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Assessment of the Clinical Nursing Supervision at Governmental Hospitals- Gaza Governorates

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Assessment of the Clinical Nursing Supervision at Governmental Hospitals- Gaza Governorates

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Assessment of the Clinical Nursing Supervision at Governmental Hospitals- Gaza Governorates

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Dedication

I dedicate this work to the soul of my father who generously dedicated his life for us.

To my dear mother that the secret of my success is her du'aa.

To my wife and my beautiful daughters "Houreya and Jomana" who are the joy of my life for their patience and support.

To the Palestinian people especially for martyrs who sacrificed their lives for Palestine and Al-Aqsa.

To the nurses who spend their times in serving patients and alleviation of their suffering.

To my brothers, sisters and all my relatives who encouraged and inspired me.

To my friends for their support and endless help.

Thank you and may Allah bless you

Ramadan Ali Ramadan Hassan

Date: June, 2011

Declaration

I certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged, and that this thesis (or any of its parts) has not been submitted for higher degree to any other university or institution.

Signed: ..R. Hassan.....

Ramadan Ali Ramadan Hassan

Date: 14 June 2011

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Abstract

The literature indicates that clinical nursing supervision has a significant impact on the quality of nursing care. The overall aim of this study was to assess the clinical nursing supervision at governmental hospitals in Gaza governorates from the perspectives of both supervisors and supervisees in order to increase the effectiveness of the supervision processes and outcomes.

The design of the study is a descriptive, analytical cross sectional one. One hospital from each governorate from the five Gaza Strip governorates was randomly selected. All supervisors (head nurses and nursing supervisors) were included and a systematic proportional random sample was selected from the supervisees. In total, 160 supervisors were included and the response rate among them was 83.1%; meanwhile, the sample size for supervisees was 300 subjects and the response rate was 90%. Two questionnaires were developed to reflect the study domains which based on the Proctor's three interactive functions of clinical supervision (formative, normative and restorative) in addition to personal, organizational and supervision related variables. Data were collected utilizing the self-administered questionnaire approach and the reliability coefficient (Cronbach's Alpha was very high (more than 0.9 for the two scales).

Findings show that relatively young male supervisors were dominating the supervisory positions (72.2% were males) at the surveyed facilities. Training opportunities in supervision for supervisors was limited as (less than 25% received training courses in supervision). The availability and use of supervisory tools was also limited; about 24% of the supervisors were using checklists. Nearly half of the supervisors reported being involved in setting hospitals' objectives and strategies. Similarly, 50% of the supervisees reported being engaged in the performance appraisal for themselves and for their peers; however, they didn't receive adequate feedback in this regard.

The study shows that overall the supervisors were more positively perceiving their supervisory roles (80.2%) than supervisees who received supervision from them (68.6%). The restorative function was the highest perceived function among both the supervisors (84.8%) and the supervisees (71.7%) while the formative function was the least positively perceived function by both supervisors (77.5%) and supervisees (63.8%). The formative function is the core function of the clinical supervision indicating that the current supervisory system is relatively administrative rather than clinical. Supervisees' perspectives indicated that positive perceptions were elicited about the clinical supervision of head nurses more than the nursing supervisors with statistically significant differences (P value < 0.05). Supervisors who are head nurses, females and having long experience had elicited higher scores than their counterparts with statistically significant differences (P value < 0.05). On the other hand, supervisees who were females, holding diploma certificate supervisees more positively perceiving the supervision they had received than their counterparts with statistically significant differences (P value < 0.05).

The researcher recommends strengthening the clinical aspect of supervision, formulation of clinical supervision policy and promoting the use of supervisory tools such as checklists.

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List of Abbreviations

ANA	American Nursing Association
ANOVA	One way Analysis of Variance
CSP	Chartered Society of Physiotherapy
CS	Clinical Supervision
DHSSPS	Department of Health, Social Services and Public Safety
DC	District of Colombia
GS	Gaza Strip
HMSO	Her Majesty's Stationery Office
IMF	International Monetary Fund
Km	Kilometer
LSD	Least Significant Difference
MOH	Ministry of Health
NCETA	National Centre for Education and Training on Addiction
NGOs	Non- Governmental Organizations
NHS	National Health Service
NMC	Nursing and Midwifery Council
PCBS	Palestinian Central Bureau of Statistics
PNGO	Palestinian Non-Governmental Organization Network
RAND	Research and Development
Sq. Km	Square Kilometer
SPSS	Statistical Package of Social Science
TIPS	Theory into Practice Strategies
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery, and Health Visiting
UNRWA	United nations Relief and Works Agency for the Refugees of Palestine
WB	World Bank
WHO	World Health Organization

Chapter (1): Introduction

1.1 Research Background

Clinical Supervision (CS) is considered an important tool used for quality improvement in health care. Many studies reflect the great effect of CS on the quality of nursing care and consider it as a tool to improve the quality of nursing care (Hyrkas & Paunonen-Ilmonen, 2001). The implementation of CS is now seen as essential element in the delivery of safe and accountable practice. It is essential that employees and managers understand and become involved in the development of CS (Butterworth, 1995). The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) supports the establishment of CS as an important part of clinical governance and in the interests of improving standards of patient care (UKCC, 2002).

CS is focused on assisting, guiding, and supporting workers to become experienced employees (Todd & O'Connor, 2005). CS seeks to have practitioners and skilled supervisors together to reflect on practice, to solve clinical problems, to increase understanding of professional issues and, most importantly, to improve standards of care provided. CS needs enough time, energy and resources and is an ongoing process rather than an incidental event (Butterworth, 1995). To improve the supervisee's satisfaction, the supervisors should be educators, role models, supporters, and to be effective clinical decision makers (Turban, 2007). One benefit of CS is to reduce the stress of nurses and support them in working during stressful situations (Atherton, 2009).

It is important to distinguish between the managerial and clinical supervision in order to make CS more effective. The term CS implies a degree of misconception and confusion in the minds of many as a result of the negative misconception of managerial relationship with it (Sloan, 2006). In the Palestinian health care system there is a great burden over the nurses especially in the hospitals due the unstable political situation and the great strain on the health services so there is pressing need for the implementation of clinical nursing supervision to support nurses particularly during crisis and to decrease work stress and tension. The absence of clear job description for health care providers especially for nurses makes supervision and communication more difficult and complicated (PNGO, 2009).

In Palestine there is a great demand for high quality of care provided by nurses in order to deal with challenges facing the health system (PNGO, 2009). Nurses at hospitals are

overloaded by heavy duties and responsibilities which need huge efforts for accomplishment and coordination (Hajaj, 2007)

This study assesses the status of clinical nursing supervision at governmental hospitals and focuses on the strength and weakness areas, perceptions of supervisors and supervisees about clinical nursing supervision, supervisory tools and others.

1.2 Research Problem

There is a great focus all over the world on improving the clinical nursing supervision as a tool for quality improvement. CS is a process through which nurses can review their practices, develop, enhance skills & Knowledge, maintain and improve standards of care (Butterworth & Faugier, 1992).

Within the MOH in Palestine, at least in nursing profession, there is an existing supervisory system especially at hospitals but there are inadequate studies concerned with supervision especially in the area of clinical supervision. This study will try to assess to which extent the nursing supervision system in MOH hospitals in Gaza is consistent with the international concepts of clinical nursing supervision that has been reported to have a great impact on the heath of clients. The study bridges a gap in information in the hospitals sectors; it could be seen complementary to the work conducted earlier by Turban (2007) in PHC settings.

1.3 Justification of the Study

Many studies reflected high emphasis on implementing CS related to its great impacts on the effectiveness and quality of care provided to the clients. There are many policies, regulations and guidelines that regulate the clinical supervisory relationships between the supervisors and supervisees in an attempt to make it more effective. Nursing care is a critical part of health care provision for patients/clients at all of the three levels of health care (primary, secondary, and tertiary) especially in secondary care where patients stay in hospitals to receive direct nursing care. Nurses stay with patients most of the time, in addition, nurses have direct utilization of resources and expenditures of MOH. Supervision greatly influences nurses provision of efficient and effective care; the development of effective clinical nursing supervision increases the productivity, effectiveness, and efficiency of the health care (Edward, et al., 2006).

In Palestine, the supervisory system in nursing, in PHC has been studied (Turban, 2007); but within governmental hospitals there were no studies which had investigated deeply the supervisory system exploring its effectiveness, weaknesses and strengths, its effects on supervisees' satisfaction, turnover and burnout. Nurses at governmental hospitals undergo work overload as Hajaj (2007) who found that nurses at Al Shifa Hospital were overloaded in their work. Many studies claimed that clinical supervision decreases work stress and increases level of job satisfaction (Hancox, et al., 2004, Driscoll, 2000). So this study tries to explore the weakness and strength points in the current nursing supervision system, obstacles confront this system and how to improve this system to be more clinical than administrative.

Also the unstable political situation in Palestine greatly affects the provision of health care related to scarcity of resources and lack of staff development and motivation. With the siege on Gaza, most training programs were suspended and efforts were pointed to the importance of finding alterative coping systems including intensifying supervision (PNGO, 2009). All these factors are important motives to study supervision in order to sustain and improve the quality of health care.

1.4 Aim of the Study

The overall aim of this study is to assess the status of clinical nursing supervision according to Proctor's (1987) Model at governmental hospitals in Gaza Governorates from the perspectives of both nursing supervisors and supervisees (nurses) in order to provide suggestions contributing to improving the quality of nursing services and thus positively impacting services outcomes and clients' satisfaction.

1.5 Objectives of the Study

1. To assess to which extent the current nursing supervision system in governmental hospitals is congruent with functions of clinical supervision according to Proctor's Model.
2. To appraise the perceptions of supervisors and supervisees about the current nursing supervision system.
3. To ascertain areas of strength and areas of weakness in the current supervisory system.
4. To identify the relationships between socio-demographic and organizational variables and perceptions of supervisors and supervisees regarding the clinical nursing supervision at governmental hospitals.

5. To provide recommendations for nursing supervisors and managers to effectively improve the role of supervision in improving the quality of nursing services.

1.6 Research Questions

1. Are the international concepts of clinical nursing supervision applicable to the existing nursing supervision system at governmental hospitals?
2. How nursing supervisors perceive the application of clinical nursing supervision?
3. How nursing supervisees perceive the application of clinical nursing supervision?
4. What are the main functions of the current supervisory system in governmental hospitals according to Proctor's three functions model of clinical supervision?
5. Is the supervision system in the governmental hospitals more clinical or administrative?
6. What are the strong and weak areas in the existing nursing supervision at governmental hospitals?
7. Are the nursing supervisors satisfied with the supervision they provided?
8. Are the supervisees feel satisfied from the clinical supervision they received?
9. How the socio-demographic variables and organizational variables affect perspectives related to clinical supervision?
10. Are there supervisory tools used in nursing supervision at governmental hospitals?
11. What are interventions that could improve the clinical nursing supervision at governmental hospitals?

1.7 Context of the Study

The researcher provides an overview about the context where the study was performed and variables that influence the topic under the study. The context involves socio-demographic variables, economic, political and the health care system in which the study concerning with the clinical nursing supervision at governmental hospitals.

1.7.1 Demographic Context:

Palestine is an Arabic Country, relatively small one. The total surface area of the historical Palestine is about 27.000 Km^2 (Palestine, MOH, 2006). Palestine has been occupied in 1948 by Israel and the two remaining parts are separated geographically (West Bank and Gaza Strip) after the war in 1967 (Palestine, MOH, 2006). Palestine is surrounded by Lebanon, Syria, Gordon, Egypt, and Mediterranean Sea. The total area of the Gaza Strip

(GS) and West Bank is about 6020 Sq. Km with total population living in is about 4,108,631 individuals (1,561,906 in GS and 2,546,725 in West Bank) with a population density of 682 capita per sq. Km (Palestinian Central Bureau of Statistics-PCBS, 2011).

GS is a narrow piece of land lying in the coast of Mediterranean Sea (Annex1). The total area of GS is about 365 square kilometer (PCBS, 2011). GS is overcrowded area with total population about 1.561.906 with population density of 4279 inhabitants/ Km^2 and about 69% of them are refugees as estimated by the year 2010 (PCBS, 2011).

GS is divided into five governorates: Gaza Governorates, North Governorates, Mid-zone Governorate, Khan-Younis Governorate, and Rafah Governorate. This high population density in GS increases the overload on the hospitals care which stress on the great need for providing a high quality of care with minimal cost through effective clinical nursing supervision.

1.7.2 Socio-economic and Political Context:

The GS undergone a restriction, political and economic closure after the Palestinian election in 2006, the conflict between the two main parties Fateh and Hamas resulted in a division of control between Palestinian Authority and Hamas government which has been complicated by the Israeli closure have had a profoundly negative impact on the public health and access to basic health services.

The Israeli war on Gaza in December 2008 through January 2009 resulted in hundreds of fatalities and thousands of injuries; and further badly affected the already weakened status of the water, sanitation and power sectors in the GS (WB, 2009). Medical supplies were in very short supply and health facilities were often not able to treat the sick during the crisis (WB, 2009). The ongoing deteriorating economic situations in the GS lead to the rise in the unemployment rate to 40% in 2008 and 80% of households were living under the poverty line in 2007 household survey (International Monetary Fund - IMF, 2009). The overall bad economic status of the Palestinians in GS increases the load on the governmental hospitals to provide secondary care especially in case of emergency and violence. This also increases the need for efficient health care provision and effective clinical supervisory system to effectively managing the services.

1.7.3 Health Care Context:

Health care system in Palestine is complex (Palestine, MOH, 2006). Health service delivery in Palestine is divided into five types of health care providers: two public providers (the Ministry of Health and the Ministry of Interior – Military health services-), multiple private providers (hospitals, clinics) and numerous NGO providers (the United Nations Relief and Works Agency-UNRWA and other local NGOs). UNWRA operates an extensive network of outpatient services for the registered refugee population following 1948 (WB, 2009)

MOH provides a package of primary, secondary, and tertiary health care services. About 50% of all the visits to health care providers are attained to the MOH facilities (PCBS, 2005). The main roles and responsibilities of the MOH according to the Palestinian Public Health Law are: providing, regulating and supervising the provision of health care in Palestine. Also, MOH is responsible about planning the health care services in coordination with different stakeholders, enhancing health promotion to improve the health status, developing human resources in health sector, managing and disseminating health information, and others (Palestine, MOH, 2008). In the past four years, the governmental health care system is fragmented due to the two available ministries of health in the west bank and the GS that results in fragmented decision making (WB, 2009).

1.7.4 Governmental Hospital Services:

MOH is the main provider of secondary care in the GS. It is responsible for 13 hospitals across the five governorates and the number of hospital beds in GS is about 1593 and percent of hospital bed per 1000 capita is about 1.4 (Palestine, MOH, 2010). The average occupancy rate at hospitals in the GS is about 78%. The unstable Palestinian political situation increases the load on the health care services in Gaza and West Bank. There's also a great load on the health care workers in the hospitals especially nurses that already undergo shortages. The total number of nurses working at governmental hospitals in GS is about 1788 nurses (MOH, Nursing Unit, 2010) and this is relatively not satisfactory number in relation to the large number of the population served in the GS. Shortage of nursing may influence the quality of care provided and greatly stress the need for effective clinical supervisory system in governmental hospitals.

1.7.5 Management and Supervision in Governmental Hospitals:

MOH is responsible for coordinating the activities of all health care providers in Palestine as stated in the Palestinian Public Health Law. In the Palestinian MOH, the number of managers is relatively large (Palestine, MOH, 2008). There is a supervision system in nursing at governmental hospital for many years. Supervisors supervise and monitor the nursing activities especially administrative issues. Other disciplines don't have the supervisor position as nursing. The number of nursing supervisors in governmental hospitals in GS is about 281 supervisors (128 nursing supervisors and 153 head nurses) who supervise about 1507 supervisees according to the statistical data from Nursing Unit in MOH (Personal interview with the Manager of Nursing Unit, 22 October, 2010). Still, functions and policies of supervisors are not well defined (PNGO, 2009). Most of MOH organizations lack effective management skills; therefore strengthening management systems in the MOH facilities such as supervision, leadership, performance appraisal, human resource management, communication and follow up are essentials (Hamad, 2009). Developing effective management tools such as checklists, supervision tools and scorecard is also important (Hamad, 2009).

Supervision in nursing at governmental hospitals is conducted by nursing supervisors or first-line managers and head nurses of departments. Nursing supervisors are responsible for supervising departments and the work flow in these departments and are directly responsible about the head nurses of these departments. Evening and night shifts are covered with nursing supervisors who are responsible for managing the overall nursing activities in these work periods. There are no clear job descriptions for supervisors or supervisees and this makes the supervisory efforts difficult and complicated. A head nurse is the second supervisory player in the hospital. Head nurses are responsible about nurses in the department and therefore they are on direct contact with patient care more than nursing supervisors.

In the Palestinian health system, as in many other health systems, planning has frequently functioned better than policy implementation so there is a need to strengthen and maintain the skills of health system managers, evaluate new programs and policies, and collect comprehensive data about the health system (Schoenbaum et al., 2005). Strengthening the management of the MOH require real leadership from the senior management team of the Palestinian MOH. This will only be possible if the key individuals see their task as one of system improvement on behalf of the Palestinian people (Schoenbaum et al., 2005).

Political considerations or personal connections to powerful groups or factions can not be the basis for appointment to these positions. Vision, leadership ability, a willingness to make difficult decisions -these are the not easy- to find qualities that the current situation demands in senior ministry leaders (Schoenbaum et al., 2005). After the splitting up between Gaza and West bank there is a managerial conflicts between the two parts and that affects the commitment of employees and create a conflicting atmosphere within the ministry.

1.8 Operational Definitions

Clinical Supervision:

"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" (UK, Department of Health, 1993).

Supervisor:

Supervisor who is the link between the supervisees and the clients from one side and the managers from the other side. The term is used in this context to refer to nursing supervisor and head nurses of departments.

Clinical Supervisor:

"A registered practitioner who may be experienced in the area of practice of the supervisees, who is adequately prepared for the role of supervisor. This preparation may have been undertaken via appropriate on the job or off the job training." (NHS, 2009).

A practitioner:

"Is anyone who offers a professional service to a client, so the term refers equally to doctor, psychiatrist, psychotherapist, nurse, lawyer, and teacher" (Sloan and Waston, 2001).

Supervisee:

An individual member of staff who is receiving formal CS from a designated supervisor (NHS, 2009); in this study we refer to the nurse who provides the care for the patients.

Nursing:

"The protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations "(ANA, 2003).

Quality:

"Proper performance, in accordance with standards, of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition" (WHO, 2007).

Perception:

"A process by which individuals organize and interpret their sensory impressions in order to give meaning to their environment" (Robbins, et al., 2009).

Formative Function:

Concerns with increasing the knowledge and skills of supervisees (Proctor, 1988).

Normative Function:

Concerns with the managerial aspects of supervision like maintaining adherence with standards and guidelines (Proctor, 1988).

Restorative Function:

Concerns with decreasing the stress and stressors facing supervisees in the workplace (Proctor, 1988).

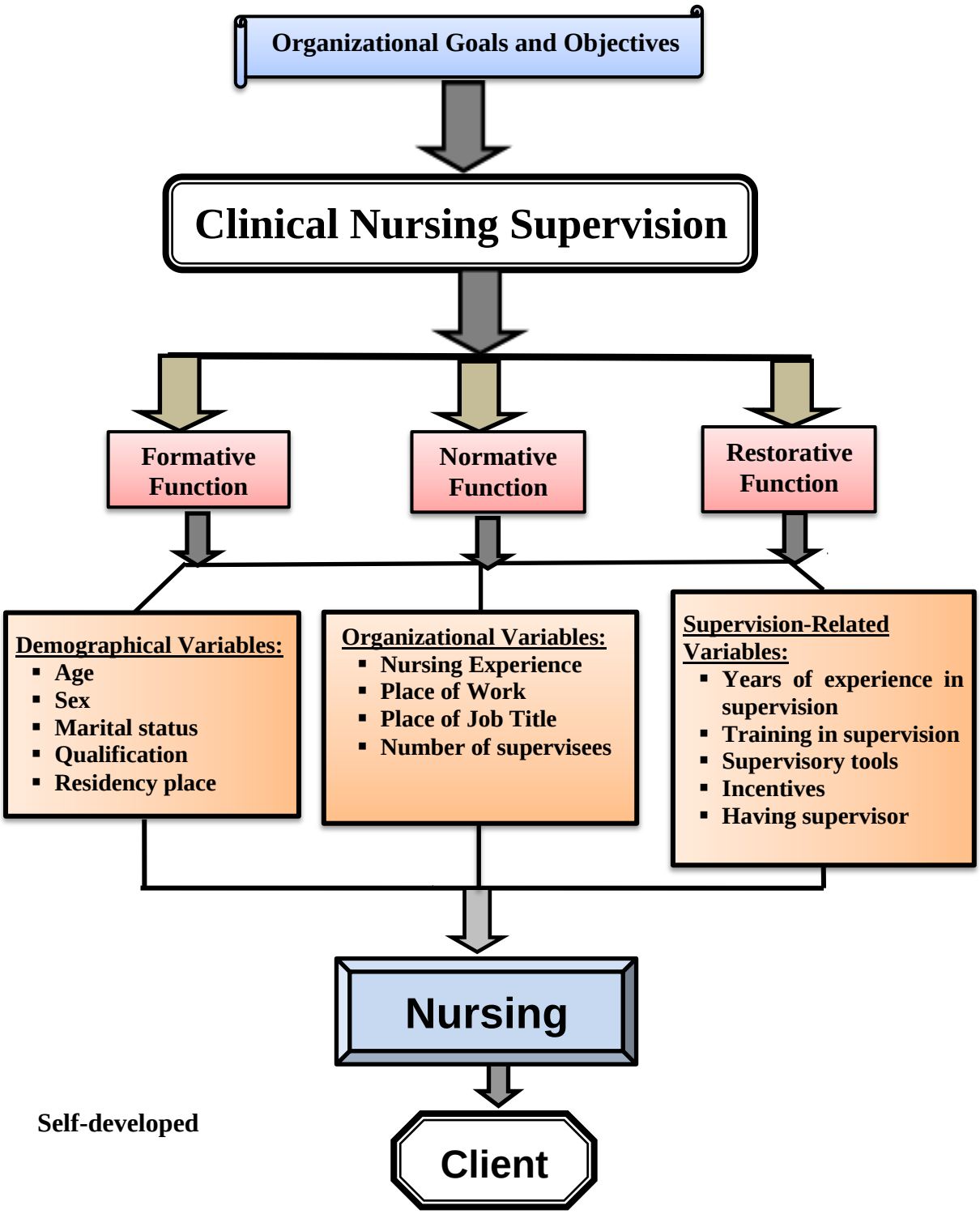
On the Job Training:

" Is a structured process conducted at the employee's work area to provide the employee with the knowledge and skills to perform job tasks (Lawson, 1997)

Chapter (2): Literature Review

In this chapter the researcher discussed deeply the concept of clinical supervision, its applicability to nursing profession, the benefits of clinical nursing supervision, characteristics of good supervisor, models suitable for clinical nursing supervision and many others.

2.1 Conceptual Framework



Self-developed

This conceptual framework was developed by the researcher to illustrate the functions of CS based on Proctor's (1987) three functions model of clinical supervision which is popular in nursing especially in UK. The researcher explains that there are three major elements in CS process: the first is the supervisor who is the link between the supervisees and the clients from one side and the managers from the other side, the second is the supervisees who are the nurses who provide the care for the patients and the third is the clients who receive the care from nurses. The three dimensional relationship: supervisor, supervisee and client is controlled and regulated by clinical supervision. The role of supervisor is to be a connector between nurses and clients to attain the organizational goals in providing safe, high quality, effective and efficient nursing care.

The role of clinical nursing supervisors goes with the proctor's three functions model of CS that are:

2.1.1 Formative Function:

Focuses on increasing the supervisees' knowledge and skills which is the original basis for CS. It includes performing needs assessments for knowledge and practice of nurses and satisfying them, performing on- job training, trying to link between theory and practice, providing consultation, training nurses on used protocols, performing enough orientation for the newly employed nurses, reviewing supervisees regarding their works and discuss the strong and weak areas, updating the knowledge of nurses....., and so on.

2.1.2 Normative Function:

Concerns with the managerial aspects of supervisions including the maintenance of professional standards i.e. follows norms or standards of practice. It focus on maintaining the professional standards, sharing in decision making, sharing in job rotation, clarifying job description for supervisees, making delegation, organizing the work, maintain organizational goals, assurance of readiness of department for emergency, assuring the quality of nursing care using checklists to monitor nursing activities, maintaining the organizational goals and objectives,....etc.

2.1.3 Restorative Function:

Aims to alleviate the stresses and tension in the workplace like maintain a safe and collaborating work environment, listen carefully to supervisees, effectively resolving

conflicts, enhance team work, allow open discussion and participation, assist in periods of crisis and overwork, supporting supervisees, enhancing social relationships, motivate and encourage supervisees, ..., and so on.

By attaining these three functions of the proctor's model of CS, the nurses will deliver high quality, effective, and efficient care for the clients and eventually attaining the organizational goals and objectives.
The researcher also investigated other factors that affect the perspectives of CS like:

2.1.4 Socio-demographic Factors:

Include age, sex, marital status, residency place, academic qualifications, and place of the study.

2.1.5 Organizational Variables:

These include, nursing experience, place of work, job title and number of supervisees.

2.1.6 Supervision- Related Variables:

Include having supervisor, years of experience in supervision, training in supervision, using supervisory tools, receiving incentives for supervisory position, performing regular meeting, having job description and feeling of satisfaction regarding supervisory work.

The study framework illustrates the three functions of CS: formative, normative and restorative functions. The researcher will explore to what extent does the current supervisory system is consistent with these three functions, what is the mainly used function in the current supervisory system, what gaps present and how to fulfill it and what are the strength and weakness aspects from the view of supervisors and supervisees. There are many organizational and socio- demographic factors affecting the implementation of CS, so the researcher investigated these factors and its relation with CS.

2.2 Definitions of Clinical Supervision

UK department of health (1993) defined CS 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. It can also be defined as an exchange between practicing professionals to enable the development of professional skills (Butterworth and Faugier, 1992). Both definitions focused on the educational and quality of care benefits of CS. It is also defined as an interpersonal process where a skilled practitioner helps a less skilled experienced practitioner to achieve professional abilities appropriate to his/her role (Barber & Norman, 1987).

CS is a formal arrangement enabling nurses to discuss their work regularly with another experienced professional. It involves reflecting on practice in order to learn from experience and improve competence (Kohner, 1994). CS is designated interaction between two or more professionals, within a safe and supportive environment, which enables a continuum of reflective, critical analysis of care, to ensure quality patient care (Bishop, 1994).

CS is a formal process of consultation between two or more professionals. The focus is to provide support for the supervisee(s) in order to promote self-awareness, development and growth within the context of their professional environment (Hancox and Lynch, 2002).

There are terms like mentorship and preceptorship used instead of CS but have the same meaning (Sloan, 2006). Some authors differentiate between preceptorship, mentorship, and CS. Preceptorship is commonly directed for students, mentorship is directed for younger employee while CS for supervisees in the same career who needs professional support (Lynch et al., 2008)

By looking to the different definitions of CS we noticed that there are some phrases or words that are repeated and recurring such as:

- A formal practice of professional support and practice.
- Enhancing safety of care and client protection.
- Sharing and learning of experience.
- Assuming responsibility in practice.
- Improvement of clinical skills and knowledge.
- A formal arrangement enabling nurses to discuss their practice.
- Improving quality of care.

- Reflective practice.
- Experienced practitioner/ supervisor.

2.3 Clinical Supervision in Nursing

Despite CS having a presence in nursing since the 1920s (Burns, 1958), it has a great interest in the UK in the comparatively recent past. It is well known that Florence Nightingale recommended the supervision of junior nurses by more senior nurses to improve their practice and skills (Abel- Smith, 1960). CS is now a frequently debated concept in nursing as manifested by the extensive articles in nursing journals (Sloan, 2006).

Many studies were made concerned with the clinical nursing supervision and its impact on the quality of nursing care, burnout, and turnover. There were many articles explain the benefits of CS and models of CS especially in nursing. Many of the popular publications, for example Nursing Times and Nursing Standard particularly during the latter part of the 1990s, regularly featured articles on CS (Sloan, 2006). The scholarly journals: Journal of Psychiatric and Mental Health Nursing and Journal of Advanced Nursing have provided a platform for critical debate from clinicians, educators and researchers viewpoints (Sloan, 2006). Furthermore, following the Butterworth and Faugier (1992) publication: CS and Mentorship in Nursing, one of the first CS texts for nursing in the UK, several other books have been written e.g. Bishop, 1998a; Bond and Holland, 1998; Power, 1999; Bassett, 2000; Driscoll, 2000a; Cutcliffe et al., 2001,....etc.

There can be little doubt that a familiarity with CS is expanding within the nursing profession (Sloan, 2006).

UK, DOH (1993) emphasizes the development of CS as one of the key elements that enable nurses to maintain clinical competence, describing it 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 situations.

2.4 Distinguishing Clinical Supervision from Administrative Supervision

CS has a doubt in its relation with managerial supervision. In the literature some authors claimed that CS is similar to managerial supervision and others recommend to clearly distinguishing CS from managerial or administrative supervision.

White and Winstanley (2006) found that nurses in hospital mistrust CS process due to confusion between CS and managerial supervision. Many countries employed first-line managers or head nurses as clinical supervisors to their subordinates especially in Scandinavian countries, Finland and other countries (Cutcliffe and Hyrkas, 2006). Other countries like UK distinguish between clinical and administrative supervision. Administrative or managerial supervision is directed at assisting the worker to meet organizational requirements (Hart, 1982). Administrative supervision addresses employee performance in regard to organizational goals, expectations and standards. Administrative supervision is typically provided by a worker's manager or supervisor (Todd & O'Connor, 2005).

CS is focused on enhancing the clinical effectiveness of the supervisee (Kavanagh et al., 2002). It is characterized by flexibility, and the purpose of CS may change over time and in different situations (Todd & O'Connor, 2005). Although the focus of CS is on developing the supervisee's clinical and interpersonal skills, the clinical supervisor may help the supervisee to meet organizational standards. It is preferable that the clinical supervisor is someone who is "not accountable operationally or professionally" for the supervisee (i.e., they are not the worker's manager or supervisor (Todd & O'Connor, 2005). There is a clear difference between CS and administrative or managerial supervision, and it is important to avoid overlap between clinical and administrative supervisory roles (Todd & O'Connor, 2005).

Bush (2005) said that providing CS by line managers to their staff is considered a barrier to effective CS as: staff may not have chosen that person as a supervisor; staff may not wish to disclose personal material to such a person and staff may feel that a negative evaluation by a line manager could have a direct influence on their future career success. Clear difference should be made between CS and line management/supervision. CS is focused on developing the worker's clinical roles and performance. Line management/supervision, in contrast, is concerned with the evaluation and appraisal of all aspects of a worker's performance. Ideally, a clinical supervisor will not be the worker's line manager/ supervisor, and for counseling staff there are advantages in having a clinical supervisor who is external to their agency and therefore independent of organizational processes and issues (Ask & Roche, 2005).

Another term used in the literature is administrative clinical supervision. It defined as a CS directed to managers, administrators and leaders in the organization (Sirola-Karvinen & Hyrkas, 2006)

2.5 Benefits and Aims of Clinical Supervision

The stressful working conditions that nurses frequently face have been highlighted as a major factor contributing to nurses leaving the profession (Lynch et al., 2008). CS is important for nursing as a profession and it is necessary to be performed in the workplace as nurses feel comfort when they practice or receive clinical supervision (Hancox, et al, 2004).

CS aims to increase the knowledge, skills, and practice of supervisees, it also enables the supervisor to constantly evaluate and improve the quality of care provided for patients (UKCC, NMC, 2002). Hancox, et al (2004) claimed that CS is a good tool used to improve job satisfaction for nurses and the quality of care provided. CS supports the supervisees emotionally and thus decreases the level of burnout and increases the level of job satisfaction and also increases the quality of care provided by nurses (Hyrkas, et al, 2006). Edward, et al (2006) supposed that if CS is performed effectively then the degree of burnout will be reduced.

Team supervision has an effect on the quality of care provided for clients by nurses and it can be considered as a quality improvement method in nursing practice as team supervision was consisted of multi-professional team including physicians, nurses and other allied professionals (Hyrkas & Panuonen- Ilmonen, 2001). CS helps the organization to develop an evaluation system in order to improve the quality of care, improve efficiency and effectiveness of services, help in proper recruitment and retaining of nurses and eventually to develop a system for responsibility and accountability (Royal College of Nursing, 2003).

Todd & O'Connor (2005) suggested that CS affects both practitioners and the organization as it improves the quality of care especially in complex skills, improves the interpersonal relationships and communication, facilitates a supportive work environment for supervisees, standardizes the performance of procedures, increases the job satisfaction, enhances the worker retentions, and finally decreases the administrative costs.

Coffey and Coleman (2001) suggested that nursing is a stressful profession. It's suggested that CS will reduce the stress experienced by nurses (Butterworth and Faugier, 1992).

CS is considered alternative approach to nursing care, it also enhances patient-centered nursing care, increases professional support, reduces stresses, improves morale, encourages motivation and helps in nurse- supervisor confidence (Department of Health, Social Services and Public Safety (DHSSPS), 2004).

DHSSPS (2004) claimed that CS has benefits for both practitioners and managers; practitioners feel valued, self-esteem is increased and openness is also encouraged, in addition, practitioners experience an increase in professional confidence and competence. CS encourages safe autonomous practice, enhances personal and professional development and assists practitioners in meeting standards, Furthermore, practitioners feel empowered and facilitated to take responsibility for their professional actions and decisions and practitioners also acknowledge managers that are placing importance on their need to have protected time to review clinical practice and re-evaluate their professional and personal development (DHSSPS, 2004). CS also enables managers to satisfy themselves in which guidelines and standards are effectively performed by practitioners (DHSSPS, 2004).

Engagement in CS facilitates improvements in practice, leads to increased safe care delivery that results in reduced complaints (DHSSPS, 2004). CS is a key safeguard for managers who clearly support practitioners to review and continually reassess their professional actions; CS also provides opportunities to manage conflict and to examine resolution strategies and it greatly assists managers to meet quality requirements and assists in ensuring accountability and assured that regulatory functions are not ignored (DHSSPS, 2004). Morton-Copper and Palmer (2000) concluded that benefits of CS are: improving patient care through reflection on practice, distribution of an effective practice, ongoing learning and education, continuous support for professional development, creating a participative culture, helping in ideas exchange, increasing job satisfaction and motivation and reducing turnover and burnout.

UK National Health Services (NHS) (2004) stated that CS aims to ensure a high quality service provided to clients, encourage and provide reflective practice and provide a place for staff to receive support, encouragement, praise and positive feedback. CS assists staff to work in accordance with organizational and professional standards of practice and competence; it also assists staff to be effective in their practice, assists staff to work efficiently during their workload and provides a space for staff to discuss any problems they may be experiencing and influencing the work (NHS, 2004).

Chartered Society of Physiotherapy (CSP) (2005) claimed that CS is a useful system to support continuing professional development, increases self-confidence, enhances staff morale, supports staff retention, enhances patient care, encourages clinical effectiveness, promotes evidence-based practice, enhances professional knowledge, increases analytical thinking and develops reflective skills.

Driscoll (2000) claimed that CS helps to increase job satisfaction and self-confidence of nurses and assists to their adaptation to changes in practice.

2.6 Models of Clinical Supervision

CS is a relationship that needs to be guided and developed according to a particular orientation or philosophical attitude. In general, this means that clinical supervisors will base their approach to practice on a particular model. There are many of models that have been developed for or adapted for use in CS. While it is not possible to cover all possible models, an overview of some of those most commonly used has been provided.

2.6.1 Proctor's Interactive Model:

Proctor's (1987) three functions interactive model has a popular use in nursing practice especially in UK (Sloan and Waston, 2002). This model addressed three main functions for clinical supervisors: formative functions, normative functions and restorative functions (Proctor, 1988). It was developed initially for use in a counseling context, can focus on all or any one of three areas at any time (Sloan and Waston, 2001).

The formative function of supervision is the educative process of developing skills, understanding and abilities of supervisees. This is achieved by exploration of the supervisees work with clients through qualified and experienced supervisor (Faugier and Butterworth, 1994). In this function the nurse might be helped by supervisors by better understanding of clients and their needs, examining nursing interventions and its consequences on the clients, exploring other nursing interventions for patient care, and evaluating the nurse interaction with other disciplines to provide high quality of care (Faugier and Butterworth, 1994). Increasing the supervisees' knowledge and practice through conducting training and education activities, assessing the supervisees' needs and satisfying these needs, providing feedback for supervisees regarding their work, performing training for newly employed nurses through complete orientation package... and so on.

The normative aspect concentrates on managerial issues including the maintenance of professional standards (Cutcliffe & Proctor 1998). The normative functions included: assuring quality of nursing care, using check lists to monitor and improve nursing care, maintaining organizational goals and standard... and etc.

The restorative function is focused on providing support in an attempt to alleviate the stress inherent in the occupation of nursing (Sloan and Waston, 2001). Restorative functions concern with enhancing team work, decreasing work load, limiting and managing the conflicts, improving social relationships, allow for openness and active listening to complains and so on. To achieve educative, supportive and managerial functions of CS the nursing supervisors may focus on one or more of these functions but it is preferable to view these three functions as interrelated and overlapped to provide high quality clinical supervision (Faugier and Butterworth, 1994).

White et al. (1998) indicates that the advantages from implementing the Proctor model include: evaluation, consistency, benchmarking, measuring quality and ease of training.

The main disadvantages include: model may be not suited to some supervisors and supervisees, difficulty in ensuring people adhere to the model, difficulty in evaluation if people do adhere to the model and the model may not suited to some clinical settings (White et al., 1998).

2.6.2 Heron's Intervention Analysis Framework:

Heron's (1989) six category intervention analysis is initially developed to better understanding of interpersonal relations particularly between clients and practitioners so that heron's six category interventions can be used as a method or tool to perform CS in nursing (Sloan and Waston, 2001). The six categories are: prescriptive, informative, confronting, cathartic, catalytic and supportive. Heron summarized these under authoritative interventions and facilitative interventions. Authoritative interventions are those which permit for the supervisor to maintain a degree of control over the supervisees and include the prescriptive, informative and confronting categories. Facilitative interventions are those that yield some degree of control for supervisees and are cathartic, catalytic and supportive. Authoritative interventions are neither more nor less useful and valuable than facilitative ones (Sloan and Waston, 2001).

Prescriptive interventions aim to direct the behavior of supervisees for example by offering advice, and giving suggestions. Informative interventions are to give information or instructions. To be confronting is to challenge the person’s behavior, attitudes or beliefs.

Cathartic interventions involve alleviating tensions and stresses of the supervisees regarding their work. Catalytic interventions enable the supervisees to better express themselves and explore the strong characteristic they have. To be supportive is to stress on

the value and worth of the supervisees and their effective contribution to the work (Sloan and Waston, 2002).

2.6.3 Practice- Centered Supervision Model:

It is developed by Nicklin in 1997. This model relatively resembles to proctor interactive model. Nicklin substitute restorative, normative and formative functions determined by proctor (1987) by managerial, educative and supportive functions. He also transferred the stages of the nursing process into a supervision cycle that is practice analysis, problem identification, objective setting, planning, implementation/action and evaluation instead of assessment, planning, diagnosis, implementation and evaluation (Nicklin, 1997).

2.6.4 Problem- Focused Model:

Rogers and Topping Morris (1997) described the problem- focused model for CS which focused on the supervisor's role to solve the clinical problems facing the supervisees and modify the ineffective care plan to improve the quality of care provided, it also focused on improving the supervisees knowledge and practice to solve the clinical issues who have no or little experience regarding it. Problem- oriented clinical supervision is described as a collaborative process by which the supervisors identify the solutions for clinical problems reported by the supervisees (Sloan and Waston, 2002).

2.6.5 Solution- Focused Clinical Supervision Model:

This model focused on giving solution by supervisors and supervisees in advance or in proactive way rather than focusing in the reasons of the problems (Driscol, 2000b).
Solution –focused CS makes the assumption that the supervisee has the solutions within his self and the role of supervisors is to find the way to clarify the solution **(**Fowler et al., 2007**).** Supervisors use different techniques to engage collaboratively with supervisees and therefore focusing on solutions such as using scales focused questions, looking for exceptions, constructive feedback, and follow-up tasks.

2.6.6 Growth and Support Model:

Faugier (1998) describes a growth and support model in an attempt to provide some guidelines to the characteristics of the supervisory relationship. Faugier argues that the role

of the supervisor is to facilitate growth and provide essential support to the practice of clinical excellence (Faugier, 1998). It is essentially a guide for supervisors regarding the attitudes they express during CS. While it provides a broad range of characteristics, it was neither developed from, nor has it been evaluated by empirical research. Here the role of the supervisor is to facilitate growth both educationally and personally in the supervisee, while providing essential support to their developing clinical autonomy. The elements of the relationship for which the supervisor should be considered responsible for are summarized as follows: generosity, sensitivity, rewarding, personal, openness, practical, willingness to learn, orientation, thoughtful and thought provoking, trust relationship and humanity. Each of these aspects is offered as a framework on which to base the supervisory relationship and provide one possible structure to the supervisory process (Faugier, 1998).

2.6.7 The Integrated Model:

It is a CS model developed by Philip Rich in (1993). It's a comprehensive model which explains the four functions of clinical supervision: facilitation, staff development, staff socialization and service delivery (Rich, 1993). It also explains six stages cycle of supervision: relationship building, planning, observation, analysis, conference and follow up (Rich, 1993). It also clarifies the primary elements of supervision: facilitative environment, supervisory relationship, structural elements, supervisory skills, provision of learning experience, and supervisory roles (Rich, 1993).

2.7 Methods of Clinical Supervision

NHS (2004) described methods to practice clinical supervision as one to one supervision, one to one – co supervision, peer supervision, and group session with identified supervisor

2.7.1 One to One "Supervisor – Practitioner":

This involves a single supervisor providing supervision to one practitioner who is less experienced than others.

2.7.2 One to One - Co-Supervision:

This involves two practitioners providing supervision for both by alternating between the

roles of practitioner and supervisor.

2.7.3 Peer Supervision:

A one to one session with peer in the role of supervisor e.g. instant colleague or someone from another work related setting. It is important that the session remains focused and structure and those supervisor/supervisee roles are maintained.

2.7.4 Group Session with Identified Supervisor:

There are a number of ways that can be arranged and operated but in all conditions, the supervisor acts as a resource for the group. The group may set limits and protocols within the group or the supervisor may act as group leader and allocate supervision time accordingly.

It may be useful to combine a group method of supervision with one to one sessions depending on the individual's circumstances and clinical settings. The two practitioners involved should be able to maintain a clear understanding of their roles within each session and be able to challenge practice. It is recommended that these methods are only performed by practitioners who are experienced in supervision.

2.8 Characteristics of Good Supervisor

Clinical supervisors should be expert in the work performed by the supervisees, be in close contact with patients, monitor and follow up the nursing care and have supervisory tools for monitoring and evaluation of performance.

Fleming and Steen (2005) claimed that effective supervision requires the supervisor to have good communication skills. Kilminster and Jolly (2000) concluded that supervisors need to be clinically competent and knowledgeable, and have good teaching and interpersonal skills.

Supportive supervisory behaviors include giving direct guidance on clinical work, linking between theory and practice, adopting problem-solving approach, offering feedback, reassurance and role models (Kilminster and Jolly, 2000).

Ineffective supervisory behaviors include rigidity, low empathy, failure to offer support, failure to follow the supervisees concerns, being indirect and intolerant and emphasizing negative aspects in the evaluation process (Kilminster and Jolly, 2000).

Fleming and Steen (2005) stated that the supervisor has a critical role in ensuring the ethical practice of supervisees so that the supervisors need to be ethically accepted to assure ethical considerations and to be a role model for their supervisees.

Sloan (1999) performed a qualitative study using a questionnaire and focus group to identify characteristics of a good supervisor from the supervisees perspective (staff nurses working in a mental health setting), the nurses perceived a good supervisor as has the ability to form supportive relationships, having relevant knowledge and clinical skills, expressing a commitment to provide supervision, and having good listening skills. Supervisees viewed their supervisor as a role model, someone who they felt inspired them, whom they looked up to and had a high regard for their clinical practice and knowledge base.

Good supervisor is one who has the ability to confirm the supervisee's professional practice (Severinsson & Hallberg, 1996).

Powell and Brodsky (1998) explained that successful supervisors have a good characteristics that are described as the "four A's of clinical supervision": **Available:** open, sympathetic, trusting, non-threatening, **Accessible:** easy to approach and speak freely with supervisees, **Able:** having enough knowledge and skills to transmit, **Affable:** pleasant, friendly, reassuring.

Kohner (1994) stated that the proper skills that a supervisor should own are: listening, giving positive and negative feedback, facilitating reflection and teaching. In effect, what Kohner is describing are the fundamental skills of counseling which are the key skills of interpersonal nursing. Further training to improve these skills and to apply the skills to the supervisory process will be required by all nurses who take on the role of supervisor.

CPS (2005) recommended that clinical supervisor should be, or be able to become: open minded, analytical, trustworthy, constructive in their feedback, non-directive, challenging, clinically knowledgeable, questioning, active in their listening, supportive and self-aware.

Lynch et al. (2008) reported that when clarifying the characteristics of a good or effective clinical supervisor it is useful to divide them into two main categories: interpersonal skills and practical skills.

Interpersonal skills are those that make us human and are often those skills that are essential for nurses in order to care for their patients. While some of these skills can be taught and the others may be personality traits. Some examples of 'good' interpersonal skills in a supervisor include being non-judgmental, open and honest, warm, friendly,

engaging, having a good sense of humor, authentic, being insightful and self-reflective, and the ability to gently and respectfully challenge or question people without seeming critical (Lynch et al., 2008).

Lynch et al. (2008) claimed that clinical supervisor needs practical skills to be highly skilled as a communicator. This includes the ability to actively listen, ask clarifying questions and summarizes the main points or issues. It is also important that clinical supervisors have sound clinical skills and are respected within the organization.

Regarding to practical skills there are different perspectives of management and clinicians. For example, managers may tend to place a high value on nurses who are able to practice efficiently and safely or who are reliable and punctual. Clinicians may be more concerned about clinical skills and the ability to communicate with patients and other nurses. As clinicians are the target population for clinical supervision it is advantageous to involve them in the process of identifying suitable supervisors, for example by nominating nurses they believe would make suitable supervisors (Lynch et al., 2008).

Ministry of health and population of Malawi identified responsibilities of a supervisor that included: determine standards of good practice and performance and communicate these to staff, follow up in a regular basis the staff performance against the agreed standards, provide feedback to staff about their performance, collaborate with staff to identify appropriate interventions that will lead to improved delivery of quality services, mobilize resources from different sources to implement interventions and ensure that the interventions have the desired effects (Malawi, MOH, 2003).

2.9 Clinical Nursing Supervision in Different Context

Clinical nursing supervision is extensively evident in the literature from many European countries especially UK, Ireland, Australia, Finland and Scandinavian Countries. Most of the studies focused on the benefits of CS and its effects on many professional and organizational issues like job satisfaction, burnout, turnover, etc. Most of CS studies were in mental health nursing, psychiatric nursing and geriatric nursing and little studies were found concerned with hospital nurses. This extensive presence of CS studies reflects the great concentration on CS internationally. Some studies adopted Proctor model of CS, one of these studies was performed by Kilcullen (2007) who analyzed the experience of CS on registered nurses while they undertake diploma in renal and urological nursing and on their supervisors. She used a qualitative descriptive research design in her study and a purposive

sample of 10 registered nurses participated in the study; five were clinical supervisors and the other five were supervisees. The study was undertaken in a large teaching hospital in Ireland. Data were collected by semi-structured questionnaire then analyzed using content analysis. Proctor's Interactive Model (1987) was used as a framework during the program. Both supervisors and supervisees positively perceived the clinical supervision in these clinical sessions. She found that the restorative function was highly rated by the study group. The other two elements of the model (normative and restorative functions) were also well rated. She said that it may be necessary to feel supported before the other functions of clinical supervision can be achieved. One limitation of this study was the small sample size that may affect the generalization of the study findings.

Bowles and Young (1999) conducted a study on the benefits reported from participation in CS by registered nurses working in a large English community and mental health NHS Trust. The study was based on Proctor's three function interactive model, each of Proctor's three functions were expressed in seven questionnaire items enabling the calculation of a mean overall benefit value and a mean value for each of the three dimensions. The development of this instrument through semi-structured interviews with supervisors and supervisees is described. The study aims to assess and compare reported benefits in each of the three functions of accountability, skill development and support in order to examine the effects of contract use, length of experience of clinical supervision and length of service as a registered nurse on reported benefits by using non-parametric statistical analysis. The results indicated that reported benefits are experienced in almost equal proportion across each of these three functions. Statistical analysis indicates a significant positive correlation between experience of clinical supervision and its reported benefits. An inverse correlation is reported between length of service and overall benefits; however, no similar reduction over time against normative benefits was found. There was no relationship between contract use and reported benefits.

Walsh, et al. (2003) developed, implemented and evaluated a group model of CS developed by a small team of mental health nurses in a community mental health setting. The need for a new model of clinical supervision arose from the desire of a group of nurses at the Enfield Community Team, Royal Adelaide Hospital Mental Health Service, to develop their clinical practice. It also arose from the fact that these nurses were not satisfied with other models of supervision to which they had been exposed over their

working lives. In addition, some had experience of models of supervision which they believed were too closely linked with line management. They decided to use the work of Proctor as a framework for the model overall and for each group supervision session. This framework consists of three key objectives or functions (formative, normative and restorative) which were incorporated into the model. After implementing this model for 6 months, they evaluated the CS model by using a questionnaire for collecting data on the group aims, adherence to group norms, personal objectives, supervision functions and overall usefulness. The results indicated that respondents clearly felt the major supervision function met by the model was education or formative. The restorative or support function, in contrast did not rate as highly.

In the Arab context, there were little literature concerned with supervision but it was mentioned in some health projects or protocols as training of supervisors on how to deal with some protocols and performance guidelines.

Jarrala and Khoja (1998) studied the perception of supervisors about their roles in PHC and mentioned it as the first study in Saudi Arabia. They found that supervisors at PHC positively perceived their roles in supervision at PHC. About 97% of the supervisors developing the skills and knowledge of personnel, 91.9% of them coordinating the activities and 83% looking for areas of defects. Solving the problems of the personnel was also included as a function of supervision, discovering mistakes was perceived by 22.2% of the supervisors as a meaning of supervision. The main problems were related to communication, transport and logistics. Only a quarter of the supervisors faced technical problems and very few faced the problem of staff shortages (12.6%). The majority thought that supervision could be improved by training supervisors (71.1%) and increasing the frequency of visits (54.1%). Increasing the number of supervisors was suggested by 25.9% of respondents. Giving more incentives was mentioned by very few (3.7%). The majority (97%) were aware of the quality assurance program of the MOH. They perceived their role in the programme was to implement the programme (40%), to monitor its progress (29.6%) and to train the staff (14.8%). The majority (91.9%) believed that they had enough support from the higher authorities in order to do this.

In Palestinian context, a study about satisfaction among managers in Gaza governmental hospitals studied the supervision as one variable affect the satisfaction (Thabet, 2004). She found that there is significant relationship between trained managers and level of

supervision and reveled that training is effective for manager. Also, in Palestine, primary health care has supervisory system. Turban (2007) studied the status of supervision in PHC in GS from multidisciplinary approach; she studied the perception of both supervisors and supervisees toward supervision in PHC. She used questionnaire for supervisors and another for supervisees. The study main domains were: managerial role, quality improvement, human resource management, supervisory approach, facility and environment management. Both supervisors and supervisees perceived supervision positively. There is a lack of checklists usage as a supervisory tool. The study found that the majority of supervisors are not involved in hiring and promotion. They also didn't share in decision making and not included in putting of organizational goals. There is a lack of training for both supervisors and supervisees and this negatively impact the perception of supervisees. Many demographic, organizational and supervisory variables were compared with the domains of the study to explore its relation with the domains. Nurses were positively perceived their supervision. Internal supervisors were positively perceived their supervision than external. Supervisors who had training courses were found to be statistical significant difference in regard to supervision domains from those who didn't. Supervisees whose supervisors reviewed with them reports and work showed positive perception to all domains with statistical significant differences. Supervisees who worked in their preferable department showed positive perception with statistical significant differences. Turban study considered the unique study concerned with supervision in MOH.

2.10 Characteristic and Organizational Factors of the Supervisors and Supervisees

Characteristics differ from person to person as each person is unique in his personality, behavior, attitudes and values. These personal characteristics of both supervisors and supervisees affect the supervisory relationship so it's important to study the effects of these characteristics on the supervision. Gender is critical in communication in addition to cultures. In Arabic culture communication is better within the same genders and many studies reflected that as most of supervisors in Arabic countries were male (Turban, 2007; Thabet, 2004). This is in contrast to Europe countries and America where they prefer female supervisors (Hyrkas, 2006). Same cultures and ethnic background may facilitate the supervision relationship (Powell & Brodsky, 1998).

Age of supervisors and supervisees play a major role in clinical supervision, supervisors usually in the middle ages but supervisees is relatively younger than supervisors. (Turban, 2007; and Thabet, 2004) found that supervisors and managers relatively in the middle age. (Turban, 2007) found that almost of supervisees in PHC is below age of 40 years.

Organizational factors also play a role in supervision. Type of supervisors (internal or external) is important in implementation of clinical supervision as the internal supervisor is present in the organization and more oriented to the supervisees needs and this is evident in Turban, 2007 who found that internal supervisors perceived supervision domains (human resource management, supervisory approach, and communication and support) more positive than external ones.

Supervisory relationships where the supervisor and supervisee are from the same discipline may be more effective (Todd & O'Connor, 2005). Experience is another organizational factor that may affect the supervision, as less experienced supervisees may prefer supervision that is more directive, problem-focused and skills-based where as more experienced supervisees may prefer supervision that focuses on examining conceptual issues that arise from work practice (Todd & O'Connor, 2005). The relationship between the supervisor and supervisee changes as the supervisee takes the required experience (Kilminster and Jolly, 2000).

Experience of supervisors is vital for effective CS as CS is transition of knowledge and skills from experienced practitioner to less experienced one.

Training for supervisors is important for conducting effective CS as many of literature explained this (Kliminster and Jolly, 2000; Claxton, 1984,....etc).

2.11 Clinical Supervision and Training

Training is vital for both supervisors and supervisees. Well trained supervisors will be more competent in providing CS than untrained others. Supervisors who are not trained will practice as his supervisors where practiced supervision when he was supervisee and will act as imitator. Nursing supervisors are prompted to supervisory level because of their experience in nursing, good work, academic qualification, their residence in the organization and -in some instance their political loyalty- and are expected to perform well in their new work without enough training or preparations (Ben-salem and Beattie, 1996).

It's important to train experienced supervisees on supervisory skills in advance and engaged them in practicing CS for less experienced supervisees and this is the core of CS.

Fowler (1998) recognizes that the role of the supervisor is one requiring many skills, therefore education, training, and role preparation, are essential elements of a successful system of CS. Kliminster and Jolly (2000) stressed on the importance of training for supervisors not only in professional but also in supervisory skills. Wright (1989) described the use of supervision seminar as a method for support and training.

Clarkson and Glibert (1991) have suggested a structured model for training of supervisors with three structured stages of training:

- Awareness: bringing the supervisors from unconscious incompetent to conscious incompetent
- Accommodation: making the move from conscious incompetent to conscious competent.
- Assimilation: from conscious to unconscious competent.

Claxton (1984) has identified the four believes which may get in the way of training for supervisor: I must be competent, I must be in control, I must be consistent, and I must be comfortable.

Jarrala and Khoja (1998) reported that the majority of the supervisors believed the training of supervisors is essential for improvement of supervision.

It is clear that education and training of staff is an essential function of the supervisors. It also requires important skills of planning and communication and can improve the image of the supervisor among the staff (Jarrala and Khoja, 1998). In the Palestinian health care system it is essential to overcoming the widely existing training gaps by coordinating with the educational institutions-universities and focusing on integrating national protocols, skills deficit and health systems needs into training curricula (Hamad, 2009).

Chapter 3: Methodology

This chapter presents the method of the study to answer the research questions. In this chapter different items were explained: study design, place of the study, study population, sample size, sampling process, period of the study, inclusion and exclusion criteria, ethical and administrative consideration, study tools, reliability, validity, pilot study, data collection, data management, and limitation of the study.

3.1 Study Design

The design of this study is descriptive, analytical, cross sectional study as it assesses the clinical nursing supervision at Governmental hospitals in Gaza governorates. Cross-sectional study was chosen because it is appropriate for describing the status of phenomena or for describing relationships among phenomena at a fixed point in time (Polit & Beck, 2004).

3.2 Place of the Study

The study was conducted in the governmental hospitals in GS throughout the five governorates. The total number of governmental hospital in GS is 13 hospitals (Annex 2).
The researcher selected one hospital from each governorate randomly. The selected hospitals were: Al Helal Al Emaratee hospital from Rafah governorate, Nasser hospital from Khan Younis governorate, Shohadaa Al-aqsa hospital from the Mid-zone governorate, Al-Shifa hospital from Gaza governorate and finally Kamal Edwan hospital from the North Gaza governorate.

3.3 Study Population

This study focused on the perceptions of both the nursing supervisors and supervisees who were working at governmental hospitals so that study population classified into 2 categories:

- The first target population was all the nursing supervisors who were working at the selected governmental hospitals in Gaza governorates. The nursing supervisor included nursing supervisors and head nurses. The total number of nursing supervisors in these hospitals was 160 supervisors

including 66 nursing supervisors and 94 head nurses according to the statistical data from MOH Nursing Unit (Annex 3).

- The second target population was supervisees (nurses) who were working in the selected governmental hospitals. The total number of nurses working in these governmental hospitals is about 956 nurses according to the statistical data from MOH Nursing Unit (Annex 4).

3.4 Sample Size

- **For supervisees**: The total number of supervisees in the selected hospitals (target population) was 956 nurses. The researcher took around 30% of the study population, thus the sample size was 300 nurses.
- **For supervisors:** The researcher included all nursing supervisors in the target population for supervisors group (census study-no sample was taken). The total number of supervisors in the selected hospitals was 160 supervisors divided into: 66 nursing supervisors and 94 head nurses.

3.5 Sampling Process

For selecting supervisees (nurses), the researcher used proportional systematic random sampling method with the following steps:

1. The researcher obtained the number of nurses of each selected governmental hospital.
2. Then divided the number on the total number of the target population in the selected hospitals to obtain the proportion of each hospital.
3. Then the researcher determined the required number to be included from each hospital.
4. After that the researcher arranged the names of nurses of each hospital alphabetically.
5. To select the sample from each hospital randomly, the researcher calculated Kth number by dividing the required number of nurses to be selected on the total number of nurses in the hospital.
6. Then the sample selected systematically with random start.

3.6 Period of the Study

The study was conducted at the beginning of year 2010. After obtaining approval for the study proposal from the School of Public Health, an administrative letter was sent to the department of human resource development at MOH in July, 2010 to offer facilitation for

conducting the study in MOH hospitals. Data collection was started at October till December, 2010. Data analysis and discussion were finished at January, 2011. The study took approximately one year in total from its beginning.

3.7 Eligibility Criteria

3.7.1 Inclusion Criteria:

- **For supervisors:** all supervisors including nursing supervisors and head nurses of departments who were working at the selected governmental hospitals in Gaza governorates.
- **For supervisees:** all formally employed nurses who were working in these governmental hospitals at the time of the study.

3.7.2 Exclusion Criteria:

- Nurses working at the selected governmental hospitals who were not formally employed (volunteers, internship or on job creation program).

3.8 Ethical and Administrative Considerations

The researcher maintained all ethical and administrative requirements to conduct this study. Approval from the School of Public Health at Al-Quds University (annex 7), Helsinki committee (annex 8) and General Directorate of Hospitals at the Palestinian MOH (annex 9) were obtained before conducting the study. Subjects under the study were selected randomly, received guarantee of privacy and knew about voluntary participation.

3.9 Study Tools

The researcher constructed two questionnaires; one for the supervisors and the other for the supervisees. The researcher used the questionnaires of Turban (2007) study in the PHC on supervision and modified many items and add many others in order to be suitable for the functions of CS (formative, normative and restorative) which were the study domains then the two questionnaires were reviewed and validated by experts.

The two questionnaires were stated in a simple language, avoiding duplications and double parallel questions.

- The first questionnaire for supervisors investigated the three main domains: formative, normative and restorative functions according to the adopted model of clinical supervision in this study (Proctor's model) in order to explore the status of clinical nursing supervision. It also contained socio-demographic data including: age, sex, marital status, residency place, academic qualifications and place of the study, organizational data which includes: place of work, job title and years of experiences in nursing and supervisory variables including: number of supervisees, years of experience in supervision, receiving training courses in supervision, having job description for their supervisory work, having supervisor, using supervisory methods, receiving incentives and level of satisfaction about their supervisory work (Annex 5).
    - The second questionnaire investigated the above three domains from the perspective of supervisees. It also included socio-demographic data including: age, sex, marital status, residency place, academic qualification and place of the study. Organizational data include place of work, nursing experience, having job description, revising patients' files and daily reports by supervisors and number of supervisor visits in working shift (Annex 6).

      organizational data also including: working at preferable department, knowing occupational rights, knowing clinical duties, receiving training inside or outside the hospital, receiving orientation at beginning of work, and level of satisfaction about head nurse and nursing supervisors .

3.10 Reliability

Reliability refers to the consistency of a measure. A test is considered reliable if we get the same result repeatedly. To measure the internal consistency of the instruments, the researcher conducted “Cronbach alpha coefficient". Cronbach’s alpha reliability coefficient normally ranges between 0 and 1. However, there is actually no lower limit to the coefficient. The closer Cronbach’s alpha coefficient is to 1.0, the greater the internal consistency of the items in the scale. George and Mallery (2003) provide the following rules of thumb: If the Cronbach’s alpha coefficient > 0.9 = Excellent, – > 0.8 = Good, – > 0.7 = Acceptable, – > 0.6 = Questionable, – > 0.5 = Poor, and – < 0.5 = Unacceptable.

For supervisors' questionnaire: Cronbach's Alpha equation was used to compute the reliability coefficient, it was 0.961. It is considered as excellent reliability coefficient.

Table (3.1) shows the reliability estimated of the derived factors for the supervisor's questionnaire.

For the supervisees' questionnaire: Cronbach's Alpha equation was used to compute the reliability coefficient; it was 0.964, it is also considered as excellent reliability coefficient. Table (3.2) shows the reliability estimated of the derived factors for supervisee's questionnaire.

Table 3.1: Reliability for Supervisors Instrument

Factor No	Factor name	No of cases	No of items	Cronbach Alpha
1.	**Normative function**	119	30	0.910
2.	**Formative function**	124	15	0.907
3.	**Restorative function**	128	19	0.938
	Overall	110	60	0.961

Table 3.2: Reliability for Supervisees Instrument

Factor No	Factor name	No of cases	No of items	Cronbach Alpha
1.	**Normative function**	233	21	0.949
2.	**Formative function**	241	9	0.930
3.	**Restorative function**	245	14	0.855
	Overall	201	44	0.964

3.11 Validity

3.11.1 Face Validity:

To increase the response rate it is important to maintain good face validity for the questionnaire so the researcher constructed the questionnaire in an appealing design. The researcher asked the subjects in the pilot study about their opinions about the structure, shape, clarity and format; comments received were considered.

3.11.2 Content Validity:

The two constructed questionnaires were sent to 14 experts to validate the questions and its relation to the domains that reflect the study. Comments of the experts were considered and modification was performed accordingly.

3.12 Pilot Study

The researcher performed a pilot study in Al Nasser Pediatric hospital after receiving the approval to perform it from the hospital general directorate. The researcher conducted the pilot study in order to refine the methodology of the larger study by using the same subjects, settings, and methods of data collection and analysis as those used in large study as recommended by (Fitzpatrick and Wallace, 2006). Twenty questionnaires for nursing supervisors and another twenty questionnaires for supervisees were distributed then collected. Cronbach's Alpha equation was used to compute the reliability coefficient for both questionnaires; it was more than 0.90; it is considered as excellent reliability coefficient.

The subjects asked to determine any ambiguity or misunderstanding in words or sentences to avoid it in the study. Some minor change and modification were performed without any effect on the main domains. The subjects were not included in the study.

3.13 Data Collection

Data were collected by using two self-administered questionnaires; one for supervisors and the other for the supervisees in order to explore their perceptions toward the supervisory functions at governmental hospitals. The researcher distributed the questionnaires to the participants at the working hours in the day and evening work shifts and then receiving them after completion of the questionaires. The average time for filling the questionnaire was 20 minutes. The covering letter of the two questionnaires outlined the title and the purpose of the study and the identity of the researcher.

3.14 Response Rate

Supervisors' Part: the total number of target population was 160 subjects. 133 of them are positively responded with response rate of 83.1%.

Supervisees Part: the sample size was 300 subjects. 270 of them are positively responded with response rate of 90%. These response rates are considered satisfactory.

3.15 Data Management

3.15.1 Data Entry:

The collected data entered into the computer software "Statistical Package for Social Sciences" SPSS program by the researcher after coding of the questions and then cleaning of the entered data.

3.15.2 Data Analysis:

The collected data for both questionnaires were analyzed by using the SPSS software program. After data entry and data cleaning, the researcher performed frequency distribution for all variables of the questionnaires. After that, the researcher performed recoding for continuous variables. Cross tabulation was done as needed. To quantify the responses into scores, the researcher coded the responses as 1= strongly disagree, 2= disagree, 3= don't know, 4= agree, 5= strongly agree. Responses from questions pertaining to each function were computed and the average was calculated to quantify perceptions of participants about the domains of the study. The dependent variables were the three functions of Proctor (1987) model of CS (formative, normative and restorative functions). The independent variables were the age, education level, experience years, receiving training courses in supervision ...etc. In inferential statistics the researcher used one sample t-test to investigate the variation of perception of subjects to dependent variable (CS domains) among independent variable that consist of 2 categories and used one way ANOVA test for continuous variable composed of 3 and more categories.

The researcher used least significant difference (LSD) as a post hoc test. Post hoc tests are designed for situations in which the researcher has already obtained a significant omnibus F-test with a factor that consists of three or more means and additional exploration of the differences among means is needed to provide specific information on which means are significantly different from each other (Stevens, 1999). (LSD) is one test of the post hoc tests developed by Fisher; it was to explore all possible pair-wise comparisons of means comprising a factor using the equivalent of multiple t-tests (Stevens, 1999).

3.16 Limitations of the Study

- Scarcity of literatures and access to published articles.
- Limited published up-to-date reports especially from the MOH due to political conflict between Gaza and West bank.
- Limited data about nursing activities in governmental hospitals.
- Unstable political situations.

Chapter (4): Results and Discussion

4.1 Supervisors' Part

This part concerns with supervisors and included descriptive statistics (demographical and supervision related variables), perceptions regarding study domains and inferential statistics.

4.1.1 Descriptive Part

4.1.1.1 Demographical Variables:

Table 4.1: Distribution of supervisors by demographic and organizational variables

Variables	Categories	Count	%
Gender	Male	96	72.2%
	Female	37	27.8%
Marital status	Not-Married	22	16.5%
	Married	111	83.5%
Academic qualification	3 years diploma	31	23.3%
	Bachelor	91	68.4%
	Others	11	8.3%
Residency place	North of Gaza	28	21.1%
	Gaza	30	22.5%
	Mid of Gaza	28	21.1%
	Khan-younis	23	17.3%
	Rafah	24	18%
Age group	Up to 30 years old	25	19.8%
	31-37 years old	19	15.1%
	38-45 years old	49	38.9%
	46-50years old	22	17.5%
	Over 50 years old	11	8.7%
	Total	126	100%
	M= 40.34, **SD**= 8		
Experience in nursing	5 and less years	10	7.5%
	6– 15 years	52	39.1%
	16–25 years	55	41.4%
	26+ years	16	12%
	M= 16.4, **SD**= 7.65		

Table 4.1 shows the frequencies and percentages for demographic variables of the supervisors. About 84% of participants were married and 16% were not- married (single, divorced and widows). Regarding academic qualifications, 23.3% of supervisors were holding 3 years diploma, while 68.4% of supervisors had bachelor degree. Almost of the supervisors hadn't postgraduate qualification and this is consistent with Jarallah and Khoja (1998) who reported that 85 % of the supervisors held no postgraduate qualification.

Regarding the residency place, 22.5% of supervisors were from Gaza Governorate, 21.1% from North of Gaza Governorate and the same percent were from middle of Gaza Governorate, 17% of the respondents were from Khan-younis and 18% were from Rafah governorate. Figure 4.1 shows the distribution of gender as male respondents represented 72.2% while female represented 27.8% of the total respondents. This result illustrates that male were dominant among supervisors in this study.

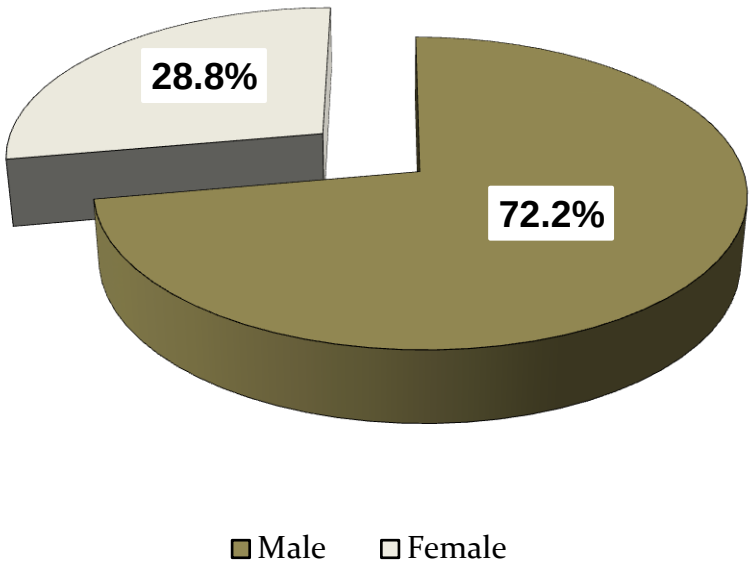


Figure 4.1: Distribution of supervisors by gender

Regarding the supervisors experience in nursing, the mean of nursing experience was 16.4 years. About 42% of the supervisors were having experience from 16-25 years and 39% of them had experience from 6-15 years. This result indicates that the nursing supervisors had satisfactory years of experience in nursing and this is considered as a strong point in the supervisors' characteristics. Supervisors need to be experts in the field of supervision to be as a good reference for supervisees in clinical settings.

Figure 4.2 shows that 43.9% of the respondents were nursing supervisors and 56.1% of them were head nurses. By performing cross tabulation between gender and job title we noticed that female head nurses were 25 out of the 74 head nurses in the study and the remaining were male head nurses (49) (annex 10). The female nursing supervisors were 12 nursing supervisors out of the 58 nursing supervisors and the remaining were 46 male nursing supervisors. In other word female head nurses represented about 34% of head nurses and female nursing supervisors represented 21% of nursing supervisors. This result is consistent with a study performed in PHC in Gaza governorate that revealed the male dominance in supervisory position as male respondents were about 82.2% and females were 17.8% (Turban, 2007). Jarallah and Khoja (1998) reported that all supervisors in PHC at Saudi Arabia were male. These results reflect the effect of Arab culture that tends to be male dominant. This is in contrast to Europe countries and America where they prefer female supervisors (Hyrkas, 2006). This result points on the importance of increasing the female representations in supervisory position especially in women wards to further improve the communication between supervisors and female supervisees as gender is considered a barrier toward effective communication.

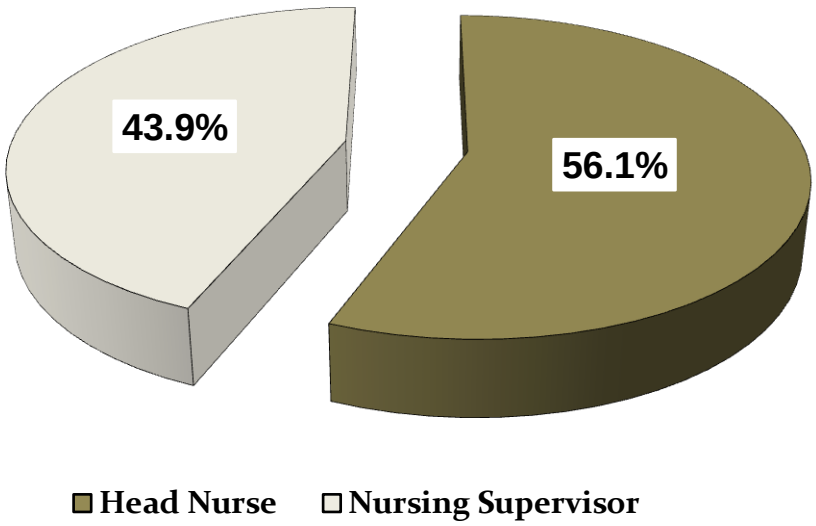


Figure 4.2: Distribution of nursing supervisors by job title

Regarding to supervisors age, figure 4.3 shows that the highest age group was from 38-45 years old, while the lowest was more than 50 years. The age of 45 years and less constituted about 70% of the supervisors and this indicates that the supervisors' age is relatively young and this may be an opportunity for developing their skills and knowledge

to perform effective clinical nursing supervision. This finding is similar to Turban (2007) who reported that the age of the supervisors were young (mean 45.16, SD 7.75). Jarallah and Khoja (1998) reported that the majority of the supervisors (77%) were aged between 35 years and 45 years and mean age was 41.4 ± 5.2 years.

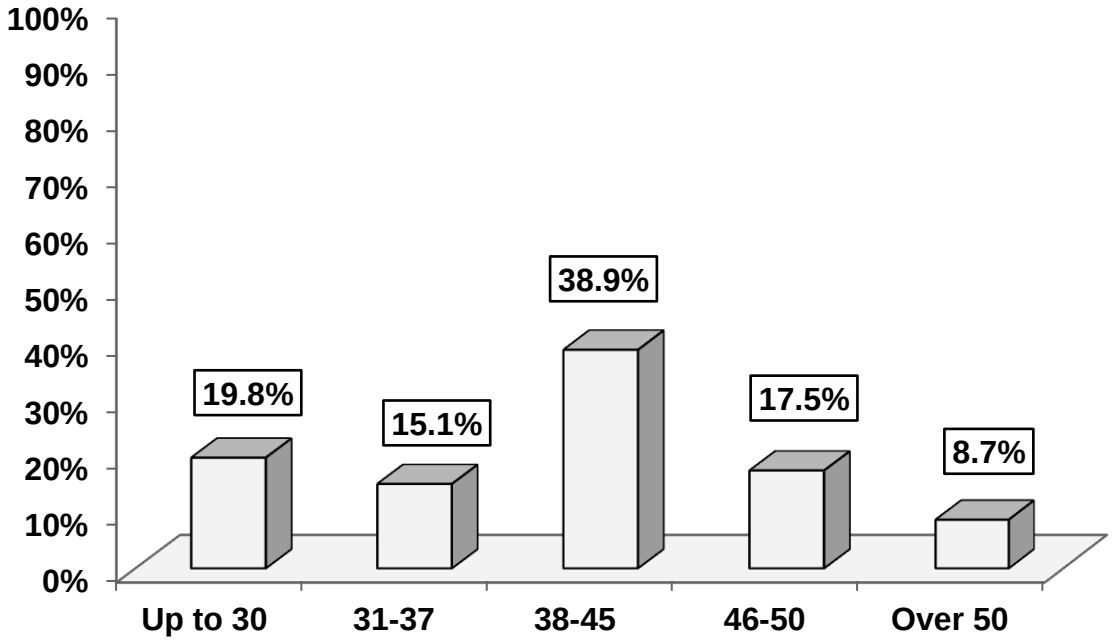


Figure 4.3 Distribution of supervisors by age group

4.1.1.2 Supervision- Related Variables:

Table 4.2 shows that 77.3% of the respondents did not receive any training courses in supervision or management. Turban (2007) reported that approximately 40% of supervisors in PHC didn't receive training courses. Jarallah and Khoja (1998) reported that only 35% of the supervisors had formal training in supervision and very few (15%) had training in leadership development. Jarallah and Khoja (1998) reported that more than 90% of the supervisors said they would like to receive formal training in supervision.

This high percent of supervisors who didn't receive any training courses in supervision calls for the need for assessing and satisfying the supervisors' needs in supervisory skills, knowledge and using supervisory tools through advanced training and education program. Training is crucial for skills development so we need to establish training program to improve the skills of supervisors to improve the clinical supervision.

Table 4.2: Distribution of supervisors by supervision related variables

Variables	Category	Freq.	Percent
Job title	Head nurse	74	56.1%
	Nursing supervisor	58	43.9%
Receiving training courses in supervision or management	Yes	30	22.7%
	No	102	77.3%
Having job description	Yes	63	48.1%
	No	68	51.9%
Having a supervisor	Yes	114	89.1%
	No	14	10.9%
Using supervisory methods	Yes	92	70.2%
	No	39	29.8%
Satisfaction about supervisory work	Strongly agree	17	13.0%
	Agree	100	76.3
	Not agree	13	9.9%
	Strongly not agree	1	0.8%
Conducting regular meetings	Yes	90	68.2%
	No	42	31.8%
Incentives related to supervisory position	Yes	23	17.3%
	No	110	82.7%
Years of experience in supervision	5 years and less	108	81.2%
	6 – 15 years	17	12.7%
	Over 15 years	8	6.1%
	Total	133	100%
	M= 4.6 **SD**= 5.33		

Also in the same table 4.2, about half of the supervisors reported not having clear job description illustrating their duties and responsibilities while in open ended questions almost all the supervisors claimed that the absence of job description for both supervisors and supervisees is one of the problems that interfere with the implementation of adequate

clinical nursing supervision. This result is relatively agreed with the result of the study in PHC in Gaza governorate that revealed that about 77% of supervisors reported having a clear job description (Turban, 2007). These results increase the need for clear job description for both nursing supervisors and supervisees to effectively regulate the relationship between supervisors and supervisees and thus decreasing the conflicts between them. Nurses are overloaded by many of non-nursing duties that are resulted from job uncertainty due to the absence of job description not only for nursing but to other disciplines in the health care system.

More than 89% of the supervisors were satisfied about their supervisory work. This positive signal encourages efforts towards increasing the skills and knowledge of the supervisors for further improvement of the clinical nursing supervision as they feel satisfied with their work. Regarding meetings between head nurses and supervisors, 68.2% of the supervisors claimed that they performed regular meetings between supervisors and head nurses of the departments. These meeting are necessary to improve the nursing care as head nurses are in close contact with nurses and clients than nursing supervisors and thus improving collaboration and coordination between them.

Approximately 83% of supervisors didn't receive incentives related to their supervisory work. Fair rewarding system to assure that supervisors are satisfied in their work is essential in improving their performance. Jarallah and Khoja (1998) reported that low percent of supervisors reported that giving more incentives to supervisors may improve the supervision.

Regarding supervisors experience in supervision, about 80% of the supervisors had experience of five years and less in supervision and this may be due to the political issues as many supervisors refrained and/or expelled from their work after the internal division. In this study, the mean years of supervision experience was 4.6 years. Turban (2007) found that the mean years of experience in supervision were 11 years and about half of the supervisors had experience in supervision from 6-15 years. Jarallah and Khoja (1998) reported that the mean number of years of experience as supervisor was 1.6 ± 0.5 years. There is a missed opportunity for improvement of skills and knowledge of supervisors through extensive training program on effective clinical supervision and thus we build an experience based on knowledge rather than habits.

Regarding using supervisory methods in supervision, 70.2% of the respondents reported that they used supervisory methods in their supervisory work. Figure 4.4 shows that

60.3% of respondents reported using reports as supervisory tools, while 43.5% of respondents reported using meetings, and the same percentage reported using work fields visit as a supervisory method, and only 23.7% of respondents reported using checklists.
There is a limited usage of checklist as a supervisory tool and this was consistent with Turban (2007) who found that about 46.5% of PHC supervisors used checklists and 93% of them were using reports as a supervisory tool. This result is in contrast with Jarallah and Khoja (1998) who reported that the majority of the supervisors (87.4%) use checklists in supervision. This limited usage of checklists reinforce the need for developing supervisory checklists for supervisors in their supervisory activities and also for nursing procedures to enable the supervisors to effectively improve the quality of nursing care.

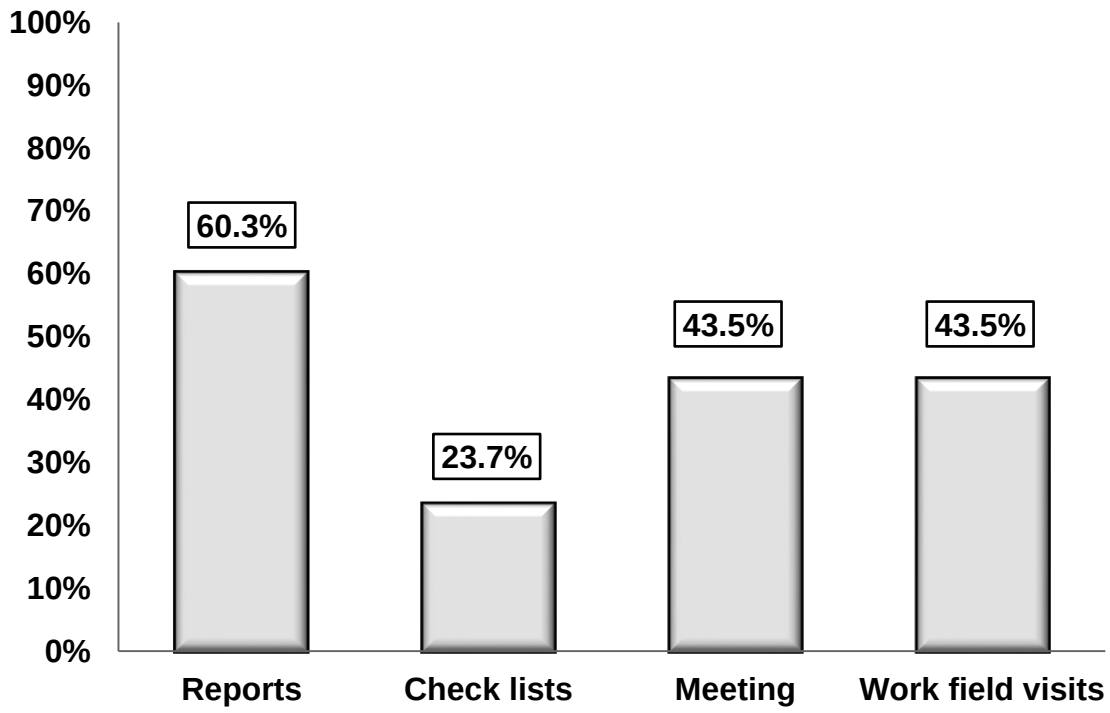


Figure 4.4: Distribution of supervisors by using of supervisory methods

Figure 4.5 shows that 61.4% of supervisors had a span of control from 6 to 20 supervisees (nurses). By performing cross tabulation between job title (head nurse and nursing supervisors) and the number of supervisees, we noticed that the span of control for head nurses is relatively smaller than nursing supervisors, about 93% of head nurses had a span of control of 1-20 supervisees (Annex 11).

City and Hackney Teaching Primary Care Trust recommend that the supervisors are preferable to supervise 6 – 8 supervisees to facilitate the supervision process (NHS, 2006).

The number of supervisees for each supervisor differs from place to place, and depends on the type of supervision, type of health care institution and nature of the supervisor job.

In this study at governmental hospitals, nursing supervisors included both head nurses and nursing supervisors. The large number of supervisees under nursing supervisors may interfere with the implementation of effective clinical nursing supervision so we recommend increasing the number of nursing supervisors to decrease the work load and improve the quality of supervisory work and differentiate between administrative supervisors and clinical supervisors especially in the evening and night shifts that all nurses in the hospital are supervised by one supervisor.

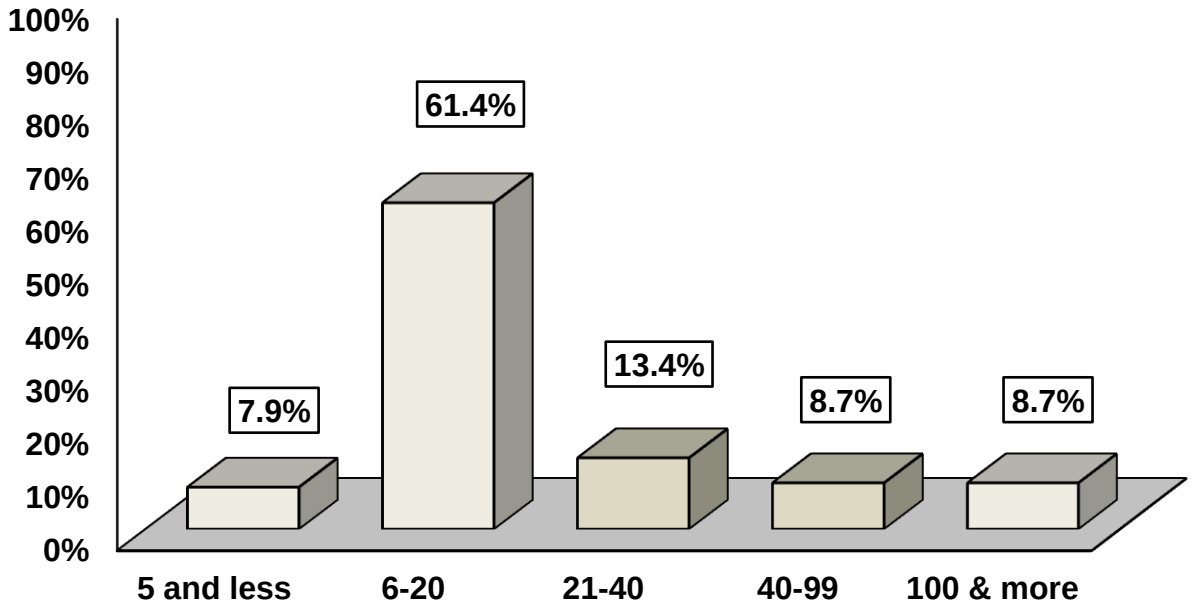


Figure 4.5: Distribution of supervisors by span of control

4.1.2 Clinical Nursing Supervision Domains:

The nursing supervisors perceived their roles and responsibilities positively as illustrated in table (4.3). The overall perception is the summation of the three domains above. The supervisors perceived their roles positively with mean 4.010, the means of the three factors range from 3.874 to 4.010. The highest mean was for restorative function and lowest was for formative

Table 4.3: Distribution of clinical nursing supervision domains as perceived by nursing supervisors

Clinical nursing supervision domains	Number of items	Mean (Total 5)	SD	Percent
Formative function	15	3.874	0.530	77.5%
Normative function	30	3.905	0.426	78.1%
Restorative function	19	4.238	0.473	84.8%
Overall perception	64	4.010	0.412	80.2%

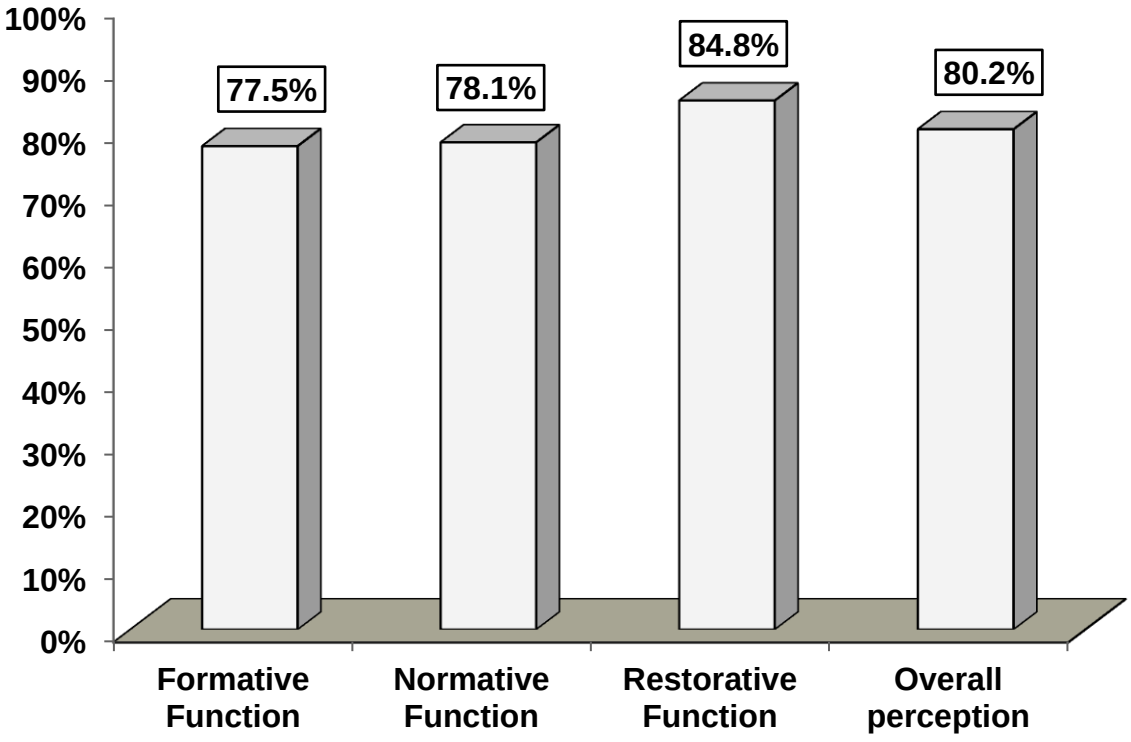


Figure 4.6: Percent of clinical nursing supervision domains

4.1.2.1 Overall Perception:

To quantify the responses into scores, the researcher coded the responses as 1= strongly disagree, 2= disagree, 3= don't know, 4= agree, 5= strongly agree. Responses from questions pertaining to each function were computed and the average was calculated as reported in the table (4.3).

The percentage of the overall perceptions of the clinical nursing supervision domains was 80.2% and the mean was 4.010 (maximum 5). This means that the nursing supervisors have positive perceptions toward their roles and responsibilities but there were areas that need development and improvement. As we see in table 4.3, the mean of clinical nursing supervision domains ranges from 3.87 to 4.23. The highest percentage of clinical nursing supervision domains was in the restorative function domain with a mean of 4.238 and a percent of 84.8% and the lowest was in the formative function with a mean of 3.874 and a percent of 77.5%.

This positive perception of the supervisors regarding their roles is consistent with Kilcullen (2007) who found that clinical nursing supervisors positively perceived the clinical supervision they provided in the clinical sessions. She also found that the restorative function was highly rated by this study group. The other two elements of the model (normative and restorative functions) were also well rated. She said that it may be necessary to feel supported before the other functions of clinical supervision can be achieved. This study is inconsistent with Walsh, et al. (2003) who found that supervisors clearly felt that the major supervision function met by the developed and implemented group supervision model was education or formative function and the restorative or support function, in contrast did not rate as highly.

4.1.2.2 Formative Function Domain:

Formative function focuses on increasing the supervisees' knowledge and skills. The core function of clinical supervision is the formative function. The nursing supervisors perceived this domain as the least positive one among the three domains with a percentage of (77.5%). Nursing supervisors need to focus on the educative aspects of clinical supervision by performing need assessment for supervisees and satisfying these needs through lectures, training and case studies. The researcher formulated many items to measure the formative function. These items included: performing needs assessment, participation in providing lectures for supervisees, providing feedback for supervisees regarding their work, providing training for newly employed nurses, trying to link theory and practice together, training the supervisees on the used protocols and guidelines, and so on. Detailed description of the items under this domain is provided in Annex 12.

As clear in Annex 12, about 68% of the supervisors performed regular meeting with nurses to improve the services. This result fosters the need to regulate these meeting at regular

basis to discuss clinical problem and solving it. It's important to found a place for these meetings and well preparation and facilitation before meeting. Regarding training of newly employed nurses, 76 % of supervisors reported they train newly employed nurses and 73.5% of them provided in-service training for nurses. Using orientation package/program for the newly employed nurses that clarifies the right and duties of the nurses is essential as Hamad (2009) reported that orientation programs for the newly hired are rarely available or implemented. Also enough time should be given to the newly employed nurses for reviewing and corrections of their actions and to be more oriented to the nursing roles in workplaces and thus to be accountable for their performance. Annex 12 shows that about 71.5% of supervisors reported participating in lectures for nurses. There is a need for more engagement of supervisors in in-service education to improve the skills and knowledge of supervisees. Jarallah and Khoja (1998) found that the majority of supervisors (85.4%) rated training and education as an essential function of supervision.

Of supervisors, 82% reported providing consultation for nurses. About 81% of supervisors discuss with nurses the weakness and strength points in their practice (Annex 12). About 78 % of the supervisors reported providing feedback to the nurses regarding their nursing care. Supervisees need clear feedback about their mistakes; corrections must be transmitted unambiguously so that supervisees are aware of mistakes and weaknesses they may have (Kilminster and Jolly, 2000).

4.1.2.3 Normative Function Domain:

Normative function concerns with the managerial aspects of supervision. The nursing supervisors perceived this domain positively with a percentage of 78.1%, mean: 3.905 and SD: 0.4258.

In order to assess the normative function of clinical supervision the researcher focuses on questions investigating the following; sharing in setting objectives and strategies in the hospital, explaining the objectives of the hospital and department to the nurses being supervised, involvement in decision making in the hospital, involvement in hiring and promotion, performance appraisal for nurses, assessment of the clinical skills of staff, using checklists to evaluate and monitor the nursing intervention, informing the nurses with strength and weakness points and so on. Detailed description of the items under this domain is provided in Annex 13.

Concerning involving supervisors in hiring and promotion of supervisees, 61.2 % of the nursing supervisors reported that they were not involved in hiring and promotion and this is may be attributed to the MOH policy in hiring and promotion (Annex 13). About half of the supervisors were not included in setting hospitals objectives and strategies and this is consistent with Turban (2007) who found that almost of supervisors in PHC were not included in designing the objectives of the hospitals. This result calls for more involvement of supervisors in putting goals, objective and plans of the department to allow them to work effectively toward achieving these goals and thus working on clear plans to eventually attain these goals. Jarallah and Khoja (1998) claimed that the majority of supervisors were included in planning; implementation of plans and coordination of work as essential components of their job but they rated policy-making to be the least essential function of their supervision work (28%).

Annex 13 shows that about half of the supervisors reported that they were not included in decision making and about 35% of them didn't receive support from their managers in decision they made. This result is consistent with Turban (2007) in PHC who found that 37% of supervisors were not participating in decision making. This result may affect badly the supervisors so it is important to include the nursing supervisors in decision making. About 43% of the supervisors reported not being engaged in performing job rotation for supervisees and this result directs toward including them in job rotation especially head nurses to effectively distribute the nursing manpower between departments. Approximately one third of the supervisors did not discuss with their supervisees the performance appraisal to clarify the weakness and strong points in their performance (Annex 13). This result directs toward effectively improving the appraisal system to become more clear and evident to accomplish its aims in correction of the weaknesses and reinforcement of the strengths and not to be a secrete report. Almost of supervisors were satisfied their department needs with medical supplies and equipments and fulfill the shortage in supplies.

4.1.2.4 Restorative Function Domain:

Restorative function aims to alleviate the stresses and tension in the workplace.
The nursing supervisors perceived this domain as the highest positive one among the three domains with percentage of 84.8%, mean 4.2384 and SD0.47305. Detailed description of the items under this domain is provided in Annex 14. All items under this domain are

highly perceived by nursing supervisors especially good communication with nurses and providing them with safety and occupational security. Supervisors need to improve their social interaction with nurses like performing recreational events ....etc.

4.1.3 Inferential Statistics:

Regarding gender, marital status, residency place, certificate, receiving courses in management or clinical supervision, receiving incentives for supervision position and experience in supervision, there were no statistically significant differences in the mean of the overall perceptions and the clinical nursing supervision domains (Annexes 15).

Table 4.4: Differences in clinical nursing supervision domains by job title

Dependent variable "CS domains"	Independent variable "Job title"	N	Mean	SD	t	Sig.
Normative function	Head nurses	74	4.003	0.381	3.231	0.002*
	Nursing supervisors	58	3.771	0.445		
Formative function	Head nurses	74	4.034	0.397	4.373	0.000*
	Nursing supervisors	58	3.655	0.596		
Restorative function	Head nurses	74	4.315	0.483	2.280	0.024*
	Nursing supervisors	57	4.128	0.439		
Overall perception	Head nurses	74	4.115	0.368	3.635	0.001*
	Nursing supervisors	58	3.865	0.420		

***Statistically significant**

The researcher used the t-test to examine the clinical nursing supervision domains by job title. Table 4.4 shows that there were statistical significant differences in the mean of the overall perceptions and the clinical nursing supervision domains (formative, normative and restorative) functions between head nurses and nursing supervisor at P value < 0.05.

Results illustrate that the head nurses had more positive perceptions (higher mean) than nursing supervisors and this may be due to the clinical nature of the work of head nurses as they are in direct contact with both nurses and patients more than nursing supervisors as their work tend to be managerial rather than clinical.

Table 4.5: Differences in clinical nursing supervision domains by age group

Dependent variable "CS domains"	Independent variable (Age group)	N	Mean	SD	F	Sig.
Normative function	up to 30	25	3.760	0.483	2.378	0.056
	31-37	19	3.798	0.506		
	38-45	49	4.003	0.382		
	46-50	22	3.950	0.346		
	over 50	11	4.095	0.282		
	Total	126	3.922	0.421		
Formative function	up to 30	25	3.691	0.554	2.517	0.045*
	31-37	19	3.777	0.568		
	38-45	49	3.990	0.443		
	46-50	22	3.990	0.471		
	over 50	11	4.084	0.249		
	Total	126	3.907	0.491		
Restorative function	up to 30	25	4.099	0.451	2.136	0.080
	31-37	19	4.046	0.644		
	38-45	49	4.356	0.420		
	46-50	22	4.271	0.460		
	over 50	10	4.311	0.466		
	Total	125	4.239	0.485		
Overall perception	up to 30	25	3.856	0.442	2.947	0.023*
	31-37	19	3.875	0.529		
	38-45	49	4.117	0.355		
	46-50	22	4.066	0.342		
	over 50	11	4.176	0.272		
	Total	126	4.025	0.408		

* Statistically significant

One way ANOVA was used to examine clinical nursing supervision domains by age group. Table 4.5 shows statistically significant differences in the mean score in the overall perceptions (sig. = 0.023) and in the mean score of formative function (sig. = 0.045) regarding to the age group. Also there were no statistically significant differences in the mean score of normative function and restorative function at $\alpha = 0.05$.

LSD test shows that supervisors at age group (38-45) and at age group (46-50) had more positive perceptions than other age groups and this may be due to their experience in nursing as we noticed that age of supervisors is closer to the middle group 38-50. This result was inconsistent with Turban (2007) who found no statistical differences in the perception of supervisors by age groups.

Table 4.6: Correlation between clinical nursing supervision and experience in nursing and supervision

Dependent variable "CS domains"		Independent variable	
		Experience in nursing	**Experience in supervision**
Normative function	Correlation	0.343**	0.064
	Sig.	0.000	0.466
Formative function	Correlation	0.323**	0.154
	Sig.	0.000	0.076
Restorative function	Correlation	0.266**	0.023
	Sig.	0.002	0.790
Overall perception	Correlation	0.357**	0.097
	Sig.	0.000	0.268

Table 4.6 shows the correlation between experience in nursing and clinical nursing supervision domains and there is positive association between experience in nursing and overall perceptions, normative function, formative and restorative functions at $\alpha = 0.05$.

This result indicates that experience in nursing affects the perception of supervisors toward clinical nursing supervision and this means that perception of clinical nursing supervision by nursing supervisors increases as the experience in nursing increases.

There was no significant correlation between experience in supervision and overall perceptions of nursing supervisors about the clinical nursing supervision. This result means that perception about supervisors is not affected by their experience in supervision. This result disagrees with Turban (2007) who found no statistical differences between experiences in organization and perceptions of supervisors regarding domains of the study but agreed with her result regarding experiences in supervision and perceptions of supervisors regarding domains of the study that revealed no statistical differences. These results disagree with Bowles and Young (1999) who found positive correlation between experience in clinical supervision and the perceived benefits of its functions.

Table 4.7: Differences in clinical nursing supervision domains by experience in nursing

Dependent variable "CS domains"	Independent variable (Nursing experience)	N	mean	SD	F	Sig.
Normative function	5 and less	10	3.663	0.395	5.638	0.001*
	6 - 15	52	3.781	0.477		
	16 - 25	55	3.995	0.349		
	More than 25	16	4.147	0.327		
	Total	133	3.905	0.426		
Formative function	5 and less	10	3.636	0.502	4.957	0.003*
	6 - 15	52	3.711	0.633		
	16 - 25	55	3.995	0.417		
	More than 25	16	4.135	0.279		
	Total	133	3.874	0.530		
Restorative function	5 and less	10	4.032	0.428	4.059	0.009*
	6 - 15	52	4.104	0.475		
	16 - 25	55	4.365	0.450		
	26+	15	4.379	0.435		
	More than 25	132	4.238	0.473		
Overall perception	5 and less	10	3.779	0.375	6.492	0.0001*
	6 - 15	52	3.872	0.459		
	16 - 25	55	4.118	0.336		
	More than 25	16	4.227	0.295		
	Total	133	4.009	0.412		

*** Statistically significant**

One way ANOVA was used to examine clinical nursing supervision domains by experience in nursing. Table 4.7 shows that there were statistical significant differences in the mean score of overall perception (Sig = 0.0001), normative function (sig. = 0.001), formative function (sig. = 0.003) and restorative function (sig. = 0.009) according to experience in nursing. LSD test shows that the supervisors who had experience in nursing "more than 26 years and from 16 to 25 years of nursing experience" had more positive perceptions than the less nursing experienced supervisors. Turban (2007) in her study on supervision at PHC didn't find statistical differences between study domains and years of experience in supervision position and at organizational experiences

4.2 Supervisee's' Part

This part concerns with supervisees (nurses) and included descriptive statistics (demographical, organizational and supervision related variables), perceptions regarding study domains and inferential statistics.

4.2.1 Descriptive Part

4.2.1.1 Demographical Variables:

Table 4.8: Distribution of supervisees by demographic data

Variable	Categories	Count	%
Gender	Male	139	51.5%
	Female	131	48.5%
Age group	20-30 years	196	75.1%
	31-40years	21	8%
	41-50 years	32	12.3%
	Over 50 years	12	4.6%
	Total	261	100%
Residency place	North Gaza	37	13.8%
	Gaza	62	23%
	Mid zone	65	24.2%
	Khan-younis	66	24.5%
	Rafah	39	14.5%
	Total	269	100%
Marital status	Not- married	86	32%
	Married	183	68%
	Total	269	100%
Academic qualification	Diploma (2 and 3 years)	153	56.4%
	Bachelor	118	43.6%
	Total	271	100%

Table 4.8 shows that the highest percentage of respondents according to residency place was in Khan-younis Governorate (24.5%). Regarding marital status, 68% of respondents were married and 32% were not married. Regarding academic qualifications, the majority of respondents had Diploma (2 and 3 years) with 56.4% and about 43.6% had bachelor

degree. About three-quarters of the participants were aged 20-30 years and this reinforce the importance for implementing effective clinical nursing supervision because of young age of supervisees who needs guidance and support. The provided supervision will benefit them for a long period.

Figure 4.7 shows that males represented 51.5% of the respondents, and females represented 48.5%. Females were relatively equal to males and this in contrast to supervisors that show male dominance in supervisory positions and this also calls for increasing the representation of females in supervisory positions especially in female departments in order to improve supervisory relationships and enhance communications.

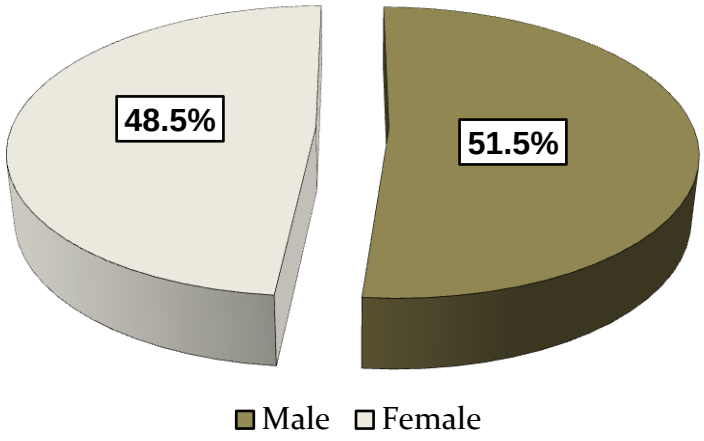


Figure 4.7: Distribution of supervisees (nurses) by gender

Figure 4.8 shows that the majority of the respondents were at the age group 20-30 years with a percentage of 75.1% of respondents, with a mean of 29.6 years, SD 9.1.

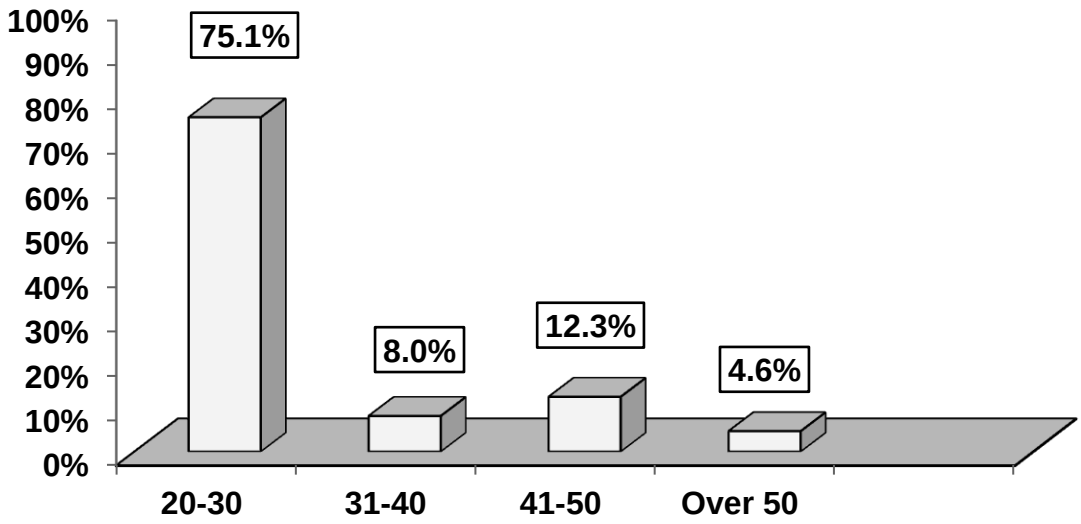


Figure 4.8: Distribution of supervisees by age categories

4.2.1.2 Organizational Variables:

Table 4.9: Distribution of supervisees by organizational variables

Variable	Category	Count	%
Years of experience	**5 years and less**	193	71.8%
	6 - 15	40	14.8%
	16 - 25	24	8.9%
	More than 25	12	4.5%
	Total	269	100%
	M= 6.68, **Median**= 3, **SD**= 7.79.		
Job description	**Yes**	177	66.3%
	No	90	33.7%
Work at department of preference	**Yes**	213	79.8%
	No	56	20.8%
Aware about benefits package	**Yes**	205	76.8%
	No	62	23.2%
Know clinical duties	**Yes**	249	92.2%
	No	21	7.8%
Engaged in training courses within the hospital performed by supervisors	**Yes**	89	33.35%
	No	178	66.7%
Engaged in training courses outside the hospital	**Yes**	136	50.4%
	No	134	49.6%

Table 4.9 shows that 71.1% of the respondents had an experience in nursing for 5 years and less, (mean 6.7 years, SD 7.8). The experience of supervisees was relatively short and this points to the importance of the implementation of the clinical nursing supervision performed by expert supervisors. Less experienced supervisees need more training to develop and improve their skills and practice.

About 66.3% of respondents reported that they had job descriptions and 76.8% of them knew their job benefits package. These results refer to increasing the knowledge of supervisees about their rights and duties. In the MOH, there is no clear job description for hospital professionals not only nurses. It seems there was confusion among nurses about their job descriptions and what it means. Many of the supervisees claimed that they work

on the principle "This Is What We Saw our Fathers" and this make the care delivery fragmented and unclear and increases the conflicts between health care providers and make the nurses overload with non-nursing practices. We recommend to clearly documenting job description and job specification for health care providers in order to decrease role ambiguity among nurses and improve accountability.

The majority of the supervised staff were working at their preferable departments and this increases the performance of supervisees as they like themselves in their current workplaces. This result is consistent with Turban (2007) who found that supervisees in PHC were working in their preferable departments. Working in the preferable department increases the productivity of the employees and make experiences in the field more interesting. However, job rotation may cause stress because people tend to avoid change but there are many advantages for job rotation as it makes employees experience less boredom, greater task variety, and less feeling of task repetition (Mc Donough, 2010).

One third of the participants were engaged somewhat in training courses within their hospitals; implemented by supervisors; while half of participants were engaged in training courses outside their hospitals. These results indicate that there is a deficit in performing training courses in the hospitals and inadequate activities for that there is a great demand to effectively activate on-the-job training especially because the supervisees were less experienced as mentioned before. The value of training is reported extensively in the literature.

4.2.1.3 Supervision-Related Variables:

Table 4.10 shows that the majority of the supervised staff reported that their supervisors reviewed with them the medical file of the patients and the daily reports by (71%); yet 29% did not perform this. The majority of the supervisees (78%) received an orientation at the beginning of their work from their supervisors and this calls for designing of orientation program to be available for the newly employed nurses that identifies the rights and duties of nurses from the beginning for all nurses. Current orientation program require implementations and revisions.

Table 4.10: Distribution of supervisees by supervision related variables

Variable	Category	Count	%
Supervisor reviewed with nurses medical files and daily reports	Yes	191	71
	No	78	29
	Total	169	100.0
Nurses received an orientation at the beginning of their work from their supervisors	Yes	211	78.1
	No	59	21.9
	Total	270	100
Satisfaction about the clinical supervision of the head nurses.	Strongly agree	61	22.6
	Agree	160	59.2
	Don't know	14	5.2
	Not Agree	20	7.4
	Strongly not agree	15	5.6
	Total	270	100
Satisfaction about the clinical supervision of nursing supervisors.	Strongly agree	19	7
	Agree	149	55.4
	Don't know	33	12.3
	Not Agree	42	15.6
	Strongly not agree	26	9.7
	Total	269	100

Around 89% of the respondents were satisfied about the clinical supervision they received from their head nurses and about 62.5% were satisfied about the clinical supervision of their nursing supervisors. The high level of satisfaction for head nurses more than nursing supervisors may be related to the close contact of head nurses to the nurses under their supervision rather than nursing supervisors who made less contact with them.

Figure 4.9 shows that there were only 18.8% of participants reporting that their supervisors visit them one visit during each working shift, 44.7% answered that their supervisors were visiting them two visits during working day and 36.5% of them reported that their supervisors visited them three times and more. This result is considered satisfactory as one nursing supervisor is responsible for many departments in the hospital in the evening and night shifts so there is a need to increase the number of supervisors in these working shifts to increase the time for supervisors to effectively supervising the employees and their

works. A question is remained about the type of supervisory activities provided during these visits.

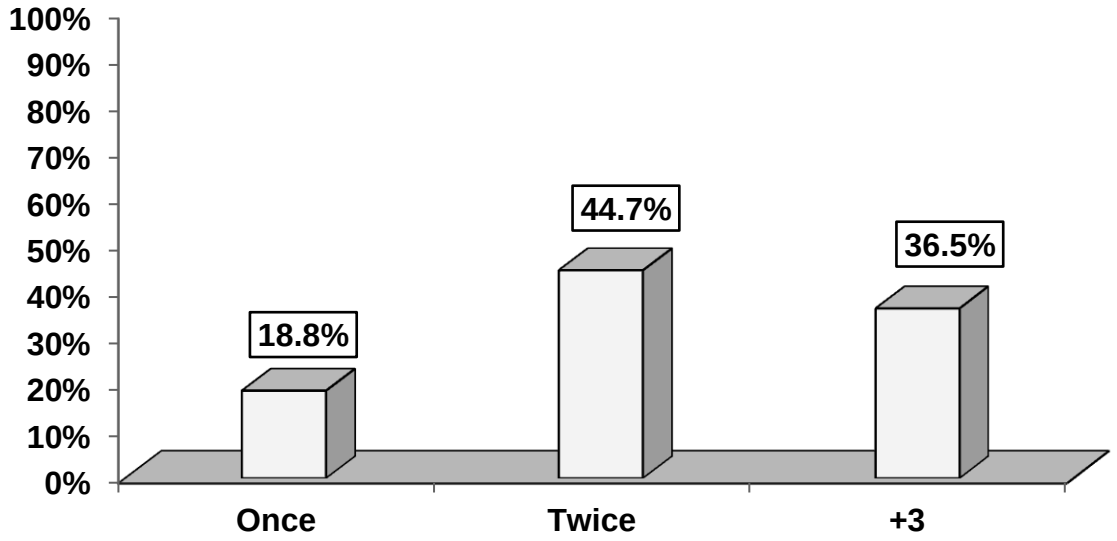


Figure 4.9: Distribution of supervisees by number of supervisor visits

4.2.2 Nursing Supervisees Domains:

The researcher used the same clinical nursing supervision domains that were used in the supervisors' part (Formative, Normative and Restorative Function) in order to assess supervisees' perceptions toward their supervisors' performance. The nursing supervisees reported relatively positive perceptions toward their supervisors' roles and responsibilities as illustrated in table 4.11.

Table 4.11: Distribution of clinical nursing supervision domains as perceived by nursing supervisees

Clinical nursing supervision domains	Number of items	Mean	SD	Percent
Formative function	9	3.19	0.99	63.88%
Normative function	21	3.51	0.82	70.22%
Restorative function	14	3.59	0.70	71.75%
Overall perception	44	3.43	0.77	68.66%

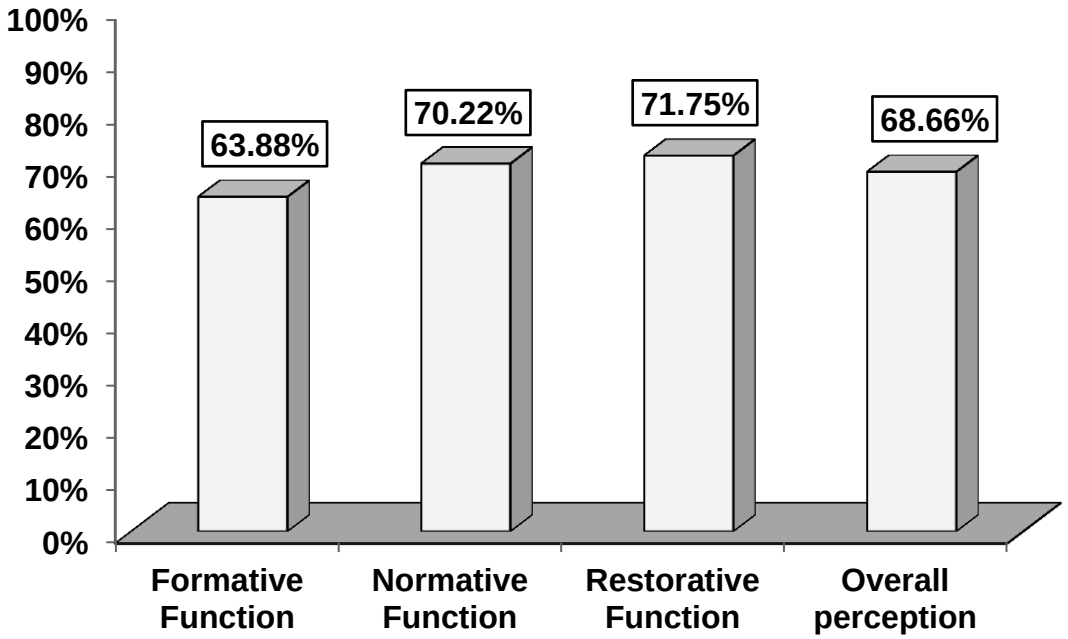


Figure (4.10): Percent of clinical nursing supervision domains

4.2.2.1 Overall Perception:

The overall perception of the clinical nursing supervision domains as revealed by supervisees was 68.66% and the mean was 3.43 (maximum 5). This means that the nursing supervisees had relatively positive perceptions toward roles and responsibilities of their supervisors. As we see in table 4.11, the mean of clinical nursing supervision domains ranges from 3.19 to 3.59. The mean of the overall perception was 3.43 with a total percent of 68.7. The highest percentage was in the restorative function and the lowest was in the formative function.

The perception of supervisees is lower than the supervisors as the mean of overall perceptions for supervisors was 4.010 and for supervisees was 3.43. The supervisees as supervisors perceived restorative function as the highest function performed and the formative function as the lowest one. Bowles and Young (1999) found that supervisees perceived benefits from the three functions positively with normative functions most highly rated and the formative function was the least rated one. Kilcullen (2007) found that clinical nursing supervisees in addition to the supervisors were positively perceived the clinical supervision. She also found that the restorative function was highly rated by this study group. The other two elements of the model (normative and restorative functions)

were also well rated. Teasdale, et al. (2001) found that nurses who are clinically supervised reported positive perceptions toward their supervisors than those who didn't.

4.2.2.2 Formative Function Domain:

Formative function focuses on increasing the supervisees' knowledge and skills. The nursing supervisees perceived this domain as the least positive one among the three domains with percentage of 63.8%. Detailed description of the items under this domain is provided in Annex 16. The supervisees reported that they didn't receive a satisfactory level of on the job training and this calls for the needs for effective and well- organized on the job training program to improve the knowledge and skills of the supervisees and to involve the nursing supervisors in these activities. Training may be performed by expert employee in case of overload on supervisors. The results imply that supervisees return to their supervisors in case of suspicion and this indicates the good communication and trust relationship between supervisees and their supervisors.

4.2.2.3 Normative Function Domain:

Normative function concerns with the managerial aspects of supervision that focus on accountability, attaining the organizational goals and quality improvement. The nursing supervisees perceived this domain positively with a percentage of 70.2%, mean: 3.51 and SD: 0.82. Detailed description of the items under this domain is provided in Annex 17.

About 50 % of the supervisees reported that they were not engaged in the performance appraisal for themselves and for their peers and they also reported that they didn't receive feedback about their appraisal to know their weak and strong points in the appraisal (Annex 17). As the results indicate that special attention on the used appraisal system should be done to include peer review and provide feedback for supervisees about the appraisal in order to identify the weak and strong points in order to improve the weak and reinforce the strong.

Annex 17 shows that about 50% of the supervisees claimed that they didn't receive explanation about the aim of job rotation when they were being rotated. This result directs toward the need for discussion with supervisees about job rotation and explaining the aims and benefits from job rotation to decrease the tension on the supervisees when they suddenly turned to another department. Approximately 60% of the supervisees and 50% of supervisors were involved in decision making and this reflects the relatively centralized

management style. Both supervisors and supervisees need to be involved in decision making. As Annex 17 illustrated, around 85% of the supervisees know their duties and responsibilities and about 75% of them said that their supervisors explained to them their duties and responsibilities. About 77% of the supervisees reported that their supervisors assure the quality of care they provide to the patients.

4.2.2.4 Restorative Function Domain:

Restorative function aims to alleviate the stresses and tension in the workplace. The nursing supervisees perceived this domain as the highest positive one among the three domains with a percentage of 71.7%, mean: 3.59 and SD: 0.70. Detailed description of the items under this domain is provided in Annex18.

The supervisees reported a weak area in the supervisors' communication with supervisees especially in sharing them with their celebrations (Annex 18). About 40% of the supervisees claimed that there is a role conflict between supervisors. The relationship between supervisors and supervisees seems to be good as reported by almost of supervisees and this is considered as a strong point in the supervisory system and this consistent with Turban (2007) who found that supervisees showed positive perception in communication and support domain in her study.

4.2.3 Inferential Statistics:

Regarding marital status, residency place, and receiving training courses outside hospitals, there were no statistically significant differences in the mean of overall perceptions and the clinical nursing supervision domain (Annex 19)

An independent t-test was used to examine the clinical nursing supervision domains by gender. Table 4.12 shows that there were statistical significant differences in mean of overall perception (Sig=0.004), normative function (Sig=0.004), formative function (Sig=0.022) and restorative function (Sig=0.001) between male and female.

This result indicates that female nursing supervisees had more positive perceptions than male about clinical nursing supervision they received. This is inconsistent with Turban (2007) who found that there were no statistical significances in gender in reference to the perceptions toward supervisory domains in her study.

Table 4.12: Differences in clinical nursing supervision domains by gender

Dependent variable "CS domains"	Independent variable (Gender)	N	Mean	SD	t	Sig.
Normative function	male	139	3.373	0.862	-2.896	0.004*
	female	131	3.658	0.747		
Formative function	male	137	3.060	1.071	-2.302	0.022*
	female	128	3.338	0.882		
Restorative function	male	137	3.447	0.743	-3.434	0.001*
	female	128	3.738	0.630		
Overall perception	male	139	3.304	0.822	-2.881	0.004*
	female	131	3.569	0.678		

*** Statistically significant**

One way ANOVA was used to examine the clinical nursing supervision domains by age group. Table 4.13 shows that there were statistically significant differences in the mean score of the overall perception (Sig= 0.008), normative function (Sig = 0.025), formative function (Sig= 0.030) and restorative function (Sig = 0.001) in regard to age groups. This result is inconsistent with Turban (2007) who found that there were no statistical significant differences in the age groups of supervisees and supervision domains in her study.

LSD test shows that supervisees at age group 41-50 had more positive perceptions than the supervisees at age group 20-30 in the normative function domain and there were no any other statistical differences between other age groups. LSD test shows that supervisees at age group 31-40 and 41-50 had more positive perceptions in the formative function domain than supervisees at age group 20-30 and there were no any other statistical differences between other age groups in overall perception. LSD test shows that supervisees at age group 41-50 had more positive perceptions in the restorative function domain than the supervisees at age group 20-30 and 31-40 and there were no any other statistical differences between other age groups.

LSD test shows that supervisees at the age group 41-50 had more positive perceptions than the supervisees at age group (20-30) in overall perception and there were no any other statistical differences between other age groups in overall perception.

Table 4.13: Differences in clinical nursing supervision domains by age group

Dependent variable (CS domains)	Independent variable (Age group)	N	mean	SD	F	Sig.
Normative function	20-30	196	3.413	0.838	3.181	0.025*
	31-40	21	3.692	0.743		
	41-50	32	3.818	0.729		
	More than 50	12	3.761	0.719		
	Total	261	3.501	0.824		
Formative function	20-30	192	3.083	1.000	3.019	0.030*
	31-40	20	3.588	0.835		
	41-50	32	3.488	0.962		
	More than 50	12	3.370	0.757		
	Total	256	3.187	0.986		
Restorative function	20-30	192	3.496	0.718	5.443	0.001*
	31-40	20	3.603	0.653		
	41-50	32	4.016	0.580		
	More than 50	12	3.752	0.585		
	Total	256	3.581	0.710		
Overall perception	20-30	196	3.333	0.779	4.068	0.008*
	31-40	21	3.631	0.640		
	41-50	32	3.774	0.698		
	More than 50	12	3.628	0.629		
	Total	261	3.425	0.767		

*** Statistically significant**

An independent t-test was used to examine the clinical nursing supervision domains by qualification. Table 4.14 shows that there were statistical significant differences in mean of overall perception (Sig=0.003), normative function (Sig=0.004) and formative function (Sig=0.004) between Diploma and Bachelor. There were no significant differences in mean of restorative function at $\alpha = 0.05$ (Sig=0.057). This result indicates that supervisees who have Diploma certificate had more positive perceptions than those who have Bachelor certificate in the overall perception, normative, and formative functions and there is differences in their perceptions in restorative function. This result is inconsistent with

Turban (2007) who found no statistical differences between academic certificate and domains of her study.

Table 4.14: Differences in clinical nursing supervision domains by qualification

Dependent variable "CS domains"	Independent variable (Certificate)	N	Mean	SD	t	Sig.
Normative function	Diploma (2 &3) years	152	3.637	0.813	2.906	0.004*
	Bachelor	118	3.349	0.803		
Formative function	Diploma (2 &3) years.	150	3.349	1.012	2.940	0.004*
	Bachelor	115	2.993	0.932		
Restorative function	Diploma (2 &3) years.	150	3.660	0.724	1.910	0.057
	Bachelor	115	3.494	0.669		
Overall perception	Diploma (2 &3) years.	152	3.553	0.772	2.975	0.003*
	Bachelor	118	3.278	0.733		

*** Statistically significant**

One way ANOVA was used to examine supervision domains by years of experience. Table 4.15 shows that there were statistically significant differences in the mean score of overall perception (Sig = 0.028) and restorative function (Sig. = 0.003) according to years of experience. The test also shows that there were no significant differences in the mean score of the normative function and formative functions at $\alpha = 0.05$.

LSD test shows that supervisees at years of experience from (16-25) had more positive perception than the other groups (5 and less) and (6 – 15 years). Turban (2007) found no statistical difference between years of experience of supervisees and their perception of supervisory domains

Table 4.15: Differences in clinical nursing supervision domains by years of experience

Dependent variable (CS domains)	Independent variable (Years of experience)	N	mean	SD	F	Sig.
Normative function	5 &less	192	3.437	0.816	2.206	0.088
	6 – 15	40	3.554	0.856		
	16 – 25	24	3.850	0.752		
	25 &more	12	3.714	0.672		
	Total	268	3.504	0.817		
Formative function	5 &less	188	3.100	0.993	1.798	0.148
	6 - 15	39	3.316	1.023		
	16 - 25	24	3.535	0.883		
	25 &more	12	3.324	0.795		
	Total	263	3.182	0.985		
Restorative function	5 &less	188	3.509	0.708	4.740	0.003*
	6 - 15	39	3.610	0.692		
	16 - 25	24	4.051	0.614		
	25 &more	12	3.788	0.562		
	Total	263	3.586	0.707		
Overall perception	5 &less	192	3.351	0.767	3.067	0.028*
	6 - 15	40	3.497	0.772		
	16 - 25	24	3.812	0.700		
	25 &more	12	3.609	0.592		
	Total	268	3.426	0.764		

*** Statistically significant**

Table 4.16: Differences in clinical nursing supervision domains by working at department of preference

Dependent variable "CS domains"	Independent variable (working at department of preference)	N	Mean	SD	t	Sig.
Normative function	Yes	212	3.686	0.762	-7.494	0.0001*
	No	56	2.844	0.693		
Formative function	Yes	208	3.362	0.959	-5.772	0.0001*
	No	55	2.542	0.848		
Restorative function	Yes	208	3.722	0.614	-6.817	0.0001*
	No	55	3.051	0.771		
Overall perception	Yes	212	3.595	0.706	-7.572	0.0001*
	No	56	2.802	0.661		

*** Statistically significant**

An independent t-test was used to examine the clinical nursing supervision domains by the working at department of preference. Table 4.16 shows that there were significant statistical differences in mean of overall perception (Sig = 0.0001), normative function (Sig=0.0001), formative function (Sig=0.0001) and restorative function (Sig=0.0001) between supervisees working at their favorite department and those who are not.

This result agreed with Turban (2007) who found that there were statistical significant differences between working at preferable department and the overall perception toward supervisory domains and sub-scale domains (management behavior, communication, support domains) and no statistical significant difference in sub- scale (fairness and involvement). These results indicate that supervisees who were working at favorite department had more positive perceptions toward clinical nursing supervision they received from their supervisors than who were not. Turban, 2007 recommended to recruit persons at places they preferred to increase the productivity and quality of care and we also recommend that to create specialty of experience.

Table 4.17: Differences in clinical nursing supervision domains by engagement in on the job training

Dependent variable "CS domains"	Independent var. " Engagement in on- job training"	N	Mean	SD	t	Sig.
Normative function	Yes	89	3.758	0.817	-3.640	0.0001*
	No	177	3.379	0.794		
Formative function	Yes	86	3.493	0.958	-3.494	0.001*
	No	175	3.047	0.975		
Restorative function	Yes	86	3.789	0.631	-3.324	0.001*
	No	175	3.485	0.723		
Overall perception	Yes	89	3.692	0.728	-4.065	0.0001*
	No	177	3.298	0.753		

*** Statistically significant**

An independent t-test was used to examine the clinical nursing supervision domains by engagement in on-the-job training. Table 4.17 shows that there were significant statistical differences in mean of overall perception (Sig = 0.0001), normative function (Sig=0.0001), formative function (Sig=0.001) and restorative function (Sig=0.001) between supervisees who were engaged in on- job training and those who are not. Supervisees who were

engaged in on- job training had more positive perception than who were not. This result is inconsistent with Turban (2007) who found that there were no statistical significant differences between engagement in-service education and the supervisees' perception toward supervisory domain except in involvement domain. This result calls for creating well organized program for in-service education and training to improve the knowledge and skills of supervisees based on the needs of the supervisees.

Table 4.18: Differences in clinical nursing supervision domains by receiving enough orientation at beginning of work

Dependent Variable (CS domains)	Independent variable (Receiving adequate orientation at work beginning)	N	Mean	SD	t	Sig.
Normative function	Yes	210	3.689	0.756	-7.367	0.0001*
	No	59	2.875	0.726		
Formative function	Yes	206	3.381	0.946	-6.210	0.0001*
	No	58	2.523	0.870		
Restorative function	Yes	206	3.730	0.619	-6.622	0.0001*
	No	58	3.086	0.768		
Overall perception	Yes	210	3.605	0.695	-7.671	0.0001*
	No	59	2.819	0.698		

*** Statistically significant**

Table 4.18 shows an independent t-test which used to examine the clinical nursing supervision domains by receiving adequate orientation at the startup of the work. Table 4.18 shows that there were significant statistical differences in mean of overall perception (Sig = 0.0001), normative function (Sig= 0.0001), formative function (Sig= 0.0001) and restorative function (Sig= 0.0001) between supervisees who had received orientation at work beginning and those who didn't. Supervisees who had received orientation at work beginning had more positive perceptions than who didn't. This result is pointing to the need for developing of effective orientation program that explains the job description, organization charts, job benefits package and so on.

Table 4.19: Correlation between clinical nursing supervision domains and satisfaction about head nurses and nursing supervisors:

Dependent Variable (CS domains)		Satisfaction about head nurses	Satisfaction about supervisors
Normative function	Correlation	0.607	0.554
	Sig.	0.0001*	0.0001*
Formative function	Correlation	0.513	0.447
	Sig.	0.0001*	0.0001*
Restorative function	Correlation	0.541	0.445
	Sig.	0.0001*	0.0001*
Overall perception	Correlation	0.607	0.529
	Sig.	0.0001*	0.0001*

*** Statistically significant**

Table 4.19 shows correlation between **satisfaction about head nurses** and clinical nursing supervision domains. There is a relationship between **Satisfaction about head nurses** and overall perception, normative functions, formative functions, and restorative functions at P value < 0.05. Table 4.18 shows correlation between **satisfaction about supervisors** and clinical nursing supervision domains and there is a relationship between **satisfaction about supervisors** and overall perception, normative functions, formative functions and restorative functions at P value < 0.05.

These results indicate that there is positive relationship between supervisees' satisfaction about their supervisors (head nurses and nursing supervisors) and their perception about the clinical nursing supervision they received from their supervisors.

Chapter (5): Conclusion and Recommendation

5.1 Conclusion

This study aims to assess the clinical nursing supervision at governmental hospitals in Gaza governorates from the perspectives of both nursing supervisors and supervisees. It was a descriptive, analytical and cross sectional study. One hospital from each governorate from the five governorates was selected randomly. The target population classified into two groups: the first group was nursing supervisors which included head nurses and nursing supervisors and the second was supervisees (nurses). All supervisors were included in the study and proportional systematic random sample was selected for the supervisees group. The response rate for supervisors was 83.1% and for the supervisees it was 90%.

The study tool was a self- administered questionnaire for both supervisors and supervisees. Both questionnaires contained demographic, organizational and supervisory variables in addition to the study domains that reflect the functions of clinical nursing supervision based on the Proctor's (1987) Interactive model which includes: formative, normative and restorative functions. Male supervisors were more dominant in the study so more presentation of females in supervisory positions especially in women wards is necessary. The majority of the supervisors were young and this is a chance for developing their skills and knowledge by training on supervision. Subjects' experiences in nursing were high but their experience in supervision was relatively limited. Two thirds of the supervisees had experience of 5 years and less. Only 22.7% of the supervisors had received training on supervision and about 34% of supervisees reported being trained by their supervisors inside their hospitals. These results regarding training imply that it is crucial to effective clinical supervision for both supervisors who were less experienced in supervision and for supervisees who were less experienced in nursing. Supervisees were satisfied from head nurses more than from nursing supervisors regarding CS they received and this may be related to the availability of head nurses more than nursing supervisors to the staff. There was severe gap in the usage of checklists as a supervisory tool and this calls for developing checklists for supervision and for nursing procedures to effectively improving the quality of nursing care.

Supervisors had more positive perceptions about the adopted supervision domains than the supervisees. The overall perception of supervisors toward supervision domains was 80.2% while supervisees overall perception was 68.6%.

Both supervisees and supervisors perceived the formative function as the least one (63.8% and 77.5%) respectively while both of them perceived restorative function as the highest one (71.7% and 84.2%) respectively. The supervisors scored their roles in the normative function as 78.1% while supervisees scored it as 70.2%. These variations in the perception of supervisors and supervisees call for further evaluation studies to explore and evaluate the system of supervision in more objective manner. Meanwhile, the formative function which is considered as the core function of clinical supervision, both the supervisors and the supervisees perceived it as the least one of the three functions. We can conclude that the existing supervision system at governmental hospital is relatively administrative rather than clinical. There was absence of clear supervision policy that clarifies the roles of the supervisors, supervisees, methods of supervision, supervisory activities, models of supervision, and time for supervisory session ...etc. Absence supervision policy made the supervision process vague, complex, non-organized and not a systematic process.

Involvement of supervisors in setting the hospital objectives is also necessary and participation in decision making is important as these roles were poorly perceived. The used appraisal system was an issue that requires an improvement as half of the supervisees did not participate in the appraisal of themselves and their peers and they did not receive feedback for their appraisal performance. Job rotation was a problem for both supervisors and supervisees as about half of the supervisors were not engaged in job rotation and about half of the supervisees reported that their supervisors did not explain the aim and benefits of job rotation. About 60% of the supervisees reported that there was a role conflict between supervisors. The relationship between supervisees and supervisors was good.

Some demographic, organizational and supervisory variable were statistically tested to explore its effects on the perception of the supervisees and supervisors toward study domains (formative, normative and restorative functions). Regarding marital status, residency place, certificate, receiving courses in supervision, receiving incentives for supervision position and experiences in supervision showed no statistically significant differences in the overall perception of supervisors regarding study domains.

The head nurses had more positive perception toward their supervisory roles than nursing supervisors. Nursing experience plays a role in shaping the overall perception and study domains; supervisors who are more experienced had more positive perceptions than the experienced ones.

In supervisee's part, marital status, residency place, receiving training courses outside hospitals showed no statistically significant differences in the mean of the overall

perception and clinical nursing supervision domains. Female nursing supervisees had more positive perceptions than males about clinical nursing supervision they received. Regarding age group the study showed statistically significant differences between supervisees' perceptions at different age groups. Supervisees at age group (41-50) had more positive perceptions than other age groups. Supervisees who hold diploma certificate had more positive perceptions than those who hold bachelor. Supervisees who have experience of 16-25 years had more positive perception in the overall perceptions, and restorative functions than other groups. Supervisees who were working in their preferable department had more positive perceptions than those who were not. Supervisees who received an adequate orientation program had perceived the role of their supervisors more positively than those who were not received. Supervisees who were engaged with on- job training had more positive perceptions regarding their supervisors' roles than those who were not engaged.

There was positive relationship between supervisees' satisfaction about their supervisors work and their perceptions toward the clinical nursing supervision they received.

Special attention for training, education, appraisal system, involvement of supervisors in objectives of the hospitals and in decision making should be made. Also, increasing presentation of female supervisors in supervision positions, ensuring the availability of supervisory tools especially checklists and formulation of supervision policy that regulate the supervisory relationship are priority areas.

5.2 Recommendations

- Engaging in a dialogue at the policy making level to sensitize policy makers, managers and health providers about the concept and functions of clinical supervision is necessary.
- Formulation of clinical supervision policy that clarifies the roles of supervisors, supervisees and the relationship between them is vital to strengthen supervision system.
- Formative function of clinical supervision was the weakest circle in the supervisory functions; therefore, it should be strengthened.
- A clear distinction between administrative and clinical supervision is necessary to avoid dominance of the administrative functions on the clinical functions of supervision.
- Developing supervisory tools particularity checklists is vital to enable supervisors' ability to effectively perform their functions more effectively.
- Provision of training for both supervisors and supervisees in supervision field is a priority.
- Enhancing the capacity of the supervisors to provide on-the-job training is very important as it takes place at the natural place of work.
- Provision of job descriptions for human resources including supervisors and health care providers in governmental hospitals is a basic necessity that should be urgently done.
- Upgrading the performance appraisal system is necessary.
- Promoting the effective implementation of an orientation program for the newly employed nurses.
- Paying attention to the structure of the organization in order to create a system conducive to effective supervision is crucial. Measures in this regard may include;
    - Considering designing fair span of control (Reasonable number of supervisees per each supervisor).
    - Increasing nurses' managers' involvement in decision making
    - Increasing the number of females supervisors.
    - Reform of the supervisors appointments to be based on nursing experience.

5.3 Recommendations for Further Research

- Further studies on effects of clinical supervision on the quality of care, burnout, turnover, job satisfaction....etc. may be necessary.
- More objective studies by performing clinical supervision intervention and trying to implement it and performing pre and post evaluation studies.
- Assessment of the clinical nursing supervision at nursing students.

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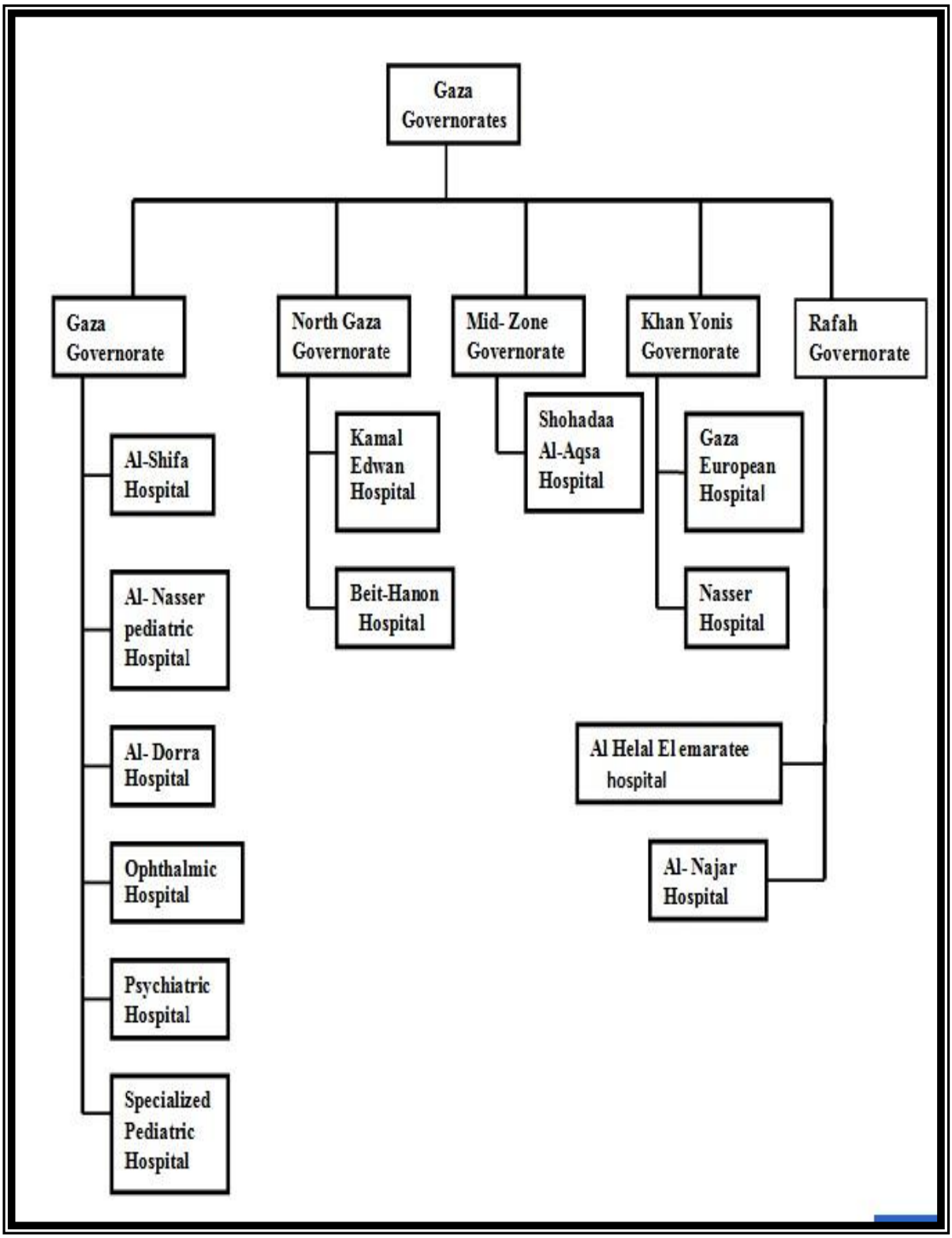
Annex 1: Map of Palestine

PCBS, 2008

Annex (2) Distribution of governmental hospitals according to its location among Gaza governorates



Annex (3): Distribution of head nurses and nursing supervisors among Governmental hospitals in Gaza governorates

No	Governmental Hospital	Number of Head Nurses	Number of Nursing Supervisor	Total
1.	Al- Shifa Hospital	39	27	**66**
2.	Nasser Hospital	25	21	**46**
3.	Gaza European Hospital	11	19	**30**
4.	Al Helal El Emaratee hospital	7	5	**12**
5.	Al- Najar Hospital.	9	7	**16**
6.	Shohadaa Al Aqsa Hospital	12	8	**20**
7.	Nasser Pediatric Hospital	9	8	**17**
8.	Ophthalmic Hospital	5	5	**10**
9.	Specialized Pediatric Hospital	7	7	**14**
10.	Psychiatric Hospital	5	4	**9**
11.	Al Dorra Pediatric Hospital	6	6	**12**
12.	Kamal Edwan Hospital	11	5	**16**
13.	Beit Hanoon Hospital	7	6	**13**
Total		**153**	**128**	**281**

Annex (4): Distribution of nurses among governmental hospitals in Gaza governorate

No	Governmental Hospital	Number of Nurses
1.	Al- Shifa Hospital	439
2.	Nasser Hospital	257
3.	Gaza European Hospital	195
4.	Al Helal El Emaratee hospital	60
5.	Al- Najar Hospital.	66
6.	Shohadaa Al Aqsa Hospital	111
7.	Nasser Pediatric Hospital	89
8.	Ophthalmic Hospital	35
9.	Specialized Pediatric Hospital	55
10.	Psychiatric Hospital	24
11.	Al Dorra Pediatric Hospital	47
12.	Kamal Edwan Hospital	89
13.	Beit Hanoon Hospital	40
	Total	**1507**

Annex (5.1): Questionnaire (1) for supervisor's English copy

Assessment of the Clinical Nursing Supervision at Governmental Hospitals - Gaza Governorates

Dear participant:

This study aims to assess the clinical nursing supervision at governmental hospitals in Gaza governorates as a requirement to obtain a master degree in public health – health management at the Al-Quds University – Palestine.

The researcher ascertains that you are selected randomly and you have the right to refuse participation in this study.

Researcher thanks you for your participation and collaboration in this study that we hope to improve the nursing care at governmental hospitals.

The researcher would like to emphasize that the information will remain confidential and for the purpose of scientific research that does not need to mention your name.

Thank you for your participation

Ramadan Ali Hassan
Mobile: 0599485221
Email: ramadan4ps@yahoo.com

Thesis title: "Assessment of the Clinical Nursing Supervision at Governmental Hospitals - Gaza Governorates"

Code: (……) for researcher

Number: (……) for researcher

Demographical variables:

(1) Sex: 1. Male ☐ 2. Female ☐

(2) Age:…….. years.

(**3) Marital status:** 1. Single ☐ 2. Married ☐

2. Divorced ☐ 4. Widow ☐

(4) Residency place:

1. Gaza Governorate ☐ 2. North Gaza Governorates ☐

3. Mid-zone Governorates ☐ 4. Khan Younis Governorate ☐

5. Rafah Governorate ☐

(5) Academic qualification: 1. Diploma 3 years ☐ 2. Bachelor ☐ 3. Master ☐

4. PHD ☐ 5. others:.....

(6) Place of study: University / college: …….....Country: …….

Organizational variables:

(7) Place of work: Hospital: ……..…….. Department: ….....

Governorate: ……

(8) Job title: 1. Head Nurse ☐ 2. Nursing supervisor ☐

(9) Years of experience in nursing: ……..years.

Supervision related variables

(10) Years of experience in supervision: ……. years.

(11) Number of nurses you supervise: ……. nurses.

(12) Did you receive any training course in clinical supervision or management?

1. Yes ☐ 2. No ☐ **If yes:**

Explain the title of training course, place where it held, and date of your training period.

No.	Training Course	Place	Date
1.			
2.			
3.			
4.			

(13) Dou you have a job description for your supervisory work? 1. Yes ☐ 2. No ☐

(14) Do you have a supervisor? 1. Yes ☐ 2. No ☐

(15) Do you use supervisory methods in your work? 1. Yes ☐ 2. No ☐

if Yes: does it?

☐ 1. Reports

☐ 2. Checklists

☐ 3. Meeting

☐ 4. Work field visits

☐ 5. Others: (Explain): ……..……..

(16) Do you feel satisfied about your supervisory work?

1. Strongly Agree ☐ 2. Agree ☐

3. Disagree ☐ 4. Strongly disagree ☐

(17) Are there continuous meetings between supervisors and head nurses that aim to improve the clinical supervision? 1. Yes ☐ 2. No ☐

(18) Do you receive benefits for your supervisory work? 1. Yes ☐ 2. No ☐

The following questions concern with functions of the clinical nursing supervision (Normative, Formative, and Restorative): please answer the following questions to assess these 3 functions.

(SA) Strongly Agree (A) Agree (DK) Don't Know (SD) Strongly Disagree (D) Disagree

No.	Item	SD	D	DK	A	SD
	1. Normative Function					
(19)	You share in setting of objectives and strategies in the hospital.					
(20)	You explain the objectives of the hospital and department to the nurses you supervise.					
(21)	You can easily identify the work problems.					
(22)	You involved in decision making in the hospital.					
(23)	You involved in hiring and promotion.					
(24)	You coordinate the work flow between the departments in the hospitals.					
(25)	You do performance appraisal for nurses regularly.					
(26)	You assure that medical equipments are working well.					
(27)	You assure that safety devices are working well at the department.					
(28)	You asses the clinical skills of your staff continuously.					
(29)	You discuss the performance appraisal with your staff and explain the weakness and strength points.					

No.	Item	SD	D	DK	A	SA
(30)	You assign the responsibilities for nurses according to their abilities.					
(31)	You assure the quality of nursing care provided to the patients.					
(32)	You follow up the readiness of the department to work in case of emergency.					
(33)	You ensure the readiness of the emergency trolley with drugs and supplies.					
(34)	You assess the work needs.					
(35)	You fulfill the work needs in case of shortage or depletion.					
(36)	You review with the nurses the nursing care plan for patients.					
(37)	You review patients' files to follow up nursing documentation to assure the quality of care provided.					
(38)	You visit the department under your supervision continuously to monitor the work flow and resolve the technical and managerial problems.					
(39)	You play effective and leadership role in the department.					
(40)	You receive enough support from your managers in decision making.					
(41)	You explore the mistakes of nurse.					
(42)	You monitor the nurses coming and leaving.					
(43)	You tend to fulfill the shortage in nurse in case of absence of shortage.					
(44)	You use supervisory tools in supervisory process to monitor and improve the work.					
(45)	You discuss the problems with nurses and resolve it.					
(46)	You use checklists to evaluate and monitor the nursing intervention and inform the nurses with strength and weakness points.					
(47)	You monitor the nurses during providing nursing care for patients to assure its adherence to the approved standards.					
(48)	You engage in nursing rotation between departments.					
	2. Formative Function					
(49)	You assess the needs of nurses and satisfy it.					
(50)	You participate in in-service training for nurses.					
(51)	You provide nurse with updated skills and knowledge.					
(52)	You provide feedback for nurses about their work.					
(53)	You participate in providing lectures for nurses to increase their knowledge and practice.					
(54)	You perform regular meeting with nurses to improve nursing services.					
(55)	You participate in training for newly employed nurses.					
(56)	You assess and measure the level of professional development for nurse.					
(57)	You develop the professional and occupational performance of the nurses.					
(58)	You discuss with nurses the strength and weakness points.					
(59)	You provide consultation for nurses.					

No.	Item	SD	D	DK	A	SA
(60)	You link between nurse's experience and hospital's needs.					
(61)	You train nurses on nursing medical equipment in effective way.					
(62)	You train the nurses on used protocols and guideline used in the work like safety manual, infection control guidelines …. Etc.					
(63)	You provide enough orientation for newly employed nurses through out orientation program in hospital.					
3. Restorative Function						
(64)	You build team work in hospital.					
(65)	You motivate and encourage the nurses.					
(66)	You communicate with nurses in a good and respective manner.					
(67)	You appreciate the ideas and suggestion of nurses and take it into account.					
(68)	You understand the social and cultural aspects in the hospital.					
(69)	You criticize the nurses in a constructive manner.					
(70)	You provide enough support for nurses.					
(71)	You alleviate the tension of nurses and provide them occupation security.					
(72)	You share social activities with your staff.					
(73)	You assure patient's safety.					
(74)	You assure nurse's safety.					
(75)	You manage conflicts between staff in hospital effectively.					
(76)	You support nurses during work stress and crisis.					
(77)	You approximate between nurses and patients.					
(78)	You approximate between nurses and other professionals in the hospital.					
(79)	You resolve nurse's problem and report their problem to the management and follow up solutions.					
(80)	You provide nurse with enough emotional support especially during crisis.					
(81)	You share in recreational meetings to the nurses to decrease work stress.					
(82)	You listen carefully to the nurses and their problems.					

(83) What are the obstacles that face you during your supervision?

……

(84) What are your suggestion do improve the clinical nursing supervision?

……

Thank You

Annex 5.2: Questionnaire (1) for supervisors' Arabic copy

استبانة

" تقييم الإشراف الإكلينيكي التمريضي في مستشفيات محافظات غزة الحكومية "

الإخوة والأخوات الحكماء الأفاضل.....

تحية طيبة وبعد

هذه الدراسة تهدف إلى تقييم الإشراف الإكلينيكي التمريضي في مستشفيات محافظات غزة الحكومية وذلك كمتطلب للحصول على درجة الماجستير في الصحة العامة- الإدارة الصحية من جامعة القدس/ أبو ديس.

يود الباحث التأكيد علي انه تم اختياركم بطريقة عشوائية ولكم كل الحق بقبول أو رفض المشاركة في هذه الدراسة.

الباحث يشكر لكم حسن تعاونكم وتكرمكم بالمشاركة في هذه الدراسة التي نأمل أن تأتي بالفائدة لتحسين الخدمات التمريضية المقدمة في مستشفيات محافظات غزة الحكومية.

نعلمكم انه لا داعي لكتابة الاسم و نؤكد على ضمان سرية المعلومات واستخدامها لإغراض البحث العلمي.

الرجاء نزع اللاصق الذي يحمل اسم المشارك بعد تعبئة الإستبانة.

شكرا لكم حسن المشاركة

الباحث/ رمضان علي حسان

جوال: ٠٥٩٩٤٨٥٢٢١

E-mail: ramadan4ps@yahoo.com

استبانة رقم (١) خاص بالمشرفين

عنـوان الـدراسـة:

" تقييم الإشراف الإكلينيكي لدى تمريض المستشفيات الحكومية في محافظات غزة "

المفتـاح: (.....) لاستخدام الباحث.

الرقـم: (.....) لاستخدام الباحث.

المعلومـات الشخصيـة:

[١] الجنس: ١. ذكر ☐ ٢. أنثى ☐

[٢] العمر: ..... سنة.

[٣] الحالة الاجتماعية: ١. أعزب / ة ☐ ٢. متزوج / ة ☐ ٣. مطلق / ة ☐

٤. أرمل / ة ☐

[٤] السكن: ١. محافظة غزة ☐ ٢. محافظة شمال غزة ☐ ٣. محافظة الوسطى ☐

٤. محافظة خانيونس ☐ ٥. محافظة رفح ☐

[٥] المؤهل العلمي: ١. دبلوم ٣ سنوات ☐ ٢. بكالوريوس ☐ ٣. ماجستير ☐

٤. دكتوارة ☐ ٥. اخرى:.....

[٦] مكان التخرج: الجامعة/الكلية: .....البلد: .....

معلومات عن المؤسسة:

[7] مكان العمل: المستشفى:..... القسم: ..... المحافظة:.....

[٨] المسمى الوظيفي: ١. رئيس قسم ☐ ٢. مشرف تمريض ☐

[٩] عدد سنوات الخبرة في مهنة التمريض: ..... سنة

[١٠] عدد سنوات الخبرة في المسمى الإشرافي:..... سنة

[١١] عدد الممرضين المشرف عليهم: ..... ممرض.

[١٢] هل تلقيت دورات تدريبية في مجال الإدارة أو الإشراف الإكلينيكي؟

١. نعم ☐ ٢. لا ☐

إذا كانت إجابتك بنعم:

وضح اسم الدورة ومكان وتاريخ الانعقاد في الجدول التالي:

رقم	اسم الدورة	مكان الانعقاد	تاريخ الانعقاد
١.			
٢.			
٣.			
٤.			
٥.			
٦.			
٧.			
٨.			

[١٣] هل لديك وصف وظيفي لمهامك الإشرافية؟ ١. نعم ☐ ٢. لا ☐

[١٤] هل لديك مشرف؟ ١. نعم ☐ ٢. لا ☐

[١٥] هل تستخدم أدوات إشرافية في عملك؟ ١. نعم ☐ ٢. لا ☐

إذا كانت إجابتك بنعم فهل هي؟

☐ ١. تقارير

☐ ٢. قوائم فحص Checklist

☐ ٣. لقاءات

☐ ٤. جولات ميدانية

أخرى:.....

[١٦] هل أنت راضٍ عن عملك الإشرافي؟ ١. موافق بشدة ☐ ٢. موافق ☐

٣.غير موافق ☐ ٤. غير موافق بشدة ☐

[١٧] هل يتم عمل لقاءات دورية بين المشرفين ورؤساء الأقسام بهدف تحسين الإشراف الإكلينيكي: ١. نعم ☐ ٢. لا ☐

[١٨] هل تتلقى علاوات بدل إشراف: ١. نعم ☐ ٢. لا ☐

- **البنود التالية تهتم بتقييم وظائف الإشراف الإكلينيكي وهى ثلاثة:**

Normative, Formative, and Restorative Functions.

م.	البنود	أوافق بشدة	أوافق	لا أدري	لا أوافق	لا أوافق بشدة
1. Normative function						
١٩.	تشارك في وضع الأهداف والاستراتيجيات في المستشفى.					
٢٠.	تشرح أهداف المستشفى و القسم للممرضيين.					
٢١.	تستطيع أن تتعرف على مشاكل العمل بسهولة.					
22.	تشارك في عملية صنع القرار داخل المشتشفى.					
٢٣.	تشارك في عملية التوظيف والترقية.					
24.	تقوم بتنسيق المهام داخل المستشفى وبين الأقسام.					
25.	تقوم بتقييم أداءالممرضيين لديك باستمرار.					
٢٦.	تقوم بالتأكد من فعالية الأجهزة الطبية في القسم.					
٢٧.	تقوم بالتأكد من فعالية أجهزة السلامة في القسم.					
٢٨.	تقوم بتقويم مهارات الممرضيين العملية.					
٢٩.	تناقش التقييم مع الممرضيين وتوضح نقاط الضعف والقوة.					
٣٠.	تقوم بتفويض العمل على الممرضيين حسب قدراتهم.					
٣١.	تحرص على جودة الخدمات التمريضية المقدمة للمرضى.					
٣٢.	تقوم بمتابعة جاهزية القسم للعمل في حالة الطوارىء.					
٣٣.	تتأكد من جاهزية عربة الطوارىء من ادوية و مستلزمات طبية بشكل يومي.					
٣٤.	تقوم بتقييم الاحتياجات اللازمة للعمل.					
٣٥.	تقوم بتلبية الاحتياجات اللازمة للعمل في حالة النقص أو النفاذ.					

م.	البنود	أوافق بشدة	أوافق	لا أدري	لا أوافق	لا أوافق بشدة
٣٦.	تراجع الخطة التمريضية للعلاج مع الممرضيين.					
٣٧.	تراجع ملفات المرضى بهدف متابعة التوثيق التمريضى للتأكد من صحته والعمل على تحسينه.					
٣٨.	تقوم بزيارات متكررة للقسم والتأكد من سير العمل وحل المشاكل الفنية و الادارية.					
٣٩.	تلعب دوراً قيادياً وفعالاً في القسم.					
٤٠.	تتلقى دعماً كافياً من مسئوليك في قراراتك.					
٤١.	تستكشف أخطاء الممرضيين.					
٤٢.	تقوم بمراقبة حضور الممرضيين و انصرافهم.					
٤٣.	تعمل علي سد النقص في الكادر التمريضي في حالة الغياب أو العجز.					
٤٤.	تستخدم أدوات إشرافية في عملية الإشراف بهدف مراقبة العمل وتحسينه.					
٤٥.	تناقش المشاكل مع الممرضيين بشكل فعال وتتعمد الحل المناسب.					
٤٦.	تستخدم check lists لتقييم العمليات والاجراءات التمريضية وتقوم باعلام الموظف بنقاط الضعف و القوة.					
٤٧.	تقوم بمراقبة الممرضيين أثناء تقديم الخدمة للمرضى وتعمل على تقييم مدى مطابقتها للمعايير السليمة.					
٤٨.	يتم إشراكك في عمل تنقلات للممرضيين بين الأقسام المختلفة.					
	2. Formative Function					
٤٩.	تقوم بتحديد الاحتياجات اللازمة للممرضيين وتعمل على تلبيتها.					
٥٠.	تشارك في عملية التدريب الداخلي للممرضيين.					
٥١.	تقوم بتزويد الممرضيين بالمعلومات و المهارات الجديدة.					
٥٢.	تقوم بإعطاء الممرضيين تغذية راجعة feedback عن عملهم.					
٥٣.	تشارك في اعطاء محاضرات للممرضيين لزيادة معرفتهم العلمية و العملية.					
٥٤.	تقوم بعقد اجتماعات منتظمة للممرضيين من أجل تطوير الخدمات التمريضية.					
٥٥.	تشارك في تدريب الممرضيين الجدد.					
٥٦.	تعمل على تقييم وقياس مستوى التطوير المهني للممرضيين.					
٥٧.	تقوم بتطوير الأداء الوظيفي و المهني للممرضيين.					
٥٨.	تناقش الممرض بنقاط ضعفه وقوته.					
٥٩.	تقدم المشورة للممرضيين المسئول عنهم.					
٦٠.	تربط بين خبرة الممرضيين واحتياجات المستشفى لها.					
٦١.	تقوم بتدريب الممرضيين على استخدام الاجهزة الطبية بشكل جيد.					
٦٢.	تقوم بتدريب الممرضيين على البروتوكولات المتبعة في العمل مثل: safety manual, infection control guidelines,...etc					
٦٣.	تقوم بعمل orientation كافٍ للممرض الجديد ضمن orientation program داخل المستشفى.					

م.	البنود	أوافق بشدة	أوافق	لا أدري	لا أوافق	لا أوافق بشدة
3. Restorative Function						
٦٤.	تعزز العمل بروح الفريق بين الموظفين.					
٦٥.	تقوم بتحفيز الممرضيين وتشجيعهم على أدائهم.					
٦٦.	تتعامل مع الممرضيين بشكل لائق وجيد واحترام.					
٦٧.	تقدر مقترحات الممرضيين وأفكارهم وتأخذها بعين الاعتبار.					
٦٨.	تتفهم النواحي الاجتماعية و الثقافية داخل المستشفى.					
٦٩.	تقوم بنقد الممرضيين بشكل بناء.					
٧٠.	تمنح الدعم الكافي للممرضيين.					
٧١.	تخفف من توتر الممرضيين وتعمل على إعطائهم الأمن الوظيفي.					
٧٢.	تشارك في الأنشطة الاجتماعية للممرضيين.					
٧٣.	تقوم بالحفاظ على سلامة المرضى.					
٧٤.	تقوم بالحفاظ على سلامة الممرضيين.					
٧٥.	تستطيع أن تحد من نزاعات العمل بين أفراد المؤسسة.					
٧٦.	تقوم بمساندة الممرضيين اثناء الأزمات وضغوط العمل.					
٧٧.	تعمل على التقريب بين الممرضيين و المرضى.					
٧٨.	تعمل على التقريب بين الممرضيين و الموظفين في المهن الاخرى.					
٧٩.	تعمل على حل مشاكل التمريض ورفع شكواهم للادارة ومتابعة حلها.					
٨٠.	تقوم بتزويد الممرضيين بالدعم النفسي المطلوب وخاصة اثناء الازمات.					
٨١.	تشارك في عمل لقاءات ترفيهية للممرضيين للتقليل من ضغوط العمل.					
٨٢.	تستمع بشكل جيد لهموم ومشاكل التمريض.					

[٨٣] أذكر أهم المشاكل والمعوقات التي تواجهها أثناء عملك كمشرف؟

.....

.....

.....

[٨٤] ما هي اقتراحتك لتحسين الإشراف الإكلينيكي التمريضي في المستشفيات الحكومية؟

.....

.....

Annex 6.1: Questionnaire (2) for supervisees' English copy

Thesis title: "Assessment of the Clinical Nursing Supervision at Government Hospitals - Gaza Governorates"

Code: (……) for researcher.

Number: (……) for researcher.

Personal Data:

(1) Sex: 1. Male ☐ 2. Female ☐

(2) Age:…….. Years.

(3) Residency place: 1. Gaza Governorate ☐ 2. North Gaza Governorates ☐
3. Mid-zone Governorates ☐ 4. Khan Younis Governorate ☐
5. Rafah Governorate ☐

(**4) Marital status:** 1. Single ☐ 2. Married ☐ 3. Divorced ☐ 4. Widow ☐

(5) Academic qualification: 1.Practical nurse ☐ 2. Diploma 3 years ☐ 3. Bachelor ☐
6. Master ☐ 5. PHD ☐ 6.Others: .....

(6) Place of study: University / college: ……....Country: …….....

Organization Data:

(7) Place of works: Hospital: ……..…Department: …… Governorate: ……

(8) Years of experience in nursing: ……..years.

(9) Does your supervisor review with you medical file and daily reports?
1. Yes ☐ 2. No ☐

(10) Do you have a clear job description? 1. Yes ☐ 2. No ☐

(11) How many times does the nursing supervisor visit you during your working shift? …… times

(12) Do you work at your favorite department? 1. Yes ☐ 2. No ☐

(13) Do you know yours occupational rights? 1. Yes ☐ 2. No ☐

(14) Do you know your clinical duties? 1. Yes ☐ 2. No ☐

(15) Do you engaged in training courses within your hospital performed by your supervisors? 1. Yes ☐ 2. No ☐

(16) Do you engaged in training courses outside your hospital? 1. Yes ☐ 2. No ☐

(17) Did you receive an orientation at your beginning in the work from your supervisors?
1. Yes ☐ 2. No ☐

Explain your agreement with the following items:

(SA) Strongly Agree (A) Agree (DK) Don't Know (SD) Strongly Disagree (D) Disagree

NO.	Item	SA	A	DK	D	SD
18.	You are satisfied about the clinical supervision of your head nurse.					
19.	You are satisfied about the clinical supervision of your nursing supervisors.					

NB: Supervisor means either head nurse or nursing supervisor.

The following questions concern with functions of the clinical nursing supervision (Normative, Formative, and Restorative): please answer the following questions to assess these 3 functions.....

(A) Always (O) Often (S) Sometimes (R) Rarely (N) Never

No.	Item	A	O	S	R	N
	1. Normative Function					
(20)	Your supervisor explains your duties in the work.					
(21)	Your duties & responsibility are clear.					
(22)	Your supervisor explains occupational rights and tends to satisfy and maintain it.					
(23)	Your supervisor explains the reasons & aims of job rotation when performed.					
(24)	Your supervisor assigns the work on the nurses to facilitate the work.					
(25)	Your supervisor assures that medical devices are working well and ready to use.					
(26)	Your supervisor assures that safety devices are working well at the department.					
(27)	Your supervisor assures the quality of care you provide.					
(28)	Your supervisor reviews patient's files and improve your work.					
(29)	Your supervisor is adherent to your work with the patients and improve your work.					
(30)	Your supervisor satisfies the shortage in nursing personnel in case of shortage or absence.					
(31)	The clinical supervision you receive helps you to improve your work.					
(32)	Your supervisor assures that emergency trolley is ready with drugs & medical equipment daily.					
(33)	Your supervisor assures the readiness of your department to work in case of emergency.					
(34)	Your supervisor reviews with you the nursing care plan for your patients.					
(35)	Your supervisor monitors you while you provide nursing care to the patients to assure that are consistent with standards and provide you with feedback.					
(36)	Your supervisor visits the patients and appraises your performance throughout patient satisfaction about it.					
(37)	Your supervisor visits the department many times to follow up the work.					
(38)	You participate in decision making.					
(39)	You engaged in appraisal of yourself and your peers.					
(40)	Your supervisor provides you with feedback about your performance appraisal.					

No.	Items	A	O	S	R	N
	2. Formative Function					
(41)	Your supervisor assesses your practical & educational needs.					
(42)	Your supervisor satisfies your practical & educational needs.					
(43)	Your supervisors perform on- job training in a continuous basis to improve your performance.					
(44)	Your supervisor reinforces the strength points & treats your weakness points in your performance.					
(45)	Your supervisor trains you on the use of medical equipment in a good manner.					
(46)	Your supervisors are involved in the in service education program in the hospital.					
(47)	Your supervisor trains and orients you on the used protocol in the work like safety manual, infection control guidelines …. Etc					
(48)	You return to your supervisors in case of suspicion in performing a nursing intervention like the route of administering of medication …. Etc					
(49)	The trainings you received are enough to improve the work.					
	3. Restorative Function					
(50)	Your relationship with your supervisors is good.					
(51)	Your relationship with your peers is good.					
(52)	Your supervisor supports you in case of work problem.					
(53)	Your supervisor encourage your & improve your clinical skills.					
(54)	Your supervisor listens to your opinions and work problem carefully and seriously.					
(55)	There is No fair and there is discrimination from your supervisor.					
(56)	Your supervisor criticizes your performance in front of your peers & clients.					
(57)	Your supervisor tends to detect your mistakes.					
(58)	Your supervisor criticizes you in a positive way to improve the work.					
(59)	Your supervisor supports you emotionally & psychologically specially in care of crisis and work stress.					
(60)	There is a trust between you and your supervisor.					
(61)	There is a role conflict between your supervisors.					
(62)	Your supervisor shares in the celebration meeting with nursing staff.					
(63)	Your supervisor visits you in your celebrations.					

(64) What are the positive characteristic in your supervisor?

(65) What are the negative characteristic in your supervisor?

(66) What are you suggestion to improve the clinical nursing supervision in the hospital?

Thank You For

Your cooperation

Annex 6.2: Questionnaire (2) for supervisees' Arabic copy

استبانة رقم (٢) خاص بالممرضين

عنـوان الـدراسـة :

" تقييم الإشراف الإكلينيكي التمريضي في المستشفيات الحكومية في محافظات غزة "

المفتـاح: (.....) لاستخدام الباحث.

الرقـم: (.....) لاستخدام الباحث.

ملاحظة: الباحث من خلال هذه الدراسة يسعى لتقييم الإشراف الإكلينيكي الذي يقوم به مشرف التمريض أو رئيس القسم فكلمة المشرف في الإستبانة تحتمل أياً من الاثنين.

المعلومـات الشخصيـة:

[١] الجنس: ١. ذكر ☐ ٢. أنثى ☐

[٢] العمر: ..... سنة

[٣] السكن: ١. محافظة غزة ☐ ٢. محافظة شمال غزة ☐ ٣. محافظة الوسطى ☐

٤. محافظة خان يونس ☐ ٥. محافظة رفح ☐

[٤] الحالة الاجتماعية: ١. أعزب / ة ☐ ٢. متزوج / ة ☐

٣.مطلق / ة ☐ ٤. أرمل / ة ☐

[٥] المؤهل العلمي: ١. دبلوم سنتين ☐ ٢. دبلوم ٣ سنوات ☐ ٣. بكالوريوس ☐

٤. ماجستير ☐ ٥. دكتوراة ☐ ٦. غير ذلك .....

[٦] مكان التخرج: الجامعة/الكلية: ..... البلد: .....

معلومات عن المؤسسة:

[٧] مكان العمل:المستشفى: ..... القسم:..... المحافظة: .....

[٨] سنوات الخبرة في مهنة التمريض: ..... سنة

[٩] هل يراجع مشرفك معك ملفات المرضى والتقارير اليومية؟ ١. نعم ☐ ٢. لا ☐

[١٠] هل لديك وصف وظيفي لمهنتك؟ ١. نعم ☐ ٢. لا ☐

[١١] كم عدد الزيارات التي يقوم بها مشرف التمريض لك أثناء دوامك اليومي؟ ..... مرة.

[١٢] هل تعمل في قسمك المفضل؟ ١. نعم ☐ ٢. لا ☐

[١٣] هل تعرف حقوقك الوظيفية؟ ١. نعم ☐ ٢. لا ☐

[١٤] هل تعرف واجباتك العملية في وظيفتك؟ ١. نعم ☐ ٢. لا ☐

[١٥] هل اشتركت في دورات تدريبية داخل مؤسستك عقدت من قبل مشرفيك؟ ١. نعم ☐

٢ . لا ☐

[١٦] هل اشتركت في دورات تدريبية خارج مؤسستك؟ ١. نعم ☐ ٢. لا ☐

[١٧] هل تلقيت توضيح orientation في بداية عملك الوظيفي من قبل مشرفك؟ ١. نعم ☐ ٢. لا ☐

وضح مدى موافقتك على البنود التالية:

م.	البنود	موافق بشدة	موافق	لا أدري	لا أوافق	لا أوافق بشدة
18	أنت راضٍ عن الإشراف الإكلينيكي لرئيس قسمك.					
19	أنت راضٍ عن الإشراف الإكلينيكي لمشرفي التمريض.					

ملاحظة: المقصود بالمشرف هنا رئيس القسم أو مشرف التمريض.

- **البنود التالية تهتم بتقييم وظائف الإشراف الإكلينيكي وهى ثلاثة:**

Normative, Formative, and Restorative Functions.

م.	البنود	دائماً	غالباً	أحياناً	نادراً	أبداً
1. Normative Function						
٢٠	يوضح لك مشرفك مهامك وواجباتك في العمل.					
٢١	واجباتك ومسئولياتك واضحة بالنسبة لك.					
٢٢	يوضح لك مشرفك حقوقك الوظيفية ويعمل على تلبيتها والمحافظة عليها.					
٢٣	عندما يتم نقلك من قسم لآخر يوضح لك مشرفك أسبابه وأهدافه.					

	البنود	دائماً	غالباً	أحياناً	نادراً	أبداً
٢٤	يقوم مشرفك بتوزيع الأدوار على الممرضيين لتسهيل العمل.					
٢٥	يقوم مشرفك بالتأكد من سلامة الأجهزة و المعدات الطبية في القسم و جاهزيتها للعمل.					
٢٦	يقوم مشرفك بالتأكد من فعالية أجهزة السلامة في القسم.					
٢٧	يتأكد مشرفك من جودة عملك الإكلينيكي.					
٢٨	يقوم مشرفك بمراجعة ملفات المرضى ويحسن من أدائك.					
٢٩	مشرفك قريب منك في عملك مع المرضى ويعمل على تحسين أدائك.					
٣٠	يقوم مشرفك بسد النقص في الكادر التمريضي في حالة الغياب أو العجز.					
٣١	يساعدك الإشراف الاكلينيكي الذي تتلقاه من مشرفك على تحسين عملك.					
٣٢	يقوم مشرفك بالتأكد من جاهزية عربة الطوارىء من أدوية و مستلزمات طبية بشكل يومي.					
٣٣	يقوم مشرفك بمتابعة جاهزية القسم للعمل في حالة الطوارىء.					
٣٤	يراجع مشرفك معك الخطة التمريضية لعلاج المرضى.					
٣٥	يقوم مشرفك بمتابعة عملك اثناء تقديمك العناية للمرضى للتأكد من مطابقتها للمعايير السليمة ويزودك بتغذية راجعة عن عملك.					
٣٦	يقوم مشرفك بزيارة المرضى و تقييم ادائك من خلال رضى المرضى عن الخدمة.					
٣٧	يقوم مشرف التمريض (مشرف الفترة) بزيارات متكررة للقسم لتفقد العمل.					
٣٨	تشارك في صنع القرار.					
٣٩	تشارك مشرفك في تقييم زملائك ونفسك.					
٤٠	يزودك مشرفك بتغذية راجعة feedback حول تقييم أدائك السنوي.					
	2. Formative Function					
٤١	يقوم مشرفك بتقييم احتياجاتك العلمية والعملية.					
٤٢	يعمل مشرفك على تلبية احتياجاتك العلمية والعملية.					
٤٣	يقوم مشرفك بعمل تدريبات ميدانية مستمرة لتحسين الاداء.					
٤٤	يقوم مشرفك بتعزيز نقاط القوة ومعالجة نقاط الضعف في أدائك.					
٤٥	يقوم مشرفك بتدريبك على استخدام الاجهزة الطبية بشكل جيد.					
٤٦	يشارك مشرفك في عملية التعليم الداخلي للممرضيين.					

	البنود	دائماً	غالباً	أحياناً	نادراً	أبداً
٤٧	يقوم مشرفك بتدريبك و اطلاعك على البروتوكولات المتبعة في العمل مثل: Safety manual, infection control guidelines,...etc					
٤٨	ترجع إلى مشرفك في حالة الشك في عمل تدخل تمريضي للمرضى مثل كيفية اعطاء علاج ما ....الخ.					
٤٩	التدريبات التي تتلقاها كافية لتحسين العمل.					
	3. Restorative Function					
٥٠	علاقتك مع مشرفك جيدة.					
٥١	علاقتك مع زملائك في العمل جيدة.					
٥٢	مشرفك يساندك عند حدوث مشكلة في العمل.					
٥٣	مشرفك يشجعك ويسهم في تحسين مهاراتك العملية.					
٥٤	يستمع مشرفك لآرائك ومشكلاتك باهتمام وجدية.					
٥٥	لا يوجد عدالة ويوجد تمييز من قبل مشرفك.					
٥٦	يقوم مشرفك بنقد أدائك أمام الزملاء والمرضى.					
٥٧	المشرف يسعى لتصيد أخطائك.					
٥٨	يقوم مشرفك بنقدك نقداً إيجابياً بهدف تحسين العمل.					
٥٩	يقدم مشرفك الدعم النفسي والعاطفي لك في حالة الأزمات وضغط العمل.					
٦٠	توجد ثقة بينك وبين مشرفك.					
٦١	يحدث صراع في الأدوار لكثرة المشرفين.					
٦٢	مشرفك يشاركك في اللقاءات الترفيهية بين افراد التمريض.					
٦٣	يقوم مشرفك بزيارتك في مناسباتك الاجتماعية.					

[٦٤] ما أكثر الصفات الايجابية التي يتحلى بها مشرفك؟

.....

.....

[65] ما أكثر الصفات السلبية الموجودة في مشرفك؟

.....

.....

[٦٧] ما هي اقتراحاتك لتحسين الإشراف الإكلينيكي في المستشفى؟

.....

.....

Annex (7): An official letter of request

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

2010/7/13

الأخ/د. ناصر أبو شعبان المحترم
مدير عام تنمية القوى البشرية–وزارة الصحة
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالب رمضان علي حسان

يقوم الطالب المذكور أعلاه بإجراء بحث بعنوان:

"Assessment of the Clinical Nursing Supervision at Governmental Hospitals-Gaza"

كمتطلب للحصول على درجة الماجستير في الصحة العامة–مسار إدارة صحية و عليه نرجو التكرم للإيعاز لمن ترونه مناسب لتسهيل مهمة الطالب في جمع البيانات اللازمة من طاقم التمريض العاملين في جميع المستشفيات التابعة لوزارة الصحة.
علماً بأن المعلومات ستكون متوفرة لدى الباحث و الجامعة فقط.

و اقبلوا فائق التحية و الاحترام،،،

د. بسام أبو حمد
منسق عام برامج الصحة العامة

نسخة:
– الملف

Jerusalem Branch/Telefax 02-24799234
Gaza Branch/telefax 08-2884422-2884411
Sphealth@admin.alquds.edu
فرع القدس/تلفاكس 02-2799234
فرع غزة/تلفاكس 08-2884422-2884411
ص.ب/51000–القدس

Annex (8): Approval from Helsinki committee –Gaza governorate

30

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ 7/6/2010

Name:

الاسم: رمضان علي رمضان حسان

I would like to inform you that the committee has discussed your application about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

Assessment of the clinical nursing supervision at governmental hospitals-Gaza Governorates.

In its meeting on June 2010

و ذلك في جلستها المنعقدة لشهر 6 2010

and decided the Following:-

و قد قررت ما يلي:-

To approve the above mention research study.

الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member	Member	Chairperson
عضو	عضو	

Conditions:-

- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Annex (9): An agreement letter from MOH Hospitals General Administration

Palestinian National Authority
Ministry Of Health
Hospitals General Administration

السلطة الوطنية الفلسطينية
وزارة الصحة
الإدارة العامة للمستشفيات

الرقم:عام

التاريخ:٢٠١٠/٧/٢٠

الأخوة / مدراء المستشفيات

المحترمون

م. الشفاء
م.كمال عدوان
م.ناصر
م.شهداء الأقصى
م.الهلال الإماراتي

السلام عليكم ورحمة الله وبركاته

الموضوع/ إجراء بحث

بالإشارة لكتاب السيد مدير عام تنمية القوى البشرية بخصوص الموضوع أعلاه يرجى تسهيل مهمة الطالب/ رمضان علي رمضان حسان وملتحق ببرنامج ماجستير الصحة العامة- إدارة صحية- جامعة القدس لإجراء بحث بعنوان.

"Assessment of Clinical Nursing Supervision at the Governmental Hospital "

حيث سيقوم الباحث بتعبئة استبانه من التمريض(مدراء تمريض ، رؤساء أقسام ،مشرفين ،ممرضين) العاملين في المستشفيات التالية(م.الشفاء، م.كمال عدوان ، م.ناصر، م.الهلال الإماراتي، شهداء الأقصى) وذلك بما لا يتعارض مع مصلحة العمل وضمن ضوابط وأخلاقيات البحث العلمي، دون تحمل الوزارة أي أعباءه مع موافقة خطية من المشاركين في البحث.

ولا مانع لدينا من إجراء الاستبيان.

آملين حسن تعاونكم،،،

د.محمد الكاشف
مدير عام المستشفيات

الإدارة العامة للمستشفيات
الصادر
رقم: ٦١
التاريخ: ٢٠١٠/٧/٢٠

-صورة للسيد مدير عام تنمية القوى البشرية المحترم
-صورة للسادة مدراء المستشفيات المعنية المحترمون

فندق الأمل – وزارة الصحة

تليفاكس : ٢٨٢٠٧٣٤

Annex (10): Cross tabulation between job title of supervisors and gender

Gender	Job title		Total
	Head nurses	Nursing supervisors	
Male	**49**	**46**	95
Female	**25**	**12**	37
Total	**74**	**58**	132

Annex (11): Cross tabulation between job title of supervisors and span of control

Span of control	Job title		Total
	Head nurses	Nursing supervisors	
5 & less	7	3	10
6 - 20	62	15	77
21-40	5	12	17
41-99	0	11	11
100 +	0	11	11
Total	74	52	126

Annex (12): Rank of means for formative function items (Supervisors' part)

No	Items of formative function	N	Mean	SD	%
Q54	You perform regular meeting with nurses to improve nursing services.	130	3.42	0.99	68.3
Q53	You participate in providing lectures for nurses to increase their knowledge and practice.	132	3.58	0.97	71.5
Q50	You participate in in-service training for nurses.	133	3.68	0.90	73.5
Q56	You assess and measure the level of professional development for nurse.	133	3.71	0.83	74.3
Q57	You develop the professional and occupational performance of the nurses.	130	3.78	0.84	75.7
Q55	You participate in training for newly employed nurses.	133	3.82	0.97	76.4
Q52	You provide feedback for nurses about their work.	133	3.88	0.76	77.6
Q62	You train the nurses on used protocols and guideline used in the work like safety manual, infection control guidelines …. Etc.	132	3.92	0.89	78.5
Q60	You link between nurse's experience and hospital's needs.	132	3.94	0.71	78.8
Q49	You assess the needs of nurses and satisfy it.	133	3.95	0.74	78.9
Q63	You provide enough orientation for newly employed nurses throughout orientation program in hospital.	131	3.95	0.94	79.1
Q61	You train nurses on nursing medical equipment in effective way.	132	4.02	0.74	80.5
Q51	You provide nurse with updated skills and knowledge.	132	4.05	0.83	80.9
Q58	You discuss with nurses the strength and weakness points.	132	4.05	0.57	81.1
Q59	You provide consultation for nurses.	131	4.10	0.51	82.0

Annex (13): Rank of means for normative function Items (Supervisors' part)

No	Items of normative function	N	Mean	SD	%
Q23	You involved in hiring and promotion.	132	1.92	1.02	38.3
Q22	You involved in decision making in the hospital.	131	2.61	1.21	52.2
Q19	You share in setting of objectives and strategies in the hospital.	132	2.83	1.16	56.5
Q48	You engage in nursing rotation between departments.	133	2.85	1.20	57.0
Q46	You use checklists to evaluate and monitor the nursing intervention and inform the nurses with strength and weakness points.	133	3.26	1.09	65.1
Q24	You coordinate the work flow between the departments in the hospitals.	133	3.35	1.15	66.9
Q40	You receive enough support from your managers in decision making.	132	3.74	0.97	74.8
Q20	You explain the objectives of the hospital and department to the nurses you supervise.	133	3.80	0.90	75.9
Q29	You discuss the performance appraisal with your staff and explain the weakness and strength points.	133	3.86	0.80	77.1
Q44	You use supervisory tools in supervisory process to monitor and improve the work.	131	3.86	0.92	77.3
Q25	You do performance appraisal for nurses regularly.	130	3.92	0.91	78.3
Q36	You review with the nurses the nursing care plan for patients.	133	3.95	0.86	78.9
Q45	You discuss the problems with nurses and resolve it.	133	4.04	0.68	80.8
Q47	You monitor the nurses during providing nursing care for patients to assure its adherence to the approved standards.	133	4.05	0.77	80.9
Q27	You assure that safety devices are working well at the department.	132	4.06	0.79	81.2
Q30	You assign the responsibilities for nurses according to their abilities.	132	4.08	0.67	81.7
Q28	You assess the clinical skills of your staff continuously.	133	4.09	0.63	81.8
Q21	You can easily identify the work problems.	131	4.10	0.77	82.0
Q41	You explore the mistakes of nurse.	133	4.21	0.60	84.2
Q39	You play effective and leadership role in the department.	133	4.25	0.72	85.0
Q26	You assure that medical equipments are working well.	133	4.26	0.73	85.3
Q35	You fulfill the work needs in case of shortage or depletion.	133	4.26	0.55	85.3

Q43	You tend to fulfill the shortage in nurse in case of absence of shortage.	133	4.30	0.60	86.0
Q31	You assure the quality of nursing care provided to the patients.	133	4.32	0.70	86.5
Q34	You assess the work needs.	133	4.32	0.65	86.5
Q38	You visit the department under your supervision continuously to monitor the work flow and resolve the technical and managerial problems.	133	4.34	0.60	86.8
Q37	You review patients' files to follow up nursing documentation to assure the quality of care provided.	133	4.34	0.76	86.8
Q42	You monitor the nurses coming and leaving.	132	4.36	0.57	87.1
Q32	You follow up the readiness of the department to work in case of emergency.	133	4.37	0.58	87.4
Q33	You ensure the readiness of the emergency trolley with drugs and supplies.	132	4.39	0.66	87.7

Annex (14): Rank of means for restorative function items (Supervisors' part)

NO	Items of restorative function	N	Mean	SD	%
Q81	You share in recreational meetings to the nurses to decrease work stress.	132	3.83	1.07	76.5
Q71	You alleviate the tension of nurses and provide them occupation security.	132	4.08	0.79	81.5
Q70	You provide enough support for nurses.	132	4.13	0.72	82.6
Q78	You approximate between nurses and other professionals in the hospital.	131	4.15	0.71	83.1
Q80	You provide nurse with enough emotional support especially during crisis.	131	4.16	0.79	83.2
Q75	You manage conflicts between staff in hospital effectively.	132	4.17	0.73	83.3
Q72	You share social activities with your staff.	132	4.19	0.76	83.8
Q68	You understand the social and cultural aspects in the hospital.	131	4.21	0.71	84.1
Q69	You criticize the nurses in a constructive manner.	132	4.22	0.66	84.4
Q77	You approximate between nurses and patients.	132	4.23	0.57	84.5
Q82	You listen carefully to the nurses and their problems.	132	4.24	0.71	84.8
Q65	You motivate and encourage the nurses.	132	4.24	0.62	84.8
Q79	You resolve nurse's problem and report their problem to the management and follow up solutions.	131	4.29	0.63	85.8
Q67	You appreciate the ideas and suggestion of nurses and take it into account.	132	4.30	0.59	86.1
Q76	You support nurses during work stress and crisis.	132	4.31	0.61	86.2
Q74	You assure nurse's safety.	132	4.41	0.57	88.2
Q64	You build team work in hospital.	132	4.42	0.55	88.5
Q73	You assure patient's safety.	132	4.43	0.51	88.6
Q66	You communicate with nurses in a good and respective manner.	132	4.52	0.55	90.3

Annex (15): Tables of inferential statistics for supervisors' part

Table (15.1): Independent t- test comparing marital status of supervisors with clinical nursing supervision domains

Dependent variable CS domains	Independent variable (Marital status)	N	Mean	SD	t	Sig.
Normative function	not married	22	3.775	0.556	-1.579	0.117
	married	111	3.931	0.393		
Formative function	not married	22	3.656	0.751	-2.139	0.054
	married	111	3.917	0.467		
Restorative function	not married	22	4.222	0.496	-0.172	0.864
	married	110	4.242	0.471		
Overall perception	not married	22	3.894	0.537	-1.443	0.151
	married	111	4.032	0.381		

Table (15.2): Independent t- test comparing academic qualification of supervisors with clinical nursing supervision domains

Dependent variable (CS domains)	Independent variable (Certificate)	N	Mean	SD	t	Sig.
Normative function	Diploma 3 years	31	3.775	0.556	-1.579	0.117
	Bachelor	91	3.931	0.393		
Formative function	Diploma 3 years	31	3.656	0.751	-2.139	0.054
	Bachelor	91	3.917	0.467		
Restorative function	Diploma 3 years	31	4.222	0.496	-0.172	0.864
	Bachelor	90	4.242	0.471		
Overall perception	Diploma 3 years	31	3.894	0.537	-1.443	0.151
	Bachelor	91	4.032	0.381		

Table (15.3): Independent t- test comparing receiving courses in management or supervision with clinical nursing supervision

Dependent variable (CS domains)	Independent variable (Management courses)	N	Mean	SD	t	Sig.
Normative function	No	102	3.918	0.446	0.782	.436
	Yes	30	3.848	0.353		
Formative function	No	102	3.869	0.551	0.170	.865
	Yes	30	3.888	0.472		
Restorative function	No	101	4.265	0.492	1.285	.201
	Yes	30	4.139	0.399		
Overall perception	No	102	4.023	0.430	0.802	.424
	Yes	30	3.954	0.347		

Table (15.4): One way ANOVA comparing supervision domains by supervisors residency place

Dependent variable (CS domains)	Independent variable (Residency place)	N	mean	SD	F	Sig.
Normative function	Gaza	30	3.8245	.51925	1.629	.171
	North of Gaza	28	3.8513	.42155		
	Mid zone	28	4.0491	.45911		
	Khan younis	23	3.8203	.36402		
	Rafah	24	3.9806	.25966		
	Total	133	3.9049	.42581		
Formative function	Gaza	30	3.8223	.56181	2.783	.029
	North of Gaza	28	3.8717	.53384		
	Mid zone	28	4.1020	.51156		
	Khan younis	23	3.6273	.58425		
	Rafah	24	3.9105	.34304		
	Total	133	3.8738	.53013		
Restorative function	Gaza	30	4.1018	.62304	1.898	.115
	North of Gaza	28	4.1796	.33938		
	Mid zone	27	4.3281	.39798		
	Khan younis	23	4.1991	.35447		
	Rafah	24	4.4145	.52799		
	Total	132	4.2384	.47305		
Overall perception	North of Gaza	30	3.9160	.50862	2.233	.069
	Mid zone	28	3.9659	.37127		
	Khan younis	28	4.1597	.43099		
	Rafah	23	3.8992	.34853		
	Total	24	4.1077	.29376		

Table (15.5): Independent t- test comparing receiving incentives for supervisory position with clinical nursing supervision

Dependent variable (CS domains)	Independent variable (Incentives)	N	Mean	SD	t	Sig.
Normative function	No	110	3.888	0.423	-1.021	0.309
	Yes	23	3.987	0.440		
Formative function	No	110	3.840	0.537	-1.610	0.110
	Yes	23	4.035	0.476		
Restorative function	No	109	4.208	0.488	-1.614	0.109
	Yes	23	4.382	0.370		
Overall perception	No	110	3.984	0.417	-1.560	0.121
	Yes	23	4.131	0.368		

Table (15.6): One way ANOVA comparing supervision domains by years of supervision experience

Dependent variable (CS domains)	Independent variable (Experience in supervision)	N	mean	SD	F	Sig.
Normative function	5 years and less	108	3.889	0.450	1.312	0.273
	6 - 15	17	3.951	0.263		
	16 - 25	7	3.917	0.276		
	More than 25	1	4.708	.		
	Total	133	3.905	0.426		
Formative function	5 years and less	108	3.829	0.561	1.751	0.160
	6 - 15	17	4.034	0.333		
	16 - 25	7	4.084	0.206		
	More than 25	1	4.571	.		
	Total	133	3.874	0.530		
Restorative function	5 years and less	108	4.218	0.487	0.686	0.505
	6 - 15	17	4.362	0.401		
	16 - 25	7	4.256	0.424		
	More than 25	0	.	.		
	Total	132	4.238	0.473		
Overall perception	5 years and less	108	3.984	0.434	1.405	0.244
	6 - 15	17	4.108	0.261		
	16 - 25	7	4.068	0.258		
	More than 25	1	4.677	.		

Annex (16): Rank of means for formative function items (Supervisees' part)

No	Items of formative function	N	Mean	SD	%
Q43	Your supervisors perform on- job training in a continuous basis to improve your performance.	262	2.569	1.290	51.37
Q44	Your supervisor reinforces the strength points & treats your weakness points in your performance.	262	3.027	1.252	60.53
Q42	Your supervisor satisfies your practical & educational needs.	261	3.065	1.231	61.30
Q41	Your supervisor assesses your practical & educational needs.	264	3.159	1.198	63.18
Q46	Your supervisors are involved in the in service education program in the hospital.	262	3.168	1.287	63.36
Q47	Your supervisor trains and orients you on the used protocol in the work like safety manual, infection control guidelines …. Etc	262	3.176	1.330	63.51
Q49	The trainings you received are enough to improve the work.	257	3.214	1.258	64.28
Q45	Your supervisor trains you on the use of medical equipment in a good manner.	262	3.466	1.261	69.31
Q48	You return to your supervisors in case of suspicion in performing a nursing intervention like the route of administering of medication …. Etc	264	3.886	1.118	77.73

Annex (17): Rank of means for normative function items (Supervisees' part)

No	Items of normative function	N	Mean	SD	%
Q39	You engaged in appraisal of yourself and your peers.	266	2.583	1.333	51.7
Q23	Your supervisor explains the reasons & aims of job rotation when performed.	267	2.603	1.427	52.1
Q40	Your supervisor provides you with feedback about your performance appraisal.	266	2.628	1.433	52.6
Q38	You participate in decision making.	266	2.993	1.363	59.9
Q36	Your supervisor visits the patients and appraises your performance throughout patient satisfaction about it.	265	3.060	1.287	61.2
Q22	Your supervisor explains occupational rights and tends to satisfy and maintain it.	269	3.186	1.259	63.7
Q34	Your supervisor reviews with you the nursing care plan for your patients.	267	3.258	1.252	65.2
Q35	Your supervisor monitors you while you provide nursing care to the patients to assure that are consistent with standards and provide you with feedback.	269	3.398	1.182	68.0
Q30	Your supervisor satisfies the shortage in nursing personnel in case of shortage or absence.	270	3.500	1.324	70.0
Q37	Your supervisor visits the department many times to follow up the work.	266	3.587	1.100	71.7
Q29	Your supervisor is adherent to your work with the patients and improve your work.	268	3.627	1.228	72.5
Q28	Your supervisor reviews patient's files and improve your work.	263	3.650	1.178	73.0
Q31	The clinical supervision you receive helps you to improve your work.	267	3.685	1.116	73.7
Q20	Your supervisor explains your duties in the work.	269	3.777	1.031	75.5
Q27	Your supervisor assures the quality of care you provide.	268	3.866	1.008	77.3
Q26	Your supervisor assures that safety devices are working well at the department.	269	3.903	1.155	78.1
Q33	Your supervisor assures the readiness of your department to work in case of emergency.	268	3.959	1.068	79.2
Q24	Your supervisor assigns the work on the nurses to facilitate the work.	269	4.000	1.054	80.0
Q32	Your supervisor assures that emergency trolley is ready with drugs & medical equipment daily.	270	4.052	1.152	81.0
Q25	Your supervisor assures that medical devices are working well and ready to use.	266	4.143	1.029	82.9
Q21	Your duties & responsibility are clear.	269	4.264	0.959	85.3

Annex (18): Rank of means for restorative function items (Supervisees' part)

No	Items of restorative function	N	Mean	SD	%
Q61	There is a role conflict between your supervisors.	263	2.958	1.284	59.2
Q63	Your supervisor visits you in your celebrations.	264	3.034	1.491	60.7
Q62	Your supervisor shares in the celebration meeting with nursing staff.	262	3.038	1.378	60.8
Q55	There is fair and there is no discrimination from your supervisor.	262	3.076	1.368	61.5
Q59	Your supervisor supports you emotionally & psychologically specially in care of crisis and work stress.	261	3.226	1.252	64.5
Q58	Your supervisor criticizes you in a positive way to improve the work.	262	3.340	1.063	66.8
Q56	Your supervisor doesn't criticize your performance in front of your peers & clients.	263	3.384	1.362	67.7
Q57	Your supervisor does not tend to detect your mistakes.	262	3.496	1.392	69.9
Q54	Your supervisor listens to your opinions and work problem carefully and seriously.	264	3.701	1.191	74.0
Q53	Your supervisor encourage your & improve your clinical skills.	265	3.740	1.153	74.8
Q60	There is a trust between you and your supervisor.	265	3.955	1.090	79.1
Q52	Your supervisor supports you in case of work problem.	265	3.985	1.101	79.7
Q50	Your relationship with your supervisors is good.	265	4.491	0.764	89.8
Q51	Your relationship with your peers is good.	265	4.653	0.634	93.1

Annex (19): Tables of inferential statistics for supervisees' part

Annex (19.1): Independent t- test comparing marital status of supervisees with clinical nursing supervision domains

Dependent variable (CS domains)	Independent variable (Marital status)	N	Mean	SD	t	Sig.
Normative function	not married	85	3.410	0.793	-1.430	.154
	married	183	3.564	0.832		
Formative function	not married	85	3.043	1.022	-1.805	.072
	married	178	3.278	0.969		
Restorative function	not married	85	3.487	0.704	-1.602	.110
	married	178	3.636	0.705		
Overall perception	not married	85	3.313	0.752	-1.800	.073
	married	183	3.494	0.770		

Annex (19.2): Independent t- test comparing attending training courses outside hospital with clinical nursing supervision domains

Dependent variable (CS domains)	Independent variable (Training courses outside hospitals)	N	Mean	SD	t	Sig.
Normative function	No	133	3.414	0.757	-1.926	.055
	Yes	136	3.606	0.871		
Formative function	No	130	3.108	0.963	-1.363	.174
	Yes	134	3.275	1.020		
Restorative function	No	130	3.553	0.698	-.798	.426
	Yes	134	3.623	0.714		
Overall perception	No	133	3.359	0.738	-1.566	.118
	Yes	136	3.505	0.791		

Table (19.3): One way ANOVA comparing clinical nursing supervision domains by supervisees' residency place

Dependent variable (CS domains)	Independent variable (Residency place)	N	mean	SD	F	Sig.
Normative function	Gaza	62	3.400	0.846	1.469	.212
	North of Gaza	37	3.536	0.823		
	Mid zone	65	3.479	0.812		
	Khan younis	65	3.486	0.774		
	Rafah	39	3.789	0.833		
	Total	268	3.516	0.818		
Formative function	Gaza	62	3.134	1.052	1.297	.272
	North of Gaza	35	3.159	0.985		
	Mid zone	64	3.150	1.040		
	Khan younis	64	3.134	0.909		
	Rafah	38	3.537	0.934		
	Total	263	3.200	0.993		
Restorative function	Gaza	62	3.534	0.820	.704	.590
	North of Gaza	35	3.677	0.652		
	Mid zone	64	3.546	0.733		
	Khan younis	64	3.567	0.541		
	Rafah	38	3.732	0.716		
	Total	263	3.592	0.699		
Overall perception	North of Gaza	62	3.356	0.828	1.331	.259
	Mid zone	37	3.457	0.787		
	Khan younis	65	3.390	0.770		
	Rafah	65	3.401	0.670		
	Total	39	3.687	0.758		

حالة الإشراف الإكلينيكي التمريضي في المستشفيات الحكومية في محافظات غزة.

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ملخص:

مقدمة

ليس هناك شك في أن الإشراف الإكلينيكي التمريضي له تأثير كبير على جودة الرعاية التمريضية المقدمة للمرضى كما توضحه الكثير من الدراسات. يعاني الكادر الصحي العامل في المستشفيات الحكومية الكثير من ضغط العمل و خاصة التمريض وذلك نتيجة الوضع السياسي الغير مستقر وتأثيره على القطاع الصحي وخاصة الاعتداءات الاسرائيلية المتكررة على قطاع غزة و ما يخلفه من الكثير من الجرحى التي تزيد من العبء على الكادر الصحي. تظهر الكثير من الدراسات أثر الإشراف الإكلينيكي التمريضي على زيادة المهارات و المعرفة لدى الممرضين و كذلك تقليل ضغط العمل وزيادة الرضى الوظيفي لدى الممرضين.

أهداف الدراسة

الهدف العام لهذه الدراسة هو تقييم الإشراف الإكلينيكي التمريضي في المستشفيات الحكومية في محافظات غزة من وجهة نظر كل من المشرفين و الممرضين .

استخدم الباحث في دراسته نمط بروكتر للإشراف الاكلينيكي و الذي يقسم الوظائف الإشراقية الى ثلاثة وظائف وهي: Formative Function و التي تهتم بزيادة المعلومات و المهارات لدى الممرضين و Normative function والتي تهتم بالجانب الاداري للإشراف والتي من خلاله يسعي المشرف الى تحقيق اهداف المؤسسة و ضمان جودة الخدمة المقدمة للمرضى و Restorative Function و التي تسعى الي تقليل ضغط العمل و الضغوط النفسية للممرضين.

منهجية الدراسة

كانت هذه الدراسة وصفية وتحليلية مقطعية. تم اختيار مستشفى واحد من كل محافظة من محافظات قطاع غزة الخمس بطريقة عشوائية. الدراسة شملت جميع المشرفين (رؤساء الأقسام ومشرفي التمريض) وتم اختيار عينة عشوائية

نسبية منتظمة من الممرضين حيث كان حجم العينة من المشرفين 160 شخصا مع معدل استجابة 83.1 ٪ في حين أن حجم العينة للمرضيين كانت 300 شخصا مع معدل استجابة 90 ٪. تم جمع البيانات عن طريق استبيان ذاتي التعبئة يحتوي على مجموعة من المتغيرات الشخصية و الوظيفية و الإشرافية التي تؤثر على وجهة نظر المشرفين و الممرضين. لقد تم التأكد من ثبات الاستبانة عن طريق استخدام معادلة ألفا كرونباخ والتي بلغت قيمتها0.961 في استبيان المشرفين و 0.964 في استبيان الممرضين.

أهم النتائج

- أظهرت النتائج أن ادراك المشرفين لأدوارهم الإشرافية كان بمقدار (80.2%) وأن ادراك الممرضين لأدوار المشرفين الإشرافية الاكلينيكية كان بمقدار (68.6%) مما يعكس تباين الإدراك فيما بينهم تجاه الأدوار الإشرافية على الرغم من أن التوجه ايجابي. كان اقل المحاور إدراكاً هو محور Formative Function عند كلاً من المشرفين (77.5%) و الممرضين (63.8%) حيث يعد هذا المحور هو الوظيفة الأساسية للإشراف الإكلينيكي و من هنا تم استخلاص أن الإشراف الحالي هو إدارياً إلى حد ما أكثر منه إكلينيكياً.
- أظهرت النتائج سيطرة الذكور على الوظائف الإشرافية حيث كان الذكور يشكلون حوالي 70% من المشرفين ولم تكن هناك فروق ذات دلالة احصائية بين ادراك الذكور والاناث لوظائفهم الإشرافية.
- اظهرت النتائج ان غالبية المشرفين لديهم خبرة عالية في التمريض وخبرة اقل في الاشراف حيث بينت النتائج ان حوالي 80% من المشرفين لديهم سنوات خبرة في التمريض اكثر من 5 سنوات و ان حوالي 80% منهم ايضاً لديه سنوات خبرة في الاشراف أقل من 5 سنوات. كما وتبين أن هناك ارتباط ذو دلالة احصائية ما بين سنوات الخبرة في التمريض وبين ادراك المشرفين لمهامهم الإشرافية مما يدلل على أنه كلما زادت الخبرة في التمريض لدى المشرفين كلما زاد ادراكهم لمهامهم الإشرافية.
- اظهرت النتائج ان رؤساء الأقسام (Head nurses) كانوا اكثر ادراكاً لمهامهم الإشرافية الاكلينيكية من مشرفي التمريض (Nursing supervisors).
- اظهرت النتائج نقص واضح في التدريب لكل من المشرفين والممرضين حيث اوضحت الدراسة ان حوالي 25% فقط من المشرفين تلقوا دورات تدريبية في مجال الادارة او الاشراف وان حوالي 33% من

الممرضين تلقوا تدريبات من المشرفين داخل المستشفيات وبينت الدراسة ان الممرضين الذين تلقوا تدريبات من قبل مشرفيهم كانوا اكثر ادراكاً لمهام ووظائف الاشراف.

- ❖ كان هناك قلة في استخدام الأدوات الإشرافية و خاصة قوائم الفحص الإشرافية checklists من قبل المشرفين.
- ❖ كان رضا الممرضين عن الإشراف الإكلينيكي لرؤساء الأقسام أكثر من رضاهم عن مشرفي التمريض.
- ❖ أظهرت النتائج أن الممرضات اكثر ادراكاً من الممرضين تجاه الاشراف الاكلينيكي لمشرفيهم.
- ❖ و كذلك أن افراد التمريض الذين تلقوا دورات تدريبية داخل المستشفى و الذين تلقوا orientation في بداية عملهم و الذين يعملون في اقسامهم المفضلة أكثر ادراكاً تجاه ادوار المشرفين الإشرافية من غيرهم من الممرضين.

أهم التوصيات

خرجت الدراسة بعدة توصيات منها:

- أهمية التمييز و الفصل بين الإشراف الإداري و الإشراف الإكلينيكي.
- عمل سياسة واضحة للإشراف الإكلينيكي تبين مهام المشرف و المشرف عليهم و العلاقة الإشرافية بينهم.
- استخدام و تطوير الأدوات الإشرافية المناسبة بهدف متابعة العمل و مراقبته وتطوير جودته.
- زيادة تمثيل الإناث في المواقع الإشرافية وذلك لتحسين سبل التواصل الإشرافي بين الممرضات.
- عمل وصف وظيفي للقوى العاملة في وزارة الصحة وخاصة لفئات التمريض المختلفة.
- زيادة التدريب للمشرفين لتطوير قدراتهم الإشرافية و القيادية.
- العمل على اشراك المشرفين في صنع القرار داخل المستشفيات.
- العمل على تحديد عدد مناسب من المشرف عليهم تحت اشراف مشرف التمريض Fair span of control.
- تفعيل دور التعليم الداخلي في المستشفيات و عمل تقييم لكفاءته و انجازاته.
- عمل تدريب كاف للمرضين الجدد.