

First-Line Nurse Managers' Clinical Supervision Effectiveness and Supervisory Working Alliance: Proctor's Model Application

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Abstract: Clinical supervision (CS) is a process of professional support to assist nurses in developing their practice. The supervisory working alliance (SWA) is central component of CS that is focused on professional support through facilitated reflection. This study aimed to examine the effect of Proctor's Model application on first-line nurse managers' clinical supervision effectiveness and supervisory working alliance. The study was conducted at all critical and intensive care units, at Damanhour National Medical Institute. All first-line nurse managers and their assistants, (n=24) and all staff nurses (n=157) were included in the study. Three tools were used; Tool (I): is composed of two parts: first part is Demographic data sheet; second part is Manchester Clinical Supervision Scale. Tool (II): Supervisory Working Alliance Inventory (SWAI). Finally, tool (III): Clinical supervision knowledge assessment. Results showed that both first-line nurse managers and staff nurses scored highest for restorative CS domain, at the three times of workshop implementation; followed by normative domain; then, formative domain. Moreover, both of them had the highest score for rapport SWA domain; followed by client focus, at the three times of workshop implementation. Highly significant differences between first-line nurse managers and staff nurses regarding total clinical supervision effectiveness and total supervisory working alliance were found. Highly positive significant correlation between majority of CS domains and majority of SWA domains were detected. Conclusion: Proctor's Model application on first-line nurse managers (supervisors) had positive effect on them and their staff nurses (supervisees') perceptions of CS effectiveness and their SWA; at immediately after and after three months from application; compared to pre-application. Significant improvement of first-line nurse managers' knowledge related to clinical supervision after application. Recommendations: Hospital administrators should conduct clinical supervision workshops periodically; inspire team building among staff members and plan for the coordination of care especially within multidisciplinary teams. Moreover, first-line nurse managers should follow steps of clinical supervision process and encourage reflective practice among nurses.

Key words: Clinical Supervision • Proctor's Model • Supervisory Working Alliance

INTRODUCTION

First-line nurse managers have an essential role in enabling staff development and quality improvement. They have a critical role to play in quality improvement efforts to provide ongoing leadership and accountability for quality care issues. They are accountable for their role in assisting their staff to meet quality and to decrease barriers to provide quality patient care [1, 2]. Assessing the quality of care provided to patients in the clinical

setting is an important nurse manager skill that illustrates more efficiently the benefits of clinical supervision (CS) [3].

Clinical supervision (CS) is a process of professional support and learning in which, nurses are supported in developing their practice through consistent discussion time with experienced and knowledgeable colleagues. It is increasingly being recommended as a mean of supporting professional practice, safeguarding standards, developing professional expertise and improving the

delivery of quality care. Moreover, it can contribute to the development of a more articulated and skilled workforce, which in turn, impacts positively on organizational objectives [4, 5]. It also supports and holds the supervisee, provides a 'restorative' function to assist the supervisee in managing challenges and promotes resilience [6].

There is a variety of models for CS, among them is Proctor's model which has become one of the most influential and widely adopted models in nursing contexts; and put forward a categorization of supervision that would help identify the functions and components of CS in healthcare settings today [7]. The Proctor's Model of clinical supervision [8] comprises three domains, each of these components have two key constructs underpinning them: firstly, a *managerial* category – *normative* domain, where a clinical supervisor is helping the supervisee to examine and reflect on the work done and explored ways of maintaining and improving quality and efficiency for the good and care of the patient; as well as managerial and ethical responsibilities, such as: overseeing the number of clients and ensuring that the guidelines of the organization in which the work is carried out are adhered to. Supervision provides an opportunity to reflect on complex cases and issues. Individual thoughts and feelings regarding approaches to treatment, care, evaluation and planning can be reflected upon in clinical discussions that take place within the clinical environment. Such discussions provide an opportunity to demonstrate accountability and responsibility in the continuous improvement for practice [9]. The normative category is in place also to ensure national and clinical guidelines are adhered to and the supervisee is working to those objectives. The two subscales are: (1) *importance/value of clinical supervision*: importance of receiving clinical supervision and whether clinical supervision process is valued or necessary to improve quality of care and (2) *finding time*: time available for the supervisee to attend clinical supervision sessions [7].

Secondly, a *supportive* category – *restorative*, where supervisor help supervisee to expressing feelings and concerns as an individual in their work and can also help in developing insights into and new perspectives on ways to manage; as well as exploring the emotional effects of the work and the impact of personal life events on the supervisee [7]. Hawkins and Shohet [10] refer to this category as 'pit head time': 'the right to wash off the grime of the work in the manager's time, rather than take

it home'. This protected and planned time is also a time to balance up the positive aspects by encouragement, praise and constructive feedback. The many factors and issues that arise in each of the categories are integrated and feed into each other. To develop the skills of being a clinical supervisor, therefore, it will require flexibility, creativity and knowledge of individual supervisees' needs and experience. The two subscales are: (1) *trust/rapport*: level of trust, rapport with the supervisor during the clinical supervision session and ability to discuss sensitive/confidential issues and (2) *supervisor advice/support*: extent to which the supervisee feels supported by the supervisor; and level of guidance and direction received [7].

Thirdly, a *learning and educative* category – *formative*, where the supervisee is assisted to become aware of strengths and weaknesses in their work; as well as the supervisee's learning and development. By developing insight through reflective practice and becoming more knowledgeable, the supervisee can relate theory to practice and integrate this learning in their clinical practice. This may lead to identification of specific training and development needs. The two subscales are: (1) *improved care/skills*: extent to which the supervisee feels that the clinical supervision sessions have affected his/her delivery of care and improvements in skills; and (2) *reflection*: measure of how supported the supervisee feels with reflecting on complex clinical experiences [8].

The supervisory working alliance (SWA) is the central and pivotal component of CS [11]. There is growing evidence that an officially established alliance between nurses, in which the roles of supervisor(s) and supervisee(s) are well-defined and that is focused on professional support through facilitated reflection, is likely to have positive outcomes for the supervisees [12]. Efstation *et al.* [13] operationalize supervisory working alliance as: "the relationship in clinical supervision and the set of actions supervisors and supervisees use to facilitate the learning of the trainee (supervisee)"; through a set of identifiable activities or tasks performed by each participant in the relationship. The supervisory working alliance are affected by three factors from the supervisor's perspective: (1) *rapport* refers to the supervisors' effort to build rapport with supervisees by supporting and encouraging them; (2) *Client focus* refers to the emphasis the supervisor placed on promoting the supervisee's understanding of the client; and finally, (3) *identification* represents the supervisor's perception of

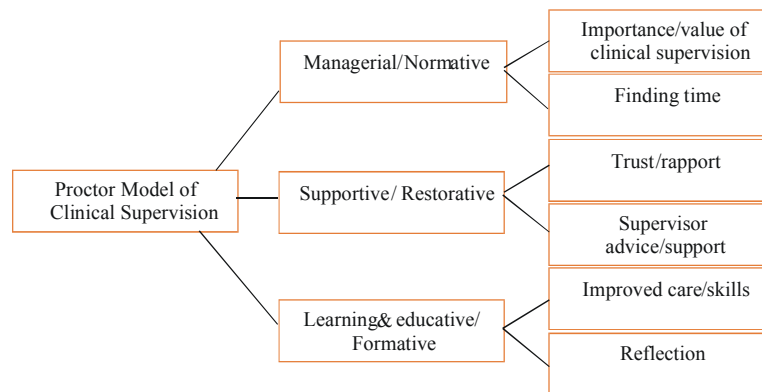


Fig. 1: Proctor's Model of Clinical Supervision [7]

the supervisee's identification with his or her supervisor. The first two factors are also measured from the supervisee's perspective ⁽¹³⁾. The degree to which a good supervisory relationship develops is related to the supervisee's perception of the quality of the supervisory alliance [14].

Recently, the formation of the supervisory alliance has been made a core competency [15]. Clinical supervisors need to develop their own style and not attempt to emulate the style of others. Learn from own experience alongside developing new knowledge, understandings and experiences that a competent training program can offer, as awareness-raising sessions, which in turn will help nurses to avoid burnout and job-related stress, enhance well-being and improve clinical performance, leading to improved nurses' decision-making abilities and job satisfaction [16-18]. Moreover, there is evidence demonstrating that the uptake of clinical supervision has positive impacts not just on the retention and absenteeism rates of nurses but that it also has a positive effect on the quality of patient care [19].

Lately, health professionals will be expected to regularly engage in clinical supervision practice in their health care settings [20]. Researchers found that supervisee perceptions of strong supervisory working alliances are related to enhanced work satisfaction [21]; greater emotional intelligence [22]; stronger supervisor ethical behaviors, lower levels of perceived stress and increased coping resources [23]; and reduce unwanted turnover and mitigate burnout [24]. According to WHO [25], an international shortage of health care workers has meant that health care organizations are keen to adopt workforce strategies that encourage staff retention and reduce burnout. For these reasons, organizations have

taken a greater interest in facilitating the provision of clinical supervision for their health workforce. In Egypt, clinical supervision has gained lately some attention [26, 27]; however, no research has been conducted on supervisory working alliance. To the best author's knowledge, there is no published research on the CS effectiveness and working alliance in the health sector in Egypt. Therefore, this study aims to examine the effect of applying Proctor's CS Model on first-line nurse managers' CS effectiveness and supervisory working alliance.

Aim of the Study: The present study aims to examine the effect of Proctor's Model application on first-line nurse managers' clinical supervision effectiveness and supervisory working alliance.

Study Hypotheses:

H1: The Proctor's Model of CS application for first-line nurse managers will have a positive effect on their clinical supervision effectiveness and their supervisory working alliance.

H2: The Proctor's Model of CS application for first-line nurse managers will have a positive effect on staff nurses (supervisees') perception of clinical supervision effectiveness and supervisory working alliance.

H3: There will be significant improvement of first-line nurse managers knowledge related to clinical supervision after implementing the Proctor's Model.

MATERIALS AND METHODS

Research Design: A quasi-experimental, interventional, one-group, pretest /posttest study was utilized.

Setting: The study was conducted at Damanhour National Medical Institute; at all critical and intensive care units (N=12), namely: general Intensive Care Unit (ICU); coronary care unit; emergency unit (male and female); diagnostic and treatment heart catheter; open heart surgery; neurosurgery ICU; recovery; dialysis; pediatric ICU; high risk; and obstetrics & gynecology ICU. The institute is affiliated to the General Organization for Teaching Hospital and Institutes; and is considered the main teaching hospital at El-Beheira governorate equipped with 336 beds. The facility offers a full range of services including acute inpatient care, intensive care units and partial hospitalization services; as well as paramedical services.

Sample: All first-line nurse managers and their assistants, who were working in the previously mentioned settings and had at least one year of working experience as first-line nurse manager or as assistant, were included. (N = 24)

All staff nurses, working at the aforementioned settings, with at least one year of experience with their first-line nurse managers, were comprised. (N = 157)

Tools of the Study: The data was collected through self-administered questionnaire containing three tools:

Tool (I): is composed of two parts. The *first part* is a *Demographic data questionnaire*: concerning age, educational qualification, working unit, experience in nursing (years) and in the current position (years) and marital status. The *second part* is the Manchester Clinical Supervision Scale-26 (MCSS-26) developed by White & Winstanley [7], which was used to measure the perception of the nursing clinical supervision effectiveness as perceived by participants. It has 26 items, grouped into three domains of clinical supervision as outlined in the Proctor CS Model; using six subscales (two subscales/domain), namely: (1) managerial/normative domain dealing with: importance/value of CS (5-item) and finding time (4-item); (2) supportive/restorative domain consisted of: trust/rapport (5-item) and supervisor advice/support (5-item); and finally, (3) learning, educative/formative domain divided into: improved care/skills (4-item) and reflection (3-item). Responses were measured on a 5-point Likert scale ranging from 1 "Strongly disagree" to 5 "Strongly agree". The scale has high internal consistency ($\alpha=.868$). *Scoring System:*

The scale is scored by summing the items (several negatively worded items are reverse scored), with greater effectiveness indicated by higher scores. The total scores are the average of the item ratings and can range from 26 – 130.

Tool (II): The Supervisory Working Alliance Inventory (SWAI). It was developed by Efstathiou *et al.* [13], to measure the perceived strengths and satisfaction of the working alliance in supervision from both a supervisor and supervisee perspective. The SWAI was administered in two versions: the supervisee's and the supervisor's versions. The supervisee's version contains 19 items that are grouped into two subscales: rapport (13-item) and client focus (6-item). The supervisor's version of the SWAI contains 23 items that are clustered into three subscales: the first two subscales are the same as the supervisee's version; in addition to, identification (4-item). Responses are measured on a 7-point Likert rating scale ranging from 1 "almost never" to 7 "almost always". The scale had high internal consistency for both supervisees' and supervisors' versions ($\alpha=.897$; .921), respectively. *Scoring System:* The scores for each subscale are calculated by obtaining the mean score for all items on each subscale. The total scores are the average of the item ratings and can range from 19 - 133 (supervisee's version); and 23 - 161 (supervisor's version). The higher overall and subscales scores are interpreted as supervisee's perceptions of strong and effective supervisory working alliances.

Tool (III): Clinical supervision knowledge assessment: It was developed by the researchers based on the related literature [1, 2, 28], to assess first-line nurses managers' knowledge regarding clinical supervision and supervisory working alliances, as a pre- and posttest questionnaire. It included 10 questions, encompassing: concepts of clinical supervision and supervisory working alliance; purpose; scope; core characteristics; basic functions of clinical supervision; key features of productive supervision relationships; boundaries in supervision; benefits; and Proctor's Model of CS. All questions were prepared in accordance with raising-awareness workshop content with total score 20 degrees. *Scoring System:* The Score "two" was given for correct and complete answer; "one" was given for each correct and incomplete answer and "zero" for incorrect answer. For each section

of knowledge, the scores of the items were summed up and the total score divided by the number of the items. These scores were converted into a percent score. The total nurses' knowledge was considered good if Knowledge $\geq 75\%$, fair $50 - < 75\%$ and poor knowledge $\leq 50\%$.

Methods: An official permission was granted from the Director of Damanhour National Medical Institute and the departments' heads in which the study was conducted. Researchers met and discussed with nursing administrative personnel the aims and objectives, as well as gaining better cooperation and full support, to stimulate first-line nurse managers to participate positively in the study. Tools (I, II & III) were translated into Arabic and tested for its content and face validity by a jury of five experts (three professors and two assistant professors of nursing administration) and some modifications were done.

Ethical Considerations: The purpose of the study was clarified to participants and oral informed consent to participate in the study was obtained from them. Confidentiality and anonymity of participants; as well as their right to withdraw from the research at any time were guaranteed without any consequences.

Pilot Study: It started, once ethical approval had been obtained, to test the clarity, feasibility and applicability of the study tools. It was conducted on (10%) two first-line nurse managers and 16 staff nurses, rather than the study sample. Based on the results of the pilot study, modifications were done and then the final forms were developed.

Afterwards, the study was conducted through four consecutive phases: assessment, planning, implementation and evaluation.

Assessment Phase: This initial assessment was intended to recognize the studied subjects' demographic characteristics; the perception of both CS effectiveness; and the satisfaction of the supervisory working alliance from the perspective of both the supervisee and supervisor; to assess: (a) first-line nurse managers' knowledge and practices regarding CS effectiveness and supervisory working alliances practices; and (b) staff nurses' perceptions regarding CS effectiveness and supervisory working alliances practices.

Planning and Preparatory Phase: The Proctor's [8] CS Model was applied through raising-awareness workshop, to assist first-line nurse managers for their usage of the reflective opportunity of CS or to assist the formation of clinical supervisors. It is not 'about' supervision, but about learning 'how to do it well'. Based on the assessment phase, the workshop sessions' content and media (in the form of handout and visual materials) were prepared by the researchers, in Arabic language to outfit first-line nurse managers' level of understanding, to improve their application of the CS activities through applying the Proctor's CS Model based on the related literature; through using theoretical knowledge, illustrative pictures, role play and some case studies. The handout was revised by a group of seven experts from nursing administration and nursing education departments. Accordingly, some modifications were done and then the final forms were developed.

Implementation Phase: Tools (I & II) was filled in the clinical area by the studied subjects in the presence of the researchers. The workshop sessions took place at the hospital setting for all first-line nurse managers and their assistants by the two researchers. The handout was delivered to each participant prior to implementation. Four training sessions: an *introductory session* lasting 3 hours; followed by *Proctor's Model of CS initial session* lasting 4 hours; followed, with circa 6 weeks' interval, *two follow-up sessions* lasting 1¼ hours each.

The *introductory session* started with setting the agenda; introducing the purpose of the raising-awareness workshop; and assessing the first-line nurse managers' and their assistants' knowledge (tool III). Then, it was composed of four parts, namely: *part one* was a teaching session: defining concepts; purpose; scope; core characteristics and basic functions of CS. In *part two*, the participants described supervisory relationships, including: identifying the key features of productive supervisory relationships; how much CS they had participated in and the type and structure of the present CS on their units. In *part three*, the participants explored consideration of the limits to CS; boundaries in CS; experienced benefits and barriers to the potential they saw in CS. Lastly, *part four* had a problem-solving focus and participants practicing building supervisory relationships; and get feedback from peers on the simulated activity; and were asked to formulate strategies to overcome barriers and strengthen the potential benefits of their CS.

Afterwards, the *Proctor's Model of CS initial session* involved two parts, as follows: the *first part*, theoretical content of the model with illustrative pictures, concerning its three domains: (1) *managerial/normative*, which relates to the responsibility of the first-line nurse managers to put in place mechanisms for developing competence and supporting nurses in the interest of clinical governance and risk management (maintaining and developing standards of safe, ethical and quality practice; enhancing the effectiveness and ability of the supervisee's clinical role and performance for and within the organization); (2) *supportive/restorative*, which through the development of a supportive relationship with the supervisor, the nurse deals with emotional issues arising from practice which can induce stress (how the supervisee responds emotionally to the stresses of working in a helping environment and caring for others, while allowing time for self-appraisal and well-being; building a nurturing supportive relationship that can help reduce stress while providing motivation and encouragement); and lastly, (3) *learning, educating/formative*, which refers to the aspect of CS that relates to the professional development of nurses through reflection on practice and self-awareness (reflect with confidence on professional role; strength and weakness of supervisee; knowledge and skills as an individual and within a multidisciplinary team; enable to learn and develop professional skills by receiving feedback and to develop new ideas) [8]. Next, *part two*, the application of the model by first-line nurse managers and their assistants through interviewing each other to practice the skills related with building a supervisory relationship and to articulate the skills they desired to develop because of the workshop. Participants reported that they needed to develop skills in providing positive feedback; supervising underperforming nurses and debating the likelihood of a fail. In addition, as all were currently supervising or planning to supervise staff, they expressed a desire to transfer skills learnt in the raising-awareness workshop to their supervised staff. After each exercise, they were provided with structured feedback by their peers and the researchers on how to improve their approach.

The two *follow-up sessions* were based on activities aimed at developing 'second loop learning' by systematically re-exploring insight in the context of new experiences after first-line nurse managers' and their assistants' actual application of the model. It has been

suggested that supervisors should be meeting individually with supervisees on a weekly basis for sixty minutes per session [29]. Depending on the participants' appraisals, these reflections would lead to a validation of their own strategies; an adaption of these strategies and/or to the formulation of additional ones. The follow-up sessions aimed to ensure the first-line nurse managers and their assistants' compliance with the model's application in their clinical setting.

Methods of teaching used were: interactive lectures, group discussion and role play. Instructional media was used; it included handout and visual materials showed with laptop.

Evaluation Phase: The evaluation phase was emphasized by using the study tools (tool I & II) to assessing the effect of Proctor's Model application, through the raising-awareness workshop, for first-line nurse managers' and their staff nurses' at immediately and after three months' post-implementation; for both clinical supervision effectiveness and supervisory working alliance. The first-line nurse managers' knowledge is assessed before and immediately after the sessions (tool III).

Data was collected three times (pre; immediately post; and post three months from raising-awareness workshop implementation), by the above-mentioned tools that were distributed among the subjects at their working units. Each questionnaire took approximately from 30 to 45 minutes/participants. The data was collected for a period of 6 months started from the 1st of January 2016 to the 31st of July 2016.

Statistical Analysis: Data were collected, tabulated and analyzed statistically using an IBM personal computer with Statistical Package of Social Science (SPSS) version 20. The following statistics were applied. 1. *Descriptive statistics:* in the form of mean percent score with standard deviation; and qualitative data were presented in the form of frequencies and percentages. 2. *Analytical statistics:* The Friedman test is the non-parametric alternative to the one-way ANOVA with repeated measures; and Correlation coefficients are used to measure the strength of the relationship between two variables. All statistical analysis was done using two tailed tests and alpha error of 0.05. Regarding *P* value, it was considered that: non-significant (NS) if $P > 0.05$, Significant (S) if $P < 0.05$, Highly Significant (HS) if $P < 0.01$.

RESULTS

Table (1) demonstrated that the mean age of first-line nurse managers and their assistants was 46.65 ± 4.21 ; compared to 37.68 ± 12.53 for staff nurses. All first-line nurse managers and their assistants were holding a Bachelor of Nursing Sciences; however, above two thirds of staff nurses (67%) had Diploma of Secondary Nursing School. The first-line nurse managers and their assistants were equal at all critical and intensive care units (8.3%); while the highest percentage of staff nurses (19.1%) worked in kidney dialysis unit; and the lowest percentage of them (3.2%) worked in diagnostic and treatment heart catheter unit. All nurses had more than 10 years of nursing experience; The highest percentage of first-line nurse managers and staff nurses were married (75% & 66.2%), respectively. Additionally, more than half (58.3%) of first-line nurse managers and their assistants attended a CS training previously.

Table (2) indicated that first-line nurse managers and their assistants' (supervisors) perception of the clinical supervision effectiveness domains were highly significant differences between the three times of workshop implementation (pre, immediately after and after three months), for total CS, normative, restorative and formative domains (where $P = 0.007, 0.000, 0.001$ & 0.003), respectively. the highest domain was for restorative at the three times of workshop implementation ($31.47 \pm 5.81, 45.30 \pm 6.21, 42.60 \pm 7.21$), respectively; followed by normative domain ($27.90 \pm 9.40, 40.00 \pm 7.41, 38.60 \pm 5.14$), consequently; then, formative domain ($21.34 \pm 8.51, 32.61 \pm 7.80, 33.79 \pm 4.60$), respectively.

Table (3) illustrated that staff nurses' (supervisees) perception of the clinical supervision effectiveness domains were highly significant differences between the three times of workshop implementation (pre, immediately after and after three months), for total CS, normative and formative domains ($P = 0.004, 0.002$ & 0.000), respectively. Whereas, a significant difference was found between the three times of evaluation and restorative domain ($P = 0.011$). The highest domain was for restorative at the three times of workshop implementation ($29.74 \pm 6.21, 41.25 \pm 6.24, 39.67 \pm 8.31$), respectively; followed by normative domain ($20.45 \pm 5.60, 36.08 \pm 7.11, 34.59 \pm 4.81$), consequently; then, formative domain ($19.36 \pm 4.54, 28.30 \pm 4.90, 30.25 \pm 5.97$), respectively.

Table (4) stated that first-line nurse managers' and their assistants (supervisors) perception of the supervisory working alliance domains were highly significant differences between the three times of

workshop implementation (pre, immediately after and after three months), for total SWA and identification domains ($P = 0.000, 0.001$), respectively. Whereas, a significant difference was found between the three times of evaluation and both rapport and client focus domains ($P = 0.010, 0.020$), consequently. The highest domain was for rapport at the three times of workshop implementation ($57.31 \pm 6.4, 69.32 \pm 5.9, 71.60 \pm 4.3$), respectively; followed by client focus domain ($29.47 \pm 4.6, 34.30 \pm 3.9, 39.70 \pm 2.8$), consequently; lastly, identification domain ($14.53 \pm 1.9, 19.80 \pm 2.6, 23.70 \pm 3.2$), respectively.

Table (5) mentioned that staff nurses' (supervisees) perception of the supervisory working alliance domains were significant differences between the three times of workshop implementation (pre, immediately after and after three months), for total SWA, rapport and client focus domains ($P = 0.027, 0.020, 0.031$), consecutively. The highest domain was for rapport at the three times of workshop implementation ($52.50 \pm 4.6, 63.70 \pm 6.8, 75.66 \pm 8.3$), respectively; followed by client focus domain ($25.90 \pm 6.1, 30.21 \pm 4.5, 29.54 \pm 3.6$), consequently.

Fig. (2) illustrated that first-line nurse managers' knowledge score related to clinical supervision and supervisory working alliances were good (96%) immediately after workshop implementation; compared to (91%) of them, who had poor knowledge pre-implementation of the raising-awareness workshop.

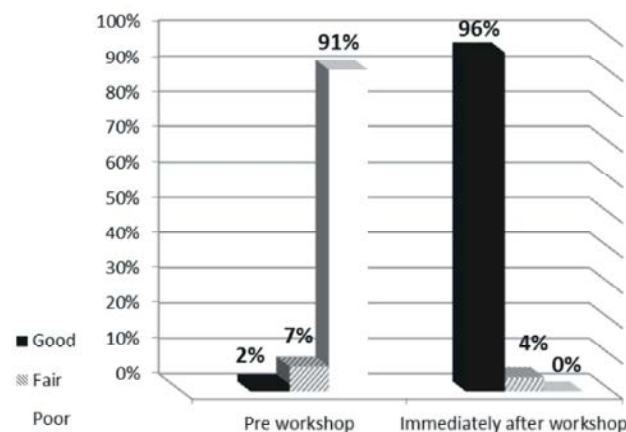
Table (6) showed highly significant differences between first-line nurse managers and staff nurses regarding total clinical supervision effectiveness and normative domain ($P = 0.000, 0.003$), consecutively. However, significant differences were found between both of them regarding restorative and formative domains ($P = 0.020, 0.010$), respectively.

Table (7) displayed highly significant differences between first-line nurse managers and staff nurses regarding total supervisory working alliance and client focus domain ($P = 0.000, 0.001$), consecutively; compared to, a significant difference related to rapport domain ($P = 0.020$).

Table (8) indicated highly positive significant correlation between normative CS domain and restorative and formative domains; and rapport, client focus SWA domains ($P = 0.000, 0.004, 0.001, 0.004$), respectively. Moreover, highly significant correlations were found between restorative CS domain and formative CS domain, rapport and identification SWA domains ($P = 0.001, 0.001, 0.001$), consecutively. Furthermore, high significant correlations were found between formative CS domain and rapport SWA domain, also between rapport SWA domain

Table 1: Demographic characteristics of studied sample working at Damanhour National Medical Institute

Demographic characteristics	First-line nurse managers (N = 24)		Staff nurses (N = 157)	
	No.	%	No.	%
Age				
Less than 30	0	0.0	34	21.7
30-40	6	25.0	68	43.3
40-50	16	66.7	32	20.4
50-60	2	8.3	23	14.6
Age (mean \pm SD)	46.65 \pm 4.21		37.68 \pm 12.53	
Educational level				
Diploma of Secondary Nursing School	0	0.0	105	67.0
Diploma of Technical Institute of Nursing	0	0.0	13	8.2
Bachelor of Nursing Sciences	24	100.0	39	24.8
Working unit				
General intensive care	2	8.3	15	9.6
Coronary care	2	8.3	12	7.6
Emergency - male	2	8.3	7	4.6
Emergency - female	2	8.3	10	6.4
Diagnostic and treatment heart catheter	2	8.3	5	3.2
Open heart surgery	2	8.3	6	3.8
Neurosurgery intensive care	2	8.3	12	7.6
Recovery	2	8.3	6	3.8
Dialysis	2	8.3	30	19.1
Pediatric intensive care	2	8.3	22	14.0
High risk	2	8.3	12	7.6
Obstetrics & gynecology intensive care	2	8.3	20	12.7
Years of nursing experience				
1-5 years	0	0.0	36	22.9
5-10	0	0.0	83	52.9
More than 10 years	24	100.0	38	24.2
Years of current position experience				
1-5 years	4	16.7	29	18.5
5-10	3	12.5	75	47.8
More than 10 years	17	70.8	53	33.7
Marital status				
Single	2	8.3	43	27.4
Married	18	75.0	104	66.2
Widow	4	16.7	7	4.5
Divorced	0	0.0	3	1.9
Attendance of previous training on clinical supervision				
Yes	14	58.3	--	--
No	10	41.7	--	--



Good Knowledge= 75%; fair 50-<75%; poor = 50%

Fig. 2: Distribution of total first-line nurse managers' knowledge score regarding clinical supervision and supervisory working alliances, pre and immediately after Proctor's Clinical Supervision Model application raising-awareness workshop (N = 24)

Table 2: Distribution of first-line nurse managers and their assistants (supervisors) perceptions of the Clinical Supervision (CS) effectiveness mean percent at pre, immediately after and post three months after Proctor's Model raising-awareness workshop

First-line nurse managers/assistants (Supervisors) (N = 24)								
Clinical Supervision (CS) effectiveness Domains	Pre		Immediately after		Post three months		Friedman test	p
	Mean%	SD	Mean%	SD	Mean%	SD		
Normative	27.90	9.40	40.00	7.41	38.60	5.14	4.25	.000**
Restorative	31.47	5.81	45.30	6.21	42.60	7.21	4.01	.001**
Formative	21.34	8.51	32.61	7.80	33.79	4.60	3.921	.003**
Total CS	81.73	11.28	116.29	13.54	113.8	10.97	2.845	.007**

*Significant at P< 0.05; **highly significant at P<0.01

Table 3: Distribution of staff nurse (supervisees) perceptions of the Clinical Supervision (CS) effectiveness mean percent at pre, immediately after and post three months after Proctor's Model raising-awareness workshop

Staff nurses (Supervisees) (N = 157)								
Clinical Supervision (CS) effectiveness Domains	Pre		Immediately after		Post three months		Friedman test	P
	Mean%	SD	Mean%	SD	Mean%	SD		
Normative	20.45	5.60	36.08	7.11	34.59	4.81	3.25	.002**
Restorative	29.74	6.21	41.25	6.24	39.67	8.31	1.625	.011*
Formative	19.36	4.54	28.30	4.90	30.25	5.97	3.98	.000**
Total CS	75.32	9.91	101.7	8.76	105.64	7.52	2.78	.004**

*Significant at P< 0.05; **highly significant at P<0.01

Table 4: Distribution of first-line nurse managers and their assistants (supervisors) perceptions of their supervisory working alliance mean percent at pre, immediately after and post three months after Proctor's Model raising-awareness workshop.

First-line nurse managers/assistants (Supervisors) (N = 24)								
Supervisory Working Alliance (SWA) domains	Pre		Immediately after		Post three months		Friedman test	P
	Mean%	SD	Mean%	SD	Mean%	SD		
Rapport	57.31	6.4	69.32	5.9	71.60	4.3	3.21	.010*
Client focus	29.47	4.6	34.30	3.9	39.70	2.8	2.17	.020*
Identification	14.53	1.9	19.80	2.6	23.70	3.2	3.145	.001**
Total SWA	88.4	10.6	115.3	11.7	131.2	12.7	4.15	.000**

*Significant at P< 0.05; **highly significant at P<0.01

Table 5: Distribution of staff nurses (supervisees) perceptions of their supervisory working alliance mean percent at pre, immediately after and post three months after Proctor's Model raising-awareness workshop.

Staff nurses (Supervisees) (N = 157)								
Supervisory Working Alliance (SWA) domains	Pre		Immediately after		Post three months		Friedman test	p
	Mean%	SD	Mean%	SD	Mean%	SD		
Rapport	52.50	4.6	63.70	6.8	75.66	8.3	2.01	.020*
Client focus	25.90	6.1	30.21	4.5	29.54	3.6	1.782	.031*
Total SWA	57.13	12.2	75.31	9.6	72.31	8.7	1.69	.027*

*Significant at P< 0.05; **highly significant at P<0.01

Table 6: Comparison between first-line nurse managers and staff nurses' perceptions of the Clinical Supervision (CS) effectiveness at Damanhour National Medical Institute

Clinical Supervision (CS) effectiveness Domains	First-line nurse managers (N=24)		Staff nurses (N=157)		T-test	P-value
	Mean	SD	Mean	SD		
Normative	38.6	5.14	34.59	4.81	4.21	.003**
Restorative	42.6	7.21	39.67	8.31	2.98	.020*
Formative	33.79	4.6	30.25	5.97	3.27	.010*
Total CS	113.8	10.97	105.64	7.52	4.74	.000**

*Significant at $P < 0.05$; **highly significant at $P < 0.01$

Table 7: Comparison between first-line nurse managers and staff nurses' perceptions of the Supervisory Working Alliance (SWA) at Damanhour National Medical Institute

Supervisory Working Alliance (SWA) Domains	First-line nurse managers (N=24)		Staff nurses (N=157)		T-test	P-value
	Mean	SD	Mean	SD		
Rapport	71.6	4.3	75.66	8.3	2.61	.020*
Client focus	39.7	2.87	29.54	3.6	4.619	.001**
Total SWA	93.71	12.7	72.31	8.7	4.38	.000**

*Significant at $P < 0.05$; **highly significant at $P < 0.01$

Table 8: Correlation matrix between Proctor's Model of Clinical Supervision (CS) effectiveness and Supervisory Working Alliance (SWA) among first-line nurse managers (n = 24).

CS/SWA domains		Restorative	Formative	Rapport	Client focus	Identification
Normative	r	2.920	1.34	.946	1.01	.701
	P	.000**	.004**	.001**	.004**	.030*
Restorative	r		2.170	1.36	.970	1.84
	P		.001**	.001**	.011*	.001**
Formative	r			.741	.420	.632
	P			.005**	.040*	.020*
Rapport	r				2.14	1.90
	P				.000**	.002**
Client focus	r					.871
	P					.020*

*Significant at $P < 0.05$; **highly significant at $P < 0.01$

and both client focus and identification SWA domains ($P = 0.005, 0.000, 0.002$), respectively. Significant correlations were found between normative CS domain and identification SWA domain ($P = 0.030$), as well as between restorative CS domain and client focus SWA domain ($P = 0.11$); also, between formative CS domain and both client focus and identification SWA domains ($P = 0.040, 0.020$), consecutively; furthermore, between client focus and identification SWA domains ($P = 0.020$).

DISCUSSION

Clinical supervision has been variously described as an educational process, a way for organizational goals accomplishment, or as a personally focused competence development process [30]. This uncertainty concerning the nature and objectives of clinical supervision highlights the vitality of clarifying its definition and goals, when approaching the overview of clinical supervision.

"Clinical supervision is systematic, protected time to facilitate in-depth reflection of clinical practice". Its intentions were to enable the supervisee to accomplish, sustain and develop creatively a high quality of care, through the means of intensive support and development. The supervisee reflects on the part played as an individual in the complexities of the procedures and the quality of care. This reflection is enabled by one/more experienced colleagues, who have some facilitation experiences and regular, ongoing sessions that are led by the supervisee's schedule. The process of clinical supervision should endure throughout the supervisee's career, whether remaining in clinical practice or moving into management, education or research [31]. The supervisory working alliance has come to be increasingly regarded as the crucial and pivotal component in the effective examination of clinical supervision relationship, considered to practically affect and contribute to its continuing process and eventual outcomes [32].

The findings of the present study indicated that the raising-awareness workshop on Proctor's Model of CS for first-line nurse managers (supervisors) had a positive outcome on their clinical supervision effectiveness at immediately and after three months from implementing the workshop (H1). Regarding the three domains of CS, a highly significantly difference at immediately and after three months than before the implementation was found. The restorative domain ranked first, followed by, normative and finally, formative. From the researcher point of view, this may be due to the benefit first-line nurse managers got, when they perceived clinical supervision as a supportive mechanism for staff development, as well as being concerned with maintaining and monitoring the effectiveness of their practitioner's everyday practice; by responding emotionally to the stresses and demands of practice; and the development of knowledge, skills and attitudes through regular reflection on practice provided. However, they pointed out that lack of time, nurses' shortage during shift and simultaneously of activities seem to display dissatisfaction as regards educating their staff nurses during clinical practice. This is in line with Brunero and Stein-Parbury study's [12], which was conducted in Australia, to measure the effectiveness of clinical supervision in nursing: as an evidenced-base literature review. They reported that a high score for any domain reflects a high degree of effectiveness for that aspect of the clinical supervision process. A high total evaluation score reflects a high level of overall effectiveness of the CS process. They stated that CS also supports and holds the supervisee, provides a 'restorative' function to assist the supervisee in managing challenges and promotes resilience. Additionally, Gonge and Buus [33] added that the intervention apparently had the strongest effect on those staff already engaged in clinical supervision or staff employed in wards with a progressive attitude towards clinical supervision. Moreover, White and Winstanley [34] mentioned that interventions promoting clinical supervision probably have the best chances of a positive result when given to staff with a prepared mind employed in wards actively engaged in clinical supervision. On the contrary, the most tense, self-protective, anxious or even hostile nurses or wards are possibly those least likely to involve themselves in the process of self-disclosure and reflection that would be required to find clinical supervision useful [35].

The findings of this study also indicated a highly significant difference for staff nurses (supervisees), related to normative and formative domains of clinical supervision effectiveness, a significant difference was

also found on behalf of restorative domain between the three-evaluation times of workshop implementation (H2). Furthermore, results of the present study indicated that staff nurses' perceptions of total clinical supervision effectiveness increased significantly immediately and after three months from implementation. This could be attributed to the changes in nurses' perceptions after implementing the raising-awareness workshop, because their first-line nurse managers learned knowledge and gained skills about clinical supervision and how to implement it for them, resulting in positive nurses' perceptions toward the effectiveness of CS provided by their nurse managers. This comes in line with Heshmati *et al.* [36], who studied the effect of implementing CS Model on patient education outcomes and indicated that training on CS could result in changes in attitudes, values and behaviors of supervisors, as well as the supervisees' perceptions of their managers. Moreover, it is concluded that the participation in clinical supervision is associated with the experience of a positive effectiveness [37].

Regarding first-line nurse managers' (supervisors') perceptions of their supervisory working alliance, highly significant differences was noted between the three times of raising-awareness workshop evaluation (pre, immediately after and after three months), for rapport, client focus and identification. This result could be due to gained ability of the nurse managers to provide nurses with the needed support, advice; find the ways and time to gain and improve more skills and develop themselves personally and professionally. This result was supported by Nasiriani *et al.* [38], who stated that CS might help nurses to better understand their personal and professional issues and to think about nursing care in new ways; as well as consider their personal and professional management of their practice and relationship with others. Furthermore, it helps nurses to reflect about day-to-day management with their first-line nurse managers that could develop trust and rapport as working alliances. Moreover, in Jordan, Alaedein [39] concluded that supervisory working alliance was the strongest and unique predictor of their self-efficacy. This is also supported by Watkins [32], who concluded that the vision of the supervisory working alliance as tripartite in nature-encompassing a solid rapport, shared goals and tasks/duties between supervisor and supervisee.

Pertaining to staff nurses' (supervisees') perceptions of their supervisory working alliance domains, highly significant differences were found between the three times of workshop evaluation (pre, immediately after and after three months), regarding rapport and client focus.

This could be explained as, the first-line nurse managers recognized and learned in the clinical supervision raising-awareness workshop, the way and the importance of building good supervisory working relationships and alliance with their nurses as a part of their role, leading to better patient outcomes. This led to more concern and contact from first-line nurse managers with nurses in forms of: building trust and rapport with them; giving advice and support; guidance and improving their skills; and lastly, finding time to reflect on practice and personal issues. These findings were also supported by the results of the current study, where significant correlation was found between staff nurses' perception of supervisory working alliance and first-line nurse managers' knowledge and perception of clinical supervision. This result could be supported by Abbasi and Norouzi [40], who indicated that clinical supervision might help nurses to better understand their personal and professional issues and think about their clinical practices in new ways, as well as consider their personal and professional relationships and alliance with each other's. Furthermore, when participants reported having higher perceived supervisory working alliances, they tended to have a strong sense of security and emotional closeness with their supervisors [41, 42]. This is also supported by Alaedin [39], who indicated that supervisees compared to supervisors rated significantly their supervisory working alliance in higher levels.

The current study findings showed improvement of first-line nurse managers regarding their knowledge of CS after implementing the raising-awareness workshop (H3). This reflects the willingness and motivation of first-line nurse managers to apply what they learned during the CS raising-awareness workshop and the period given between sessions to apply the learned materials; then getting back to present the outcomes in front of their colleagues. Moreover, due to the nature of the workshop implementation method, as they were asked to apply Proctor's Model learnt materials, during the implementation phase, by giving them time for application to promote knowledge retention and skills application. This comes in line with Milne and James [43] who observed impact of application on competence in clinical supervision. They concluded that clinical supervision training resulted in supervisors' knowledge and experience gain, which reflected positively on their supervisees' perspectives about CS. This also could be supported by Neill [44], who studied clinical supervision and pointed out that CS improved and was related mainly to the clinical supervisors' training and education in clinical supervision. Additionally, it was found that the

effectiveness of CS has been affected by supportive facilities; working conditions; and communication and relationships with supervisors. Furthermore, frequent participation was an important effect of the intervention because according to the applied model, participation functions as the prerequisite for any effectiveness or benefits of clinical supervision.

The findings of the present study also indicated that the raising-awareness workshop on Proctor's Model of CS for first-line nurse managers (supervisors) showed statistically significant increase in the total score of both their and their staff nurses, regarding normative, restorative and formative CS effectiveness domains, throughout all the three evaluation times of the workshop. This is in agreement with Sheridan *et al.* [45] who carried out a study about a conceptual model for the expansion of clinical supervision training. They stated that CS is essential to promote supervisee growth and development; to protect the welfare of the client; to monitor supervisee performance and act as a gatekeeper for the profession; and lastly, to empower the supervisee to self-supervise and become an independent professional. Moreover, the growth and development of nurses, who receive an effective clinical supervision, is achieved through an organized process to facilitate reflective practice. This strategy of professional development is considered to increase nurses' well-being and self-awareness and contributes also to an amelioration in the quality of practice, which consequently, could improve outcomes for clients [45].

The findings of the present study show statistically significant increase in the mean score of first-line nurse managers and staff nurses regarding Supervisory Working Alliance (SWA) domains: rapport and client focus, throughout pre, immediately post and after three months from workshop implementation. This is supported by Gonsalvez and Milne [46] who conducted a study, in Australia, about clinical supervisor training: a review of current problems and possible solutions. They stated that nurse manager as a clinical supervisor has an important role for supporting nurses especially in complex care situations and preventing them from becoming overwhelmed by patients' situations and allowing them to deal with emotions that the caring relationship may cause. The more contact with clinical supervisor, the more support nurses received in these caring situations. Furthermore, the findings of the present study illustrate positive correlation between Proctor's Model of Clinical Supervision (CS) effectiveness and Supervisory Working Alliance (SWA) among first-line nurse managers. This could be supported by Ellis and Ladany [47] who studied

the inferences concerning supervisees and clients in clinical supervision through an integrative review. They mentioned that statistical significance gradual increases between Proctor's Model of CS effectiveness and SWA among studied subjects. In addition to that, they concluded that good relationship and contact of nurses (supervisees) with their first-line nurse managers (supervisors) is a potential mean for working constructively with each other; bring about renewed, flexible harmonious relationships with colleagues; and improve their performance that bear positive effect on clinical care management and staff welfare. Moreover, the supervisory working alliance is the medium, through it teaching, transfer and perpetuation process occurs, by enhancing its practical application and implementation throughout the clinical supervision process [32].

CONCLUSION

The current study findings concluded that Proctor's Model application on first-line nurse managers (supervisors) had positive effect on their clinical supervision effectiveness and their supervisory working alliance; as well as on their staff nurses (supervisees') perceptions of clinical supervision effectiveness and supervisory working alliance, at immediately after and after three months from Model application through raising-awareness workshop; compared to pre-application. Moreover, significant improvement of first-line nurse managers knowledge related to clinical supervision after applying the Proctor's Model was found compared to pre-application.

Recommendations: Based on the findings of the study, the following recommendations are suggested:

Hospital administrators should:

- Conduct clinical supervision workshops periodically for all first-line nurse managers based on their job description as a refreshment course.
- Support and inspire team building among staff members and plan for the coordination of care especially within multidisciplinary teams, through encouraging teamwork that can develop cooperation for the benefits of patient welfare.
- Assist all staff members, upon appointment, to become fully oriented to clinical supervision arrangements and supervisory working alliance, including new graduates and others transferring into the health workforce.

First-line nurse managers should:

- Follow steps of clinical supervision process and conduct it daily with their staff nurses.
- Encourage reflective practice among nurses to promote better communication and rapport between them.
- Inspire their aspire leaders and in-charge nurse to attend clinical supervision training, to apply it during their on-duty shift.
- Future research is needed to investigate the factors affecting clinical supervision application; to apply the Proctor's CS Model in medical and surgical wards; and to examine relationship between clinical supervision and communication.

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