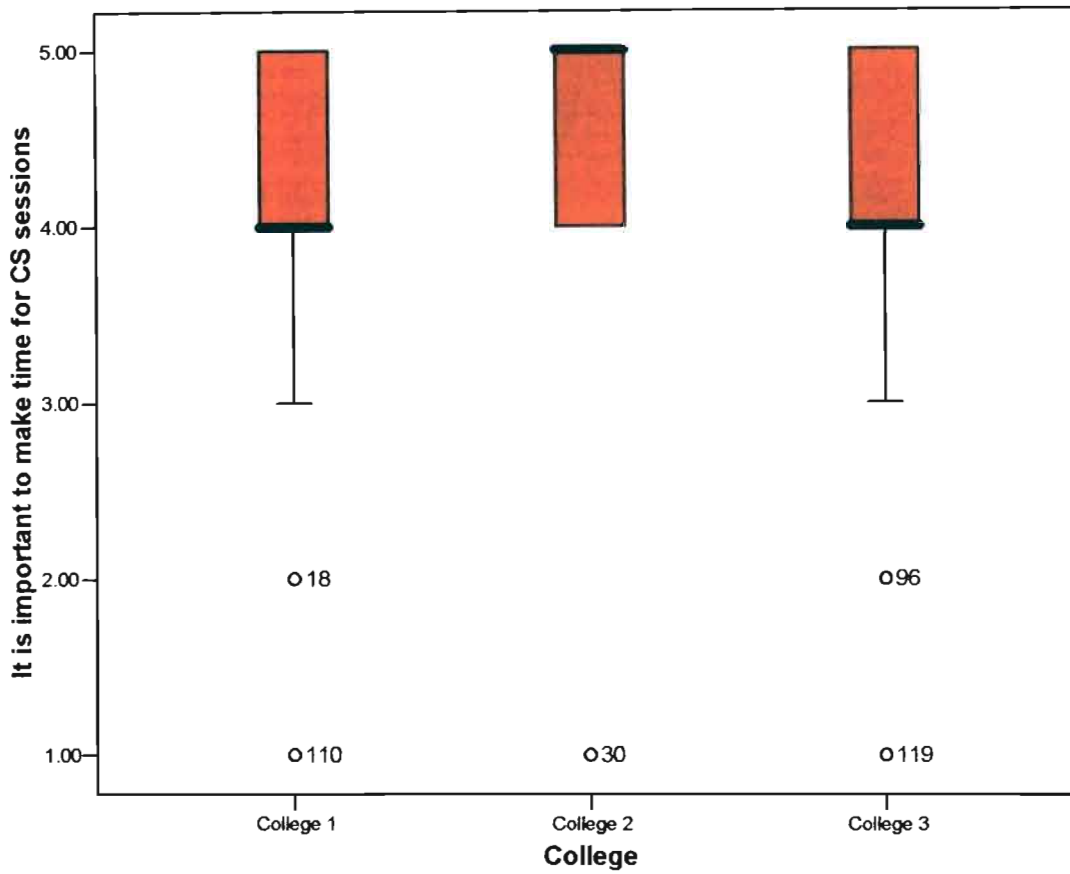


Figure 21: boxplots of statement 20 by colleges

College 3 respondents disagreed more with the statement that it is important to make time for clinical supervision than College 2 respondents (Figure 21).

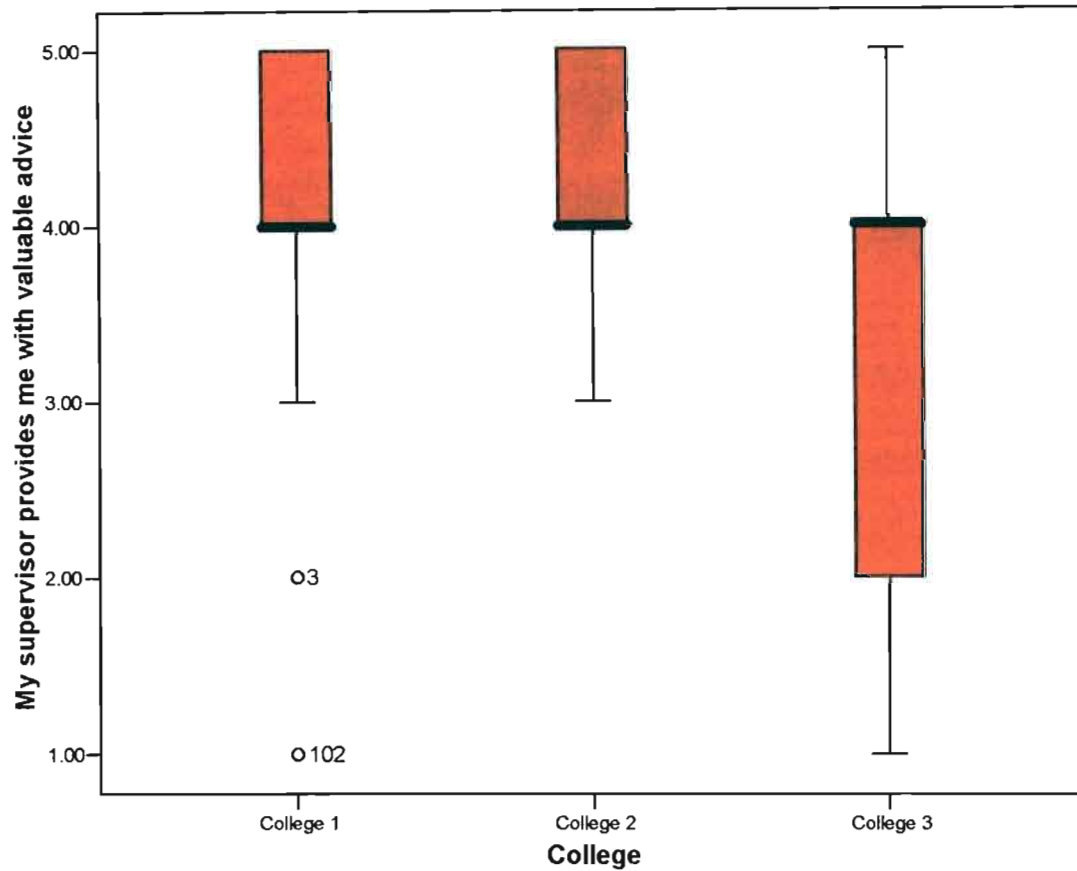


Figure 22: boxplot of statement 21 by colleges

Both College 1 and College 2 responses differed significantly from College 3 for the statement that the supervisor provided them with valuable advice. College 3 disagreed more than the other two hospitals (Figure 22).

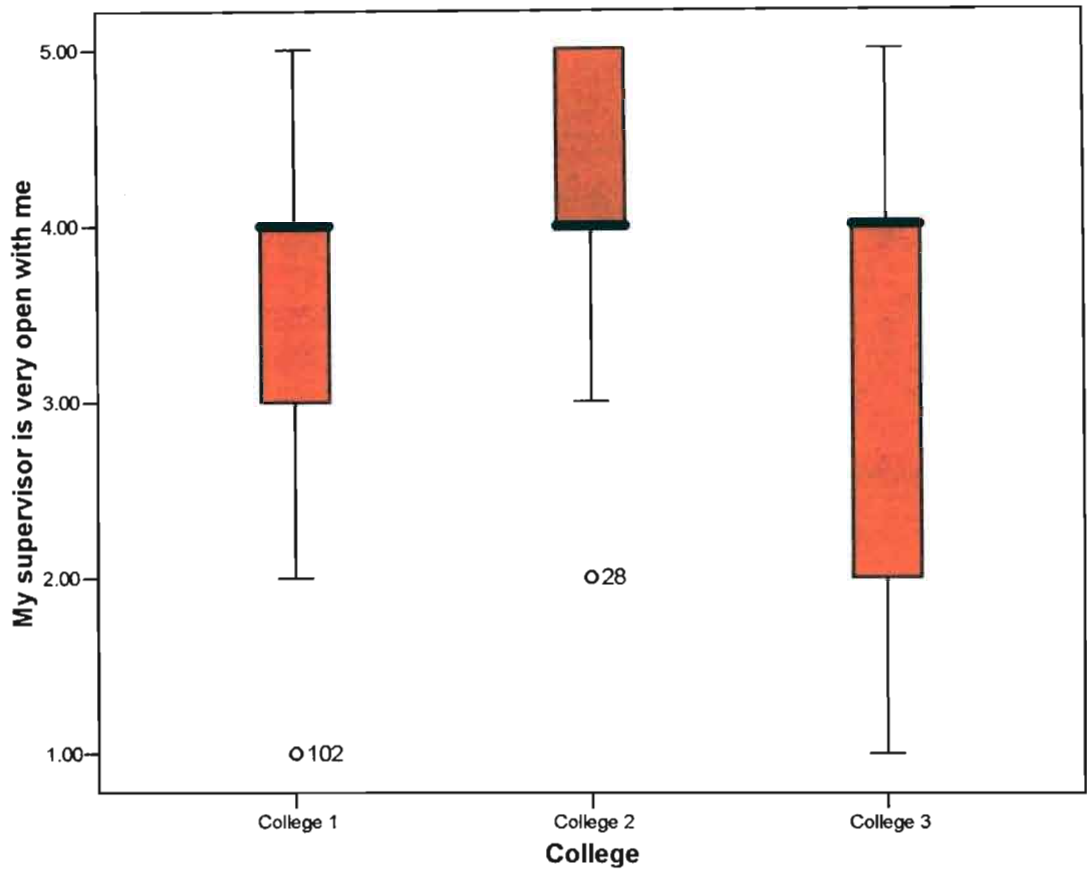


Figure 23: boxplot of statement 22 by colleges/hospitals

For the statement that the supervisor is very open with the students, College 3 respondents tended to disagree more than College 2 respondents (Figure 23).

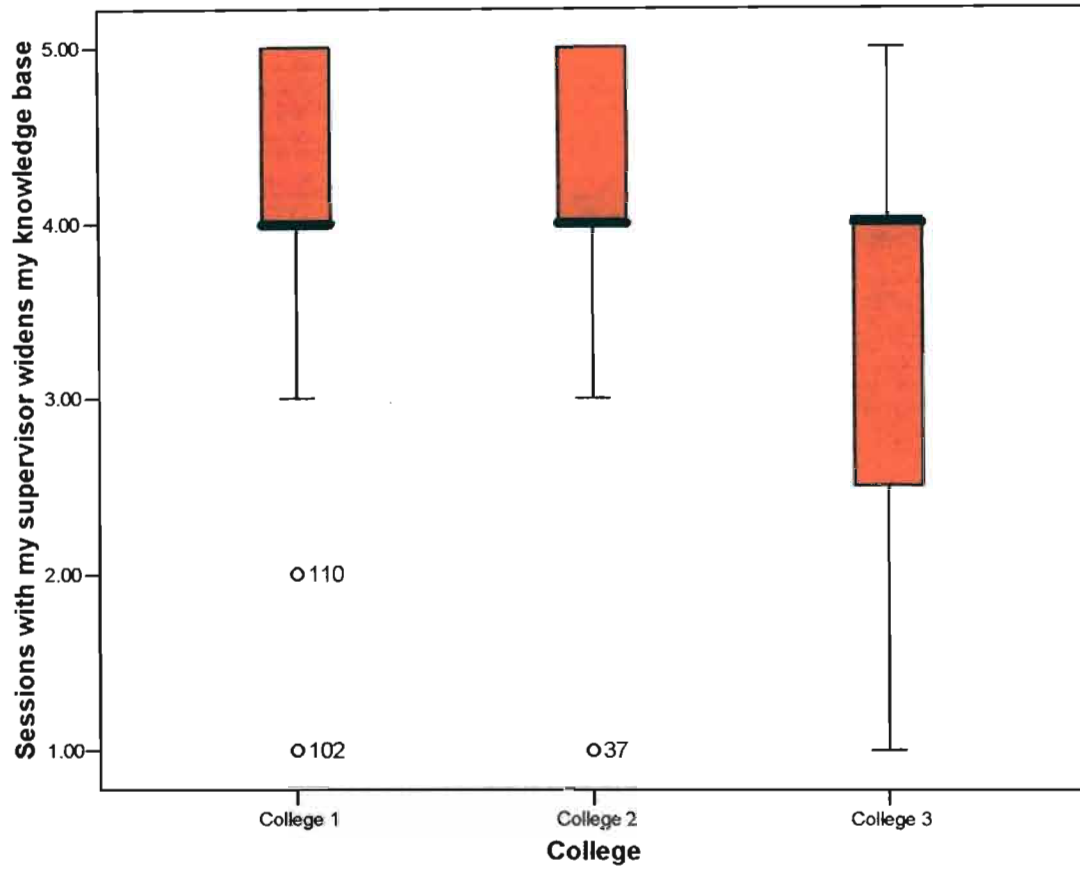


Figure 24: boxplots of statement 23 by colleges/hospitals

Although College 3 respondents disagreed more with the statement that the supervisor widens their knowledge base, there was no significant difference between any of the hospitals (Figure 24).

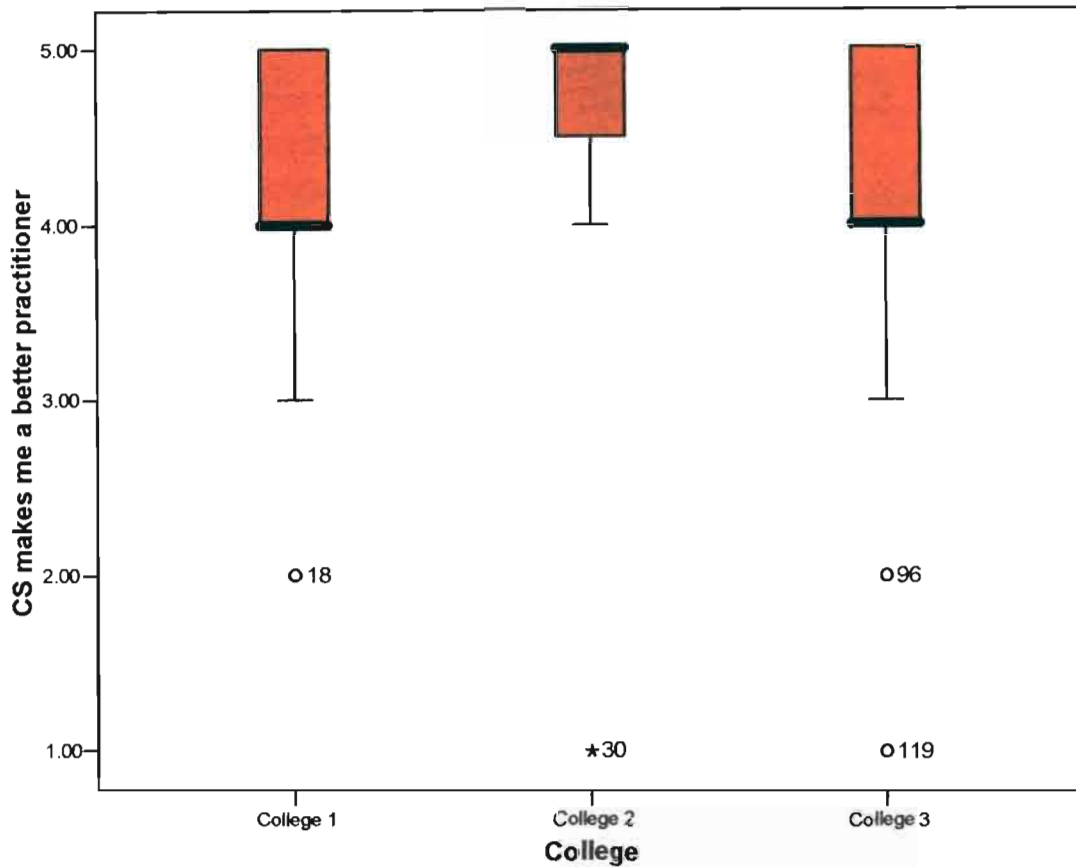


Figure 25: boxplot of statement 27 by colleges/hospitals

College 3 respondents disagreed more with the statement that clinical supervision makes them better practitioners, than College 2 respondents (Figure 25).

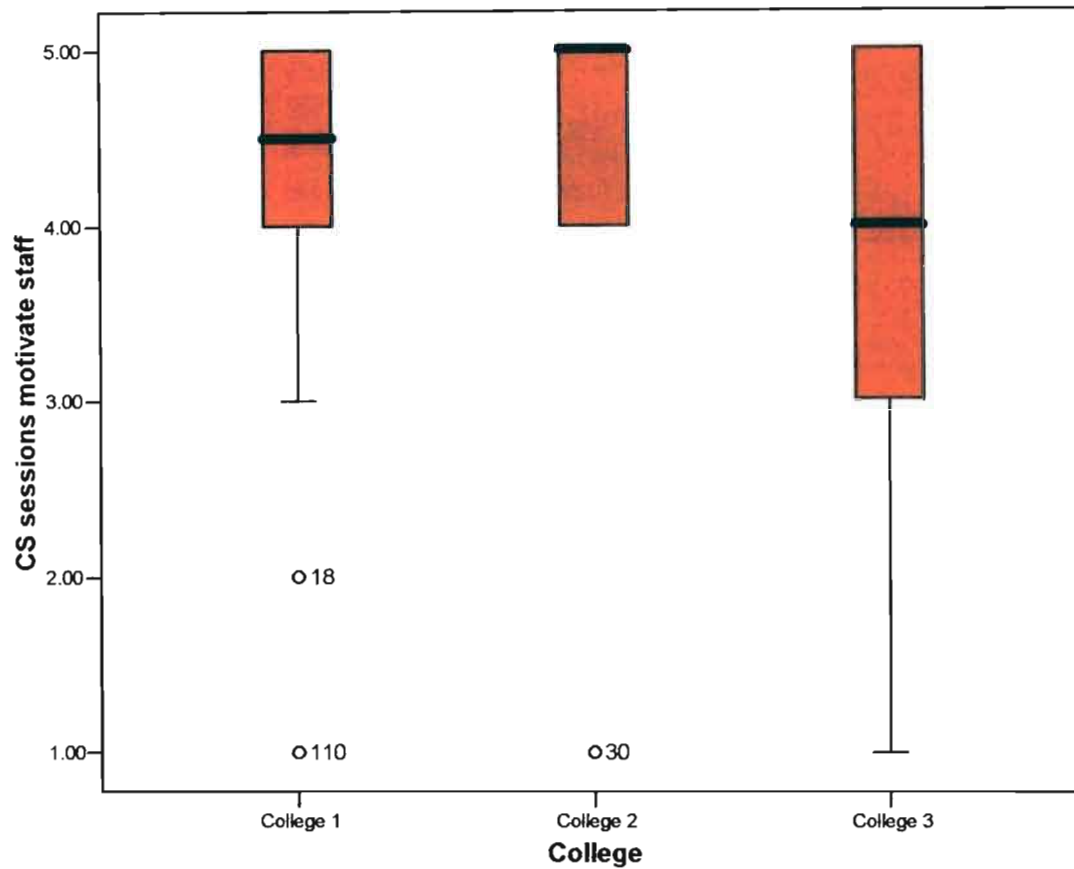


Figure 26: boxplot of statement 29 by colleges/hospitals

College 3 respondents disagreed more with the statement that clinical supervision sessions motivate them than those from College 2 and College 1 (Figure 26).

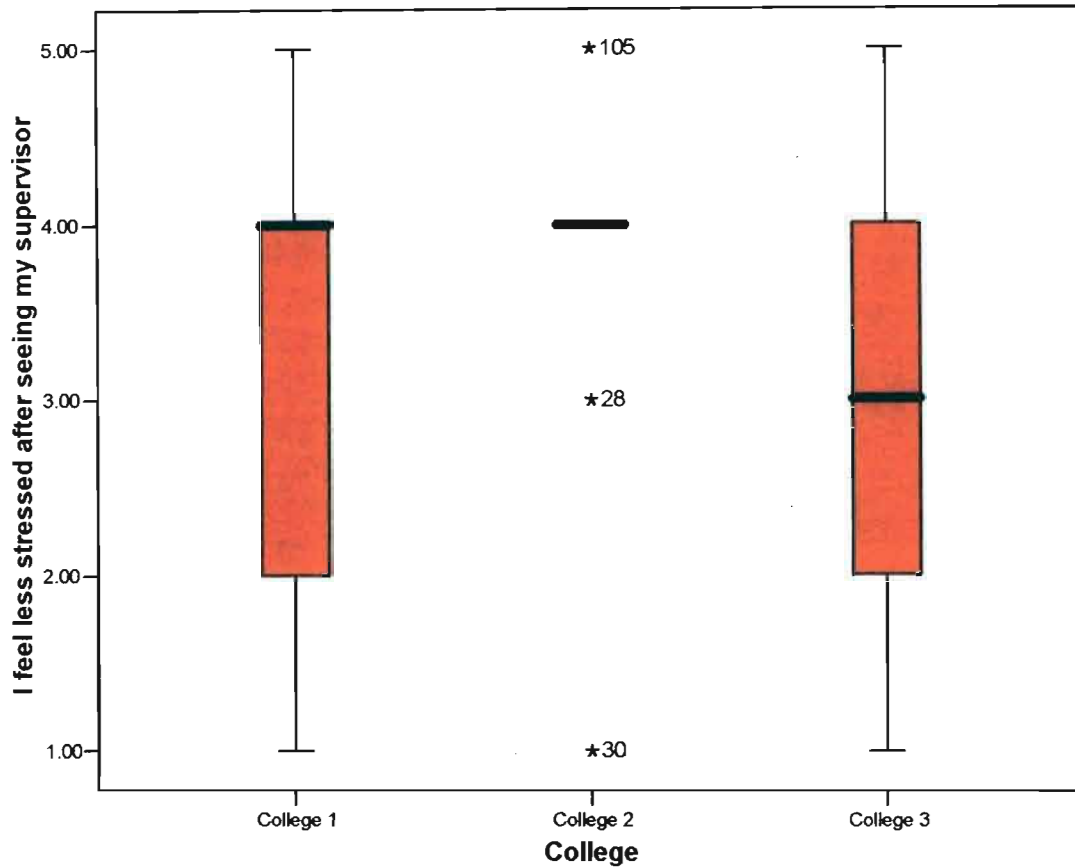


Figure 27: boxplot of statement 30 by colleges/hospitals

College 3 respondents disagreed more with the statement that there is less stress after seeing the clinical supervisor than those from College 2 (Figure 27).

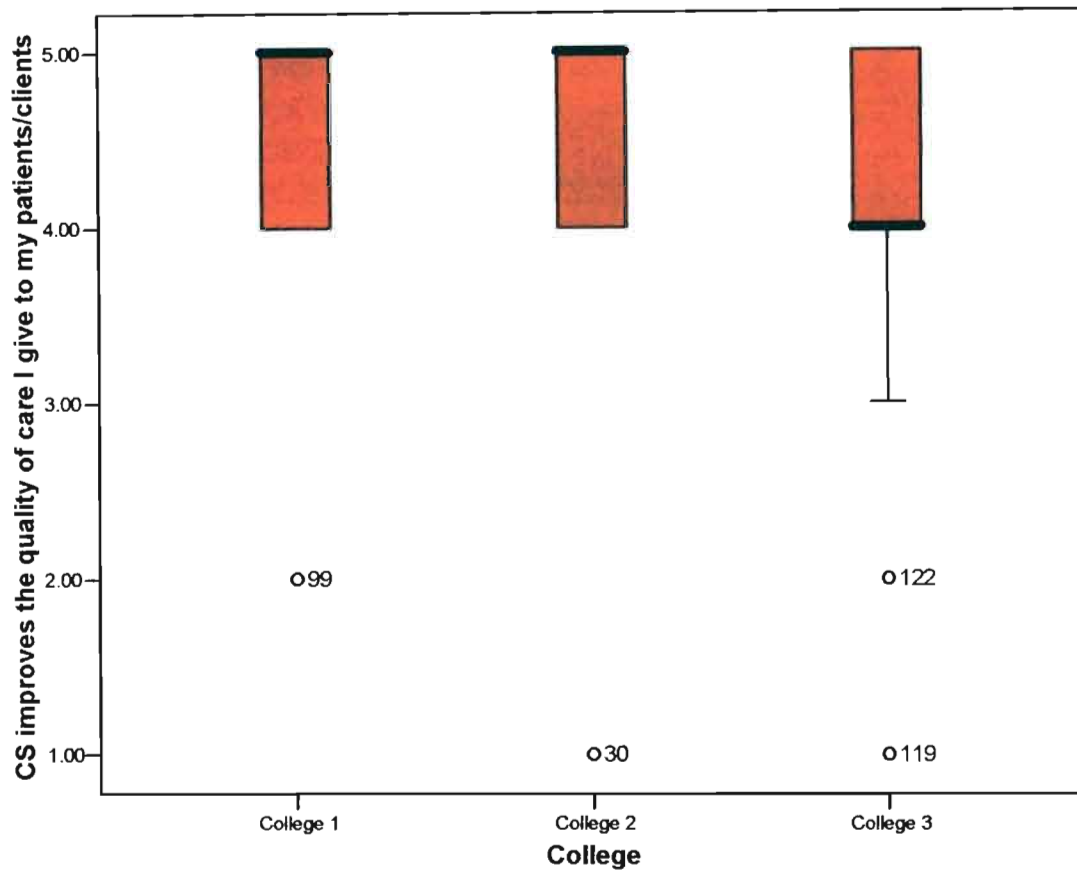


Figure 28: boxplot of statement 31 by colleges/hospitals

At College 3, respondents disagreed more with the statement that clinical supervision improves the quality of care given to patients than at the other two hospitals; however, there was no statistically significant difference between the responses from the individual hospitals (Figure 28).

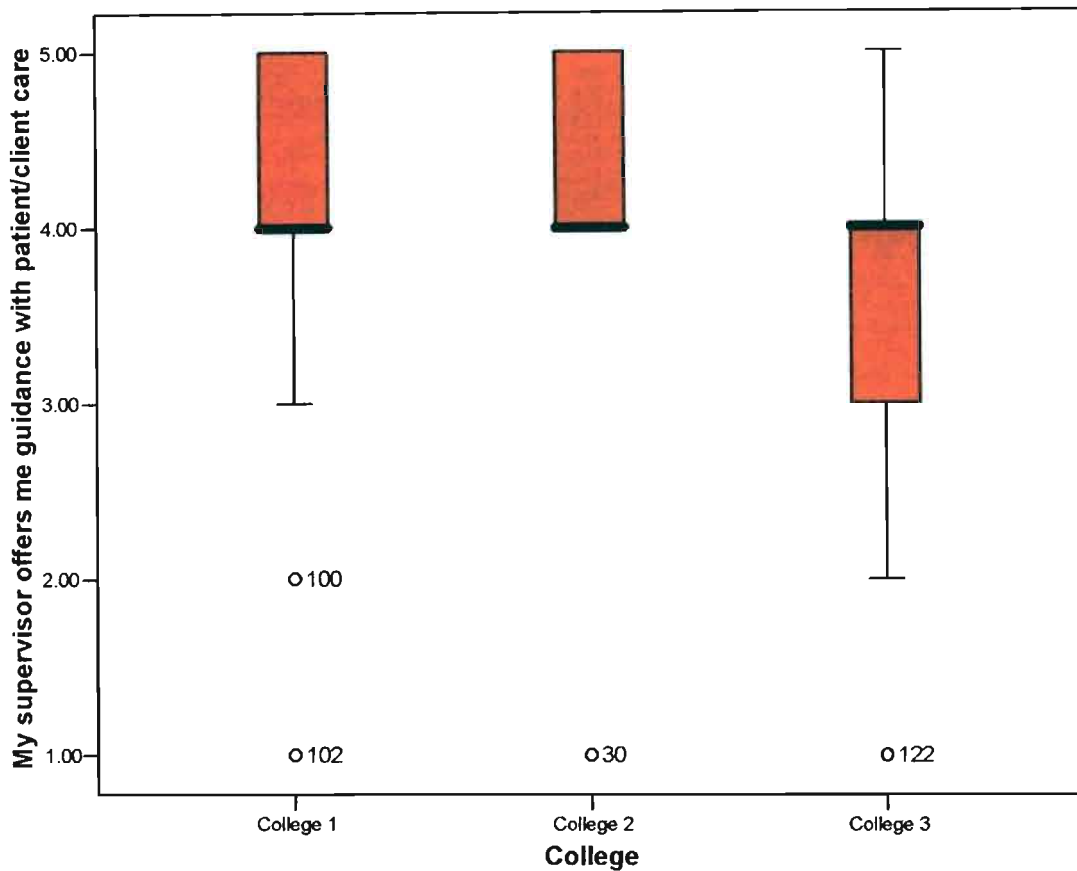


Figure 29: boxplot of statement 33 by colleges/hospitals

College 3 scored lower than College 2 for the statement that the supervisor offers guidance with patient care and the perception of the student that clinical supervision improves the quality of patient care. (Figures 29).

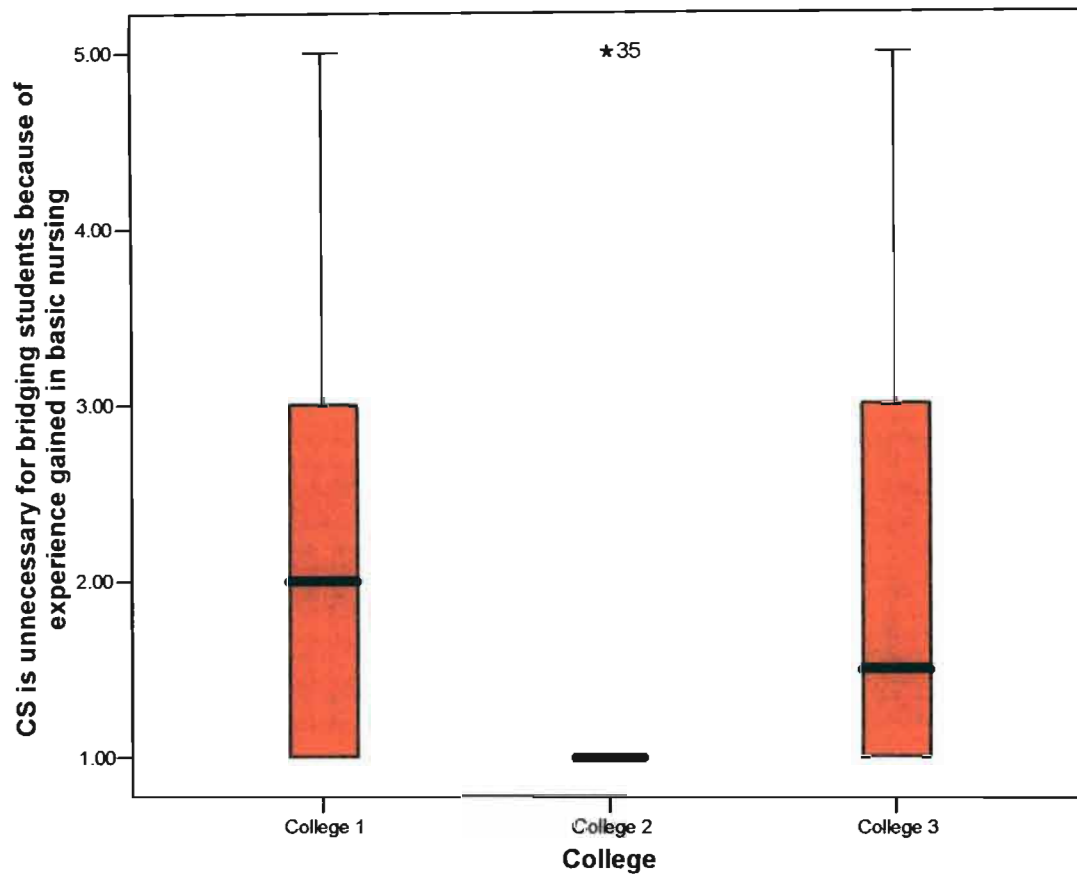


Figure 30: boxplot of statement 34 by colleges/hospitals

College 2 respondents disagreed more with the statement that clinical supervision is unnecessary for bridging students because of the experience gained during basic training, than college 3 respondents (Figure 31).

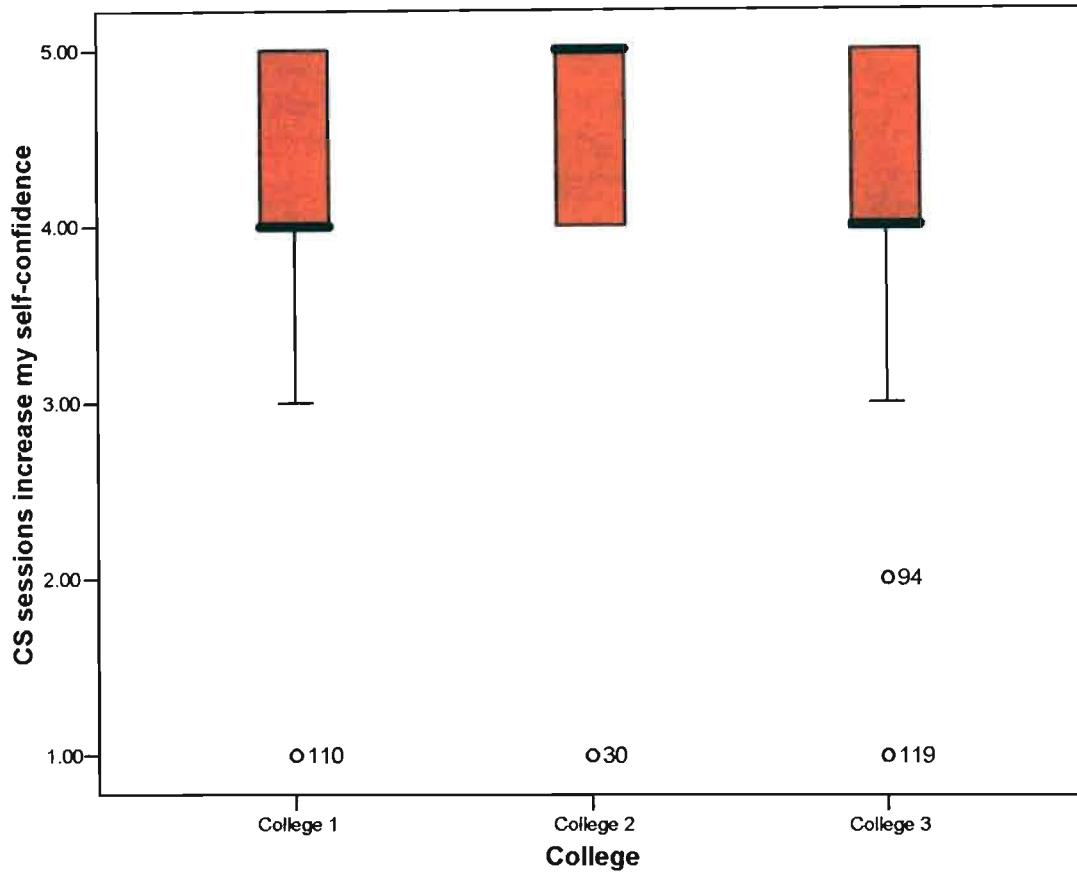


Figure 31: boxplot of statement 36 by hospital/colleges

College 3 respondents disagreed more with the fact that clinical supervision increases self-confidence than College 2 respondents (Figure 22).

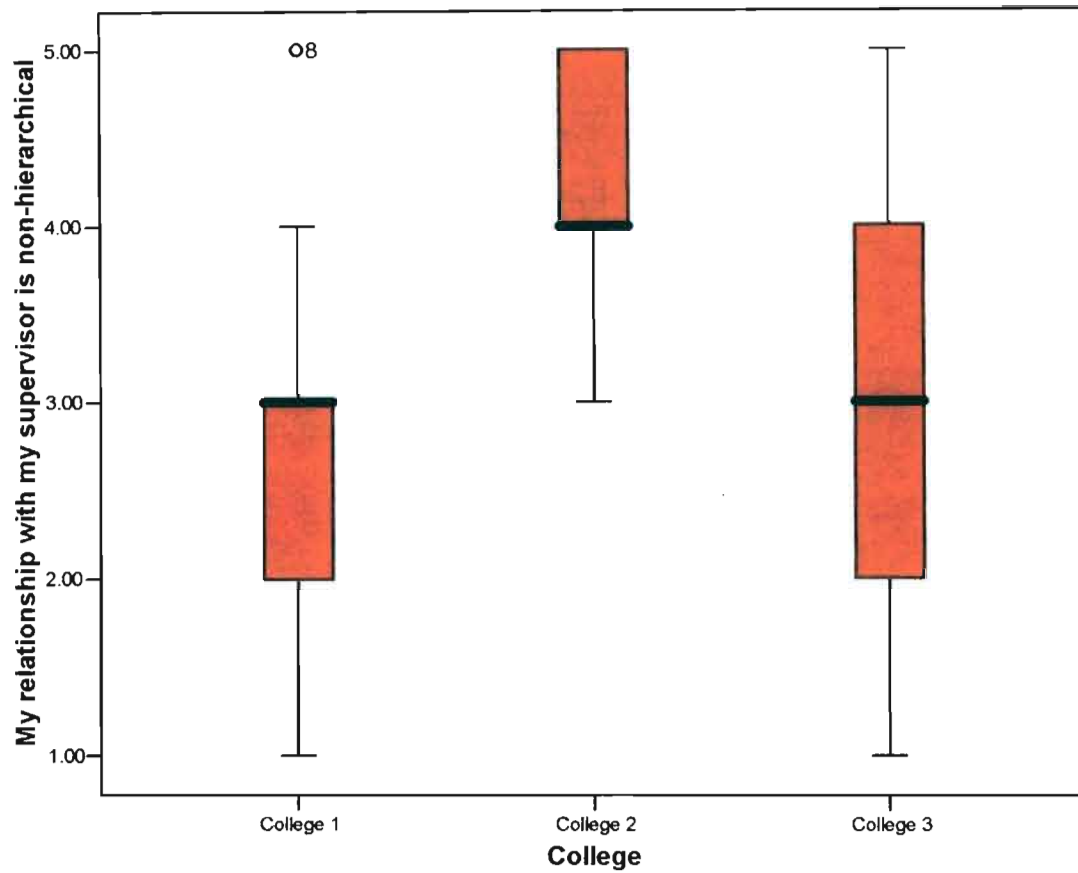


Figure 32: boxplot of statement 39 by college/hospitals

College 3 respondents disagreed more with the statement that the relationship between the supervisors is non- hierarchical than College 2 (Figure 33).

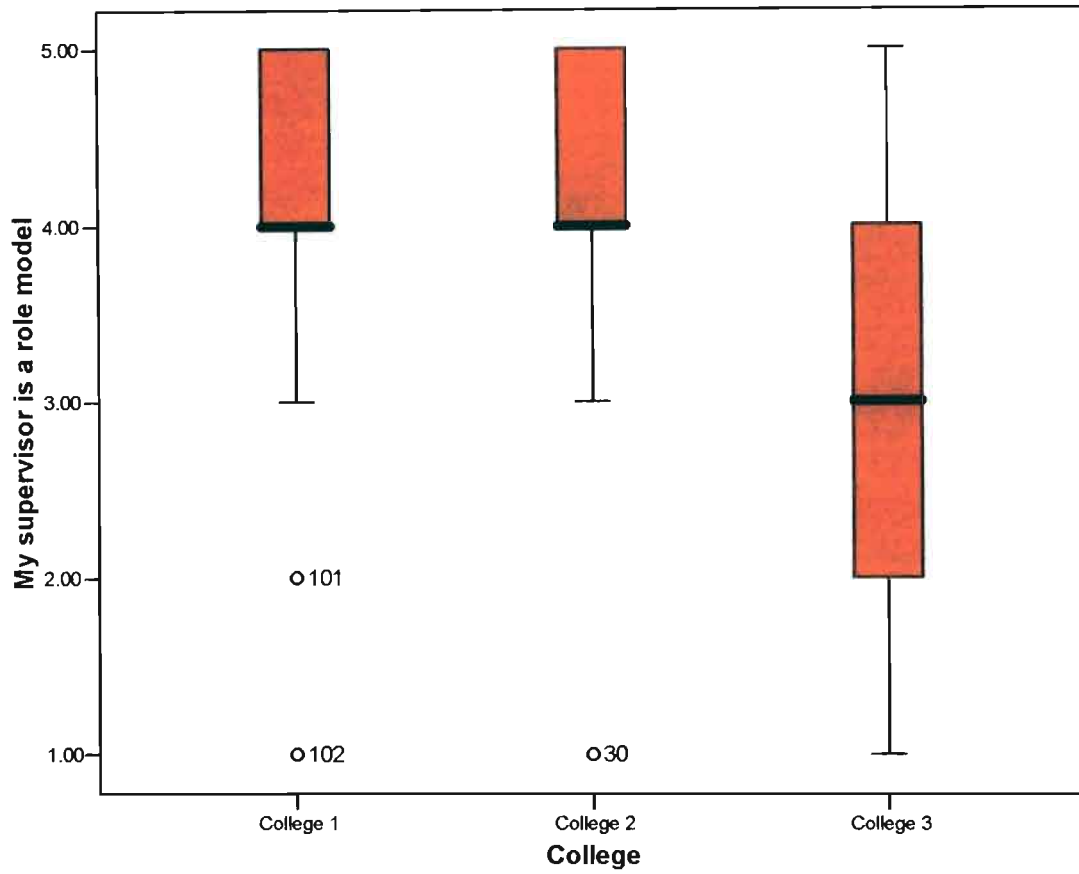


Figure 33: boxplot of statement 40 by hospital/colleges

Both College 1 and College 2 agreed more with statement 41 than College 3 (Figure 34).

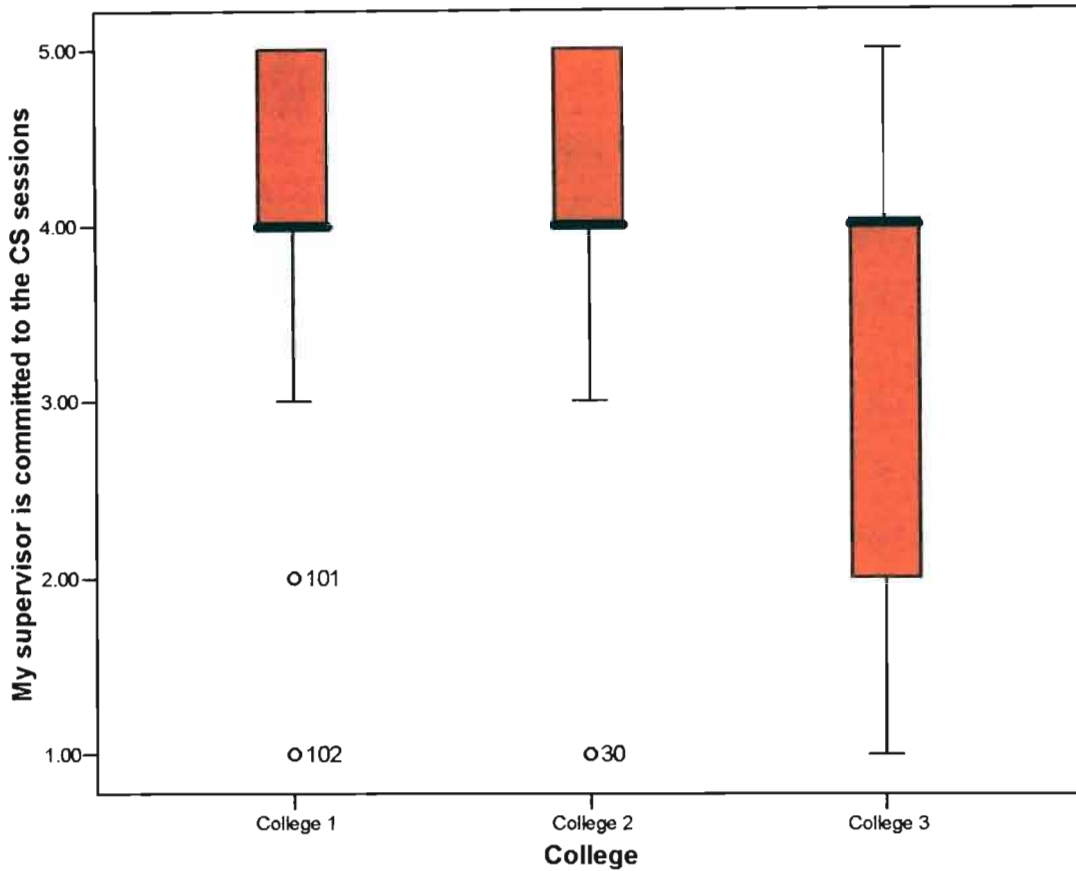


Figure 35: boxplot of statement 41 by hospital/colleges

College 3 disagreed more with statement 42 than College 2 respondents (Figure 35).

In summary, participants from College 3 were more inclined to disagree with the positively phrased statements and agree with the negatively phrased ones, than the participants from College 2 and College 1.

4.3.5. Comparison of scores between the hospitals/colleges

The overall statistics for total score are shown in Table 2. Since the scores were non-parametrically distributed, a median and an interquartile range were used to describe and compare this variable between the hospital groups. The median score was 150.5, and the range was from 54 to 195.

Table 1: Statistics for total score

N	Valid	122
	Missing	0
Median		150.50
Minimum		54
Maximum		195
Percentiles	25	133.75
	75	165.25

There was an overall significant difference between the median scores for the three hospitals. However, the post hoc test revealed that only College 2 and College 3 were significantly different from each other, whereas College 1 was not significantly different from College 2 or College 3. This is shown in Table 3. College 3 had the lowest median score and College 2 had the highest median score. This is graphically shown in the boxplot in Figure 26.

Table 2: Kruskal-Wallis test for comparison of median score between the three hospitals

Hospital	n	Mean Rank	p value	Post hoc comparisons
College 1	32	66.81	<0.001	College 1 vs. College 2 $p>0.05$ College 1 vs. College 3 $p>0.05$ College 2 vs. College 3 $p<0.05$
College 2	19	88.74		
College 3	71	51.82		

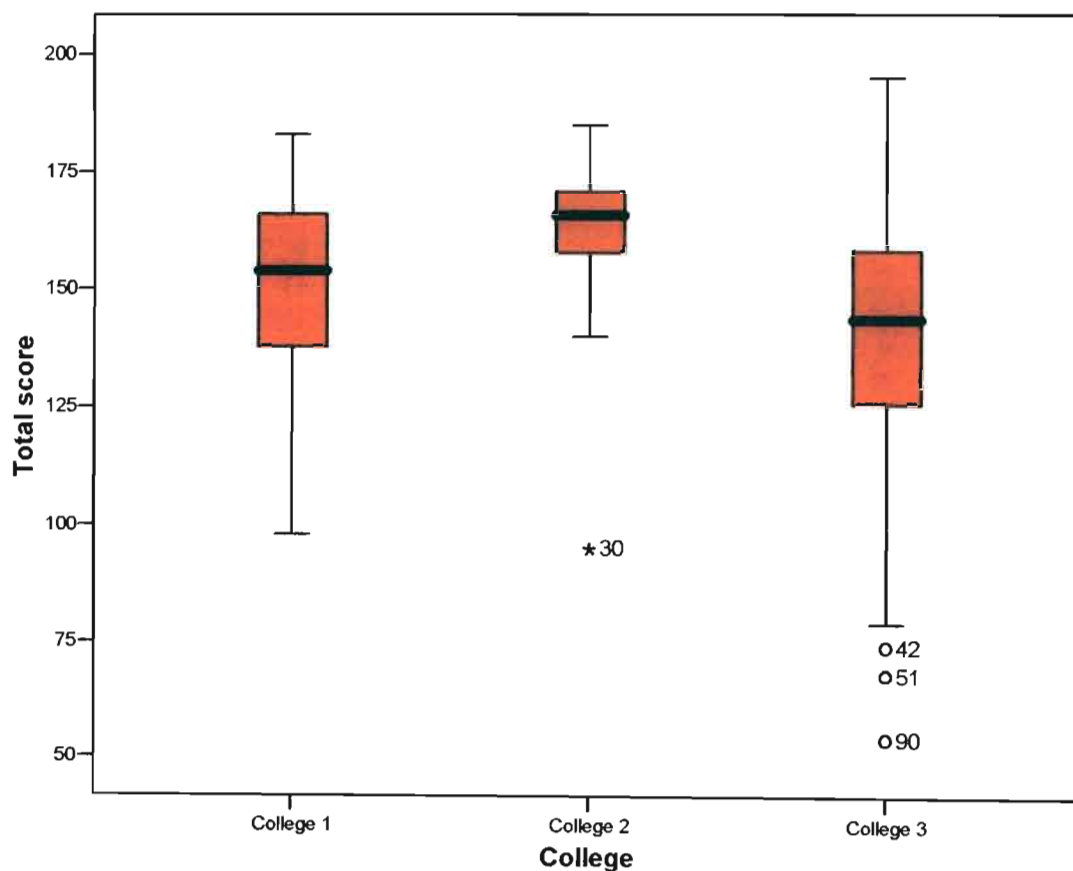


Figure 35: boxplot of total score by hospital

4.3.6 Comparison of critical incidents between the three hospitals

Respondents who reported a critical incident were cross-tabulated by colleges in Table 5.

The p-value for the association between incidents and hospital was 0.007, which was statistically significant. The highest proportion of incidents was reported in College 1, followed by College 2 and the lowest in College 3 (see Table 4). Overall 21.2% (n=25) of respondents reported critical incidents.

Table 3: Number and percentage of subjects who reported critical incidents by hospital

			Critical incident		Total
			no incident	incident	
Hospital	College 1	Count	19	12	31
		Row %	61.3%	38.7%	100.0%
	College 2	Count	13	5	18
		Row %	72.2%	27.8%	100.0%
	College 3	Count	61	8	69
		Row %	88.4%	11.6%	100.0%
Total		Count	93	25	118
		Row %	78.8%	21.2%	100.0%

Table 4: Support received in participants who reported critical incidents by hospital

			situation		Total
			no support	received support	
Hospital	College 1	Count	5	6	11
		Row %	45.5%	54.5%	100.0%
	College 2	Count	1	2	3
		Row %	33.3%	66.7%	100.0%
	College 3	Count	1	7	8
		Row %	12.5%	87.5%	100.0%
Total		Count	7	15	22
		Row %	31.8%	68.2%	100.0%

Of the 25 participants who reported critical incidents, 68.2% received support (Table 6).

There was no difference in the proportion receiving support by hospital ($p = 0.313$). Thus similar proportions of participants who reported incidents received support in the three hospitals.

4.4 Critical Incidences

From the critical incidences shared by the students the following categories emerged: a) academic support, and b) emotional support.

4.4.1 Academic support

Some of the participants indicated that they were able to obtain academic support from the unit staff if the needs arose. The unit staff made themselves available to teach students in the absence of the clinical supervisor. One student reported that the ward was grossly short staffed and that she was allocated to care for a patient with a tracheotomy. This was her first time caring for a tracheotomy. The other staff members were busy with their responsibilities

and were not available to help. This task was allocated to her because it was assumed that as an old student, she would have been exposed to such a procedure, but, unfortunately for her, it was her first time. The student felt uncomfortable reporting this to the unit manager, but the unit manager noticed that this student had a problem, and made herself available to teach the student.

The unit manager was very supportive. She demonstrated to me the procedure, starting from the setting of the tracheotomy tray, to the procedure of caring for a tracheotomy.

Some of the participants however reported that they did not receive academic support because they were regarded as a burden by the unit staff. Sometimes the unit were grossly short staffed and they were expected to function independently even when they required some guidance. The unit staffs' attitude towards them when they requested to be taught something was very negative. They were regarded as old nurses with experience, neglecting the fact that they were being trained or prepared to be a different category of nurse (registered nurse). They had never functioned as registered nurses before. Whatever they had learned was mainly in service as enrolled nurses. The participants reported that they were treated differently as opposed to four-year comprehensive students. These received more support compared than they did. Time was made available for such students to attend teaching sessions, whereas in most cases it was assumed that old students knew most of what was taught in the ward and therefore should continue with their work. They were not given an opportunity to choose whether to attend the sessions or not. Sometimes, due to staff shortages, they were used as part of the workforce because of their experience, bypassing the reason for their presence in the units, namely to learn what would be expected from them as

registered nurses. One of the participants reported that being regarded as part of the workforce delayed her in completing her objectives in particular units.

Sometimes we were highly stressed to complete our tasks before the end of the year.

We were overworked and not given enough time to learn. As a result we found ourselves behind compared to other students.

Sometimes the unit staffs are biased towards four-year course students. They get different treatment compared to us. They get academic support. Time is made available for them to attend learning sessions. According to the bridging programme students, they are treated differently.

I wanted to attend a demonstration as was expected according to my workbook, but the sister who was leading our team just said no, because there was no one to continue with my tasks. She did, however, allow the four-year course student to attend.

Some of the participants felt that their input was not appreciated by some of the unit staff. These participants reported that sometimes they identified some shortcomings in the way care was provided to patients. Instead of being encouraged by unit staff for identifying problems or gaps:

I noticed that every morning during the hand-over, most of the drips were dry or others were not running. I queried that, but the night sister was not happy about my comment. I expected the unit manager to back me, but it was as if she was not there. The silence that followed told me that what I did was incorrect. I thought I would be

appreciated for being observant and pointing out something that might affect the quality of care given to our patients.

4.4.2 Emotional support

Some of the participants, although only a few, pointed out that in critical incidences they did receive some form of support. There were times where the unit staff ensured that they received support even from other professionals:

I was blaming myself because we lost a baby in the unit. I was the only one in the unit. The sister and other staff members were on a tea break and the other staff member was busy with the errands. The critically ill child suddenly turned blue and required resuscitation. The doctor was not available. In private hospitals, getting a doctor for resuscitation takes time, and there was no readily available team for resuscitation. I called for help, but the response was poor and we lost that baby. I could not take what happened, but the ward staff went out of their way to support and counsel me. I was even referred to the psychologist for help.

Some of the participants received emotional support especially when dealing with difficult patients. It emerged from the findings that some of the patients undermined students and only respected qualified nurses. About three of the participants reported that they were physically assaulted by patients who undermined them, but who changed their behaviour when the qualified nurses attended to them. In two of these incidences the unit staff supported the students and intervened. One of the participants was bitten by a patient on the arm. She was counselled and the procedure of needle stick injury was followed and she was started on Anti-retro-viral drugs. In one of the incidences, it was as if the student invited the

assault. Instead of being supported, she was made to complete a statement independently with no one guiding her through the process. She was humiliated by the patients in front of the patients and unit staff, and was also humiliated by the unit manager who shouted at her in front of all these people and ordered her to write a statement, instead of attending to her as she had been assaulted by the patient:

I was working in casualty and was assaulted by a drunken patient. The sister was very cruel to me, instead of checking how I was feeling; she started shouting at me and ended up by ordering me to write a statement. I was in tears because I was shocked by the whole incident, and the person I expected to support me shouted at me as if I was the one who attacked the patient first. She made me write a statement immediately and submit it, without even telling me how it ought to be written. I wanted to resign from my training with immediate effect, but my peers advised me and counselled me.

From the participants' critical incidences it also became evident that the emotional support they received was very limited, especially from the unit managers. They were mainly expected to work, even when they had social or health problems. The unit managers' concerns were the coverage of the ward. One participant reported the following:

I once worked in a unit where a sister was not sympathetic to our needs as students. I was pregnant and I started to bleed while I was at work. When reporting my problem to the sister she ignored me instead of allowing me to go and seek medical assistance. I was made to continue with my work. After some time I decided to phone my clinical instructor and report to her because the problem was getting worse. She then intervened, and that is when I was allowed to attend to my problem.

Another participant reported that:

We fight our own battles as we are regarded as senior students. I lost my mother and I was instructed to work until the day before the funeral. I worked the first two days but could not continue. I was planning to abscond, and then the other unit staff pleaded with the unit sister. Her argument was that as students we are expected to cover a certain number of hours where we are allocated. The unit sisters can be very mean to us sometimes. We are not treated as human beings with feelings.

What emerged from these critical incidences however, revealed that they facilitated the students' growth, personally and academically. For example, there was a participant who stated that she was made to prepare and assist the doctor put up a CVP monitoring line without any assistance. When requesting help from other unit members she was denied help. Instead of taking this negatively, after assisting the doctor she approached the unit manager and suggested that preparing for this procedure should be added to the procedure manual and that a list of the requirements should be kept on the CVP line trolley, to assist those not familiar with the procedure. The unit manager appreciated the student's suggestion, and in this particular unit, the CVP trolley has a list of requirements hanging on it. This participant learned to confront the situation and come up with a solution that would avoid the repetition of a similar incident, which might put a patient's life at risk.

4.5 Conclusion

There were 122 participants in the study, 26, 2% (n=32) were from College 1, 15, 6% (n=19) were from College 2 and the majority, 58, 2 % (n=71) were from College 3.

The responses to 25 of the 41 questions or statements differed significantly between the three hospitals. There was an overall significant difference between the median scores for the three hospitals. However, the post hoc test revealed that only College 2 and College 3 were significantly different from each other, whereas College 1 was not significantly different from College 2 and 3. This is shown in Table 4 where College 3 had the lowest median score and College 2 had the highest median score.



CHAPTER FIVE

DISCUSSION OF FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

This chapter presents a discussion of the most significant findings of this research, the conclusions drawn, as well as the recommendations made for nursing education and further research. The purpose of this study was to describe the nature of clinical supervision and support provided to bridging programme students in the clinical settings in the Greater Durban area. The research objectives were a) to analyse and describe preconditions taken into consideration in a bridging programme for clinical supervision to be effective; b) to analyse the teaching/ learning process during clinical supervision in a bridging programme, to describe the type of support provided to bridging programme students when they encounter a critical incident in the clinical settings and; c) to describe and analyse how clinical supervision and support influences the learning outcomes. The findings will be discussed in relation to the conceptual framework used in this study, as well as in relation to the previous studies and other literature about clinical supervision.

5.2 Discussion of Findings

The majority of the respondents acknowledged the need for clinical supervision. The students found clinical supervision useful in promoting working practices and in facilitating their professional development. It is difficult to establish supervision without the dedicated support of the clinical supervisor. It takes great energy to keep the groups focused and

committed in an environment where there are continuous high patient workloads and frequent shortages of staff.

In this study, clinical supervision emerged as a formal process of facilitating growth from the students, with the clinical supervisor playing a leading role. This process focused on developing students personally, academically and professionally. Clinical supervision was not only the responsibility of the clinical supervisors as some of the clinical staff provided support to the students. The nature of support provided ranged from academic support, to social (emotional, psychological) and professional support to facilitate the growth of students in these areas. Although some of the clinical staff was not supportive of the students' learning in the clinical settings, a number of clinical staff supported them.

How clinical supervision emerged in this study is in line with how Winstanley et al (2003) view clinical supervision. These authors however also add that clinical supervision enables individuals to develop competence and assume responsibility for their own practice and to enhance consumer protection and safety in a complex situation. Enhancing patient safety emerged when participants were reflecting on critical incidences. In some situations where participants were not skilled, or not familiar with a procedure to be performed, the clinical staff made themselves available to help the participants and to protect the patients.

The findings in this study revealed that other institutions lacked trained staff to carry out supervision. They used clinical supervisors without a nursing education qualification, which is not in line with the SANC's expectations. Lack of trained staff was one of the difficulties of clinical supervision, which was pointed out by Thomas and Reid (1995). It emerged in

this study that the time available was insufficient for clinical supervision, and the opportunities for reflection were limited due to busy wards. Some of the clinical staff was not in favour of releasing students to attend clinical supervision sessions because students served as an extra pair of hands. The bridging programme students were still regarded as part of the unit staff, and releasing them for clinical supervision sessions meant that some activities would not be performed.

The first session of clinical supervision was used to explain the goals of clinical supervisions, the expectations, roles and responsibilities of each party (clinical supervisor and student). The purpose of clinical supervision emerged as being to promote academic, personal and professional growth in the students. Although this was not supported in some units, there were units, which supported this aim. This was in line with the developmental model, which was described by Leddick (1994) as having three developmental phases with the student moving towards competence, self-assurance and self-reliance. To facilitate growth, each student had a copy of objectives to be covered in the clinical settings, but the participants raised the concern that they were unable to cover all the objectives on time because they were overloaded with work in the units, and were not regarded as students. They did not have enough time to develop themselves towards becoming professional nurses. They were still treated as staff nurses who were part of the work team.

Other participants regarded the clinical supervisors as teachers by some and facilitators. The reason for regarding clinical supervisors as teachers was that some of them assumed the position of an instructor and gave information to students instead of engaging them in dialogue, encouraging them to think, and giving them an opportunity to reflect on their

experiences. Leddick (1994) advised that clinical supervisors should act as consultants, counsellors and facilitators of learning and that they must be sensitive to the needs of the students. The findings suggested that clinical supervisors assumed a paternalistic approach with the students regarded as being dependent on the clinical supervisor's wealth of knowledge. They assumed more of a supervisory role than that of facilitators of clinical learning. Responding to this type of relationship between the clinical supervisor and the students, Cotrell and Smith (2000) indicated that mutuality of the dialogue occurring within the contracting process is essential to enhance successful outcomes. These authors advise that with an emphasis on collaborative contracting, a collegiate relationship can be established leading to a sound basis upon which the two parties (clinical supervisor and student) may build and develop self-esteem.

The formative aspect (educative) of clinical supervision was more pronounced compared to restorative and normative aspects. According to the findings in this study, clinical supervisors focused more on facilitating the development of technical skills instead of facilitating the development of competencies (knowledge, attitude and skills), and the ability to reflect. According to the Open University cited in Winstanley and Edward (2003), clinical supervision should provide an opportunity, in the context of an ongoing professional relationship with an experienced practitioner, to engage in guided reflection on current practice, in ways designed to develop and enhance that practice in future. This aspect of promoting guided reflection did not come out clearly in this study.

The participants reported that they had individual as well as group clinical supervision sessions, and most of the participants, (71%) reported that sessions lasted less than 15

minutes. Relatively few participants (29%) received clinical supervision that was longer than 30 minutes. This suggests that less time was allocated to clinical supervision. According to the framework, which was used in this study, adequate time should be allocated to clinical supervision sessions, because clinical supervision facilitates the development of students as professionals. The participants pointed out that more time should be dedicated to clinical teaching and learning, they should have more frequent sessions, and should not be regarded as part of the workforce but as students first, then secondly as part of the clinical staff. This supports the findings in the study by Winstanley and Edward (2003) that longer sessions and more frequent sessions may be more effective.

According to the participants in this study a good supervisor should be well informed, have relevant or current knowledge and skills, and be able to provide support to the students. The findings revealed that there was a large age gap between the clinical supervisors and the students and that all clinical supervisors were females. According to Hyrkas (2002) these differences might result in some tension between supervisors and students.

Some of the clinical supervisors were not qualified nurse educators, whereas according to the South African Nursing Council, they should possess a qualification in nursing education. It was not easy to establish why certain institutions used unqualified nurses, but according to Thomas and Reid (1995) untrained staff in their study was used as a result of a lack of trained staff. The researcher was unable to establish from participants whether those who possessed a nursing education qualification were prepared academically for this role. This answer would have been answered if nurse educators were included in this study. From the researcher's experience, the training and education of nurse educators does not go in-depth with clinical supervision. Only the basics of clinical supervision are discussed.

The findings show that most ward staff in the three hospitals found clinical supervision sessions to be time consuming. This is confirmed by the analysis, which shows that there is a statistical difference ($\chi^2 = 0,005$, $df=8$, $p<0,05$). The result also shows that the ward staff and students feel that it is difficult to find time for clinical supervision sessions. There is no statistical significance on finding time for clinical supervision sessions.

At the same time, most ward staff and students feel that clinical supervision sessions are of great importance in the hospital settings. They do not agree with the view that clinical supervision sessions do not solve everything ($\chi^2 = 0,96$, $df=8$, $p<0,05$). Ward staff fails to get involved in clinical supervision sessions because they feel that other work pressures tend to interfere with these sessions ($\chi^2 = 0,021$, $df=8$, $p<0,05$).

The analysis shows that the students in the three hospitals are of the view that those clinical supervision sessions with their supervisors do not broaden their knowledge. This is indicated by the result, which shows that there is no significant relationship between clinical supervision sessions and the acquisition of knowledge ($\chi^2 = 0,019$, $df=8$, $p<0,05$). Despite this, most ward staff and students point out that most supervisors in these hospitals are open enough to answer questions and give feedback to students. The results show a statistical significance on the openness of supervisors to students during clinical supervision sessions ($\chi^2 = 0,019$, $df=8$, $p<0,05$).

Most students felt that their supervisors acted normally towards them. They did not act in a superior manner as is indicated in the results ($\chi^2 = 0.081$, $df=8$, $p<0.05$), and they also provided valuable advice as indicated in the results ($\chi^2 = 0.007$, $df=8$, $p<0.05$). It was found that most ward staff and students become motivated during clinical supervision sessions, despite the fact that the clinical supervisor may discuss sensitive issues that have been encountered during clinical supervision sessions ($\chi^2 = 0,375$, $df=8$, $p, 0,05$).

The analysis also reveals that most students agree that there is commitment from the supervisors during the clinical supervision sessions, and that the clinical supervision sessions improve the quality of care that the patients receive. The results are indicative of this ($\chi^2 = 0.030$, $df=2$, $p<0.05$). There was a significant difference in response in relation to the support and encouragement that students received. Students from college /hospital 3 disagreed more than college/ hospital 2 respondents.

The critical incident results are based on 25 participants. The low response to this critical incident question was because it took longer to answer than the other questionnaire, and some students said that the questions intruded upon the confidentiality of student and clinical supervisor. The highest proportion of critical incidents was reported in college 1, followed by college 2 and then college 3. Of the 25 participants who reported critical incidents, 68, 2% received support. There was no difference in the proportion receiving support by hospitals. All three hospitals provided a similar type of support and encouragement.

Clinical supervision sessions are a crucial teaching component in order to bridge the gap, which has existed for a long time between students and professionals. As pointed out earlier, most nurses who are in the bridging programme for enrolled nurses towards becoming professional nurses find it difficult to change their mind-set. According to the findings of this study, it was found that most supervisors do not find time for clinical supervision and at the same time, pressure of work interferes with the carrying out of clinical supervision sessions ($\chi^2=0.021$, $df=8$, $p<0.05$). This can be argued as resulting from the fact that most students in the bridging programme have been working in the wards for a long time, and that supervisors did not make the time to involve them in clinical supervision sessions.

There is strong support in literature for the notion that supervision is beneficial to the student. Authors including Hallberg (1994) and Butterworth, Carson (1995) have used measures such as the Maslach Burnout inventory to demonstrate the effectiveness of clinical supervision in improving staff morale and attitude.

A significant body of research finds nurses consistently value the provision of support through supervision (Butterworth 1993, Fyffe, 1997, Nicklin, 1997, Roden, 1997.), and finds supervision to be a positive and a worthwhile experience, expressing satisfaction at the provision of this personal time.

On the other hand, supervisors were noted to offer biased opinions on different areas upon being asked ($\chi^2=0.07$, $df=8$, $p<0.05$ which results in most students ending up not asking

questions when there is something they don't know ($\chi^2=0.25$, $df=8$, $p<0.05$). Some students even highlighted the issue that their supervisors did not offer them support with regard to patient care ($\chi^2=0.173$, $df=8$, $p<0.05$). This tendency can make clinical supervision ineffective thus diminishing the essence of clinical supervision sessions. According to the United Kingdom Central Council for Nursing (2001) in order to create a climate and culture of support, ground rules should be agreed upon, so that the clinical supervisor and the student approach clinical supervision openly, confidently, and so that both are aware of what is involved. On the other hand, staffs acknowledge that clinical supervision is not only for inexperienced students, but is for everyone ($\chi^2=0.18$, $df=8$, $p<0.05$). This is complemented by the fact that most ward staff feel they learn from their supervisor's experience ($\chi^2=0.046$, $df=8$, $p<0.05$). As a result, they need to have their supervisors available when needed ($\chi^2=0.112$, $df=8$, $p<0.05$).

The critical incident analysis revealed that supervised nurses continued to use informal support as well as their supervision sessions to discuss clinical issues.

5.3 Recommendations

The partnership between educational staff and clinical staff is extremely useful as it helps to keep a balance between theory and practice. An ongoing professional development programme ought to be developed that would encourage educators and supervisors to reflect on what they are doing educationally, and why. In order to support students in the bridging programme, an open, effective and supportive relationship based on mutual trust and respect needs to develop, and be maintained at all times throughout the period of training. Support for clinical supervision by management, and by those who are involved in clinical supervision is essential.

Ongoing facilitation is required for the bridging programme students. Both the supervisor and the student need to recognize that clinical supervision is a process and requires commitment to 'get it right'. Initial training in clinical supervision should be provided for the clinical instructors and ward staff. Regular updates in training are necessary to maintain clinical supervision. Dedicated time should be available for clinical supervision.

The introduction of peer supervision could be effected through the placement of a junior student with a senior student. It would be beneficial for the student who is in the second year of training and the first year student to form a supportive relationship, which would aid the development of both parties. The way in which a peer support system is organized will vary according to the individual students' abilities and needs, and the local environment.

A structured learning contract with agreed learning outcomes should be in place between the student and the supervisor.

The use of a clinical supervisor emerged in this study, but it was not possible to establish the competence of trained nurse educators compared to those without a nursing education qualification. It was also not possible to establish the adequacy of the preparation of qualified nurse educators in clinical teaching and supervision. From the researcher's experience as a qualified nurse educator, the preparation of nurse educators for clinical teaching and supervision is very limited. Very few nurse educators have an in-depth understanding of clinical supervision and teaching, starting from the planning phase during the curriculum developing phase, identifying appropriate clinical facilities, negotiating a working partnership with the clinical settings, planning for the actual process of clinical supervision, how to conduct clinical supervision, and evaluate learning and the expected outcomes of clinical supervision, including strategies to achieve the expected outcomes. It is recommended in this study that nursing education programmes review this aspect, and come up with learning experiences that prepare nurse educators for their clinical supervision role. Practical experiences in most of the nurse educators' programmes focus on teaching theory and teaching in a demonstration room. There is a need to expand the scope of the practical to include learning to facilitate clinical learning.

5.4 Conclusion

The results of the study and the literature support the need to rethink clinical supervision for students in the bridging programme in colleges and hospitals where the study was undertaken. However, the development of clinical skills as a joint venture can be seen as being problematic. Time, resources and ideological differences are issues that may impede progress.

From the above discussion and based on the findings of the study, it has been established that clinical supervision sessions are vital for the development of clinical skills amongst the bridging programme students. It has also been found that there is a need for mutual support between ward staff and supervisors, as well as among the students themselves. The experience of supervisors is very important, and hence there is a need for it to be utilised to the optimum.

Integral to the concept of clinical supervision is the notion that the patient must be the focus of the exercise. In reinforcing the importance of that focus, Yedlich (1999) emphasises that the supportive aspect of supervision is, and must remain, distinct from therapy. The positive outcomes of clinical supervision are that there is reduced professional isolation, professional development, improved quality care, reduced clinical risks, improved colleague support, problem-solving, better-informed staff and improved teamwork. Effective clinical supervision has to be encouraged and supported. It requires enthusiasm and commitment from students and those involved in clinical supervision.

6 REFERENCES:

- Benoliel, J.Q. 1988. "Some Reflections on Learning and Teaching" In Journal of Nursing Education, 27(8) pp340-341.
- Begat, I,
Berggren, I,
Ellefsen, B, and
Severinsson, E. 2003. "Australian Nurse Supervisors' Styles and their Perceptions of Ethical Dilemmas within the Healthcare" In Journal of Nursing Management, Vol. 11/ Issue1
- Bjork, I. T. 1995. "Neglected Conflicts in the Discipline of Nursing: Perception of the Importance and the Value of Practical Skill" In Journal of Advanced Nursing.22 (1), pp 6-12.
- Bond, M. and
Holland, S. 1998. Skills of Clinical Supervision for Nurses. A Guide for Supervisees, Clinical Supervisors and Managers. Buckingham: Open University Press.
- Borders, L.D,
Bernard, J.M,
Dye, H.A, Fong, M.L,
Henderson, P. &
Nance, D.W. 1991. "Curriculum Guide for Training Counsellor Supervisors: Rationale Development and Implementation" In Counsellor Education and Supervision, 31, pp 58-80.

Brocklehurst, N. 1999. An Evaluation Study of Clinical Supervision in Six NHS Trusts. PhD Thesis, University of Birmingham.

Burrow, S. 1995. "Supervision: Clinical Development or Management Control?" In British Journal of Nursing. Vol.4. No.15 pp.879-882.

Burns, N.

&Grove, S.K. 1994. The Practice of Nursing Research. Philadelphia: W.B. Saunders Company.

Butterworth, T.

& Faugier, S. 1992. Clinical Supervision and mentoring in nursing. London: Chapman & Hall.

Butterworth, T. &

Faugier, J. 1994. "Clinical Supervision in Nursing, Midwifery and Health Visiting. A Brief Paper" In Nursing Times. Vol. 90 No.48 pp.38-42.

Butterworth, T,

Bishop, V, &

Carson, J. 1996. "First Steps Towards Evaluating Clinical Supervision in Nursing and Health Visiting. Part1: Theory, Policy and Practice Development" In Journal of Clinical Teaching pp127-132.

Butterworth, T. &

Faugier, J. 1998. Clinical Supervision and Mentoring in Nursing. 2nd edition. London. Stanley Thomas Publishers.

Butterworth, T. &

Woods, D. 1998. Clinical Governance and Clinical Supervision, Working Together to Ensure Safe and Accountable Practice, A Briefing Paper. Manchester: Manchester University.

- Cottrell, S. &
Smith, G. 2000. The Development of Models of Nursing Supervision in the UK
London
- Carson, J. 1995. Stress and Coping in Mental Health. London. Chapman & Hall.
- Cohen, L,
Manion, L, &
Morrison, K. 2000. "Questionnaires" In Research Methods in Education. London:
Routledge Falmer. pp245-266.
- Dana, N. 1997. Perceptions of Student Nurses about the Community as a
Clinical Learning Environment. Masters thesis. University of Natal,
Durban.
- Department of Health 2000. Making a Difference: Clinical Supervision in Primary Care.
London: Department of Health.
- Elkan, R. &
Robinson, J. 1993. "Project 2000: The Gap Between Theory and Practice" In Nurse
Education Today 13 (4), pp295-298.
- Emmerton, A. 1999. "Address given to Florence Nightingale Memorial Service",
Westminster Abbey, London.
- Ewan, C. &
White, R. 1991. Teaching Nursing: a Self-Instructional Handbook. London:
Chapman Hall.
- Fawcett, T.N.
& McQueen A. 1994. "Clinical Credibility and the Role of the Nurse Teacher" In
Nurse Education Today, 14, pp.264-271.

- Feasy, D. 2002. Good Practice in Supervision with Psychotherapists and Counsellors: A Relational Approach. London: Wurr Publishers.
- Farrington, A. 1995. "Defining and Setting the Parameters of Clinical Supervision" In British Journal of Nursing. Vol. 4. No. 15. pp 874-875.
- Faugier, J. 1992. "The Supervisory Relationship" In Clinical Supervision and Mentorship in Nursing. pp.18-36. London: Chapman Hall.
- Faugier, J. & Butterworth, T. 1993. Clinical Supervision- A Position Paper. School of Nursing Studies. University of Manchester. Manchester.
- Faugier, J. 1994. "Thin on the Ground Nursing Times" In Nursing Times 18 (90), pp.64-65.
- Flagler, S,
Loper-Powers, S. &
Spitzer, A. 1988. "Clinical Teaching is More than Evaluation Alone" In Journal of Nursing Education. 27(80), pp342-347.
- Friedman, S, &
Marr, J. 1995. "A Supervisory Model of Professional Competence: a Joint Service/ Education Initiative" In Nurse Education Today 15, pp 239-244.
- Fowler, J. 1996. "The Organization of Clinical Supervision within the Nursing Profession: A Review of the Literature" In Journal of Advanced Nursing, 23, pp 471-478.
- Fyffe, T. 1997. Clinical Supervision Exploratory Study of Staff Experiences and Perceptions. Unpublished Master of Medical Education Thesis. University of Dundee.

- Gephart, R. 1999. "Paradigms and Research Methods" In Academy of Management Research Methods Division. Research Methods Forum, 4, pp 1-9.
- Hallberg, I.R. 1994. "Systematic Clinical Supervision in a Child Psychiatric Ward: Satisfaction with Nursing Care, Tedium, Burnout and the Nurses' own Report on the Effects of it" In Archives of Psychiatric Nursing VIII (1), pp 44-52.
- Hansebo, G. 2001. "Assessment of Patients' Needs and Resources as a Basis in Supervision for Individualised Nursing Home Wards. Evaluation of an Intervention Study" (PhD Thesis). In Journal of Advanced Nursing 31(3), pp 722-729. Stockholm: Department of Clinical Neuroscience, Karolinska Institute.
- Hawkins, P. & Shohet, R. 2000. Supervision in the Helping Professions. Buckingham: Open University Press.
- Hawkins, P & Shohet, R. 1989. Supervision in the Helping Professions. Milton Keynes: University Press.
- Henderson, S. 1995. "Clinical Teaching Involves more than Evaluating Students" In Summers, L. (ed), A Focus on Learning, pp 121-125. Proceedings of the 4th Annual Teaching Learning Forum, Edith Cowan University, February 1995. Perth: Edith Cowan University
<http://lsn.curtin.edu.au/tlf995/Henderson.html>.

- Hess, A. K (ed.) 1980. Psychotherapy Supervision: Theory, Research and Practice. New York: Wiley.
- Hinchliff, S. 1986. Teaching Clinical Nursing. New York: Churchill Livingstone
- Hill, J. 1989. "Supervision in the Caring Profession: A Literature Review" In Community Psychiatric Nursing Journal. Vol. 9, pp 9-15.
- Hintze, J 2001 Post hoc Kruskal-Wallis Multiple Comparison Z value tests Number Cruncher Statistical Systems (NCSS) and Power Analysis and Sample Size (PASS)
- Holloway, E. 1985 Clinical Supervision: A Systems Approach. London. Sage.pp 41-55.
- Howie, J. 1988. "The Effective Clinical Teacher: A Role Model" In Howie, J, Australian Journal of Advanced Nursing, 5(2) pp.23-26.
- Hyppa, H. 1993. Open Systems Theory as a Framework for Clinical Supervision. Faculty of Education. University of Oulu.
- Hyrkas, K. 2002 "Clinical Supervision and Quality Care" (Academic Dissertation)
- Irby, D.M. 2004 "Clinical Teacher Effectiveness in Medicine" In J. Med. Educ. 53. pp 808-815.

- Infante, M.S. 1996. "The Conflicting Roles of Nurse and Nurse Educators" In Nursing Outlook. 34, pp 94-96.
- Jinks, A. &
Pateman, B. 1998. "Neither this nor that: The Stigma of Being an Undergraduate Nurse" In Nursing Times 2(2), pp.12-13.
- Jones, N.R. 2003 Basic Counselling Skills: A Helpers Manual. London. Sage Publications
- Jowet, S.J,
Walton, I. &
Payne, S. 1992. The Introduction of Project 2000- Early Perspectives from the Students. Interim Paper No. 5. Slough: National Foundation for Educational Research.
- Kelly, L. 1986. Clinical Inference in Nursing: Part 1 A Nurses Viewpoint. Nursing Research 15, 1, pp.23-26.
- Kadushin, A. 1976. Supervision in Social Work. New York: Columbia University Press.
- Knutton, S &
Pover, J. 2004. "The Importance of Honesty in Clinical Supervision" In Journal of Nursing Management – UK Feb 2004. Vol.10, Issue9.

- Kohner, N. 1994. "Clinical Supervision an Executive Summary" In Nursing Developmental Units. pp 1-4.
- Kramer, M. 1976. Reality shock. St Louis: C.V. Mosby.
- Leddick, G.R. 1994. "ED372340 94 Models of Clinical Supervision" In ERIC Digest. Greensboro, NC: ERIC Clearinghouse on Counselling and Student Services.
- Loganbil, C. 1982. "Supervision: a Conceptual Model" In Counselling Psychologist. 10, pp3-42.
- Luker, K, Carlisle, C,
Riley, E, Stilwel, J,
Davies, C, &
Wilson, R. 1996. Project 2000. Fitness for Purpose- Report to the Department of Health.Coventry: University of Warwick.
- Lyth, G.M. 2000. "Clinical Supervision, a Concept Analysis" In Journal of Advanced Nursing 31(3), pp 722-729.
- McCallion, H, &
Baxter, T. 1995. "Clinical Supervision Take it from the Top" In Nursing Management. Vol. 4.No. 10. p. 9.
- McCabe, B.W. 1985. "The Improvement in the Clinical Area: a Challenge Waiting to be Met" In Journal of Nurse Education.33. pp 422-425.

- Moeller, P. 1984. "Clinical Supervision: Guidelines for Managing the Problem Student" In Journal of Allied Health, August, pp 205-211.
- Mogan, J. & Knox, J.E. 1997. "Characteristics of Best and Worst Clinical Teachers as Perceived by University Nursing Faculty and Students" In Journal of Advanced Nursing, 12, pp331-337.
- Morris, M. 1995. "The Role of Clinical Supervision in Mental Health Practice" In British Journal of Nursing, Vol.4 No. 15 pp.886-888.
- Nicklin, P. 1995 "Super Supervision" In Nursing Management, Vol.2.No. 5. pp.24-25. NHS Management Executive (1993) "A Vision for the Future". London: Department of Health.
- Open University 1998. K509: A Clinical Supervision Development Pack for Nurses Milton Keynes: Open University
- Page, S. & Wosket, V. 1994. Supervising the Counsellor. Routledge.
- Page, S. & Wosket, V. 2001. Supervising the Counsellor: A Cyclical Model. Second edition. Hove: Brunner- Routledge.
- Perry, L. 1991. "Continuing Professional Education: Luxury or Necessity?" In Journal of Advanced Nursing 21, pp766-771.
- Polit, D.F. & Hungler, B.P. 1995. Nursing Research. Principles and Methods. 4th edition. Philadelphia: J.B. Lippincott Company

- Proctor, B. 1996. Supervision: A Co-operative Exercise in Accountability. Leicester: National Youth Bureau and Council for Education and Training in Youth and Community Work.
- Quinn, F. M. 2000. The Principles of Nursing Education. 2nd ed. London: Chapman Hall.
- Reilly, D.E. & Oerman, M. H. 1985. The Clinical Field: Its Use in Nursing Education. Norwalk: Appleton–Century–Crofts.
- Reilly, D.E. & Oermann, M.H. 1990. Clinical teaching in Nursing Education. 2nd ed. Natal League of Nursing. New York
- Royal College of Nursing 1999. Quality Patient Care: The Dynamic Standard Setting System. Harrow: Scutari Press.
- Roden, H. 1997. Clinical Supervision: The Outcomes Using Grounded Theory Approach. BSc Dissertation,
- Saliba, V. 1997. “Clinical Supervision: A Critical Review” In Dip HE Nurse Studies, PG Dip Nurse. Edu.. Intensive Care N.O.
- Severinsson, E. 2001. “Confirmation, Meaning and Self-Awareness as Core Supervision Model” In Nursing Ethics 8 (1), pp 36-44.
- Smith, G. 2000. “Friendship with Clinical Supervision: A Model for the NHS”. [Hptt://www. clinical supervision. com](http://www.clinical supervision. com).

South African

Nursing Council.

1989. R683 Guidelines for Bridging for Enrolled Nurses Leading to Registration as a General or a Psychiatric Nurse. Pretoria: SANC

Schweer, J.E.&

Gebbie, K.M.

1976. Creative Teaching in Clinical Nursing. St. Louis: C.V. Mosby.

South African

Nursing Council.

1985. R425: Regulations Relating to Approval for the Education and Training for the Nurse (General, Psychiatric, and Community) and the Midwife Leading to Registration. Pretoria: SANC.

Teasdale, K.

2001. "Clinical Supervision and Support for Nurses: an Evaluation Study" In Journal of Advanced Nursing. 32.pp.216-224.

Thomas, B. &

Reid, J.

1995. "Multidisciplinary Clinical Supervision" In British Journal of Nursing. Vol.4. No.15.pp. 883-885.

United Kingdom

Central Council for

Nursing, Midwifery

and Health Visiting

1995. Position Statement on Clinical Supervision for Nursing and Health Visiting. Registrar's Letter, 1 May 1996. London: UK Central Council for Nursing, Midwifery and Health Visiting.

United Kingdom

Central Council for

Nursing, Midwifery

and Health Visiting

2001. Supporting Nurses and Midwives through Lifelong Learning. London: UK Central Council for Nursing, Midwifery and Health Visiting. .

- United Kingdom
Department of
Health (Doll). 1993. A Vision for the Future. The Nursing Midwifery and Health
Visiting Contribution to Health and Health Care. HMSO, London.
- Van Ooijen, E. 2003. Clinical Supervision made easy. A Practical Guide for the
Helping Profession. The three step method. London, Churchill
Livingstone
- Willis, S. 2004. Pre Registration Student Nurses' Expectations and Experiences
of Clinical Skills Training Programme. North East Wales: School of
Community and Health Studies, Institute of Higher Education.
- Winstanley, J, &
Edward, W. 2003. "Clinical Supervision Models, Measures and Best Practice" In
A Nurse Researcher, 13515578, Vol. 10, issue 4.
- White, R. &
Ewan C. 1994. Clinical Teaching in Nursing. London: Chapman and Hall.
- Wright, H. 1989. Group Work: Perspectives and Practice. Oxford: Sutton Press.
- Wood, V. 1982. "Evaluation of Student Nurse Clinical Performance: A
Continuing Problem" In International Nursing Review, 29(1) pp. 12-
18.
- Yedlich, T. 1999. "Lost in the Crucible of Supportive Clinical Supervision:
Supervision is not Therapy" In Journal of Advanced Nursing, 29(5).
pp 1265-1275.

Zulu, F.

2003. Experiences of Non-traditional Students Enrolled in the Conversion Programme in Zambia. Masters in Nursing Education. (Dissertation) University of Kwazulu Natal.

ANNEXURE 1

Table 1: Kruskal-Wallis tests for comparison of the median responses to statements between the 3 hospitals/colleges

Statement	Kruskal-Wallis p value	Post hoc tests [^]
1. Ward staff find CS sessions time consuming	<0.001*	College 1 vs. College 2 p<0.05 College 1 vs. College 3 p<0.05 College 2 vs. College 3 p>0.05
2. Other work pressure interferes with CS sessions	0.001*	College 1 vs. College 2 p<0.05 College 1 vs. College 3 p<0.05 College 2 vs. College 3 p>0.05
3. Difficult to find the time for CS	0.071	
4. CS sessions are not solving anything	0.154	
5. Time spent on CS takes me away from real work in the clinical arena	0.604	
6. I can 'unload' during my CS sessions	0.950	
7. Fitting CS session in can lead to more pressure at work	0.248	
8. My supervisor gives me support and encouragement	0.009*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
9. CS does not solve personal issues	0.074	
10. CS sessions are intrusive	0.825	
11. CS gives me more time to reflect	0.038*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
12. Work problems can be tackled constructively during CS sessions	0.194	
13. If there is something I don't understand there is always someone to ask	0.014*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p<0.05 College 2 vs. College 3 p>0.05
14. My supervisor offers an unbiased opinion	0.009*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
15. I can discuss sensitive issues encountered during my clinical casework with my supervisor	<0.001*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05

16.Having someone to talk to about personal issues was a great help	0.126	
17.My CS sessions are an important part of my routine	0.025*	College 1 vs. College 2 p<0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
18.My supervisor is never available when needed	0.019*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
19.I learn from my supervisor's experience	0.008*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p>0.05
20.It is important to make time for CS sessions	0.038*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
21.My supervisor provides me with valuable advice	<0.001*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p<0.05 College 2 vs. College 3 p<0.05
22.My supervisor is very open with me	0.002*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
23.Sessions with my supervisor widen my knowledge base	0.020*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p>0.05
24.My supervisor puts me off when asking about sensitive issues	0.638	
25.My supervisor acts in a superior manner during our sessions	0.176	
26.CS is for students with no experience	0.216	
27.CS makes me a better practitioner	0.044*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
28.Without CS the quality of patient/client care will deteriorate	0.104	
29.CS sessions motivate staff	0.005*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p<0.05 College 2 vs. College 3 p<0.05
30.I feel less stressed after seeing my supervisor	0.029*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
31.CS improves the quality of care I give to my patients/clients	0.035*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p>0.05

32.I can widen my skill base during CS sessions	0.097	
33.My supervisor offers me guidance with patient/client care	0.007*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
34.I think clinical supervision improves the quality of care I give to my patients	0.023*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
35.CS is unnecessary for bridging students because of experience gained in basic nursing	0.022*	College 1 vs. College 2 p<0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
36.CS sessions increase my self-awareness	0.104	
37.CS sessions increase my self-confidence	0.035*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
38.CS sessions empower me	0.127	
39.CS sessions increase my self-esteem	0.103	
40.My relationship with my supervisor is non-hierarchical	<0.001*	College 1 vs. College 2 p<0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05
41.My supervisor is a role model	<0.001*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p<0.05 College 2 vs. College 3 p<0.05
42.My supervisor is committed to the CS sessions	0.004*	College 1 vs. College 2 p>0.05 College 1 vs. College 3 p>0.05 College 2 vs. College 3 p<0.05

* Statistically significant at 0.05 level

^ only reported where K-W p value is significant

QUESTIONNAIRE

Demographic/personal details

PLEASE ANSWER THE FOLLOWING QUESTIONS BY TICKING THE APPROPRIATE BLOCK.

1. ABOUT YOURSELF

SEX: MALE FEMALE AGE IN YEARS

2. ARE YOU BASED IN A: GOVERNMENT HOSPITAL
PRIVATE SEMI PRIVATE CLINIC

3. UNIT: ADULT CHILDREN MENTAL HEALTH
OTHER

4. LENGTH OF TIME IN PRESENT NURSING PROGRAM

1YEAR 1-2 YEARS

5. NATURE OF SESSIONS: FORMAL INFORMAL
BOTH

6. ABOUT YOUR SUPERVISOR

GENDER: MALE FEMALE

7. APPROXIMATE AGE IN YEARS

8. QUALIFICATIONS: MIDWIFERY NURSING
MANAGEMENT COMMUNITY HEALTH NURSE
OTHERS SPECIFY _____

9. WAS YOUR SUPERVISOR

ALLOCATED CHOSEN BY YOURSELF
OTHER

10. AREA OF SPECIALITY _____

11. HOW OFTEN DO YOU HAVE CONTACT WITH YOUR SUPERVISOR DURING THE NORMAL WORKING ROUTINE

DAILY BASIS WEEKLY FORTNIGHTLY

12. ROLE OF SUPERVISOR: TEACHER **FACILITATOR**

GUIDE SUPPORT MENTOR

13. ABOUT YOUR CLINICAL SUPERVISION SESSIONS

HOW LONG HAVE YOU BEEN RECEIVING CLINICAL SUPERVISION

SESSIONS: YEARS MONTHS

14. HOW OFTEN ARE YOUR SESSIONS:

EVERY WEEK EVERY TWO WEEKS MONTHLY

2-3 MONTHS OVER 3MONTHS APART

15. WHERE DO YOUR SESSIONS TAKE PLACE:

WITHIN THE UNIT AWAY FROM THE UNIT

16. ARE YOUR SESSIONS: ONE TO ONE BASIS

GROUP SESSIONS TRIAD

17. HOW LONG IS YOUR SESSIONS <15MINS 15-30 MINS

31-45MINS 46-60MINS

18. AVAILABILITY OF LEARNING EXPERIENCES _____

19. CLIMATE: IS THERE SUPPORT FROM UNIT STAFF

PEERS **HOSPITAL COORDINATOR**

20. IS THERE ANY FORM OF CONTRACT / AGREEMENT SIGNED

BETWEEN YOU AND THE SUPERVISOR **YES** **NO**

21. IF YES DOES IT ENTAIL THE FOLLOWING:

NATURE OF WORK **ROLE OF SUPERVISOR**

22. GOALS _____

CLINICAL SUPERVISION SCALE

Drawing on your experiences of receiving clinical supervision please indicate your level of agreement with the statements by ticking the number which best represents your answers.

1 means that you strongly disagree.

2 means that you disagree

3 means that you have no opinion

4 means that you agree

5 means that you strongly agree

KEY: CS will mean CLINICAL SUPERVISION

QUESTIONS	1	2	3	4	5
1. I find CS sessions time consuming					
2. Other work pressure interfere with the CS sessions					
3. It is difficult to find the time for CS					
4. CS sessions are not solving anything					
5. Time spent on CS takes me away from real work in the clinical arena					
6. I can 'unload' during my CS session					
7. Fitting CS session in can lead to more pressure at work					
8. My supervisor gives me support and encouragement					
9. CS does not solve personal issues					
10. CS sessions are intrusive					
11. CS gives me more time to reflect					
12. Work problems can be tackled constructively during CS sessions					
13. If there is something I don't understand there is always someone to ask					
14. My supervisor offers an unbiased opinion					
QUESTIONS	1	2	3	4	5

15. I can discuss sensitive issues encountered during my clinical casework with my supervisor					
16. Having someone to talk to about personal issues was a great help					
17. My CS sessions are an important part of my work routine					
18. My supervisor is never available when needed					
19. I learn from my supervisor experience					
20. It is important to make time for CS sessions					
21. My supervisor provides me with valuable advice					
22. My supervisor is very open with me					
23. Sessions with my supervisor widens my knowledge base					
24. My supervisor puts me off when asking about sensitive issues					
25. My supervisor acts in a superior manner during our sessions					
26. CS is for students with no experience					
27. CS makes me a better practitioner					
28. Without CS the quality of patient/ client care will deteriorate					
29. CS sessions motivate staff					
30. I feel less stressed after seeing my supervisor					
31. CS improves the quality of care I give to my patients/clients					
32. I can widen my skill base during CS sessions					
33. My supervisor offers me guidance with patient/client care					
34. CS is unnecessary for bridging students because of experience gained in basic nursing					
35. CS sessions increase my self-awareness					
36. CS sessions increases my self confidence					

QUESTIONS	1	2	3	4	5
37. CS sessions empower me					
38. CS sessions increases my self esteem					
39. My relationship with my supervisor is non- hierarchical					
40. My supervisor is a role model					
41. My supervisor is committed to the CS sessions					

ANNEXURE 2:

UKZN ETHICAL CLEARANCE- COPY



UNIVERSITY OF
KWAZULU-NATAL

RESEARCH ETHICS COMMITTEE

Student: PADMINI PILLAY

Student No: 200279321 Qualification: MASTERS IN NURSING EDUCATION

Research Title: Analysis of Clinical Supervision and Support of Bridging Programme Students in the Clinical Settings in Greater Durban Area

A. The proposal meets the professional code of ethics of the Researcher:

YES

NO

B. The proposal also meets the following ethical requirements:

	YES	NO
1. Provision has been made to obtain informed consent of the participants.	✓	
2. Potential psychological and physical risks have been considered and minimised.	✓	
3. Provision has been made to avoid undue intrusion with regard to participants and community.	✓	
4. Rights of participants will be safe-guarded in relation to:		
4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	✓	
4.2 Access to research information and findings.	✓	
4.3 Termination of involvement without compromise.	✓	
4.4 Misleading promises regarding benefits of the research.	✓	

Signature of Student: P. Pillay Date: 10/11/2004

Signature of Supervisor: [Signature] Date: 9/11/2004

Signature of Head of School: [Signature] Date: 11/11/2004

Signature of Chairperson of the Committee: [Signature] Date: 10.11.2004

SIGNATURE OF THE FACULTY POSTGRAD COMMITTEE [Signature]
Faculty of Community & Development Disciplines DATE: 15/11/04

Postal Address: Durban 4041, South Africa

ANNEXURE 3:

COPIES OF LETTERS REQUESTING

PERMISSION

Office:

Dr Bouwer & Partners Inc.
601 Durdoc Centre
460 Smith Street
P.O. Box 62700
Bishopsgate
4008
Tel: 031 327 7500
Direct Line: 031 327 7600
Fax: 031 327 7590

Residence:

"Bethel"
621 Currie Road
Berea
Durban
4001
Tel: 031 209 5020
Fax: 031 207 9324
Email: pillays@bouwer.co.za

Department of Health

To Whom It May Concern:

Re: Requesting permission in initiating a research study at Prince Mshiyeni Hospital. Umlazi Hospital and any other provincial hospitals where students are placed.

I am a student studying a Masters in Nursing Education at the University of Kwazulu Natal, Durban.

The title of my study is The Analysis of Clinical Supervision and Support of Students in a Bridging Programme in the Clinical setting in the Greater Durban Area.

The aim of the study will be to establish and describe preconditions of clinical supervision in a bridging programme between clinical supervisor and student, to analyse the main elements in clinical supervision (i.e. clinical supervisor, student and the environment) and to describe the outcomes of clinical supervision to students.

I hereby request your permission to conduct this study in the above institutions.

I would like to collect data from the 2nd year students that are in a bridging programme from enrolled nurses to professional nurses.

I would like to commence the data collection process by early January 2005.

Permission for voluntary participation will be requested from students. Students will be required to fill in a questionnaire. This will be done during the tea and lunch breaks. Their rights related to confidentiality, anonymity, informed consent, freedom of choice will be observed.

I hope my request will be considered. I have provided you with a letter from the ethical committee of the University of Kwazulu Natal as well as a copy of my research proposal. I can be contacted on the above fax number 031- 3277590 and on 031- 2095020.

Thanking you

Padmini Pillay (Masters Student in Nursing education) 0826530179.

Office:

Dr Bouver & Partners Inc.
601 Durdoc Centre
460 Smith Street
P.O. Box 62700
Bishopsgate
4008
Tel: 031 327 7500
Direct Line: 031 327 7600
Fax: 031 327 7590

Residence:

"Bethel"
621 Currie Road
Berea
Durban
4001
Tel: 031 209 5020
Fax: 031 207 9324
Email: pillays@bouver.co.za

The Principal
Afrox College of Nursing
Glenwood

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Thanking you
Padmini Pillay (Masters Student in Nursing education) 0826530179.

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Prince Mshiyeni
Umlazi

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"Bethel"
621 Currie Road
Berea
Durban
4001
Tel: 031 209 5020
Fax: 031 207 9324
Email: pillays@bouwer.co.za

The Principal
Netcare Training Academy
Kwazulu Natal
Glenwood

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I can be contacted on the above fax number 031- 3277590 and on 031- 2095020.

Thanking you
Padmini Pillay (Masters Student in Nursing education) 0826530179.

ANNEXURE 4:

RESPONSES FROM

KWAZULU-NATAL DEPARTMENT

OF HEALTH

AND

NURSING EDUCATION

INSTITUTIONS WHERE DATA WAS

COLLECTED

PROVINCE OF KWAZULU-NATAL
HEALTH SERVICES

ISIFUNDAZWE SAKWAZULU-NATALI
EZEMPILO

PROVINSIE KWAZULU-NATAL
GESONDHEIDSDIENSTE

PRIVATE BAG X 9051
PIETERMARITZBURG
3200



330 LONGMARKET STREET
PIETERMARITZBURG
3201

TELEPHONE : (033) 395-2542

ENQUIRIES: Miss NP Beeton
EXTENSION: 2542
REFERENCE: 9/2/3/R

2005-02-09

Padmini Pillay
University of KwaZulu Natal
Department of Nursing
King George V Avenue
Durban
4001

Dear Ms Pillay

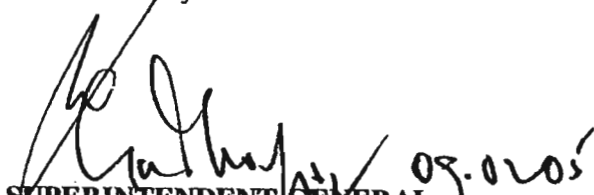
REQUEST TO CONDUCT RESEARCH ON THE ANALYSIS OF CLINICAL SUPERVISION AND SUPPORT OF STUDENTS IN A BRIDGING PROGRAMME IN THE CLINICAL SETTING IN THE GREATER DURBAN AREA.

Your letter dated 23 November 2004 refers.

Please be advised that authority is granted for you to conduct a research regarding the analysis of clinical supervision and support of students in a bridging programme in the clinical setting in the greater Durban area, provided that;

- (a) Confidentiality is maintained;
- (b) The Department is acknowledged;
- (c) The Department receives a copy of the report on completion; and
- (d) The staff of the hospital are not disturbed and/or inconvenienced in their work and that patient care is not compromised.

Yours sincerely


SUPERINTENDENT-GENERAL
HEAD: DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

PROVINCE OF
KWAZULU-NATAL
HEALTH SERVICES

ISIFUNDAZWE
SAKWAZULU-NATALI
EZEMPULO

PROVINCE
KWAZULU NATAL
GESONDHEIDIENSTE

PRINCE MSHIYENI CAMPUS
PRIVATE BAG X10
MOBENI

4060

TELEPHONE NO.: 031 - 9078313/4

FAX NO.: 031 - 9067772

REF: PMMH/CAMPUS
ENQ: A.S. RADEBE

DATE: 06/01/2005

Miss P. Pillay
P.O. Box 62700
BISHOPGATE
4008

Dear Madam

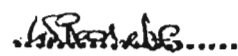
**RESEARCH STUDY AT PRINCE MSHIYENI HOSPITAL: MASTERS IN NURSING
EDUCATION**

Your fax dated 03/01/2005 refers.

Kindly be advised that permission is hereby granted for you to conduct your research study at this institution with proviso that the conditions laid down by the Department of Health is adhered to.

Thanking you

Yours faithfully


A.S. Radebe
Principal



AFROX COLLEGE OF NURSING

148 South Ridge Road
Durban
4001

P.O. Box 2230
Durban
4000

Tel : (031) 204-1352/3
Fax : (031) 261-6852

23rd November 2004

Dear Mrs Pillay

RE : RESEARCH PROJECT

I hereby give permission for you to do your Research Project on the Bridging Course 2nd Year.

As we discussed on the phone you will be coming on the 10th January 2005 at 13h00 to handout questionnaires to the abovementioned group.

B SMITHARD
NURSE EDUCATOR



NETCARE TRAINING ACADEMY KWA-ZULU NATAL

*P.O. Box 30641
Mayville
4058*

*364 Clark Road
On The Berea
Durban*

*Tel: (031) 202 0300
Fax: (031) 202 0312*

25 November 2004

Ms P Pillay
621 Currie Road
BEREA

Dear Ms Pillay

PERMISSION GRANTED TO DO RESEARCH STUDY AT NETCARE TRAINING ACADEMY

I hereby grant you permission to conduct your research project at Netcare Training Academy, KwaZulu Natal the first week of December 2004.

The understanding being that it is a voluntary decision on the part of the student to participate and the students may only be approached during their teatimes and lunch breaks, or after college hours.

I wish you everything of the best with your studies and hope that you find your time at Netcare Training Academy a fruitful exercise.

Yours faithfully

**MS YVETTE SILVA
CAMPUS MANAGER**

ANNEXURE 5:

**LETTER WRITTEN TO STUDENTS
REQUESTING PERMISSION**



THE SOUTH AFRICAN CENTRE
OF EVIDENCE-BASED NURSING & MIDWIFERY



THE JOANNA BRIGGS INSTITUTE

November 2004



UNIVERSITY OF
KWAZULU-NATAL

University of KwaZulu Natal
Department of nursing
King George V Avenue
Durban
4001.

Dear Student,

Re: Requesting your participation.

I am a Masters student doing a research project in the Department of Nursing, University of KwaZulu Natal, Durban.

The title of the study is "An Analysis of Clinical Supervision and Support for Bridging Programme Students in the Clinical Settings in Greater Durban Area.

I am requesting you to participate in this research study and spare some time to answer the questionnaire. Participation is voluntary and you have a right to withdraw from the study. Your refusal or acceptance to participate will not in anyway affects your studies at the Nursing Institution.

Confidentiality and anonymity will be observed by using codes for the questionnaire. This letter will serve as a form of consent from you.

Your participation in this regard will be highly appreciated.

Yours truly,
Padmini Pillay (Masters in Nursing Education)

Permission from student

I would like to participate in the above research. I understand that this is voluntary.

Students Signature:

School of Nursing, Howard College Campus

Postal Address: Durban, 4041, South Africa