Review of European Studies; Vol. 7, No. 11; 2015
ISSN 1918-7173 E-ISSN 1918-7181
Published by Canadian Center of Science and Education

Clinical Supervision: Challenging the Nursing Environment?

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Received: May 7, 2015 Accepted: June 23, 2015 Online Published: July 30, 2015

doi:10.5539/res.v7n11p273 URL: http://dx.doi.org/10.5539/res.v7n11p273

Abstract

Models of clinical supervision implementation generally focus on the importance of organisational culture. Questions remain regarding the detailed nature of such a culture. There is a scarcity of information related to the culture of the nursing environment in the Czech Republic; however, it is upon this culture that any future strategy must be based. The goal of this paper is to grasp the ways in which nurses in Czech hospitals perceive the culture of the nursing environment with regard to the implementation of clinical supervision. An explorative research design was used based on qualitative approach. Fourteen in-depth interviews were conducted face to face. The interviews were recorded, transcribed in full, and then coded. Thematic analysis and axial coding led to the paradigm model *reversed face of the nursing environment* which makes visible the contrasts between cultural features of the Czech nursing environment and the culture of supervision as perceived by informants. Given the research evidence regarding the similarities between nursing culture in various countries, the paradigm model might be a source of inspiration beyond the Czech context.

Keywords: clinical supervision, Czech Republic, implementation strategy, nursing environment, nursing culture, organisational culture, paradigm model, qualitative research

1. Introduction

The term “clinical supervision” is used primarily in English-speaking countries. It is mainly used to describe a formal process of professional support for the reflection on and development of the practitioner’s interaction with patients and team members to ensure that the best quality of care is provided. According to Proctor’s (1987) frequently used definition, one can distinguish between formative, restorative, and normative functions of supervision. In Central European countries, those in the field refer to the same concept as “supervision”, and this activity is regulated by national professional associations for supervision and the umbrella Association of National Organisations for Supervision in Europe. It is in this sense that we use the term “supervision”. Analogously with the term “clinical supervision”, we define supervision as non-authoritative external support provided to professionals to develop higher-quality practice. By external support, we mean the work of independent professionals who are outsiders to the organisation they are supporting.

In the Czech Republic, supervision has been officially implemented in social service provision for about 15 years, and there is an abundance of mostly positive experiences of participants with the process. Typically, social services organisations hire external supervisors to conduct team supervision. Individual and group supervision are also widespread. Students of social work obtain their first experience with supervision as part of their education (Havrdová et al., 2008). There have been two independent methods of implementing supervision in the field: through schools of social work and directly through social services providers. Supervision is mostly conducted by trained professional supervisors, and training is provided through a master’s programme at Charles University, as well as by a number of professional alliances.

There is little experience with nursing supervision in the Czech Republic. The only existing two-year master’s programme has successfully trained only eight nurses since 2003 because of its high admission demands. Awareness of supervision in the nursing community has been raised primarily through further education courses in which students are able to experience model sessions. However, few healthcare establishments have actually implemented and tested supervision to date.

Nursing as part of the healthcare system in the Czech Republic is undergoing major structural changes. It is

facing a transformation of the system of nursing education, as well as a series of inconsistent changes implemented by each new government. Some members of the Czech Association of Nurses, which is currently the largest organisation of non-medical professionals in the Czech Republic, have been promoting the idea of implementing supervision in clinical settings, with the primary aim of supporting nurses in this difficult time of transformation (Česká asociace sester, 2013). In this context, in her master's thesis, the first author raised the question of how far supervision could be implemented through nursing education (Vanclová, 2014). The author's in-depth interviews produced plenty of interesting data, which were not fully explored for the thesis, and after its defence, she invited the co-author to work collaboratively on the secondary analysis of the data for this paper. The shifted goal of the analysis was to grasp the ways in which nurses perceive the nature of the nursing environment with regard to supervision. The investigation was conducted under the Institutional Research Development Programme, where both authors undertake research, and it was approved by the council of the programme. Both authors are clinical supervisors. The first author is a doctoral student and an experienced nurse with insider knowledge of the nursing environment. The second author is a teacher of supervision who has gained abundant experience implementing it in the social services field since the 1990s; she is also a researcher with an interest in issues related to organisational culture. Analogously with the field of social services in CR, the authors have assumed that supervision in Czech nursing might be implemented primarily through nursing schools and nursing education, not through the workplace.

2. Methods

Exploratory qualitative research was conducted based on semi-structured, in-depth interviews and the researchers' field notes. The aim was to gain insight into nurses' experiences with supervision and to elicit their opinions regarding the prospects of implementing supervision in the workplace and/or in nursing education. The sampling strategy aimed to represent different types of groups involved in contemporary debates about the implementation of supervision. Suggestions for implementation, which were based on content analysis of the data, were presented in the first author's master's thesis. All participants gave their informed consent and were assured that all the data they provided would remain confidential and anonymous. They were advised that participation was voluntary and that they were free to decline or to withdraw from the study at any stage. The secondary analysis, which was based on the transcripts of the original interviews, attracted the researchers' interest in the nurses' perceptions of their working environment. This was not the original focus of the interviews; however, the theme unintentionally occupied a large proportion of the nurses' accounts.

2.1 Sample

In the non-probability, theoretical sampling strategy, the choice of each additional informant was based on the results of the content analysis thus far. The informants' experiences with clinical supervision, nursing practice, and the system of nursing education were defined as the sampling criteria, and snowball sampling was used as an additional strategy. These choices helped to explore the area of interest as extensively as possible; however, they severely limited the target group of eligible informants (Hendl, 2008; Miovský, 2010). The sample consisted of 14 informants—inadvertently all women—four of whom were clinical supervisors, two general nurses, three nursing teachers, two charge nurses, and three nursing administrators. At the time of conducting the fieldwork, the nurses were working in different areas (operating rooms, surgery, urology, internal medicine, preventive care, otolaryngology, and stomatology) and had experienced one or several different nursing areas in the past. Their places of work were also diverse, and they reported a relatively high frequency of switching between jobs and positions. The variability of the sample allowed the researchers to view the topic through the lens of people working in a university hospital in the capital city, in local hospitals, for a private healthcare provider, or for a social service provider with nursing in its portfolio. The nursing teachers gained experience in a number of areas of clinical nursing; after steering their careers towards the target group of non-medical professionals, they started teaching at public colleges in the capital city and also in a regional city.

2.2 Data Collection

Semi-structured interviews (Hendl, 2008) were the main method of data collection. Fourteen in-depth interviews were conducted by the first author. Data collection was concluded when similar information began to arise concerning the supervision implementation strategy and additional interviews were not expected to bring new information with respect to the original research topic (data saturation). In her field notes, the main author recorded any insights and observations gained during the course of interviewing.

2.3 Data Analysis

The interviews were audio-recorded and transcribed in full. The initial stage of the secondary data analysis took the form of Strauss and Corbin's (1999) open coding. Using pen and paper, concepts were first delimited and,

subsequently, a key categorization system was formed. In this stage, each author proceeded separately. The second author then conducted axial analysis and drafted the paradigm model. On an ongoing basis, both authors verified their emerging insights and interpretations in mutual discussion, as well as by consulting primary data and the relevant literature.

The paradigm model resulted from thematic analysis and axial coding (Strauss & Corbin, 1999). The model's central category was labelled *the reversed face of the nursing environment*, while efforts to implement clinical supervision were treated as specific strategies of change.

2.4. Limitations of the Study

The results rely on data obtained from nurses working in Czech hospitals and are specifically linked to this environment. The interviews did not centre primarily on research on the culture of the nursing environment; rather, the purpose was to collect experience and ideas about implementing supervision in the environment. The paradigmatic model can serve only as a mind map for organisational culture research in an actual health facility should supervision be implemented there.

The interviews might have been shaped by a preconception of the authors' assumptions regarding the two main strategies of implementing supervision with the preference for a school-based strategy. However, this expectation was not supported by the accounts. The results section details the contents of these strategies and admits the mixture of both in a concrete implementation strategy.

The positions and opinions of physicians and top managers—two groups that were frequently mentioned in the interviews—were not considered in this study. These groups pursue a range of strategies of change that, unfortunately, extend beyond the scope of the present study. The concrete implementation strategy must include their positions, which, importantly, shape the nursing environment in relation to supervision.

Finally, gender bias cannot be ruled out, because both researchers and the sample comprised females exclusively.

3. Results

The results will be presented in the form of the paradigm model (Figure 1) derived from the primary data using axial analysis. Although a complex body of informants' accounts (a total of 200 pages of transcripts) have been gathered, the text will be kept concise, and the resulting categories and subcategories used to build the model will be illustrated with only brief portions of primary data. Examples of the expressions used by informants, or their larger accounts, are used to illustrate the most constituted categories. Codes and numbers are used for the participants whose accounts are cited (e.g. R4). Furthermore, links will be drawn between the categories and the contemporary scholarly discourse by presenting brief findings from the literature that resonate with them and that were found during the course of the analysis. This will be done in an effort to enhance triangulation.

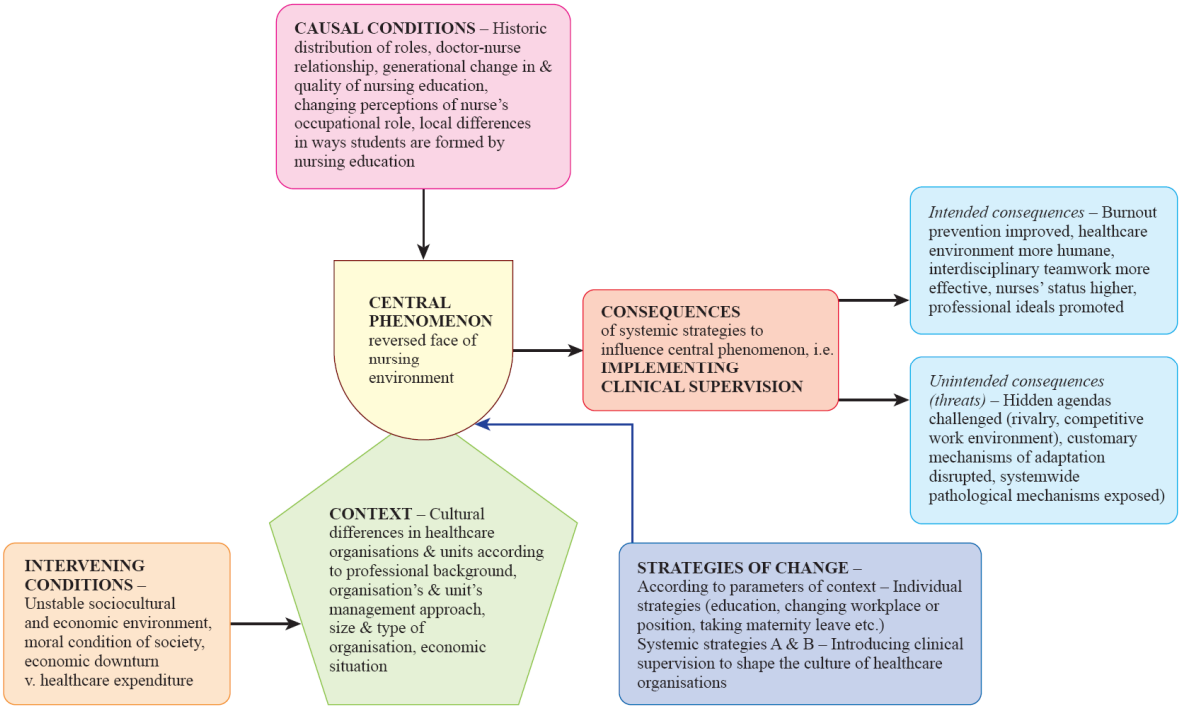

Figure 1. Clinical supervision challenging the nursing environment? A paradigm model

3.1 Central Phenomenon: Reversed Face of the Nursing Environment

According to McLuhan (in Belohradsky, 2009), every concept (or narrative) influences us like a figure which attracts our attention, intensifies and strengthens certain fields of new possibilities, and supplies something to us. The illuminated figure leaves behind in the shadow something which was here before and which now seems archaic. However, this shadow resists the figure and will eventually defeat it and change it into something else.

Contemporary healthcare discourse is dominated by concepts such as quality and safety of care, a holistic approach to the patient, and organisational effectiveness (World Health Organization, 2011; Department of Health, 2002). **We understand these concepts as the illuminated figure of the public discourse of doctors and nurses, which is supposed to capture how successful or advanced a healthcare provider is.** Quality and safety of care and the holistic approach to the patient were also the dominant underlying concepts to which our respondents repeatedly referred in their accounts. It is against the background of this illuminated figure that we began to discern the shadow aspects of what was according to respondents **allegedly successful and advanced.** These aspects of the working environment, in which nurses must do their job day by day, seem to contradict the illuminated figure of rationality, controlled quality, and efficiency. These aspects embrace, for example, the high amount of unresolved emotional distress (e.g. R 5: ... *couldn't stand it anymore... had to leave.*), neglectful behaviour, or exploitation of relationships (e.g. R 13: ... *as if I were a lightning rod: they would scold us for anything, including bad weather*.) We refer to these as the ***reversed face of the nursing environment***, and we believe that, by its nature, Schein's (2004) concept of organisational culture is a good apposite for this complex phenomenon. (Note 1) The ways in which this reversed face of the working environment was perceived by the nurses who were interviewed were attested to by their frequently used formulations or terms. Our informants sometimes provided accounts of *disorder, confusion, chaos,* or even *anarchy.* Although the patient is expected to lie at the centre of the entire system and to be the focus of the healthcare professionals' attention, their daily concerns revolve primarily around the worldly struggles and pressures of the working environment, while the patient in fact receives only marginal attention.

The climate of the nursing environment was characterised by *discomfort* and unspecified *discontent.* The informants referred to it as *demotivating, and not just financially*; *extremely demanding;* many times *uncertain*; and as being at the intersection of problems from a number of areas of the nurses' professional lives (see intervening conditions).

In their nursing practice, the informants experienced discrepancies between declared priorities and those that were actually pursued (complex care in line with modern nursing vs. economic efficiency, which may force them to reduce care to comply with the minimum requirements).

The nurse finds herself pressured by expectations to serve as the doctor's lightning rod (in the interest of the patient), while she has to control her emotions and "keep her temper".

The combination of all these pressures results in a *sense of being overwhelmed and dissatisfied* that they "cannot stand" and on which they blame the *high levels of employee turnover* affecting certain types of nursing teams.

3.2 Causal Conditions

Three interrelated categories of accounts were conceptualised as causal conditions affecting the nature of experiences—the central phenomenon. While informants expressed their situational perceptions, the interpretation based on evidence from the analysis and sources from the scholarly discourse led to its eventual roots in history and different educational pathways (see categories 3.2.1., 3.2.2., 3.2.3.).

3.2.1 Historic Distribution of Roles and the Coctor—Nurse Relationship

Many authors stated that the nursing environment is strongly shaped by the *doctor–nurse relationship*. According to Staňková (1996), both doctors and nurses have traditionally viewed the nurse as a passive, submissive worker. These views are deeply rooted in nurses' professional identity, as well as in past decades of vocational education, when it was the doctor who "raised" his nurses. Staňková argued that these relations are extremely resistant to change.

According to the respondents' accounts, the patterns related to this historic distribution of roles still exist. At the same time, the respondents critiqued it and maintained that different levels of inequality exist in different workplaces.

R4: It depends on where … in which field. In some places I felt like the doctor's colleague; elsewhere the role is subservient to the doctor. And somewhere else, nurses are basically regarded as cleaners or medical orderlies. I also worked in the OR, and that was relatively okay.

The high relevance of the doctor–nurse relationship can also be illustrated in other aspects of organisational culture. It was with regard to this relationship that our informants mentioned *rivalry and a conflict climate* among the nurses themselves. The same relationship—and, in particular, doctors' appreciation—was also responsible for nurses' job satisfaction. Doctors' opinions were allegedly decisive regarding whether and how nurses would develop the nursing practice. As some nurses shared, a doctor's praise was the strongest booster of their job motivation. They also mentioned intimate relationships between nurses and doctors as one of the causes of rivalry in the workplace and worsening job performance in terms of teamwork, communication, or even management.

R2: The way it is ... the doctor needs a charge nurse who will do what he says... who will obey and cause no trouble. Elsewhere, in my experience, the only thing one needed to become a charge nurse was, excuse me, to establish relations with the head physician... they don't want to be working with someone with some kind of vision of making health care a better place; they definitely want to avoid that.

On the one hand, the respondents argued, and appreciated, that the relationships are shifting towards collegiality. On the other hand, they compared the situation in the Czech Republic to that which exists abroad in Western countries, where they experienced more genuine collegiality.

R13: …the way it's normal in the west—that the nurse is the doctor's co-worker… here, the doctor is still Mr. Somebody, who is looked up to, while the nurse does the unskilled labour, as if she's an assistant.

Generational changes in nursing education and its quality

A decade ago, the educational requirements for general nurses shifted from the secondary to the tertiary level. As a result, older and younger nurses, who have their professional qualifications from different level schools and programmes, work now side by side on the same workplace. This is a frequent source of rivalry and confusion. Thus, the topic of *generational change in nursing education and its quality* elicited strong emotions from the study's respondents regardless of the conflicting opinions they held on this matter.

R3: I have been a nurse for the past thirty years, and there's no way I'm going back to nursing school. And all of a sudden, people like me are called "those with just a high school diploma". Those coming straight from college with their bachelor's degrees, they really think they're special... but then again, at the end of the day, almost no one attends to the patient.

3.2.2 Changing Perceptions of the Nurse's Occupational Role

In line with global trends, Czech nursing is oriented towards holistic care, which is centred upon the patient and the diversity of his or her needs (Staňková, 1996). The informants also associated confusion in the nursing environment with disunity regarding the ways in which people view the nurse's role in the transformation towards holistic care. Among the dilemmas mentioned were the following: *Is there more value in bedside experience than in education? The imperatives of precisely, in time, immediately, keeping the patient dry and clean,* or *saying kind words and staying in touch? which of them are more important?* The common denominator of this diverse discourse, which was rarely mentioned explicitly, lies in the following question: *Who is a good enough (the right) nurse?* This question is relevant to the situation in the Czech Republic, as well as internationally (Currie & Carr, 2013; Dury et al., 2014).

The informants were arguably somewhat reconciled that holistic nursing is rather a vision for the future—a utopia—even if it has been inscribed in government policy for more than a decade (Ministerstvo zdravotnictví České republiky, 2004). Consequently, in practice, nurses tend to declare moments when "all work is finished" and to long for "a moment to sit down" or to avoid "facing extra problems".

3.2.3 Local Differences in the Ways in which Students Are Shaped by Nursing Education

Every nursing education process takes place within a social and political context (Průcha, 2009) and ultimately shapes the values and professional behaviour of nurses. The shift of the nursing education requirement to the tertiary level resulted in an increased demand for lifelong education in the nursing community, thereby giving rise to a number of new schools with unstable educational quality both in the Czech Republic and abroad. The collective determination of nurses to further their professional knowledge and skills, as is apparent based on the statistics, was generally applauded. At the same time, criticism was addressed, in particular, towards the foreign-based private colleges that enrolled Czech students in nursing programmes of questionable quality.

R14: We have got an abundance of educated, college-educated nurses, from excellent public colleges, but those are not getting the executive jobs. And their bosses are still recruited from among people who have four-year secondary education in nursing—some don't even have any specialisation—or who paid tuition at a private college (of inferior reputation). And this is what I think is crazy.

3.3 Context

The central phenomenon is embedded in—and, importantly, shaped by—the nature of the health facility, which is referred to in the paradigmatic model as *context*. Context involves categories of accounts that are attributed to cultural differences in hospitals and units according to **professional background** (e.g. internal medicine, surgery, operating rooms, long-term care), the **management approach** that is implemented in the hospital or unit (some more and others less hierarchical and authoritative), the **hospital's size and type** (university, local, etc.) and **economic condition** (indebted, prosperous), and **local customs and traditions** (workplace climate, established rites, etc.).

3.3.1 Professional Background

The respondents exhibited a tendency towards elitism; this was perhaps related to the fact that each specialisation tends to develop its own sources of pride or attributes of prestige, identify with them, and express them in the culture of "how we do things here".

R3: We're kind of a special sort of nurse (us in the OR), because we are there so that the doctor can operate on the patient.

Staňková (1996) also stated that nurses are fond of activities that fall into the doctors' realm of responsibility, use these as a source of prestige, and are consequently reluctant to give up these activities (Staňková, 1996). Mowforth (1999) discussed horizontal elitism and the status differences between nursing specialisations that are derived from attributes such as technical knowledge or "clean work" in intensive care units, paediatric intensive care units, and so on.

3.3.2 Management Approach

The informants' accounts demonstrate how hierarchical management and the distribution of power affect their motivations and relations. They are *resigned* to their inability to infuse their work with the values and ideals they believe in, as well as to their powerlessness with respect to the nature of their working environment.

R10: As a rule, there's the head physician, who comes first, then the doctors, then the nurse manager, then nothing … NOTHING … then the charge nurses, and that's it. When something is being discussed, they only laugh at us. I've given up trying to change that. I used to want to change that, but I can't. I wanted to establish

better teamwork, but we can only talk things over with people, who are polite, and we're unable to talk things over with the impolite ones, and I can't change that, because it all depends on the unit's head physician.

Other authors also argued that organisational culture is shaped by the management approach. The field of health care has a tradition of **hierarchical** organisation. As Staňková (1996) explained, the ways in which care is organised, as well as its morality, its strictness, its military-like hierarchy, and even the arrangement of nursing units all have their roots in the history of army nursing. This gives rise to a hierarchy of vertical elites (Mowforth, 1999). In his studies of cultural differences, Hofstede (2001) identified "power distance" as a factor indicating the acceptance of power hierarchies as natural or given. This aspect shapes the ways in which an organisation is managed and its leaders behave (ibid.) According to our informants, different levels of "power distance" can be felt in different units, even within the same hospital.

Size and type of organisation and its economic condition

"Our team is shrinking, and the to-do list never ends"; the respondents voiced this kind of experience along with their concerns that one must succumb to on-the-job extortion or risk losing her job.

R1: This is madness. With the same number of staff, one has to manage somehow. Now we're being charged with the ORs, including supplies …with just everything. There's been a tremendous increase in workload. A TREMENDOUS one.

Given their limited options (for example, the poor employment prospects for someone who loses her job at a small, rural hospital), the nurses are obliged to comply with the demands of the environment, even when it leads to inadequate patient care they provide. Similarly, the culture of the nursing environment is clearly dependent on the hospital's economic condition. Even the International Council of Nurses criticises the ways in which health care is shaped by private firms, which cut their expenditure by reducing the number of nurses (International Council of Nurses, 2015) while the same amount of work remains.

3.4 Intervening Conditions

The following categories related to the condition of the society as a whole construct the category of intervening conditions in the paradigmatic model. These conditions may affect the central phenomenon in important ways, and their effects vary according to the parameters of the organisational context.

3.4.1 The Unstable Sociocultural, Political, and Moral Environment of Czech Society as a Whole

The lack of stability in society affects nursing in a variety of ways, as exemplified by the following account:

R1: The way we work here is that when the ruling party changes, they also change the regional commissioner, and then… the director, the nurse manager, etc. ... It's a kind of quadrennial ritual here; what you see in the hospital before the elections these days is a lot of people stressing about keeping their jobs. That's how screwed up it is.

Such arrangements facilitate corruption, which was reflected in our informants' accounts of the ways in which different lobbies had grown into the structure of the healthcare system. With respect to working conditions, the informants mentioned being subjected to illegitimate demands and external pressure to provide services that are not in their job description, and they are likely to be afraid to mention such issues during the course of supervision.

3.4.2 Healthcare Finance

Most healthcare providers in the Czech Republic are businesses rather than non-profit organisations. Financial results, payables, and receivables are the fundamental determinants of firms' behaviour in the healthcare system, and this comes into full view upon examining the everyday care that is delivered to the patient when providers deliberately produce services that patients do not need in order to earn more fee-for-service money. As a respondent mentioned in the context of supervision as a setting in which even painful issues can be discussed,

R2: Oh yeah, if only they agreed on it. But there's always the money aspect. The instruments… you know what I mean… But, then again, suppose we all agree it's harmful to patients… think about it, there's so much unnecessary work done in health care all the time.

This category is linked to the previous one (the moral condition of society) and intervenes not only in the central phenomenon but also, according to the context, in other categories.

3.5 Strategies to Implement Clinical Supervision

The *reversed face of the nursing environment* is detrimental to job satisfaction and motivates nurses to develop a whole range of strategies and responses, old and new, depending on context and individual dispositions. These

strategies appeared repeatedly in the accounts of the nurses and warrant further investigation, although we cannot expand on this topic in the present paper. We will pay attention only to hypothetical supervision implementation as a system-level strategy of changing the central phenomenon (which, as a category, arose from the intentional questions in the original data collection). As we stated in the introduction, it was due to our preconception that we chose to distinguish between two possible strategies, and the same preconception is now structuring the data we obtained from our informants.

(a) **The workplace-based option** implies that supervision is implemented either by a trained member of staff or a charge nurse as an inherent component of the nursing process (internal supervision) or by hired external supervisors as a recognised form of on-the-job lifelong education (external supervision). In both cases, supervision is arranged by the organisation itself and is implemented during working hours.

(b) **The school-based option** implies that supervision is implemented in one of the nursing education programmes, whether they are degree programmes, specialisation courses, or lifelong education courses. As a result, the nurses become accustomed to supervision and learn how to use it for their professional growth during their school years, and in the next stage, the workplace-based option might also be implemented.

The interviewer did not refer to these two options explicitly and inquired only about the informants' experiences with and/or ideas about implementing supervision in nursing. Their answers were then sorted into the above two categories.

3.5.1 The Workplace-Based Option

The respondents did not perceive the existing nursing environment as supervision-friendly, and both the registered nurses and the supervisors in our sample expressed concerns about the idea of implementing supervision directly in the workplace.

The argument that the environment is not ready for implementation of supervision was backed by the claims that, given the degree of gender rivalry, the safety of the supervisees cannot be guaranteed should they openly and critically reflect on their working process and job relations. Even our supervisor informants stated that they would be cautious and reluctant regarding entering such an emotionally volatile setting.

The respondents also doubted that external supervision could be funded as on-the-job training. For instance, management may be more likely to support expenditure on educational activities (potentially including supervision) if they are associated with an (ideally) immediate and measurable effect on patients' physical condition.

Should supervision be implemented, the nurse practitioners stated that they would prefer to focus on *job relations,* bringing us back to the characteristics of the central phenomenon. Their ambition was to improve nurse–nurse and nurse–doctor relations, and they regarded supervision as a *lifeline to escape the "systematic bullying"* they had encountered in nursing practice. They indicated that another practical potential of supervision was to *improve communication* between different nursing units in the same hospital or to *make room for improving the coordination and quality of nursing care.* **Precisely what was perceived as an obstacle to implementing supervision in the nursing environment, the nurses recommended as the focus of supervision.**

3.5.2 The School-Based Option

Educational institutions were regarded as safer and friendlier settings for supervision and, under the present circumstances, were expected to be more open and inclined towards its implementation.

The nursing educators presented themselves as being well acquainted with the possible benefits of supervision for nursing practice, and they clearly supported its implementation. They believed that it might be advantageous to implement school-based supervision first. This would enable nurses to have their first encounter with supervision within the safe environment of an educational institution and would, consequently, encourage them to become more open to supervision in the workplace. They envisioned that by mastering the kind of autonomous attitudes and values developed by nursing supervision during their school years, they would also become the pioneers of this kind of change in nursing practice. The teachers referred to the students and graduates as *"a hope for nursing"* and as being capable of bringing about change and *"amend[ing] the negative situation we're in today"*. Future nurses would be *"unspoiled by the practice"* and would still have the strength to perform their nursing duties *"the way they're supposed to be done"*. They saw the focus of supervision as *supporting nursing students to maintain good practices in their subsequent jobs* and not to give up (*"so that they endure the internship among all the nurses"*, *"able to keep pace with the team"*, and *"persist and don't run away to exile"*). The educators considered supervision *an indispensable part of nursing education* and viewed it as a

way for nurses to resolve their *"frustration"*.

The opinions expressed by the nursing administrators and practitioners contrasted with the above optimism regarding changing nursing practice through nursing students and fresh graduates. These informants viewed such newcomers primarily as a burden to their colleagues rather than as making any kind of contribution. Both groups also reflected on the *strong effects of the environment on newcomers* who recently graduated from college, referring to these effects as a *centrifuge that will absorb them and crush them.*

R6: Students regard the practice critically ...so, I do think they are motivated to do things right. But then they get their first job, and the job absorbs them, and few of them can really stand the pressure and keep up with their commitment to work how they learned it and how they wanted it.

R2: In order to make any difference, such a newcomer would have to be hired into a leading position… "You're new around here, you have no idea, and you're gonna do what we tell you". The seniors will rather crucify you, because it's extremely difficult to make one's way up these days, and they don't really say no to bullying.

Consequently, none of the two strategies has been approved as potentially effective in the present situation in the hospitals, as without changes being made to the stated cultural aspects of the nursing environment, the effect of school-based implementation was seen as rather low.

3.6 Consequences of Strategies to Implement Clinical Supervision

3.6.1 Expectations regarding the Intended Consequences

The informants shared the following expectations regarding the consequences of supervision implementation in the nursing environment in case it did take place: *Improved burnout prevention, more effective interdisciplinary teamwork, higher nurses' status, promoted professional ideals,* improved overall condition of the nursing occupation, *improved job relations, and a generally more humane nursing environment.*

R9: What could supervision do? I think that supervision could make nursing more humane. And perhaps it could also help those nurse practitioners see things from a different perspective and better cope with their jobs.

It was primarily the supervisor informants who emphasised the support function of supervision, whereby the nurse can obtain support, especially to prevent burnout. They mentioned specific ways in which supervision can support nurses and prevent burnout by creating a safe environment for reflection and the expression of accumulated feelings. The supervisors equally reflected on the weak position of the patient, who is the final consumer of nursing care, on the one hand, but who finds himself or herself at the very bottom of the healthcare hierarchy on the other. The supervisors also mentioned the ways in which supervision might aim to *protect the patient,* and these resonate with the general scholarly discourse.

3.6.2 Expectations regarding the Unintended Consequences (Threats of Supervision)

Simultaneously with any intended effects on nursing practice, the respondents also shared their concerns regarding the various unintended consequences that supervision might have—namely, threats of supervision to the system and its members.

The administrators voiced their concerns about the negative effects of supervision on teamwork, whether as a result of *holding up a mirror to oneself* (hurt feelings and the realisation of the things one cannot change), *the system not being ready for any changes required,* or *low confidence in nurses' abilities* to cope with the effects of supervision. Several respondents asked rhetorical questions about *what would be left in those nurses' lives* should they realise that things are not the way they seem. They voiced concerns that organised reflection might cause some workers to realise that they are not sufficiently skilled and/or emotionally strong enough for the job and, eventually, after considering all implications, cause them to quit. Paradoxically, this same hypothetical consequence was viewed by other managers as one of the top advantages of supervision, and for the purpose of separating *"those who have the balls from those who don't"*, they recommended supervision not only in the workplace but also as part of nursing students' internship.

The supervisors considered the nursing environment *a high-risk setting for clinical supervision* due to high levels of rivalry, fear of failure, and the fear of exposing one's weaknesses to others. They believed that participants might perceive the act of reflecting on one's weaknesses or looking for ways to improve one's work as a manifestation of insufficient competences and skills and might subsequently use the information against the individual who contributed it.

All categories of respondents viewed doctors' opinions as the key to the success of supervision. The informants assumed that Czech doctors would likely not be excited about supervision activities. Across occupational categories (supervisors, practitioners, teachers, and managers alike), the informants expected doctors to *"laugh*

in the nurses' faces", "make them an object of amusement", or authorise supervision that was *"subject to all kinds of conditions",* such as *"doing it as a hobby"* or *"as long as it doesn't affect their job".*

4. Discussion

Clinical supervision in nursing is typically regarded as a tool for nurses' clinical reflection on their professional roles, relationships and work with patients. Recently, some authors have pointed out that supervision as an independent professional field also bears a specific culture which is rooted in a relatively stable pattern of shared meanings among supervisors in various fields and various countries (Havrdová, 2006). This culture includes the holistic approach to each individual person and an attitude formed by the intention to support and develop one's skills and competences on the job. The supervision culture is supposed to be built on shared practices that have been used and developed for decades to best support and develop one's reflection, learning, and creativity in his or her job-related role and tasks (Havrdová, 2013). Any effort to implement supervision in a new setting may imply the mingling of one culture with another, may cause friction between them, and may shed light on their differences. This is what we believe occurred in the course of the study reported here.

The paradigm model titled "Clinical Supervision: Challenging the Nursing Environment?" maps the complex relations between selected aspects of the organisational culture of the nursing environment in Czech hospitals from the perspectives of nurses, nursing teachers, and supervisors. It is based on the informants' weighing of the prospect of implementing supervision in this environment. We argue that the phenomenon of the reversed face of the nursing environment has become most visible because of the contrasts between certain cultural features of the Czech nursing environment and the informants' notions of (or beliefs about) the culture of supervision which they have experienced. While the culture of supervision is based on respect for the individual, safe reflection and emotional work, active participation, and the creative search for nursing practices that are best for the client, the culture of healthcare organisations is, according to our informants, often marked by rivalry, conflicts, a discomforting climate, the threat of being devalued and disqualified by the doctors, and a lack of space for participation and emotional validation.

Similar obstacles to implementing supervision and reflection in healthcare organisations have been observed in the United Kingdom and Australia (e.g. Dilworth et al., 2013, Mantzoukas, 2004), which, based on our interpretation, suggests that similar differences might exist there between the nursing and clinical supervision cultures. In short, some important aspects of the nursing environment culture, which contrast with the culture of supervision identified in the Czech context, have also been found by researchers in other countries. However, these authors did not understand the reported resistance to supervision in terms of cultural frictions, as evidenced here. The added value of such interpretation might be the greater attention which it may bring to the often devalued clinical supervision as a profession that supports today's values, attitudes, and practices which are often declared but seldom practiced in contemporary health care.

5. Conclusion

The goal of this study was to grasp the ways in which nurses perceive the culture of the nursing environment with regard to supervision. The exploratory qualitative study in the context of Czech hospitals was based on data from 14 in-depth interviews with registered nurses, nurse administrators, nursing teachers, and clinical supervisors. The researchers inquired about their experiences with and ideas about implementing supervision in their workplace and in education. The secondary analysis of data raised the point that, during the inquiry about supervision implementation, the informants put forward a set of perceived features of organisational culture that are referred to here as the *reversed face of the nursing environment.* These aspects are interpreted as resulting from what the respondents perceived as a clash of two cultures—the culture of supervision and the culture of the existing nursing environment.

Based on the analysis of the interview data, the following paradigm model was constructed: "Clinical Supervision: Challenging the Nursing Environment?" Expanding upon the model as a mind map may serve to facilitate the development of a complex strategy to implement supervision in a given healthcare organisation. Such a mind map would have to be informed by specific characteristics of the given cultural context, such as professional background; management approach; hospital's size, type, and economic condition; local customs and traditions, including the status quo of power games and the managers' struggle to maintain their positions; doctors' attitudes towards nurses and supervision; and other aspects covered by the model.

The paradigm model suggests that any efforts to implement supervision in Czech nursing practice should initially be aimed at organisations that are more liberal in terms of power distance, practice participative management, treat doctors and nurses as colleagues, are more advanced in promoting the ideal of holistic care (also with regard to their economic parameters), are open to innovation and change, and exhibit a friendly

attitude towards supervision. According to respondents' expectations, supervision may help humanise the working environment; reflect the different views of a nurse's role; reflect the nurse–doctor relationship; improve the distribution of job responsibilities; eliminate sources of stress that nurses "cannot stand"; stabilise the team; and raise the levels of trust, safety, and satisfaction among nurses. The option to implement supervision in nursing schools in the Czech Republic is welcome and is seen as an opportunity to pave the way for workplace-based supervision; however, on its own, it cannot bring about the desired change within the nursing environment.

The paradigm model suggests that efforts to implement supervision in a given working environment are shaped, prevented, and facilitated by complex cultural interaction. If the challenge of cultural differences is sizable, supervision cannot be implemented without a prior strategic effort to change the workplace culture. This study sheds light on one advantage of such a challenge: It works as a magnifying glass through which we are able to observe the shadow aspects of the target culture that are in friction with the declared humanistic and developmental values. In this way, the choices between changing and preserving these aspects can be made for the benefit of workers and patients. Given the research evidence regarding the similarities between some aspects of nursing culture in various countries (e.g. Dilworth et al., 2013, Mantzoukas, 2004), the paradigm model titled "Clinical Supervision: Challenging the Nursing Environment?" might be a source of inspiration beyond the Czech context from within which it arose.

Acknowledgments

This research was supported by the Ministry of Education, Youth and Sports, Institutional Support for Long-Term Development of Research Organizations, Charles University, Faculty of Humanities (Charles Univ., Fac. Human, 2015).

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Note.

Note 1. Schein (2004) understands the concept of culture as a relatively stable pattern of meanings, attitudes, and practices that result from shared learning and mutual experiences over a period of time within specific environments.