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Clinical Supervision
and
Quality Care

Examining the Effects
of Team Supervision
in Multi-professional Teams

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ACADEMIC DISSERTATION
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1. BACKGROUND OF THE STUDY

Quality of care and quality improvement have been the target areas of WHO's policy towards year 2000 (World Health Organisation 1983) from the early 1980s. In different European countries, including Finland, the quality of health care services has attracted attention also at national level (Mäkelä 1992). In Finland, the Finnish National Research and Development Centre for Welfare and Health (STAKES) has issued official recommendations concerning quality management and improvement. One of the most important recommendations was issued in 1995. The quality policy defined in the literature as the 'bottom-to-top' approach (e.g. Tilbury 1992), guided the recommendation and thus emphasised the unit- and organisation-based origins of quality management and quality improvement efforts. The principles laid out in the recommendation (Laadunhallinta sosiaali- ja terveydenhuollossa 1995) stressed that quality management should (1) be included in everyday work, (2) perceive patient's central position and (3) be guided by knowledge (i.e. production of information by evaluation, following trends at organisational levels and comparison between organisations). The recommendation implied that ultimately the responsibility for quality management and improvement lies with individual employees. It implied, as well, that responding to patients' needs was regarded as a central attribute of quality and the precondition for improving quality in unit- and also organisational level, with a systematic follow-up and evaluation of services at all levels (e.g. Outinen et al. 1995). However, changes in the national health care policy, such as e.g. transferred responsibility for organisation of health care services from the state to the municipalities, occurred at the same time with the recommendation (e.g. Marjamäki 1998). At the beginning of the 1990s, the advancements of quality management and improvement efforts were considered promising, but in the mid-1990s it was also found that the development was lacking unity and above all it seemed that differences between organisations were starting to escalate (see e.g. Voutilainen et al. 1994, Mikkola and Outinen 1997, Taipale et al. 1998). Some reports also claimed that the quality of health care services had decreased in some respect (e.g. Markkanen and Pokki 1999). Several reasons for these problems were cited, for instance, health care policy with reduced resources, lack of manpower in hospitals, the overwhelming workload of staff, inefficient collaboration between different health care professionals, and insufficient guidance or training especially in relation to new patient groups being transferred to the unit or organisation (e.g. Marjamäki 1998, Markkanen and Pokki 1999, see also e.g. Launis 1994, Elovainio et al. 1997)

The quality of health care services comprises different health care professionals' work contributions or 'chains' (e.g. Kumpusalo and Mäkelä 1993). From the patient's perspective, the quality of services has been examined since the early 1980's mainly in the form of satisfaction and by now several survey and follow-up instruments have been developed and validated (see e.g. Thomas and Bond 1996). However, the results of and the trends shown by satisfaction surveys indicate that patients are mainly satisfied with the services they received. The instruments used for satisfaction surveys have been criticised for their biased results, validity, reliability, sensitivity and specificity (see e.g. Leino-Kilpi and Vuorenheimo 1992, Redfern and Norman 1995, Poulton 1996, Lin 1996, Salmela 1996). Regardless of these difficulties, patient satisfaction surveys have been deemed important, despite the varying indicators of and reservations about the findings, in showing levels, trends and changes in the quality of patient care (see e.g. Kitson 1986, Smith et

al. 1995, Hudson-Sholle et al. 1996, Idvall et al. 1997). However, during the mid-1990s, more attention was paid to the efficiency of collaboration between the different health care professionals and to finding 'mutual understanding' of the best ways of implementing operations (e.g. Heinänen and Soveri 1996, Kaltiala-Heino 1998). Harvey (1996) has argued that different traditions and histories of professions seem to have influenced the quality management efforts. The author claims that it is unclear whether different professional groups have followed the same route, reached the same point and whether clinical quality developments are in congruence with organisational and managerial developments relating to quality. However, the difficulties seem to indicate that the development and implementation of different kinds of quality efforts have rested on on the particular profession's and discipline's (nursing, medicine, other therapy professions) differing backgrounds, which makes them slightly different.

The issues of education together with those of service quality have been topical during the 1990s (e.g. Hogston 1995, Perry 1995, Lindner 1998). The importance of education has been acknowledged and often explained with the challenges of continuous changes in society and working life with links to education and professional development such as (1) strong and rapid increase in information and knowledge, (2) complexity of knowledge (especially in multidisciplinary fields like nursing), (3) rapid development of technology with new innovations (e.g. information technology) and (4) increasing world-wide competition (e.g. Ruohotie 1993, Korte 1997, see also e.g. Launis et al. 1998, Kovero and Launis 1999). The requirements and needs for education seem to have been unlimited, but also faced with several challenges in health care after the mid-1990s. For example (1) cutbacks in funding for education, (2) lack of staff has diminished participation in education and (3) education has become more sporadic, lacking in cyclicity or holisticity (e.g. Barriball and White 1996, Furze and Pearcey 1999, Markkanen and Pokki 1999).

From the perspective of the quality of services, the interests have focused especially on continuing professional education (CPE). Continuing professional education refers to education that is organised by the organisation (i.e. internal, in-service training) or by another institution (i.e. external education). The need for CPE is based on that of individual practitioners and the education is financed by the health care organisation, the unit or individual employee. The purpose of CPE is to maintain and renew professional skills, to improve career development and responsibility taking and to broaden or deepen professional skills (see e.g. Korte 1997). Hogston (1995) and Perry (1995) have argued that CPE has a positive contribution to nursing practice, but also to individual and professional development of nursing practitioners and ultimately to the quality of services. However, little research has been conducted to evidence the impact of CPE on the quality of services, patient care or outcomes with the main argument that the links and effects of CPE are difficult to explicate and substantiate with empirical evidence. (see also Furze and Pearcey 1999)

One of the main challenges for CPE pointed out by Perry (1995), Gibson (1998), Furze and Pearcey (1999), Dunmore and Wells (1999) seems to be the difficulty of identifying and prioritising the 'real' development and educational needs among health care professionals. Lindner (1998) has showed that the assessments of learning needs reflect personal interests and perceptions of one's own learning needs rather than actual knowledge and skills deficits, the amendment of which would benefit patient care and quality of services most (Hogston 1995, Dunmore and Wells 1999, Furze and Pearcey 1999), or perceptions of collaborating medical doctors and managers (Hicks and Hennessy 1998). This has been offered as an

explanation for the practitioners' tendency to express a number of educational needs while complaining about that failure of in-service education to recognise and address their education needs (e.g. Lindner 1998). Hogston (1995) has made a point that a record of participation in education does not necessarily give proof of any impact on practice. Lindner (1998) has summarised that the core of the problem seems to lie further, in the difficulty of transferring new knowledge into everyday practice and thus consequently giving rise to the constant difficulty of improving nursing practice. Solutions such as situational analysis (Cowley 1995), triangulation of training needs profiles (Hicks and Hennessy 1998) and information technology applications (Lindner 1998) have been suggested for a more sensitive and accurate assessment of educational needs.

During the mid-1990s, an increasing interest has been focused on organisations (e.g. Sarala and Sarala 1996) and on the possibilities to learn at work (e.g. Järvinen et al. 2000). In the field of health care, Cowley (1995) and Gibson (1998) have emphasised the importance of organisation and contextual factors that seem to influence learning at the workplace and promote professional development. The point made is that besides education, professional development efforts can take many forms and development at work can actually produce learning experiences, which are as valuable as formal course attendance (Gibson 1998). Cowley (1995) has suggested that a developing organisation as a learning environment with rapid and multiple changes, can in fact be stimulating for professional development and promote improvements in patient care.

Clinical supervision (CS) and its different modes were introduced in nursing in the early 1980s, at first in psychiatry, counselling and psychiatric nursing (see e.g. Paunonen 1991, Butterworth et al. 1997). However, the popularity of CS has increased during the 1990s and many definitions have been given with the majority of these emphasising that the essence of this practice-focused professional relationship is on reflecting upon practice in order to learn from experience, but also to improve practice and give support to practitioners (e.g. Työnohjaustyöryhmän muistio 1983, Niskanen et al. 1988, Kohner 1994, Dooher et al. 1998). In the literature, however, the focus has been so far on the supervisory relationship and the issues of implementing CS (e.g. Bond and Holland 1998, Fowler and Chevannes 1998) and the empirical studies have placed emphasis on evidencing the effects of CS on the health care practitioners' well-fare (e.g. Berg et al. 1994, Pålsson et al. 1996, Butterworth et al. 1997). The research endeavours have been worthy so far and the value of investigating the effects on the practitioners are without doubt important, but it seems also necessary and important to extend the focus of research to cover the possibilities of CS more widely. These promising prospects have been pointed out by several authors (e.g. Bishop 1998, Butterworth 1998, Lyle 1998), but at the same time the authors have cautioned against such difficulties as complexity of the constructs for research in practice (e.g. Butterworth 1998), problems of differentiating between managerial supervision and CS (e.g. Lyle 1998) and most of all, circularity of the definitions with related characteristics of the concept (e.g. Niskanen et al. 1988, Karvinen 1996).

The challenges presented in relation to quality management and improvement efforts served as the background for this study. This promising and unstudied prospect presented in the literature for CS was regarded as an interesting starting point and important topic of empirical study, since a CS intervention seemed to offer a possible solution to the challenges for quality improvement efforts, education and CPE, while involving patients and health care professionals representing different professional groups in the same

study. The aim of the study is to describe the effects of team supervision on teams and its individual members from the perspective of professional development and within an organisation. The aim is also to describe the effects of team supervision on the quality of care.

2. LITERATURE REVIEW

2.1. The challenging concept of clinical supervision

Clinical supervision (CS) is not a new phenomenon: its origins can be traced back to the early 1900s in social work (e.g. Brettschneider 1983, Työnohjaustyöryhmän muistio 1983, Karvinen 1996). The practice of CS has been known among Finnish nursing since the early 1980s (Työnohjaustyöryhmän muistio 1983). However, a closer look into the conceptual basis of this phenomenon shows that the concept and the definition of CS are still actively discussed in the late 1990s (e.g. Hyyppä 1983, Virtaniemi 1985, Sava 1987, Paunonen 1989, Butterworth 1992, Siltala et al. 1993, Moilanen 1994, Fowler 1996a, Hawkins and Shohet 1996, Karvinen 1996, Severinsson and Borgenhammar 1997, Bishop 1998, Butterworth 1998, Dooher et al 1998, Sloan 1998, Lyth 2000).

The literature has described the concept of CS as vague and complex (Sava 1987, Butterworth 1992, Siltala et al. 1993, Moilanen 1994, Severinsson 1995, Karvinen 1996, Sloan 1998, Paunonen and Hyrkäs 2001). The reasons for this ambiguity have been examined from several perspectives. For example, Hyyppä (1983) has pointed out that there exist several definitions describing the concept and that this is acceptable as they expose different angles and viewpoints of the phenomenon. Severinsson and Borgenhammar (1997) also stated that it is possible to define CS in many different ways. The differences in the definitions emphasise different things and foci of interest concerning the phenomenon. The varying practices of and needs for CS have also been suggested as a cause for the variety of definitions. This has led to an attempt to express and emphasise several things at the same time in a single definition (Virtaniemi 1985, Paunonen 1989). The complexity of the concept has been described in terms of a 'roof title' (Siltala et al. 1993), an 'umbrella' term (Butterworth 1992) or a 'sub-category' for a wider concept of supervision (Severinsson 1995). The complexity is then seen from the perspective of conceptual hierarchy and other concepts or terms related to CS. This has been considered a cause for the problems concerning the use of the concept and related terms in practice (Fowler 1996a).

The foundation of the conceptual ambiguity has been traced back to the history of the phenomenon. Butterworth (1998) and Dooher et al. (1998) pointed out that clinical supervision has developed among many professions (see also Paunonen 1989). The authors see that this diverse background has shaped the practice of CS but also confused the conceptual basis. It is argued that the diversity of the literature has made a useful contribution to CS in nursing, but that it has also raised debate, fears and prejudice (Butterworth 1998).

Although the difficulties related to the concept of CS have been identified, a number of definitions have been suggested. The early literature of the 1980s (Ojanen 1985, Sava 1987, Paunonen 1989) was critical of the definitions of CS because of their superficiality, inaccuracy and inexhaustive nature. Circularity and mixing the functions, goals, roles and outcomes in the definitions have been criticised as well

(Karvinen 1996, Paunonen and Hyrkäs 2001). However, too strict definitions are also considered inappropriate as they may restrict the development of CS practice (Butterworth 1992). As a result, the definitions seem to be rather general in nature emphasising the common characteristics of CS (Työnohjaustyöryhmän muistio 1983, Moilanen 1994)

The difficulty in defining the concept of CS has been debated (Paunonen 1989, Bishop 1998, Faugier 1998, Paunonen and Hyrkäs 2001) especially from the point of view of its importance for practice and CS's development based on research. It is pointed out that because of these difficulties, research and development of CS seem to have been scarce, piecemeal in nature and fragmented (Paunonen 1989, Bishop 1998, Faugier 1998). However, evident progress has taken place since the early 1980s as evidenced by numerous international publications in the 1990s and e.g. an article analysing the concept of CS, published in an academic journal (Lyth 2000). In order to accomplish this study, defining the concept of CS was the first challenge.

2.1.1. Defining the concept

A dictionary definition gives the first and neutral description of a concept. This type of analysis of the concept of CS has been undertaken by several authors (Virtaniemi 1985, Sava 1987, Holloway 1995, Severinsson 1994, 1995, Bond and Holland 1998, Lyth 2000). Sava (1987) has made a thorough analysis of the concept of CS in the Finnish language. The important and interesting point emphasised by the author is that in Finnish, the concept of clinical supervision is formed of two separate terms 'työ' [=work] and 'ohjata' [=guide, advise, instruct, direct, supervise]. However, it is not simple to combine these terms because both have a distinctive conceptual meaning in the Finnish language and are value laden culturally. Virtaniemi (1985) has come to a similar conclusion emphasising that it is not possible to give a word-by-word lexical definition of the concept 'työnohjaus' [=clinical supervision]. The point is important even without further examination, as it seems to reveal the obvious reason for the misconceptions concerning CS (see e.g. Paunonen 1989).

The dictionary definitions of CS have been analysed by e.g. Severinsson (1994, 1995) and in the English language by Holloway (1995), Bond and Holland (1998) and Lyth (2000). Summarising these analyses, the authors found that the meaning of the concept can be described as a 'broadened view and vision', precisely according to the separate terms of 'super and vision' (Bond and Holland 1998). The prefix 'clinical' then refers to direct observation or patient treatment (Lyth 2000). The ending 'supervision' introduces the ideas of 'vision', 'setting eyes on' or 'overseeing', in the sense of highlighting something that is probably unclear, requires insight or viewing work with the eyes of an experienced clinician, sensitive teacher or discriminating professional (Severinsson 1994, 1995, Holloway 1995). However, even stronger administrative meanings for the term 'supervision' were found in the definitions such as 'keep watch over' and 'superintend' or 'control'. Bond and Holland (1998) debated the semantics of the concept from this perspective as they see that the suspicious attitudes are connected to the meanings 'keeping an eye on someone', 'observation' and 'in-depth exploration of practice, errors and what has not been achieved'. Bond and Holland's (1998) analysis highlights the origins of the negative emphasis on the concept.

2.1.2. Characteristics related to clinical supervision

Clinical supervision agreement

Several authors have discussed the requirements or preconditions for CS (e.g. Hyyppä 1983, Virtaniemi 1985, Proctor 1986, Siltala et al. 1993, Hawkins and Shohet 1996, Severinsson and Borgenhammar 1997, Bishop 1998, Bond and Holland 1998, Dooher et al. 1998, White et al. 1998, Sloan 1999a, Lyth 2000). From the perspective of conceptual examination, these factors are seen as antecedents and referred to as those events or incidents that occur prior to the occurrence of the concept (Walker and Avant 1992, see also Hupcey et al. 1996, Morse et al. 1996)

In the literature, the concrete arrangements and resources such as money, time and place have been considered important preconditions for CS (Lyth 2000). The important role and facilitation of management and administrative structures is emphasised (e.g. Dooher et al. 1998) and it is also pointed out that the lack of resources seems to be the biggest threat to the occurrence of CS (White et al. 1998). This means that the requirements focus on the commitment to CS above all at organisational level to ensure the possibility and continuity of CS (Bond and Holland 1998).

However, the most important preconditions discussed in the literature are the voluntary nature of CS for supervisee/supervisees (e.g. Hyyppä 1983, Virtaniemi 1985) and the participants' commitment to CS (e.g. Bond and Holland 1998, Lyth 2000). These characteristics are materialised in the CS practice as a free choice of supervisors (e.g. Sloan 1999a) and as an agreement between supervisor and supervisee (e.g. Hyyppä 1983). Several authors have discussed and described the important nature and functions of the CS agreement. For example, Virtaniemi (1985) emphasised that the agreement between supervisor and supervisee is the crux of CS. The agreement is described most often as a contract where the practical arrangements (e.g. duration of CS, frequency, place) and the 'play rules' (e.g. roles, preparing issues for sessions, confidentiality, evaluation) are agreed upon (e.g. Niskanen et al. 1988, Bernard and Goodyear 1998). These are seen to form the boundaries or framework for CS practice (Hawkins and Shohet 1996, Severinsson and Borgenhammar 1997)

The crucial nature and functions of the agreement have been explained from a number of perspectives. It is seen that the agreement forms the boundaries and baseline for the supervisory relationship (Hawkins and Shohet 1996) and creates a safe and secure climate and environment for learning (Siltala et al. 1993). The reasons underlying the need for a safe and secure framework have been explained from the perspective of confidentiality, assessment and self-evaluation (Severinsson and Borgenhammar 1997), resistance (Siltala et al. 1993), fears (Hawkins and Shohet 1996), and sharing doubts and anxiety (Bishop 1998). It is seen that the formal structure provides for supervisee safety, clarity, and gives to supervisor the possibility to offer challenges and feedback but also to maintain a positive approach (Proctor 1986, Bishop 1998). Hawkins and Shohet (1996) have also indicated that the formal structure is important because there is natural resistance and defences on the part of both supervisor and supervisee. Without a formal structure, avoidance behaviours are easily produced and this can create a climate where CS is requested only for recognisable problems, which means fulfilling CS original functions only partly. To sum up, the basis of CS

is formed of the supervision contract, practical arrangements and agreement on the interdependency of supervisor and supervisee.

Supervisor, supervisee and contextual factors

In the literature, several authors (e.g. Proctor 1986, Holloway 1995, Hawkins and Shohet 1996) have identified the supervisor, supervisee, client and contextual factors as the main elements of CS. All these are closely related and they often occur at the same time e.g. during a CS session. However, although the elements are manifestly interrelated, the following examination is done separately for the sake of clarity. The 'client' variable is intentionally excluded from this examination and the emphasis is placed on the consideration of the core factors and content of CS.

Descriptions, definitions and official recommendations concerning 'supervisor' are readily available in the literature and voluminous in content. The characteristics that have been emphasised in the official recommendations are connected to a supervisor's experience and status in organisation hierarchy, especially in relation to supervisee (Työnohjaustyöryhmän muistio 1983). Supervisor is defined as a person with practical and professional experience (expertise) and theoretical knowledge that is equal or more advanced in comparison with supervisee (e.g. Hyyppä 1983, Työnohjaustyöryhmän muistio 1983, Sava 1987, Paunonen 1989, Moilanen 1994, Karvinen 1996, Dooher et al. 1998). It is argued that ideally supervisor is in non-hierarchical relation to supervisee (e.g. Siltala et al. 1993).

Several different roles of a supervisor have been described and compared with those of a teacher, facilitator, 'therapist', consult and 'a person with managerial oversight' (Moilanen 1994, Hawkins and Shohet 1996). It is assumed that the varying roles originate from differing needs during a 'life-long' supervision process and the varying needs of supervisee (see e.g. Morton-Cooper and Palmer 2000). The role is described e.g. supportive in accomplishing, assessing and solving work related problems with supervisee (Sava 1987, Faugier 1998) and assisting supervisee to reflect practice (Marchant 1986, Lyth 2000). The educational and managerial roles assist supervisee in assessing their skills and capabilities, in gaining knowledge for the purpose of professional development and in achieving professional abilities appropriate to their role (Hawkins and Shohet 1996, Fowler 1996a, Faugier 1998).

The research focusing on supervisors seems to have centred on finding and defining the important characteristics of a good and effective supervisor (Sloan 1998, 1999a, see also e.g. McKay 1986, Chambers and Long 1995, Bishop 1998, Lyth 2000). Sloan (1998, 1999a) has examined characteristics considered important by supervisees and depicted it as a long and varying list of different qualities. To summarise, the three broader categories related to supervisor are (1) outcomes or effects related characteristics (e.g. inspiring with knowledge and skills), (2) qualities of interaction and relationship (e.g. sensitivity, listening) and (3) supervisor's self-awareness (i.e. knowing one's limitations). The important characteristics related to supervisor' characteristics are adequate knowledge, and supervisory and interaction skill (see also Bishop 1998). However, Sloan (1998, 1999a) has also pointed out the variance concerning the suggested characteristics among the interviewed supervisees assuming that this was related to supervisees' level of experience and knowledge (see also Lyth 2000). The author argues that many of the suggested characteristics were compassionate qualities (e.g. wise, kind, honest) and in fact general personal qualities with no specific

relation to supervisor or his or her role. Sloan (1998, 1999) indicated that supervisees place importance on supervisor's personal qualities but also on interpersonal and other qualities. However, the problem pointed out is the discrepancy between supervisors' and supervisees' beliefs as to what these important characteristics and behaviour are (Sloan 1998, 1999a, see also Holloway 1995, Hyrkäs et al. 1999b).

The theoretical orientation or framework in use is a less examined characteristic and intervening factor of CS even though authors have argued its crucial effects on e.g. supervisor's style, discourse of sessions, working methods and content of CS (Moilanen 1994, Holloway 1995, Hawkins and Shohet 1996, Severinsson and Borgenhammar 1997). The reason for this might be that the conceptions concerning the desirability of supervisor's theoretical orientation are contradictory. Some authors (e.g. Butterworth 1992) have been cautious and argued that theories might even restrict the CS practice. Another viewpoint suggested by Hawkins and Shohet (1996) is that supervisor's theoretical framework or eclectic approach is not necessarily counterproductive as long as there is a common language and belief-system to ensure joint learning and working. It is even assumed that some differences may be fruitful for learning. The reasons proposed by Severinsson and Borgenhammar (1997), supporting supervisor's theoretical framework, are that without an integrative and relevant nursing theory, CS may become subjective in nature.

Supervisor's demographic background characteristics such as gender, age, personality and cultural background are cited as a factor affecting CS. In the literature (e.g. Holloway 1995, Hawkins and Shohet 1996; see also Crespi 1995 Schoenholzt-Read 1996), the background of supervisor is discussed as a factor affecting e.g. the way in which supervisors see and understand supervisees. It is assumed that if the background characteristics differ between supervisor and supervisee, 'blind spots' and even such reactions as ignorance and defensiveness with feelings of guilt and anxiety can develop (Hawkins and Shohet 1996). However, empirical nursing research confirming or supporting these claims is missing.

Interestingly enough, supervisee and the respective characteristics are examined to a lesser degree in the literature. Work experience and speciality are emphasised as these are seen to contribute to the perceived supervisory needs (Työnohjaustyöryhmän muistio 1983, Marken and Payne 1986, Holloway 1995, Dooher et al. 1998). The supervisory needs are described as learning needs, individual in nature, varying in the different phases of professional development and as a foundation for CS sessions' agenda and content (Työnohjaustyöryhmän muistio 1983, Virtaniemi 1985, Marken and Payne 1986, Dooher et al. 1998). From the perspective of learning, individuality in terms of supervisees' specific learning styles, is emphasized (Virtaniemi 1985, Holloway 1995). Supervisee's theoretical orientation is rarely mentioned in the literature, but rather it is claimed that no clear theoretical designation exists (e.g. Holloway 1995). However, psychological research has shown that similarity between supervisor's and supervisee's frameworks seemed to enhance perceptions of the quality of supervision (see e.g. Holloway 1995)

Some authors have examined the demographic factors related to supervisee such as age, gender and personal characteristics suggesting that these are important intervening variables in research (Hyyppä 1983, Virtaniemi 1985, Holloway 1995, White et al. 1998). However, research evidence in nursing confirming these claims is limited. Based on psychological research, Holloway (1995) has claimed that gender is involved in CS practice in that female supervisees employ less power as they are not encouraged to do so in interactive relationships. Personal values are central to an individual's group identity and relevant to CS from

this perspective. Hyyppä (1983), Proctor (1986), Holloway (1995) and White et al. (1998) have stated that certain specific personal characteristics of supervisee are important to successful CS. These can be summarised in terms of self-confidence, openness, willingness to acquire feedback, and self-disclosure, which have also been identified as characteristics of self-awareness (Proctor 1986, see also Severinsson 1995). The motivation factor as a personal characteristic has been considered essential as it is seen that the outcome of CS depends ultimately on supervisee's willingness to 'invest' on CS (Hyyppä 1983, White et al. 1998).

The contextual factors and intervening variables in research have been discussed only by a few authors although their importance has been acknowledged (McKay 1986, Holloway 1995, Hawkins and Shohet 1996, Bishop 1998). The influences of CS have been deemed powerful on team and organisation levels in the form of changed group or organisation dynamics, processes, climate, structure (i.e. leadership and administration), and collaboration and professional standards (Holloway 1995, Hawkins and Shohet 1996, Nigel 2000, see also Higgins and Routhieaux 1999, cf. Blejwas and Marshall 1999). However, McKay (1986) and Proctor (2000) have pointed out that organisation or team context can also have negative influences the other way around, in the form of suspicions, jealousy, tensions between team/group members, and high expectations and demands. Interestingly, the clientele is rarely examined in the literature even though it has been argued that this may be one of the important sources of job-related stress or job-satisfaction (see e.g. Holloway 1995, Hawkins and Shohet 1996).

2.1.3. The core of clinical supervision

The core of CS has been described as process–like in nature by several authors (e.g. Sava 1987, Moilanen 1994, Fowler 1996a, White et al. 1998, Sloan 1999a). The process has been connected to time and duration of CS. Defining the time aspect has been considered important in the sense that the time used for CS should be protected from other duties (Fowler 1996a, Bishop 1998). The time frame ranges from a defined period in years (Paunonen 1989, Moilanen 1994) to a life long process covering the whole professional career (Hawkins and Shohet 1996, Bond and Holland 1998). Time is described as a necessity for learning (Siltala et al 1993). As for the time perspective, it is emphasised that CS should have continuity and be arranged at regular intervals (Marken and Payne 1986, Karvinen 1996).

The core process is described more specifically as a professional learning and development process (e.g. Brettschneider 1983, Hyyppä 1983, Paunonen 1989, Siltala et al. 1993, Fowler 1996a, Bond and Holland 1998 1998), or as a pedagogical (Severinsson 1995) or didactic process (Severinsson and Borgenhammar 1997). The core of the process is described as continuous learning from experience, practice or problem solving (Hyyppä 1983, Paunonen 1989), but also as an integration process of professional experiences, skills and knowledge (Severinsson and Borgenhammar 1997). Depending on the emphasis, the learning process has been described as supervisee's internal (Hyyppä 1983) or interpersonal (Fowler 1996a) process. However, the dynamic or non-straightforward characteristic of the CS process is emphasised in the literature in connection with the learning and development perspectives (Marken and Payne 1986, Severinsson 1995, Hawkins and Shohet 1996).

When discussing the core of CS, the important issues of its goals, content and focus are set forth. It is even argued in the literature (see e.g. Hyyppä 1983, Dooher et al. 1998) that the formal nature of CS is specifically attained from its goals, focus and objectivity. The goals are described as individually emphasised, based on supervisee's specific needs, but also as coherent with the organisation's or unit's activities, development of positive culture and the profession's functions (Hyyppä 1983, Karvinen 1996, Dooher et al. 1998). The content is described as practice oriented, comprised of everyday experiences and characterised by examination (assessment) of one's performance in relation to objectives, system requirements, professional practice, research evidence or otherwise relevant knowledge (Fowler 1996a, Karvinen 1996, Severinsson and Borgenhammar 1997, Bishop 1998, Sloan 1999a). The content embraces an examination of dissonance between individual supervisee's and the profession's or organisation's expectations concerning performance and reality in practice (Hyyppä 1983, Sava 1987, Moilanen 1994, see also Paunonen 1989). The issues concerning the content have been found to focus on (a) practice (e.g. problems related to patient care), (b) organisation and management (e.g. division of work, team's functionality, co-operation, collaboration), (c) education, training and personal development (e.g. supervisee's work related issues and problems) (Moilanen 1994, White et al. 1998). However, the characteristics concerning the content, goals and focus of CS have also been considered difficult to explore because of their constantly varying nature, selectivity and subjectivity (see e.g. Payne and Marken 1986, Proctor 1986).

The supervisory relationship is examined in the literature most commonly through the different models and phases of CS. The forms of one-to-one, team and group supervision (e.g. Moilanen 1994, Severinsson 1995) and the stages such as introductory, implementation and consolidation (e.g. Severinsson 1995) of the developing relationship are then presented. It is also emphasised that the CS relationship is non-hierarchical and that it is characterised by mutuality (Marken and Payne 1986, Sava 1987, Chambers and Long 1995, Holloway 1995, Sloan 1999a). However, the supervisory relationship and especially the interaction between supervisee and supervisor are seen as core elements of CS (see e.g. Brettschneider 1983, Sava 1987, Virtaniemi 1985, Chambers and Long 1995, Holloway 1995, Hawkins and Shohet 1996, Karvinen 1996, Severinsson and Borgenhammar 1997, Faugier 1998). It is argued that the success of CS depends on the success of interaction (e.g. Brettschneider 1983) and the importance of this is related to the fact that the learning occurs in this relationship (e.g. Virtaniemi 1985). From this perspective, the interaction and its characteristics have been deemed essential. The qualities related to the relationship and interaction have been described with several attributes such as supporting and facilitating (Chamber and Long 1995), encouraging (Faugier 1998), sharing (Severinsson and Borgenhammar 1997), non-possessive, independent and valuing supervisee's knowledge, personal learning style and tempo (Brettschneider 1983).

2.1.4. Empirical working methods: reflection and assessment of work

Several authors (Hyyppä 1983, Työnohjaustyöryhmän muistio 1983, Johns 1993, Moilanen 1994, Chambers and Long 1995, Hawkins and Shohet 1996, Johns 1996, Karvinen 1996, Bishop 1998, Bond and Holland 1998, Dooher et al. 1998, Faugier 1998, Johns and McCormac 1998, Maggs and Biley 2000) have argued that CS materialises in practice as reflection upon supervisee's work-related issues. In the literature, CS is described as an enabling factor or a means to encourage, facilitate and promote assessment (e.g. Työnohjaustyöryhmän muistio 1983), reflection (e.g. Bond and Holland 1998, Dooher et al. 1998) and learning (Sava 1987, Paunonen 1989) on clinical practice. However, even though it is seen that CS, assessment of work, reflection and learning are intrinsically linked and that one cannot exist without the other, several authors have expressed critique from the viewpoint of reflection and learning (e.g. Karvinen 1996, Neufeldt et al. 1996, Ojanen 1996, Mackintosh 1998, Tsang 1998, Dewar and Walker 1999). The criticism is justified, but confusing as it relates to the concept of reflection, its different definitions (e.g. Karvinen 1996), which are multi-dimensional, -layered and complex in nature (e.g. Ojanen 1996, Tsang 1998) and diverse theoretical background based on theorists such as Dewey, Mezirow, Schön, VanManen and Kolb (e.g. Mackintosh 1998, Tsang 1998). However, the important argument made is that in the context of CS reflection is a method to achieve the aims of CS and not a concept or goal in itself (see Ojanen 1996). From the perspective of CS, reflection is seen in relation to practice, experiences, learning from experience and finding optional ways of acting (Karvinen 1996).

Certain preconditions have proved to be important with respect to reflection. (Johns 1995, 1997b, Johns and McCormac 1998, Tsang 1998). The factors emphasised in the literature are willingness, commitment, curiosity, openness, moral concern and courage (e.g. Johns 1995, Tsang 1998). Time is also mentioned as an essential requirement for reflection (e.g. Fisher 1996). These factors are related to a person's self-disclosure during the course of CS, and their significance is specified from the perspective of learning (e.g. Proctor 1986, Karvinen 1996, Ojanen 1996). Neufeldt et al. (1996) indicated that there are intervening conditions for reflection such as supervisee's personality, cognitive capacity and environment.

As for the content of reflection, the complexity of practice is emphasised by several authors (e.g. Johns 1995, Karvinen 1996, Neufeldt et al. 1996, Johns 1997a). The complexity of practice on its different levels is revealed through reflection, and this provides a reason for continuous assessment of the prevailing situation in relation to oneself and one's work e.g. before decision making, actions or interventions. The content of reflection embraces work-related issues and concerns (e.g. McKay 1986, Hawkins and Shohet 1996) and it is characterised as continuous and systematic analysis and assessment of work related issues and attitudes, and continuous re-assessment of efficiency (Proctor 1986, Moilanen 1994, see also Ojanen 1996, Maggs and Biley 2000). The function of reflection facilitates finding valid and careful feedback (Johns 1995, Johns 1996, Bond and Holland 1998, see also Severinsson 1995). From one perspective the content of reflection is regarded as focussing on the practice producing information for the normative, formative and restorative domains of CS (see e.g. Fisher 1996).

Some authors (e.g. Johns 1995, 1997a,b, Holyoake 2000) have emphasised the role of supervisor for promoting and supporting reflection. It is argued that guidance is needed to utilise the learning potential from

experience and practice (Johns 1995, 1996, see also Dewar and Walker 1999). The main point made here is related to the systematic, critical and deep content of reflection (Holyoake 2000, see also Marrow et al. 1997) because from the perspective of learning it is important, for instance, to confront contradictions. However, this is difficult as the content of reflection may be closely related to one's work and admitting one's own biases, distortions and limited horizons embedded within practice (Johns 1996, 1997b, Johns and McCormac 1998). Johns (1997b) has argued that guided reflection can promote and support reflection and learning but also avoid problems such as practitioners hurtling naively into different barriers with a risk of frustration. Supervisor's important role in reflection is to maintain the 'balance' between challenge and support (Johns 1996, 1997b, see also Dewar and Walker 1999). Challenging is necessary for confronting contradictions and support for sustaining commitment, courage and efforts to resolve contradictions and transform one's perspective (Johns 1996, Johns and McCormac 1998). The supervisor's role is also emphasised from the perspective of delineating reflection so that significant learning can happen. The delineation suggested by Johns (1997b) is related to contents such as efficiency, philosophy of care, role, theory, parallel problems and time framing. However, it is pointed out that a supervisor's role is process rather than outcome focused (Johns 1997b) and that the supervisor is available as a support person for the supervisee (Johns 1997 b).

The reflection process is most often described in relation to time by using Schön's notions of reflection-in-action and reflection-on-action (see e.g. Tsang 1998). Some authors (e.g. Fisher 1996, Karvinen 1996, Ojanen 1996, Holyoake 2000) have also examined the reflection process more closely and in relation to CS. The characteristics of the process that have been described are the experiential basis which triggers reflection (Ojanen 1996, see also Holloway 1995, Karvinen 1996, Dewar and Walker 1999) and its active and intentional nature for aiming at rationale, justification and meaning of actions, beliefs, perceptions, knowledge or change (e.g. Ojanen 1996, Tsang 1998). It is also suggested that the reflection process consists of interrelated and sequential elements (e.g. Fisher 1996, Neufeldt et al. 1996) which are characterised with attributes such as locus of attention, stance, sources of understanding and depth (Neufeldt et al. 1996). Karvinen (1996) has argued that there may be at least two different perspectives for reflection as this can focus on (1) conscious examination of one's experiences and learning from these, but also (2) on one's own ways of acting: making observations, communicating, thinking and acting. Depending on the perspective, the reflection process acquires different characteristics.

The other commonly discussed characteristic of the reflection process is its nature described as critical assessment, examination and systematic exploration of work related issues (e.g. Karvinen 1996, see also Työnohjaustyöryhmän muistio 1983, Severinsson 1995). Assessment means that reflection exposes conflicts, contradictions and commitment to achieve desirable outcomes for work (Johns 1996, see also Ojanen 1996, Marrow et al. 1997).

Different types of reflection have been suggested such as self-reflection and co- or group reflection depending on the number of participants in the process (e.g. Tsang 1998, see also Howie et al. 1995, Holyoake 2000). Self-reflection is catalysed during CS (e.g. Holyoake 2000). It is argued that co-reflection is effective as it brings into focus one's orientation, biases and punctuation which are not revealed during self-reflection. It is also claimed that co-reflection calls attention to one's strengths, weaknesses, and revocable or irrevocable commitments (e.g. Tsang 1998). Empirical evidence is available only concerning group

reflection processes showing that as others' experiences are shared, support is received for the process, group members and self-confidence (Howie et al. 1995).

Reflection has also been examined in relation to 'tacit knowledge', intuition and decision making. Johns (1995) has defined tacit knowledge as a mixture of norms, values, prejudices and experiences. Intuition is defined as an active expression of 'tacit knowledge', and intuition and tacit knowledge develop, become explicit and conscious through intuition (Johns 1995, see also Ojanen 1996). This improves and promotes decision making in practice and in complex situations as 'tacit' knowledge and intuition are used more efficiently (Johns 1995, 1997a). Johns (1997a) has pointed out that when a person becomes aware of intuition and 'tacit knowledge', the value of practice is also shown explicitly (Johns 1997a). Johns (1995) has examined personal knowledge and its development through reflection in more detail. The author argues that the disciplinary knowledge is the 'body' of knowledge and professional knowledge is the one used in practice. These are assimilated with personal knowledge and manifested through actions (Johns 1995). The point is that the personal knowledge that counts for professional knowledge and practice develops through reflection as its relevance is mirrored against reality through reflection (Johns 1995, Maggs and Biley 2000, see also Ojanen 1996). Some authors (e.g. Virtaniemi 1985, Johns 1995, Ojanen 1996, Tsang 1998) have examined reflection from the broader perspective of theory and practice. Reflection is seen to promote meaningful integration of knowledge and research into practice such as knowledge utilisation, generalisations and application of theories. Johns (1995) has pointed out that this is an interesting perspective for further examination of evidence-based practice.

In the literature it is emphasised that reflection has always a direction, otherwise it is useless (e.g. Fisher 1996, Tsang 1998). The most common argument is that reflection aims at learning by means of extended, deepened personal knowledge and advanced judgement abilities (e.g. Ojanen 1996). It is claimed that through reflection experiences become meaningful and conscious (e.g. Karvinen 1996, see also Sava 1987, Paunonen 1989). Learning in the form of professional and competence development is also related to reflection (e.g. Ojanen 1996, see also Dooher at al. 1998). Johns (1997a) has suggested that reflection leads to emancipation. Through reflection, one becomes aware of assumptions and internal factors that constrain one's vision and contradictions (Johns 1997a). Several authors have described the manifestations of reflection in practice such as (a) decision making that is conscious and justified (e.g. Dooher et al. 1998), (b) improved problem solving skills (e.g. Hyyppä 1983, Tsang 1998, cf. Ojanen 1996) (c) development of practice (Johns 1995, see also Dooher et al. 1998), (d) policy changes (Ojanen 1996, see also Neufeldt et al. 1996, Dooher et al. 1998) and (e) improvement in quality (Ojanen 1996, see also Bishop 1998, Dooher et al. 1998).

Some authors (e.g. Marchant 1986, Howie et al. 1995, Holyoake 2000, Maggs and Biley 2000) have examined problems of reflection during CS such as increased anxiety, defensiveness and passive resistance. Resistance to change and inconvenient feelings are also mentioned (Karvinen 1996). The background of these difficulties has been examined from different perspectives. It is argued that anxiety is related to involvement of 'self' and uncertainty caused by changes in practice or policy as a result of reflection (e.g. Dooher et al. 1998). It is also suggested that equilibrium is distorted when discrepancy or contradictions are noted and anxiety is caused by the disorientation. The reflection process might also lead to re-orientation, a

new approach or synthesis (e.g. Dewar and Walker 1999). Johns (1995) has examined this interesting paradox by pointing out that inconvenience and frustration related to reflection may lead to empowerment, learning and finding one's limitations. From this perspective 'anxiety' is seen as a positive aspect and aimed at learning through experience rather than 'defending' against it (Johns 1996). Johns (1997b) has also suggested that anxiety may act as a trigger for paying attention to specific experiences such as 'interpersonal conflicts', 'working with difficult patients and relatives' or 'habituated practice' indicating the currently important focus for reflection.

The concept of reflection and the problems related to it in practice have also been criticised heavily (e.g. Mackintosh 1998, see also Ojanen 1996, Tsang 1998). The arguments have been that the process and framework for reflection have not been well defined and a common belief that practitioners can reflect spontaneously seems to be untrue. It has also been claimed that recollection of things for reflection can be vague, uncertain and biased. Finally, the benefits of reflection have been challenged because of weak evidence (e.g. Mackintosh 1998, see also Ojanen 1996, Tsang 1998).

2.1.5. Suggested outcomes of clinical supervision

The outcomes related to the concept of CS have been described in the literature in many different ways. However, the examination has been mostly indirect and instead of the term 'outcome', authors have expressed their ideas and logical reasoning in the context of 'goals', 'aims', 'purpose', 'effects' or 'benefits' of CS. The following examination is based on the suggested outcomes presented in the literature and examined from the learning and development, quality maintenance and improvement, restorative and supportive perspectives (cf. Proctor 1986).

Learning and development outcomes
The learning and development outcomes in relation to CS have been emphasised most of all in the literature. These have been examined first of all from supervisee's perspective. It is suggested that during CS development of personal characteristics occurs in relation to work (Työnohjaustyöryhmän muistio 1983, Sava 1987, Paunonen 1989, Moilanen 1994, Chambers and Long 1995, Severinsson and Borgenhammar 1997, Dooher et al. 1998, White et al. 1998). This is described more specifically in terms of development and improvement of self-understanding (Hyyppä 1983, Siltala et al. 1993, Severinsson 1994, Karvinen 1996, Severinsson and Borgenhammar 1997) and improved self-esteem through learning from practice (Bond and Holand 1998, White et al. 1998). The outcomes of professional growth and development through self-awareness have been suggested by several authors (Työnohjaustyöryhmän muistio 1983, Marchant 1986, Sava 1987, Siltala et al. 1993, Moilanen 1994, Severinsson 1995, Chambers and Long 1995, Hawkins and Shohet 1996, Severinsson and Borgenhammar 1997, Bond and Holland 1998, Dooher et al. 1998, Lyth 2000) and some authors have focused more closely on identity (Brettschneider 1983, Työnohjaustyöryhmän muistio 1983, Chambers and Long 1995, Severinsson 1994, 1995, Severinsson and Borgenhammar 1997) or on an awareness of the profession's special characteristics (Brettschneider 1983). Growth and development as an employee (Hyyppä 1983, Työnohjaustyöryhmän muistio 1983, Faugier 1992, Chambers and Long

1995, Bishop 1998, Dooher et al. 1998, Faugier 1998) and in relation to team/community have also been suggested (Työnohjaustyöryhmän muistio 1983, Sava 1987, Karvinen 1996, White et al. 1998).

Learning and development outcomes have also been described from a broader perspective of work and profession. The suggested outcomes have been related to (a) skills, competency and expertise, (b) knowledge and knowledge base and (c) profession. From this perspective, it is suggested that during CS improvement and development occur in professional skills (Brettschneider 1983, Työnohjaustyöryhmän muistio 1983, Virtaniemi 1985, Paunonen 1989, Butterworth 1992, Faugier 1992, Siltala et al. 1993, Severinsson 1995, Hawkins and Shohet 1996, Karvinen 1996, Severinsson and Borgenhammar 1997, Lyth 2000), competence (Marchant 1986, Severinsson 1995, Fowler 1996a, Hawkins and Shohet 1996, Karvinen 1996, Severinsson and Borgenhammar 1997, Bond and Holland 1998, Dooher et al. 1998, Sloan 1999a) in mastering one's work (Moilanen 1994, Hawkins and Shohet 1996) or in clinical expertise (Sava 1987, Bond and Holland 1998). Some authors (e.g. Severinsson and Borgenhammar 1997) have also suggested that learning and development outcomes are related to job satisfaction.

The interesting perspective found in the literature is knowledge–related learning outcomes as a result of CS (Paunonen 1989, Siltala et al. 1993, Severinsson 1994, Fowler 1996a, Karvinen 1996). This is described as an increased or extended professional knowledge base (Faugier 1992, Severinsson and Borgenhammar 1997, Bond and Holland 1998, Sloan 1999a, Lyth 2000) and as integrated theory and practice or experiences (Virtaniemi 1985, Sava 1987, Severinsson 1994). From a broader perspective, development of profession is also described (Brettschneider 1983) by means of socialisation (Karvinen 1996) and development of organisation/team through the members' evolving interdependency, team or group cohesion, functionality (Moilanen 1994), advanced co-operation and productivity (Hyyppä 1983). Moilanen (1994) has argued that work motivation is a consequence of this development.

Maintenance and promotion of quality of care and services
The outcomes of CS concerning the quality of care and services are less examined in the literature. The perspectives focused on are those of (a) a patient, (b) staff and (c) organisation. The following suggested outcomes in relation to the quality of patient care have been described: developed (Työnohjaustyöryhmän muistio 1983), improved (Dooher et al. 1998, Sloan 1999a) and enhanced (Brettschneider 1983, Bishop 1998, Lyth 2000) care. The more specific descriptions have focused on characteristics of care such as improved interaction (Siltala et al 1993), relationships (Severinsson and Borgenhammar 1997, Bishop 1998, Lyth 2000) and communication (Severinsson and Borgenhammar 1997). The impacts on efficiency and effectiveness of services have also been described (Chambers and Long 1995, Bishop 1998) and from the opposite perspective, consumer protection is emphasised as expressed in safety (Siltala et al. 1993, Chambers and Long 1995, Fowler 1996a, Bond and Holland 1998) and security of care (Severinsson and Borgenhammar 1997).

From the staff's perspective, the quality outcomes have been related to developing personal commitment and impact on different kinds of quality promoting actions. The summarised outcomes are as follows: moral commitment to patient care (Severinsson and Borgenhammar 1997) and staff's improved morale (Lyth 2000) which is described through accountability (Siltala et al. 1993, Lyth 2000) and

responsibility (Fowler 1996a, White et al. 1998). Increased and improved professionalism is also related to the quality of services (Työnohjaustyöryhmän muistio 1983) and this is specified in terms of professional standards maintaining quality (Butterworth 1992). CS is seen to influence standard setting (Bishop 1998), development of evidence-based practice (Bishop 1998) and critical analysis of care (Bishop 1998). CS is also described as a specific form of quality assurance (Sava 1987, Bishop 1998), and quality monitoring and maintenance (Hawkins and Shohet 1996, Severinsson and Borgenhammar 1997, Bishop 1998). Reduction in complaints is highlighted as an outcome of CS as well (Sloan 1999a, Lyth 2000).

Only a few authors have examined the quality outcomes of CS in relation to services from the organisation's perspective. The literature refers to the organisation's developed services (Karvinen 1996) and service level (Moilanen 1994), clarified business ideas (Työnohjaustyöryhmän muistio 1983), and well defined, internalised mission tasks (Siltala et al. 1993). The point emphasised is that the quality outcomes of CS are clearly linked to the support it provides for leadership that is further seen to influence the maintenance of and improvement in the quality of services and the achievement of an organisation's defined goals (Työnohjaustyöryhmän muistio 1983).

Restorative and supportive outcomes

The restorative and supportive outcomes of CS have been examined by several authors. The perspectives used are those of (a) supervisee and (b) organisation. The benefiting restorative and supportive outcomes for an individual supervisee have been described in terms of decreased anxiety (Virtaniemi 1985), fears (Severinsson and Borgenhammar 1997) reduced stress (Siltala et al. 1993, Severinsson 1994, Butterworth 1992, 1998, Hawkins and Shohet 1996, Dooher et al. 1998, Sloan 1999a, Lyth 2000), strain (Työnohjaustyöryhmän muistio 1983, Dooher et al. 1998, Lyth 2000), burnout (Butterworth 1992, Severinsson 1994, Hawkins and Shohet 1996, Butterworth 1998, Lyth 2000) and feelings of being drained (Hawkins and Shohet 1996). Contradictory to these, increased stress has also been reported as a consequence of an increased number of tasks, one of which is CS (Severinsson and Borgenhammar 1997). The links between CS and restorative and supportive outcomes have been described in the literature starting with an assumption that work load causes psychological problems and emotions such as distress, stress, strain and burnout. It is claimed that CS allows practitioners to become aware of the effects of distress and pressure and of how to deal with these emotions (Hawkins and Shohet 1996). It is suggested that e.g. increased capacity to tolerate problems (Työnohjaustyöryhmän muistio 1983) and an ability to anticipate forth-coming problems (Moilanen 1994) are developed through CS. It is also claimed that the outcome, in general, is related to the fact that the work-load reduces (Moilanen 1994) as a result of a more organised approach to work.

The following outcomes of support for an individual person (Sava 1987, Paunonen 1989) have been described: improved self-confidence or confidence (Karvinen 1996, Severinsson and Borgenhammar 1997, Bond and Holland 1998, Dooher et al. 1998, White et al. 1998, Sloan 1999a, Lyth 2000), self-respect (Moilanen 1994, Dooher et al. 1998), self-esteem (Bond and Holland 1998, White et al. 1998), confirmation (Severinsson 1994), independence (Moilanen 1994) and interdependence (Virtaniemi 1985). Outcomes such as empowerment (Bond and Holland 1998, Dooher et al. 1998, see also Butterworth 1998) and emancipation

(Moilanen 1994) linked to professional support (Siltala et al. 1993, Fowler 1996a) in finding one's personal working patterns (Sava 1987) and in gaining support for work related problems (Hawkins and Shohet 1996) have also been described.

The restorative and supportive outcomes have been described from the broader perspective of organisation and staff. It is suggested that wellbeing in general is improved (Severinsson and Borgenhammar 1997, Butterworth 1998, White et al. 1998). It is emphasised that CS is a form of employee mental health care (Siltala et al. 1993) or preventive mental welfare (Sava 1987, Siltala et al. 1993) and part of occupational safety (Työnohjaustyöryhmän muistio 1983). Through support, the outcomes are linked to improved job satisfaction, motivation (Työnohjaustyöryhmän muistio 1983, Virtaniemi 1985, Sava 1987, Severinsson 1995, Severinsson and Borgenhammar 1997, Dooher et al. 1998) and retention of staff (Severinsson and Borgenhammar 1997, Dooher et al 1998, Sloan 1999a). The impact on the organisation's cohesion is also described as a consequence of support (Moilanen 1994).

2.1.6. Related concepts

There are several related concepts to CS that have been examined in the literature. White et al. (1998) have referred to different kinds of relationship-based activities (or concepts) which are easily confused and mixed with CS. Some authors (e.g. Butterworth 1992, Bond and Holland 1998, Lyht 2000) have argued that CS is an 'umbrella term' and that the terms 'mentor', 'assessor' and 'preceptor' are linked to the CS practice. The relation between the terms is described as forming a system that covers the whole career development (Bond and Holland 1998, Morton-Cooper and Palmer 2000). The ambiguity of CS even as an 'umbrella term' has been criticised based on the argument that the defined attributes for the related terms have not in fact clarified the concept of CS (Lyth 2000). In the following examination, the emphasis is on describing the discriminating attributes of the related concepts and terms with regard to the concept of CS.

The closely related concepts have been examined in different ways, emphasising concrete differences in the CS practice. The interest has focused on (a) defined goals and functions of CS, (b) duration and (c) nature of the relationship, (d) process, (e) content, (f) practice, (g) participant roles, (h) participants and (i) assessment and its function (Paunonen 1989, Severinsson 1994, Fowler 1996a, Bond and Holland 1998). In the following examination the focus is on those attributes that were found important in the previous chapters (2.1.2. – 2.1.5.) for analysing the concept.

Related concepts to CS identified through the different educational roles and linked to professional development throughout the 'whole career' include assessor (Butterworth 1992, Fowler 1996a, Lyth 2000), mentor (Butterworth 1992, Fowler 1996a, White et al. 1998, Lyth 2000) and preceptor (Butterworth 1992, Fowler 1996a). These concepts are widely examined in the British literature (e.g. Morton-Cooper and Palmer 2000, see also Stewart and Krueger 1996). 'Mentor' is usually defined as an experienced professional nurturing and guiding noviciate. The relationship can last several years and it is characterised as encompassing choices, emotional ties and possibly sponsorship. The concept also implies guidance, assistance and support in learning new skills, adopting new behaviours and acquiring new attitudes (see e.g. Butterworth 1992, Fowler 1996a). The interactive relationship, mentor's experience and practical knowledge

are attributes similar to CS and those of a supervisor (see e.g. Severinsson 1994). The difference compared with the core of CS is the time frame and nature of mentoring that is focused, even more clearly in the American literature, on career guidance and long term career plans (e.g. Stewart and Krueger 1996). The definition of assessor emphasises that the role is formal and includes responsibility for evaluating pre- and post-registration students (see e.g. Butterworth 1992, Fowler 1996a, Lyth 2000). These are the main differences compared with CS, which is supervisee-initiated and involves self-assessment and examination of work (see also Bond and Holland 1998). The definitions of a preceptor's role emphasise its focus on orientation to work, teaching with regard to routine work of clinical area, enabling development of professional skills and supporting a person during a transition period in a new work (see e.g. Butterworth 1992, Fowler 1996a, Dooher et al. 1998). The main difference in relation to CS is the time frame which is short and the emphasis on teaching in the relationship (see also Bond and Holland 1998, Lyth 2000). The Finnish health care and nursing culture have no titles or roles such as an assessor, mentor or preceptor. However, in the Finnish literature the concept orientation has been examined as a related concept to CS with similar attributes as those for 'preceptor' (e.g. Hyyppä 1983, Sava 1987, Paunonen 1989, Moilanen 1994).

In the Finnish literature, concepts related to post-registered education (Työnohjaustyöryhmän muistio 1983) and training (Moilanen 1994) such as in-service and continuing education (Työnohjaustyöryhmän muistio 1983, Sava 1987) and study group and ward hours (Hyyppä 1983, Sava 1987, see also Hyrkäs et al. 2001a) have been examined as related concepts to CS. The definitions of in-service- and continuing education and study groups share similar attributes with CS as these are professionally focused, goal oriented and organised by employer. However, the essential difference between these concepts and CS is that the nature of 'education and training' is usually characterised as the attainment of new, factual and extrinsic knowledge whereas CS is focused on examining intrinsic and experiential knowledge utilising interpersonal interaction. Time frame and participation in in-service and continuing education are not necessarily regular and these are controlled by the employer in terms of educational funding (see e.g. Hyyppä 1983, Työnohjaustyöryhmän muistio 1983, Sava 1987, Paunonen 1989). In the British health care system, there are close similarities in terms of educational arrangements organised for pre- and post-registration students, including supervision (Fowler 1996a, Lyth 2000).

It has been argued that concepts sharing supportive and restorative perspectives similar to CS are related concepts to CS. In the literature concepts such as peer support (Butterworth 1992, Bond and Holland 1998), debriefing (Bishop 1998), consultation (Hyyppä 1983, Työnohjaustyöryhmän muistio 1983, Sava 1987, Paunonen 1989), counselling (Moilanen 1994, Dooher et al. 1998, White et al. 1998) and psychotherapy (Hyyppä 1983, Sava 1987, Paunonen 1989, Faugier 1992) or therapy (Hyyppä 1983, Työnohjaustyöryhmän muistio 1983, Moilanen 1994) have been examined. Peer support is defined as a form of support that occurs regularly, but mostly on an informal basis which makes it different from CS. Peer support is aimed at allowing colleagues to share stressful clinical situations, acquire sympathy from peers but also feedback concerning a specific situation (see e.g. Butterworth 1992). Interestingly, debriefing for staff shares similar characteristics with peer support, especially the focus on examining and sharing stressful clinical situations. However, debriefing occurs on a formal basis and its duration is short, which distinguishes it from CS (see e.g. Wright et al. 1997, Bishop 1998, Robbins 1999). In the Finnish literature,

'consultation' is also examined as a related concept to CS. The similarity of these two concepts lies in the focus on problem solving. The essential differences are that consultation is short in time and not a process–like concept like CS. By definition consultation is aimed at solving a specified and outlined problem with clear instructions and concrete actions (see e.g. Järvinen 1997, Miettinen 1999, see also Keskinen 1996)

Some authors have considered counselling (Moilanen 1994, Dooher et al. 1998, White et al. 1998), psychotherapy (Hyyppä 1983, Sava 1987, Paunonen 1989, see also Faugier 1992) and therapy (Hyyppä 1983, Työnohjaustyöryhmän muistio 1983, Moilanen 1994) as related concepts to CS. The essential difference between these concepts and CS lies in the core of the concepts. Therapy, psychotherapy and counselling are focused on personality, not on examination of work related issues between two (or more) professionals. For example, the goals of therapy and psychotherapy have been defined as solving personal problems and individual's inner contradictions, relieving psychical symptoms and unifying a personality (e.g. Työnohjaustyöryhmän muistio 1983, Sava 1987, Paunonen 1989, Moilanen 1994). Hyyppä (1983) has summarised the essential attributes by pointing out the differences: in CS the focus is external in relation to individual, whereas in therapy it is internal.

The related concepts sharing an administrative perspective and compared with CS in the literature have been individual performance review (Hyyppä 1983, Bishop 1998, Dooher et al. 1998), leadership (Hyyppä 1983, Sava 1987, Severinsson 1994), performance supervision (Bond and Holland 1998, Dooher et al. 1998), organisation development (Hyyppä 1983) and quality circles (Hyyppä 1983). The concepts of organisation development (OD) and quality circles are not examined in this chapter as these have not been a focus of discussion in the literature during the 1990s.

Individual performance review (IPR) is an interesting concept as it is regarded as close and complementary to CS (Hyyppä 1983, Bishop 1998). The essential differences between CS and IPR are, however, related to the attributes of time frame (i.e. regularity and continuity), goal orientation, assessment and interaction. In other words, the authors (e.g. Hyyppä 1983, Dooher et al. 1998) have pointed out that the objectives for IPR are set and agreed with a line manager and are linked intentionally with the organisation's goals for the purpose of ensuring e.g. efficiency. Employee's progress is assessed systematically but infrequently (e.g. semi-annually or annually) in the context of organisation. The relationship in IPR is characterised as hierarchical in nature.

The essential attribute of leadership that distinguishes it from CS is the hierarchical nature of the relationship between participants (i.e. in relation to subordinates) that is also authorised by organisation (Sava 1987). Hyyppä (1983) has described this relationship in detail and characterised the hierarchical nature with attributes such as authority, manipulation, 'non-voluntary basis' and employer initiated starting points. In comparison with CS, the attributes are lack of formal control, confidentiality (e.g. issues examined are not forwarded unless jointly agreed), voluntary basis and support for independent problem solving. The power and authority of the leadership relationship distinguish it from management, characterised with attributes such as control and authority (e.g. Severinsson 1994). Dooher et al. (1998) have examined performance management as a related concept to CS (see also Marchant 1986). The distinguishing attributes defined are the hierarchical relationship (i.e. performance management is provided by a line manager) that is characterised by inspection (e.g. assessment) and control (i.e. manager is authorised to give feedback).

2.2. Theoretical perspectives on the concept of clinical supervision (CS)

The theoretical perspectives on the concept of CS are interesting, as the number of well-defined models has increased during the 1990s (van Ooijen 2000, cf. Fowler 1996a). However, before examining these more closely the 'practical model' is examined first. At the end of this chapter, the theoretical perspectives on CS are discussed from the supervisor's viewpoint.

2.2.1. The practical viewpoint related to the models of CS

Some authors (e.g. Farrington 1995a, see also Fowler 1996b, Butterworth 1998) have argued that a theoretical perspective on the concept of CS is not possible or that it is risky to define. The reasons behind these claims are based on the fact that the characteristics or attributes of the concept differ in various contexts (e.g. Farrington 1995a) and depending on a number of factors such as supervisees or target group, purpose of CS for the group, nature of the supervisory relationship, time involvement and a necessity to specify certain areas for examination (Fowler 1996b). Farrington (1995a) has summarised the danger of implementing theoretical models by pointing out that CS easily looses its meaning and connections to professional practice if formal systems are developed with the imposition of rigid models (see also Butterworth 1998). The main argument has been that there does not appear to be a single model of CS appropriate for all levels of staff and all clinical specialities but that a model implemented in practice should always be tailored for specified needs and purposes (Fowler 1996b). When the emphasis has been on the practical viewpoint, specific working definitions have been presented of the concept of CS (e.g. McCallion and Baxter 1995a) and a model of CS has been suggested. For example, McCallion and Baxter (1995a,b) (see also Porter 1997) have described this approach or practice emphasising the 'differing' models of CS and suggested flexibility as an advantage as this allows consideration for the organisation's different policies, and units' and participants' needs without losing core requirements.

2.2.2. Examination of perspectives on CS through theoretical models

The theoretical models of CS are numerous today (see e.g. Faugier and Butterworth 1993, Fowler 1996a, van Ooijen 2000). However, several of the models presented have been borrowed and applied from other professional disciplines such as psychotherapy and counselling (Fowler 1996a), but it is also evident that during the 1990s an increasing number of authors have introduced models of CS for nursing (see e.g. Proctor 1986, 1991, 2000, Faugier 1992, Johns 1993, Friedman and Marr 1995, Severinsson 1995, 2001, Paunonen 1999).

In order to present an overview of the models and to show the different theoretical perspectives on the concept of CS some authors (Faugier and Butterworth 1993, Farrington 1995b, Cutcliffe and Epling 1997, Bernard and Goodyear 1998) have approached the models through categorisation. Faugier and Butterworth (1993) have found that the CS models fall into three major categories: (1) those describing CS in

relation to the supervisory relationship and its main constitutes; (2) those describing the main functions or role of supervision and (3) developmental models that emphasise the process of supervisory relationship. Farrington (1995b) has suggested that the CS models can be categorised into (a) client centred (b) triadic, (c) multicultural, (d) interactive and (e) growth and support models. Cutcliffe and Epling (1997) have argued that there are four central rudiments that are present to a greater or lesser extent in each of the CS models. Based on this idea the authors make a loose classification into (1) supportive and enabling, (2) developmental, (3) client centred and (4) 'staff investing' models. Bernard and Goodyear (1998) have suggested a categorisation of the models based on that used in mental health and counselling such as (1) psychotherapy theory based models, (2) developmental models, (3) social-role supervision models and (4) eclectic and integration models. To sum up, the categorisations and their basis seem to vary from a pragmatic emphasis on the nature, core essence and functions of CS to theoretical perspectives with the emphasis on different disciplines and their combinations. What can be extrapolated from the literature, is also a general consensus concerning the perspectives that are deemed to be important and the interrelations between them. This means that the models address at least four broad theoretical perspectives on the concept of CS by emphasising development, functions of CS in practice and supervisory relationship, including a client/patient relationship within a model. These are examined next more specifically focusing on the models of CS presented or cited and applied frequently in nursing.

Developmental models

Faugier's (1992) model is one of the most cited 'growth and support' models in the nursing literature. The model focuses on supervisee's 'growth and development' both educationally and personally whilst supervisor's role is seen to 'facilitate growth' and provide essential support to the practice of clinical excellence. The key characteristics underpinning the 'growth and support model' are as follows: generosity, rewarding, openness, willingness to learn, thoughtful and thought provoking, humanity, sensitivity, uncompromising, personal, practical, orientation, relationship and trust. Friedman and Marr's (1995) model shares a similar perspective with Faugire's (1992) model concerning the emphasis on development, but a clear difference is in its focus on competence. The model aims at setting standards for clinical competence through integrating educational and professional systems by linking relevant education to skills and competencies required in clinical practice and facilitating professional development through a practitioner's whole career. Friedman and Marr (1995) also stress the supervisor's facilitating role and this is expressed as a linkage between CS and the concepts of 'support', 'empowerment' and 'development'.

Models focusing on CS's functions in practice

Proctor (1986, see also Proctor 1991) has suggested a three function interactive model for CS that is widely cited in today's nursing literature. The three interactive functions in the model are termed 'formative', 'restorative' and 'normative'. The formative function of CS is defined as its educational characteristic and linked to developing skills, understanding and abilities. This is achieved through reflection on, and exploration of, supervisee's work. The restorative function is defined as supportive actions and responses to unload stress, but also to maintain adequate emotions, stability and boundaries by becoming aware of the

effects of emotional stress and of how to deal with any reactions. The normative function is defined as a managerial aspect of CS, as a crucial quality control element but also as crucial for developing standards. Proctor's (1986) model combines all three functions of CS and describes how CS can focus predominantly on one or the other functions at different times. However, it is pointed out that the functions are inter-related and overlapping. Paunonen's (1999) model differs slightly from Proctor's as it focuses on quality assurance in health care services. The model has an interesting similarity with Friedman and Marr's (1995) model as it also suggests integration of CS, in-service training and further education arguing that this is beneficial to supporting and promoting nursing practitioners' professional development as a continuous process. The model aims at defining the standards of quality in practice, but also at specifying practitioners' expertise and challenges to professional development. The model emphasises that personal involvement improves motivation and commitment to develop unit's clinical practice. The model is based on an assumption that in the long run this process will have a beneficial effect on quality of services and health care practitioners' wellbeing.

Models of supervisory relationship

Heron (1990) has presented a six-category intervention style model, originally developed for counselling and professional training for counsellors, which has recently been adopted in nursing and applied by several authors (see e.g. Farrington 1995b, Cutcliffe and Epling 1997). The model is focused on the supervisory relationship and its different styles. In Heron's (1990) model, equal value is placed on each of the six intervention styles. It is assumed that these can be used interchangeably or in combination at any point in supervision. The six styles are classified into two broader intervention styles: authoritative and facilitative. The authoritative style is concerned with assertive styles in the supervisor's on supervisee's actions and practice. The authoritative style is composed of prescriptive, informative and confronting interventions. Prescriptive intervention involves giving advice directly and directing supervisee's behaviour explicitly. Informative intervention seeks to instruct, impart knowledge and inform supervisee. Confronting intervention is concerned with being up-front with supervisee, giving clear, direct feedback and challenging beliefs and attitudes. Facilitative style is defined as a less directive one, eliciting information about supervisee. It consists of cathartic, catalytic and supportive interventions. Cathartic intervention means that supervisor attempts to enable supervisee to release tension and emotions, e.g. grief and anger. Catalytic intervention encourages supervisee to be reflective, self-directive and resourceful. Supportive intervention means that supervisor aims to confirm and validate the value and worth of supervisee. Cathartic and supportive interventions seem to be close to what Proctor (1986) has described as being the restorative function of CS. Interesting similarities exist between the definition of catalytic intervention and Severinsson's definition of the characteristics of the CS process.

Severinsson's (1995, 2001) model of CS is one of the newly published models in nursing focusing on supervisory relationship. The emphasis of CS is defined as support for the development of supervisee's job identity, competence, skills and ethics. The model is based on an assumption that during CS the supervisor transforms knowledge on different levels by inviting a supervisee to begin and participate in a dialogue. An essential element in the model is the dialogue that is defined as dialectic for the purpose of

understanding and explaining various phenomena in practice. The dialogue is important in order to receive and give (1) confirmation and gain insights. Confirmation is seen to have supportive and motivating, but also closeness promoting functions in relation to patients. According to the model, knowledge of and values concerning caring are transformed and learned during the CS process. This is conceptualised in the model as (2) giving a 'meaning'. The second assumption in the model is that the CS process is largely a learning process in which growth and development take place, especially in the form of spiritual and emotional development. The third concept in the model is (3) self-awareness. It is seen that the dialectic dialogue starts the development process in which the active factor is self-awareness. To sum up Severinsson's (1995, 2001) model: it integrates into CS three main concepts, which are confirmation, meaning and self-awareness. The model is interesting as it clearly emphasises supervisor's competence and responsibility for establishing the key concepts in the nursing supervision process.

Models of CS integrated in patient care

Ekstein and Wallerstein's (1972) model of supervision is interesting as it has been classified as one of the pioneering works (Bernard and Goodyear 1998) portraying and defining CS clearly as a teaching and learning process. It is argued that this model has distinguished CS explicitly from psychotherapy. The 'rhombus' model emphasises relationships describing them as mutual interaction and as processes of interplay among supervisor, supervisee/therapist, patient/client and administrator that constitute the processes of teaching and learning. The relationships are seen as stratification of the relationships, which also reflect the different functions and responsibilities that the participants carry. It is assumed in the model that the relationships confronted by supervisee are those with client/patient and supervisor and defined as 'helping' and 'learning' relationships. It is assumed that a supervisor has a quasi-indirect relationship to a client/patient as the main responsibility is teaching psychotherapeutic skills, but an additional responsibility consists of maintaining clinical and training standards. An administrator's function is identified as being relevant to an extent that it provides insight into the aspects of the learning process and the employed teaching techniques. Ekstein and Wallerstein's (1972) model is interesting because of its clearly defined educational perspective and indicated links of CS to the quality of practice and services.

Hawkins and Shohet (1996) developed their model originally for social work and other helping professions but it has been often cited and applied also in nursing (see e.g. Farrington 1995b, Cutcliffe and Epling 1997). The authors' double matrix model has similarities with Ekstein and Wallerstein's (1972) model in that it involves different professionals and emphasises the client relationship. The model turns the focus away from the context and wider organisational issues and looks more closely at the process of the supervisory relationship. Hawkins and Shohet's (1996) model is based on an assumption that the different styles of supervision cannot be explained by developmental stages, primary task or intervention style. Instead it is assumed that the different styles of CS are connected to the constant choices and decisions that supervisors make about the focus in the tripartite relationship between supervisor, supervisee and client. Based on these assumptions, the suggested model is composed of two interlocking systems or matrices. These are (1) the therapy system (interconnecting supervisee and client) and (2) the supervision system (involving supervisee and supervisor). These two systems are further divided into six sub-categories

depending on the emphasis and focus of attention. This gives six modes of CS within an integrated model in which the therapy system deals with: (1) reflection on the content of therapy system, (2) exploration of strategies and interventions used by supervisee and (3) exploration of the therapy process and relationship. The supervision system deals with (4) supervisee's counter-transference, (5) supevisory relationship and (6) supervisor's own counter-transference. The model is considered flexible and during the CS session movement between modes and adoption of several modes of CS can occur. The essential assumption in Hawkins and Shohet's (1993) model is similar to Ekstein and Wallerstein's (1972) in that identical parallel processes occur in therapy and in supervision.

2.2.3. Perspectives on CS practice

It is possible to summarise from the literature that CS practice, its working methods and interventions have developed mainly on a pragmatic basis focusing on working practices and concrete problems (e.g. Hyyppä 1983, Pohjola and Jokiranta 1991, see Ellis 1991). It has been claimed that this has led to the adoption of theories from other disciplines. Such authors as Ojanen (1982), Sergiovanni (1982), Hyyppä (1983), Totro (1985), Sava (1987), Pohjola and Jokiranta (1991) Farrington (1995b) and Bernard and Goodyear (1998) have made interesting contributions by examining the 'borrowed' theories and their utilisation in CS practice. The examination focuses, as Ojanen (1982) and Pohjola and Jokiranta (1991) have explicated, on the discussion and critique concerning the 'theories-in-use' and 'espoused theories'.

The importance and meaning of a theory in CS practice have been expressed from several perspectives. Hyyppä (1983) who examined the issue in the early 1980s came to the conclusion that a theory seemed to bring clarity to CS practice and better chances to develop it. Sava (1987) came to similar conclusions as Hyyppä (1983) with the findings that supervisor's theoretical conceptions are important as these seem to affect how problems are conceptualised and what actions are chosen. More recently Pohjola and Jokiranta (1991) have concluded that through a theory a 'singular phenomenon' can be unified as a theory gives perspective for thoughts and increases awareness of the implementation of CS. Theories are seen to make different phenomenon feasible for analysis, conceptualisation and understanding. Pohjola and Jokiranta (1991) indicated that theories give a meaning to a phenomenon under examination, but remind that different theories give different kinds of meanings. Bernard and Goodyear (1998) make an important observation by pointing out that the theoretical orientation is very likely to affect supervisor's conceptions, but also behaviour (Bernard and Goodyear 1998).

In the literature the utilisation of 'borrowed' theories is said to vary from literal use of one single theory to flexible applications (e.g. Ojanen 1982, Bernard and Goodyear 1998). Totro (1985) and Bernard and Goodyear (1998) have claimed that the eclectic or integrative utilisation of theories is more common in CS practice. This is evidenced through the examinations of such authors as Ojanen (1982) and Totro (1985). The eclectic utilisation of theories is defined as an approach where the best possible theory fitting a current situation is chosen. Integration of theories is defined as an approach that means merging several theories for utilisation in practice (Bernard and Goodyear 1998).

From the 'borrowed' theories Ojanen (1982), Hyyppä (1983), Sava (1987) and Bernard and Goodyear (1998) share the opinion that the (1) psychoanalytic theories seem to have given most to CS practice. Bernard and Goodyear (1998) have explicated that psychoanalytic theories have provided a rich source of theoretical ideas and concepts such as transference, counter-transference, parallel process and resistance to CS. However, the concepts have been infused from the respective theories through practice to CS. Sava (1987) has discussed more specifically the contribution of psychoanalytic theories to CS and found that these have advanced concentration on examination of supervisee's 'inner world', self-conceptions and unconscious motives. Ojanen (1982) has examined the issue from another perspective focusing on personality theories and found that the contribution of these theories seems to lie in their focus on 'self-analysis'. The author has suggested that through these theories a supervisor may help a supervisee to understand oneself, clarify conceptions of self and in relation to one's work. The contributions of group psycho-dynamic theories (such as e.g. Bion 1979) seem to focus on explaining in-group phenomenon and interpersonal behaviour (Ojanen 1982). However, critics have claimed that psychoanalytic theories may be difficult and demanding, but also focusing only marginally on 'external' world and reality (Sava 1987, see also Bernard and Goodyear 1998). Ojanen (1982) has problematized the past emphasis of psychoanalytic theories meanwhile CS is oriented towards the present and future. The other mentioned difficulty concerns the number of personality theories, their mastering and marginal emphasis on relationships between individual, environment and work. Pohjola and Jokiranta (1991) have been doubtful of utilising theories involving a personality because of their narrow focus for the purpose of CS practice and indirect inclusion of work related issues and problems. The other risks pointed out seem to involve a temptation to try to develop 'a model employee' and individualisation of work related problems. Pohjola and Jokiranta (1991) argue that through psychoanalytic and personality theories the CS process and its focus are not necessarily clarified as the focal point shifts towards the supervisee's 'inner world'.

The theories of (2) learning and interaction have been considered interesting frameworks for CS practice by several authors (Ojanen 1982, Totro 1985, Pohjola and Jokiranta 1991) as these describe and explain 'inner growth' and interaction. Ojanen (1982) has examined critical learning theories (such as e.g. Freire 1972) pointing out that their contribution to CS lies in the emphasis on encouraging independence, critical thinking, and creativity and confronting things that have been taken for granted. According to the theories, a critical attitude and approach develop in equal and dialogue–based relationship, which would offer a link to CS process. Torto (1985) has examined those learning theories focusing on professional and vocational education. The findings and conclusions are interesting as, through this, theoretical links are indicated between CS, work motivation, job satisfaction and, for instance, Maslow's and Herzberg's well known theories. Totro (1985) has also discussed the theories of different learning styles, experiential learning and creativity arguing that these may be utilised for explaining how to learn from work, how learning can be developed and improved and creativity promoted by supporting learning based on intuition. The theories are also seen to give rationale for the importance and focus on self-assessment, evaluation and feedback as a basis for learning and development. Ojanen (1982) has examined the contribution of interaction theories to CS suggesting that these may account for a person's role and formation of realistic conceptions of oneself based on communication and continuous feedback from others. By contrast, Pohjola and Jokiranta (1991)

have criticised learning theories arguing that examination of work and related issues may remain marginal. Sava (1987) has also expressed doubts suggesting that learning and interaction theories seem to focus on superficial problems.

Ojanen (1982) has discussed the contribution of gestalt theories such as Lewin (1953) to CS practice. The utility found by the author is in their description of making observations and interpretations of objective reality. The theories seem to explain the finding that not facts but their meaning is important to an individual. The theories also provide a rationale for making a 'real' change by changing the ways of making observations, analysing feelings and attitudes. This involves self-assessment and self-observations because these are seen to function as a basis for one's behaviour, but also to affect one's skills and adaptation. Ojanen (1982) suggested that these theories seem to have promoted support for supervisees in finding their specific work patterns, in acting effectively, fulfilling themselves and achieving their goals in work. Totro (1985) has argued that the theories of learning psychology (such as e.g. Beatty 1976) may be useful in CS practice as these integrate self-conception with motivation and learning. The suggested contribution of these theories lies in their description of 'ideal- and real-selves' and working environment's supportive or suppressing effects on self in the form of feedback. Totro (1985) has argued that the theories of learning psychology give a useful rationale for CS concerning the importance of support, working environment and feedback.

Some authors (e.g. Ojanen 1982, Sava 1987, Pohjola and Jokiranta 1991) have examined (3) organisation theories (such as Argyris and Schön 1976) and found that these can give substance for analysing professional growth, interpersonal skills and changes in organisation on its different levels. The contribution of these theories seems to focus on clarifying factors and values influencing decision making. However, Pohjola and Jokiranta (1991) have suggested that the background of organisational theories is heterogeneous and especially their focus and levels of examination are varying. The authors point out the temptation to apply these theories as 'adaptive integration' when the intentions for 'true' change and development are not real (Pohjola and Jokiranta 1991). Sava (1987) has also suggested that organisation theories seem to focus minimally on examination of interaction and relationships.

To sum up 'the theories-in-use' seem to have contributed to CS practice by giving explanations and rationale for important but complex phenomena such as individual and organisational changes, self-understanding, growth and development. However, it is also necessary to pay attention to questions and critique. Sergiovanni (1982) has made an important observation by pointing out that the utilisation of theories is in every case questionable because every CS session and interaction situation between supervisor and supervisee is unique. This means that the CS process is unpredictable. These facts place high expectations on a theory and its utilisation. In this respect Sergiovanni (1982) and Hyyppä (1983) share the same criticism that a rigid application of a theory is impossible in CS practice as no theory will never completely cover the whole nature of practice, and punctilious adherence to one theory may rule out important issues resulting in failure to meet the supervisee's needs. The critique seems to confirm the eclectic application of theory, which has, however, its own problems. Totro (1983) has pointed out that the eclectic approach has an obvious risk of misinterpretations. Pohjola and Jokiranta's (1991) criticism of a random selection of 'borrowed' theories is even heavier. The authors argue that the practice based on a variety of theories may easily lead to a situation where the 'espoused theories' and 'theories-in-use' are in

fact far from each other and this gives easily a wrong impression of acting theoretically when the practice is in fact quasi-theoretical. The point made by Pohjola and Jokiranta (1991) is that a theory should serve as a tool for critical thinking and reflection of reality, but this is not realised if a theory is chosen based on arguments of convenience and randomly, which fails to take beneath 'the surface'. However, the main point is that supervisors should be aware of their 'theories-in-use' or else the 'unconscious' theories start to direct practise instead of supervisee's goals.

2.3. Review of earlier empirical research: research designs, methodological solutions and results

An overview is provided of selected empirical studies of CS for health care professionals in Appendix 1. The selection draws on a computer-based literature search carried out using CINAHL, MEDLINE, NURSING COLLECTION, SPRILINE and LINDA databases starting from year 1986 and using the key words 'clinical supervision' [the key word was 'työnohjaus' in the Finnish database] and 'empirical research'. The search yielded a vast amount of bibliographic data for further examination. However, only reports and articles based on empirical data and focusing on health-care professionals have been selected for closer analysis. These inclusion criteria ruled out several articles describing student supervision (e.g. Snowball et al. 1994, Severinsson 1998, Holm et al. 1998, Halvarsson and Johansson 2000, Nylund 2000), supervision in other that health care organisations (e.g. Tapp and Wright 1996, Olsson and Hallberg 1998, Rundqvist and Severinsson 1999) and anecdotal papers (e.g. Rekola 1987, Virtanen 1987, Keinänen-Kiukkaanniemi and Virtanen 1988, Aalberg and Luotoniemi 1989, Olkinuora and Taskinen 1991, Rekola 1991, Aalberg 1993, Jones 1997a,b, 1998, Hurskainen 2000, Makkonen 2000). The references of the selected research reports and articles were further studied to identify other studies of the subject, but not found from the literature databases.

In the CS studies (see Appendix 1) under examination the studies focused in the first place on investigating the effects of CS (Paunonen 1988, Segesten 1993, Berg et al. 1994, Hallberg 1994, Hallberg et al. 1994, Pålsson et al. 1994, Pålsson and Norberg 1995, Edberg et al. 1996, Pålsson et al. 1996, Butterworth et al. 1997, Elmcrona and Winroth 1997, Marrow et al. 1997, Berg and Hallberg 1999, Arvidsson et al. 2000, Teasdale et al. 2001), but also on the effects of supervisor training (Paunonen 1991, Jakonen-Kaasalainen 1993, Vienola 1995). The effectiveness studies have had several foci of interest. These studies seem to have focused on such topics as tedium (Berg et al. 1994, Hallberg 1994), strain (Berg and Hallberg 1999) stress, burnout (Berg et al. 1994, Hallberg 1994, Pålsson et al. 1996, Butterworth et al. 1997) and job satisfaction (Hallberg 1994, Hallberg et al. 1994, Butterworth et al. 1997, Arvidsson et al. 2000, Teasdale et al. 2001). Only a few studies have focused on examining the effects of CS on quality of care (Paunonen 1988, Hallberg 1994) or climate and interplay within staff (Berg and Hallberg 1999). The approaches used included sample surveys, case studies and action research studies. The focus of interest in these studies has been on describing the state of supervisory practice by exploring the respondents' expectations and conceptions related to CS and its functions (Kaltiala and Sorri 1989, Aavarinne et al. 1992, Kilpiä and Virta 1997, Fowler and Chevannes 1998), supervisory strategies (Titchen and Binnie 1995, Cutcliffe and Epling 1997), supervisory relationship (Scanlon and Weir 1997) and structures of CS (Bowles and Young 1999, Hadfield 2000).

In the effectiveness studies a longitudinal study design has been applied with repeated inquiries at the baseline, in some studies at the middle, and at the end of CS intervention (Paunonen 1988, Segesten 1993, Berg et al. 1994, Hallberg 1994, Hallberg et al. 1994, Edberg et al. 1996, Pålsson et al. 1996, Butterworth et al. 1997, Berg and Hallberg 1999, Arvidsson et al. 2000). The most common data collection method in the longitudinal studies has been a questionnaire while interviews have been an exception (Arvidsson et al. 2000). The questionnaires in use have been developed for the study in question, whereas several studies have employed various translated instrument such as the Creative Climate Questionnaire, Burnout Measure, Maslach Burnout Inventory, Empathy Construct Rating Scale, Sense of Coherence Scale and Minnesota Job Satisfaction Scale according to the interests of the study. Besides longitudinal study designs, quasi-experimental study designs with control and experiment groups (Paunonen 1988, Segesten 1993, Berg et al. 1994, Hallberg et al. 1994, Kiuttu 1994, Pålsson et al. 1996, Butterworth et al. 1997, Edberg 1999, Teasdale et al. 2001) seem to have been common, but also 'one group pre- and post-test designs' have been utilised in the effectiveness studies for evidencing the effects of CS (Paunonen 1991, Jakonen-Kaasalainen 1993, Hallberg 1994, Bégat et al. 1997, Berg and Hallberg 1999). The variety of the above mentioned study designs mirrors the challenges highlighted by effectiveness studies of CS with regard to its control: the difficulties of randomisation in order to achieve a true experimental design, but also problems of finding a suitable control group (see e.g. Ellis et al. 1996, Tsui 1997, Hyrkäs et al. 1999a).

The cross-sectional study design has been utilised in the sample and descriptive studies of the expectations and conceptions concerning CS (Kaltiala and Sorri 1989, Aavarinne et al. 1992, Kilpiä and Virta 1997, Fowler and Chevannes 1998), experienced effects of CS (Pålsson et al. 1994, Pålsson and Norberg 1995, Elmcrona and Winroth 1997, Scanlon and Weir 1997), but also CS's relations to working milieu, moral stress and moral sensitivity (Severinsson and Hallberg 1996, Severinsson and Kamaker 1999). Cross-sectional study designs have used questionnaires as a data collection method, especially in sample surveys, but semi-structured interviews and tape-recorded supervision sessions have been used as well. An interesting finding was that besides longitudinal and cross-sectional designs, in two of the selected CS studies (Appendix 1) the study design was a case study (Vienola 1995, Cutcliffe and Epling 1997) while two had applied action research to generate (Titchen and Binnie 1995) and apply theory (Marrow et al. 1997). Vienola's (1995) case study is interesting as it utilised evaluative and repeated inquiries and diaries for data collection with the aim of promoting and intensifying the CS intervention. The study showed that continuous evaluation deepened and directed the learning process during the intervention. Sava (1987) has reported similar findings in a study with a longitudinal design which applied trend monitoring of repeated evaluation and profile monitoring related to teachers' supervision.

The review of the earlier research shows that the CS interventions have been based on a variety of different models, and approaches or on supervisor's own framework. However, it is also necessary to point out that Appendix 1 contains some intervention studies, which do not explicate the approach applied in the intervention. In some research reports the framework of the intervention is expressed implicitly, but it is possible to conclude that the approach has been psycho-dynamic (see e.g. Hallberg 1994, Hallberg et al. 1994). The CS intervention has been based explicitly on such CS models as Ekstein and Wallerstein's model (Pålsson et al. 1994, Pålsson and Norberg 1995, Pålsson et al. 1996), Heron's model (Cutcliffe and Epling

1997, Marrow et al. 1997), Proctor's model (Hadfield 2000) and models of nursing such as Eriksson's caritative model (Severinsson and Hallberg 1996, Bégat et al. 1997), Yura and Walsh's model (Paunonen 1991) and Sarvimäki and Stenbock-Hult's model (Arvidsson et al. 2000). Thus, an interesting finding from earlier research is that the CS intervention has been combined in several studies with different kinds of educational (e.g. study days) and development projects on patient care (e.g. individually planned care and development of documentation). However, only Bowles and Young (1999) test explicitly a model in their study. The duration of the CS session in the studies selected for Appendix 1 was from an hour and a half to two hours, at intervals of three weeks. The length of CS intervention varied from the minimum of four months (Segesten 1993) to the maximum of two years (Paunonen 1991, Jakonen-Kaasalainen 1993, Kiuttu 1994, Vienola 1995, Elmcrona and Winroth 1997, Marrow et al. 1997, Arvidsson et al. 2000). The educational interventions related to CS varied from two days to 40 - 400 hours. The topics of the educational intervention varied from a nursing care plan to the care of demented and breast cancer patients.

In the studies of CS (see Appendix 1) there seem to be no dominating theories, but the researchers have grounded their studies in a variety of theoretical frameworks such as experiential learning theory, Bion's theory of therapeutic groups or Antonowski's theory of sense of coherence, depending on the perspective on CS and the aim of the study. Related to the researcher's perspective and selected theoretical framework, such concepts as stress, burnout, job satisfaction and professional growth have been discussed and operationalised in the effectiveness studies as these are assumed as the outcomes of CS. What this means is that the operationalisations of the concept of CS differ considerably. However, it is also possible to claim that the theoretical frameworks of CS studies are closely related to the CS intervention and the model it is based on, especially in those studies where the researcher has acted as a supervisor (see more in Hyrkäs et al. 1999a). This has given the reason to examine these two together in Appendix 1.

The participants were in the majority (19/32) of the CS studies nursing professionals representing selected specialities in nursing such as cancer, dementia, medical, neurological, orthopaedic, paediatric and psychiatric care. In two (2/32) of the examined studies (Kaltiala and Sorri 1989, Kiuttu 1994) the respondents were medical doctors. Team and multi-professional supervision was recognisably less examined. Only in one (1/32) study the respondents represented multi-professional health-care teams (Kilpiä and Virta 1997), but mixtures of different nursing specialities were represented in five (5/32) of the studies (Paunonen 1988, Butterworth et al. 1997, Fowler and Chevannes 1998, Bowles and Young 1999, Teasdale et al. 2001). Three (3/32) studies focused on health care professionals undergoing supervisor training (Paunonen 1991, Jakonen-Kaasalainen 1993, Vienola 1995). Only in two studies (2/32) patient groups were included in the study design (Kiuttu 1994, Edberg 1999).

Summarising the main results of earlier surveys, both nursing professionals and doctors seem to be aware of CS, its effects and reasons for its need (Kaltiala and Sorri 1989, Aavarinne et al. 1992, Fowlers and Chevannes 1998). The conceptions of CS are mostly positive (e.g. Fowlers and Chevannes 1998), but doubts (e.g. Kaltiala and Sorri 1989) and variation in the expectations have also been evidenced (Fowlers and Chevannes 1998).

The results of several studies seem to evidence the supportive element and function of CS by showing that CS gives support to nurses and nursing staff (Butterworth et al. 1997, Elmcrona and Winroth

1997, Teasdale et al. 2001). However, it is also found in relation to CS that the need for support is caused by emotionally demanding work (Pålsson et al. 1994, Pålsson and Norberg 1995), work pressures (Kaltiala and Sorri 1989) and complex caring relationships (Scanlon and Weir 1997). The support seems to focus on mental health (Aavarinne et al. 1992). It is also evidenced that through the support of CS professional development is enabled (Scanlon and Weir 1997), more specifically the development of expert practice, skills and knowledge (Aavarinne et al. 1992).

The effectiveness studies have shown that CS can promote professional (Paunonen 1988, Hallberg et al. 1994) and personal growth (Paunonen 1988, Arvidsson et al. 2000, see also Cutliffe and Epling 1997), broaden and improve knowledge base and competence (Hallberg 1994, Arvidsson et al. 2000), increase independence (Jakonen-Kaasalainen 1993), decrease tedium (Berg et al. 1994, Hallberg 1994) and work strain (Berg and Hallberg 1999), improve the quality of care (Hallberg 1994, Edberg et al. 1996, Edberg 1999) and documentation (Paunonen 1988, Hallberg et al. 1994), increase creativity (Berg et al. 1994, Berg and Hallberg 1999) and job satisfaction (Hallberg et al. 1994, Arvidsson et al. 2000). However, some findings of the effectiveness studies are clearly contradictory. For example, both significant and non-significant results have been reported regarding the effects of CS on professional identity (Paunonen 1988, Segesten 1993), burnout (Berg et al. 1994, Pålsson et al. 1996, Butterworth et al. 1997), sense of coherence (Pålsson et al. 1996; Berg and Hallberg 1999) and empathy (Pålsson et al. 1996).

When examining study participants it is possible to find that teams have served as target for research only in one survey (Kilpiä and Virta 1997). In some of the studies (Berg et al. 1994, Hallberg et al. 1994, Pålsson et al. 1996) that have utilised the quasi-experimental design the respondents have been drawn from the same ward or a group of nurses. In these studies, however, the focus of interest has not been on examining the effects of CS in the groups or teams, but on specified outcomes and assessed by the respondents from their individual perspective. The results seem to suggest that changes happen in the climate (Berg et al. 1994, Berg and Hallberg 1999) and co-operation (Hallberg 1994, Hallberg et al. 1994) in groups during CS intervention, but the findings regarding the effects of CS in relation to work milieu have been contradictory (Severinsson and Hallberg 1996, Bégat et al. 1997).

The findings seem also to suggest that the quality of patient care (Paunonen 1988, Hallberg 1994), documentation (Paunonen 1988, Hallberg et al. 1994), co-operation and encounter between patients and nurses (Edberg et al. 1996, Edberg 1999) improve as a result of CS intervention. These findings are based on nursing professionals' self-reported assessments. However, patients have rarely been involved as respondents in CS studies. The only two reports that were found from the databases were Kiuttu's (1994) and Edberg's (1999) studies. Both studies used the quasi-experimental study design to show CS's effects also from the patients' perspective. Kiuttu's (1994) study showed a difference between the two patient groups: the respondents in the control group rated their doctors more often as hasty and less frequently as broad-minded and comprehensive than the respondents in the experiment group. The results from Edberg's (1999) research are interesting as they describe the nurse-patient encounter and the importance of mutual, confirming and empowering actions of both parties. The encounter seemed to improve significantly as a result of the intervention and this also seemed to have a positively effect on the condition of dementia patients.

2.4. Summary of the literature

Concept of CS in this study

The literature review focused on examining the concept of CS, the related theoretical perspectives, developed modes and empirical research in health care with the emphasis on nursing. The complexity of the concept was evidenced while describing the different angles and viewpoints found in the definitions including also the presented critique and doubts concerning the possibilities of an accurate definition of the concept. The literature review evidenced that there is no consensus of a single definition or model for CS, but that flexible definitions and flexible solutions are required in the form of 'working definitions' of the concept (e.g. Bishop 1998).

In this study CS was defined as a professionally oriented learning alliance between a supervisor and a supervisee/supervisees in a non-hierarchical relationship that is formal, dynamic, process–like in nature and focusing on supervisee's/supervisees' work. The principal antecedents of CS were its voluntary nature and commitment to the relationship. The core characteristics of CS were conceptualised through the definitions of the concept in the developmental (see Faugier 1992, Friedman and Marr 1995) and supervisory relationship–focused models (see Heron 1990, Severinsson 1995, 2001) emphasising professional development in relation to relevant education for practitioners (see also Paunonen 1999, Sosiaali- ja terveysministeriön monisteita 2000). In this study reflection and systematic assessment of one's work were defined as the empirical references of the concept (e.g. Työnohjaustyöryhmän muistio 1983, Niskanen et al. 1988, Dooher et al. 1998, see also Severinsson 1995, 2001). The contextual factors of CS in relation to patient care were linked in this study through the integrated patient care models of CS (see Ekstein and Wallerstein 1972, Hawkins and Shohet 1996) as these gave the theoretical rationale for connecting a patient-perspective in the study design. The assumed outcomes of CS based on the literature are a supervisee's /supervisees' learning and development (e.g. Faugier 1992) impact on quality of services (e.g. Proctor 1986, Paunonen 1999), and support and facilitation (e.g. Severinsson 1995, 2001). However, in this study the focus was confined to the examination of the professional development and quality related outcomes. Figure 1 presents a summary of how CS was conceptualised in this study (see also Appendix 2)

Based on the literature the following assumptions were made in this study:

- CS is an intervention that promotes professional development in a team and among its individual members,
- educational needs are enhanced and raised during CS intervention because of its impact on prompting professional development
- as the focus of CS is on job related issues, these can be intensified and promoted through continuous self-monitoring of one's work and systematic patient satisfaction feedback related to the intervention
- in the long run CS intervention has an impact on the quality of care in the teams and their individual members.

Summary of earlier studies and methodological considerations

Summarising the studies examined in the previous chapter (see Appendix 1) and the critique, the important and critical points of CS research seem to be related to the (a) study design, (b) research methods, (c) implementation of the intervention and (d) critical examination of the results. As for the (a) study design, the examination showed that the quasi-experimental study design in the effectiveness studies had proved in most of the cases to be difficult and an unsuitable methodological solution thus producing an inadequate control over the study and results (see Ellis et al. 1996, Hyrkäs et al. 1999a). The difficulty seems to be related to the complexity and multi-layered essence of the phenomenon, but also to the inevitable selection of participants because of the voluntary nature of CS, which ultimately leads to the impossibility of randomisation. Recent studies (e.g. Edberg 1999) have also acknowledged the ethical problems caused by the quasi-experimental study design in health care. In the longitudinal studies the pre- and post–test designs seem to have been acceptable and suitable as they exclude most of the problems pointed out above and thus improve the validity of the study.

The chosen (b) research methods have been another critical point of CS research. The complexity of the phenomenon under study seems to require application of more than one data collection method (e.g. Ellis et al. 1996). It has been claimed that a narrow perspective has caused a bias through the selected and few methods in use by excluding by mistake the possible intervening factors thus decreasing the validity of the study (Ellis 1991, Ellis et al. 1996, Hyrkäs et al. 1999a). The use of quantitative methods has been very common so far, but in the recent studies (see e.g. Teasdale et al. 2001) using both qualitative and qualitative methods for complementing each other have been discussed. The rationale behind the argument has been the discrepancy found in a number of CS studies showing an evident, unexplained difference between the relatively few statistically significant findings, whereas qualitative methods yield considerable positive findings. A critical factor related to the quantitative methods has been the reliability and validity of the questionnaires in use (see e.g. Teasdale 2001). Especially in the longitudinal studies, maturation of respondents (e.g. Polit and Hungler 1997) and the lacking assessment of statistical power (Ellis et al. 1996, Hyrkäs et al. 1999a) for detecting the existing effects in the population (i.e. growth, development or improvement) seemed to threaten the internal validity of the studies. These threats seem to be controllable to some degree through the instrument and the scale in use (see e.g. Tsui 1997, Hyrkäs et al. 1999a).

The sample sizes have been criticised quite often in CS research (see Appendix 1 and also Ellis et al 1996, Hyrkäs et al 1999a). This commentary is justified especially if quantitative methods have been applied for data analysis with small sample sizes. The confidence intervals and levels for ensuring the validity of the results have rarely been assessed in the studies of CS in nursing (see Hyrkäs et al. 1999a). In relation to sample sizes involving the other parties (i.e. patients and supervisors) of CS in the research has been uncommon in nursing, but not in the closely related disciplines (see Ellis et al. 1996, Tsui 1997). The claims of involving patients/clients as informants in CS study find support in the models of CS (see e.g. Ekstein and Wallerstein 1972, Hawkins and Shohet 1996), but especially in the critique concerning the validity of a study, such as how valid the results of a CS study are in practice if based exclusively on self-reported data.

Contextual factors:

Supervisor:
-professional experience [2]
-theoretical knowledge and orientation [2]
-role expectations [2]
-individual characteristics: e.g. gender, age, personal values, cultural background [2]

Supervisee:
-experience, speciality [1]
-theoretical orientation [3]
-learning style and needs [3]
-individual characteristics: e.g. gender, age, personal values [1]
-motivation [1]

Organisation:
-clientele [1]
-organisation, structure and climate professional standards [1]
-first-line management and leadership [1]

Antecedents:
-pre-requisites: voluntary nature, commitment and engagement in relationship [1]
-agreement defining concrete arrangements of CS and establishment of tasks, functions and goals of CS [2]
-establishment of safe and secure climate and environment for CS relationship for the sake of confidentiality [2]

Core of clinical supervision:
-relationship: learning alliance between supervisor and supervisee / supervisees [1]
-formal nature: professionally focused, goal and practice oriented continuous examination and assessment of one's work related issues [1]
-interpersonal interaction: nature of discourse knowledge focused and individual learning needs directed [1]
-flexible, dynamic and developing process: from non-interpersonal to personal, dependence to independence, continuity [1]
-characteristics of the process: encouraging mutuality, supporting and facilitating non-hierarchical relationship [1]
-time-frame: duration in years, regularity [1]

Empirical referents:
-reflection on one's works [1]
-systematic assessment of one's work [1]
-problem solving, judgement and decision making [3]

Outcomes (= suggested effects of CS as presented in the literature)
Learning and development
-personal characteristics in relation to work [3]
-self-awareness, -understanding, -esteem [3]
-professional development and growth: skills, competence, mastering of work, clinical expertise [1]
-professional knowledge base [1]
-development of profession [3]
Quality of services and care
-improved interaction, relationships, communication, safety and security [1]
-effects on quality promoting actions [1]
-staff's morale and professionalism [1]
-development of organisation: services and leadership [1]
Restorative and supportive outcomes
-supervisee's decreased stress, burnout [3]
-empowerment, emancipation and professional working methods [3]
-improved self-confidence, -esteem [3]
-organisational level: well-being, job satisfaction, -motivation and retention of staff [3]

1) foci of interest in this research
2) reported in another publication (Hyrkäs et. al. 2002a)
3) not measured in this study

Figure 1. The concept of CS in this study

On the other hand, the doubts concerning the basis of intervention are justified if the supervisor's theoretical framework is unknown (e.g. Ellis 1991). In other words, there seems to be a strong rationale to improve the validity of the study through involving supervisors and patients as informants.

As for the (c) implementation of the intervention, the examination of the studies revealed that an extensive variation in the duration of CS and integration of simultaneous interventions was characteristic of nursing. It is justified to doubt the effects of CS and their stability if the intervention has been very short, and to ask whether it is feasible to evaluate the effects of more than one intervention at the same time (see e.g. Hyrkäs et al. 1999a, Teasdale et al. 2001). However, an interesting and challenging finding from the previous studies (see Appendix 1) was that CS intervention can be made more effective and intensive through continuous assessment and evaluation (see Sava 1987, Vienola 1995)

There is some discrepancy in the results (see Appendix 1) of the different CS studies and (d) in this respect, critical examination of the results and conclusions is required. The reason behind the contradictory results, suggested by Ellis et al. (1996), is the ambiguity of causal direction adopted by researchers, but also the vast amount of different intervening factors. These have to some extent resulted in circular and inadequate results and conclusions (see also Ellis 1991), also in CS studies of nursing (see also Hyrkäs et al. 1999a).

The studies of CS in health care (Appendix 1, see also Hyrkäs et al. 1999a), but also in social work (Tsui 1997) and psychology (Ellis et al. 1996) have relied mainly on self-administered questionnaires with Likert-type answering scales. This has been criticised especially by Tsui (1997) who has pointed out that the item scales are not necessarily sensitive to the differing intentions of individual supervisees and supervisors. Hyrkäs et al. (1999a) have criticised the problems of the answering scales because of their 'roof and floor' effects especially if the purpose of a study is to explore the effects of CS in the form of growth, development or change. In other words, respondents who score high in the initial measurement cannot score higher in the follow-up measurements and vice versa.

The issues of validity and reliability in CS studies are very interesting. Ellis et al. (1996), Tsui (1997) and Hyrkäs et al. (1999a) have all argued that the current CS research seems to have evident problems with internal, external and construct validity. Ellis et al. (1996) have pointed out that in psychology the main threats regarding the internal validity of CS studies seemed to be selection bias (77%) and ambiguity of causal direction (69%) in the sample of 144 studies. These threats were seen to pertain largely to longitudinal or pre-test – post-test designs. Hyrkäs et al. (1999a) have also referred to the obvious problem related to the selection of participants in the studies of CS in nursing. The main threats to construct validity in psychological studies (Ellis et al. 1996) were mono-method bias (79%), confounding of the construct with limited levels of the theoretical and conceptual constructs (69%) and inadequate pre-operational explication of the constructs (69%). In the studies of nursing, Hyrkäs et al. (1999a) have indicated similar limitations with regards to explicitly expressed theoretical assumptions or theoretical and conceptual starting points of the studies and interventions. The focus of the critique is that in the studies of nursing the conceptions of the study subjects have differed in the level of concepts and theories and in the number of other interventions included in the CS intervention, which seem to have produced incoherent studies and results. Regarding the sample sizes, both Ellis et al. (1996) and Hyrkäs et al. (1999a) have discussed inadequate material and

sample sizes in CS research. Ellis et al. (1996) found that in psychology 31% of the examined 144 studies involved inappropriate control groups, 78% had inadequate sample sizes, 66% had relied exclusively on self-reported data and 43% of the samples were not representative of the target population. Similarly Hyrkäs et al. (1999a) have criticised the representativeness and comparability of the study results in nursing, the emphasis being mainly on quantitative research methods, but also the large differences in the implementation of CS intervention, in their contents and duration. Especially the interaction of combined interventions, such as CS and education (e.g. courses, training programmes) still remain unexamined. Another serious problem for the validity of the studies and found only in the studies of nursing, seems to be the combined roles of a supervisor and a researcher.

3. AIMS OF THE STUDY

The purpose of this research was to explore development and changes in multi-professional teams that occurred during the team supervision intervention. The main goal was to examine the effects of team supervision on quality of care. More specifically, the study had the following aims:

1.) To describe the effects of team supervision through the changes in supervisees and teams during the team supervision intervention

2.) To identify changes in educational needs during the intervention

3.) To assess the impact of supervisees' continuous self-monitoring of work and patient satisfaction feedback as part of the intervention aiming at supporting and intensifying the effects of team supervision

4.) To describe the conceptions of the effects of team supervision on the quality of care from the perspectives of supervisees, team and organisation

4. METHODS

4.1. Methodological basis of the study

The complexity and the dynamic nature of the concept CS, the study findings on the flaws of reliability and validity in the earlier, mainly quantitative studies (see chapter 2.3) and the aims of this study guided the planning of the study design. Since the purpose of this study was to describe effects of team supervision and the effects of this intervention on quality of care the focus of the study was clear, but the challenge was to find the methodological solutions to describe the multifaceted complexity of responses to the intervention in the teams, but also individually within the team members. It was thought that no single method would be adequate to ensure a comprehensive approach in this kind of study, but a set of complementary and confirming methods would be needed to accomplish the study and to ensure the validity and credibility of the findings.

The use of two or more data sources, methods, theories or investigators in a study of a single phenomenon, that is, triangulation, has been utilised in nursing studies since the early 1980s (e.g. Mitchell 1986, Murphy 1989). The strategy of triangulation refers to the use of multiple methods or perspectives to collect and interpret data on a phenomenon, in order to converge an accurate and/or overtake a complete representation of reality (Mitchell 1986, Denzin 1989, Dootson 1995, Begley 1996 a, b, Polit and Hungler 1997). The different types of triangulation (Denzin 1989, Burns and Grove 1997, Polit and Hungler 1997) such as data, method, investigator, theoretical and multiple triangulation have been found useful in nursing studies (e.g. Murphy 1989, Connelly et al. 1997, Shih 1998, Hyrkäs and Paunonen 2000), because the phenomenon under investigation is complex and dynamic in nature, but also cutting across the traditional disciplines (Mitchell 1986). Thus, the strength of triangulation for overcoming the biases of 'a single method, investigator or theory' has been evidenced for increasing the confidence in and validity of the results, deepening and broadening understanding of the domain under study, but also for overcoming the biases, and on the other hand, the holistic fallacy of naturalistic research allowing divergent results to enrich explanations and descriptions of reality (Mitchell 1986, Dootson 1995, Begley 1996 a, see also Murphy 1989, Connelly et al. 1997, Shih 1998)

The use of a triangulative approach integrating research methods is based on the assumptions that (1) the world is viewed as a whole, an interactive system with patterns of information change between sub-systems or levels of reality, (2) both subjective and objective data are recognised as legitimate avenues for gaining understanding, (3) atomistic and holistic thinking are used in design and analysis, (4) all those involved in the study are study participants and (5) conflicting views are not ignored but sought with provision for systematic and controlled confrontation, since conflicts are seen to offer a potential for expanding questions and consequent understanding. (Myers and Haase 1989, Burns and Grove 1997). The assumptions were acknowledged by the researcher and guided the course of the study.

Multiple triangulation was seen justified because of the complex and dynamic nature of the concept containing many dimensions. Triangulation was utilised in this study as an attempt to increase the information obtained from the participants in team supervision to provide a more holistic view on the effects

of the intervention (see Foster 1997). The advantages of triangulation were seen to improve validity and credibility of the study, but also to enhance the completeness of the findings by combining various techniques of triangulation (see Knafl and Breitmayer 1991, Dootson 1995). Multiple triangulation was seen to increase the investigator's possibility to describe and understand in depth and breath and thus more fully and thoroughly the perceptions and experiences of the intervention in the ward/team context of the supervisees studied (see Mitchell 1986, Begley 1996 b). Further, the purpose of multiple methods was to overcome the deficiencies and biases that stem from any single method (see Mitchell 1986). The aim was to achieve findings in which the variance that was obtained reflected the trait being studied rather than the method being used to measure (see Mitchell 1986)

Multiple triangulation was accomplished in this study by means of data and methodological triangulation (see also Mitchell 1986, Denzin 1989, Begley 1996a, Burns and Grove 1997). Data triangulation involved using multiple data sources, in other words patients, supervisees and teams. The patients and participating health-care professionals represented two 'data source groups' with a similar focus on provided care, but from their own and divergent perspectives in order to validate the impact of self-monitoring and patient satisfaction feedback on the intervention. The other sources of data were the supervisees and the teams, representing triangulation by person, to obtain the different views about the effects of the intervention on different levels in order to contribute a more complete description and understanding of the topic under investigation. Data triangulation also involved using the five participating wards as 'data sources' and applying triangulation by space in order to test the consistency of the findings in multi-sites.

As a means of methodological triangulation, both qualitative and quantitative methods were used in the study. This occurred at the level of data collection and design to address the same research task (see Kimchi et al 1991, Morse 1991). The selection of the methods was based on the assumption that each would tap a different aspect (i.e. individual as a team member and the team) and dimension (i.e. prerequisites, changes and effects) of the research tasks to produce a rich, comprehensive and complete picture of the phenomenon under study. The multiple procedures for data collection and analysis are illustrated in Table 1 (Table 1). The approach to triangulation was simultaneous. The ultimate purpose of the across methods triangulation was to look for commonalties and thus obtain more confidence and convergent validity in the findings. The unit of analysis triangulation occurred in this study through incorporating two levels (i.e. individual and team/ward) in the analysis and thus trying to take into account individual team-member's perceptions, and to describe these across the team members, the extent of a coherent team perspective, whether shared, conflicting or complementary (see Knafl and Breitmayer 1991, Begley 1996 a) for obtaining a more complete description and understanding of the phenomenon under study.

The process of triangulation progressed by conducting first the qualitative and quantitative studies true to the paradigmatic assumptions of each method (Dootson 1995, Foster 1997). Pertinent results within each method were distinguished next, and the confidence and validity of the findings were examined. Integration across the methods occurred after the qualitative and quantitative results were achieved and the integration was guided through conceptual validation of the findings (Mitchell 1986, Foster 1997).

Table 1. Methodological triangulation, unit of analysis and the instruments used in the study

Prerequisites for professional development (quantitative, individual)	Changes in the selected effects of CS (quantitative, individual)	Described effects of CS during the intervention (qualitative, individual)	Effects of team supervision at the end of intervention (qualitative, team)
TEAM FACTORS Atmosphere (AF1) Team spirit (GF1) Team's functionality (GF2) Commitment to work and organisation (OC2)	Effectiveness on team work Multi-professional collaboration	In relation to team Human relations	Interview theme: Team supervision and the team
INDIVIDUAL FACTORS Performance motivation (OC3) Growth motivation (OC1) Reflectivity (RF1)	Effects on expertise Clarified theoretical approach to practice Deepened self-awareness Personal strengths at work	Work patterns Supervisee	Interview theme: Team supervision and work
ORGANISATIONAL FACTORS Work's encouragement value (WF1) Possibility to influence (WF2) Participatory management style (MF1) Performance oriented management style (MF2) Task and goal systems (OF2)	Strengthened practical facilities One's contribution to the ward's overall functioning	Working on the ward Quality of care	Interview theme: Team supervision and quality of care

4.2. Intervention

Finding supervisors for the teams was a challenge. The university hospital database listing the qualified supervisors was extensive (see Hoitotyön työnohjaus 1997, see also Työnohjauksen koordinointi 2001), but many of the contacted supervisors hesitated to commit themselves to an extensive team supervision project. The reason for hesitation was that although the supervisors had experience of one-to-one and group supervision, many were unfamiliar with multi-professional team supervision in somatic health care. The majority of the contacted supervisors suggested a solution of two supervisors working together, and a list of those accepting this settlement was sent to the participating wards. This procedure enabled the teams to choose their own supervisor pair, and the supervisors were provided with profound information about the arrangements for team supervision and the study.

The chosen ten (10) supervisors, two on each of the five wards, were trained and experienced professionals from a variety of disciplines (i.e. nursing, medicine and psychology) within the organisation, but not belonging to the unit in question. The mean of the supervisors' work experience in CS was 15 years. They had used a psychoanalytic, psycho-dynamic and systems theoretic approach or an eclectic combination of these as a frame of reference in their work as supervisor. (Hyrkäs et al. 2002a)

The team supervision intervention started on the participating wards in August/September 1995. The sessions were organised at intervals of about 3 to 4 weeks, with sessions lasting for an hour and a half. The team supervision sessions were arranged in a secluded room or on other premises in the hospital. The criterion emphasised while choosing the place for team supervision was that it was not too far from the ward, but at a distance that the sessions were not interrupted or disturbed by the ward's activities. The intervention intervals were from January to May and from August/September to December. During the summer months (from June to August) the team supervision was not organised because of the holiday season. The planned duration of the intervention was three years, but the final decision was transferred to the supervisees on the participating wards.

4.3. Respondents and data collection

4.3.1. Supervisees in this study

The research was started during the fall 1995 in the university hospital. Five (5) wards (A, B, C, D and E) from three (3) different clinics were interested in and willing to participate in team supervision and the research. Three (3) of the five participating wards were regular hospital wards and two (2) were operating theatres. The medical specialities of the wards were neuro-surgery, ophthalmology and otorhinolaryngology.

The intervention started towards the end of 1995, when team supervision was introduced at different dates on the wards. In the beginning altogether 82 participants had agreed to join the team supervision process by wards. The proportion of participants in team supervision was over three-quarters of the total number of staff on the wards. The participation and involvement of short-term substitutes in the process was considered difficult within the teams and thus gainless. Six different professional groups were represented:

medical doctors (9), ward and assistant ward managers (8) specialised nurses (23), nurses (19), assistant nurses (14) and other (9) assisting staff such as ward secretaries and equipment maintenance personnel (Kilpiä and Virta 1997). Even though the number of supervisees by wards was high, the actual number of participants in the team supervision sessions was lower and varied by work shifts. However, in the operating theatres all the team members participated in the sessions without exception since team supervision was taken into account when planning surgery schedules. (see more in chapter 5.1.)

During the intervention and the study, however, the number of respondents decreased for several reasons. The reasons as reported voluntarily by the respondents were as follows: one (1) nurse retired before the termination of the study, three (3) suspended their participation because of maternity leave, three (3) doctors and two (2) nurses left for another organisation and placement. Towards the end, the remaining doctors in the sample missed the opportunity to respond to the questionnaire as their specialisation contract with the university hospital terminated. Two (2) persons interrupted participation in team supervision because of long sick leaves, while personal reasons for closing the contract were mentioned by 11 participants. Some respondents participated irregularly in the team supervision sessions for several reasons (e.g. work shifts, off-duty days, short sick leaves and study leaves) and thus responded to the inquiries randomly. The highest loss of respondents (47%) occurred on ward D and the smallest (27%) on ward E. On the other wards the number of drop-outs was as follows: ward A 35%, ward B 40% and ward C 37.5%. The number of respondents in the follow-up inquiries by wards and the drop-out percentages are described in Table 2. (Table 2) The final sample of this study was formed of those 46 respondents who had completed all inquiries and participated actively in the team supervision sessions.

4.3.2. Patient sample

Convenience samples of patients responded to the questionnaire, delivered by the supervisees on a monthly basis, with the aim of acquiring feedback on satisfaction. The data collection was parallel with the supervisees' work monitoring during the intervention periods from January to May and August/September to December. A total of 1,643 patients answered the questionnaire. The number of patients on ward A was 616, on ward C 559 and on ward D 468. Nursing staff delivered the questionnaires and the researcher did not know the number of patients who refused to participate.

Table 2.   Participation in the inquiries and the drop-out percentages

	Inquiry 6/96 (n)	Inquiry 12/96 (n)	Inquiry 6/97 (n)	Inquiry 12/97 (n)	Inquiry 6/98 (n)	Participants of all inquiries	Drop-out percentage
Ward A	17	20	19	15	16	13 (65 %)	35 %
Ward B (*	10	9	6	-	-	6 (60 %)	40 %
Ward C (*	16	14	10	-	-	10 (63 %)	37 %
Ward D	16	14	15	17	11	9 (53%)	47 %
Ward E (*	11	9	9	-	-	8 (73 %)	27 %

*) Wards B, C and E participated in the study for two years

4.3.3. Data collection

Data collection with questionnaires

The study design for data collection from the staff that participated in team supervision was longitudinal (see Figure 2). As the main interest of the study was to explore professional development in teams and in its individual members, the 'Prerequisites for professional development'- and 'Professional individual development'- questionnaires were considered a suitable data collection method for this purpose. The self-report questionnaire was developed for this purpose through modifying and combining Ruohotie's (1993 see also Ruohotie and Grimmett 1996) and Paunonen's (1989) instruments. This process is described in chapter 4.4.

During the team supervision intervention, the follow-up inquiries for staff were repeated after every six months. The decision to repeat the inquiries at half-year intervals was based on the fact that the timing of CS was organised in terms, that is, the inquiries were repeated at the end of every spring and autumn term. The researcher delivered the questionnaires and the covering letters, but the actual data collection procedure on the wards was co-ordinated by the ward managers who delivered the questionnaires personally to their staff. The ward managers reminded staff of the timetable for returning the questionnaire and of including the respondent's code number in the questionnaire. At the beginning of the study wards managers were asked to devise a list of staff who had agreed to participate in team supervision and to give each participant a number that was in use throughout the study. These lists were stored in the ward managers' locked offices and the numbers were checked during the study only if a respondent had forgotten their code number. An envelope always followed the questionnaire for returning it via mail or internal mail to the author. The data collection procedure was repeated three times (6 / 96, 12 / 96, 6 / 97) on wards B, C and E, which participated for two years and five times (6 / 96, 12 / 96, 6 / 97, 12 / 97, 6 / 98) on wards A and D which participated for there years in team supervision and the study.

As the aim of this study was to explore the effects of team supervision on the quality of care, the data collection was seen possible through inquiries into the staff's continuous self-monitoringt of work and the systematic follow-up of patient satisfaction feedback. The two self-report questionnaires were developed for this purpose by the researcher (see chapter 4.4.). The staff's continuous self-monitoring of work through questionnaire started in January 1996 and ended in May 1998, coinciding with the ward's participation in team supervision. Continuous self-monitoring of work was accomplished weekly with a structured self-report questionnaire with two open-ended questions. The completed questionnaires were returned monthly to the researcher via internal mail. However, during the summer months from June to August the data collection was interrupted, since the team supervision sessions were not organised because of the holiday season.

FOLLOW-UP INQUIRIES

- supervisees' assessments of the effects of the intervention by answering the follow-up inquiries semi-annually

CONTINUOUS MONITORING OF WORK
- supervisees assess their own work once a week during the intervention
- data analysis and reports monthly

TEAM INTERVIEWS
- at the end of the intervention
- team's perceptions of the effects of the intervention on the quality of care

TEAM SUPERVISION

PATIENT SATISFACTION FEEDBACK
- continuous data collection (goal: minimum number of 10 patients/ week, 40 patients/ month)
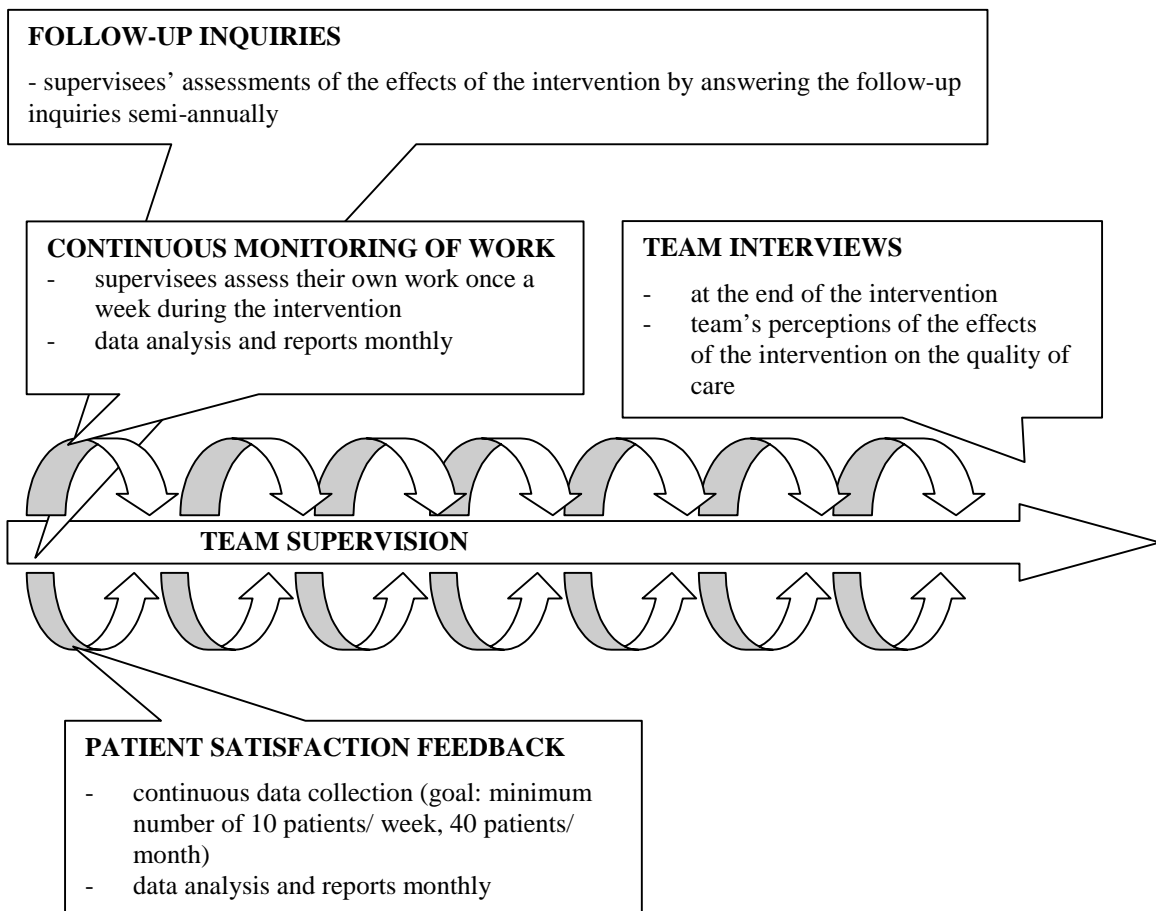- data analysis and reports monthly

Figure 2. Design of the study: intervention and data collection

Data on 'patient satisfaction feedback' were collected on three wards: A, C and D. Data were collected with a structured self-report questionnaire including two open-ended questions. The timing of this data collection was parallel to the staff's self-monitoring of work. Staff delivered the 'patient satisfaction feedback' questionnaires and managed the data collection procedure. Staff were asked to explain the purpose of giving feedback to patients and to provide the materials: the questionnaire, the cover letter from the researcher and an empty envelope. The goal was to acquire feedback from approximately ten patients each week or from 30 – 40 patients each month. The recommended number of respondents was stated explicitly to ensure the possibility of using statistical methods for data analysis. Patients answered the questionnaire on the day of discharge and were asked to leave the completed questionnaire in a sealed envelope in the ward office. Patient participation was voluntary. Ward managers collected the returned questionnaires in envelopes monthly and sent them to the author via internal mail.

Data collection with group interviews

As the intervention was implemented and focused on groups in the form of team supervision, group interview was considered an appropriate data collecting method for producing information from the teams' perspective (e.g. Frey and Fontana 1991, Kitzinger 1994, Moilanen 1995). The other important fact that

supported the selection of this data collection method was that the main interest of the study was to explore the effects of team supervision on quality of care (see Fitzpatrick 1994). This aim implies that the quality of care is produced jointly by the members of a team or collective, but not by its single individuals. Thus, the implication was that the teams' descriptions of the effects on quality of care exceed and differ from an individual's description (see also e.g. Harvey 1996).

In the literature (e.g. Frey and Fontana 1991, Kitzinger 1994, Asbury 1995, Vaughn et al. 1996), group interview is referred to as a unique method for collecting data from group members that cannot be obtained through individual interviews or questionnaires. Interaction between group members, but also with the interviewer/researcher influences the knowledge generated. This process allows to deal with complex issues, which is further enhanced by the possibility to elaborate upon the subject and to examine it synergistically. The method may also bring out the 'polyphony' or range of conceptions of the topic in a group. It has been claimed that group interview as a data collection method gets closer to the reality and practice, if compared with other methods, because the interview takes place in the social setting in which people live and operate together. The researcher shares the group's experiences and reality during the interview. (Frey and Fontana 1991, Kitzinger 1994, Asbury 1995, Vaughn et al. 1996)

In this study, the group interviews were undertaken on each participating ward 4 - 6 months after the termination of team supervision. There were 6 to 10 interviewees per group and altogether six interviews were conducted. Two interviews were made on ward C because of the difficulties in staff and work shift arrangements. The total number of participants in the six interviews was 62, which differed from the number of those (46) who had completed the questionnaires. However, as the researcher was not aware for ethical reasons of the respondents' names behind the code numbers, it was not possible to classify active vs. passive respondents or participants in team supervision.

One hour was reserved for each interview. The interviews were carried out on the same premises, outside the ward, as the team supervision sessions to eliminate interruptions. However, two of the interviews (wards C and E) were accomplished on the ward's coffee or day room, because it was impossible for staff to leave the ward because of an extremely busy work situation. Participants had agreed beforehand to tape recording the interviews and it had been emphasised that the participation was voluntary. Two tape recorders were used simultaneously to assure the quality of recording. During the interviews, the author observed the group and made notes. The notes were not detailed nor was the observation systematic, but descriptive, since the author managed the data collection and the tape recorders single-handed.
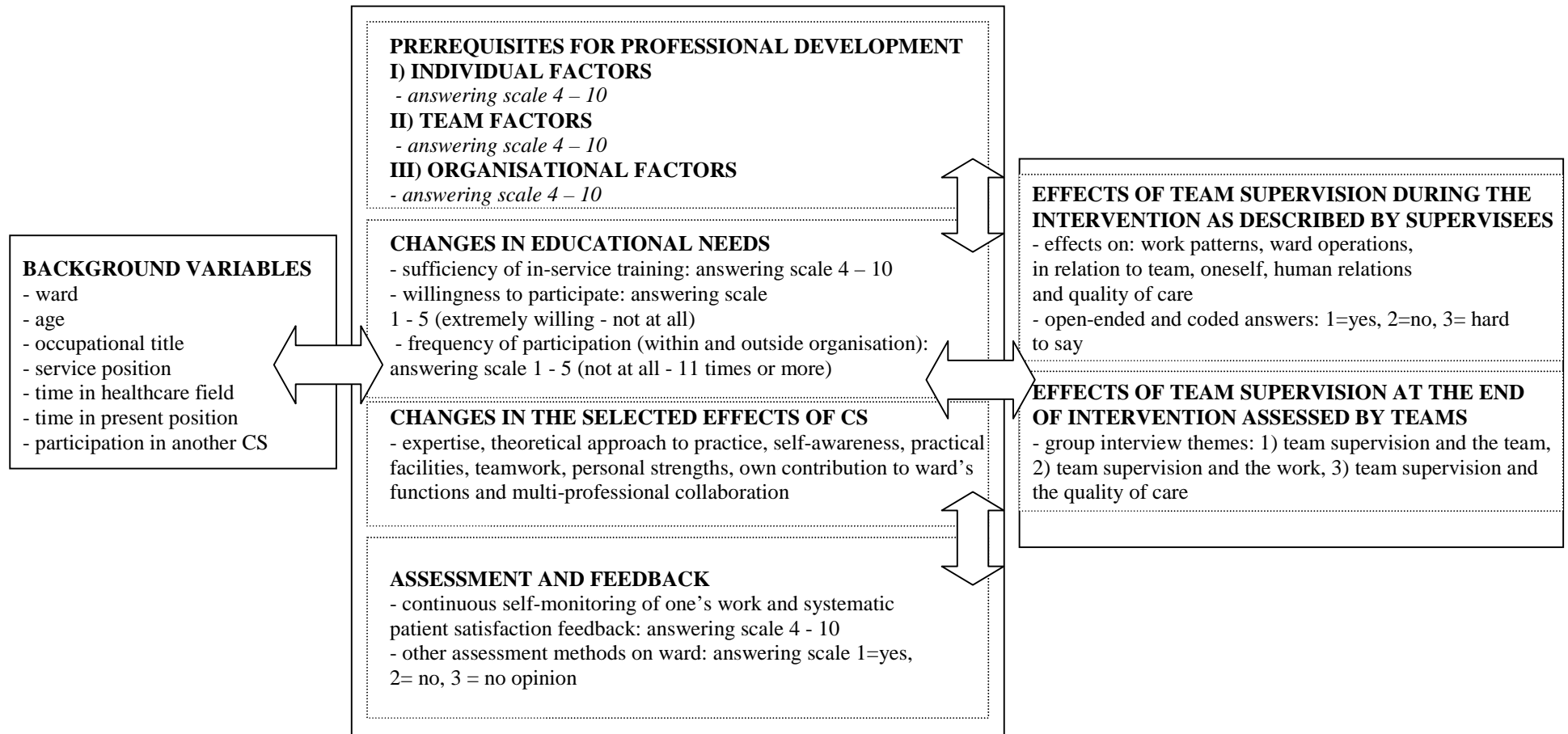
PREREQUISITES FOR PROFESSIONAL DEVELOPMENT
I) INDIVIDUAL FACTORS
 - answering scale 4 – 10
II) TEAM FACTORS
 - answering scale 4 – 10
III) ORGANISATIONAL FACTORS
- answering scale 4 – 10

CHANGES IN EDUCATIONAL NEEDS
- sufficiency of in-service training: answering scale 4 – 10
- willingness to participate: answering scale
1 - 5 (extremely willing - not at all)
 - frequency of participation (within and outside organisation):
answering scale 1 - 5 (not at all - 11 times or more)

CHANGES IN THE SELECTED EFFECTS OF CS
- expertise, theoretical approach to practice, self-awareness, practical
facilities, teamwork, personal strengths, own contribution to ward's
functions and multi-professional collaboration

ASSESSMENT AND FEEDBACK
- continuous self-monitoring of one's work and systematic
patient satisfaction feedback: answering scale 4 - 10
- other assessment methods on ward: answering scale 1=yes,
2= no, 3 = no opinion

BACKGROUND VARIABLES
- ward
- age
- occupational title
- service position
- time in healthcare field
- time in present position
- participation in another CS

**EFFECTS OF TEAM SUPERVISION DURING THE
INTERVENTION AS DESCRIBED BY SUPERVISEES**
- effects on: work patterns, ward operations,
in relation to team, oneself, human relations
and quality of care
- open-ended and coded answers: 1=yes, 2=no, 3= hard
to say

**EFFECTS OF TEAM SUPERVISION AT THE END
OF INTERVENTION ASSESSED BY TEAMS**
- group interview themes: 1) team supervision and the team,
2) team supervision and the work, 3) team supervision and
the quality of care

Figure 3. Operationalisation of the concept

4.4. Instruments used in the study

The data collection methods used in this study were questionnaires and group interview. The instruments in use were the following:

> (1.) The 'Prerequisites for professional development in organisation' (Ruohotie 1993) and 'Professional individual development' (Paunonen 1989) questionnaires
>
> (2.) The 'Continuous self-monitoring of work' and (3.) 'Patient satisfaction feedback' questionnaires
>
> (4.) Thematic group interviews

The instruments were modified (instrument 1.) and developed (instruments 2., 3. and 4.) by the author with reference to the literature and pilot-tested. The instruments consisted of structured and open-ended questions. The group interviews were based on predetermined themes. The instruments and their subsequent operationalisation in this study are summarised in Figure 3.

The 'Prerequisites for professional development in organisation' and 'Professional individual development' questionnaire

The 'Prerequisites for professional development in organisation' questionnaire is originally developed by Ruohotie (1993) and draws on several studies (Ruohotie 1977, 1983, 1985, 1990). Ruohotie (1993) has not specifically named the questionnaire, but called it as an 'atmosphere inquiry'. In this study the instrument is called 'Prerequisites for professional Development in Organisation' (PDO) inspired by Ruohotie's (Ruohotie et al. 1999, see also Ruohotie and Grimmett 1996) recent publications and theoretical works based on earlier research. The instrument has been utilised in its original form for exploring the prerequisites for work motivation and associated with organisation development interventions in several Finnish companies (Ruohotie 1983). However, considerations of the reliability and validity of the instrument were not found in the summarising reports and the emphasis in these seemed to be strongly practice oriented (see e.g. Ruohotie 1983).

The original PDO questionnaire (Ruohotie 1993) is an 82–item self-report instrument. Each item is rated on a five point Likert–type scale ranging from (1) 'definitely true', to (5) 'definitely false' based on respondent's conceptions of the statement's correctness in their work situation. The instrument is scored to obtain five (5) factors describing prerequisites for professional growth and development in organisation through fourteen (14) sum variables. The factors and related sum variables are shown in Table 3.

Joronen (1993) has applied Ruohotie's (1993) instrument in her study 'Prerequisites for professional development in organisation'. The target organisation in the study was a national company producing laundry, cleaning and textile rental services. In the study Ruohotie's (1993) instrument was revised and shortened to a 70–item questionnaire. The reasons for these alterations were that the original instrument was considered long and the number of variables was high.

Table 3. The 'Prerequisites for professional development in organisation' instrument and its revision

Variables (Ruohotie 1990, 1993, 1996)	Joronen (1993) Cronbach's alpha	Kilpiä and Virta (1997) Cronbach's alpha	Pilot study (1996) Cronbach's alpha
(I) Organisational factor			
(OF1) communication system (5 items)	.82	-	-
(OF2) task and goal systems (6 items)	.78	.77	.7937
(OF3) encouragement system (9 items)	.87	-	-
(AF1) atmosphere [*] (5 items)		[*] .87	[*] .8227
(II) Managerial factor			
(MF1) participatory management style (12 items)	.95	.78	.9386
(MF2) performance oriented management style (4 items)	.90	.77	.8931
(III) Group process related factor			
(GF1) team spirit (6 items)	.84	.52	.8719
(GF2) team's functionality (5 items)	.84	.82	.8464
(GF3) co-operation with clients and other collaboration groups (3 items)	-	-	-
(IV) Work process related factor			
(WF1) work's encouragement value (6 items)	.89	.46	.7544
(WF2) possibility to influence (3 items)	.81	.77	.7174
(WF3) esteem of work and external rewards (6 items)	.60	-	-
(V) Outcome factor:			
(OC1) growth motivation (5 items)	.78	.59	.8775
(OC2) commitment to work and organisation (7 items)	.80	.70	.5020
(OC3) performance motivation (3 items)	.71	.50	.7040
(RF1) reflectivity [*] (5 items)		[*] .73	[*] .4971

[*] Variables included in the original instrument

Joronen (1993) has also pointed out that the complexity of the phenomenon under study, the difficulty of operationalizing related concepts and of controlling their relations were the reasons for the revisions and the reductions in the number of variables in the instrument. The revision process was based on factorial analysis. However, regardless of the revision process, the main body of the original instrument remained the same and the alterations in the final factors and items were slight. The scale used in the original instrument also remained the same. The Cronbach's alpha values reported by Joronen (1993) are listed in Table 3. The values show that the internal homogeneity and consistency in the sum variables of the factors were good after the revision process.

Kilpiä and Virta (1997) developed a questionnaire based on the PDO questionnaire, the version generated by Joronen (1993) and the literature for the purpose of examining professional development in health care organisation. The developed questionnaire was revised and shortened by consulting an 'expert panel'. The panel members (N=12) were representatives of different health care professions (i.e. doctors, nurses and assistant nurses) in one university hospital. The panel members made a careful, joint assessment of the items in the questionnaire and their relevance for use in health care organisation. The developed questionnaire consisted of 45 items from Ruohotie's (1993) and Joronen's (1993) instruments including 44 additional structured and open-ended questions. As a result of the revision and reviewing process, the authors included two additional sum variables (i.e. atmosphere and reflectivity) in the questionnaire. The item scale in use was not a Likert–type, but a seven-point scale ranging from (4) 'describes extremely

poorly' to (10) 'describes extremely well'. The developed questionnaire was pilot–tested before its use (N=11). The Cronbach's alpha values (Table 3.) reported by Kilpiä and Virta (1997) were moderate, but also a few low values were found.

The final version of the 'Prerequisites for professional development in organisation' questionnaire for health care professionals for this study was revised and pilot–tested by the author. The questionnaire was developed based on the studies and literature introduced by Ruohotie (1993), Joronen (1993) and Kilpiä and Virta (1997). The study and questionnaire developed by Kilpiä and Virta (1997) formed the basis for the work, but the instruments presented by Ruohotie (1993) and Joronen (1993) were carefully examined as well and their items were re-assessed for suitability (face validity) for health care professionals. This meant that only slight revision of the items was necessary. The total number of selected items for the questionnaire was 63. However, 70 structured and open-ended questions were added to the final version of the questionnaire. The questionnaire is presented in Appendix 3. Before the first inquiry of this study, the revised instrument was pilot tested in May 1996 with a multi-professional expert group of social and health care professionals (N=19) undergoing clinical supervisor training. The participants answered the questionnaire independently and assessed the face validity of the instrument. The Cronbach's alpha values of the pilot study are reported in Table 3. The values show that the internal homogeneity and consistency of the sum variables were good (.7040 - .9386), and the low values seemed to be related to the fact that several respondents of the pilot-group did not belong coherently to any team or even organisation, but had very different backgrounds in this respect. The respondents gave this feedback in the group discussion after answering the questionnaire.

The author revised the 'Professional individual development' instrument developed by Paunonen (1989). The original instrument consisted of 44 items including structured and open-ended questions. The instrument was composed of four parts focusing on the conceptions of (I) materialisation of CS, (II) supervisors and supervision groups, (III) the effects of CS and (IV) assessment of supervisor training (Paunonen 1989). The open-ended questions from the part three (III) of the original instrument were adopted in the questionnaire. The questions focused on assessing the effects of CS on (1) one's work patterns, (2) ward operations, (3) in relation to one's team, (4) oneself and (5) human relations in general. Three additional questions were included for exploring (6-7) topics of CS and conceptions of their benefit and (8) conceptions of the effects on quality of care.

The demographic characteristics included gender, age of the participants, position in the organisation and work status, work experience and experience in current position in years. In addition, participation in another CS was asked. The respondent's ward and code numbers were included in the section for demographic characteristics. The questionnaire is presented in Appendix 3 in Finnish.

The 'Continuous self-monitoring of work' and 'Patient satisfaction feedback' questionnaires
There are several validated instruments that have been developed for surveying patient satisfaction and some for health care professionals for assessing the quality of care (see e.g. Leino-Kilpi et al. 1994). However, review of the literature revealed that a few instruments have been developed in parallel processes (e.g. Leino-Kilpi and Vuorenheimo1992, Töyry et al. 1993, Leino-Kilpi et al. 1994, see also Arnetz and Arnetz 1996) but none was developed for simultaneous use for patients and health care professionals. In contrast, it

has been evidenced (e.g. Nelson et al. 1990, Häggman-Laitila and Åsted-Kurki 1994, Poulton 1998) that there are differences regarding the criteria for quality emphasised by health care professionals and service users i.e. patients. It has also been found that some instruments developed for patient satisfaction surveys place emphasis on organisation and services, focusing on professional rather than the service user's agenda (e.g. Poulton 1998, Hyrkäs et al. 2000, Hyrkäs and Paunonen 2000). This emphasis seems to contradict the current arguments that healthcare services should be more responsive to the service users' needs and client centred (Poulton 1998, Laadunhallinta sosiaali- ja terveydenhuollossa 1995, Sosiaali- ja terveydenhuollon laadunhallinta 2000-luvulle 1999).

Today there is a strong rationale for satisfaction surveys that emphasise the patient's perspective. However, the research designs and reporting of the results of satisfaction surveys have been heavily criticised (e.g. Salmela 1996, 1997, Räsänen 1996). The most popular approach has been the ex-post-facto design, and it has been argued that there is no evidence of the implications of the study results on services and especially of those evidencing quality improvement. The emphasis on continuous quality improvement (CQI) in the literature (e.g. Leino-Kilpi and Vuorenheimo 1992, Leino-Kilpi et al. 1994, Lin 1996) has promoted recommendations that longitudinal and systematic research is important to understanding the stability of patient satisfaction and the factors that have an impact on it.

The lack of suitable assessment, satisfaction and feedback instruments and the need for two instruments for continuous, parallel and simultaneous data collection initiated the development and testing of patient and staff questionnaires by the author. The goal as to the questionnaires was that they should be applicable and practical: brief (only one page and less than 20 items), comprehensive: simple (clear statements or questions and clear scale) and responsive, because of their continuous use and production of large amount of data from staff and patients (see also Leino-Kilpi et al. 1994, Harris and Warren 1995, Poulton 1998). These facts strongly supported the selection of questionnaire as data collection method, even though the problems related to this method, i.e. biased data, were known from earlier studies (e.g. Lin 1996, Poulton 1998, Hyrkäs et al. 2000, Hyrkäs and Paunonen 2000).

The items for the instruments were created using the studies of patient satisfaction (e.g. Larson 1981, Niemelä and Mäkinen 1982, Hall and Dornan 1988, Vuorela 1988, Leino-Kilpi and Vuorenheimo 1992, Westman 1992, Sohlberg 1993, Töyry et al. 1993, Wilde et al. 1993, 1994, Leino-Kilpi et al. 1994, Lin 1996, Piccirillo 1996) with the emphasis on national publications. The starting point for selecting the foci of interest was the need to produce feedback information from patients to staff and for CS related to this normative function. This led the author to examine issues of dissatisfaction in the earlier studies. The viewpoint received support from the literature and such authors as Davis and Adams-Greenly (1994) who have reported that satisfaction and dissatisfaction are not the opposite ends along a continuum of 'satisfaction', but that these ultimately seem to focus on different things. In other words, if the aim was to influence the quality of health care services and produce information for this purpose it was essential that the instruments focused on dissatisfaction. Finison et al. (1993) have recommended that creating and choosing the items and variables for examination of CQI can be based on a rational hypothesis of (1) the causes of variation in the process and (2) the foci of interest in the process over time in order to detect possible changes in process quality (see also Sava 1987, Iberg 1991). Besides the rational hypothesis, it is also

suggested that creation of the items and the instrument could be based on a 'fish-bone' analysis as this is seen to link the instrument to practice and make the results more useful (Finison and Finison 1996).

The examination of the patient satisfaction studies exposed that the main issues for dissatisfaction were lack of information and guidance (e.g. Leino-Kilpi and Vuorenheimo 1992, Leino-Kilpi et al. 1994), competency of professionals (e.g. Wilde et al. 1993, 1994), sensitivity to patient needs and wishes (e.g. Töyry et al. 1993), responsiveness and participation possibilities (e.g. Leino-Kilpi et al. 1994), level of care in general (e.g. Lin 1996, Piccirillo 1996), availability of staff, collaboration and continuity of patient care (e.g. Sohlberg 1993, see also Sava 1987, Laadunhallinta sosiaali- ja terveydenhuollossa 1995) and socio-cultural atmosphere (e.g. Wilde et al. 1993, 1994). In the examined studies, dissatisfaction was reported concerning the hospital environment, amenities and access to care or discharge. However, these issues were considered not to have a relation to or effects on CS and were not included in the items.

The following items were selected for the developed questionnaires: 1) overall satisfaction with care, 2) satisfaction with treatment, 3) adequacy of information, guidance and advice, 4) consideration for opinions and wishes, 5) staff's competence, 6) assistance with problems and 7) staff collaboration. The items were the same for the patient and staff instruments, but in the patient questionnaire, the items were set in a question form and for the staff in a statement form. The answering scale in both instruments was from 4 to 10 in which the grade 4 means 'poor' and grade 10 'excellent'. This scale has been found to be clear and less threatened by biased ratings in the Finnish studies as the scale corresponds to the traditional system of grading used in Finnish schools (e.g. Leino-Kilpi et al. 1994, seen also Lin 1996). Two open-ended questions were included in the questionnaires for describing the positive and negative experiences during hospital stay (patients) and during the workweek (staff). Demographic questions were purposefully excluded from the questionnaires based on the findings of earlier satisfaction studies that these seem continuously to produce identical results (e.g. Lin 1996, cf. Leino-Kilpi et al. 1994) which are in fact of little importance for quality improvement efforts. The patient questionnaire was marked only with a 'serial number', ward and the date of response. The staff questionnaire was equipped with the respondent's code number, ward and the date of response.

The questionnaires were pilot-tested in December 1995. The staff on all the participating wards (A, B, C, D and E) answered the questionnaire twice a week during the month. On the wards A, C and D the number of patients participating in the pilot study was 90. The main interest of the pilot-tests was to examine the face-validity of the instruments. Based on the respondents' oral and written comments, the items in the staff questionnaire were slightly modified and focused on work-related issues. Two items were added to the patient questionnaire. The first additional item was based on the operating theatre staff's wish to gain feedback from patients. The other additional question was based on the suggestions in the patient pilot study to divide the question about information giving and guidance/advice into two. The final patient questionnaire was formed of nine (9) closed and two (2) open-ended questions. The staff's self-monitoring questionnaire was composed of seven (7) closed statements and two (2) open-ended questions. The both questionnaires are represented in Appendix 4 in Finnish.

Thematic group interviews

Group interviews proceeded by three themes, which were as follows: 1) team supervision and the team, 2) team supervision and work and 3) team supervision and the quality of care. The themes were modified based on the aims of the study and set in an order that was assumed to promote the progress on the interviews. The themes were purposefully broad so as to allow the teams to describe the issues from their own perspective and in relation to their work, ward and the team. The themes were copied on paper and distributed on the table on the premises were the interviews were accomplished so that the interviewees could check them at any time.

The initial questions were carefully planned and written on paper so that these were repeated in similar form during each interview. The initial questions were formulated so that they prompted the group members' joint reflection on the issues: to describe, thematize and explicate the conceptions of the issue under examination (see e.g. Uljens 1992). The initial questions were such as 'Could you please tell me, what was team supervision like in your team'… or 'How did you find team supervision in your team in relation to your work'… After introducing the aim of the study and the initial questions of the themes the author's role was rather passive. The chosen role was a conscious decision, because it was known that the interviewer's questions always influence the course of discussion in a group and that the questions would to some extent interfere with the discussion. (Frey and Fontana 1991, Kitzinger 1994, Henderson 1995, cf. Morgan 1995)

The author had prepared several questions by themes through operationalisation to be asked when necessary. These were used flexibly, for example, in situations when the interviewees had difficulty in starting the discussion or started to digress from the subject. Additionally, more specified probing questions were presented spontaneously when necessary (Pötsönen and Pennanen 1998). These questions were often like 'Could you please explain this in more detail…' or 'Pardon, what do you mean by…'

4.5. DATA ANALYSIS

4.5.1. Statistical analysis

The statistical analysis of the follow-up inquiries was carried out using SPSS/Win 7.0 Software. The analysis begun after each inquiry by forming frequency distributions in order to identify possible coding errors and to examine the distributions of each variable. The validity of the sum variables in the instrument was tested with the data of the first inquiry with confirmatory factor analysis. This confirmed the relevancy of the factors (see Table 3), but also indicated three main factors which were as follows: (I) individual factors: growth motivation (OC1), performance motivation (OC3), reflectivity (RF1), (II) team factors: atmosphere (AF1), team spirit (GF1), team's functionality (GF2), commitment to work and organisation (OC2), (III) organisational factors: encouragement value of work (WF1), possibility to influence (WF2), participatory management style (MF1), performance oriented management style (MF2), task and goal systems (OF2). The sum variables were calculated next for all the follow-up inquiries, and the respective graphs were examined to check the normality of the distributions. In the third phase, the data files from the different inquiries were merged for final analysis. The analysis of variance for repeated measures was used for exploring the changes

in the prerequisites for professional development during the team supervision intervention. This method included the following components: the ward effect as the between factor, the time effect and the interaction between the ward and time as within factors. The level of significanse was set at ≤ .05. (Polit 1996, Burns and Grove 1997, Polit and Hungler 1997)

The methods of statistical process control and control chart were used for analysing and reporting the 'Continuous self-monitoring of work' and the 'Patient satisfaction feedback' questionnaires monthly. This statistical analysis was carried out using the Statistica software for Windows. The literature characterizes the methods of statistical process control as effective and practical tools as they provide an approach to describing and analysing the structures and processes that affect the quality, but also produce information that promotes the understanding of variation (Finison et al. 1993, Benneyan 1998). The method is based on an assumption that natural variation will always occur in any process and consequently the results or outcomes of the process vary as well (Finison et al. 1993, Benneyan 1998, see also Iberg 1991). The variation is caused by common and special causes. The purpose of statistical process control is to detect statistically and objectively the variation in process quality, to distinguish and differentiate variation due to common (random effects) or special causes (non-random effects) and provide longitudinal information of process quality and its possible changes. It is claimed that evidencing the variation, its nature and extent are the statistical starting point for quality improvement, as the causes of variation are generally difficult to determine through ordinary observation or intuitively because of minor variation. (Finison et al. 1993, Finison and Finison 1996, Benneyan 1998)

The control chart is defined as a graphic presentation of the performance in a process or outcome observation through the parameters of statistical process control (e.g. Finison et al. 1993) in a sample that is arrayed in some rational sequence (Finison and Finison 1996). The key components in control chart are the central line (describing the means of the observations), upper and lower warning ($\overline{x} + \pm 2\sigma$) and acting ($\overline{x} + \pm 3\sigma$) limits calculated from the standard deviation (SD) within the group of observations. The warning and acting lines are based on .05 (±1.95 SD) and .01 (±3.09 SD) statistical significance levels and the 95% and 99.8% confidence intervals. The process and its variation are examined against the statistically determined limits (Finison et al. 1993, Finison and Finison 1996, Benneyan 1998). The examination of control charts is done visually and utilising the warning and acting lines. The process is said to be 'in control' when the variation occurs between the acting limits and the causes for variation are assumed to be common (Benneyan 1998). The process is said to be 'out of control' when the observations are outside the acting limits and the variation is assumed to be due to special causes (Finison and Finison 1996, Benneyan 1998). The improvements in quality are expected to show statistically and in control chart through decreased variation of common causes and observations that fall constantly between the acting limits. It is claimed that the acting limits get narrower, thus reflecting the reduced variation and the shift of the central line to a positive and beneficial direction (Finison et al.1993).

4.5.2. Qualitative analysis

Content analysis

The written answers to the open-ended questions in the follow-up questionnaire, the continuous self-monitoring of work and the patient satisfaction feedback questionnaires were analysed using content analysis. The method is common in qualitative research studies, but it is also used in quantitative studies. The method allows to describe the data (e.g. written answers) qualitatively, systematically and objectively, to manage large volumes of data, to quantify the categories created and to analyse them further with statistical methods (Morgan 1993, see Nieswiadomy 1993, Polit and Hungler 1997, Burns and Grove 1997, see also Krippendorff 1980). Some authors (e.g. Polit and Hungler 1997, Burns and Grove 1997) have even defined content analysis as a process during which the created categories are quantified. However, this definition has been criticised (see e.g. Krippendorff 1980, Tesch 1990) because the difference between qualitative and quantitative content analysis is regarded as blurred and too vague. When the focus of interest is on 'what is this /what is happening here', content analysis and its basis are qualitative, whereas the nature is quantitative when the interest is on finding 'how many times this has happened' (see also Morgan 1993, Nieswiadomy 1993, Polit and Hungler 1995, Burns and Grove 1997, Kyngäs and Vanhanen 1999).

This study used inductive content analysis. The analysis started by careful reading of the data that had been transcribed verbatim after every inquiry (i.e. monthly for the self-monitoring of work and patient satisfaction questionnaires and half-yearly for the follow-up inquiries). The unit of analysis was a theme describing, for instance, the patients' positive and negative experiences during their hospital stay. The data were next organised into themes and after this the content of data in each theme was classified into sub-categories. Finally, the sub-categories were combined into categories and further into main categories. (see Kyngäs and Vanhanen 1999). The analysis was undertaken separately for the staff's self-assessment, patient satisfaction and follow-up inquiries. After the analysis was completed two researcher colleagues evaluated the relevance, clarity and completeness of the classification in the staff and the patient inquiries. The differences of opinions concerning the categories were discussed until an agreement was reached. The data on the staff's inquiries were quantified by coding it according to the themes to be able to combine it with the rest of the statistical data.

Phenomenography

A noteworthy special feature of group interview is that the analytic unit is the group instead of individuals. This is why an analysis and description of the group's situation is always needed alongside the interview material. The results are examined from a related context, that is, from that of the group. The reason for this is that the group's interaction and actions influence the nature of the data collected (Sulkunen 1991, Carey and Smith 1994). The researcher's notes served this end.

The literature on group interview revealed that the methods of analysing group interview data are inadequately developed and that no mutually agreed technique exists. It has been suggested that depending on the purpose of the study, group interviews could be analysed using the phenomenological method,

grounded theory, the ethnographic method, narrative analysis or content analysis. (Carey and Smith 1994, Pötsönen and Pennanen 1998, also Henderson 1995). Critique has, however, been expressed concerning the incompatibility of the group-oriented data collection methods with the above-mentioned data analysis methods (Webb and Kevern 2001). The problems pointed out have concerned the 'essence' of the method, features of the methodological approach, approved procedures for ensuring the validity or rigour of the findings and the contradictions that may arise when the data have been collected from a group of people. In this study an assumption was made that after the long and intensive team supervision, the teams would be able to express their conceptions due to the 'collective mind' that had developed during the intervention (Marton 1988, see also Svensson 1984).

Several researchers (Carey and Smith 1994, Kitzinger 1994, Carey 1995, Krueger 1995, Morgan 1995) have indicated that the solutions used so far in relation to group-oriented data have not been fully satisfactory. Criticism has especially focused on the fact that insufficient attention has been paid to the impact of group context in the analysis of these type of data. The group context is inherently complex and this places demands on data analysis, the method and the description of the analysis process. The results and reporting strategies have come under criticism due to their alleged triviality and resemblance to those of individual interviews. The results of group interviews have been considered shallow, mainly lists of participants' comments, although the data were produced in social interaction. (Carey 1995, Morgan 1995, Reed and Payton 1997, Smith 1995)

Phenomenography studies reality as people conceptualise it. Phenomenography is not interested in why people think the way they do, but in describing the variation of different conceptions of different things in a group of people under study. The interest is directed at what people are interested in (the 'what' aspect), but also at how study subjects construct their conceptions of the phenomenon under study (the 'how' aspect). Categories formulated by the researcher, which describe the variation of the conceptions occurring in the data, are considered the results of phenomenographic research. The categories may be hierarchically, horizontally or vertically inter-related. This means that the method permits the description of the spectrum of different conceptions. (Marton 1988, Uljens 1989, Uljens 1993, Bowden 1995)

The group interviews were first transcribed verbatim and printed out. This produced 200 pages of text with 1.5 line spacing. The tapes were listened to once more ensuring the correspondence of the text and the tape. The analysis proceeded by condensing literal text without changing the content. Sequences of discussion were sought out first to discover what the group was actually talking about (see Reed and Payton 1997, cf. Launis 1994, Niemistö 1998). The next step was to examine how group members dealt with the topic while examining their experiences. Then a spectrum of conceptions started to emerge. The formation of categories required that data analysis actually proceeded at three different levels: at the level of the group, that of its individual members and of the context (i.e. wards) (Carey and Smith 1994). The initials of the interviewees were retained during the analysis process and these were included in the chosen quotations to illustrate the interaction between the interviewees. It was also deemed important to maintain a sense of the teams as a whole in the presentation of the findings and thus whenever possible quotations from at least two or more participants have been presented. During the interviews the teams could form a common conception

of the topic or it could be seen from different angles or even in contradictory ways. A sequential examination made it possible to describe the nature of the conceptions and the way they were composed in the teams.

4.6. Ethical considerations

When the team supervision project started in 1995, all the hospital ward managers were informed of the project in advance and equal possibility was given to staff to participate in the project. Within the prescribed time the ward managers of the five wards expressed their wards' interest in and willingness to take part in team supervision and the study. The decision to participate had been done on ward meetings and it was based on democratic resolution. However, the participation was ultimately voluntary because those who refused to take part in team supervision and the study or interrupt their involvement were given a chance to withdraw. The teams on the wards were also given an opportunity to select their supervisor pair i.e. the supervisors were not allocated. The ethical points related to team supervision and especially confidentiality of issues discussed during the sessions were taken into considerations through the working methods and discussed regularly by the supervisors in the teams (Hyrkäs et al. 2002a).

Permission from the ethical committee (number 338, 11/1995) of the hospital was applied for and granted as a large number of patients and staff were involved in data collection. The cover letters, according to the ethical committee's instructions, emphasised the voluntary nature of answering, but also explained the importance of the study. The author's and the supervisors' names and contact information were always included to provide the respondents with the possibility to receive further information of the study.

Confidentiality was assured for the patients and staff by using code numbers in the questionnaire. The staff members used throughout the study their own code numbers, but these were known by name only by the ward managers and identified only in case of necessity. In the patient questionnaire no demographic information was asked. The questionnaires in use were always sealed in an empty envelope and returned directly to the author.

The ethical perspective related to the group interviews was carefully considered. The voluntary nature of participation was emphasised to the team members beforehand and they were also told that the interviews would be tape-recorded. This was seen to ensure that staff members had a possibility to make a decision of their own participation. Before starting the interviews, participants were informed of the confidentiality principles concerning a group interview. This was performed to minimise the ethical threats in a group when privacy is excluded and when there is a possibility of inadvertently disclosing delicate matters in public (Kitzinger 1994). Smith (1995) calls this threat 'participant's over-disclosure'. During the interviews all group members were encouraged to speak and no direct 'first-move' questions were asked personally. However, what the author cannot know is whether team members felt they were pressured by their colleagues and the team to take part in the interview, study and team supervision. Anonymity of the interviewees was ensured by not asking names, code numbers or occupations. During the transcription of the tapes the interviewees were assigned 'alphabetical codes' to improve the quality of the written material for analysis. Numbers were not in use as there was a chance that these could have been connected, by mistake, with the respondents' answering code.

5.   RESULTS

5.1. Study participants

The sample for this research consisted of those 46 respondents who participated in every inquiry. The mean age of the respondents was 41.5 years, the youngest participant being 26 years of age and the oldest 58 years. Almost half of the respondents (41%, n=19) in the sample were 31-40 years of age and their work experience varied from 11 to 20 years (48%). Three respondents out of four (74%, n=34) had stayed in their present post up to ten years. The majority of the participants in the study were nursing professionals representing different educational degrees. Table 4 presents respondents' background information by wards (Table 4). The material was distributed almost equally between those who participated in team supervision and research for two (n=24) and three (n=22) years.

The respondents on wards B, C, E reported that they had attended on average 12 supervisory sessions (min. 4 and max. 20 times) during the two years. On wards A and D, supervisees had attended on average 16 supervisory sessions (min. 7 and max. 27 times) during the three years. Most of the respondents had attended the team supervision sessions within the limits of their work shifts, and vacations, night shifts and days off with long work distances were cited as reasons preventing participation in the sessions. However, four persons reported during the intervention that they had attended the sessions 1-3 times during their days off. The reasons these supervisees mentioned were curiosity, interest, the need to talk about an important or urgent thing in 'rarely organised sessions'.

Table 4. Respondents' background in this study (n=46)

WARDS	A		B		C		D		E		Total	
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
Age												
- 30 years	2%	(1)	4%	(2)	-	-	2%	(1)	-	-	9%	(4)
31-40 years	17%	(8)	4%	(2)	7%	(3)	9%	(4)	4%	(2)	41%	(19)
41-50 years	7%	(3)	2%	(1)	11%	(5)	2%	(1)	7%	(3)	28%	(13)
51years-	2%	(1)	2%	(1)	4%	(2)	7%	(3)	7%	(3)	22%	(10)
Total	28%	(13)	12%	(6)	22%	(10)	20%	(9)	18%	(8)	100%	(46)
Present position												
10 years	22%	(10)	13%	(6)	13%	(6)	15%	(7)	11%	(5)	74%	(34)
11-20 years	7%	(3)	-	-	2%	(1)	2%	(1)	4%	(2)	15%	(7)
21years-	-	-	-	-	7%	(3)	2%	(1)	2%	(1)	11%	(5)
Total	29%	(13)	13%	(6)	22%	(10)	19%	(9)	17%	(8)	100%	(46)
Work experience												
- 10 years	4%	(2)	4%	(2)	2%	(1)	7%	(3)	2%	(1)	19%	(9)
11 - 20 years	17%	(8)	4%	(2)	11%	(5)	9%	(4)	7%	(3)	48%	(22)
21 years -	7%	(3)	4%	(2)	9%	(4)	4%	(2)	9%	(4)	33%	(15)
Total	28%	(13)	12%	(6)	22%	(10)	20%	(9)	18%	(8)	100%	(46)
Position												
assistant- and ward sisters	4%	(2)	2%	(1)	4%	(2)	4%	(2)	4%	(2)	19%	(9)
nurses and specialised nurses	15%	(7)	9%	(4)	9%	(4)	11%	(5)	14%	(6)	57%	(26)
assistant nurses and paramedics	4%	(2)	2%	(1)	4%	(2)	4%	(2)	-	-	15%	(7)
secretaries, equipment maintenance staff and others	4%	(2)	-	-	4%	(2)	-	-	-	-	9%	(4)
Total	28%	(13)	13%	(6)	22%	(10)	19%	(9)	18%	(8)	100%	(46)

Respondents reported several other organisational reasons that had prevented their participation in the team supervision sessions. The activities on the ward and hospital organisation such as in-service education sessions and meetings or busy situations on the ward with a number of patients and substitute nursing staff might have made withdrawal from the ward impossible. During the intervention three nurses started to work part-time or with the out-patient services provided on the ward, thus with a limited possibility for CS. Six respondents reported that they participated in another CS group, peer group supervision for ward managers or supervisor education.

5.2. Effects of team supervision on the teams during the team supervision intervention

The effects of team supervision on teams were examined using follow-up inquiries and group interviews after the termination of the intervention. The following chapter focuses on addressing the first study aim (see chapter 3).

During the team supervision intervention significant changes were found in the team factors of the team's functionality and commitment to work and organisation (Tables 5 – 8). The functionality had, however, deteriorated on the wards which participated for two years (inquiry I mean of sum 36.6, SD 5.0 → inquiry III mean of sum 34.9, SD 4.8, p= .008) and this had occurred especially (p= .015) on wards B (inquiry III mean of sum 34.0, SD 4.3) and E (inquiry III mean of sum 36.6, SD 4.4). The decreased functionality was accompanied with deterioration (p= .031) in the atmosphere (ward B inquiry III mean of sum 31.7, SD 3.6 and ward E mean of sum 36.0, SD 4.8) and team spirit (ward B inquiry III mean of sums 35.8, SD 4.8 and ward E inquiry III mean of sums 36.8, SD 4.1, p= .048) (Tables 5 – 8).

Tables 5.-8. Prerequisites for professional development: team factors

Atmosphere (AF1)

	Inquiry I mean SD		Inquiry II mean SD		Inquiry III mean SD		n	Inquiry IV mean SD		Inquiry V mean SD		n	Total sum. mean	
ward B	36.8	3.7	35.1	5.0	31.7	3.6	6	-	-	-	-	-	103.6	34.5
ward C	33.4	4.9	35.8	6.4	35.0	4.5	10	-	-	-	-	-	104.1	34.7
ward E	37.6	4.1	37.1	4.5	36.0	4.8	8	-	-	-	-	-	110.7	36.9
(total)	35.7	4.67	36.1	5.3	34.5	4.5	24	-	-	-	-	-	106.3	35.4
ward A	39.9	3.3	39.6	4.6	40.1	4.0	13	40.8	3.3	41.1	3.3	13	201.5	40.3
ward D	34.1	3.9	31.8	2.3	34.9	3.3	9	34.7	4.85	33.7	2.7	9	169.2	33.8
(total)	37.6	4.5	36.4	5.4	38.1	4.6	22	38.3	5.0	38.1	4.8	22	188.5	37.7

wards B, C and E) statistical significance: between wards .478, factor .057, factor and ward .031,
wards A and D) statistical significance: between wards <.001, factor .110, factor and ward .541

(continues)

Team-spirit (GF1)

	Inquiry I mean	SD	Inquiry II mean	SD	Inquiry III mean	SD	n	Inquiry IV mean	SD	Inquiry V mean	SD	n	Total sum.	mean
ward B	39.8	3.1	35.5	5.8	35.8	4.8	6	-	-	-	-	-	111.1	37.0
ward C	34.3	4.0	35.4	6.0	36.3	3.7	10	-	-	-	-	-	106.0	35.6
ward E	38.5	2.9	38.8	2.4	36.8	4.1	8	-	-	-	-	-	114.1	38.0
(total)	37.1	4.1	36.5	5.1	36.3	4.0	24	-	-	-	-	-	109.9	36.6
ward A	40.1	3.4	40.9	3.8	41.3	3.0	13	42.2	3.1	41.6	3.0	13	206.1	41.2
ward D	35.1	3.3	33.7	3.1	36.2	2.0	9	35.8	3.5	34.4	2.1	9	175.2	35.0
(**total**)	38.2	4.2	37.9	5.0	39.2	3.6	22	39.6	4.5	38.7	4.5	22	193.6	38.7

wards B, C and E) statistical significance: between wards .266, factor .365, factor and ward .048
wards A and D) statistical significance: between wards <.001, factor .068, factor and ward .344

Team's functionality (GF2)

	Inquiry I mean	SD	Inquiry II mean	SD	Inquiry III mean	SD	n	Inquiry IV mean	SD	Inquiry V mean	SD	n	Total sum.	mean
ward B	38.8	6.1	36.7	5.	34.0	4.3	6	-	-	-	-	-	109.5	36.5
ward C	34.1	4.9	35.4	6.2	34.1	5.4	10	-	-	-	-	-	103.6	34.5
ward E	38.0	3.0	36.0	3.7	36.6	4.4	8	-	-	-	-	-	110.6	36.9
(total)	36.6	5.0	35.9	5.1	34.9	4.8	24	-	-	-	-	-	107.4	35.8
ward A	38.3	3.9	38.1	5.4	37.9	4.5	13	39.0	4.2	39.5	4.5	13	192.6	38.5
ward D	36.1	4.3	35.0	3.0	37.4	3.1	9	35.8	4.6	35.2	4.4	9	179.5	35.9
(total)	37.4	4.1	36.8	4.7	37.7	4.0	22	37.7	4.4	37.8	4.8	22	187.4	37.5

wards B, C and E) statistical significance: between wards .530, factor .008, factor and ward .015
wards A and D) statistical significance: between wards.038, factor <.001, factor and ward .782

Commitment to work and organisation (OC2)

	Inquiry I mean	SD	Inquiry II mean	SD	Inquiry III mean	SD	n	Inquiry IV mean	SD	Inquiry V mean	SD	n	Total sum.	mean
ward B	39.8	2.6	39.8	4.2	38.0	3.4	6	-	-	-	-	-	117.6	39.2
ward C	40.2	5.2	40.7	3.5	41.4	3.1	10	-	-	-	-	-	122.3	40.8
ward E	43.0	3.2	42.3	2.8	41.8	3.7	8	-	-	-	-	-	127.1	42.4
(total)	41.0	4.1	41.0	3.4	40.7	3.6	24	-	-	-	-	-	122.7	40.9
ward A	44.6	3.6	44.0	2.7	44.1	3.0	13	41.0	1.22	44.7	2.1	13	218.4	43.7
ward D	39.6	3.3	39.8	3.3	41.1	2.0	9	37.4	4.0	39.3	3.5	9	197.2	39.4
(total)	42.6	4.2	42.3	3.6	42.9	3.0	22	40.0	3.2	42.5	3.8	22	210.3	42.1

wards B, C and E) statistical significance: between wards .199, factor .619, factor and ward .352
wards A and D) statistical significance: between wards <.001, factor <.001, factor and ward .343

However, the majority of the supervisees on wards B, C and E assessed that the effectiveness of teamwork (I inquiry 75%, n=18 → III inquiry 79.2%, n=19) and multi-professional collaboration (I inquiry 79.2%, n=14 → III inquiry 83.3 %, n=20) had remained the same during the intervention (Table 9 a)

The findings on the team factors were different on wards A and D which participated for three years in that the team's functionality showed to improve (inquiry I mean of sum 37.4, SD 4.1 → inquiry V mean of sum 37.8, SD 4.8, p< .001). This was confirmed through a slight increase in the number of perceptions that the effectiveness of teamwork had improved (I inquiry 40.9%, n=9 → V inquiry 54.5%, n=12). However, multi-professional collaboration had remained the same (I inquiry 72.7%, n=16 → V inquiry 77.3%, n=17)(Table 9 b). On the wards which participated for three years, commitment to work and organisation improved (inquiry I mean of sum 42.6, SD 4.2 → inquiry V mean of sum 42.5, SD 3.8, p<.001) as well. Between wards A and D, however, significant differences existed. Differences were found in the atmosphere (AF1, p< .001), team spirit (GF1, p< .001), team's functionality (GF2, p= .038) and commitment to work and organisation (OC2, p< .001) in that on ward A the scores were higher than on ward D (Tables 5 – 8)

The effects of CS in relation to the team (wards B, C and E: I iquiry 52.4 %, n=11 → III inquiry 61.1%, n=11 and wards A and D: I inquiry 85.0%, n=17 → V inquiry 94.7%, n=18) and human relations (wards B, C and E: I inquiry 40.0%, n=8 → III inquiry 53.3 %, n=8) were described by over half of supervisees in the follow-up inquiries (Table 10 a, b). The effects and development were described in terms of one's relation to the team and in the relations between team members. The supervisee's own relation to the team was characterised by increased courage, self-monitoring, helpfulness and understanding towards the other team members. During the course of team supervision, the courage to examine issues in the team improved including sensitive topics. Through the course of team supervision the supervisees found their own and their colleagues' limits, but also learned to take into account other opinions and to give space. Supervisees reported that the relations between the team members had become closer, which in turn had improved collaboration, team spirit, feelings of togetherness, and also increased joint discussion. Supervisees also reported explicit improvement in their discussion practices. Towards the end of the intervention, the relations between the team members grew more mature, and their 'community spirit', solidarity and conflict solving skills evolved. Several problems and negative effects were also described. One of the problems was that the discussions started during team supervision were not restricted to the sessions, but continued afterwards in smaller groups of friends. Suspicion, envy and different kinds of negative feelings arouse and had negative effects on the teams. Another problem described was that from time to time some of the supervisees experienced the manners in which they discussed, the negative tone (e.g. verbal attacks, pressuring, tearing apart) and the topics as embarrassing, which had negative effects on the team, for instance, when the discussion shifted from the common topic to a supervisee and his/her personality. (Table 11)

The effects of team supervision on human relations, and described especially among the members of the wards with two-year attendance, focused on the attitudes towards others, interdependency and its nature. The attitudes towards colleagues were described through increased tolerance, permissiveness, decreased reservations with colleagues, and improved understanding of others after their own problems were solved.

Table 9 (a). Changes in the selected effects of CS during the intervention on wards B, C and E

| | Inquiry I | | | | | | Inquiry II | | | | | | Inquiry III | | | | | |
| | Increased | | Remained the same | | Decreased | | Increased | | Remained the same | | Decreased | | Increased | | Remained the same | | Decreased | |
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
Effectiveness of team work	4.2	(1)	75.0	(18)	-	-	20.8	(5)	70.8	(17)	4.2	(1)	20.8	(5)	79.2	(19)	-	-
Multi-professional collaboration	-	-	79.2	(14)	16.7	(4)	8.3	(2)	83.3	(20)	4.2	(1)	12.5	(3)	83.3	(20)	-	-
Expertise	4.2	(1)	95.8	(23)	-	-	4.2	(1)	87.5	(21)	-	-	4.2	(1)	95.8	(23)	-	-
Theoretical approach to practice	4.2	(1)	95.8	(23)	-	-	4.2	(1)	83.3	(20)	4.2	(1)	-	-	100	(24)	-	-
Self-awareness	4.2	(1)	70.8	(17)	4.2	(1)	29.2	(7)	58.3	(14)	8.3	(2)	29.2	(7)	66.7	(16)	-	-
Personal strengths	-	-	87.5	(21)	12.5	(3)	4.2	(1)	79.2	(19)	4.2	(1)	8.3	(2)	83.3	(20)	8.3	(2)
Practical facilities	4.2	(1)	95.8	(23)	-	-	8.3	(2)	87.5	(21)	-	-	4.2	(1)	95.8	(23)	-	-
Contribution to ward functions	-	-	87.5	(21)	8.3	(2)	4.2	(1)	83.3	(20)	8.3	(2)	12.5	(3)	83.3	(20)	4.2	(1)
Total	3.0	(5)	91.0	(160)	6.0	(10)	11.0	(20)	85.0	(152)	4.0	(8)	12.0	(22)	86.0	(165)	2.0	(3)

Table 9 (b). Changes in the selected effects of CS during the intervention on wards A and D

| | Inquiry I | | | | | | Inquiry II | | | | | | Inquiry III | | | | | |
| | Increased | | Remained the same | | Decreased | | Increased | | Remained the same | | Decreased | | Increased | | Remained the same | | Decreased | |
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
Effectiveness of team work	40.9	(9)	54.5	(12)	-	-	27.3	(6)	63.6	(14)	9.1	(2)	40.9	(9)	54.5	(12)	4.5	(1)
Multi-professional collaboration	22.7	(5)	72.7	(16)	-	-	18.2	(4)	72.7	(16)	9.1	(2)	27.3	(6)	72.7	(16)	-	-
Expertise	27.2	(6)	68.2	(15)	-	-	4.5	(1)	90.9	(20)	4.5	(1)	18.2	(4)	81.8	(18)	-	-
Theoretical approach to practice	18.2	(4)	77.3	(17)	-	-	9.1	(2)	81.8	(18)	9.1	(1)	13.6	(3)	86.4	(19)	-	-
Self-awareness	40.9	(9)	54.5	(12)	-	-	28.6	(6)	71.4	(15)	-	-	47.6	(10)	52.4	(11)	-	-
Personal strengths	31.8	(7)	63.6	(14)	-	-	22.7	(5)	63.6	(14)	13.6	(3)	22.7	(5)	72.7	(16)	4.5	(1)
Practical facilities	22.7	(5)	72.2	(16)	-	-	18.2	(4)	77.3	(17)	4.5	(1)	31.8	(7)	68.2	(15)	-	-
Contribution to ward functions	22.7	(5)	72.7	(16)	-	-	13.6	(3)	72.7	(16)	13.6	(3)	31.8	(7)	63.6	(14)	4.5	(1)
Total	30.0	(50)	70.0	(118)			18.0	(31)	75.0	(130)	7.0	(13)	29.0	(51)	69.0	(121)	2.0	(3)

(continues)

| | Inquiry IV | | | | | | Inquiry V | | | | | |
| | Increased | | Remained the same | | Decreased | | Increased | | Remained the same | | Decreased | |
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
Effectiveness of team work	36.4	(8)	63.6	(14)	-	-	54.5	(12)	45.5	(10)	-	-
Multi-professional collaboration	22.7	(5)	77.3	(17)	-	-	22.7	(5)	77.3	(17)	-	-
Expertise	9.1	(2)	90.9	(20)	-	-	22.7	(5)	77.3	(17)	-	-
Theoretical approach to practice	18.2	(4)	81.8	(18)	-	-	18.2	(4)	81.8	(18)	-	-
Self-awareness	38.4	(8)	63.6	(14)	-	-	45.5	(10)	54.5	(12)	-	-
Personal strengths	18.2	(4)	77.3	(17)	4.5	(1)	27.3	(6)	63.6	(14)	9.1	(2)
Practical facilities	13.6	(3)	86.4	(19)	-	-	22.7	(5)	77.3	(17)	-	-
Contribution to ward functions	22.7	(5)	77.3	(17)	-	-	36.4	(8)	59.1	(13)	4.5	(1)
Total	22.0	(39)	77.0	(136)	1.0	(1)	31.0	(55)	67.0	(118)	2.0	(3)

Towards to the end of the intervention, supervisees reported that inflexible attitudes had decreased and that they had learned 'not to interfere in trivial things'. Interdependency and its development were also referred to. The focus was on the improved qualities of interdependency and the respondent's own impact (in the form of respect, trust, empathy, tactful communication) on these, but also with an effect on the 'good relationships' that deepened and the 'poor relationships' that became more superficial. The problems and negative effects that had emerged were described as contradicting feelings and confusion when, for instance, different attitudes were revealed, but also if the attitudes were not explicitly expressed. (Table 11)

Table 10 (a). The effects of team supervision on wards B, C, E according to the open-ended, coded answers

	Inquiry I						Inquiry III					
	Effects, yes		No effects		Hard to say		Effects, yes		No effects		Hard to say	
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
In relation to team	52.4	(11)	47.6	(10)	-	-	61.1	(11)	33.3	(6)	5.6	(1)
Human relations	40.0	(8)	50.0	(10)	10.0	(2)	53.3	(8)	40.0	(6)	6.7	(1)
Work patterns	40.9	(9)	59.1	(13)	-	-	42.9	(9)	47.6	(10)	9.5	(2)
Supervisee	57.1	(12)	33.3	(7)	9.5	(2)	44.4	(8)	38.9	(7)	16.7	(3)
Working on the ward	47.6	(10)	52.4	(11)	-	-	38.9	(7)	61.1	(11)	-	-
Quality of care	31.6	(6)	52.6	(10)	15.8	(3)	33.3	(5)	26.7	(4)	40.0	(6)
Total	45.2	(56)	49.2	(61)	5.6	(7)	45.7	(48)	41.9	(44)	12.4	(13)

Table 10 (b). The effects of team supervision on wards A and D according to the open-ended, coded answers

	Inquiry I						Inquiry III					
	Effects, yes		No effects		Hard to say		Effects, yes		No effects		Hard to say	
	%	(n)	%	(n)	%	(n)	%	n	%	(n)	%	(n)
In relation to team	85.0	(17)	10.0	(2)	5.0	(1)	87.5	(14)	12.5	(2)	-	-
Human relations	55.6	(10)	44.4	(8)	-	-	42.9	(6)	42.9	(6)	14.3	(2)
Work patterns	52.6	(10)	47.4	(9)	-	-	50.0	(9)	44.4	(8)	5.6	(1)
Supervisee	68.4	(13)	21.1	(4)	10.5	(2)	60.0	(9)	33.3	(5)	6.7	(1)
Working on the ward	57.9	(11)	36.8	(7)	5.3	(1)	52.6	(10)	36.8	(7)	10.5	(2)
Quality of care	47.4	(9)	47.4	(9)	5.3	(1)	46.7	(7)	46.7	(7)	6.7	(1)
Total	61.4	(70)	34.2	(39)	4.4	(5)	56.7	(55)	36.1	(35)	7.2	(7)

(continues)

	Inquiry IV						Inquiry V					
	Effects, yes		No effects		Hard to say		Effects, yes		No effects		Hard to say	
	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)	%	(n)
In relation to team	70.0	(14)	20.0	(4)	10.0	(2)	94.7	(18)	-	-	5.3	(1)
Human relations	70.6	(12)	23.5	(4)	5.9	(1)	38.9	(7)	38.9	(7)	22.2	(4)
Work patterns	36.8	(7)	47.4	(9)	15.8	(3)	66.7	(12)	27.8	(5)	5.6	(1)
Supervisee	70.6	(12)	17.6	(3)	11.8	(2)	84.2	(16)	10.5	(2)	5.3	(1)
Working on the ward	53.3	(8)	20.0	(3)	26.7	(4)	73.3	(11)	20.0	(3)	6.7	(1)
Quality of care	43.8	(7)	25.0	(4)	31.3	(5)	43.8	(7)	37.5	(6)	18.8	(3)
Total	57.8	(60)	25.9	(27)	16.3	(17)	67.6	(71)	21.9	(23)	10.5	(11)

Table 11. Impact of team supervision on work community and human relations

	WORK COMMUNITY	HUMAN RELATIONS
INITIAL STAGE OF CS	OWN RELATION TO WORK COMMUNITY - courage to speak out, listen and disagree - observing oneself and one's actions, self-criticism in relation to work community - helpfulness and understanding of colleagues RELATIONSHIPS BETWEEN MEMBERS OF WORK COMMUNITY - increased and improved collaboration, team spirit and feeling of togetherness - more joint discussions, seeing causal connections and problems more objectively PROBLEMS AND NEGATIVE EFFECT - discussions in 'cliques' after CS - conflicts, envy and varying feelings in the work community - deteriorated work climate, increased annoyance and carefulness after getting to know colleagues better - disappointment with scarce results and changes	ATTITUDE TOWARDS OTHERS - tolerance, permissiveness and understanding for others - increased reserve towards others INTERACTIVE RELATIONSHIPS AND THEIR NATURE - strengthened relationships, more closeness and broader scope - increased respect for and confidence in others - easier to discuss issues, lower threshold for tackling difficult issues - deepened collaboration - increased consideration for others and empathetic attitude PROBLEMS AND NEGATIVE EFFECT - conflicts related to learning about other's attitudes, muteness, discomfort, annoyance, backbiting
INTERMEDIATE STAGE OF CS	OWN RELATION TO WORK COMMUNITY - increased courage to demand more and discuss - findings one's own and other's limitations RELATIONSHIPS BETWEEN MEMBERS OF WORK COMMUNITY - increased joint discussions about work, work performance and patient's best interest - development of discussion: search for alternatives and self-assessment instead of muteness, 'verbal attacks' and blame - improved climate, team spirit and collaboration - softened human relations PROBLEMS AND NEGATIVE EFFECT - increased divisions, chaos, conflicts and anxiety - emerging discord - unpleasant and confusing negative 'attacks', indulging in personalities and tackling personal affairs in the group	ATTITUDE TOWARDS OTHERS - permissiveness, acceptance of others, consideration for others for who they are, as individuals who have a distinctive way to think and experience things - freer feedback - increased understanding for others after one's own 'problems' were sorted out INTERACTIVE RELATIONSHIPS AND THEIR NATURE -'purification' after discussions - good relationships became deeper and poor relationships became more superficial - increased discretion, more careful attitude and relaxed relationships - increase openness and courage to inquire into matters PROBLEMS AND NEGATIVE EFFECT - confused human relations
END STAGE OF CS	OWN RELATION TO WORK COMMUNITY - courage to tackle sensitive issues - consideration for opinions of others and 'giving space' to others RELATIONSHIPS BETWEEN MEMBERS OF WORK COMMUNITY - increased 'sense of community', feeling of togetherness and flexibility - more open atmosphere - increased and more open discussions: learned to discuss both difficult and pleasant issues - increased criticalness, assessment and self-assessment - develop skills to tackle conflicts PROBLEMS AND NEGATIVE EFFECT -'subjugation' of some members and inability to express opinions	ATTITUDE TOWARDS OTHERS - decreased inflexibility; learned not to interfere in 'trivial' matters INTERACTIVE RELATIONSHIPS AND THEIR NATURE - improvement in good relationships, opening of 'deadlocked' ones and findings 'sole mates' - more fairness and humanity towards others

The team perspective on the development in the team

The development and effects of the intervention were examined from two aspects: (a) <u>what</u> had happened during team supervision in the teams and (b) <u>how</u> this was described within the teams. The categories found were the following (1) feelings of togetherness, (2) communication, (3) relations between the team members

and (4) the teams' working methods and work motivation. Since the conceptions varied considerably on the wards, it was considered important to describe the qualitative differences that characterised the perceptions.

Feelings of togetherness

The feeling of togetherness was described on all the five participated wards. The conceptions were different but describable on three hierarchically related levels. On the highest category level, interviewees described togetherness as a feeling that had evolved between team members. The feeling of togetherness was also described extensively with allusions to its flexibility, but it was seen as a separate entity, not related to practice. Flexibility indicated that the interviewees were capable of considering the issue from different perspectives and in relation to different factors. The following example represents these conceptions expressed in one of the teams.

Example 1 (ward E)
Interviewee H. 'I guess it's a fundamental issue... What it (team supervision) gave us as a group ... it's really hard to say... I have to take some time to think!'
Interviewee K. 'I don't know ... our work community has always been really good ... as a team?'
Interviewee A. 'I think ... we've always talked a lot ...but now we talk even more ... It (team supervision) taught us to listen to what others have to say ... in a big group ... You started to think about the things that people brought forward and shortcomings in my attitudes ... I've experienced that before, you know ... It added to the feeling of being 'in the same boat''...

The conceptions that togetherness either evolved between team members or through experiences of practice represented the second level. The feeling of togetherness was described between team members, but with hesitation since this was more of an expectation. The feeling of togetherness had materialised only partially during team supervision and not all the conceptions presented by the interviewees sprang up in the team. The following example describes this level of conceptions presented in one of the interviewed teams.

Example 2 (ward C)
Interviewee P. 'It's been a while (=since CS)... somehow I have become alienated from the whole idea. At least this year ... I rarely attended'...
Interviewee N. 'Me too...'
Investigator 'What about the rest of you?'
Interviewee T. 'Well I haven't noticed any great changes in our team because of CS ...'
Interviewee N. 'It was not what we expected' ...
Investigator 'What did you expect?... Could you be more specific?'
Interviewee N. 'That's a tough one... It's hard to say ...
(some comments excluded)
Interviewee T. 'But when we finally got there ... You really hadn't thought about the situation and work of others like that ... At least our horizons broadened' ...

The conceptions with descriptions of togetherness through some of its features represented the lowest category level in this category. The interviewees' expressed conceptions were, within the explicated perceptions of the team, contradictory and rather rigid. A clear emphasis was on the fact that the effects of team supervision on the teams were virtually non-existent. This is shown in the following extract from one team interview.

Example 3 (ward B)
Interviewee N. 'As I see it … we didn't get any benefit from it … at least I didn't … I expected more … I'm not sure about the effects on the work community … I've noticed no effects whatsoever'…
Interviewee K. 'We had great expectations in the beginning … But with no earlier experience of CS we didn't know what to expect'…
Interviewee S. 'The group formation was difficult and slow in the beginning… we sat in the same room … Then we started to discuss in smaller groups'…
(some comments excluded)
Interviewee K. 'And the issue discussed … we talk about them all the time anyway'…
Interviewee N. 'You can have perfectly good discussions without CS… we work so close together and know each other so well, we can talk about anything'…

Communication

Conceptions related to communication were described on all the five wards. The conceptions in the teams were describable on three hierarchically related levels. On the highest category level, the way the conceptions were expressed shaped a view within the team that communication was more widely connected to the relationships between team members. It was characteristic of the conceptions that they conveyed the interviewee's personal contribution to the communication. The emphasis was on the teams' perceptions that communication had developed during team supervision. The next example describes this level of conceptions presented in one of the interviewed teams.

Example 4 (ward A)
Interviewee H. 'My impression is that most of them were … cautious… Dissenting opinions were expressed, but with caution… There was no 'consensus'' …
Interviewee S. … 'Our personal relations … were discussed cautiously … tamely … Whereas in relation to practice issues … we sometimes heard 'outright' opinions…

The conceptions that formed the second level described communication through a number of features, such as sensitivity of communication. These conceptions indicated, as on the above-mentioned level, that communication was related to the relationships between team members with different effects. However, the team members' own contribution or conceptions of their own contribution to the team's communication were not explicitly expressed. It was characteristic of the conceptions that the problems with communication had in fact culminated during the intervention and thus the conceptions were characterised by negative aspects such as 'tirade of abuse' or silence. This is described in the following extract of one team interview.

Example 5. (ward D)
Interviewee U. 'But … to be subjected to a … tirade of abuse … during CS … it was hard for me … Everyone is entitled to have an opinion, I know … but to be subjected to verbal abuse … Am I really such a bad worker that we have to discuss it here and now … And I wasn't the only one … I'm sure they did not mean it that way'…
(some comments excluded)
Interviewee H. 'I think that you shouldn't discuss people who are not present … Those present can discuss their problems … they can even argue … but backbiting should be avoided … It's kind of dangerous … talking about those who are not present in a group'…

The conceptions that touched the issues of communication in passing formed the lowest category level of the category. The interviewees' conceptions were contradictory and the perceptions of the impact on communication were reversed. The interviewees' own contribution to team communication was not explicitly described. The conceptions conveyed a negative emphasis, and some interviewees were unwilling to express their perceptions. The next example describes this level of conceptions presented in one interviewed team.

Example 6 (ward B)
Interviewee U. 'On the other hand... they sort of tried ... we tend to express things indirectly'... We did not understand that ... We were not able to get to the heart of the matter ... openly. There are things that no-one wants to discuss... frankly ... Which people discuss anyway' ...
Interviewee S. 'And could we have trusted them ... if we had tried to disentangle matters?'
Interviewee P. 'Awkward and unbearable situations in the group!'

Relations between the team members

The conceptions concerning the relations between the team members were discussed in all the interviewed teams. The different perceptions found within the teams were describable on three hierarchical levels. On the highest category level, the relations between team members were presented from different points of view such as individuals and representatives of different professions. The interviewees perceived that the team members' relationships were interrelated and connected to the team's coherence. The conceptions conveyed a clear emphasis on the fact that team supervision had improved relationships between team members and the coherence of the team. The following extract describes this in one of the team interviews.

Example 7 (ward E)
Interviewee H. 'I feel ... that communication between different occupational groups became more effortless ... not that we've had any problems in the past ...but somehow I felt I could see beyond their professional roles...'
Interviewee E. 'Me too ... Of course we talk during coffee breaks and so ... somehow I could see them as real persons (=during team supervision)... although usually the same people attended. I do agree ...we have good team collaboration as it is... but now I am able to understand a colleague better...'
Interviewee H. 'We are more courageous and honest in our interactions'...
Interviewee P. 'Yes ... we have the courage to be what we are ... multi-professionally ... My attitude towards doctors changed as well ... I started to think about our relations with them ... It was easier to understand their 'outbursts' ... It was a revelation to me... we started to see each other as people ...

The conceptions that formed the second level focused on discussing relationships with the emphasis on colleagues as 'individuals'. The team members' relationships were described in passing compared with the highest category level of conceptions, but interviewees concentrated on discussing the depth of relationships. However, interviewees perceived that the team members' relationships were interrelated, but the conceptions conveyed that negative features resulted from a deeper knowledge of colleagues and thus from team supervision. The conceptions also conveyed an aspect of weakened coherence in the team. The next example describes this in one team interview in the following way.

Example 8 (ward D)
Interviewee A. 'It was the bold ones who got the chance to talk ... and those who were more silent but had something valuable to say were not able to express themselves'...
Interviewee K. 'It wasn't as if they weren't allowed to'...
Interviewee A. '...they did not have the courage.... That's the point, they were scared!... of certain people... it just developed'...

The conceptions that touched the team members' relationships in passing formed the lowest category level of the category. The interviewees provided only a few comments. Within the team, the expressions were contradictory and interviewees did not explicitly discuss the team members' relationships. The perceptions also conveyed a negative emphasis and attitude towards team supervision since it was seen that it had not solved the 'hidden' problems between team members. The following example provides a short extract of the group interview on ward B.

Example 9 (ward B)
Interviewee K. 'The things we talked about ... are the same things that we discuss every day ... I mean we really have no need for a further opportunity to discuss!'....

Teams' working methods and work motivation
The conceptions concerning the teams' working methods and these in relation to work motivation were discussed in four out the five interviewed teams (A, B, C, D). The perceptions found were describable on three hierarchical levels. Conceptions describing the teams' work broadly such as decision making, common discussions and concrete actions formed the highest level of the category. The working methods were discussed and were extended to work motivation at both the level of individuals and the team. The interviewees' perceptions emphasised a positive attitude towards team supervision and its benefits for developing work as a team. The following example describes this level of the category in one of the interviewed teams.

Example 10 (ward A)
Interviewee A. 'Come to think of it ... we reviewed our guidelines for care... which made us see ... that we should try to generalise our experience to other situations ... in terms of actions ... We agreed that if we get patients with tetraplegia which we know are bound to be long-term patients ... that we should discuss the situation and ask for help ... So as not to wait until problems start to emerge... but sort of try it the other way round ... try to make it easier on nurses ... and on relatives and patients'...
(some comments excluded)
Interviewee N. 'Did we raise the question of home care instructions back then? ... We have devised them now!...Or was that earlier?... We made clear we need them'....

The second level was formed of conceptions describing the teams' working methods, but with an emphasis on main questions compared with the highest category level. These perceptions involved descriptions of problems: the slow or insubstantial progress within the team and working as a team. The teams' work patterns were closely related to work motivation, but only in connection with individual employees' performance. The interviewees' perceptions clearly conveyed suspicion of the contributing role of team supervision. The next example describes this in one team interview in the following way.

Example 11 (ward C)
Interviewee M. ...'It was difficult ... to be free to discuss whatever we wanted ... We did not have clear topics of discussion, which had apparently been a problem... But all that freedom ... we did not know what to discuss ... And we had a limited number of sessions ... sometimes we felt that just as we got going we had to finish' ...
Interviewee A. 'We did not know what...we were responsible for everything ... As we sat down at the table we fell silent ... were should we start ... We should have attended (=CS) as a ward... To come up with a topic of the day'...

The conceptions with contradictory descriptions of team's working methods during the interview formed the lowest category level. The team's working methods were mainly perceived through individual performance or certain principles discussed in the team. On this level, like the level of conceptions described before, the perceptions involved descriptions of different problems. The working methods were seen in connection with individual employees' work motivation. The interviewees' conceptions again conveyed deep suspicion of the effects of team supervision on the team. This is described in the following extract.

Example 12. (ward B)
Interviewee U... 'I took it as an opportunity...It was really important to me... I gained something..'
Interviewee N...'I don't know!...Supervisors should know something of our field (=work in the operating theatre) ... and to establish some sort of rapport... If the first impression is that nothing is going to come out of this'...
Interviewee K. 'CS contributed absolutely nothing to our work ... On the contrary!'

To sum up the <u>findings of the follow-up inquiries,</u> the functionality and commitment to work and organisation showed improvement in the teams. The supervisees' assessments confirmed that improvement had occurred in the effectiveness of teamwork. The effects of team supervision in relation to team were described in the supervisee's changed, closer and more interactive relationships with their team and between their colleague team members that had grown more mature with social interaction. The changes in supervisees' human relations focused on attitudes towards others that become more flexible and thus the interaction improved as well. The effects that were found in the <u>group interviews</u> focused on the evolving feelings of togetherness and communication between team members. Further effects were the developed relations between team members that seemed to form the basis for coherence within the team and the team's evolved working methods (i.e. decision making, common discussions, concrete actions) that had an impact on work motivation within the team and among its individual members.

5.3. Effects of team supervision among the individual team members from the perspective of professional development

The effects of team supervision among team members were examined using follow-up inquiries and group interviews after the termination of the intervention. The following chapter focuses on addressing the first study aim from an individual team member's perspective (see chapter 3).

During team supervision some changes were evidenced in the factors describing the individual factors of the prerequisites for professional development (Tables 12 – 14). Reflectivity (p= .010) improved on ward A (I inquiry mean of sum 43.3, SD 3.1 $\rightarrow$ V inquiry mean of sum 43.7, SD 3.2), but only occasionally and

slightly on ward D (I inquiry mean of sum 40.2, SD 2.7 → V inquiry mean of sum 40.4, SD 2.6). However, performance motivation (wards B, C and E, p=. 964 and wards A, D p=. 685) and growth motivation (wards B, C and E, p= .832 and wards A, D p= .092) remained unchanged during the intervention.

The low evidence of individual professional development was confirmed through the fact that the majority of the supervisees found that their expertise, theoretical approach, self-awareness and personal strengths remained the same during the intervention (Tables 9 a, b). A closer examination showed that especially the theoretical approach to practice had remained unchanged throughout the intervention (wards B, C and E: III inquiry 100%, n=24 and wards A and D: V inquiry 81.8%, n=18). However, an increasing number of respondents had reported deepened self-awareness (wards B, C and E: I inquiry 4.2 %, n=1 → III inquiry 29.2 %, n=7 and wards A, D: I inquiry 40.9 %, n=9 → V inquiry 45.5 %, n=10). Especially on wards A and D, which participated for three years, an increasing number of supervisees (I inquiry 68.4%, n=13 → V inquiry 84.2%, n=16) described the effects of CS on supervisees themselves, but also on their work patterns (I inquiry 52.6 %, n=10 → V inquiry 66.7%, n=12) (Table 10 b).

The described effects of team supervision on oneself focused on one's self-relationship, self-examination, openness and degree of freedom (Table 15.) The supervisees' attitude towards themselves became less critical meanwhile the positive view increased. During the course of the intervention the respondents' attitudes had developed towards a 'positive criticality' and increased gentleness towards one-self (e.g. forgiving one's mistakes and admitting weaknesses) with increasing fearlessness and courage. Supervisees described increased self-examination and their behaviour and reactions with patients and colleagues. During the course of team supervision some respondents reported how they had learned to know themselves, their 'blind spots' and own goals, which directed their actions. Improved self-knowledge contributed to expressing one's emotions and opinions. Increased openness and freedom were mentioned as effects of team supervision on oneself through consideration of things that had occupied one's mind, but also listening to colleague. The above-mentioned effects served as a means of 'emotional relief' and increased effectiveness regardless of increased work pressures. Problems and negative effects were again mentioned. Supervisees emphasised that team supervision had aroused very strong, negative and fluctuating feelings such as irritation, frustration and tensions that consumed energy. In extreme, but rare descriptions the feeling led to fears, depressed feelings or hardening. The discussed topics had also provoked awkwardness, displeasure, cynicism and withdrawal because of being 'misunderstood'. Some supervisees were disappointed because of 'dishonest', superficial and fruitless examination of the topics.

Tables 12.-14. Prerequisites for professional development: individual factors

Growth motivation (OC1)

	Inquiry I mean	SD	Inquiry II mean	SD	Inquiry III mean	SD	n	Inquiry IV mean	SD	Inquiry V mean	SD	n	Total sum	mean
ward B	31.3	7.8	30.5	5.4	31.0	3.4	6	-	-	-	-	-	92.8	30.9
ward C	32.6	3.5	33.5	2.2	33.2	1.9	10	-	-	-	-	-	99.3	33.1
ward E	35.5	2.2	34.6	2.8	34.4	3.5	8	-	-	-	-	-	104.5	34.8
(total)	33.3	3.7	33.1	3.6	33.0	3.1	24	-	-	-	-	-	99.4	33.1
ward A	33.2	4.1	34.3	3.1	33.2	2.8	13	33.7	2.8	34.1	2.7	13	168.5	33.7
ward D	32.7	2.7	33.8	2.1	34.1	2.7	9	32.0	4.9	33.9	3.2	9	166.5	33.3
(total)	33.0	3.5	34.1	2.7	33.6	2.7	22	33.0	3.8	34.0	2.9	22	167.7	33.5

wards B, C and E) statistical significance: between wards .069, factor .832, factor and ward .481
wards A and D) statistical significance: between wards .736, factor .092, factor and ward .272

Performance motivation (OC3)

	Inquiry I mean	SD	Inquiry II mean	SD	Inquiry III mean	SD	n	Inquiry IV mean	SD	Inquiry V mean	SD	n	Total sum.	mean
ward B	41.7	3.8	43.0	3.5	42.2	2.3	6	-	-	-	-	-	126.9	42.3
ward C	41.8	2.7	41.9	2.1	42.2	3.2	10	-	-	-	-	-	125.5	42.0
ward E	44.3	2.9	42.4	3.9	43.3	4.2	8	-	-	-	-	-	130.0	43.3
(total)	42.6	3.2	42.3	3.0	42.5	3.3	24	-	-	-	-	-	127.4	42.5
ward A	43.0	3.7	42.1	2.8	42.9	3.4	13	42.8	3.5	43.3	3.3	13	214.1	42.8
ward D	42.4	3.5	42.9	4.5	43.1	4.3	9	43.3	3.4	41.7	4.2	9	213.4	42.7
(total)	42.8	3.6	42.4	3.5	43.0	3.7	22	43.0	3.4	42.6	3.7	22	213.8	42.8

wards B, C and E) statistical significance: between wards .594, factor .964, factor and ward .285
wards A and D) statistical significance: between wards .939, factor .685, factor and ward .102

Reflectivity (RF1)

	Inquiry I mean	SD	Inquiry II mean	SD	Inquiry III mean	SD	n	Inquiry IV mean	SD	Inquiry V mean	SD	n	Total sum.	mean
ward B	42.7	1.5	42.2	1.7	41.7	2.2	6	-	-	-	-	-	126.6	42.2
ward C	41.4	2.2	41.1	3.5	41.6	3.1	10	-	-	-	-	-	124.1	41.4
ward E	43.1	2.7	41.9	2.8	43.3	2.9	8	-	-	-	-	-	128.3	42.8
(total)	42.3	2.3	41.6	2.8	42.2	2.8	24	-	-	-	-	-	126.1	42.0
ward A	43.3	3.1	42.2	3.0	42.8	2.8	13	43.2	3.1	43.7	3.2	13	216.2	43.2
ward D	40.2	2.7	41.4	3.2	41.7	2.00	9	42.6	3.2	40.4	2.6	9	206	41.3
(total)	42.1	3.3	41.9	3.0	42.3	2.5	22	43.0	3.1	42.4	3.3	22	211.7	42.3

wards B, C and E) statistical significance: between wards .448, factor .406, factor and ward .652
wards A and D) statistical significance: between wards .129, factor .143, factor and ward .010,

Table 15. Impact of team supervision on oneself and one's work patterns

	WORK PATTERN	IMPACT ON ONESELF
INITIAL STAGE OF CS	PROCESSING OF WORK PATTERNS, BROADENED AND REINFORCED JOB PICTURE - increased reflection, verification and analysis of matters, contemplation and more composed working methods - clarified and consolidated confidence in one's working methods, broadening of perspective - less 'selection' of duties and increased strength to tackle 'unpleasant' duties PATIENT-ORIENTATION - more precise treatment of patients - decrease in routine-like attitude RECONCILING AND CHANGING WORK PATTERNS OF ONESELF AND OTHERS - changing working methods to agreed upon direction - consideration for colleagues' work patterns and trust in colleagues - adopting colleagues' 'good' work patterns as one's own PROBLEMS AND NEGATIVE EFFECT - increased carefulness and frustration	SELF-KNOWLEDGE - decreased criticalness and reinforced positive self-relationship INTROSPECTION - increased introspection and self-observation, contemplation on one's feelings and reactions in relationships with patients and colleagues SENSE OF OPENNESS AND FREEDOM - relieved mind and increased openness towards expressing one's feelings as a consequence of contemplating thought-provoking issues and of listening to others PROBLEMS AND NEGATIVE EFFECT - negative, confusing and seething feelings: irritation, frustration, tension -irritation, discomfort and cynicism caused by topics - disappointment caused by superficial examination, 'dishonesty' and fruitlessness
INTERMEDIATE STAGE OF CS	DEEPENED PROCESSING AND CHANGE IN WORK PATTERNS - working method changed towards a contemplative and investigative direction examining wholes broadly from different perspectives with clarified causal relationships - development of flexibility, assertiveness and ability to tackle difficult issues, decrease in 'black-and-white' attitudes - increased observation and assessment of one's work patterns NEEDS BASED PATIENT CARE - increased consideration for patients' needs CLARIFYING AND CHANGING WORK PATTERNS OF ONESELF AND OTHERS - jointly altered work patterns - improved consideration for colleagues' different work patterns, understanding and acceptance - opportunity to change one's work patterns by adopting colleagues' best methods PROBLEMS AND NEGATIVE EFFECT - increased cynicism and reserve - drop in work motivation because of negative personal criticism	POSITIVE, CRITICAL SELF-RELATIONSHIP - increased open and positive criticalness - increased 'gentleness' towards self, forgiving one's mistakes and admitting weaknesses INTROSPECTION AND SELF-KNOWLEDGE - improved knowledge of oneself, one's 'blind spots' and goals - increased courage to express one's feelings and opinions SENSE OF FREEDOM - sense of 'psychological' relief and increased efficiency despite increased work pressure PROBLEMS AND NEGATIVE EFFECT tackling matters at personal level causing feelings of repression, exhaustion, fear and depression; criticism and 'verbal attacks' - emotional fluctuations or hardening
END STAGE OF CS	CONFIRMATION AND CONSOLIDATION OF ONE'S WORK PATTERNS - consolidation of one's work patterns, increased self-confidence and self-esteem, increased sense of responsibility - more structured and precise work CRITICAL PATIENT-ORIENTED APPROACH AND MANAGEMENT OF DEMANDING PATIENTS RELATIONS - easier to encounter difficult patients - increased consideration for treatment of patients - challenging routines based on different perspectives RECONCILIATION OF WORK PATTERNS OF ONESELF AND OTHERS - view of links between issues and actions - learning to ask for help from colleagues - broadened view of how others think dispelled conflicts	DEVELOPED SELF-RELATIONSHIP - increased fearlessness and courage to 'speak out' and to express one's opinions SELF-KNOWLEDGE - increased self-knowledge SENSE OF FREEDOM AND OPENNESS - sense of freedom and relief because of talking about joint matters with others PROBLEMS AND NEGATIVE EFFECT - risk of being misunderstood while 'speaking out' and decreased willingness to take a stand

The effects of team supervision on work patterns focused on processing and changing the patterns, matching one's own and colleagues' work patterns, but also on a patient-centred and patient-originated work approach. Supervisees reported that the processing, monitoring and assessment of their own work patterns had increased during the intervention. Respondents had also noticed that their perspectives had broadened and acquired a more investigative emphasis, whereas 'black-and white' attitudes and selecting duties had decreased. During the course of team supervision, the supervisees' confidence in their own work patterns strengthened and their pace of work slowed down. Towards the end of the intervention self-confidence and self-assurance with regard to one's work patterns improved, the supervisees' responsibility increased and led to a more accurate and organised work style. The patient centred approach with the previously increased emphasis on patients' needs, but also critical questioning of prevailing routines were described as closely related to the effects of team supervision on the work patterns. Encounters with difficult patients were perceived to be easier and more attention was paid to patient care.

Supervisees reported that during team supervision they had started to pay more attention to their colleagues' work patterns. During the intervention, the confidence in and understanding and approval of colleagues' work patterns increased and the respondents reported that they had learned to ask for help. An important effect on work patterns was that supervisees had started to adopt the work patterns of those colleagues they found 'effective and good', and the work patterns thus transformed into a more consistent direction. The problems and negative effects mentioned were that reservations, wariness, frustration and cynicism had increased, and some team members had lost some of their work motivation if their work patterns had been commented upon.

The team perspective on the development of work

The interviewed teams examined the development and effects of team supervision from the perspectives of (a) what is work/nursing about, (b) by whom and how is the nursing care implemented. The following categories were found: (1) nursing care characterised by its common course, (2) sources of knowledge for work, (3) 'oneself working within team' and (4) team composed of individual ways to work. The categories are described more closely next.

Nursing care characterised by its common course

Nursing care was discussed vividly in all the five participating teams under the interview theme of 'team supervision and work'. The conceptions in the teams differed but were describable on three hierarchically related levels. The interviewees' perceptions showed variation in the conceptions of nursing, its nature and basis. On the highest category level, the interviewees' conceptions conveyed that nursing is patient-oriented action, based on common agreements and mutual decision making. The interviewees' perceptions indicated that the work, i.e. nursing care had developed during team supervision. The following example of group interviews describes this.

Example 13(ward A):
Interviewee S: … the things discussed in CS … you learned to see how the team work … in a ward situation. And you learned how people think … when we discussed our difficult patient cases …
(some comments excluded)
Interviewee H: … yes and on the other hand we've made joint decisions … about policy lines … we've discussed them before but … but to be able to make progress … once we've decided something … we must stick to it. And then it recurs on the ward and is deployed in our work… we've been more organised in terms of planning'

The conceptions that formed the second level described nursing through the continuous changes and development processes witnessed by the interviewees. The more specific focus on care (i.e. patients) and its basis remained, however, implicit. The interviewees' perceptions of nursing and its common course indicated that the changes and developments, strongly emphasised in the teams, were brought about jointly. The conceptions in this category conveyed doubts about the effects of the intervention. It was seen that the effects were mixed with 'change' and thus impossible to distinguish as effects. The following example is an extract from the group interview made on ward D.

Example 14(ward D):
Interviewee K: '… big changes are going on at different levels … the system is about to change completely: the day surgery unit started to operate, one ward was closed down … posts were cut down… how could you even begin to specify all this?'…

The lowest category level was comprised of some interviewees' perceptions with an emphasis on practice and procedure centred nature of nursing. The interviewees' conceptions were not contradictory, and they seemed to have a shared view of the foundations of nursing actions. The perceptions were, however, focused without explicit discussions on the patient aspect, and on changes or developments in nursing. On this level of the category, the interviewees' conceptions indicated that the contribution of team supervision to nursing or to the joint actions was more or less non-existent. The next example describes this critical perspective on team supervision from ward B.

Example 15 (ward B):
Interviewee S: 'Right… this work of ours (at the operating theatre) was so alien to them … the whole system … it sort of ended there and then'.
Interviewee N: 'Our mentalities differed enormously … they (clinical supervisors) kept repeating the same thing …whereas we get right down to the point without beating about the bush'…

Sources of knowledge for work

The sources of knowledge at work were discussed in three of the five interviewed teams (A, B, C). The conceptions comprised three categories that were hierarchically interrelated. Variation showed in the interviewees' perceptions of attaining knowledge for work in relation to colleagues and to the nature of knowledge. The highest level of conceptions indicated that the colleagues were a source of knowledge in work and that this was evolving and possible to share. The interviewees' perceptions indicated that collective knowledge for work was created in team supervision. This is described in the following extract from the interviews.

Example 16 (ward A):
Interviewee A: … 'we discussed our joint care policies … patient cases … they sort of enabled us to generalise these cases to corresponding situations in the future … and ask for help … and certain policy lines as to our work … and not sit waiting until a problem arises but … and when there is a problem we don't try to patch up things but approach it from another direction, try to make things easier on ourselves, the nurses'

The conceptions forming the next level focused on discussions about common knowledge for work. The interviewees examined 'the shared knowledge' mainly because they saw that it was important to clarify it and to make it available for all team members on the ward through concrete means. The interviewees' perceptions of the nature of knowledge or their colleagues' contributing role for producing knowledge for work was not explicitly expressed during the interviews. In the following example this is shown in a discussion about a file that was created for common use.

Example 17(ward C):
Interviewee K: 'We discussed it… we all had a slightly differing approach to work … it makes it explicit … that we do differ from one another in our approaches …
Interviewee M: 'We've grown more sensitive as to other people's approaches' …
(some comments excluded)
Interviewee T: '…isn't that … the file that we are compiling for joint use? … that we would all have the same knowledge base' …

The conceptions that the knowledge for work was received during different training courses and study days formed the lowest level of the category. Interviewees perceived that a great deal of knowledge was available, and that course participants served as sources of knowledge thus making it accessible to all (i.e. in the team). The following extract from a group interview describes this.

Example 18(ward B):
Interviewee N: 'We have lots of training opportunities … people share the things they've learned with the rest of the people …'

'I as a team member'
The conceptions concerning 'I as a team member' comprised four hierarchically inter-related categories. These categories emerged in the four interviews on the wards (A, B, D, E). Variation was discovered in the interviewees' perceptions of 'oneself' in relation to patients, colleagues and team through work. The highest category was formed of wide-ranging and flexible conceptions of 'oneself' in relation to work including the different parties. Flexibility indicated support for colleagues in the team and at work. The interviewees perceived that team supervision had contributed to realising this but had also helped to manage and prevent their own feelings of guilt. The effects of team supervision were thus seen in terms of improved self-awareness. This is described in the following extract from one group interview.

Example 19 (ward A):
Interviewee S: …'We talked about collegiality … that we should act as a united front and be collegial. And sort of provide support for the other person in a difficult situation …And not to blame people for not acting in the 'right' way … but to support them and not condemn them' …

(some comments excluded)
Interviewee N: 'Well it was good to see that we all share the feeling of guilt ... that in itself was a big step forward...'
Interviewee E: 'Exactly... some people just admit to it more readily than others ... and admit to their mistakes ...'

The conceptions that focused on 'oneself' in relation to work formed a narrower level. In this category the conceptions were not wide-ranging, but described in depth one's own relation to work. Interviewees perceived that one's own genuine and individual relation to work had been clarified through distinguishing this from teamwork and the relations with colleagues. In other words, the conceptions in this category were reversed compared to the above-mentioned highest category level. However, the patient aspect was also included in this category, but in the interviewees' perceptions it was connected to 'one's credibility' in patient relations and thus as part of work. The conceptions in this category suggested a positive contribution of team supervision. The following example describes this level of conceptions in one group interview.

Example 20 (ward E):
Interviewee P: 'Right... to have the courage to act as a genuine human being ... there and then ... I feel that our attitude towards doctors has changed a bit ... although we spend eight hours a day face to face...as far as these outbursts are concerned ... we started to think about the nature of our relations and we were startled at our feelings about other people' ...
(some comments excluded)
Interviewee S...'It really made me think about what patients might think when we keep on talking and work at the same time ... do they think that we are capable of that ... or is it empty words, just things that we say without meaning it'

The conceptions that formed the next level concentrated on specific aspects of work. Interviewees presented different viewpoints, but the subject (i.e. oneself) of work was not clearly expressed. In contrast, the discussion was tinged with unachieved goals at work. The interviewees' own conceptions of their relation to work remained blurred. However, the perceptions in this category were tinged with a positive emphasis on the support provided by team supervision for the teams. It seemed that the support had also contributed to and extended the team members' self-awareness through insights and expressions elicited during team supervision. An extract of the group interview on ward D is shown in the following example.

Example 21(ward D):
Interviewee A: ... 'during the three years of CS were went through enormous changes. We introduced the primary nursing model ... it was too much to handle ... and our scope of operations exploded ... we felt that we are inadequate ... It was sort of having to give up something ... and concentrate on this one issue only.. Now I feel that we should start we should take it slowly in CS ...
(some comments excluded)
Interviewee V: 'it (team supervision) did have its value in the sense that we were able to realise how much we've accomplished ... and endured change ... and become healthier ... so we must have achieved something' ...

The conceptions that touched the requirements for one's work in passing formed the lowest level of the category. Although the interviewees described their conceptions only in a few words, it was obvious that the perceptions in the team were not contradictory. In this category the perceptions were, however, tinged with

doubts and hesitation about the support that team supervision might provide for one's work. The next example describes this in the following way:

Example 22(ward B):
Interviewee S:...'Exactly, and of course we were run down because we spent more money on surgery supplies last year'...
(some comments excluded)
Interviewee K: ... 'It is my experience that CS can provide nothing but psychological resources'...
Interviewee N: 'Well that would be the case if it would...'

Team composed of individual work patterns

The conceptions concerning 'team composed of individual work patterns' comprised three hierarchically inter-related categories. The categories emerged in the three interviews on the wards (A, C, D). Variation showed in the interviewees' perceptions concerning the team-members' individual work patterns. The highest category was formed of wide-ranging and flexible conceptions of individual work patterns in the team, including the patient aspect. The different work patterns were not called into question, but accepted among the team-members, which showed flexibility in the perceptions. However, it was thought that the differences in work patterns were a possible source of confusion from the perspective of patients and relatives. Interviewees perceived that some uniformity was necessary in the team's work, providing stability in practice. The conceptions suggested that team supervision had contributed to uniformity within the teams, while still preserving the members' individual work patterns. This is described in the following extract from one group interview.

Example 23(ward A):
Interviewee L: 'It just occurred to me that we had these long-term difficult patient exactly then ... and next of kin ... we did reach certain policy lines ... that we cannot go as far as next of kin sometimes want us to ... it made our work easier ... when we knew that this is the ultimate limit ... That we were sort of pulling the same string and not treated others as poor nurses if they did not comply'...

The conceptions that formed the second level focused on describing the team members' individual work patterns with patients and their relatives. The different work patterns were called into question, but mainly accepted by team members. However, interviewees expressed no specific need to unify the individual patterns. The interviewees' perceptions in this category suggested that team supervision had promoted the acceptance of individuality in work. The next example describes this level of conceptions presented in one of the group interviews.

Example 24(ward C):
Interviewee T:...'It really was a bit of a surprise to see that we have all those different approaches to work ... and we discussed (in CS) that we should be more permissive to others' approaches ... details don't matter that much ... if you just do the job ... but to understand this was important'
Interviewee M: 'I'm sure we've grown more sensitive ... In the sense that we have more understanding for other people!'

The conceptions that confined to observations of the team-members' individual work patterns formed the lowest category level of perceptions. The different work patterns were called into question. The interviewees' perceptions were, however, hesitant about whether team supervision had promoted the examination of work within the teams. The last example describes this level of conceptions in one of the interviewed teams.

Example 25 (ward C):
Interviewee T: 'Perhaps we do have more discussions within our module … I think?'…
Interviewee S: 'I suppose people are more ready to express their opinions in our weekly meetings' …

To sum up the findings, it was not possible to show the development of the professional factors under study during the team supervision intervention using the follow-up inquiries. However, deepening of the supervisees' self-awareness was found. The effects of the intervention on the supervisees themselves were seen as the development of a more positive and permissive scrutinisation, and open and relaxed attitude towards one-self. The other effects were that team supervision had initiated the processing and matching of working manners of individual supervisees' and their colleagues, integrating this with the patient-centred approach in care and thus contributing to managing work situations in a more organised and efficient manner.

5.4. Educational needs during the team supervision intervention

The supervisees' educational needs were examined during team supervision using follow-up inquiries. This was done to explore and identify the possible changes in these during the intervention. The following chapter focuses on addressing the second study aim (see chapter 3).

During team supervision, the majority of the respondents (45.8% - 63.6%) in all wards shared the perception that the development of work was important. Most of the respondents were also extremely willing to participate in education (40.9% - 58.3%), and the average number of in-service education sessions within and outside the organisation during a six month period was 1 – 2 times.

The variety of in-service education within and outside the organisation in which the supervisees had participated during the intervention was versatile. Respondents had participated in in-service education organised on different organisational levels (i.e. ward, clinic, hospital district), but also in national, extensive training days for different professional groups (e.g. nurses, assistant nurses, ward secretaries) or specialities (e.g. anaesthetic nurses, ophthalmology nurses, ICU and paramedics) and international conferences. The foci of education were as follows:

- managerial and leadership training (e.g. growth in leadership and change, total quality management),
- current topics of medicine in one's speciality (e.g. neuro-surgical emergencies, cataract patients' day surgery),
- nursing and patient care (e.g. ethical issues and values of nursing, primary care, supporting patients in crisis and debriefing, multi-cultural nursing, caring for dying patients),

- quality related training (e.g. projects on quality improvement, customer services, services by telephone),
- targeted computer training (e.g. laboratory services, economy follow-up, rota planning),
- protection of privacy (e.g. documentation and confidentiality)
- occupational safety and health issues (e.g. violence against health care professionals, management of catastrophic situations in hospital organisations and civil defence, gas and electricity safety) and
- collaboration (e.g. human relations and problems, team membership, developing a work community).

The variety of in-service education served for different functions and purposes on the participating wards and only in rare cases the respondents rated the benefits of education as useless or superficial. Computer training was rated as extremely important since staff used a variety of computer systems to operate a number of services and actions in hospital organisation, but providing assistance for colleagues was also very common. Occupational safety issues were another important topic. The respondents who had received in-service education on safety issues mentioned their improved feelings of safety and the practical nature of the information acquired. Managerial training was rated as beneficial. Participants, ward managers, described the support for their leadership tasks, assistance in finding strategies for intensifying the ward's operations, clarification of financial matters and assistance in understanding the factors regulating the operations in the clinic. Education on the current topics of medicine had provided important information about the newest treatment courses, increased and up-dated the staff's knowledge of medicine, but also improved motivation and stimulated their everyday work. The benefits of the education on nursing and patient care were described from several perspectives. Participants reported that their knowledge and understanding had deepened, their capacity to encounter and support patients had improved and that the in-service education had stimulated the practice by creating new ideas for further elaboration. The training days for different professionals served to support the practitioners' professional identity and increased their strengths, but also gave wider and new perspectives on professional issues. The international conferences were described as highly beneficial and important as they improved the appreciation for one's work, gave new knowledge, possibility to exchange experiences, and thus activated and increased motivation for work. The low benefit of in-service education was related to education that was 'too idealistic in practice' or 'too vague' in content.

The sufficiency of in-service education was assessed by the respondents through the possibilities to participate in education during working hours, adequacy of education and its content in terms of coping with one's work, relevance of the topics to one's educational needs, consistency of the in-service education and satisfaction with education (see Appendix 3.) During the team supervision intervention no significant changes were evidenced in the supervisees' assessments on wards B, C and E (inquiry I mean of sum 45.3, SD 8.5 → inquiry III mean of sum 45.8, SD 9.4, p= .236) or on wards A and D (inquiry I mean of sum 51.5, SD 11.3 → inquiry V mean of sum 51.4, SD 7.6, p= .848). (Table 16)

Table 16. Sufficiency of in-service education

	Inquiry I		Inquiry II		Inquiry III		Inquiry IV		Inquiry V		Total	
	mean	SD	mean	SD	mean	SD	mean	SD	mean	SD	sum	mean
ward B	46.8	10.0	49.5	7.7	43.2	8.5	-	-	-	-	139.5	46.5
ward C	46.4	5.9	46.9	11.4	49.9	8.6	-	-	-	-	143.2	47.7
ward E	42.8	10.4	48.8	10.2	42.8	10.2	-	-	-	-	134.4	44.8
(total)	45.3	8.5	48.2	9.9	45.8	9.4	-	-	-	-	139.3	46.4
ward A	54.8	9.9	51.8	8.4	48.5	9.3	52.0	5.9	53.3	8.8	260.4	52.1
ward D	46.7	11.9	50.4	8.4	49.8	2.3	49.6	8.2	48.7	4.8	245.2	49.0
(total)	51.5	11.3	51.2	8.2	49.0	7.2	51.0	6.9	51.4	7.6	254.1	50.8

wards B, C and E) statistical significance: between wards .703, factor. 236, factor and ward .250,
wards A and D) statistical significance: between wards .257, factor .848, factor and ward .170

The respondents' background variables (age, work experience, time in present post and position) were tested through the assessments of the sufficiency of in-service education. The findings showed no significant associations between the background variables and the ratings on wards B, C and E which participated for two years. However, on wards A and D which participated for three years, the ward managers' and assistant ward managers' ratings of the sufficiency of in-service education were statistically more significant (inquiry I mean of sum 62.5, SD 5.4 p=.006, → inquiry V mean of sum 60.0, SD 8.7, p= .035) than those of the assisting staff (inquiry I mean of sum 41.5, SD 15.4 → inquiry V mean of sum 50.0, SD 6.8) and nurses (inquiry I mean of sum 52.8 SD 5.1 → inquiry V mean of sum 49.3, SD 6.1) on these wards.

The changes in educational needs initiated through the team supervision intervention were explored with open-ended questions. Many of the respondents perceived these questions to be difficult to answer or peculiar or left the question unanswered (e.g. on ward A every second respondent and on ward C every fifth respondent had described the educational needs arisen during team supervision). The respondents who had answered the question had included a variety of educational needs they had discovered, but they also pointed out that many of these were 'general' and 'chronic' needs such as computer training or language courses in Swedish and English. In order to find the educational needs that were truly related to the intervention, the questions 'educational needs arisen', 'useful topics of team supervision' and 'important unaddressed topics of team supervision' were analysed in parallel. The educational needs found focused on (a) teamwork, its development and solving the emerging problems, (b) human relations, related skills and problems, (c) strengths at work, increasing the strengths and work motivation, (d) common principles and theoretical perspectives on patient care, (e) case descriptions of patient care and (f) quality related issues. (Table 17)

Table 17. The educational needs arisen during the intervention in light of necessary and unaddressed topics

	WARD A	WARD B [*)	WARD C	WARD D	WARD E
Educational needs arisen during team supervision	a) Development of collaboration between different occupational groups b) Increasing resources at work, maintaining working capacity c) Human relations and working capacity d) Aggressive, restless patient in crisis e) Case histories and ward meetings f) Quality improvement	a) Teamwork b) Different sectors of nursing c) Nursing theories and their application to work in operating theatre	a) Group work b) People skills c) Joint care principles d) Seeking to create positive climate	a) Training in people skills b) Solving problems in work community c) Accountability	a) Own working capacity and work motivation b) 'Problem': strong personalities
Useful topics addressed in team supervision	a) Collaboration issues c) Human relations on ward e, f) Management of patient cases – relieved and provided new perspectives and insight	a) Examining of close colleagues' good features	a) Division of labour on ward a, c) Collaboration between different occupational groups b) Personal relations d) Factors affecting ward situation – 'putting an end to blaming doctors'	a) Handling problems in human relations a) Assumptions and interpretations in relation to human relations and asking specifying questions b) Tensions in work community	b) Problems in personal relations Work community and human relations issues
Important topics unaddressed in team supervision	b) Facing difficult and distressing patients in crisis situations b) Maintaining working capacity with different patients c) Human relations at workplace c) Problems in human relations and working capacity d) Aggressive patient making sexual suggestions, in crisis	a) Teamwork and human relations on ward a) Issues related to work community b) Nursing principles	a, c) Task division models a) Conflicts within work community b) Human relations at workplace, problems in human relations and openness	a) How to deal with problems in human relations constructively? b) Skills to manage conflicts and deal with problems in work community c) Conduct in work group and taking responsibility as an employee	a) Professional coping and enduring pressure in a change process a, b) Coping with work with different people

*) Different medical topics were heavily emphasised in responses concerning educational needs

On the participating wards every second (wards A, D) or third (wards B, C, E) respondent assessed that the organisation had supported their professional development. The forms of support that were described to promote the development were (a) education, (b) clinical supervision, (c) change in position in organisation and (d) delegation of administrative tasks. The forms of support for participation in education included rota arrangements, financial support, paid leave of absence, part-time non-paid leave of absence or long-term arrangements with shifts allowing part-time studies e.g. in the university. The support for professional development was also related to changes in one's position from temporary to permanent or long employment contract, and changes in the educational basis or tasks in the position (i.e. switching from an assistant nurse's position to that of a nurse). Respondents pointed out the challenges of more demanding tasks and the fact that a permanent position gave the best possibility to participate in all forms of education. However, on every participating ward there were 1-2 respondents who reported no, minimal or 'detrimental' support for their professional development. Detrimental support was described as 'threats' of discontinuing the posts.

Changes in the plans for professional development were reported on the wards which participated for two years by 8% (I inquiry n=2) up to 13% (III inquiry n=3) of the respondents and on those participating for three years between 32% (I inquiry n=7) by 23% (V inquiry n=5). The changes the respondents reported were concerned with assistant nurses' plans to study at a polytechnic, nurses' master level studies at the university (14/24), plans for seeking job openings abroad or in another hospital district (2/24), plans for applying for or quitting an administrative ward manager's post (2/24), but also decasualization of one's post, switching from an assistant nurse post to a nurse post (2/24), and receiving clinical research associate's post (1/24) and switching to another discipline (1/24) were mentioned. However, the respondents who reported changes in their plans did not rate the sufficiency of in-service education as significantly higher or lower compared to those with no changes in their professional career development plans.

To sum up the findings, education and development at work were deemed extremely necessary. The in-service education within and outside the organisation was versatile and served the diverse, but essential needs of the supervisees in their everyday practice. During team supervision, however, changes in educational needs or plans for professional development were not found and the supervisees themselves found it difficult to specify any particular educational needs initiated by the intervention.

5.5. Intensification of the intervention through the supervisees' continuous work self-monitoring and patient satisfaction feedback

As part of the intervention the supervisees accomplished continuous self-monitoring of their work and they also received patient satisfaction feedback. One of the interests in the study was to assess the supporting and intensifying impact of these methods on the intervention. The following chapter focuses on addressing the third study aim (see chapter 3).

During the course of the study the supervisees' self-monitoring of work and patient satisfaction feedback were reported monthly on the respective wards in the form of control charts. Examination of the control charts showed that during the year 1996 the crossings of the upper and lower warning ($\bar{x} + \pm 2\sigma$) and

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acting ($\overline{x}$ + ±3σ) limits differed (see chapter 4.5.1). On wards A and C, the upper acting and the lower warning limits were crossed several times during the first five months of the study. After five months, the assessments continued to fall between the acting and warning limits. On wards D and E, the crossings of the upper and lower warning limits continued at regular intervals during the year 1996. Most often in all the wards the crossings of the warning and acting limits were apparent in connection with ratings of the contribution of care to the goals. An interesting observation was that the supervisees' assessments started to fall between the acting and warning limits during the course of the study in 1997-1998. However, on ward B the assessments deviated form the other wards so that no crossings of acting or warning limits were found during the whole study.

In the control charts concerning patient satisfaction feedback, the acting and warning limits were crossed several times, more often than with the supervisees and regularly during the course of the study. On wards A and C, the patient ratings of satisfaction tended to fall beyond the warning limits, but on ward D also the acting limits were crossed. An interesting observation was the difference between the staff's assessments on ward D with several crossings of the upper warning limits meanwhile the patients satisfaction feedback showed crossings of the lower acting limits. Most of the crossings of warning and acting limits were found in patient ratings of the item 'assistance with problems'.

The assessments, together with the patient satisfaction feedback on wards A-E, are presented in Figures 4 – 10 (a, b, c) and Tables 18 (a, b, c), including the answers of all those supervisees who participated in team supervision. The figures are drawn based on the original data collected for the control charts during the study, thus describing the reported monthly feedback on the wards. Visual examination of the Figures (Figures 4 – 10 a, b, c) showed that there were differences in how critical the supervisees' monitoring of work was. The figures also evidence the assessment trends and their changes during the study. The supervisees' self-monitoring on ward A showed an improved trend with regard to all the items that were under continuous examination (see also Table 18 a). Amendment was found especially in the assessments of treatment of patients (1/96 mean 8.00, 4/97 mean 8.51, 4/98 mean 8.88) and information, guidance and advice offered to patients (1/98 mean 7.62, 4/97 mean 8.36, 4/98 mean 8.64). However, on ward B, supervisees became more critical during the course of the study with regard to e.g. patient treatment (1/96 mean 8.67, 4/97 mean 8.45) and competence related to one's work tasks (1/96 mean 8.78, 4/97 mean 8.23). The assessments on ward C showed a slightly improved trend in all the items under consideration (figures 4-10 b, Table 18 b). On wards D and E, the assessments remained almost unchanged during the course of the study. The highest assessments (means) of all the participating wards were found on ward E. (Figures 4-10 c, Table 18 c)
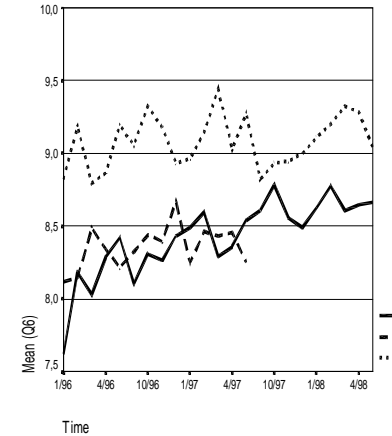
Figures 4-10 a. Continuous assessment of work and patient satisfaction feedback on wards A and B
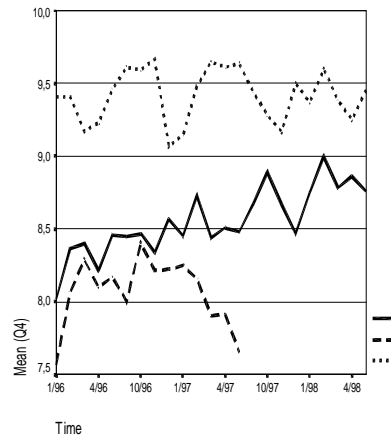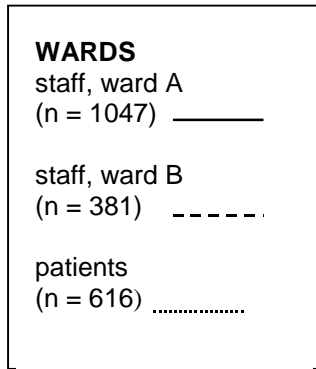
WARDS

staff, ward A
(n = 1047) ———

staff, ward B
(n = 381) - - - -
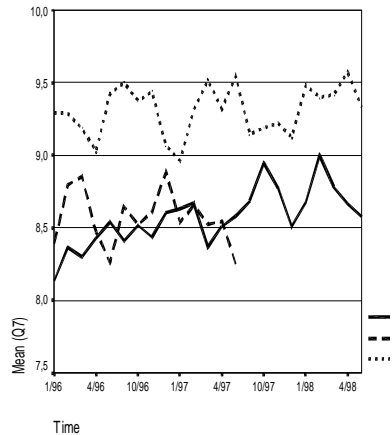
patients
(n = 616) ·············

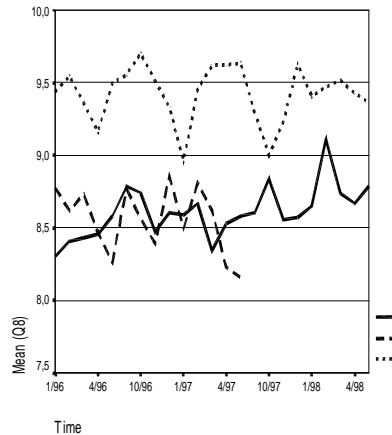4. Patients' overall
satisfaction
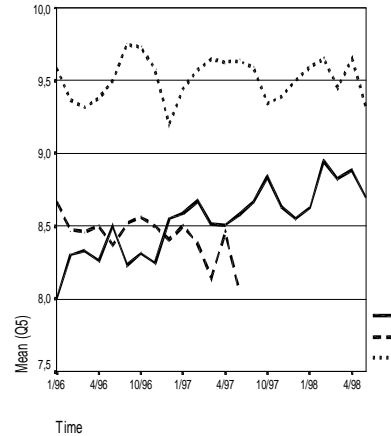
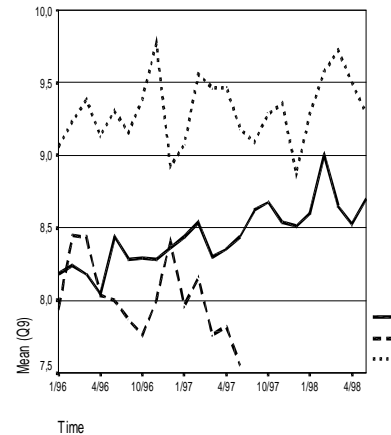5. Satisfaction with patients'
treatment

6. Adequacy of information,
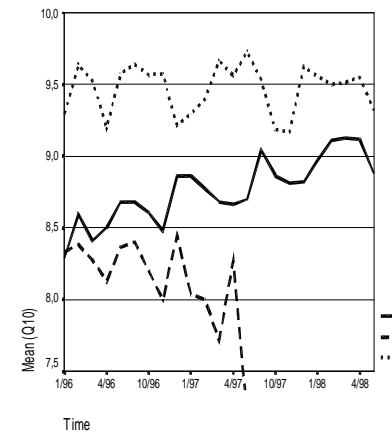guidance and advice

7. Consideration for
patients' opinions and
wishes

8. Competence in relation to
work tasks

9. Contribution of care to goals

10. Smoothness of
collaboration

Table 18 (a). Supervisees' self-monitoring of work and patient satisfaction feedback on wards A and B

Item	Time	Ward A Mean	SD	(n)	Ward B Mean	SD	(n)	Patients Mean	SD	n
1) Patients' overall satisfaction with care	1/96	8.02	.99	(53)	7.56	.81	(16)	9.41	.62	(17)
	4/97	8.51	.70	(53)	7.91	1.34	(22)	9.61	.72	(31)
	4/98	8.86	.56	(43)	-	-	-	9.25	.85	(20)
2) Satisfaction with patients' treatment	1/96	8.00	1.07	(53)	8.67	1.00	(27)	9.59	.62	(17)
	4/97	8.51	.72	(53)	8.45	1.01	(22)	9.63	.61	(32)
	4/98	8.88	.54	(43)	-	-	-	9.65	.59	(20)
3) Adequacy of information, guidance and advice	1/96	7.62	1.24	(53)	8.12	.95	(26)	8.82	1.07	(17)
	4/97	8.36	.71	(53)	8.45	1.10	(22)	9.03	1.15	(32)
	4/98	8.64	.66	(42)	-	-	-	9.25	.78	(21)
4) Consideration for patients' opinions and wishes	1/96	8.13	1.23	(53)	8.39	1.12	(23)	9.29	.92	(17)
	4/97	8.51	.67	(53)	8.55	1.30	(22)	9.32	.87	(31)
	4/98	8.67	.75	(42)	-	-	-	9.57	.75	(21)
5) Competence in relation to work tasks	1/96	8.30	.99	(53)	8.78	.93	(27)	9.44	.51	(16)
	4/97	8.53	.70	(53)	8.23	1.48	(22)	9.63	.66	(32)
	4/98	8.67	.75	(42)	-	-	-	9.43	.81	(21)
6) Contribution of care to goals set	4/96	8.05	.85	(42)	7.94	1.24	(16)	9.06	1.30	(17)
	4/97	8.35	.69	(51)	7.82	1.33	(22)	9.47	1.16	(32)
	4/98	8.52	.63	(42)	-	-	-	9.50	1.04	(18)
7) Smoothness of collaboration	1/96	8.29	1.16	(52)	8.33	1.04	(27)	9.29	.85	(17)
	4/97	8.66	.86	(33)	8.27	1.24	(22)	9.56	.72	(32)
	4/98	9.12	.55	(43)	-	-	-	9.55	1.00	(20)

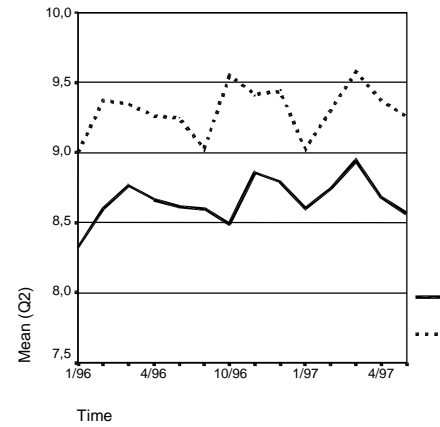Table 18 (b). Supervisees' self-monitoring of work and patient satisfaction feedback on ward C

Item	Time	Ward C Mean	SD	(n)	Patients Mean	SD	(n)
1) Patients' overall satisfaction with care	1/96	8.35	.80	(40)	8.93	1.25	(29)
	4/97	8.68	.75	(19)	9.44	.82	(39)
	4/98	-	-	-	-	-	-
2) Satisfaction with patients' treatment	1/96	8.32	.66	(40)	9.0	1.31	(29)
	4/97	8.68	.75	(19)	9.38	.77	(40)
	4/98	-	-	-	-	-	-
3) Adequacy of information, guidance and advice	1/96	8.26	.75	(39)	8.69	1.34	(29)
	4/97	8.53	.77	(19)	9.03	1.01	(39)
	4/98	-	-	-	-	-	-
4) Consideration for patients' opinions and wishes	1/96	8.31	.66	(39)	9.0	1.39	(29)
	4/97	8.68	.75	(19)	9.28	.92	(39)
	4/98	-	-	-	-	-	-
5) Competence in relation to work tasks	1/96	8.32	.80	(40)	9.04	1.32	(27)
	4/97	8.68	.75	(16)	9.34	.67	(38)
	4/98	-	-	-	-	-	-
6) Contribution of care to goals set	4/96	8.56	.56	(36)	9.19	1.39	(27)
	4/97	8.53	.77	(19)	9.56	.77	(36)
	4/98	-	-	-	-	-	-
7) Smoothness of collaboration	1/96	8.31	1.00	(39)	9.00	1.44	(28)
	4/97	8.68	.75	(19)	9.26	.79	(39)
	4/98	-	-	-	-	-	-

Figures 4-10 b. Continuous assessment of work and patient satisfaction feedback on ward C
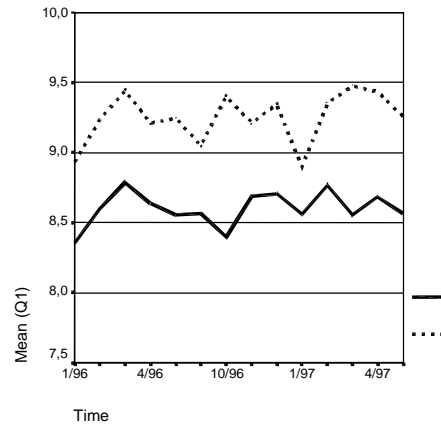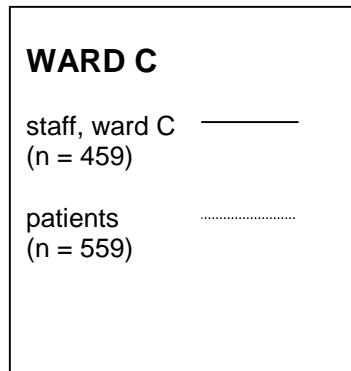
WARD C

staff, ward C ——————
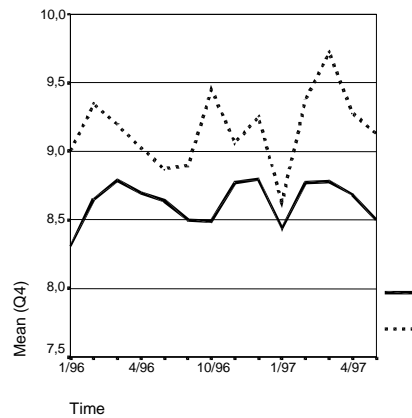(n = 459)

patients ·······················
(n = 559)

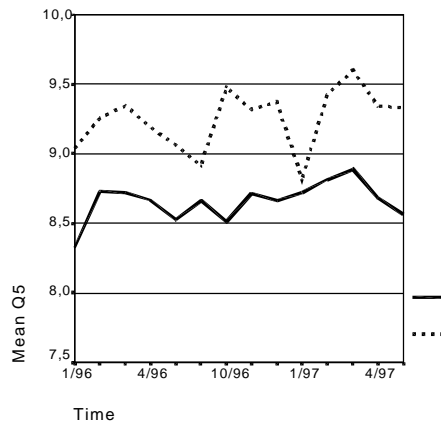4. Patients' overall satisfaction

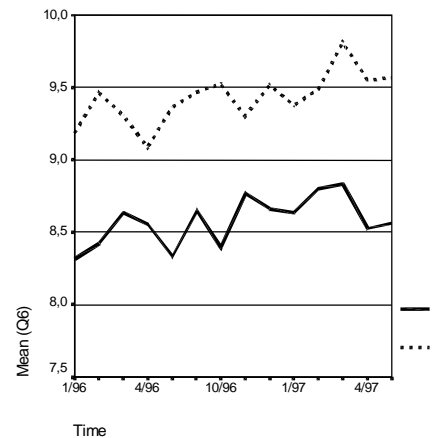5. Satisfaction with patients' treatment
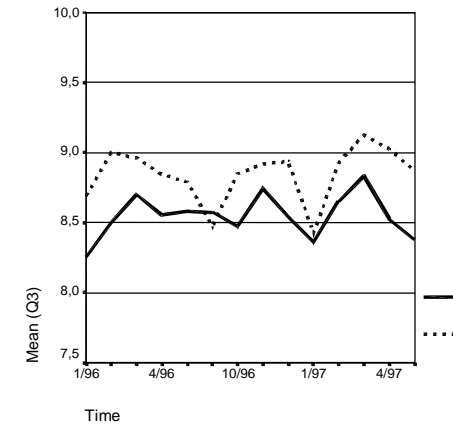
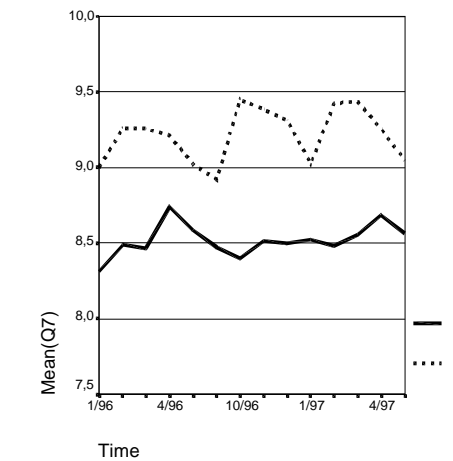6. Adequacy of information, guidance and advice

7. Consideration for patients' opinions and wishes

8. Competence in relation to work tasks

9. Contribution of care to goals

10. Smoothness of collaboration

Table 18 (c). Supervisees' self-monitoring of work and patient satisfaction feedback on the ward D and E

Items	Time	Ward D Mean	SD	(n)	Ward E Mean	SD	(n)	Patients Mean	SD	(n)
1) Patients' overall satisfaction with care	1/96	8.65	.69	(26)	9.46	.52	(13)	9.22	1.06	(18)
	4/97	8.81	.59	(32)	9.43	.51	(21)	9.64	.64	(25)
	4/98	8.63	.69	(35)	-	-	-	9.0	1.18	(11)
2) Satisfaction on patients' treatment	1/96	8.77	.76	(26)	9.31	.43	(13)	9.06	1.63	(18)
	4/97	8.97	.97	(36)	9.52	.51	(21)	9.64	.76	(25)
	4/98	8.86	.55	(35)	-	-	-	9.09	.94	(11)
3) Adequacy of information, guidance and advice	1/96	8.62	.64	(26)	9.23	.73	(13)	8.78	1.44	(18)
	4/97	8.97	.77	(36)	9.38	.50	(21)	9.04	1.33	(24)
	4/98	8.86	.65	(35)	-	-	-	8.82	.98	(11)
4) Consideration for patients' opinions and wishes	1/96	8.77	.71	(26)	9.15	.69	(13)	8.94	1.30	(18)
	4/97	9.19	.75	(36)	9.48	.51	(21)	9.67	.56	(24)
	4/98	8.74	.61	(35)	-	-	-	9.00	1.10	(11)
5) Competence in relation to work tasks	1/96	8.73	.53	(26)	9.38	.96	(13)	9.11	1.13	(18)
	4/97	8.92	.65	(36)	9.45	.51	(20)	9.28	1.21	(25)
	4/98	8.83	.62	(35)	-	-	-	8.82	1.08	(11)
6) Contribution of care to goals set	4/96	8.31	1.03	(32)	9.15	.55	(13)	8.88	1.67	(16)
	4/97	8.61	.90	(36)	9.33	.48	(21)	9.74	.62	(23)
	4/98	8.51	.78	(35)	-	-	-	8.40	1.90	(10)
7) Smoothness of collaboration	1/96	8.15	.92	(26)	8.92	.86	(13)	9.31	1.01	(16)
	4/97	8.67	.83	(36)	9.14	.48	(21)	9.50	.78	(24)
	4/98	8.14	1.24	(35)	-	-	-	8.91	1.51	(11)

Table 19. Supervisees´ self-monitoring of work and patient satisfaction feedback on wards A-E (means, standard deviations, minimum and maximum values)

Items	Ward A (1996-1998) Mean	SD	min	max	Ward B (1996-1997) Mean	SD	min	max	Patients (1996-1998) Mean	SD	min	max
1) Patients' overall satisfaction with care	8.52	.79	5	10	8.09	1.13	4	10	9.42	.76	5	10
2) Satisfaction on patients' treatment	8.49	.82	6	10	8.44	1.08	4	10	9.52	.73	4	10
3) Adequacy of information and advice	8.38	.88	4	10	8.36	1.19	4	10	9.08	1.00	4	10
4) Consideration for patients' wishes	8.53	.85	5	10	8.60	1.19	4	10	9.31	.89	4	10
5) Competence in relation to work tasks	8.58	.79	6	10	8.58	1.05	4	10	9.42	.80	4	10
6) Contribution of care to goals set	8.40	.83	5	10	8.04	1.19	4	10	9.34	1.18	4	10
7) Smoothness of collaboration	8.73	.89	4	10	8.15	1.25	4	10	9.47	.78	4	10

Items	Ward D (1996-1998) Mean	SD	min	max	Ward E (1996-1997) Mean	SD	min	max	Patients (1996-1998) Mean	SD	min	max
1) Patients' overall satisfaction with care	8.69	.68	6	10	9.12	.55	6	10	9.38	.90	5	10
2) Satisfaction with patients' treatment	8.81	.67	6	10	9.25	.56	8	10	9.42	.91	4	10
3) Adequacy of information and advice	8.73	.71	6	10	9.11	.55	7	10	9.04	1.16	4	10
4) Consideration for patients' wishes	8.86	.74	6	10	9.21	.55	8	10	9.29	.96	4	10
5) Competence in relation to work tasks	8.78	.65	6	10	9.15	.63	6	10	9.38	.89	5	10
6) Contribution of care to goals set	8.54	.74	6	10	9.02	.63	5	10	9.31	1.14	4	10
7) Smoothness of collaboration	8.25	1.03	4	19	8.89	.75	4	10	9.37	.89	5	10

Items	Ward C (1996-1997) Mean	SD	min	max	Patients (1996-1998) Mean	SD	min	max
1) Patients' overall satisfaction with care	8.59	.67	5	10	9.26	.89	4	10
2) Satisfaction with patients' treatment	8.64	.64	5	10	9.31	.90	4	10
3) Adequacy of information and advice	8.55	.67	5	10	8.85	1.14	4	10
4) Consideration for patients' wishes	8.62	.64	5	10	9.16	1.07	4	10
5) Competence in relation to work tasks	8.64	.69	6	10	9.26	.88	4	10
6) Contribution of care to goals set	8.56	.63	6	10	9.43	.98	4	10
7) Smoothness of collaboration	8.50	.88	5	10	9.22	1.01	4	10

Figures 4-10 c. Continuous assessment of work and patient satisfaction feedback on wards D and E
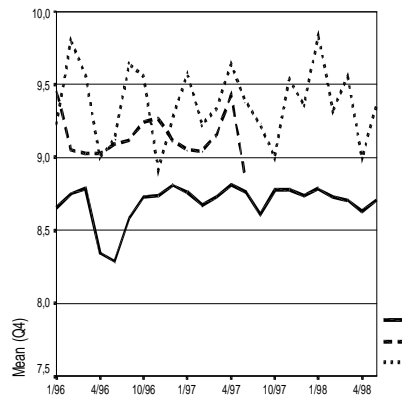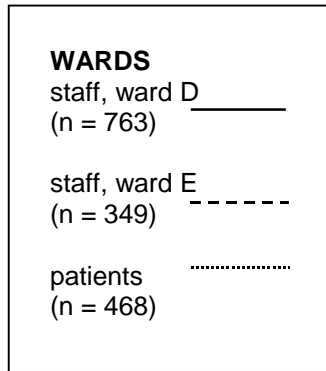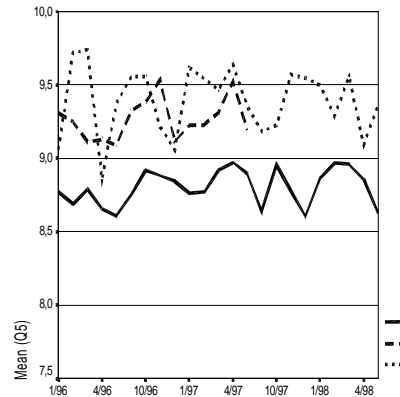
WARDS

staff, ward D
(n = 763)

staff, ward E
(n = 349)

patients
(n = 468)

4. Patients' overal satisfaction

5. Satisfaction with patients' treatment
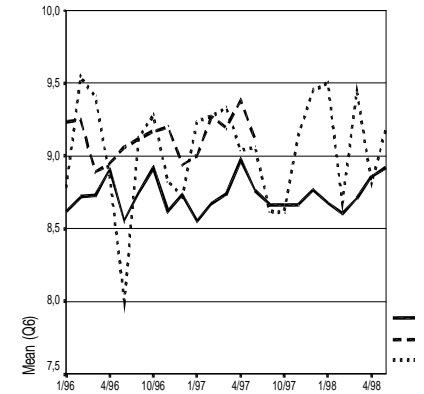
6. Adequacy of information, guidance and advice

7. Consideration for patients' opinions and wishes

8. Competence in relation to work tasks

9. Contribution of care to goals

10. Smoothness of collaboration

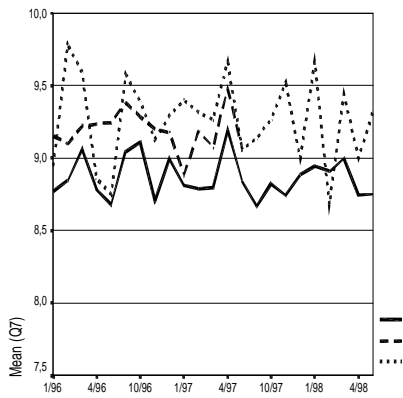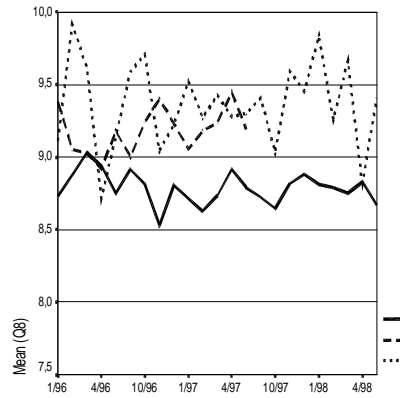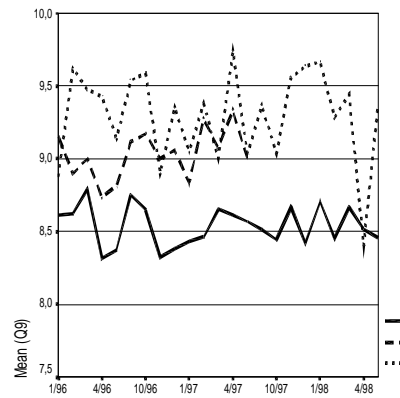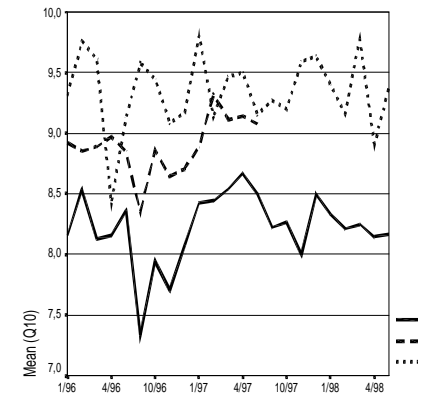An interesting item with respect to continuous assessment, because of the focus of this study, was fluency of collaboration. Examination of Figures (Figures 10 a, b, c) and Tables (Table 18 a, b, c) evidenced differing trends of collaboration in the teams during team supervision. On ward A, the assessments showed an improved trend in collaboration (1/96 mean 8.29, 4/97 mean 8.66, 4/98 mean 9.12). The same trend was found on ward C in the supervisees' assessments (1/96 mean 8.31, 4/97 mean 8.68), and slight improvement was also detected on ward E (1/96 mean 8.92, 4/97 mean 9.14). On ward D, the supervisees' assessments evidenced variation that had occurred in collaboration, but over the time period under study the assessments remained unchanged (1/96 mean 8.15, 4/97 mean 8.67, 4/98 mean 8.14). However, on ward B, a declining trend (1/96 mean 8.33, 4/97 mean 8.27) was found.

The patient satisfaction feedback has been included in Figures 4 – 10 a, b, c and in Tables 18 a, b, c. These data are presented side by side with the supervisees' assessments as the feedback was reported monthly on the wards. Visual examination of the figures evidenced that patients were in general satisfied with the assessed items. The patient satisfaction feedback given was higher than the supervisees' own assessment of work in all the respective items of the questionnaires. However, an exception was found on ward E where the supervisees' and the patients' assessments were equally high. (Table 19)

Visual examination of the Figures 4 – 10 (a, b, c) showed that the trends of satisfaction with care had remained constant during the course of the study. Examination of the means confirmed that only slight changes had occurred (see Tables 18 a, b, c). The figures revealed, however, that the variation in the patients' assessments had decreased on wards A and B. This change was detected with regard to overall patient satisfaction (11/96 mean 9.67, 12/96 mean 9.07, 1/98 mean 9.37, 3/98 mean 9.39) and adequacy of information, guidance and advice (3/97 mean 9.44, 9/97 mean 8.82, 2/98 mean 9.20, 5/98 mean 9.05). On ward C, the variation in the patients' assessments was slight and infrequent during the course of the study. The patients' assessments on wards D and E showed only slightly decreased variation in adequacy of information, guidance and advice (2/96 mean 9.54, 5/96 mean 8.00, 2/98 mean 8.68, 3/98 mean 9.44) and in smoothness of staff collaboration (4/96 mean 8.43, 1/97 mean 9.81, 3/98 mean 9.78, 5/98 mean 9.38). However, in the majority of the assessed items (see Figures 4c, 7c, 8c, 9c), the moderately wide variation continued throughout the study.

The supervisees' answers (n=2005) of the positive and negative factors that had affected their work and also caused some general variation in the practice, focused on the following main categories of (I) culture of collaboration, leadership and mutual interaction, (II) planning and organisation of activities, resources, (III) meetings and flow of information, (IV) factors related to patient care, (V) personal factors, (VI) training, teaching and guidance, (VII) participation in research and clinical supervision. It was also found that some factors (VIII) affected the practice temporarily or changed the current practice, thus causing some special variation in the practice. The current changes were related to the automatic data processing (ADP) system, threat of doctors' strike, the 'evacuation' of the ward's premises during renovation, establishing a new OR or changing a practice because of a new patient care policy. Many of these changes affecting the practice were described by the supervisees on ward D. The main and sub-categories describing the positive and negative factors that had affected the supervisees work are shown in a summarising table and the examples drawn from the different wards are presented in Appendices 5 a-e.

In the patients' answers (n=1265), the positive and negative experiences during the hospital stay differed from the supervisees' descriptions of positive and negative factors affecting their work. In the patients' answers the feedback focused on the following main categories: (I) the staff's competence and jointly created atmosphere, (II) overall quality of care, (III) medical technical care of illness and outcomes of care, (IV) interaction and exchange of information, (V) satisfied needs, changes in everyday traditions and one's values, (VI) hospital environment and its comfort (VII) factors related to the different phases of care process, and (VIII) the level of services and expenses. These factors also caused some general variation in the patients' experiences. Factors that could have been considered the cause for special variation in patient satisfaction did not emerge. The main and sub-categories describing the patients' positive and negative experiences are summarised in a table and examples drawn from the original material are presented in Appendices 6 a-c.

The supervisees' were asked to assess the impact of self-monitoring of work and patient satisfaction feedback in the follow-up inquiries with regard to their effects on the practice and quality of care. These effects were statistically significant on wards B, C and E (inquiry I mean of sum 21.9, SD 5.0 → inquiry III mean of sum 24.9, SD 4.6, p=. 017), but non-significant on wards A and D (inquiry I mean of sum 25.6, SD 4.6 → inquiry V mean of sum 25.6, SD 5.4, p=. 860). However, significant differences (p= .019) existed between the wards. On ward E, supervisees gave the most positive ratings of the impact of self-monitoring of work and feedback (inquiry III mean of sum 27.3, SD 4.6) compared to those on wards C (inquiry III mean of sum 25.9, SD 2.4) or B who had the most critical perception of a poor impact (mean of sum 20.2, SD 4.4) (Table 20). The supervisees' perceptions on wards A (inquiry I mean 6.65 → inquiry V mean 6.75) and D (inquiry I mean 6.03 → inquiry V mean 5.93) during the course of the study indicated that the effect had been moderate.

Table 20. Assesment of the impact of continuous monitoring of work

	Inquiry I mean SD	Inquiry II mean SD	Inquiry III mean SD	Inquiry IV mean SD	Inquiry V mean SD	Total sum	mean
ward B	19.0 4.3	19.0 3.5	20.2 4.4	- -	- -	58.2	19.4
ward C	22.9 4.2	23.7 4.7	25.9 2.4	- -	- -	72.5	24.2
ward E	22.8 6.0	24.9 5.3	27.3 4.6	- -	- -	75.0	25.0
(total)	21.9 5.0	33.9 5.1	24.9 4.6	- -	- -	98.7	32.9
ward A	26.6 4.8	24.6 6.4	24.3 5.2	24.3 5.7	27.0 5.6	126.8	25.4
ward D	24.1 4.0	25.7 4.2	24.3 4.5	24.9 3.7	23.7 4.6	122.7	24.5
(total)	25.6 4.6	25.1 5.5	24.3 4.8	24.6 4.9	25.6 5.4	125.2	25.0

wards B, C and E) statistical significance: between wards .019, factor .017, factor and ward .787
wards A and D) statistical significance: between wards .615, factor .860, factor and ward .232

During the study, a significant change was found by the respondent's age on wards B, C, E, which participated for two years. The youngest respondents were (inquiry III mean of sum 16.5, SD .71, p= .005) significantly more critical of the impact of continuous quality monitoring compared to their older colleagues. On wards A and D, which participated for three years, it was not possible to indicate statistically significant changes by the respondents' background (i.e. age, work experience, time in present post).

The majority of the respondents on all wards reported, however, that they practised 'self-assessment'. The described 'self-assessment' had varying foci, methods and criteria. The foci included the practitioner's own contribution to work, fluency and success of practical actions, but also fulfilment of the needs of patients or of the goals set for care, and the contribution to patients' 'good' and high quality care. The methods of 'self-assessment' varied as well. Supervisees observed, contemplated and compared their own actions with their colleagues' work patterns, discussed with their colleagues, made observations of problematic patient situations or 'listened' to their own feelings. The criteria for self-assessment included the respondent's own criteria for satisfaction with one's own performance, knowledge-base in use and skills, but also fluency of work shift, right and better or wrong ways to operate. The colleagues' opinions and 'common criteria' were also mentioned as criteria.

The other 'assessment method' reported by respondents was 'profit discussions', an official form of assessment, but used occasionally or irregularly. Some respondents perceived that they also utilised 'peer evaluation'. However, the method of 'peer evaluation' was not in systematic or official use on the wards, but some respondents thought that this method was loosely applied in discussions with colleagues. Other methods used by the respondents were 'verbal feedback' (given by e.g. ward managers, patients, students, colleagues and collaboration partners), patient inquiries and 'unofficial' feedback though the grapevine, focusing mainly on managers' dissatisfaction with their subordinates' actions. Respondents assessed that these methods of work assessment were non-supportive of professional development.

To sum up the findings, continuous self-monitoring and patient satisfaction feedback seemed to have impact on supervisees' assessments and work, and some changes were also evidenced in patients' satisfaction. In the supervisees' assessments a positive trend was found, the teams' assessments changed in to a more uniform direction, and the variation seemed to decrease in the patient satisfaction feedback. The supervisees' critical self-monitoring in the beginning approached the patient satisfaction feedback towards the end of the study. It was also found that many positive and negative factors affected the supervisees' and patients' assessments and feedback. The impact was shown especially among the teams and advanced practitioners who performed active self-monitoring and showed interest in feedback data.

5.6. Effects of team supervision described through the organisational factors and on the quality of care

The effects of team supervision were explored from the organisational perspective and on the quality of care using follow-up inquiries. The group interviews were focused especially on describing the effects of the intervention on the quality of care. The following chapter focuses on addressing the fourth study aim (see chapter 3).

During the team supervision intervention, significant changes were found in organisational factors for professional development in the ratings of participatory management style and perceptions of the possibility to influence (see Tables 21-25). Participatory management style (MF1) turned out to be an important and significant factor on wards A and D. During the intervention (I inquiry mean of sum 48.0, SD $\rightarrow$ V inquiry mean of sum 46.1, SD 8.3, p= .003) respondents grew, however, significantly more critical (p= .011) towards the participatory nature of the management style. Supervisees on the ward D (I inquiry mean of sum 41.7, SD 6.3 $\rightarrow$ V inquiry mean of sum 38.6, SD 6.7) were the most critical (p < .001) compared to their colleagues on ward A (I inquiry mean of sum 52.3, SD 4.0 $\rightarrow$ V inquiry mean of sum 51.3, SD 4.4), but also on the other wards (B, C, E).

Significant differences were found between the wards during the intervention with regard to the supervisees assessments of the work's encouragement value, performance-oriented management style and the task and goal systems of work. The assessments of the work's encouragement values (WF1) differed significantly on all the five wards (inquiry III ward B mean of sum 36.3, SD 2.7, ward C mean of sum 41.8, SD 2.7, ward E mean of sum 42.0, SD 3.8, p= .021 and ward A mean of sum 43.9, SD 3.4, ward D mean of sum 39.3, SD 3.2, p= .002). The highest encouragement value was found on ward A and the lowest among respondents on ward B. The performance-oriented management style (MF2) (p< .001) and the ward's task and goal systems (OF2) (p< .001) were also rated differently among the supervisees on wards A and D. The management style was rated as encouraging performance on ward A (inquiry V mean of sum 49.3, SD 5.1) than on ward D (mean of sum 40.6, SD 6.0). However, significant changes were not evidenced in the above-mentioned factors, but the differences between the wards persisted during the intervention. The findings were confirmed with the bulk of supervisees assessments on wards A and D (I inquiry 72.7%, n=16 $\rightarrow$ V inquiry 59.1%, n=13) and wards B, C and E (I inquiry 87.5%, n=21 $\rightarrow$ III inquiry 83.3%, n=20) that their contribution for the ward's functions had remained the same (Table 9 a, b). Supervisees on ward A (inquiry V mean of sum 48.8, SD 3.3) had a clearer vision of the task and goal systems compared to those on ward D (inquiry V mean of sum 41.6, SD 4.4)(Tables 25, 28, 29), but again the significant changes were not evidenced during the intervention and the majority of the respondents assessed (9 a, b) on wards A and D (I inquiry 72.2%, n=16 $\rightarrow$ V inquiry 77.3%, n=17) and also on wards B, C, E (I inquiry 95.8 %, n=23 $\rightarrow$ III inquiry 95.8%, n=23) that their practical facilities had remained the same during the intervention.

Tables 21-25. Prerequisites for professional development: organisational factors

Work's encouragement value (WF1)

	Inquiry I		Inquiry II		Inquiry III		n	Inquiry IV		Inquiry V		n	Total	
	mean	SD	mean	SD	mean	SD		mean	SD	mean	SD		sum	mean
ward B	39.2	3.2	37.8	4.9	36.3	2.7	6	-	-	-	-	-	113.3	37.8
ward C	40.7	2.7	40.4	3.8	41.8	2.7	10	-	-	-	-	-	122.9	41.0
ward E	42.4	2.7	42.5	2.7	42.0	3.8	8	-	-	-	-	-	126.9	42.3
(total)	40.9	3.0	40.5	4.1	40.5	3.8	24	-	-	-	-	-	121.9	40.6
ward A	43.9	3.5	43.5	3.6	43.4	2.9	13	43.4	2.9	43.9	3.4	13	218.1	43.6
ward D	38.4	3.7	40.6	2.6	40.7	2.1	9	39.4	2.7	39.3	3.2	9	198.4	39.7
(total)	41.6	4.4	42.3	3.5	42.3	2.9	22	41.8	3.4	42.0	4.0	22	210.0	42.0

wards B, C and E) statistical significance: between wards .021, factor .512, factor and ward .129
wards A and D) statistical significance: between wards .002, factor .518, factor and ward .176

Possibility to influence (WF2)

	Inquiry I		Inquiry II		Inquiry III		n	Inquiry IV		Inquiry V		n	Total	
	mean	SD	mean	SD	mean	SD		mean	SD	mean	SD		sum	mean
ward B	29.0	4.9	28.2	6.2	26.2	5.8	6	-	-	-	-	-	83.4	27.8
ward C	30.5	5.0	31.5	3.1	32.2	3.3	10	-	-	-	-	-	94.2	31.4
ward E	32.4	3.1	33.0	2.8	33.3	4.1	8	-	-	-	-	-	98.7	32.9
(total)	30.8	4.4	31.2	4.2	31.0	5.0	24	-	-	-	-	-	93.0	31.0
ward A	32.9	4.7	32.7	5.1	32.2	3.8	13	33.5	4.5	33.7	4.1	13	165.0	33.0
ward D	30.9	3.8	31.1	2.6	32.1	2.7	9	31.0	2.8	31.4	3.7	9	156.5	31.3
(total)	32.1	4.3	32.	14.2	32.2	3.3	22	32.5	4.0	32.8	4.0	22	161.6	32.3

wards B, C and E) statistical significance: between wards .077, factor .776, factor and ward .016,
wards A and D) statistical significance: between wards .305, factor .618, factor and ward .137

Participatory management style (MF1)

	Inquiry I		Inquiry II		Inquiry III		n	Inquiry IV		Inquiry V		n	Total	
	mean	SD	mean	SD	mean	SD		mean	SD	mean	SD		sum	mean
ward B	43.0	8.5	41.7	9.2	40.5	7.8	6	-	-	-	-	-	125.2	41.7
ward C	45.8	8.6	46.4	7.4	47.1	6.7	10	-	-	-	-	-	139.3	46.4
ward E	43.5	7.5	42.6	7.3	41.6	5.3	8	-	-	-	-	-	127.7	42.6
(total)	44.3	8.0	44.0	7.8	43.6	7.0	24	-	-	-	-	-	131.9	44.0
ward A	52.3	4.0	50.0	4.9	52.2	3.2	13	51.3	3.8	51.3	4.4	13	257.1	51.4
ward D	41.7	6.3	42.4	4.9	44.9	4.0	9	38.9	6.9	38.6	6.7	9	206.9	41.3
(total)	48.0	7.3	46.9	6.1	49.2	5.1	22	46.2	8.1	46.1	8.3	22	236.4	47.3

wards B, C and E) statistical significance: between wards .344, factor .676, factor and ward .680,
wards A and D) statistical significance: between wards <.001, factor .003, factor and ward .011

Performance oriented management style (MF2)

	Inquiry I mean SD	Inquiry II mean SD	Inquiry III mean SD	n	Inquiry IV mean SD	Inquiry V mean SD	n	Total sum. mean
ward B	43.7 10.3	42.7 11.9	41.2 8.9	6	- -	- -	-	127.6 42.5
ward C	43.9 8.4	44.5 8.1	45.5 6.4	10	- -	- -	-	133.9 44.6
ward E	46.0 5.8	44.5 5.5	44.3 6.7	8	- -	- -	-	134.8 44.9
(total)	44.5 7.9	44.0 8.1	44.0 7.1	24	- -	- -	-	132.5 44.2
ward A	51.3 5.5	48.9 6.1	49.1 6.1	13	49.2 5.0	49.3 5.1	13	247.8 49.6
ward D	42.4 6.5	44.0 3.1	45.2 4.1	9	40.1 6.8	40.6 6.0	9	212.3 42.5
(total)	47.7 7.3	46.9 5.6	47.5 5.6	22	45.5 7.2	45.7 6.9	22	233.3 46.7

wards B, C and E) statistical significance: between wards .804, factor .737, factor and ward .612
wards A and D) statistical significance: between wards <.001, factor .124, factor and ward .078

Task and goal systems (OF2)

	Inquiry I mean SD	Inquiry II mean SD	Inquiry III mean SD	n	Inquiry IV mean SD	Inquiry V mean SD	n	Total sum mean
ward B	43.7 6.1	43.7 8.9	42.2 7.7	6	- -	- -	-	129.6 43.2
ward C	42.7 7.5	43.9 7.6	45.8 4.8	10	- -	- -	-	132.4 44.1
ward E	47.1 5.5	46.1 5.5	48.4 6.3	8	- -	- -	-	141.6 47.2
(total)	44.4 6.57	44.6 7.1	45.8 6.3	24	- -	- -	-	134.8 44.9
ward A	50.9 4.8	48.1 4.5	48.3 4.2	13	49.6 3.3	48.8 3.3	13	245.7 49.1
ward D	44.9 4.2	44.8 4.5	45.3 4.1	9	42.6 6.0	41.6 4.4	9	219.2 43.8
(total)	48.5 5.4	46.7 4.7	47.1 4.3	22	46.7 5.7	45.8 5.2	22	234.8 47.0

wards B, C and E) statistical significance: between wards .425, factor .554, factor and ward .314
wards A and D) statistical significance: between wards <.001, factor .099, factor and ward .089

The participants' perceptions of their possibility to influence (WF2) changed (p= .016) during the intervention on the wards with two-year attendance. The changes were, however, opposite in direction on these wards. Among the respondents on ward C (inquiry I mean of sum 30.5, SD 5.0 → inquiry III mean of sum 32.2, SD 32.2) and E (inquiry I mean of sum 32.4, SD 3.1 → inquiry III mean of sum 33.3, SD 4.1) the number of perceptions according to which there is a possibility to influence increased, whereas on ward B (inquiry I mean of sum 29.0, SD 4.9 → inquiry III mean of sum 26.2, SD 5.8) it decreased.

Towards the end of the intervention the majority of respondents (I inquiry 57.9%, n=11 → V inquiry 73.3%, n=11) on wards A and D described the effects of team supervision in relation to ward operations (Table 10 b). On wards B, C, and E, the effects were described at the end of the intervention approximately by one-third (38.9 %, n=7) of the supervisees (Table 10a.). A closer examination showed that the respondents described the development of ward operations (i.e. clinical practice) from their own perspective, and from that of patient care and the team. Respondents saw the effects of team supervision in terms of a broadened perspective, developed criticality, clarified practice and towards the end of the intervention, in finding one's limitations. Improved flexibility, courage, openness and empathy towards colleagues were emphasised in the initial stage, and during the intervention, developed collaboration and interaction skills,

Table 26. Impact of team supervision on ward operations and the quality of care

	WORKING ON THE WARD	QUALITY OF CARE
INITIAL STAGE OF CS	BROADENED PERSPECTIVE ON ONE'S WORK ON WARD - increased flexibility, courage to express one's opinions, openness and empathy towards colleagues - more brisk and composed approach to work - new perspectives and increased awareness of the big picture PROBLEMS AND NEGATIVE EFFECT - increased carefulness because of observation by others - indulging in personalities and offensive criticism of absent colleagues CONSIDERING WARD ENVIRONMENT IN CARE - increased consideration for patients' needs CHANGES IN TEAM PRACTICES - clarification of collaboration between different occupational groups - change sin jointly agreed upon practices - changes in division of labour and responsibilities PROBLEMS AND NEGATIVE EFFECT - occasionally chaotic situation on ward after Cs	EMERGENCE OF FACTORS RELATED TO AND AFFECTING QUALITY - thoughts provoked by reflection about development needs and opportunities - interest in quality improvement and seeing quality-related issues PATIENT-ORIENTATION - deeper examination of patient issues - improved approach to patients OPENNESS OF TEAM - relief among team members caused by talking about problems out loud - effect of change in working climate on quality of care PROBLEMS AND NEGATIVE EFFECT - difficulty in grasping the association between CS and quality - feedback received not utilised properly - economy measures have the greatest impact on quality
INTERMEDIATE STAGE OF CS	CRITICAL ATTITUDE TOWARDS ONE'S WORK ON WARD - improved ability to collaborate, interaction skills and openness, increased critical attitude - unburdening of one's mind and improved tolerance for stress through increased acceptance of human diversity and resistance PROBLEMS AND NEGATIVE EFFECT: - adding to division and anxiety - increased carefulness due to severe criticism - disappointment caused by unchanged work patterns and lack of improvement EFFORTS TO DEVELOP JOINT TEAM PRACTICES - increased joint discussions about problems and their solutions with an understanding of and consideration for different perspectives PROBLEMS AND NEGATIVE EFFECT: - strained human relations	QUALITY IMPROVEMENT EFFORTS - concrete instructions concerning treatments and operations - noticing defects and 'pulling oneself together' despite haste DEEPENING OF PATIENT-ORIENTATION - increased attention to patients as a whole and emergence of individual needs - attention to treatment of patients and improved attitude toward clients - courage to tackle and manage difficult relationships with others and patients or to ask for help DEVELOPMENT OF TEAM'S OPENNESS - increased openness in work and discussion, shared goal, 'pulling together' and decrease in quality fluctuations PROBLEMS AND NEGATIVE EFFECT - CS focused on employees' problems, not on patients or caring - variations in quality and occasional 'setbacks' - less time for work and increase in patient numbers
END STAGE OF CS	CLARIFICATION OF ONE'S WORK ON WARD AND FINDING ONE'S LIMITATIONS - increased flexibility and permissiveness, decrease in pointless 'nitpicking' - clarifies, broadened job pictures and increased efficiency - finding one's limitations PROBLEMS AND NEGATIVE EFFECT - haste because of work hours spent in CS PATIENT-ORIENTED WARD OPERATIONS - increased discussions about care plans and solutions DEVELOPMENT OF TEAM FUNCTIONALITY, CONSOLIDATION OF PRACTICES - increased knowledge of colleagues, flexibility and better delegation of work in the group - more open discussion, reflection and joint decision-making to change routines, to reinforce the rules of the game and to arrange practicalities PROBLEMS AND NEGATIVE EFFECT - one's own and others' limitations found through struggles	CRYSTALLISATION OF QUALITY DETERMINANTS AND RELATION TO CHANGE SITUATIONS - clarification of issues - increased critical attitude towards quality in change situations PROBLEMS AND NEGATIVE EFFECT - scarce attention to problems in patient care - decline in quality because of stimulated operations, changes; improvement in quality because of relaxed economy measures CONSOLIDATION OF QUALITY IN OPEN TEAM OPERATIONS PAYING ATTENTION TO MAINTENANCE OF WORKING CAPACITY - effect of freer and improved climate on quality - quality improvement through increased attention to maintenance of working capacity - more even quality

but also an increasingly critical attitude were described. Respondents reported that they were able to express their feelings freer, and that their tolerance for stress had increased through improved acceptance of resistance and diversity. The actual work was described as more composed and relaxed due to the new

perspectives and enhanced grasp of the whole. Towards the end of the intervention, supervisees saw that their broadened views of work became clearer, thus adding to efficiency. (Table 26)

The effects of CS on working on the ward were described from the perspective of patient care as consideration for the ward environment and for patient-centred clinical practice. In other words, an effort was made to consider patients' wishes during their stay on the ward, including discussions about care plans and care solutions. From the team's perspective the effects were described as developed, established and strengthened operational practices. A closer examination of the answers showed that at the beginning of the intervention, collaboration between the different professional groups was clarified and procedures were changed as a result of increased and developed discussions accompanied with common decisions. Changes occurred, as well, in the division of labour and responsibility. Respondents described towards the end of the intervention that getting to know one's colleagues better and flexibility improved the delegation of tasks in the teams. Improved communication and decision-making had also promoted change in the routines in terms of consolidation of 'the shared rules of the game' and organisation of day-to-day practice. However, several problems and negative effects were described as well. Increased observation of practice, experiences of heavy critique and debates during team supervision had made some supervisees more cautious about their colleagues. Increased tension in relationships was also described. Some respondents had even felt that team supervision had increased their anxiety, that the experience had occasionally been destructive and caused an occasional chaos on the ward because of inflamed feelings. (Table 26)

As experienced by respondents, the effects of team supervision on the quality of care were most difficult to describe. On the wards with two-year attendance in the intervention, only one-third (33.3%, n=5), and on those with three-year attendance less than half of the supervisees (43.8% n=7) described the effects (Table 10). The respondents' answers showed that the identification of the factors related to and affecting the quality of care had occurred through team supervision followed with improved actions and crystallisation of the factors that were related to transition situations. The development of a patient-centred approach to care and sincerity in teams with attention to its members' working capacity, thus improving the quality of practice, were described as effects of team supervision on the quality of care. (Table 26)

A closer examination of the answers showed that at the beginning of the intervention, team supervision promoted the identification of needs and possibilities for developing the practice and thus the quality of care. It was seen that the intervention awakened interest to improve the quality of practice from a new perspective. For example, concrete directions for specific treatments or surgical procedures were collected in a manual-type folder. Respondents described that the defects of care were perceived more clearly and that the practice was sharpened regardless of haste. Towards the end of the intervention, the factors affecting the quality were exposed more clearly and respondents had come to see transition phases as turning points for the quality of services, requiring a critical attitude. The patient-centred approach was described as a deeper insight into patients' concerns, and as a more comprehensive and individual attention to patients' needs with intensified emphasis on treatment and attitude. It was also seen that team supervision had provided courage to confront and manage difficult relationships with colleagues and patients. The effects of team supervision on quality of care were described in the team at first as increased sincerity thus enhancing the members' freedom of expression and non-discriminatory atmosphere. The goals and common

efforts for achieving them were shared in the team and it was seen that together these decreased the fluctuation in quality. Towards the end of the intervention, respondents felt that the quality had improved through increased attention to and support for strengths in the team. The problems and negative effects pointed out were the difficulties of linking the intervention with the quality of care and the problems in utilising the supervisees' self-monitoring of work and patient satisfaction feedback. Respondents also contemplated the focus of the team supervision sessions, which was more often seen as an examination of the team members' problems than the patient or care related issues. It was felt, however, that the quality of services and its variation were related to the economic cutbacks in resources, changes in care policy and haste rather than the team supervision intervention. (Table 26.)

The team perspective on the effects of team supervision on the quality of care
The groups examined the relationship between team supervision and the quality of care from two different perspectives: (a) what (who) makes quality and (b) what the quality of care is like. The following categories were found (1) knowledge as the basis for the quality of care, (2) the effects of change on the quality of care, (3) 'team and its members as providers of quality'.

Knowledge as the basis for the quality of care
In three of the five wards (A, B and C) different conceptions of knowledge as the basis for nursing quality emerged. The conceptions formed four categories, which were hierarchically inter-related. The highest category level comprised conceptions according to which knowledge was jointly produced as 'our shared knowledge'. The shared and collective knowledge was the basis for nursing quality. The interviewees perceived that within the team the shared knowledge was a question of similar or rather of uniform properties of care, for example, while making decisions on patient care. In this category the interviewees shared a perception that team supervision had contributed to the development of shared knowledge. The following example represents these conceptions expressed in one of the teams.

Example 26 (ward A)
Interviewee M: 'Although we've always been able to discuss everything... These sessions (of CS) helped us to express our views more freely... We acquired a certain courage to say what we think'...
Interviewee V.: 'Exactly...It has been better'...
Interviewee H.: 'If you compare... we've made decisions about certain lines of action and discussed these things before... but now we make decisions and commit ourselves to a line of action. We plan things together'...
Interviewee A: 'Here (in CS) we've been able to deal with one thing at a time at a deeper level than in ordinary coffee table conversations. We are able to give reasons from different points of view'...
(some comments excluded)
Interviewee A: 'And these common agreements... form the basis for what we are striving at'...
Interviewee H: 'All the things that were discussed during CS had some effects on the quality of care. If we reach common consent or accomplish something...it's bound to have an effect on the quality of care!'

The conceptions that represented the next level focused on 'our knowledge'. Interviewees perceived that the knowledge as the basis for the quality was not developed or used jointly in practice, but available in written form, as instructions, and as such accessible to all team-members. The conceptions were that knowledge in

written form, including patient feedback, formed the basis for the quality of care. Interviewees perceived that assembling information into written form as instructions was partly enhanced by the issues that had emerged during team supervision. The next extract from one team interview describes this level of conceptions.

Example 27 (ward C)
Interviewee V: 'I see CS and work as totally separate things... I've never noticed any association between the quality of care and CS'...
Interviewee T: 'But what about the folder we started to do?'...
Interviewee K: 'You mean the black one?'...
Interviewee T: 'This is also a way of bringing unity into our action... the desire to develop our action and have something in black and white'...
Interviewee V: 'Well, sort of, yes... it's impossible to notice everything when you do it on a daily basis!'
Interviewee K: 'Critical thinking and pulling together, that's what we need'...
Interviewee T: 'I've been thinking... We could have minimum criteria and if we succeeded in fulfilling them... at least it would show that there's some sort of quality... plus the way the patient sees it'...

The next level comprised conceptions of 'my knowledge', representing a narrower category than the two categories presented above. Interviewees perceived that individual knowledge combined with patient feedback formed the basis for quality of care. The role of team in developing shared knowledge was unclear or minor, because fear of conflict or hesitation prevented discussions about quality related 'right or wrong' strategies with team members. The interviewees' conceptions were tinged with doubts about team supervision having any contribution to the quality of care since most of these issues had been purposefully ignored during the sessions. Example 28 is part of the group interview in which these conceptions emerged.

Example 28 (ward C)
Interviewee N: 'patient feedback suggested that our quality of care was rather good, didn't it?'
(some comments excluded)
Interviewee T: '...we had no courage to tackle things.'
Researcher: 'No courage?'
Interviewee T: 'To discuss these things in CS would have meant war!'
Interviewee N: 'You have so many different characters in a lot like ours... all sorts of conflicts arise... twenty people doing the same job in different ways... and how to combine these ways... that's the trick'...

The next level was formed of conceptions according to which theoretical knowledge was of importance to the quality of care. Interviewees perceived that theoretical knowledge was distributed and available to all team members. However, the team's role in processing and developing shared knowledge such as examining the implications of the applications in practice were not considered important. The interviewees' conception of the importance of knowledge developed through experience indicated denial. In this category experience was associated with age and, in a negative tone, with the quality of care. The interviewees' perceptions of team supervision and its effects were negative as well. Example 29 describes these conceptions.

Example 29 (ward B)
Interviewee N:'CS contributed nothing to work... if anything, it should contribute to the mental side... and to coping... we've got loads of training already... and people inform us of the training they attend and in my opinion CS has done nothing to guide our work...
Interviewee K: 'I agree ... everything remained the same...
Interviewee U: 'Well, if you have many old workers set in their ways... unable to transform ...CS might do them good...

The lowest category level comprised conceptions according to which it was not even possible to define the quality of care and its essence. This was seen as a result from the fact that each individual perceived the care, its goals and purpose differently. In this category the patient's viewpoint was emphasised, though in narrow terms, since respondents perceived that patients lacked knowledge of the field. The impossibility of a common knowledge base, of its development or even of discussing matters was emphasised. Example 30 represents this level of the category.

Example 30 (ward C)
Interviewee V: 'I think it's terribly hard to define what the quality of care really is'...
Researcher: 'Tell me about it...
Interviewee V: 'The question about the quality of care (continuous quality assessment of care associated with CS) was really daft... that's what I think... The care is good and the patient says it's good, and still it can be rotten...
Interviewee T: 'But that's his view!'
Interviewee V: 'Yes but that's the point... you define your work differently from the way I do... and then there's the patient'....
Interviewee K: 'But this means that different viewpoints are bound to come out'.
Interviewee V: 'And then there's the patient's view...the patient cannot understand it no matter how you try!'

The effects of change on the quality of care

Change and its impact on the ward's action and on the quality of care were reviewed in three team interviews out of five (wards B, D and E). These topics had been discussed during the team supervision sessions. The conceptions that emerged were hierarchically inter-related and formed categories which differed in how change was perceived and what its relation to the quality of care was.

The conceptions falling into the highest category level concerning the implications of organisational changes for the quality of care were real and linked to daily work. The conceptions were tinged with concern and fears of the deterioration of quality of care. Matters deteriorating the quality of care had been tackled in team supervision and concrete measures to mend the situation, including the direction of change, were also addressed, as the example 31 shows.

Example 31 (ward E)
Interviewee E: 'I don't know about quality management... the pace the doctors insist on is terrible (= in quantitative terms)... everything has to be done without a break... there might be more such doctors... the quality of care is bound to suffer from it ... there's no time left for the patient …
Interviewee H: 'I've never heard of any complaints because of the staff's attitude or conduct…
(some comments excluded)
Interviewee P: 'If we talk about the quality of care, the patient has always been number one on our ward … everything revolves around her…
Interviewee H: 'The profitability measure made by the hospital showed it was well above average, but there's always room for improvement and you cannot be lulled into thinking that everything is going great'

The conceptions that change is the basis for the development and quality of care formed the next level. The interviewees' conceptions indicated that the change originated in administrative bodies and that it was their duty to response and adapt to extrinsic demands. Team supervision was perceived as part of the change but also as a way to try to deal with issues brought about through other changes. This level of the category is represented by example 32.

Example 32 (ward D)
Interviewee S: 'We've had many changes and we've made effort to develop care... and the whole staff has been enthusiastic about it... I wish some things would remain as they were at least for a bit ... instead of continuous changes...(break)
Interviewee S: 'The amount of work... the increase in the number of patients... while some parties constantly come up with new ideas... it's fine but it's hard for us ... this continuous change...
Interviewee A: 'One thing about these changes... they come from above, and we're supposed to respond... how can we respond to these changes?'...

The lowest level comprised conceptions concerning the connection of administrative decisions to the quality of care. The change was seen in a negative sense, not as a starting point for development but initiated from administration. The changes and their effects on the quality of care had been examined in team supervision. Interviewees described how these topics had been reviewed and criticised, but without making any interventions in practice, and no initiatives or decisions about modifying strategies for practice were taken in the team. Interviewees perceived that a team had limited, if any means to influence administrative decisions. This is shown in the next example.

Example 33 (ward B)
Interviewee S: 'We do think about it constantly... It has no relation whatsoever to CS... or to the employer being supportive of our high-quality work... they mopped the floor with us for spending more on surgical supplies than last year... but we also operated on a larger number of patients than before...
Interviewee U: 'Many valuable things emerged... but CS is not the place for decision-making... about changing this or that strategy... Everything was left hanging in the air, so that if we came up with good ideas... they never came true...
Interviewee N: 'We do think about the quality, about what's best for the patient... but how long can this continue when the employer insists on economy measures'...

'Team and its members as providers of quality'
The conceptions of a team and its members as producers of the quality of care emerged in three out of five group interviews (A, B, D). The conceptions formed hierarchically inter-related categories with a difference in the extent to which the collective was assumed to influence nursing quality. The highest category level was formed of interviewees' conceptions that 'we as a team are producers of quality'. Interviewees perceived that quality was the product of a team, the members of which had first processed and decided jointly what it is. The conceptions suggested that team supervision had contributed to this process in the team. Example 34 describes this category of conceptions.

Example 34 (ward A)
Interviewee S.: 'Decisions are more effective with more people present... on the ward it's impossible to get everybody together... we do decide that this would be good but we cannot put it into practice... and things never go further'...
Interviewee M: '...and the most important thing was that we were all present. On the ward, somebody always leaves the coffee Table and the discussion remains unfinished. This time everybody heard everything... it's almost impossible to arrange such conditions on the ward'...
Interviewee S: 'And here more people wanted to take a stand, it's all up to you'...

The next level was formed of the conceptions according to which a group is the producer of quality. The interviewees' perceptions were that quality was the product of a group performing the same tasks, in a similar way. In this category the interviewees' perceptions indicated that the features of quality were not processed collectively, but the commonly held notions of quality were jointly accepted and an effort was made to put them into practice. The conceptions suggested that this was not realised during team supervision. The next example 35 describes this category.

Example 35 (ward D)
Interviewee A: 'It would have been great... if the themes of the training... would have served as the themes for the next CS session... we should have carried on with them'...
Interviewee K: 'And this brings us back to ourselves again... it's up to us... we failed to introduce them into the discussion'... (break)
Interviewee K.: 'We failed to discuss the different ways to perform the same tasks...we've tried to find a common line... everything is linked with quality...

In this material, the lowest category level comprised conceptions that an individual is the most important factor producing the quality of care. The interviewees' perceptions focused solely on the individual worker and his or her inference of what the quality is. The interviewees' conceptions suggested that team supervision may have supported the individual in this, as the following example shows.

Example 36 (ward B)
Interviewee K: 'CS does affect quality'...
(some comments excluded)
Interviewee U.: 'Quality and the work you do are solely up to you... it sort of affects our mental coping... it depends on your state of mind... then everyone does a better job'...

To sum up the findings of the <u>follow-up inquiries</u>, the supervisees attitude towards the participatory management style of ward managers became more critical. It was not possible to show the development of or changes in the other organisational factors under study in this research. The effects of team supervision on ward operations focused on the supervisees, patient care and the teams. The supervisees' own work on the ward developed through a broadened and clarified standpoint on practice, developed criticality and through finding one's limitations. The effects on the care took the form of increased attention to the ward as a care environment and to patient centred care. In the teams the effects on working on the ward were seen as developed, established and strengthened practices. The effects of team supervision on quality of care were found difficult to specify. In the <u>group interviews </u>the effects on the quality of care were found to focus on

developed, shared and collective knowledge, which formed the basis for quality of care. The common knowledge seemed to be the result of a fusion of the supervisees' own experiences, individual and theoretical knowledge including spontaneous feedback from patients. It was found that the effects of change appeared to be turning points with regard to the quality of the care provided. It was also found that the quality of services was produced together, that it required contribution from every member of the team, but also common definitions of and agreement on common lines.

5.7. Summary of the results

This study focused on describing the effects of team supervision on teams, among its individual members, from the perspective of organisational factors and on the quality of care. Figure 11 presents a summary of the findings indicating the impact of the team supervision intervention.

The development that was evidenced during the team supervision intervention took the form of improved functionality and commitment to work and organisation in the teams. The changes as assessed by the supervisees' confirmed that the effectiveness of teamwork had improved. The effects of team supervision that were found in relation to team materialised in the supervisee's changed, closer and more interactive relationships with their team and between their colleague team members that had grown more mature with social interaction. The changes that had occurred in supervisees' human relations focused on attitudes towards others that had become more flexible and thus the interaction had improved as well. The teams themselves provided, however, an additional perspective on the effects of the team supervision intervention within the teams. The effects that were found in the teams focused on the evolving feelings of togetherness and communication between the team members. Further effects were the developed relations between the team members that formed the basis for coherence within the team and the team's evolved working methods (i.e. decision making, common discussions, concrete actions) that had an impact on work motivation within the team and among its individual members.

Among the individual team member, it was not possible to show the development of the professional factors under study during the team supervision intervention. However, deepening of the supervisees' self-awareness was evidenced. The effects of the intervention on the supervisees' themselves were seen as the development of a more positive and permissive scrutinising, open and relaxed attitude towards one-self. The other important effects were that team supervision had initiated the processing and matching of working manners of individual supervisees' and their colleagues, integrating this with the patient-centred approach in care and thus contributing to managing work situations in a more organised and efficient manner.

The teams' perspective on work showed that the basis of nursing care was patient-oriented functioning, mutual decision making and common agreements. The effects of the intervention were related to clarification of the nature of nursing care within the teams, mentioned above The findings showed that the need for clarification was closely related to existing pressures of change and demands for developing the practice. The effects of the intervention found within the teams showed that clarification had also occurred in the supervisees' own relation to work, in other words, in relations to patients, colleagues and team. The study indicated that the individual work patterns within a team had realised, but the necessity for some sort of

common policy guidelines was also noted. Within the teams the different sources of knowledge for work (i.e. colleagues, courses, literature) were realised during team supervision.

The findings of this study showed that education and development at work were deemed extremely necessary. The in-service education within and outside the organisation was versatile and served the practitioners' diverse, but essential needs in their everyday practice. During the team supervision intervention, however, changes in educational needs or plans for professional development were not evidenced and the supervisees themselves found it difficult to specify any particular educational needs initiated by the intervention.

The findings evidenced the impact of continuous self-monitoring and patient satisfaction feedback. This was materialised in the form of a positive trend in the supervisees' assessments, through the teams' assessments that changed in to a more uniform direction, and especially in the form of decreased variation in the patient satisfaction feedback. The supervisees' critical self-monitoring in the beginning approached the patient satisfaction feedback towards the end of the study. The findings showed that mainly different positive and negative factors had affected the supervisees' and patients' assessments and feed back. The impact described above was shown among the teams and advanced practitioners who performed active self-monitoring and showed interest in feedback data.

During the intervention, the supervisees became more critical of the participatory management style of ward managers. However, it was not possible to show the development of or changes in the other organisational factors under study in this research. The effects of team supervision on ward operations focused on the supervisees, patient care and the teams. The supervisees' own work on the ward developed through a broadened and clarified standpoint on practice, developed criticality and through finding one's limitations. The effects on the care took the form of increased attention to the ward as a care environment and to patient centred care. In the teams the effects on working on the ward were seen as developed, established and strengthened practices.

The supervisees found it difficult to specify the effects of team supervision on quality of care. However, within the teams the effects were found to focus on developed, shared and collective knowledge, which formed the basis for quality of care. The common knowledge seemed to be the result of a fusion of the supervisees' own experiences, individual and theoretical knowledge including spontaneous feedback from patients. The finding showed that the effects of change appeared to be turning points with regard to the quality of the care provided. It was also found that the quality of services was produced together, that it requires contribution from every member of the team, but also common definitions and agreement on common lines (i.e. standards).

The findings showed, however, that during the team supervision intervention several challenges and difficulties emerged within the teams and in relation to the intervention. The implementation of the team supervision intervention was not without problems, and especially the supervisees' participation in the sessions was complicated by restrictions caused by work shifts, lack of substitutes on the wards, high number of patients and other duties on the ward or in the organisation. In other words, it is possible to claim that the factors related to the organisation and practical arrangements for CS slowed down the progress and obscured the effects.

TEAM PERSPECTIVE

SUPERVISEE

Closer interactive relations between team members

* feelings of togetherness
* improved communication

TEAM

Improved functionality, effectiveness of team work commitment to work and organisation

WORK
elaborated methods

SUPERVISEE'S PERSPECTIVE

SUPERVISEE
increased self-awareness

increased processing and matching of work related issues

* different work patterns
* colleagues as sources of knowledge

clarified relation to work

TEAM

clarification of the nature of work

WORK
integrated patient centred approach

ORGANISATIONAL PERSPECTIVE

SUPERVISEE
limitations found

critical attitude towards participatory management style

widened, clarified standpoint and critical perspective on practice

TEAM

developed, established, strengthened practice

PRACTICE
WORK
patient centred care
ward as a care environment

TEAM SUPERVISION
CONTINUOUS MONITORING OF WORK
PATIENT SATISFACTION FEEDBACK

Effects of team supervision on the quality of care
- shared and collective knowledge as a basis for quality
- managing changes, turning points for the quality
- quality is produced together, and thus definitions of and agreement on common guidelines are required
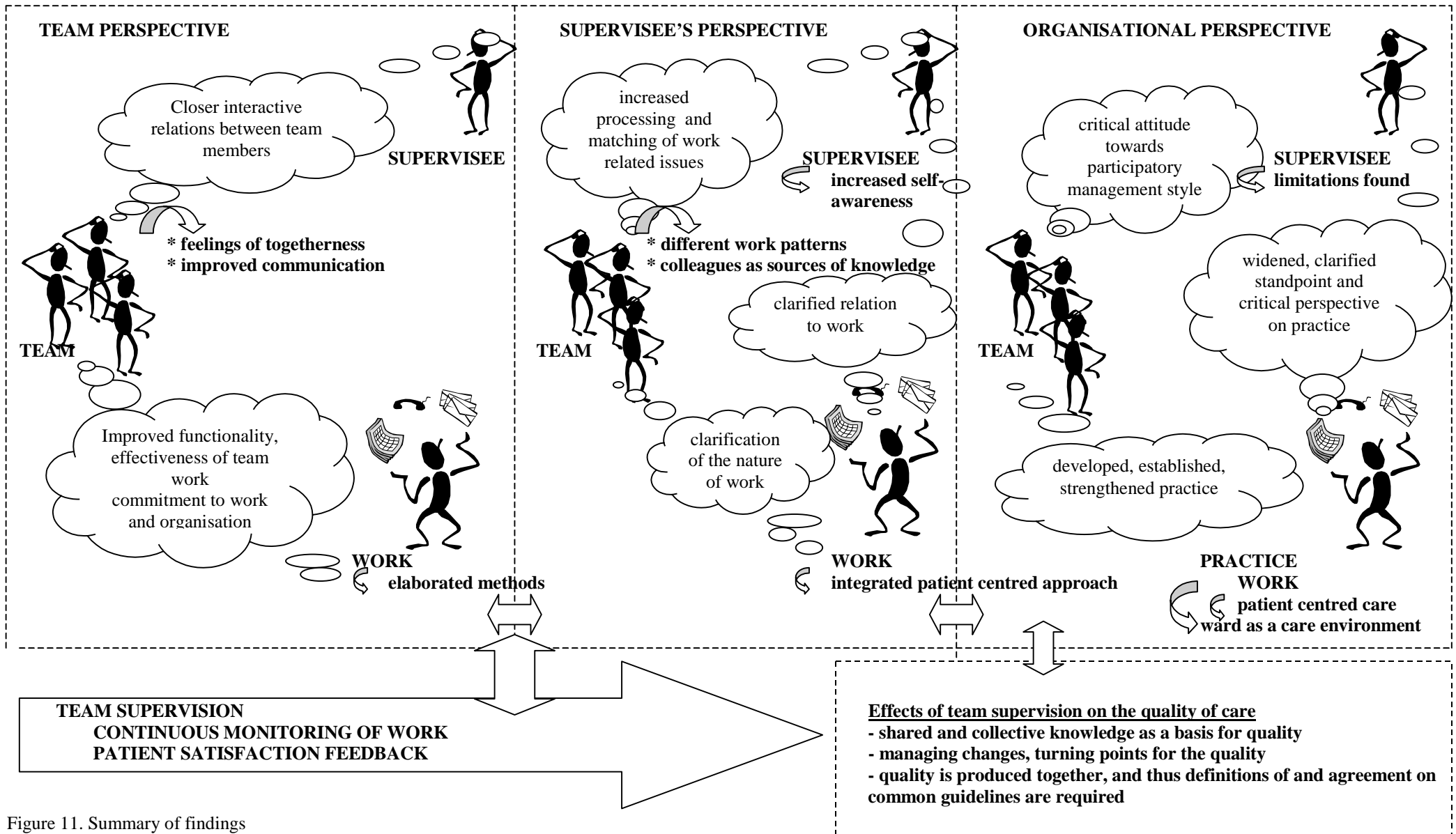
Figure 11. Summary of findings

The wards that participated in this study were different by their speciality, number and background of the staff. The findings showed that several significant differences existed between the teams. It was, however, considered interesting and important to report them both in quantitative and qualitative terms because of the richness they brought in the study, but because these also described the different group processes that occurred during and in relation to the intervention.

6. DISCUSSION

6.1. Validity and reliability of the study

In a study of a treatment or intervention, it cannot be determined with a complete certainty that the changes or development in dependent variables are accounted for by the intervention (e.g. Polit and Hungler 1997). The issues of validity and reliability thus warrant profound consideration. However, since triangulation, the combination of qualitative and quantitative research methods and of data collection methods, was used in this study, it was necessary to discuss the findings from both perspectives but also as a unity. This was rendered possible based on Lincoln and Cuba's (1985) and Merrick's (1999) studies which have presented the parallels of validity and reliability in quantitative and qualitative research. Internal validity is an important issue in an intervention study, that is, the extent to which the effects are a true reflection of reality (i.e. intervention) rather than effects of extraneous variables. Several threats to internal validity have been identified, such as: history, maturation, testing, instrumentation, selection bias and attrition (e.g. Polit and Hungler 1997). In qualitative research internal validity has been seen to parallel credibility (Lincoln and Cuba 1985, Merrick 1999). Construct validity in the studies of CS (see Ellis et al. 1996, Tsui 1997, Hyrkäs et al. 1999a) has been found important in terms of considering aspects or arrangements that are responsible for or indicate the intervention effects such as pre-operational explication and definition of key constructs, instruments, frequency of operations and variety of methods in use. In qualitative research the issues of confirmability are discussed (Lincoln and Cuba 1985, Merrick 1999). External validity is concerned with the extent to which it is possible to generalise the findings beyond the study, across populations over time, setting and people (e.g. Polit and Hungler 1997). External validity parallels to transferability in qualitative research (Lincoln and Cuba 1985, Merrick 1999). In the studies of CS the threats to external validity have been related to internal validity through interaction of selection, settings and history in the intervention (Ellis et al. 1996).

Internal validity
Threats to internal validity in terms of history refer to events taking place during the intervention that have to be taken into account in the results. In the studies of CS this threat has been considered important to address (see e.g. Ellis et al. 1996, Hyrkäs et al. 1999a) because of the process–like nature and long duration of the intervention. The longer the intervention is, the greater the possibility of major unexpected events or changes, impossible to control in a study. On the wards that participated in this study, a number of changes

occurred during the intervention, such as the establishment of an out-patient follow-up service on ward, and the establishment of a new operating theatre, new care policy and division of labour. These events may have affected profoundly the supervisees' work situation and the collaboration within teams in terms of uncertainty, decreased effectiveness and increased conflicts (see e.g. Johnson and Johnson 1997). However, it was possible to describe these significant events and changes accurately and with sufficient precision using the supervisees' weekly assessments of the factors that had affected their work.

In the earlier studies of CS, the small sample sizes have been criticised by Ellis et al. (1996), Tsui (1997) and Hyrkäs et al. (1999a). In this study the number of participating supervisees was 82 at the beginning of the intervention and the participants represented six different professional groups. However, the common difficulty of longitudinal studies, also called attrition, occurred during the study (see e.g. Polit and Hungler 1997). The number of respondents, and at the same time participants in team supervision, decreased for several reasons and the dropout rate varied between 27 – 40% by wards (see Table 2). The 46 respondents who had participated actively in the inquiries and the supervision sessions produced the quantitative data for this study. These respondents represented, however, only nursing professionals of different degrees and the original goal of examining multi-professional team supervision groups failed to materialise.

The critics of earlier CS studies (Tsui 1997, Hyrkäs et al. 1999a) have remarked that only a few have taken into account the interactive dynamics of supervisory relationship or involved patients or clients in the study, and thus the perspective on the focus has been narrow. The merit of this study is that a number of patients were involved. The convenience sample of 1645 patients represented the patients of three wards at the university hospital during the years 1996-1998. The number of participating patients was somewhat limited on the ophthalmologic ward, since some elderly people were not able to complete the questionnaire because of their poor eyesight. The researcher considered first enlarging the font size of the questionnaire from 12 dpi to 20 dpi, but decided after discussions with ward staff that handling two types of questionnaires would have been too time-consuming. Since the number of these respondents was relatively low, the idea of modifying the questionnaire was dropped.

Maturation, testing and instrumentation biases are relevant considerations in this study because of the length of the intervention, but also because of the different duration of the intervention between the wards (see Polit and Hungler 1997, Burns and Grove 1997). It is possible to argue that especially the positive trends and non-emergence of values falling beyond warning and acting limits in the supervisees' self-monitoring of work were a result of time and sensitisation to recurring issues rather than the intervention. Similarly, it is possible to claim that the positive findings among supervisees were more due to sensitising the supervisees to issues which they had rarely contemplated before, maturation and development as professionals, and the selection that occurred during the intervention in the form of dropouts. In fact, the same factors might have biased the answers in a negative direction among the most critical supervisees or participants on those wards who chose the shorter duration of intervention. The testing and instrumentation biases seemed obvious in this study because of the very frequent (i.e. at weekly and six month intervals) inquiries. What the frequent inquiries brought about was tiredness over participation in the intervention and responding, especially to the open-ended questions. An increasing number of incompletely answered

questions and unreturned questionnaires towards the end of the study could be explained through tiredness. Heavy critique was expressed verbally to the researcher towards the end of the study of the laborious data collection and feedback procedures. The possibility of instrumentation bias was taken into consideration already while revising the instruments for the follow-up inquiries. The scale that was taken into use in the instruments, from 4 to 10, was a successful solution in terms of sensitivity and allowing high fluctuation in describing different changes without the restrictions of the so called 'roof and ceiling' effects, that have been criticised especially in relation to patient satisfaction instruments (Räsänen 1996, Salmela 1996, see also Hyrkäs et al. 1999a).

The critique presented before is justified and important to consider, but not sufficient to revoke the findings. The changes in the supervisees' self-monitoring of work were supported by the patient satisfaction feedback and what is noteworthy is that the patients answered the questionnaire only once. Thus the maturation or testing biases did not hamper the patients' responding. Throughout the study positive and negative experiences and difficulties within the teams were reported carefully. Thus, the critique on earlier studies' problem of significant improvements or extremely positive findings has been therefore considered in this study (Karvinen 1996, see also Yegdich 1998, 2000). However, the merit of this study for improving the credibility was in the use of the multiple triangulation and different data sources describing the effects of team supervision through the open-ended questions and group interviews that portrayed from different perspectives the supervisees' perceptions of the effects of the intervention.

Construct validity

Even though an increasing number of research reports on CS have been published during the last two decades, endeavours focusing on teams and quality of care are still limited. In these kinds of situations descriptive research has been seen valuable as the first step towards better understanding of CS in an organisational context (see Nieswiadomy 1993). The research design of this study was longitudinal, since in the methodological literature (e.g. Polit and Hungler 1997) it is suggested to be highly useful for studying the dynamics of variables or phenomena over time. However, the decision was also supported by the critique presented by earlier research (Ellis et al. 1996, Tsui 1997, Hyrkäs et al. 1999a) showing that the solutions of experimental design have been unreliable mainly because of the impossibility of obtaining equivalent comparison groups. In this follow-up study, changes during the intervention and development among the supervisees were followed using questionnaire. The use of questionnaire was justified by ease of responding, since data were collected at numerous time points at moderately short time intervals. In the solution, known as a repeated measures design, the repetition of measures serves as the control of the extraneous variables that were built into the design for direct assessment (see e.g. Polit and Hungler 1997). The construct validity was enhanced in this study using multiple measures and methods (i.e. self-reporting questionnaires and group interviews) and triangulation (see Ellis et al. 1996).

Construct validity has been found very important for the studies of CS because of vulnerability to different kinds of threats (Ellis et al. 1996, Hyrkäs et al. 1999a) and thus this is a subject for critical consideration. At the beginning of the study the existing literature attested that the concept was complex (see e.g. Karvinen 1996), multifaceted and defined in a number of ways but also biased through a variety of

theoretical frameworks. These notions led the researcher to produce a new definition for this study. Based on the literature and earlier studies, careful attention was paid to the definition and the operationalisation of the key concept, CS. (see Figures 1 and 3)

The instruments 'Prerequisites for professional development in organisation' (PDO) and 'Professional individual development' (PID) were both developed in Finland. Thus, the suitability to Finnish culture was not a threat to the validity of the study. The instruments were further revised for this study and after that carefully pilot tested before their use among health care professionals, since the PDO was originally developed in education science (see chapter 4.4.). The PID instrument was also pilot tested at the same event even though it was originally developed in nursing science. The purpose was to test the face validity of the two instruments together (see Appendix 3.). The instruments for the supervisees' continuous self–monitoring of work and patient satisfaction feedback were both developed for this study based on the literature (see Appendix 4.). These instruments provided distinct and simultaneous insight into the phenomenon under study that was not possible to gain using standardised, general patient satisfaction instruments. The instruments were supposed to intensify the intervention, provide the supervisees with valuable information for the development of care and the researcher with information of the effects of the intervention. A surprise was, however, that even though both instruments were carefully pilot-tested before their use and the researcher reported the findings monthly both verbally and with printed control charts, the utilisation of the self-monitoring and patient satisfaction feedback reports in nursing practice remained modest. The main reason for this was revealed during reporting that applying the findings in practice proved to be difficult, since concrete conclusions, suggestions or advice were not included. The utility of the reported findings among the supervisees was seen, however, in their power to spark discussion. For the researcher the instruments provided important information for describing the effects of the intervention with sufficient precision.

Construct validation of the 'Prerequisites for professional development in organisation' (PDO) questionnaire was performed using statistical procedures i.e. confirmatory factor analysis (see Polit and Hungler 1997), but based on the literature and the pilot group, only logical validation was possible for the open-ended questions of the 'Professional individual development' (PID) questionnaire. During the study the discriminability of the PID faltered and the instrument's ability to differentiate the constructs under measure proved slightly problematic and produced overlapping information through rather similar sub-categories and categories. In the literature (e.g. Severinsson and Lindsröm 1993) CS has been described as an intensive, individual and 'holistic' experience for supervisees. The difficulties with the instrument originated thus probably from the completeness and individual nature of experiences that the supervisees sometimes found it hard to differentiate.

The internal consistency of the PDO instrument, as measured by Cronbach's alpha values, was checked in every inquiry. The values varied in the first inquiry from .7016 to .9478, the second inquiry from .6319 to .9164, the third inquiry from .6362 to .9382, the fourth inquiry from .7228 to .9538 and in the fifth inquiry from .6048 to .9446 (see Appendix 7.). These values can be considered good and they show a moderately high degree of internal consistency in the instrument during the follow-up inquiries (Burns and Grove 1995, Polit and Hungler 1997). The lowest values were found in the sum variables of 'commitment to

work and organisation' (OC2) and 'team spirit' (GF1). It was anticipated that these characteristics were those that reflected the respondents' fatigue over responding to the follow-up inquiries and decreasing commitment to the team supervision intervention. The items that lowered the internal consistency of the instrument varied by inquiry in the above-mentioned sum variables and none of these were excluded since the Cronbach's alpha values were very close to .70, which has been considered acceptable for a reliable instrument (Pierce 1995).

The similarity of the team supervision intervention and its duration on the five wards and carried out by the ten supervisors in pairs was an important issue for consideration (see Polit and Hungler 1997). Earlier studies (Ellis et al. 1996, Tsui 1997, Hyrkäs et al. 1999a) have discussed only the short duration of a CS intervention, but the issues of similarity or the common vs. individual goals set for CS have not been the focus of interest before (see Hyrkäs et al. 2002a). The duration of team supervision in this study was moderately long, ranging from two to three years. The ten supervisors of this study were informed of the aims in advance and regular group supervision was organised for them. For this purpose, two supervisors were hired outside the organisation (see Hyrkäs et al. 2001b). The described solutions served to creating conceivable common guidelines for team supervision on the different wards (see Hyrkäs et al. 2002a). The goals for team supervision were set autonomously in each team (see Hyrkäs et al. 2002a). At the beginning of the intervention it was also seen important that the researcher was not acting as a supervisor in the study, thus avoiding the possible experimenter effect among supervisors and supervisees (see also Hyrkäs et al. 1999a). This solution also limited the possibility of applying action research in the study (see Hyrkäs 1997). The researcher was in regular contact (i.e. common meetings) with the supervisors after every six months of inquiry. During these meetings the supervisors, researcher and the research team discussed the current state of the study and the implementation of the intervention. The timely findings were presented to the supervisors for commenting. This procedure served especially at the end of the intervention the purpose of confirmability of the findings from the open-ended questions and the summaries of group interviews with the supervisors. (see e.g. Brink 1991, Merrick 1999)

Issues of confirmability for group interviews as data collection method

In a group interview the interviewer always to some extent influences the information produced. The more active role the interviewer takes, the more this influences group dynamics (Frey and Fontana 1991, Kitzinger 1994, Henderson 1995, cf. Morgan 1995). During the group interviews of this study the researcher chose consciously a passive role and this was told to the interviewed groups. This meant that the discussion was not interrupted if it was in progress, misconceptions and mistakes were not corrected nor were the silent members urged to speak by the researcher. The interviews were always started with the same 'introduction' and guideline questions promoting and leading to discussion. These few questions were chosen with care, as were the questions to 'probe' more deeply the issue under discussion. The concern was that questions could easily drive the interviewees' interests to those of the researcher (see Frey and Fontana 1991, Morgan 1995, Krueger 1996, Pötsönen and Pennanen 1998). The progress of discussions and the interviewees' focus on the discussion issue was remarkable during the interviews. This was probably promoted by the arrangement that the themes were copied on the paper and continuously visible for the interviewees (see also Asbury 1995).

The interviews were also fluent probably due to the fact that the team members had learned to examine matters in an open and spontaneous atmosphere during the course of team supervision. This sometimes presented a slight difficulty, since participants could talk at the same time in the heat of the discussion. In these cases it was difficult to follow the discussion, and transcription of the text without two tape-recorders and tapes would have been impossible. The solution to use two tape-recorders was successful since this guaranteed good audibility and thus high quality data. Only minimal parts of the interviews were lost in cases were both the tapes were unclear. The most common feature of group dynamics biasing the interview, dominance of a certain group member (see e.g. Twinn 1998), did not occur during the interviews of this study. On the other hand it turned that almost all groups had a few silent members who failed to participate in the interview (see also Asbury 1995, Morgan 1995).

Five of the six interviews were arranged on the ward and one in the same premises where the team supervision sessions were held. Special attention was paid to preventing interruptions and disturbances during the interviews (Frey and Fontana 1991, Krueger 1995, Pötsönen and Pennanen 1998) by using 'meeting in progress' signs and by informing those who did not participate in the interview (e.g. temporary substitutes) of the necessity of undisturbed situation. However, the interruptions that were faced were due to some interviewees' delayed arrival or necessity to leave earlier. These seemed to interfere with the other members' concentration for a moment and the persons in question missed their chance to contribute to the first or the last theme. It is impossible to assess how these disturbances influenced the data production in the interview groups.

One serious limitation to data production with group interviews is the extreme orientation that may develop in a group. For example Carey and Smith (1994) Kitzinger (1994) Krueger (1995) and Reed and Payton (1997) have described this process by stating that in an individual interview social acceptability raises the threshold for discussing about negative issues, whereas group support may encourage people to express criticism. An extremely positive praise is also possible. Carey (1995) has pointed out that in a group interview there seems to be a 'roof' for positive, but not a 'floor' for negative issues. During the interviews of this study, this effect emerged in two interviews. In the first case the tone of the interview turned negative at quite an early stage and in the end the atmosphere was extremely negative and blaming. In the second case, a group member's tone turned suddenly very negative with accusations most of all against the teams' supervisors. However, this did not change the tone among the rest of the group and the atmosphere of the interview normalised after a long silence.

It is suggested that the quality of group interviews is improved by asking the group to correct and complement the interviewer's summary of the interview (e.g. Carey 1995). In this study, however, the wards' supervisors were allowed to familiarise themselves with first the summaries written from the interviews and then with the manuscript of the findings including the examples drawn from their own teams (see also Krueger 1995). This solution turned out to be successful, as the supervisors were able to assess the depth of the interviews, but also the correspondence of the findings with the team supervision conducted (see also Reed and Payton 1997). One supervisor pair found that their experiences within the team compared to the examples drawn from the interview were more profound. The supervisors felt that the group interview had not conveyed the deep individual experiences, but that the group experience was overemphasised with

an increasingly negative tone. It was concluded that the interaction of these issues turned the interview superficial. In the literature (e.g. Lönnqvist 1983, Tamminen-Peter 1996) this kind of group phenomenon is called relapse to regression accompanied with defensiveness.

Issues of confirmability for data analysis

The challenge in qualitative content analysis (e.g. Cavanagh 1997, Kyngäs and Vanhanen 1999), but also in phenomenographic research (e.g. Uljens 1993) is the correspondence of the original material with the categories created by researcher. The literature on qualitative content analysis (e.g. Kyngäs and Vanhanen 1999) emphasises that the relation between the categories and the data should be demonstrated, which thus verifies the confirmability of findings. In this study the answers to the open-ended questions were analysed using the method of qualitative content analysis. The content categories were constructed as they emerged from the data. The appendices 5-6 show how the material was reduced during the analysis to sub-categories and categories from the supervisees' responses to positive and negative factors that had affected their work and the patients' responses to positive and negative experiences. The researcher analysed all the collected data (2005 answers from supervisees and 1265 answers from patients) since sampling was considered not accurate enough for finding e.g. temporary, but important incidents (see Cavanagh 1997). However, only a few examples are selected from the original material for the appendices. The difficulty with the voluminous data and ambiguous answers was to create categories that are mutually exclusive (see e.g. Hickey and Kippling 1996, Cavanagh 1997). In order to be confident of the plausibility of the categories, another researcher assessed the examples, sub-categories and categories presented in Appendices 5-6. The analysis of the open-ended answers in the follow-up inquiries was accomplished similarly, but for ethical reasons no examples are drawn from the original answers. However, the wards' supervisors were allowed to familiarise themselves with the manuscripts of the findings of the open-ended answers concerning team supervision in their own group and to comment on how these corresponded to the reality.

The group interview data in this study were voluminous (200 pages, with 1.5 line spacing). The formulation of categories was laborious and the analysis process required that the preliminary categories that were created first were compared in parallel with each other and the original material in order to devise the final categories. The formation of categories required that the analysis proceeded at three different levels: at the level of team, at that of its individual members and the whole of the teams. The analytical process was demanding and required occasional interpretation as all thoughts were not necessarily made public and the team members seemed to read things 'between the lines'. The discussion that had first seemed self-evident during the interviews turned out to be ambiguous in nature in the data analysis phase (see also Pötsönen and Pennanen 1998). In these cases the researcher's notes of the interviews and interaction between the participants were used to conclude what the interviewees were talking about.

It has been debated among the phenomenographic researchers whether another person should analyse the material as is performed in some other qualitative research methods (e.g. Uljens 1991). However, Uljens (1991) has pointed out that the findings are a product of a particular researcher's actions. If another researcher were to analyse or classify the same material, the result would probably not correspond with the original material nor would the quality of research improve. In this study the researcher analysed the entire

material and no peer evaluation was performed. However, several quotes as examples of categories are included to show the correspondence of the material and the created categories. Choosing the example was, however, not easy as it was essential to include at least 2-3 participants' comments to maintain the discursive nature of the interview, but the story line was also sometimes complicated or expressed negatively (see also Webb and Kevern 2001). In order to avoid too long extracts from the interviews the researcher had to shorten the original literal interview, which meant that some material was inevitably lost.

External validity

External validity is concerned with the extent to which it is possible to generalise the findings beyond the study, across populations over time, setting and people (Ellis et al. 1996, Burns and Grove 1997). In the critique of earlier CS studies (Ellis et al. 1996, Tsui 1997, Hyrkäs et al. 1999a), questions have been raised about whether there is any possibility to generalise the findings because it is difficult to say whether the sample of supervisees is representative and what the criteria for representativeness are. Ellis et al. (1996) have also suggested that external and internal validity are twisted in the studies of CS so that the interaction of history, setting or selection in the intervention form threats to external validity. The critique seems to suggest that one cannot really generalise findings from a study to another setting or supervisees since these are likely to be different in some way and if involving experiences, these are individual (see also Burns and Grove 1997, Polit and Hungler 1997). The generalizability of the findings of this study are thus limited due to the complex nature of CS, the relatively small intervention groups and the descriptive findings that are most likely individually biased experiences. However, the transferability of some findings may be possible due to the 'thick description' of this study after careful consideration of whether transfer can be contemplated as a possibility (see also Merrick 1999).

6.2. Interpretation of findings

(1.) Team supervision and its effects on the supervisees and the teams

Team perspective on the effects of team supervision

Multidisciplinary teamwork and collaboration have been identified as essential prerequisites for high quality and the effective provision, functioning and delivery of health care services, but also as beneficial for team members and their wellbeing (e.g. Poulton and West 1993, Thomas and Reid 1995, Mullarkey et al. 2001). Teamwork has also proved to be complex and several difficulties are well documented by research (see West 1999). The problems found include lack of understanding among team members of each other's roles, working from different theoretical and knowledge bases, professional hierarchies and organisational context (e.g. Poulton and West 1993, Thomas and Reid 1995). Doubts have been expressed that the appropriate supports and integration systems for team working are missing (West 1999). A number of strategies have been introduced in order to address the problems with team-working including resource management, the blurring of roles, creating networks, joint training and team building (e.g. Øvretveit 1995, Johnson and Johnson 1997). The majority of the attempts introduced in the literature seem to relate the issues of control, hierarchy and authority, but more rarely to develop further ways of improving working relationships among

professionals. From this perspective one way to improve team working can be CS (see e.g. Proctor 2000, see also Keskinen 1996)

This study has focused on examining the effects of team supervision within five, at first multi-professional teams. The findings showed that during the intervention the teams' functionality and commitment to work and organisation improved. The supervisees' assessments indicated that the effectiveness of teamwork improved and the supervisees' relations with their team-members grew closer and more interactive with social interaction.

The complexity of teamwork in health care has inspired Launis (1994) to explore its background. In the study the researcher examined the origins of collaboration in primary health care (12 health centres) and the multi-professional team members' conceptions of collaboration and of possibilities to develop it. The study showed among other findings that the difficulties of collaboration seemed to lie in the history and in the autonomous nature of professions that schematise the work heavily. To break down this tradition for the sake of co-operation was difficult and it was also found that the teams easily return to the traditional schematic practice. Similar difficulties have been reported in the quality improvement literature. For example, Outinen et al. (1999) have emphasised the importance of multi-professional collaboration for improving the quality of health care services. However, the problem that has been acknowledged is the dissimilar perspectives of different professionals complicating the management of work as a whole and 'slipping' into traditional work patterns regardless of agreements on common lines of work. The findings reported by Launis (1994) and Outinen et al. (1999) thus raise a question whether the effects of CS within the teams that have been reported in this study are enduring. Arvidsson et al. (2001) have indicated some stability, but also transformability of the effects of group supervision. However, since this study was not extended to follow the effects after the termination of the intervention the question of lasting effects remains unanswered.

In the literature (e.g. Cartwright and Zander 1968, Johnson and Johnson 1997, see also Niemistö 1998) group cohesion has been identified as an important factor contributing to e.g. the effectiveness and performance of teams (e.g. Poulton and West 1993, Lindström and Kiviranta 1995) and as a factor, which has a crucial impact on a team's work (West 1999, see also Keskinen 1996). The findings of this study indicated that the team supervision intervention initiated changes in team relationships that grew closer and more interactive with social interaction. In other words, the findings of this study seem to be supported by the literature and the assumed effects of team supervision on group cohesiveness (e.g. Lindström and Kiviranta 1995, Niemistö 1998). The earlier empirical evidence, however, is sparse. The findings reported by Stanton et al. (2000) have shown that very different clinical and professional issues emerge in group supervision depending on the speciality in focus. The study showed that due to group supervision, patient care improved, but that staff worked in a more collaborative and supportive manner, which would imply improved group cohesion (see also Northcott 2000). The study showed as well that the higher the number of participants involved, the longer time was needed to 'saturate' for CS. The authors' conclusion was the group supervision had, among other things, promoted team building.

There are several studies available describing from different perspectives the human relations within teams and relationships between team members and the problems that might emerge. For example, Finnish

researchers Paunonen et al. (1996), Elovainio et al. (1997) and Pahkala et al. (1997) have surveyed organisations and focused on teams, multi-professional groups and human relations among the members (see also Mäkelä et al. 1998, Galvin et al. 1999). One of the main results of the survey (N=1059) reported by Paunonen et al. (1996) was that contradictions were not easily exposed to colleagues in the teams. However, respondents assessed that the interaction with patients was open, good and not based on routines. The study indicated, however, that the different professionals had dissimilar conceptions of patient care. Regardless of the differences, ¾ of the respondents were aware of the organisation's policy plan and principles. Elovainio et al. (1997) reported on a survey (N=1642) describing teams and co-operation of professionals in the Finnish health care system. To sum up the findings, the study showed that the work in health care was integrated, but often also fragmented, and that the amount of co-operation was minimal. The atmosphere in the teams and multi-professional groups was mainly positive, but it was found that new and co-operative working methods were not supported or encouraged. In this respect, development and changes were slow. Strict instructions and regulations (such as quality assurance) were presumed to be one of the causes for this. The third survey (N=1745) reported by Pahkala et al. (1997) attempted to assess and summarise the degree of the problems in teams and multi-professional groups. The researchers mention four main factors causing problems: (1.) administration: participation in decision making, (2.) management of conflicts in teams or organisation, (3.) change management and encountering changes and (4.) values of the organisation as internalised by teams. There was a four to eighteen-fold probability that these factors predicted the functionality of the team or multi-professional group. The research reports described above provide differing suggestions to improve and develop team relationships. However, Paunonen et al. (1996), Mäkelä et al. (1998) and Galvin et al. (1999) have suggested, among other things, team supervision to be such an intervention. The findings of this study are thus important since they show the impact of team supervision on the supervisees' human relations, indicating that the attitudes towards others seem to grow more flexible and thus improve the quality of interaction.

This study showed, however, that during the intervention several difficulties and problems also emerged in human relations and between the supervisees. The result is not necessarily negative but possible to see as a catalyst for development, as suggested by Cowe and Wilkes (1998). Support and supportive atmosphere are important in group supervision among supervisees, but equally important is the challenging element. Cowe and Wilkes (1998) have pointed out that if the normative element of CS is to be fulfilled, members of team supervision should be prepared to challenge their colleagues' management of situations, but also to accept constructive criticism in return. Otherwise there is a risk that CS turns into nothing but a mutual admiration (or criticism) society without examining that practice critically (see also Sexton-Bradshaw 1999). Like the findings of this study showed, however, there emerged differences between the teams but also among their individual members in how the challenges were processed and utilised during the intervention.

The findings of this study are important because they show that team supervision had positive effects, when materialising in its best form, on communication, identified as one of the difficulties in teams (Paunonen et al. 1996, Elovainio et al. 1997, Gibbon 1999). Malin (2000) has reported similar findings from community homes where team supervision was found to improve communication among team members.

Griffiths (1999) has reported, on the other hand, that in a supervision group for district nurses a 'difficulty' with examining the topics was the 'etiquette' and the members reservedness to take up contentious issues. In this study the finding was partly opposite, since in some of the teams opinions were expressed openly, and the communication could occasionally even turn offensive, which the supervisors seemed to find extremely difficult to control or turn in to 'a more positive direction' (see Hyrkäs et al. 2002a). However, this study showed that when materialising in its best form, team supervision made the communication more effective among team members, but also formed the basis for coherence within the team and elaborated working methods within the team with an impact on work motivation. Team supervision thus seems to offer a solution to the problems pointed out by West (1999) and Gibbon (1999) that communication in multi-professional teams is often ineffective and that the focus is on immediate patient issues or information delivery in response to questions rather than discussing alternatives, team strategies, processes and performance.

The effects of team supervision described in this study on the evolving relations between the team members with an impact on elaborating working methods and work motivation are interesting since there are several links to the quality assurance and improvement projects reported in the literature. Perälä and Räikkönen (1994) have reported the positive effects of quality assurance projects on staff such as increased work motivation, commitment to work, clarification of the content of nursing, more organised work, development of work, increased job satisfaction, meaningfulness of work, improved work identity, increased independence and improved collaboration. (see also Salo 1991, Outinen et al. 1999). On the other hand, Heinänen and Soveri (1996) have described a process that started from a quality assurance project, and the observations that were made during the process that the development of collaboration and team work were crucial to the achievements of quality assurance. The findings of this and earlier studies thus seem to suggest close links between CS and quality assurance and improvement efforts with similar effects on among health care staff.

Individual supervisee's perspective on the effects of team supervision
The findings of this study showed that the supervisees' self-awareness deepened during the intervention. The described effects were that a more positive and permissive self-examination and an open and relaxed self-relationship had developed. The study reported by Sexton-Bradshaw (1999) has also introduced similar findings of group supervision with such effects as emphasising CS as 'quality time', reducing stress and increasing self-awareness especially in difficult situations. Draper et al. (1999) have reported, however, that the increased awareness has also been identified as an uncomfortable feature of CS. The reason for this has been that the participants become aware of their weaknesses or things that are not possible to solve.

The concept of self-awareness is complex and ambiguous depending on the theoretical framework or theory in use. Cook (1999) and Rowe (1999) have analysed the different meanings of 'self-awareness' in the literature and urge for a more rigorous use of this concept. One of the perspectives examined by Cook (1999) is the syllabus definition of 'self-awareness' that suggests 'becoming aware of numerous personal characteristics such as values, attitudes, prejudices, beliefs, assumptions, feelings, personal motives and needs, competencies, skills and limitations'. Rowe (1999) has discussed 'self-awareness' form the

perspective of 'actual and ideal self'. Such earlier studies as Dunn (1999), Arvidsson et al. (2001) and Lanz and Severinsson (2001) are interesting since these report findings that seem to complement the findings of the effects on supervisees 'self-awareness'. Lanz and Severinsson (2001) have reported that CS clarified professional identity, strengthened the self-image and increased sense of self-assurance in work. One of the main findings reported by Arvidsson et al. (2001) was that CS improved professional competence through pronounced professional identity and thus produced a feeling of personal development. Finally, Dunn (1999) described group supervision among individual supervisees presenting such effects and implications as self-esteem, personal development and performance. The earlier studies of CS thus seem to complement and support the findings of this study.

This study showed that the intervention initiated the processing and matching of individual supervisees' work patterns with their colleagues but also the integration of these more firmly with the patient-centred approach to care. The nature of nursing care was clarified. There was also a need, however, for this clarification due to the pressure of change and the requirements for developing the practice. During the intervention, the supervisees' own relation to work clarified, the individual work patterns within the team were recognised, but also the necessity for some common guidelines was noted.

The initiating influence of CS on processing work-related issues has been described by Arvidsson et al. (2001) and Lanz and Severinsson (2001). However, the perspective presented by these researchers focuses on processing and explicating work related issues. From this perspective the study reported by Arvidsson et al. (2001) showed that the effects of group supervision in the follow-up study (n=10) indicated the promotion of explicit professional knowledge and integration in nursing care. Group supervision had contributed to processing and integrating practical and theoretical knowledge, but also explicating the knowledge that was tacit. The authors emphasise that the processing was promoted through acquiring a language for the work that the supervisees performed. The study reported by Lanz and Severinsson (2001) has found similarly that the group supervision process aided participants in verbalising thoughts and feelings and thus served as an opportunity to express and process them, but that it also increased their sensitivity to patients' signals of their feelings and needs. In the same study the researchers described the pressures of changes and requirements for developing the practice in relation to CS. The findings showed that group supervision had contributed to a focus that could be changed to improve the way the supervisees acted towards patients and relatives.

Hallberg (1994) and Lanz and Severinsson (2001) have described the influence of CS on individual supervisees' understanding of their own and their colleagues' work. The findings of these studies seem to complement those presented in this study in an interesting way. The study reported by Hallberg (1994) indicated that after one-year CS with psychiatric nurses (n=11) supervisees felt that they were understood better, but also that they themselves understood others better and thus the co-operation had improved. The study showed that the nurses' satisfaction increased significantly with regard to co-operation and comfort in work group. Lanz and Severinsson (2001) reported on a study of group supervision showing that it had developed a sense of being part of a group in the supervisees, which had also improved their understanding of others. The earlier studies seem to suggest, in other words, that the understanding of one's own and the colleague's work, promoted through team supervision, has an important role as an effect of the intervention.

This study showed that during the team supervision intervention the individual supervisees realised, in relation to their work, the existence of different sources of knowledge for work. The importance and development of knowledge have also bee described by Hallberg (1994), Arvidsson et al. (2001) and Lanz and Severinsson (2001) thus giving support to the findings of this study. The study reported by Arvidsson et al. (2001) showed that group supervision promoted the acquisition of knowledge and competence. Hallberg's (1994) study indicated that the group supervision intervention promoted a broadened and more advanced knowledge base, and thus led to more goal-oriented and active nursing actions in clinical work. And finally, the study reported by Lanzt and Severinsson (2001) showed that nurses had become more secure in their knowledge during the group supervision intervention. The findings indicated that nurses had gained better access to their own knowledge, and thus could make more explicit and varied use of it.

Organisational perspective on the effects of team supervision

The findings of this study showed from the organisational perspective that the supervisees become more critical of the participatory management style of ward managers. However, the work on the ward developed through a broadened and clarified standpoint on practice, increased criticality and through finding one's limitations. Increased attention was paid to the ward as a care environment and to patient centred care. The effects of team supervision for the teams were seen as developed, established and strengthened practices.

The effects of CS on the management or leadership style have been sparsely reported in earlier studies (see Hyrkäs et al. 2002b, cf. Severinsson and Hallberg 1996). A study reported by Stanton et al. (2000) showed that CS initiated among supervisees beliefs that CS would have an effect on managers, who would thus be more aware of the staff's training needs. The increasing critical attitude among supervisees is not an uncommon effect of CS. Draper et al. (1999) reported on a CS project among different professionals (n=21). The findings showed that the supervisees grew in general more critical of team supervision and that negativity towards team supervision increased, but that overall, supervision was perceived to be beneficial. The finding is explained through increased uncertainty and its impact on practice. If these findings are linked to the literature on quality improvement (e.g. Suhonen 1995, Outinen et al. 1994, 1999) the critical attitude is, in fact, emphasised as an important catalyst for promoting changes. The manager's role as a leader is identified as important in quality promotion, but requiring continuous changes in and development of personal strategies. In this study the development of the individual ward managers remained unexplored. This might have increased knowledge of the reasons for increased criticism among the supervisees.

The findings of this study were that work on the wards developed through a broadened and clarified standpoint on practice, increased criticality and through finding one's limitations which are supported by the studies of Draper et al. (1999), Sexton-Bradshaw (1999) and Stanton et al. (2000). Draper et al.'s (1999) findings showed that CS often involved difficult and complex processes of change, but that it also benefited staff in many ways. The positive effects, similar to the findings of this study, were related to the opportunity to acquire feedback and especially to find one's competence limits. The critical point of view in CS has been reported by Cowe and Wilkes (1998) and Sexton-Bradshaw (1999). These studies have shown, like this study, that during efficient CS the practice is reflected critically and challenging and negative experiences and issues arise, but that these experiences and the ways how they are processed in different teams and

groups differ (see also Suhonen 1995, Cowe and Wilkes (1998). The critical approach has also been discussed by Berger and Mizrahi (2001) who have pointed out the threat of 'group thinking'. This preference, combined with the need for harmony and cohesiveness within a group, may distort decision making and problem solving. The negative influence of group thinking is how to manage conflicts or encourage the exploration and evaluation of opposing viewpoints in order to facilitate diversity and cross-fertilisation to facilitate growth among group members. In other words, this challenge focuses on supervisors (Cromwell et al. 1999, Consedine 2000, Kelly et al. 2001).

(2.) The changes in educational needs during the team supervision intervention

The findings of this study showed that the supervisees rated the education (45.5% - 58.3%) and development at work (72.8%-87.5%) as highly important and necessary. Over half of the respondents had participated in education 1-2 times in six months within the organisation and almost half 1-2 times outside the organisation. The education was versatile and served the practitioners' varying educational needs well. If these findings are compared to Korte's (1997) extensive survey (n=1241) of in-service and further education for health care professionals in Finland, the chances of education for the supervisees in this study seemed to be better than for health care professionals on average. Korte (1997) has reported that during the year 1996 (n=1241), 42% of a sample of Finnish health care professionals had participated for less than two days in training arranged within the organisation, 41% had not participated in education and 7% had participated for 2-14 days. A longer duration of training was extremely rare. The number of respondents who had participated in training outside the organisation for less than two days was 33%, 48% had not participated in education and 10% had participated for 2-14 days. Very few respondents had participated in education longer than 14 days.

In this study at least every third supervisee reported that the organisation had supported his or her professional development with education and CS. The forms of support included rota arrangements, financial support, paid leave of absence and part-time non-paid leave of absence allowing university studies. These findings show that the support for education for the supervisees in the organisation was good compared to the study reported by Korte (1997). In a sample of Finnish health care professionals the majority of the respondents (78%) had not participated in self-paid education during working hours, 4% had participated in education shorter than two days and 1% in education from 2 to 14 days in length. The highest in-service education rate was found in nursing homes (73%), while hospitals had the second highest percentage (68%) of all types of social and health care organisations. The rate of education outside the organisation was highest in health care centres (70%), while the second lowest (58%) rate was in hospitals and the lowest rate in the private health care sector (53%). Self-paid further education organised during working hours was very rare for the majority (75%) of respondent in the sample. The majority of the health care professionals (92%) reported, like in this study, that the education was essential for maintaining professional skills and less than half of the respondents (38%) mentioned the invigorating function of education.

The findings of this study showed that during the team supervision intervention there were no significant changes in educational needs or plans for professional development. It was also found that the supervisees themselves found it difficult to specify particular educational needs initiated by the intervention.

Proctor et al. (1999) have reported that nursing professionals assume CS to support decisions about developmental and training needs such as identifying clinical updating needs (see also Draper et al. 1999, Stanton et al. 2000). The study showed that the feeling of professional isolation associated with the lack of confidence was related to expectations of CS's educational function enabling to gain further skills, expertise, confidence through reflection and thus the focus seems to be on learning from practice and experiences. Hale (1999) has reported similar findings.

The findings of the recent studies describing the impact of CS on educational needs seem not to meet the expectations of supervisees (cf. Proctor 1999 et al., Hale 1999) or the assumptions made in the theoretical literature (e.g. Proctor 1986). Cowe and Wilkes (1998) have described the experiences of setting up a CS group including education for specialist nurses. The authors report that during the process the supervisees' reflection with peers encouraged individual nurses to analyse their own experiences in practice. It was found that reflection with experienced and knowledgeable colleagues provided the opportunity to bridge the gap between theory, but during the process it seemed that the group's theoretical interest remained modest, the emphasis being rather on underpinning the process on reflection. Cowe and Wilkes (1998) state that the educational function during the project was achieved mainly through sharing knowledge relevant to practice. The educational issues were the least discussed, while personal support needs showed to be the most frequently addressed and valued by supervisees. Dunn (1999) has reported similar findings on a study with emphasis on pre-planned training, which showed that learning was perceived to be a major component in the project. (see also e.g. Berg et al. 1994, Hallberg et al. 1994, Pålsson et al. 1994, Pålsson and Norberg 1995, Edberg et al. 1996, Pålsson et al. 1996, Berg et al. 1997)

The studies of Sava (1987), Vienola (1995) and Burden and Jones (2001) identified the different perspectives held by supervisors and supervisees in educational issues during CS, but also the effects of the intervention on supervisees learning. Sava (1987) and Vienola (1995) have studied supervisor education and the related supervision intervention. The findings presented by Sava (1987) are interesting, since the supervisees and the supervisor assessed every group supervision sessions afterwards and the profiles of these were described as means, ranges and subtractions of the means for both parties. The findings evidenced that the supervisees' assessments varied moderately from session to session depending on the subjectivity of the issue. The supervisor's assessment trend was occasionally more critical than the supervisees' (Sava 1987). Vienola (1995) showed that continuous assessment applied in her study had prompted the supervisees' thinking regarding their own learning goals, and deepened and hastened the learning and directed the learning process. Finally, the follow-up study reported by Burden and Jones (2001) showed a change that was generated in CS for its role of helping to identify professional and educational needs, and to develop professional knowledge. A significant improvement was initiated due to the attention to educational issues and systematic interviews with supervisees focusing on the professional and educational development and development of a professional portfolio. The study showed, however, that the direct or increasing impact of CS on professional knowledge is modest.

To sum up, the findings of earlier studies seem to lend support to the findings of this study by suggesting that the impact of CS on identifying professional and educational needs is not self-evident, but differs by supervisees (see also Lees 1999) and their current interests and thus requires active contribution

and attention to central issues. The challenge and implications of these findings seem to focus on supervisors and the important role they seem to play for promoting supervisees to identify the focus of learning in CS sessions, but also their own professional and educational development needs (see also Northcott 2000, Burden and Jones 2001). It can be suggested, like Burden and Jones (2001), that supervisors could have an active role in planning the scope of educational programmes organised within the organisation, thus extending the perspective from educational profiles to teams and work communities.

(3.) The impact of continuous self-monitoring of work and patient satisfaction feedback

In this study the supervisees assessed their work regularly and the patients gave simultaneous feedback on satisfaction. An increasing number of studies exploring the effectiveness of CS and evaluation studies have recently been published in nursing (e.g. Butterworth et al. 1997, Teasdale et al. 2001) but these have rarely involved clients, focused on patient outcomes (see Hyrkäs and Paunonen-Ilmonen 2001c) or utilised continuous and systematic assessment as part of the intervention. However, studies relating CS, assessment and effectiveness of interventions on the outcomes are not uncommon in disciplines close to nursing science, such as physiotherapy (Henry 1985), psychology (Gillam et al. 1990, Iberg 1991), social work (Harkness and Hensley 1991), supervisor and teacher education (Sava 1987, Vienola 1995), thus providing an interesting perspective on examining the methods utilised in this study.

Clients had an active role in Iberg's (1991) and Harkness and Hensley's (1991) studies. Clients rated the therapist's actions (Iberg 1991) and stated their satisfaction with the received services from social workers (Harkness and Hensley's 1991). Besides client satisfaction, the focus of interest in the client–involving studies have been on factors (i.e. therapist effects) that were assumed to affect the outcomes and serve as starting points for improving the process (Iberg 1991). In both of the studies, the data collection was linked to a CS intervention and its manipulation in different points of time to evidence the trends or changes in client responses. Both studies examined an ongoing process and the possibilities to improve it. For this purpose, Iberg (1991) applied the method of statistical process control and Harkness and Hensley (1991) among other methods visual inspection of trends. The findings evidenced that client satisfaction improved due to the client-centred focus of CS (Harkness and Hensley 1991) and that the overall ratings improved due to the therapists' own suggestions (Iberg 1991).

Henry (1985) focused on examining effective feedback and evaluation in CS and Gillam et al. (1990) involved in their study supervisors who observed their supervisees' actions and behaviour in client situations. Besides evidencing how a supervisor can utilise feedback and evaluation to facilitate the supervisee's (i.e. employee or student) learning and growth, the studies showed how the analysis of feedback and evaluation findings altered (i.e. improved and increased therapeutic responses) the supervisees' actions. Gillam et al.'s (1990) study applied repeated structured observations for data collection before and after supervision. Visual inspection was utilised for comparing the baseline in control phase with the results of treatment phase. The findings disclosed, among other things, that supervisees' own perceptions of their actions were often intuitive and vague. The study evidenced that supervisors can facilitate supervisees in learning to analyse, observe and interpret data from their practice and through this improve their practice.

Henry's (1985) study confirmed the above-mentioned findings showing that feedback and evaluation are important strategies for effective CS. The significance of feedback lay in the fact that it facilitated self-awareness that is essential for effective performance (i.e. improved decision-making, change and growth) and ultimately the quality of performance.

To sum up, the earlier studies of Henry (1985), Gillam et al. (1990), Harkness and Hensley (1991) and Iberg (1991) show that involving clients seems to be a powerful means of improving satisfaction among clients due to the possibility of expressing one's opinions, but also in terms of channelling and focusing the supervisees' actions (see also Smith et al. 1995, Davis and Adams-Greenly 1994). The studies also evidence the strong impact of feedback and evaluation findings on changes in supervisees' actions by providing a more solid foundation for effective and high quality functioning.

In this study the semi-annual follow-up staff inquiries showed, however, that the continuous self-monitoring of work and systematic patient feedback were perceived to have a modest effect on action and patient care during team supervision. These findings, contrary to earlier studies (Henry 1985, Gillam et al. 1990, Iberg 1991, Harkness and Hensley 1991), may be due to the different, non-pedagogical role of the supervisors without a clear-cut emphasis on utilising the assessment and feedback findings. A surprising finding was also, as opposed to the claims of Finison et al. (1993), that the mean and standard deviation in the control charts, assumed to be simple and easy for staff to understand, were found difficult to decipher by the staff involved in this study. This may have led to the staff's perceptions that the effects of continuous self-monitoring of work and systematic patient feedback remained modest. However, the literature has also shown that the concepts related to quality assurance and quality improvement have been commonly found unclear, difficult to understand and to apply in social and health care practices (Perälä et al. 1995, Outinen et al. 1999)

In this study, however, a positive and increasing trend developed in the supervisees' assessments during the course of the intervention, and the variation within the team's assessments and within the patient satisfaction feedback decreased. These findings can be interpreted, according to Finison and Finison (1996) and Benneyan (1998), so that the patient care under examination was taken in better control during the intervention. The supervisees' assessments approached the patient satisfaction feedback towards the end of the study. The findings also showed that different positive and negative factors affected the supervisees' and the patients' assessments (see also Nash et al. 1994, cf. Lauri et al. 1997)

Arnetz and Arnetz (1996) reported on a study with a less frequent feedback reporting system, but like in this study, utilising questionnaire and collecting data from staff simultaneously with patients. The aim of the feedback system in the study was to provide staff with a tool for identifying areas for improvement, but also to motivate staff to evaluate their strengths and weaknesses during a long time span. The main findings were, supporting those presented in this study, that the patient ratings improved over time (see also Piccirillo 1996) and that the staff's assessments and views differed from patients' assessments. The staff's assessments were nearly always lower and more critical than those of patients, which may suggest, according to Arnetz and Arnetz (1996), that staff demand and expect more of themselves than do patients (see also Bartle 2000). The researchers conclude that staff involvement, but also indicating the changes and trends in a longer time interval to the staff were the cornerstones of improvements that occurred in 'the quality of work

project'. The findings of this study, with regard to the supervisees' assessments that approached the patients' feedback, thus suggest that the team supervision intervention moderated the staff's assessments in a positive and less demanding direction. Lantz and Severinsson (2001) have reported similar findings of group-oriented supervision that seemed to promote the supervisees' more merciful attitude towards themselves, but also towards colleagues with increased tolerance and with positive consequences for teamwork. This study showed that the application of time-series analysis with control charts while reporting on the positive trends and the decrease in variation was necessary, as suggested by Arnetz and Arnetz (1996), since otherwise the changes and understanding of variability over time in everyday practice would have remained unnoticed by staff (see Benneyan and Kaminsky 1995, Outinen et al. 1999, see also Northcott 2000).

(4.) The effects of team supervision on the quality of care

The findings of this study showed that the supervisees who participated in the study found it difficult to specify the effects of team supervision on the quality of care. However, joint discussions within the teams indicated that the effects manifested themselves in the developed, shared and collective knowledge that formed the basis for the quality of care. It was also found that change had served as a turning point with regard to the quality of care, but that team supervision has partly served as a means to manage change. During the intervention it was discovered that the quality was produced together and required each member's input. Thus, common definitions and agreements on common guidelines were required.

The findings presented above are important, since empirical research into the effects of CS on teams and the quality of care is virtually non-existent, although the theoretical literature (e.g. Butterworth and Faugier 1992, Bishop 1998, Bond and Holland 1998, Dooher et al. 1998) does touch the subject, but at a very general level. The hesitation that was found among the supervisees of this study with regard to the effects of the intervention on the quality of care may be due to the lack of empirical evidence, but also due to the reversed and slightly conflicting perspective expressed in the voluminous literature on quality management for health care services. In the literature, with the emphasis on quality management and improvement, CS has been identified as a tool for or method of quality improvement. CS has been suggested for (a) general practitioners (GP) for improving communication skills and as a divergent problem solving technique (Errebo-Knudsen 1998, see also Lääkärien työnohjaus 1994, Rinne and Rekola 1994), perceived as (b) a method to support quality assurance work (Salo 1991) and (c) as an optional alternative for assuring the quality (see Perälä et al. 1995). The quality assurance perspective on CS is presented more specifically by Mäntysaari (1995) who has created a model with two dimensions: (a) bureaucracy - professionality and (b) external and internal quality assurance. In the model, CS has been defined as the internal-professional quality assurance method thus emphasising the characteristics that have been identified as the main problems for effective and successful quality management efforts.

There are some pioneering studies of CS in nursing that have explored specific aspects of the quality of care. Paunonen (1989) focused her research on the nursing staff's self-reported effects on the observation of patients' needs, on the implementation of the nursing process, and on documentation. The results of the study showed improvements in nursing standards for more than half of the 74 participants. However, over

one-third felt that supervision had no impact on their performance. The conclusion was that CS seemed to have a positive impact on working climate, improve co-operation on the wards and thus the quality of practice. Edber et al. (1996) have reported the effects of CS on the quality of nurse-patient co-operation. The findings of the study showed significant differences in the co-operation style during the intervention. A distinct change was found in the nurses' style to react to severely demented patients' resistance by not turning to tasks or to others, but to the relationship. The nurses' activity in tasks and relationship aspects also increased. The conclusion was that CS improved the quality of nurse-patient co-operation. A few CS intervention studies (e.g. Hallberg and Norberg 1993, Berg et al. 1994, Hallberg et al. 1994) have also discussed the implications of an intervention for the quality of care, but most of the studies have been designed to show improvements in staff wellbeing and work satisfaction, and the effects on the quality of care have been concluded indirectly.

The findings of this study showed that the effects of team supervision included developed, shared and collective knowledge that formed the basis for the quality of care. Hallberg (1994), Sloan (1999b) and Arvidsson et al. (2001) have also reported on the effects of CS on the development of knowledge. Hallberg (1994) explored psychiatric nurses' (n=11) satisfaction with nursing care, tedium, burnout and the nurses' own reports on the effects of CS. One of the findings in this one-year follow-up study was that CS was seen as a way to show (i.e. make explicit) and introduce into use (i.e. share and reflect within a group) the knowledge embedded in practice. The CS sessions did not provide any new knowledge, but uncovered the knowledge that was embedded in daily practice and the effect of CS was more of a confirming nature. In a more recent study Sloan (1999b) has described the effect of CS on 'personal knowledge', and Arvidsson et al. (2001) reported on psychiatric nurses' (n=10) conceptions of the effects of two-year group supervision on professional competence. One of the findings was that the intervention promoted gaining knowledge and competence. This was materialised through developed insight into integrating practical and theoretical knowledge, adopting a more advanced nursing terminology (i.e. acquiring a language for work) and understanding more profoundly the essence of nursing. It was concluded that CS promoted the reflection on experiences and thus supervisees learned to identify their accumulated knowledge apart from tacit knowledge. The findings of this study concerning the shared and collective knowledge that developed during team supervision thus receive support from earlier studies of CS. On the other hand, the importance of knowledge for high quality work (e.g. Salo 1991) and the necessity of a knowledge base with critical use (e.g. Mäntysaari 1995) have also been acknowledged in the quality management and quality improvement literature and thus lend support to the findings of this study.

The findings of this study showed that change was identified as a turning point with regard to the quality of care, but it seemed that the different changes in practice were more manageable with the opportunity to process these in team supervision. McFeely and Cutcliffe (2001) have reported similar findings from a group supervision programme that was found effective and helpful with respect to copious changes resulting in increasing demands and stress among nursing staff. The effects of CS found were that the evidence-based practice had developed, the enhanced and enriched practice improved especially the safety of care, but also promoted the quality of practice. There are several recently published reports describing the benefits and support of CS for managing change (Hale 1999, Proctor et al. 1999) and

uncertainty in practice (Deery 1999b), managing the emerging and changing dynamics in patient relationships (Deery 1999a) and pressure for changing and developing advanced professional practice and competence (Burden and Jones 2000), which thus support the findings of this study.

This study showed that the intervention had contributed to the teams' recognition of quality as jointly produced, that it depended on each member's input and thus common definitions and agreements on common guidelines were required. Jokiranta (1997) has reported on a project in social care on collective improvement in services by applying CS groups and client feedback. In the project, supervisees analysed and processed the feedback collected from clients. This solution was successful, since the feedback did not remain detached or superficial, but catalysed a chain reaction in the group of supervisees: in the first phase, an examination of one's working methods from the client's perspective was begun; in the second phase, the need for additional information for working more beneficially was recognised; and in the third phase, inefficient documentation routines were changed. During the group supervision sessions, the supervisees' own knowledge and experiences were the basis for examining the practice, but these were processed further collectively within the group utilising the group members' experiences, knowledge and client feedback. The findings of this study and those reported by Jokiranta (1997) thus seem to show the power of team or group supervision in collective quality improvement efforts.

To sum up, the findings of the effects of team supervision on the quality of care presented above seem to correspond in an interesting way to the recommendations for quality management in social and health care, formulated by the Finnish National Research and Development Centre for Welfare and Health (Sosiaali- ja terveydenhuollon laadunhallinta 2000–luvulle 1999, see also Laadunhallinta sosiaali- ja terveydenhuollossa 1995). The recommendation emphasises among other things that (a) the efforts of quality management are patient-oriented and thus patient feedback should be obtained and utilised, (b) staff are the necessity for good quality and thus the promotion of professional competency is required through education (i.e. professional 'know-how'), support for well-being and commitment, (c) quality work is based on managing the processes (i.e. service lines and chains) by describing these with the recommendations supplied (d) knowledge and information are emphasised: the practice is based on knowledge by following, measuring and assessing the practice systematically. In this study, systematic patient satisfaction feedback was utilised and reported to ward staff. The team supervision intervention, known in the literature (e.g. Proctor 1986, see also Proctor 1991) for its educational, supportive and normative functions was organised on the wards. The continuous self-monitoring of work and the patient satisfaction feedback showed that the variation in the patients' assessments decreased. The finding of this study thus seem to suggest that team supervision is a method for quality management in health care.

6.3. Implications for practice and suggestions for future studies

(1) The findings of this study have produced new knowledge of the effects of team supervision in the (a) teams and of the impact of the intervention on collaboration within the teams, team relationships, communication, development of practice and management of change (see e.g. Paunonen et al. 1996, Elovainio et al. 1997, Mäkelä et al. 1998, Galvin et al. 1999). The study has also explored the effects of

team supervision in the operating theatres and on perioperative practice that has been very scantly studied (e.g. Bassett 1999, Smith 1999). The study evidenced that intervention is a powerful method and an option to develop health care services, but that the effects and experiences seemed to be quite different on the participating wards. An interesting notion was that the intervention materialised differently among staff regardless of the similarities in the theoretical frameworks used by supervisors who were, however, not utilising any specific theories. The findings showed that in every team critique and challenges were expressed, but that the teams' and supervisees' reactions and abilities for processing this 'catalysis' for change and development seemed to vary considerably. This notion supported the decision to describe the variety of the effects, difficulties and problems that were evidenced during the intervention since these seem to present important challenges for supervisors in how to manage team supervision. In this study the reasons behind the differences in the findings remained unexplored, and an interesting topic for future research would be to focus more closely on group dynamics, size of the group and the interaction within the teams during team supervision intervention. It could also be possible to apply the summarised findings of this study as a model (see Figure 11). This study has described the effects of team supervision only during the intervention that lasted from two to three years. Another interesting and important topic for future research would be whether the effects of team supervision are enduring or just a temporary reflection of the intervention (cf. Arvidsson et al. 2001).

This study showed that the team supervision intervention had in-depth influences on (b) individual supervisees. The importance of this finding is that the intervention seems to play a profound role in team members' development towards flexible and co-operative professionals. Earlier studies (e.g. Draper et al.1999, Hyrkäs et al. 2001a) and this study showed, however, that the individual experiences of team supervision vary from excitement to anxiety and thus the voluntary nature is important to emphasise especially during the team supervision. The supervisors are in a key role for this, but also in supporting supervisees during the intervention. In this study the supervisors' contribution to facilitation within the teams and among the individual team members was not explored. This would be, however, an interesting and important topic for future research since the events in a group may also increase the pressure on its individual members.

The findings of this study evidenced that the intervention clarified one's relation to work, the core of nursing, and noticing and utilising different sources of knowledge at work. These results add to knowledge of the effects CS, but also seem to suggest that this intervention could be utilised more broadly during the health care professionals' career development starting from the education (see e.g. Sairaanhoitajien urakehitys 1996, Karttunen 1999). This study showed that during the intervention (c) the supervisees' perspectives on organisation and especially on participatory management style became more critical. The finding seems to confirm that the participation of ward managers in team supervision is important, as occurred in this study, but that the team supervision intervention also initiated increased requirements for development in ward sisters' and managers' leadership and management style. It is thus possible to suggest that during team supervision wards managers should be offered a chance to receive clinical supervision such as peer supervision. (see e.g. Hyrkäs et al. 2002b)

(2) This study showed that during the team supervision intervention, educational needs did not emerge spontaneously, when access to in-service education was good and the majority of the supervisees considered that the organisation supported their professional development. Earlier studies (see e.g. Sava 1987, Vienola 1995) have shown that CS can promote defining educational needs, channel supervisees learning to essential topics for work and deepen the learning process. It is thus possible to argue that the educational function of CS is a powerful and effective resource together with in-service training. The findings of this study suggest that the educational function of CS could be utilised more efficiently. It is possible to claim that this requires active contribution from supervisors and putting emphasis during the CS sessions for pondering learning needs related to the topic under discussion (see e.g. Northcott 2000, Burden & Jones 2001). In this study the supervisors' contribution to and efforts in promoting the supervisees' and teams' learning remained unexplored. The perspective seems to be, however, an important and interesting topic for future research to produce knowledge for more efficient utilisation of CS. In this study the focus was on describing the effects of CS on the quality of care. The other interesting and important perspective for further studies would be exploring the relations between CS, education (i.e. in-service training and further education) and the quality of care.

(3) In the supervisees' self-monitoring of work a positive trend was found and the findings evidenced that variation in team assessments and in the patient satisfaction feedback decreased. These findings add to the knowledge of the methods applied in CS, which have been studied or indicated scantly (e.g. Paunonen-Ilmonen 2001). The importance of these findings was, however, related to the team supervision practice during the intervention. They showed to the supervisees concretely and visually the minor changes that occurred during the long time period. In earlier studies (e.g. Iberg 1991) the methods of feedback and assessment have been found powerful for facilitating supervisees to systematically observe, analyse and interpret realistically their practice. This study showed, however, that the systematic patient satisfaction feedback and continuous self-monitoring of work had only a moderate influence on the supervisees' functioning, and the majority of the participants criticised the heavy methods. Supervisees suggested less frequent but deeper monthly assessments. The utilisation of the monthly reports could probably also have been more efficient and closely linked with the team supervision than the researcher's contribution. This indicates that supervisors should have the opportunity to contribute to the content of the supervision sessions. In this study the supervisors' contribution and efforts remained unexplored. The supervisor's role seems to be, however, essential and thus an interesting topic for future research from the quality promotion perspective. Another interesting perspective for future studies could be the use of peer-assessment instead of supervisees' self-monitoring combined with peer-assessment and to explore these effects within a team/teams and their functioning.

(4) This study produced new knowledge of the effects of team supervision on the quality of care that has been scantly explored (e.g. Hyrkäs and Paunonen-Ilmonen 2001c) but frequently addressed in the theoretical literature without concrete links to practice (e.g. Bond and Holland 1998, Dooher et al. 1998). The findings seem to suggest that team supervision could be utilised more and probably more efficiently combined with the efforts of quality management and improvement for creating a knowledge-base for

quality promotion efforts (see e.g. Sosiaali- ja terveydenhuollon laadunhallinta 2000 –luvulle 1999) and managing changes.

7. CONCLUSIONS

(1) The intervention had a powerful influence (a) on team relationships, on the development of social intercourse, on communication and on team cohesion. Effects on the teams' functionality and effectiveness of teamwork were evidenced. The intervention seemed to promote the evolution of working methods, work motivation and commitment to work and organisation. However, besides the described positive effects also negative experiences and challenges were evidenced. Team supervision had profound influences on (b) individual supervisees' self-awareness, self-examination and self-relationship. The intervention clarified one's relation to work, the core (i.e. essence) of nursing, and noticing and utilising different sources of knowledge at work. The intervention seemed to promote the standardisation of working patterns, but also acceptance of different work patterns through defined common guidelines. The (c) perspectives on organisation and especially on participatory management style became more critical. The team supervision intervention seemed to strengthen and develop working within the teams through broadened, clarified and critical perspective on practice, patient care and care environment.

(2) Educational needs did not emerge spontaneously during the intervention, when supervisees had access to in-service training and a variety of possibilities for continuous education.

(3) Systematic patient satisfaction feedback and continuous self-monitoring of work seemed to have moderate influence on the supervisees' own functioning and the patients' satisfaction with the health care services. During the intervention, patient care and the supervisees' own functioning was taken in better control. This was evidenced by the improvements in patient satisfaction, the supervisees' more positive assessments and the decreased variation in the patients' and supervisees' assessments. The influences were, however, stronger on some wards than others.

(4) Team supervision seemed to have effects on the quality of care. The intervention initiated development of (a) collective and shared knowledge that formed the basis for the quality of care. The intervention was found (b) as a resource for managing change that acted as a turning point for the quality of care. The team supervision (c) clarified the feature of quality relying on everyone's endeavour and thus requiring common definitions and agreements of the quality requirements. The influences were, however, stronger on some wards than others.

8. SUMMARY

The purpose of this study was to examine and describe the effects of team supervision within the teams and among its individual members from the perspective of professional development during team supervision. The aim was to produce information about the effects of the intervention on the quality of care.

The team supervision intervention was organised on five (5) wards during the years 1995-1998. The medical specialities of the wards were neuro-surgery, ophthalmology and otorhinolaryngology. Ten experienced supervisions, two on each ward, worked during the intervention as a pair on the wards. The team supervision sessions were organised at intervals of about 3-4 weeks, with sessions lasting for an hour and a half. The sessions were arranged outside of the ward. In conjunction with the intervention, the supervisees accomplished weekly systematic self-monitoring of their work. This was summarised and reported back to the supervisees monthly in combination with patient satisfaction feedback (n= 1645). The duration of the intervention was three years on two of the participating wards and two years on three wards.

Data were collected by questionnaires after every six months from the supervisees. The number of respondents who participated in the inquiries was 82 at the beginning of the study. The dropout percentage was 44% and the final number of supervisees participating in the study until the end was 46. After the termination of the intervention also group interviews were conducted. The study comprised of quantitative and qualitative data. The data analysis consisted of statistical analysis and quantitative methods, and the approach was triangulative.

The development that was evidenced during the intervention took the form of improved functionality and commitment to work and organisation in the teams. The supervisees' assessments confirmed that the effectiveness of teamwork improved. The supervisees' relationships with their fellow team members became closer and more interactive along with social interaction. The changes in human relations focused on the attitudes towards others that grew more flexible and thus improved the quality of interaction. The effects within the teams showed evolving feelings of togetherness and communication between the team members. The findings also showed that the developed team relationships formed the basis for team coherence and elaborated working methods within the team with an impact on work motivation.

The findings showed deepening of the individual supervisees' self-awareness. The effects of the intervention included a more positive and permissive self-examination and an open and relaxed self-relationship. The intervention also initiated the processing and matching of work patterns and their integration with the patient-centred approach to care. The effects on work within the teams manifested themselves in clarification of the nature of nursing care. The need for this clarification resulted from pressures of change and from the demands for developing the practice. However, clarification occurred also in the supervisees' own relation to work. Individual work patterns within the teams were recognised, but the necessity of common policy guidelines was noted as well. The different sources of knowledge for work were recognised during team supervision.

The findings indicated that education and development at work were deemed extremely necessary, but changes in educational needs or plans for professional development were not evidenced. Supervisees found it difficult to specify any particular educational needs initiated by the team supervision intervention.

The impact of continuous self-monitoring and patient satisfaction feedback was evidenced. A positively increasing trend was found in the supervisees' assessments, while the variation in the teams' assessments and in the patient satisfaction feedback decreased. The supervisees' self-monitoring approached the patient satisfaction feedback towards the end of the study. The findings showed that there were several different positive and negative factors that affected the supervisees' and patients' assessments and feedback.

The findings from the organisational perspective showed that supervisees became more critical of the participatory management style of ward managers. The effects of team supervision on the supervisees' work on the ward developed through a broadened and clarified standpoint on practice, increased criticality and through finding one's limitations. Increased attention was paid to the ward as a care environment and to patient centred care. For the teams, the effects were seen as developed, established and strengthened practices.

Supervisees themselves found it difficult to specify the effects of team supervision on the quality of care. Within the teams, the effects were seen in terms of developed, shared and collective knowledge that formed the basis for the quality of care. The finding showed that change was identified as a turning point with regard to the quality of care. It was also found that the quality was produced together, that it depended on each member's contribution, required joint definitions and agreement on common guidelines.

The study showed, however, that during the team supervision intervention several challenges and difficulties emerged. The implementation of the team supervision intervention was not without problems, and several factors related to the organisation and practical arrangements for CS seemed to slow down the progress and obscure the effects. However, the wards that participated in the study were different by their speciality, number and background of staff. Several significant differences existed between the teams. It was considered interesting and important to report them in both quantitative and qualitative terms because of the richness they brought in the exploration of team supervision, and because they also described the different group processes and the group dynamics that took place during the intervention.

9. TIIVISTELMÄ

Tutkimuksen tarkoituksena oli kuvata teamien työnohjauksen vaikutuksia teameissa ja sen yksilöjäsenissä ammatillisen kehittymisen näkökulmasta. Tutkimuksen tavoitteena oli tuottaa tietoa työnohjauksen vaikutuksista hoidon laatuun.

Teamien työnohjaus toteutettiin viidellä osastolla vuosina 1995-1998. Osastojen erikoisaloja olivat neurokirurgia, korva-, nenä- ja kurkkutaudit sekä silmätaudit. Kymmenen kokenutta työnohjaajaa työskenteli pareittain tutkimusosastoilla. Työnohjausistunnot järjestettiin 3-4 viikon välein ja istuntojen kesto oli puolitoista tuntia kerrallaan. Istunnot pidettiin osaston ulkopuolella. Interventioon yhdistettiin viikottainen ja systemaattinen työnohjattavien oman toiminnan arviointi ja palaute potilaiden tyytyväisyydestä. Työnohjattavien arvioinnit ja potilaspalaute (n=1645) analysoitiin ja raportoitiin kuukausittain

tutkimusosastoille. Työnohjauksen kesto oli kaksi vuotta kolmella osastolla ja kolme vuotta kahdella osastolla.

Aineisto kerättiin kuuden kuukauden välein kyselylomakkeen avulla työnohjattavilta. Tutkimuksen alkaessa kyselyihin vastanneita osallistujia oli yhteensä 82. Intervention kuluessa kadon osuudeksi muodostui 44 % ja tutkimuksen loppuun asti osallistuneita työnohjattavia oli 46. Työnohjauksen päätyttyä tehtiin myös ryhmähaastattelut. Tutkimuksen aineisto oli määrällistä ja laadullista. Tutkimusaineisto analysoitiin käyttämällä tilastollisia analyysimenetelmiä ja laadullisia menetelmiä. Tutkimuksen lähestymistapa oli trianguloiva.

Työnohjauksen vaikutukset olivat osoitettavissa intervention kuluessa teamien toimivuuden parantumisena sekä lisääntyneenä sitoutumisena työhön ja organisaatioon. Työnohjattavien omat arviot teamin työskentelyn tehostumisesta tukivat tulosta. Työnohjattavien suhteet teamin muihin jäseniin lähenivät ja muuttuivat vuorovaikutteisemmiksi sosiaalisen kanssakäymisen myötä. Ihmissuhteissa tapahtuneet muutokset kohdentuivat asenteisiin toisia kohtaan, jotka muuttuivat joustavammiksi ja tämän myötä paransivat vuorovaikutuksen laatua. Intervention vaikutukset teameissa tulivat esiin kehittyvänä yhtenäisyyden tunteena ja teamin jäsenten välisen kommunikoinnin kehittymisenä. Tulokset osoittivat, että ryhmän jäsenten välisten suhteiden kehittyminen työnohjauksen aikana loi pohjan ryhmän kiinteydelle, työskentelymenetelmien kehittymiselle ollen yhteydessä myös työmotivaatioon.

Tutkimuksen tulokset osoittivat, että työnohjattavien tietoisuus omasta 'minästään' oli syventynyt. Intervention vaikutukset tulivat esiin siten, että työnohjattavien suhtautuminen itseensä muuttui myönteisemmäksi ja sallivammaksi, ja vapautuneisuus ja avoimuus lisääntyivät. Työnohjaus käynnisti myös omien työtapojen prosessoinnin ja sovittamisen muiden työtapoihin sopiviksi sekä yhdistämisen potilaskeskeiseen lähestymistapaan hoitamisessa. Vaikutukset työntekoon teamissa tulivat esiin hoitotyön luonteen selkiytymisenä. Tarvetta työn selkiytymiseen aiheuttivat myös muutospaineet ja vaateet toiminnan kehittämisestä. Lisäksi selkiytymistä tapahtui työnohjattavan omassa suhteessa työhönsä. Teamissa oli huomattu yksilölliset työskentelytavat, mutta myös yhteisten linjojen määrittelyn tarpeellisuus toimintatavoille oli olivallettu. Erilaiset tiedon lähteet työssä tunnistettiin teamin työnohjauksen aikana.

Tutkimuksen tulokset osoittivat, että koulutusta ja työssä kehittymistä pidettiin erittäin tärkeänä. Intervention kuluessa työnohjattavien koulutustarpeissa tai ammatillisen kehittymisen suunnitelmissa ei kuitenkaan tapahtunut muutoksia. Työnohjattavat pitivät hyvin vaikeana määritellä tai yksilöidä mitään sellaista koulutustarvetta, joka olisi aiheutunut työnohjausinterventiosta.

Oman työskentelyn jatkuvan arvioinnin ja potilastyytyväisyyspalautteen vaikutukset olivat osoitettavissa tutkimuksen kuluessa. Työnohjattavien arvioinnit kehittyivät positiiviseen suuntaan, ja vaihtelu teamien arvioinneissa ja potilastyytyväisyyspalautteissa väheni. Tutkimuksen loppupuolella työnohjattavien arviot omasta toiminnastaan lähenivät potilastyytyväisyyspalautetta. Tutkimuksen tulokset osoittivat, että monet eri tekijät vaikuttivat myönteisesti ja kielteisesti niin työnohjattavien oman työskentelyn arviointiin kuin potilastyytyväisyyteenkin.

Organisaation näkökulmasta tarkasteltuna tutkimuksen tulokset osoittivat, että työnohjattavat alkoivat suhtautua kriittisemmin erityisesti osastonhoitajien osallistuvaa johtamistyyliä kohtaan. Työnohjattavien työskentely osastolla kehittyi näkökulman laajentuessa ja selkiytyessä käytäntöön

kriittisyyden kasvun ja omien rajojen löytymisen myötä. Entistä enemmän huomiota kiinnitettiin osastoon potilaan hoitoympäristönä ja potilaskeskeiseen hoitoon. Työnohjauksen nähtiin vaikuttavan teameihin siten, että näiden käytännöt kehittyivät, vakiintuivat ja vahvistuivat.

Työnohjattavien mielestä teamin työöhjauksen vaikutuksia hoidon laatuun oli vaikea kuvata yksityiskohtaisesti. Teameissa vaikutukset nähtiin kollektiivisen ja jaetun tiedon kehittymisenä, mikä muodosti perustan hoidon laadulle. Tutkimuksen tulokset osoittivat, että 'muutos' oli tunnistettu käännekohdaksi hoidon laadulle. Lisäksi oli huomattu, että laatua tuotetaan yhdessä ja että laatu riippuu jokaisen teamin jäsenen panoksesta ja tämän vuoksi tarvitaan yhteisiä määritelmiä sekä sopimuksia yhteisistä linjoista.

Tutkimus osoitti kuitenkin, että työnohjausintervention aikana tuli vastaan monia haasteita ja vaikeuksia. Teamin työnohjauksen toteuttaminen ei sujunut ongelmitta ja useat organisaatioon sekä työnohjauksen käytännön järjestelyihin liittyvät tekijät hidastivat ja hämärsivät työnohjauksen vaikutuksia. Tutkimukseen osallistuneet osastot olivat kuitenkin erilaisia erikoisaloiltaan, osallistujamääriltään ja taustoiltaan. Teamien välillä oli merkitseviä eroja ja näiden raportoiminen nähtiin kiinnostavana ja tärkeänä niin määrällisesti kuin laadullisestikin, koska nämä rikastivat teamien työnohjauksen tutkimusta kuvaten erilaisia prosesseja ryhmissä intervention aikana.

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Tampereella huhtikuussa 2002

Kristiina Hyrkäs

Appendix 1. Overview of previous research into CS

RESEARCHER	SAMPLE (N)	METHOD OF DATA COLLECTION	METHODS OF DATA ANALYSIS	FRAMEWORK/ MODEL USED a) in report or article b) in CS intervention	DISCIPLINE: SPECIALITY	MAIN RESULTS
Paunonen (1988)	Supervisory group 74 Comparison group 70	Questionnaire: baseline and at the end of intervention (duration of CS intervention: one year)	statistical: log-linear modelling and qualitative content analysis	a) professional development b) improvement of quality, professional development and occupational safety	Nursing: many specialities	- the results evidenced personal growth, but limited effect on professional identity, - CS improved quality of care and documentation
Kaltiala & Sorri (1989)	54 medical doctors (GP) in one university hospital	Questionnaire: thematic interview	qualitative content analysis	a) modes and functions of CS	Medicine: many specialities	- GPs (1/2) were aware of CS and willing (3/4) to participate - the main function of CS was seen as unloading work pressure - the attitudes were positive (4/5), but suspicion of employer's control and manipulation of work was evidenced, of being labelled incompetent and fears of anxiety - GPs were identified as appropriate supervisors for their own profession
Paunonen (1991)	26 nurses undergoing supervisor training	Questionnaire: baseline, at the end and 1 year later (duration of CS intervention: two years)	statistical: log-linear models	a) role of CS and changes initiated by it b) nursing and patient needs, based on Yura & Walsh's model	Nursing: many specialities	- CS improved supervisees' willingness to act, freedom of action and nursing activities
Aavarinne et al. (1992)	171 nursing practitioners	Questionnaire	statistical: descriptive statistics, cross tabulations and content analysis	a) needs and goals of clinical supervision	Nursing: medical and neurological care	- CS supported mental health and expert practice, promoted knowledge and skills development - the identified main goals were personal growth and development of collaboration - haste, distressing relations and demanding nature of nursing gave rise to the need for CS

Jakonen-Kaasalainen (1993)	25 supervisees (groups: practitioners in health and social care services)	Questionnaire: baseline inquiry, 1 year and at the end of CS (duration of CS intervention: two years)	Statistical: descriptive statistics, t-test, Chi-square test, ANOVA, correlation coefficients and cross tabulations	a) Bion's theory of group development and supervisee's personal development	Psychology: target group in the study represented <u>many specialities in nursing</u> and social services	- supervisees became more independent professionals during CS - conceptions of ideal professional became more realistic - conceptions of the mission in practice changed: anticipation of outcomes of work and feedback increased - decision to continue CS was connected to the culture in the CS groups and the supervisors' professional awareness
Segesten (1993)	21 supervisees	Questionnaire: Instrument by Dagenis & Meleis - baseline and at the end (duration of CS intervention: four months)	statistical: t–test	a) role and focus of CS b) focus on professional role and identity	Nursing: orthopaedic care	- CS strengthened nurses' professional identity: the intervention affected work ethics, professionalism and empathy the most - the effect on leadership was slightest - five nurses' scores lowered during CS, explained by a more realistic self-conception
Berg et al. (1994)	Supervisory group 19 Comparison group 20	Questionnaire: Creative Climate Questionnaire, Burnout Measure, Maslach Burnout Inventory - at baseline, at six months and at the end (duration of CS intervention : one year)	statistical: Friedman two-way ANOVA, Mann-Whitney U-test	a) creativity, tedium and burnout in nursing b) individually planned and documented nursing care, two-day course in dementia and CS focusing on patient care	Nursing: dementia care	- tedium and burnout decreased significantly among nurses on experimental ward while no changes were found on control ward - CS increased nurses' creativity and innovative climate on experimental ward: changes were found in idea-support, trust, dynamism, risk-taking and idea-time; also conflicts decreased significantly
Hallberg (1994)	11 supervisees	Questionnaire: the tedium measure, Maslach Burout Inventory, satisfaction with nursing care Open-ended questions: CS's effects personally, on job performance and collaboration - at baseline, at six months and at 1 year (CS intervention: one year)	Statistical: Friedman two-way ANOVA Qualitative: open coding and categorisation	a) effects and modes of CS in nursing b) psychodynamic theory and focus on patient care	Nursing: child psychiatric care	- feeling of being understood and understanding others led to improved co-operation and self-confidence - broadened and improved knowledge base increased goal-oriented and active nursing actions - increased satisfaction with responsibility, organisation, quality of care, co-operation and comfort in the working group - decreased tedium, but no changes in the degree of burnout

(continues)

Hallberg et al. (1994)	Supervisory group 19 Comparison group 20	Questionnaire: at baseline, at six months and at the end (duration of CS intervention: one year)	statistical: principal components analysis, Willcoxon rank sum test, Friedman two-way ANOVA	a) Nurses' satisfaction with work b) individually planned and documented nursing care, two-day course in dementia, CS focusing on patient care and giving support to nurses	Nursing: dementia care	- during CS nurses on experimental ward reported improvement in praise, professional growth, autonomy and quality of care; their feelings of co-operation with colleagues and comfort improved significantly; no changes were found on control ward - the quality of written documentation on patient needs and care improved significantly - during CS nurses' satisfaction with nursing care and work improved
Kiuttu (1994)	- doctors (12) (GP) undergoing supervision during family doctor training and - control group (14) - supervised doctors' patients (85) and - control group's doctors' patients (37)	Questionnaires: baseline, after one year, and at the end of training; evaluation inquiry one year after the training and estimation of patient's diagnosis (duration of CS intervention: two years) Control group: questionnaire one year after termination of training in experimental group and opinion of satisfaction Patients: Cornell Medical Index (CMI) and satisfaction inquiry	Statistical: matched pairs (GP), Chi-square test, distribution independent mark test	a) patient-doctor relationship and the meaning of family, family therapy theories b) CS focusing on patient care within a family context (indirect CS and direct CS)	Medicine: GPs' training in family systems medicine	- conceptions of health and illness changed in a more understanding direction in the training group, also reflecting family and system orientation in the practice - transferring responsibility to others decreased and job satisfaction increased - utilising patient-doctor relationship improved - patients in the control and experimental groups were similarly satisfied with working methods, quality of care and the GP at the beginning and end of the training - patients in the control group rated the GPs more often as hasty, less frequently as broad-minded and understanding than those on the experiment group
Pålsson et al. (1994)	32 supervisees	Semi-structured interview (duration of CS intervention: one year and two months)	Phenomenological-hermeneutical method: Ricoeur	a) demanding care situations and need of support b) a model of psycho-social care for breast cancer patients, training programme (40h) for this and CS based on Ekstein & Wallerstein's model	Nursing: cancer care	- the findings indicate that there is a great need to unburden oneself of job-related thoughts and feelings, and to receive support after emotionally demanding caring situations - nurses reported that CS had provided relief, confirmation (related to one's actions, nurse as a person and one's professional role) and promoted professional development (in the form of broader and deeper knowledge, self-confidence and increased sense of well-being)

(continues)

Pålsson & Nordberg (1995)	23 supervisees	Tape-recorded supervision sessions (duration of CS intervention: one year and two months)	Phenomenological-hermeneutical method: Ricoeur	a) CS as a method to support nurses and narrative method as a means to facilitate reflection b) a model of psycho-social care for breast cancer patients, training programme (40h) for this and CS focused on supporting nurses emotionally based on Ekstein & Wallerstein's model	Nursing: cancer care	- the findings illuminated difficult care episodes and experiences expressed during CS such as: coming too close to a patient; keeping and restoring patient's hope; conflicting opinions; feeling powerless; meeting unrealistic demands; patient's trust in alternative medicine; feeling disgust, shame and guilt; relations with patients' families and communication gaps - the findings confirmed that district nurses experienced problems and difficult care episodes with seriously ill patients, but they also served as containers for patients' emotional strain and supported relatives in their anxiety - the same experiences seemed to include positive and negative dimensions - the findings confirmed that support is needed in the form of CS in demanding care situations as this relieves practitioners of feelings and thoughts evoked while providing care
Titchen & Binnie (1995)	Nursing staff in one (1) acute medical unit	Theory generating action research: participant observation, in-depth interviews and documentation review (duration of data collection: three years)	Qualitative analysis of collected material	a) facilitation of professional growth and learning in practice during a transition from traditional nursing to a method of primary nursing	Nursing: many specialities	- three supervision strategies emerged: 1) 'tell me about', 2) 'what I was trying to do' and 3) 'not just an observer' - learning was meaningful as it was based on ones' own perceived learning needs and the clinical practice
Vienola (1995)	Group (31) undergoing supervision training three (3) supervisors	Case study a) questionnaire (five) evaluative inquiries b) diary (duration of CS intervention: two years)	Qualitative: thematic content analysis	a) contents of CS education: history of CS, modes and models of CS, systems theory and change b) experiential learning, systems theory, continuous evaluation	Multi-disciplinary: teachers, social workers and <u>health care professionals</u>	- systems theory was a suitable framework for supervisor training - working methods based on systems theory were educational and suitable as they supported working in real supervision situation - continuous evaluation was heavy but contributed to thinking about supervisees' own goals, deepened learning and directed the learning process

(continues)

Edberg et al. (1996)	111 observations on experimental and control wards	non-participatory observation with field notes, observations were collected before (66) and during (45) intervention: notes were taken every 5 minutes and each observation lasted 1 hour (duration of CS intervention: one year)	statistical: observations were coded and sorted into 10 nurse-patient co-operation categories developed; the data were analysed using the Mann-Whitney U–test	a) quality of care with dementia patients and nurse-patient co-operation b) two-day training session on dementia and CS - care planning, provision, evaluation and organisation of care	Nursing: dementia care	- improved co-operation style between nurses and patients: episodes of low-quality co-operation characterised by resistance and use of force decreased and the number of high-quality co-operation episodes increased significantly on experimental ward - patients became more active and nurses turned more to patients as well as to the tasks - nurses became more aware of their own feelings, strategies and interaction with patients
Pålsson et al. (1996)	Supervisory group 21 Comparison group 12	Questionnaire: Karolinska Scale of Personality, the Burnout measure, the Empathy Construct Rating Scale, the Sense of Coherence Scale - baseline and at the end (duration of CS intervention: one year)	statistical: Willcoxon signed rank test, Mann-Whitney U-test	a) job related stress, feelings of strain and the negative impacts on quality of care, - the evidenced effects of CS and reflection on sense of coherence and empathy b) a training programme (40h) in breast cancer patients' medical and psycho-social care and CS based on Ekstein & Wallerstein's model	Nursing: cancer care	The results indicated significant correlation between burnout, empathy and sense of coherence: - the highest correlation was found between empathy scores and the somatic anxiety variables (of the Karolinska Scale of Personality) - the lower the scores of empathy and sense of coherence were, the higher were the scores of burnout and somatic and psychic anxiety - significant negative correlation was found between empathy scores and detachment – psychasthenia - negative correlation was found between empathy and burnout scores, but also between sense of coherence and burnout scores - however, no significant differences were found between these phenomena over time within the groups, nor between the groups at baseline or after CS and the researchers' conclusion was that CS had no effects on burnout, empathy or sense of coherence

Severinsson & Hallberg (1996)	26 supervisees	Questionnaire (duration of CS intervention: one and a half years)	statistical: Factor analysis, Mann-Whitney U-test	a) the objectives, pedagogical function and effects of CS on job satisfaction, duties and working milieu b) Eriksson's theory of 'caritative caring'	Nursing: psychiatric care	- the respondents' views of the effects of CS included (i) improved communication skills, (ii) improved sensibility to patients' needs and (iii) personal growth - the respondents' conceptions of effects of CS were quite similar, but differences were found in the views regarding influence on duties, patient relations and decision-making - the conceptions of the effects of CS were not related to how the working milieu or possibility to influence duties was experienced - conclusion: CS had influenced nurses' sensibility towards their patients and their personal growth
Bégat et al. (1997)	34 supervisees	Questionnaire: baseline and after 9 months (duration of CS intervention: nine months)	statistical: Mann-Whitney U–test	a) CS as a pedagogical and reflective process, its effects on job satisfaction, working situation and milieu b) Eriksson's theory of 'caritative care' (400 h education)	Nursing: medical care	- the relationship between working milieu and effects of CS were evidenced as: conceptions of changed communication possibilities, increased confirmation of one's work and improved satisfaction with information-giving including information about change
Butterworth et al. (1997)	survey of 586 nursing practitioners a) control group (n=216) b) supervisees (n=217) c) supervisor group (n=153)	Minnesota Job Satisfaction Scale, Nurse Stress Index, MBI, General Health Questionnaire, Interviews (n=34) - control group: two measures in 9 months - test group: 3 measures during 1½ yrs - after 9 months the control group was exposed to CS: this group received measures 9 months later - supervisor group was exposed to CS: three measures in 18 months	Statistical: correlations, Kruskall-Wallis, Chi –square, descriptive statistical methods Qualitative: thematic content analysis	a) background of CS, official recommendations, criticism and discussion about CS in international studies	Nursing: different degrees and many specialities	- CS had effects on the participants and their work - during the study depersonalisation and emotional exhaustion increased but in control group decreased or stabilised - supervisors' emotional exhaustion increased if there was no participation in CS - interviews confirmed that CS supported nursing staff

(continues)

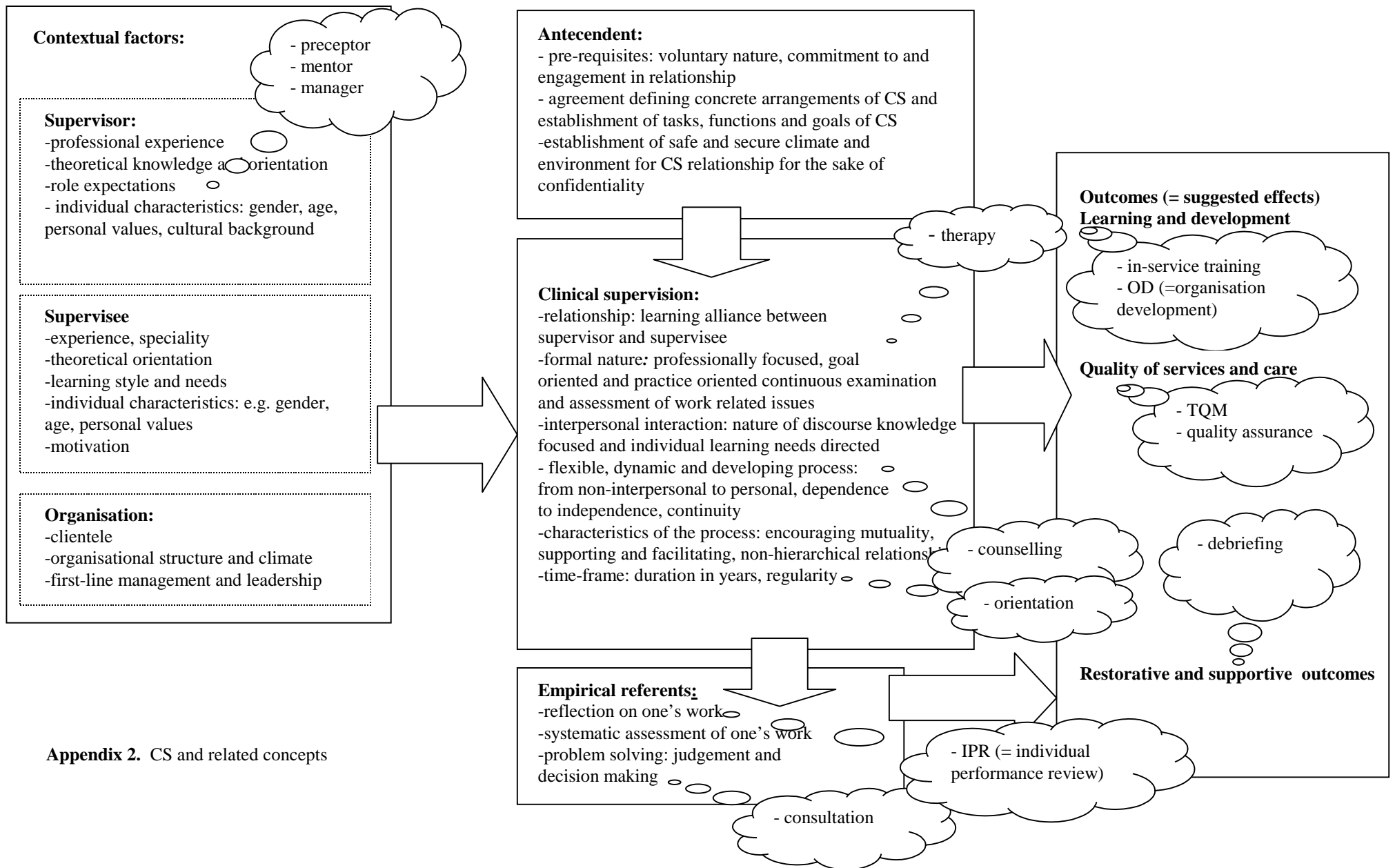| Cutcliffe & Epling (1997)	three case studies	qualitative: examples of real clinical situations	description and comparison of cases through Heron's theoretical constructs of confronting intervention	a) different models of CS and confronting interventions b) Heron's theoretical model and confronting interventions in CS	Nursing and counselling	Confronting interventions are shown to: prompt realistic appraisal of nursing interventions with a reference to level of self-confidence - catalyse personal growth and development - challenge examining values, ethics, blurred roles and boundaries through cognitive dissonance
Elmcrona & Winroth (1997)	10 supervisees	semi-structured interview at the end of two-year CS	thematic qualitative analysis	a) changes in health care organisations and CS in relation to these b) reflection of emotions	Nursing: neurological care	- CS gave nurses courage and pronounced experience of support from colleagues - CS improved nurses' sense of professionalism and self-image
Kilpiä & Virta (1997)	80 members of five (5) multiprofessional teams	questionnaire: baseline inquiry	statistical: descriptive statistics and content analysis	a) reflective learning, professional development, learning in organisation and CS b) eclectic approach to CS	Multi-disciplinary: health care teams	- team supervision was expected to support professional development and promote collaborative skills - professional development was seen to be promoted through: self-appreciation, challenging work, appreciating success, commitment, awareness of goals in practice, willingness to develop and support from colleagues - consistency and sufficiency of in-service training was rated as dissatisfactory
Marrow et al. (1997)	10 supervisors 20 supervisees	action research: structured interviews utilising repertory grid technique based on Kelly's personal construct theory and focused discussion groups (duration of CS intervention: two years)	Qualitative and quantitative: descriptive statistics	a) background of the study b) Heron's model: (framework for supervisors' diaries) and critical incident framework (framework for supervisees' diaries)	Nursing	- CS was found beneficial by supervisors and supervisees - CS enabled participants to become more aware of their own feelings, to practice and to gain insight into other practitioners' feelings and behaviours

Scanlon & Weir (1997)	10 supervisees	semi-structured interviews	Qualitative: constant comparative method and description of emerging themes	a) learning from practice effectively and reflection, practitioner-supervisor relationship and promotion of effective CS and reflection	Nursing: psychiatric care	- the most important experience was a feeling of being valued and appreciated by supervisor and the crucial component of CS was the opportunity to talk in supportive environment - the need for support focused on complex therapeutic relationships but also on interpersonal dynamics in terms of enabling a nurse to develop - an appropriate supervisor (from the perspective of learning) did not promote suspicion, but feelings of trust, a competent senior with proper education
Fowler & Chevannes (1998)	558 supervisees	questionnaire	Statistical: descriptive statistical methods	a) reflection, reflective practice and characteristics of CS based on Proctor's model	Nursing: many specialities	- almost half of respondents identified the three aspect of CS - the expectations of CS efficiency were high (i.e. not waste time; helping to focus on strengths, weaknesses and reduce stress) - expectations of the effects on the stress levels were not similar - implementation of CS was rated positively and as a way of reflecting upon and influencing on patient care
Berg & Hallberg (1999)	22 supervisees	questionnaires: Sense of Coherence scale, Creative Climate Questionnaire, Work-Related Strain Inventory and Satisfaction with Nursing Care and Work Questionnaire - baseline, six and twelve months of intervention (duration of CS intervention: one year)	Statistical: factor analysis, Friedman's two-way ANOVA, two-tailed Wilcoxon's Matched-Pairs Signed-Ranks Test, Spearman's rank-order correlation	a) stress in nursing, sense of coherence, reflective practice and CS b) introduction day and two follow-up days of care planning and documentation, CS focusing on patient care (patient care, feelings evoked in nurse-patient relationship and effects on actions)	Nursing: psychiatric care	- nurses' sense of coherence remained unchanged - no significant changes were found in sense of coherence, satisfaction with nursing care or work related factors - creativity improved in three out of ten dimensions - effects on work climate and interplay were rated as positive at 6 months and even more positive at 12 months - strong sense of coherence correlated with low work-related strain, but not with unsatisfactory working conditions/milieu
Bowles & Young (1999)	201 supervisees	questionnaire: developed from Proctor's model	statistical: descriptive statistical methods, Spearman's correlation, Kruskall-Wallis-test	a) benefits, different functions of CS and hypothesis testing based on Proctor's model	Nursing: many specialities	- the benefits for each three dimensions were almost similar: normative benefits were rated highly and formative the least - the results supported the model and challenged the notion of CS as a mechanism for off-loading occupational stress

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Edberg (1999)	19 supervisees and 20 nurses on comparison ward 106 (9+22+75) patients	1) Questionnaires: Mini Mental State Examination, Organic Brain Syndrome Scale, Demanding Behaviour Assessment Scale, Multi-Dimensional Dementia Assessment Scale, The Patient Mood Assessment Scale, General Behaviour Assessment Scale, Gottfries Bråne Steen Scale 2) Tape recordings 3) Non-participant observations 4) Notes from CS sessions Data collection: baseline, after 6 and 12 months (duration of CS intervention: one year)	statistical: Chi-square, Wilcoxon rank sum test, Mann-Whitney U-test, Kruskal-Wallis one-way ANOVA, discriminant analysis, Friedman Test, Spearman rank-order correlation, principal component analysis with varimax rotation content analysis phenomenological-hermeneutic analysis	a) nursing care for patients with dementia, the disease and reactions to it, strategies to support nurses working in dementia care b) two-day training session on dementia, individually planned care and CS - care planning, provision, evaluation and organisation of care	Nursing: dementia care	- significant improvements were found on EW for nurse-patient encounters, patients' sensitivity and demanding behaviours while the findings were opposite on CW with the nurse-patient encounters, patients' functional performance and orientation on the ward, speech performance and strength - mutuality and confirming actions characterised high quality encounters and uni-laterality, dis-confirming actions characterised poor quality encounters - the nurses' assessments of patients' state (inter-rater reliability) was acceptable for ADL and intellectual functions, but low for emotional dimensions - the nurse-patient encounter and the patients' state developed in opposite directions on the EW and the CW, positively on the EW and seemingly the intervention supported the nurses' encounter with patients (e.g. interpreting the reasons for behaviour), which in turn reflected the patients' state
Severinsson & Kamaker (1999)	158 supervisees	questionnaire: The Moral Sensitivity questionnaire	statistical: Mann-Whitney U–test, factor analysis and varimax rotation, Spearman rank correlation coefficients	a) nurses' job satisfaction, moral stress and sensitivity, ethical problems at work and CS	Nursing: nurses from one public general hospital	- moral stress (i.e. inter-personal orientation, structuring moral meaning, expressing conflict and benevolence, autonomy) was evidenced at the work place (i.e. in relation to superiors and colleagues, stress, perceived anxiety, physical /mental problems and engagement) - significant relationship existed between moral sensitivity and systematic CS

(continues)

Arvidsson et al. (2000)	10 supervisees	Interviews on two occasions: after 1 and 2 years participation in group supervision (duration of CS intervention: two years)	Phenomenographic approach	a) CS as a formal process of professional support, learning and reflection, the concept of CS: evidenced negative and positive consequences in practice from the perspective of professional competence b) Sarvimäki & Stenbock-Hult's nursing model	Nursing: psychiatric care	The influence of group supervision focused on: (i) a <u>feeling of job satisfaction</u> that was composed of such conceptions as: sharing experiences, being confirmed, being independent, gaining energy, a feeling of fellowship (ii) <u>gaining knowledge and competence</u> that was composed of such conceptions as: gaining insight, handling the terminology, changing perspectives, understanding the essence, having a role model (iii) <u>gaining a sense of security in nursing situations</u> that was composed of the following conceptions: reflecting upon personal opinions, being attentive, realising the importance of the encounter (iv) a <u>feeling of personal development</u> that was composed of the following conceptions: gaining self-confidence and achieving personal development
Hadfield (2000)	12 supervisees	Semi-structured interview applying vignettes based on Proctor's model	Content analysis and reconstructed narratives	a) background of the study b) Proctor's model of normative, formative and restorative elements of CS	Nursing: paediatric care	- CS relationship is essential for development of good practice: this is characterised by support, safety, trust, respect and impartiality - CS is analytical: exploration of and working through thoughts, feelings and actions utilising reflection: this allows debriefing, challenge and understanding - CS is consequential: the outcomes include development of personal, professional and clinical skills that influence (improve) patient care as well
Teasdale et al. 2001	96 supervised and 115 un-supervised nurses	Questionnaire: Maslach Burnout Inventory, Nursing in Context and Critical Incidents Questionnaires	Qualitative: open coding Statistical: frequencies and percentages, Mann-Whitney U statistics, Chi-square test, Kolmorogov-Smirnov –test, t-test, multivariate regression analysis	a) function of CS, recent effectiveness/ evaluation studies, cultural differences and critical examination of the studies' methodological solutions and results	Nursing: general medical, surgical and community adult nursing	- supervised nurses used additional informal support networks for more immediate support, advice and CS was used for reflection on action: the quality of support (reassurance) was most important - no significant differences were found in burnout between supervised and unsupervised nurses - supervised nurses, especially the lower grade, young hospital nurses reported a more listening and supportive management, coping better at work and feeling better access to support than unsupervised ones

Contextual factors:

- preceptor
- mentor
- manager

Supervisor:
-professional experience
-theoretical knowledge a orientation
-role expectations
- individual characteristics: gender, age, personal values, cultural background

Supervisee
-experience, speciality
-theoretical orientation
-learning style and needs
-individual characteristics: e.g. gender, age, personal values
-motivation

Organisation:
-clientele
-organisational structure and climate
-first-line management and leadership

Antecendent:
- pre-requisites: voluntary nature, commitment to and engagement in relationship
- agreement defining concrete arrangements of CS and establishment of tasks, functions and goals of CS
-establishment of safe and secure climate and environment for CS relationship for the sake of confidentiality

- therapy

Clinical supervision:
-relationship: learning alliance between supervisor and supervisee
-formal nature*: professionally focused, goal oriented and practice oriented continuous examination and assessment of work related issues
-interpersonal interaction: nature of discourse knowledge focused and individual learning needs directed
- flexible, dynamic and developing process: from non-interpersonal to personal, dependence to independence, continuity
-characteristics of the process: encouraging mutuality, supporting and facilitating, non-hierarchical relationship
-time-frame: duration in years, regularity

Empirical referents:
-reflection on one's work
-systematic assessment of one's work
-problem solving: judgement and decision making

- counselling

- orientation

- consultation

- IPR (= individual performance review)

Outcomes (= suggested effects)
Learning and development

- in-service training
- OD (=organisation development)

Quality of services and care

- TQM
- quality assurance

- debriefing

Restorative and supportive outcomes

Appendix 2. CS and related concepts

Tampereen Yliopisto
Hoitotieteen laitos
Tampereen yliopistollinen sairaala
11.6.1996

OSASTO   _____
VASTAAJAN
NUMERO   _____

KYSELYLOMAKE

Pyydämme ystävällisesti Sinua vastaamaan kysymyksiin joko **rengastamalla** Sinulle parhaiten
sopivan vaihtoehdon, **täydentämällä** avoimet kohdat tai **vastaamalla avoimiin kysymyksiin.**
Käytä tarvittaessa lomakkeen kääntöpuolta.

1. SUKUPUOLENI

   1. Nainen
   2. Mies

2. SYNTYMÄVUOTENI _____

3. VIRKANIMIKKEENI

   1. Apulaislääkäri
   2. Apulaisosastonhoitaja
   3. Apulaisylilääkäri
   4. Erikoissairaanhoitaja/terveydenhoitaja
   5. Lääkintävahtimestari
   6. Osastonhoitaja
   7. Osastonlääkäri
   8. Osastonsihteeri
   9. Perushoitaja
  10. Sairaanhoitaja
  11. Välinehuoltaja
  12. Ylilääkäri
  13. Muu, mikä _____

4. OLETKO TÄLLÄ HETKELLÄ?

   1. Vakinainen viranhaltija
   2. Viransijainen, virkaa tekevä tai väliaikainen
   3. Jokin muu, mikä _____

5. KAUANKO OLET TYÖSKENNELLYT TERVEYDENHUOLLON ALALLA?_____v

6. KAUANKO OLET TYÖSKENNELLYT NYKYISESSÄ TEHTÄVÄSSÄSI_____v

7. MILLÄ OSASTOLLA OSALLISTUT TYÖNOHJAUKSEEN?_____

SEURAAVAT VÄITTÄMÄT KUVAAVAT **KÄSITYKSIÄSI** NYKYISESTÄ **TYÖSTÄSI.** RENGASTA JOKAISESTA VÄITTÄMÄSTÄ TYÖTÄSI **PARHAITEN KUVAAVA VAIHTOEHTO.**

	Kuvaa erittäin huonosti						Kuvaa erittäin hyvin
8. Viihdyn hyvin nykyisessä työssäni	4	5	6	7	8	9	10
9. Työni on haasteellista	4	5	6	7	8	9	10
10. Voin käyttää työssäni kykyjäni ja taitojani	4	5	6	7	8	9	10
11. Minulla on mahdollisuus oppia työssäni uusia asioita ja kehittää itseäni	4	5	6	7	8	9	10
12. Haluan tehdä työtäni, koska se tuottaa minulle tyydytystä	4	5	6	7	8	9	10
13. Työtoverini eivät arvosta riittävästi työtäni	4	5	6	7	8	9	10
14. Arvostan kuulumista työyhteisöön, jossa työskentelen	4	5	6	7	8	9	10
15. Minulla on mahdollisuus vastata työkokonaisuuksista (ts. tehdä työ alusta loppuun eikä vain osasuorituksina)	4	5	6	7	8	9	10
16. Voin työskennellä itsenäisesti ja vapaasti (esim. valita työmenetelmät ja asettaa tavoitteet)	4	5	6	7	8	9	10
17. Olen hyvin selvillä osastoni toiminnan tavoitteista	4	5	6	7	8	9	10
18. Osastotoiminnan tavoitteet ovat minulle niin etäisiä, että en jaksa kiinnostua niistä	4	5	6	7	8	9	10
19. Potilaiden hoidon laatu on osastollani korkeatasoista	4	5	6	7	8	9	10
20. Työ itsessään tuottaa minulle tietoa työskentelyni tuloksista (esim. onnistumisen ja tyydytyksen kokemuksia)	4	5	6	7	8	9	10
21. Hoitotyön asiantuntemus on korkeatasoista osastollani	4	5	6	7	8	9	10
22. Voin vaikuttaa omaa työtäni ja osastoani koskevaan päätöksentekoon	4	5	6	7	8	9	10

SEURAAVAT VÄITTÄMÄT KUVAAVAT **KÄSITYKSIÄSI ITSESTÄSI TYÖSSÄSI. RENGASTA** MIELIPIDETTÄSI **PARHAITEN KUVAAVA VAIHTOEHTO.**

	Kuvaa erittäin huonosti						Kuvaa erittäin hyvin
23. Vastuu kannustaa minua kehittymään työssäni	4	5	6	7	8	9	10
24. Itseni kehittämisestä on minulle hyötyä työssäni	4	5	6	7	8	9	10
25. Osallistun mielelläni kaikentyyppiseen kehittämiseen osastollani	4	5	6	7	8	9	10
26. Minulla on monia kehittämisideoita, joista olisi hyötyä osastolleni	4	5	6	7	8	9	10

	Kuvaa erittäin huonosti						Kuvaa erittäin hyvin
27. Minulle on tärkeää, että osastoni toimintaa kehitetään	4	5	6	7	8	9	10
28. Osastollani keskustellaan usein potilashoidon kehittämisestä ja laadusta	4	5	6	7	8	9	10
29. Pyrin tekemään työni paremmin kuin muut	4	5	6	7	8	9	10
30. Minulla on tavoitteita, joiden mukaan pyrin kehittämään itseäni	4	5	6	7	8	9	10
31. Suhtaudun myönteisesti saamaani palautteeseen: se suuntaa omaa kehittymistäni	4	5	6	7	8	9	10
32. Tunnen omat heikot ja vahvat puoleni	4	5	6	7	8	9	10
33. Olen joustava muuttuvissa tilanteissa	4	5	6	7	8	9	10
34. Olen luova ratkaisuissani	4	5	6	7	8	9	10
35. Minulle on tärkeää onnistua työssäni	4	5	6	7	8	9	10
36. Kannan osaltani vastuuta osastoni kehittämisestä	4	5	6	7	8	9	10
37. Minulle on tärkeää, että osastoni hoitotyö on korkeatasoista	4	5	6	7	8	9	10
38. Minulla on mahdollisuus vaikuttaa työyhteisön ja hoitotyön kehittämiseen	4	5	6	7	8	9	10

SEURAAVAT VÄITTÄMÄT KUVAAVAT **TYÖYHTEISÖN ILMAPIIRIÄ. RENGASTA** MIELESTÄSI **PARHAITEN OSASTOSI ILMAPIIRIÄ KUVAAVA VAIHTOEHTO**

	Kuvaa erittäin huonosti						Kuvaa erittäin hyvin
39. Osaston ilmapiiri on jähmeä ja rutiineihin nojaava	4	5	6	7	8	9	10
40. Osastoni ihmissuhdeongelmat haittaavat työskentelyäni	4	5	6	7	8	9	10
41. Osastollani keskustellaan rakentavasti työhön liittyvistä arkipäivän ristiriidoista	4	5	6	7	8	9	10
42. Osastollani sopeudutaan joustavasti toiminnan muutoksiin	4	5	6	7	8	9	10
43. Osastollani on valmiutta muutoksiin	4	5	6	7	8	9	10
44. Osaston ilmapiiri on erilaisuutta hyväksyvä	4	5	6	7	8	9	10
45. Osaston ilmapiiri on kannustava ja oppimista tukeva	4	5	6	7	8	9	10
46. Osastollani keskustellaan usein potilashoidon laadusta ja siitä miten tätä voidaan kehittää	4	5	6	7	8	9	10
47. Osaston ilmapiiri on avoin ja luottamusta herättävä	4	5	6	7	8	9	10
48. Osastoni ilmapiiri on myönteinen kaikelle kehittämiselle	4	5	6	7	8	9	10

	Kuvaa erittäin huonosti						Kuvaa erittäin hyvin
49. Osastollani on helppo puhua työtovereille esim. omista ongelmista	4	5	6	7	8	9	10
50. Osastollani minut otetaan huomioon yksilönä ja työyhteisön jäsenenä	4	5	6	7	8	9	10
51. Saan tukea ja rohkaisua työtovereiltani työtilanteissa	4	5	6	7	8	9	10
52. Osastollani vallitsee avoin yhteishenki, jota ilmentää keskinäinen avuliaisuus ja yhteisiin tavoitteisiin pyrkiminen	4	5	6	7	8	9	10
53. Tiedot tärkeistä asioista ja päätöksistä välittyvät hyvin osastollani	4	5	6	7	8	9	10
54. Minulla on sananvaltaa tai vaikutusmahdollisuuksia osastollani	4	5	6	7	8	9	10

SEURAAVAKSI ESITETÄÄN **LÄHINTÄ ESIMIESTÄSI** JA HÄNEN TYÖTÄÄN KOSKEVIA VÄITTÄMIÄ. **RENGASTA** MIELIPIDETTÄSI **PARHAITEN KUVAAVA VAIHTOEHTO**

	Kuvaa erittäin huonosti						Kuvaa erittäin hyvin
55. Esimieheni on ystävällinen ja sellainen, että häntä on helppo lähestyä	4	5	6	7	8	9	10
56. Esimieheni jakaa vastuuta alaisilleen ja luottaa työntekijöihinsä	4	5	6	7	8	9	10
57. Esimieheni ottaa huomioon ehdotukseni ja toiveeni	4	5	6	7	8	9	10
58. Esimieheni kannustaa minua hyviin työsuorituksiin	4	5	6	7	8	9	10
59. Esimieheni ylläpitää osastolla hoitotyön korkeita laatuvaatimuksia	4	5	6	7	8	9	10
60. Esimieheni kysyy työryhmän jäsenten ideoita ja mielipiteitä eri asioista	4	5	6	7	8	9	10
61. Esimies rohkaisee avoimesti keskustelemaan ristiriidoista osastollani	4	5	6	7	8	9	10
62. Esimies rohkaisee osastolla osallistumaan ja sitoutumaan toiminnan kehittämiseen	4	5	6	7	8	9	10
63. Esimieheni keskustelee runsaasti kanssamme työstämme	4	5	6	7	8	9	10
64. Esimies tuntee hyvin työtehtäväni ja arvostaa työtäni osastolla	4	5	6	7	8	9	10
65. Esimies kannustaa työntekijöitä opiskelemaan ja kehittymään työssään	4	5	6	7	8	9	10
66. Esimies rohkaisee epäkohtien ja kehittämistarpeiden tunnistamiseen osastollani	4	5	6	7	8	9	10
67. Tiedän millainen käsitys esimiehelläni on minusta työntekijänä	4	5	6	7	8	9	10

	Kuvaa erittäin huonosti						Kuvaa erittäin hyvin
68. Esimies antaa tunnustusta hyvästä työstä	4	5	6	7	8	9	10
69. Esimieheni käy kanssamme kehityskeskusteluja	4	5	6	7	8	9	10
70. Esimieheni keskustelee kanssamme osaston toiminnan tavoitteista	4	5	6	7	8	9	10

SEURAAVAT KYSYMYKSET KÄSITTELEVÄT **URAKEHITTYMISTÄSI, KOULUTUSTASI** JA **TYÖNOHJAUSTA**

71. MITEN TÄRKEÄÄ SINULLE ON TÄLLÄ HETKELLÄ ELÄMÄSSÄSI TYÖSSÄ KEHITTYMINEN?

    1. Erittäin tärkeää
    2. Tärkeää
    3. Jonkin verran tärkeätä
    4. Vähän tärkeätä
    5. Ei lainkaan tärkeätä

72. ONKO AMMATTIURAASI LIITTYVISSÄ TULEVAISUUDEN SUUNNITELMISSA TAPAHTUNUT MUUTOKSIA PUOLEN VUODEN AIKANA?

    1. Ei
    2. Kyllä, jos on, niin mitä? _____

_____

73. MITEN SAIRAALAORGANISAATIOSI ON TUKENUT AMMATTIURASI KEHITTYMISTÄ VIIMEISEN PUOLEN VUODEN AIKANA?

_____

_____

74. KUINKA HALUKAS TÄLLÄ HETKELLÄ OLET OSALLISTUMAAN TYÖHÖSI LIITTYVÄÄN KOULUTUKSEEN?

    1. Erittäin halukas
    2. Melko halukas
    3. Jonkin verran halukas
    4. Vähän halukas
    5. En lainkaan halukas, perustelu_____

75. KUINKA MONTA KERTAA VIIMEISEN PUOLEN VUODEN AIKANA OLET OSALLISTUNUT ORGANISAATIOSI SISÄISEEN KOULUTUKSEEN?

    1. En lainkaan
    2. 1-2 kertaa
    3. 3-5 kertaa
    4. 6-10 kertaa
    5. 11 kertaa tai enemmän

76. KUINKA MONTA KERTAA OLET VIIMEKSI KULUNEEN PUOLEN VUODEN AIKANA OLLUT KOULUTUKSESSA ORGANISAATIOSI ULKOPUOLELLA?

    1. En lainkaan
    2. 1-2 kertaa
    3. 3-5 kertaa
    4. 6-10 kertaa
    5. 11 kertaa tai useammin
    6. En hakeudu koulutukseen, perustelu_____

77. MILLAISEEN KOULUTUKSEEN OLET OSALLISTUNUT VIIMEISEN PUOLEN VUODEN AIKANA? Kuvaa lyhyesti koulutuksen aiheet ja sisältö.

_____

_____

SEURAAVAT KYSYMYKSET **KÄSITTELEVÄT TYÖHÖSI LIITTYVÄÄ KOULUTUSTA. RENGASTA** KUSSAKIN VÄITTÄMÄSSÄ MIELIPIDETTÄSI PARHAITEN KUVAAVA NUMERO. **ARVIOI KOULUTUSTA VIIMEISEN PUOLEN VUODEN AJALTA.**

	Kuvaa erittäin huonosti						Kuvaa erittäin hyvin
78. Minulla on ollut riittävästi mahdollisuuksia osallistua työajalla koulutukseen	4	5	6	7	8	9	10
79. Työhöni liittyvä koulutus on ollut riittävää työni kannalta	4	5	6	7	8	9	10
80. Työhöni liittyvä koulutus on auttanut minua selviytymään työssäni entistä paremmin	4	5	6	7	8	9	10
81. Työhöni liittyvä koulutus on muodostanut johdonmukaisen kokonaisuuden	4	5	6	7	8	9	10
82. Työhöni liittyvän koulutuksen aihealueet ovat olleet työni kannalta oleellisia	4	5	6	7	8	9	10
83. Olen tyytyväinen työhöni liittyvän koulutuksen tasoon	4	5	6	7	8	9	10
84. Työhöni liittyvä koulutus on ollut tarpeitani vastaava	4	5	6	7	8	9	10

85. ARVIOI, MINKÄLAISTA HYÖTYÄ SINULLE ON OLLUT KOULUTUKSESTASI, JOHON OLET OSALLISTUNUT VIIMEISEN PUOLEN VUODEN AIKANA?_____

_____

86. MINKÄLAISTA TYÖHÖSI LIITTYVÄÄ / AMMATTITAITOASI TUKEVAA KOULUTUSTA HALUAT JÄRJESTETTÄVÄN LÄHITULEVAISUUDESSA?

_____

_____

ARVIOI, ONKO TYÖNOHJAUKSEN MYÖTÄ:

	Vähentynyt	Pysynyt samana	Lisääntynyt
87. Asiantuntijuutesi työssäsi	1	2	3
88. Työtäsi ohjaavan teoreettisen näkemyksen selkiytyminen	1	2	3
89. Käytännöllisten valmiuksiesi vahvistuminen	1	2	3
90. Työryhmätyöskentelyn tehokkuus	1	2	3
91. Itsetuntemuksesi syventäminen	1	2	3
92. Henkilökohtaiset voimavarasi työssäsi	1	2	3
93. Oman panoksesi jäsentyminen osastosi toiminnan kokonaisuudessa	1	2	3
94. Moniammatillinen yhteistyö	1	2	3

95. HALUAISIN JATKAA TYÖNOHJAUKSESSA OLOA

    1. Kyllä
    2. En, perustelut miksi_____

96. OLEN OSALLISTUNUT TYÖNOHJAUKSEEN   KERTAA _____VIIKOSSA
                                            KERTAA_____KUUKAUDESSA

97. KUINKA MONTA KERTAA OLET TÄHÄN MENNESSÄ OSALLISTUNUT TYÖNOHJAUKSEEN?
                                  KERTAA_____

98. JOS ET OLE VOINUT OSALLISTUA TYÖNOHJAUKSEEN, NIIN KERRO, MIKSI
_____

_____

99. OLETKO OSALLISTUNUT TYÖNOHJAUKSEEN VAPAA-AJALLASI?

    1. Kyllä
    2. Ei

100. KUINKA MONTA KARTAA OLET OSALLISTUNUT TYÖNOHJAUKSEEN
     VAPAA-AJALLASI?   KERTAA_____

Perustelut valinnallesi
_____

_____

101. MINKÄLAINEN VAIKUTUS TYÖNOHJAUKSELLA MIELESTÄSI ON OLLUT OMAAN TYÖSKENTELYTAPAASI?
_____

_____

102. MINKÄLAINEN VAIKUTUS TYÖNOHJAUKSELLA MIELESTÄSI ON OLLUT TYÖSKENTELYYSI OSASTOLLASI?
_____

_____

103. MINKÄLAINEN VAIKUTUS TYÖNOHJAUKSELLA MIELESTÄSI ON OLLUT SUHTEESSASI TYÖYHTEISÖÖN?

_____

_____

104. MINKÄLAINEN VAIKUTUS TYÖNOHJAUKSELLA ON OLLUT ITSEESI?

_____

_____

105. MISTÄ AIHEISTA OLISIT ENITEN KOKENUT TARVINNEESI TYÖNOHJAUSTA?

_____

_____

106. MISTÄ AIHEISTA ON OLLUT ENITEN HYÖTYÄ JA MIKSI ?

_____

_____

107. MINKÄLAINEN VAIKUTUS TYÖNOHJAUKSELLA MIELESTÄSI ON OLLUT IHMISSUHTEISIISI?

_____

_____

108. MINKÄLAINEN VAIKUTUS TYÖNOHJAUKSELLA MIELESTÄSI ON OLLUT HOIDON LAATUUN OSASTOLLASI?

_____

_____

109. MITÄ KOULUTUSTARPEITA ON TULUT ESIIN TYÖNOHJAUKSESSA?

_____

_____

JATKUVA HOIDON LAADUN SEURANTA JA TOIMINNAN ARVIOINTI

Jatkuva hoidon laadun seuranta alkoi joulukuussa 1995. Tästä lähtien henkilökunta ja potilaat ovat täyttäneet viikottain yksisivuista arviointilomaketta.

MITEN JATKUVA HOIDON LAADUN SEURANTA ON MIELESTÄSI VAIKUTTANUT

	Erittäin vähän			Erittäin paljon			
110. omaan työhösi	4	5	6	7	8	9	10
111. työyhteisön työskentelyyn	4	5	6	7	8	9	10
112. esimiehen toimintaan	4	5	6	7	8	9	10
113. potilashoidon laatuun	4	5	6	7	8	9	10

114. Mitä muita vaikutuksia haluat mainita?

_____

_____

KÄYTETÄÄNKÖ OSASTOLLASI SEURAAVIA ARVIOINTIMENETELMIÄ

	Kyllä	Ei	En osaa sanoa
115. Tuloskeskusteluja	1	2	3
116. Vertaisarviointeja	1	2	3
117. Arvioin itse toimintaani	1	2	3

118. Muu arviointimenetelmä, mikä?
119. Jos arvioit itse toimintaasi, niin miten

120. MITEN USEIN ARVIOINTI TAPAHTUU?
_____

_____

121. TUKEEKO OSASTOLLASI KÄYTETTY ARVIOINTIMENETELMÄ KEHITTYMISTÄSI AMMATTIURALLASI?

    1. Kyllä, miten?
_____

    2. Ei, miksi ei?
_____

122. MITEN HALUAISIT ITSEÄSI ARVIOITAVAN TYÖNTEKIJÄNÄ?
_____

_____

URA -projekti alkoi vuoden 1995 syyskesällä ja on nyt jatkunut lähes vuoden.

123. MITÄ **POSITIIVISIA** KOKEMUKSIA SINULLA ON URA-PROJEKTISTA?
_____

_____

124. MITÄ **NEGATIIVISIA** KOKEMUKSIA SINULLA ON URA-PROJEKTISTA?
_____

_____

KIITOS VASTAUKSESTASI !

TAMPEREEN YLIOPISTO / HOITOTIETEEN LAITOS __/__19__
Tampereen yliopistollinen sairaala OSASTO___
VAST NO___/VO

Ole hyvä ja arvioi tekemääsi työtä kuluneen viikon aikana allaolevien asioiden suhteen. Antamasi palaute on tärkeä hoidon kehittämiselle. Vastauksesi käsitellään luottamuksellisesti.

1. Potilaat ovat olleet tyytyväisiä saamaansa hoitoon 4 5 6 7 8 9 10

2. Olen tyytyväinen tapaan, jolla olen kohdellut potilaita 4 5 6 7 8 9 10

3. Potilaille antamani ohjaus ja neuvonta heidän hoitoon liittyvissä asioissa on ollut riittävää 4 5 6 7 8 9 10

4. Olen ottanut huomioon potilaiden toivomukset ja mielipiteet 4 5 6 7 8 9 10

5. Asiantuntemukseni on ollut riittävää suhteessa työtehtäviini 4 5 6 7 8 9 10

6. Potilaiden saama hoito on edistänyt heidän hoidolleen asetettujen tavoitteiden saavuttamista 4 5 6 7 8 9 10

7. Henkilökunnan välinen yhteistyö on ollut sujuvaa 4 5 6 7 8 9 10

8. Liittyykö kuluneeseen työviikkoon jotakin myönteistä?

_____

_____

9. Liittyykö kuluneeseen työviikkoon jotakin kielteistä?

_____

_____

Ole hyvä ja jätä lomake suljetussa kuoressa osastollasi osoitettuun paikkaan.

Kiitos!

TAMPEREEN YLIOPISTO / HOITOTIETEEN LAITOS __/__19__
Tampereen yliopistollinen sairaala OSASTO___
VAST NO___/VO

Olkaa hyvä ja arvioikaa sairaalassaoloanne allaolevien asioiden suhteen. Antamane palaute on tärkeää hoidon kehittämiselle. Vastauksenne käsitellään luottamuksellisesti.

1. Oletteko ollut tyytyväinen saamaanne hoitoon? 4 5 6 7 8 9 10

2. Miten arvioisitte leikkaussalissa saamaanne kohtelua ja hoitoa 4 5 6 7 8 9 10

3. Oletteko ollut tyytyväinen tapaan, jolla henkilökunta on kohdellut teitä? 4 5 6 7 8 9 10

4. Oliko hoitoonne liittyvä ohjaus ja neuvonta riittävä? 4 5 6 7 8 9 10

5. Oliko tiedonsaanti riitävää 4 5 6 7 8 9 10

6. Otettiinko toivomuksenne ja mielipiteenne huomioon? 4 5 6 7 8 9 10

7. Oliko henkilökunnalla riittävästi asiantuntemusta? 4 5 6 7 8 9 10

8. Saitteko avun ongelmaan, jonka vuoksi tulitte sairaalaan? 4 5 6 7 8 9 10

9. Onko henkilökunnan välinen yhteistyö ollut hoitonne kannalta sujuvaa? 4 5 6 7 8 9 10

10. Liittyikö sairaalassaoloonne jotakin myönteistä?

_____

_____

11. Liittyikö sairaalassaoloonne jotakin kielteistä?

_____

_____

Olkaa hyvä ja jättäkää lomake suljetussa kirjekuoressa osaston kansliaan.

Kiitos!

Appendix 5. Summary table and examples of the staff's responses to the open-ended questions on wards A-E

WARD A (n=635)	WARD B (n=124)	WARD C (n=318)	WARD D (n=621)	WARD E (n=307)
(I) Culture of collaboration, leadership and mutual interaction				
1.1. collaboration between doctors, nurses, different occupational groups and units 1.2. communication between doctors and nurses 1.4. atmosphere in patient care	1.2. communication among staff 1.3. relationships between ward sister and staff 1.5. support from colleagues to ward sister	1.1. collaboration between doctors and nurses and other occupational groups 1.2. communication and feedback between doctors and nurses 1.4. atmosphere on the ward and in patient care 1.5. colleagues and their personal characteristics 1.6. doctors' attitudes and personal characteristics	1.1.smoothness of collaboration and feeling of togetherness 1.2. communication and feedback between nursing staff 1.3. ward sister's leadership style and relations with staff 1.4. atmosphere and conflicts 1.5. colleagues' helpfulness with other personal characteristics 1.6. doctors' behaviour	1.1. collaboration with doctors and among staff 1.2. communication and ways to process problematic issues 1.3. issues of leadership and ward sister's relationship with staff 1.5. support and relationship between colleagues
(II) Planning and organisation of activities and recourses				
2.1. scheduling of care in relation to resources 2.2. different plans and planning 2.3. overload and effects on patient care 2.4. substitutes from different occupational groups and additional staff 2.5. work shifts with effects on work 2.6. sick leaves with effects on patient care 2.7. priority of issues and tasks 2.8. haste with piling-up of tasks and effects on care 2.9. fluency of operations in modules	2.1. reserving times for operations 2.4. substitutes 2.5. planning of work shifts and free time 2.9. collaboration of team in OR	2.3. patient load 2.4. substitutes' work contribution 2.5. work shifts and importance of holidays 2.8. haste vs. peacefulness with effects on working 2.9. clarity of work and work division	2.1. appointment times and time scheduling 2.2. planning and development work 2.3. patient load 2.4. lack of substitutes in unstable situation 2.5. work shift planning with effects on work 2.6. effects of sick leaves on work shifts 2.8. haste in work with limited time for patients 2.9. smoothness of work through clarity of actions	2.1. economy measures of resources 2.2. planning new operations 2.4. substitutes' contribution in a situation of staff shortage 2.5. work shifts and importance of free time with effects on work 2.9. clarity and functioning of operations
(III) Meetings and flow of information				
3.1. meetings and assemblies 3.2. information flow		3.1. meetings 3.3. documentation of care and information flow	3.1. joint decision making in meetings	3.2. difficulty with information flow

(IV) Factors related to patient care (WARD A)	(WARD B)	(WARD C)	(WARD D)	(WARD E)
4.1. difficult and complicated patient cases 4.2. medical care: pain medication 4.3. instructions for patients 4.4. language and communication with patients 4.5. patients' recovery 4.6. organisation of aftercare 4.7. patients' and relatives' satisfaction 4.8. standards of care 4.9. complications 4.10. support to families and relatives 4.11. death of patient	4.8. standards of patient care	4.2. implementing medical care 4.3. patient education 4.6. patients' discharge 4.7. patient feedback 4.9. safety in patient care	4.5. outcomes of care 4.7. patients' and relatives' satisfaction 4.8. individuality of care 4.9. errors and complications 4.11. death of patient	4.7. praise and positive feedback 4.8. standard of work 4.9. complications
(V) Personal factors				
5.1. own physical health 5.2. sense of coping with work 5.3. work motivation		5.1. own physical health 5.2. coping with work	5.1. own physical health 5.2. own feelings of coping and adequacy 5.3. work motivation	5.1. own physical health 5.2. own feelings of coping with work
(VI) Training, teaching and guidance				
6.1. participation in study days and in-service training 6.2. planning and organising study days 6.3. orienting and precepting new employees and students	6.1. attending study days and gaining work experience	6.1. attending in-service training and study days 6.3. factors affecting guidance of students and substitutes	6.1. attendance at study days and in-service training 6.2. planning and organising study days 6.3. guiding new employees and students	6.1. participation in study days 6.2. planning and implementing education 6.3. precepting, teaching and factors affecting these activities
(VII) Participation in research and clinical supervision				
7.1. effects of clinical supervision 7.2. motivation for laborious research	7.1. effects of clinical supervision	7.1. effects of clinical supervision and time for participation 7.2. study motivation	7.1. progress of clinical supervision and the working methods 7.2. motivation for participation in study	7.1. topics of CS 7.2. motivation for research with related effects
(VIII) Factors and changes with temporary effect				
8.1. changes with ADP –systems with effects on operations 8.2. threat of strike with effects on operations 8.3. start of outpatient clinic activities 8.4. launched study		8.1. ADP changes with effects on practice 8.3. transferred day surgery patients	8.1. ADP's impact on functioning 8.2. threat and effects of strike 8.3. new activities and projects 8.4. redecoration of premises and equipment 8.5. transfer to primary nursing	

Appendix 5 a. Examples of staff's positive and negative responses to the open-ended questions on ward A (n=635). The number of examples in this appendix is 219 and it represents 34.5% of all answers.

Example	Reduced expression	Category
…'collaboration between doctors weak'… …'doctor/nurse collaboration difficult'… …'smooth collaboration…good results'… …'flexible collaboration although ward is packed'… 'Nurses and secretaries, doctors…problems with collaboration… …'some renovators surprised at smoothness of collaboration' …'smooth collaboration with operating theatre'… 'Collaboration with operating theatre…in organising bazaar' 'Problems with lab'	occasional poor collaboration between doctors difficult collaboration between doctor and nurses good outcomes due to smooth collaboration flexible collaboration problems with collaboration due to difference of opinion smooth collaboration with renovators smooth collaboration collaboration organising a bazaar collaboration problems with laboratory	collaboration between doctors, nurses, different occupational groups and units (1.1.)
…'quarrel with doctor about patient care'… …'chief physician's nerves on edge, bitter and impertinent feedback to subordinates.' …'colleague…constructive discussion about problems…eased my mind'… …'rewarding discussions with colleague' …'clash with colleague. Negative tone'… …'minor confrontation, but is it negative or the spice of life?' …'succeeded in discussing defects and conflict with the person.' …'hard to face a colleague…friction about openness'…	clash with doctor impertinent feedback from chief physician constructive discussion with colleague rewarding discussions with colleague clash with colleague confrontation discussion about defects and conflicts friction about openness	communication between doctors and nurses (1.2.)
…'tense atmosphere reflects on my module too'… …'peaceful pace of work and atmosphere' …'too much work…tense atmosphere'… …'positive atmosphere despite work pressure'… 'Atmosphere…smooth collaboration between patients and staff '	reflection of tense atmosphere pace of work and atmosphere tense atmosphere positive atmosphere atmosphere between patients and staff	atmosphere in patient care (1.4.)
…'delays in waiting list for surgery…tense atmosphere'… …'patients in queue…schedule not realised…holidays… patient keeps asking'… …'doctors again changed schedule…trouble for patients and extra work for secretary' …'next week's schedule changed on a short notice'… …'informed patients of schedule changes…many months' delays' …'emergency patients at the end of the week…elective operations cancelled' …'operations cancelled…disappointment for prepared patients' …'calls to patients…insufficient resources for surgery…queue'. 'Lack of resources…and slow action and bureaucracy' …'access to care delayed…few resources…being on call'…	delays in waiting list for surgery delays in scheduled queue times rescheduled operation times changes in schedule on a short notice changes in surgery schedule cancellation of scheduled operations cancelling procedure lack of resources for surgery lack of resources for different reasons delay in access to care due to lack of resources	scheduling of care in relation to resources (2.1.)
…'positive feedback from staff…plans for collaboration'… …'plans according to calculations…did what I promised'… …'action and training plans became clearer'… 'Plans for next year finished'. 'Administrative plans and calculations…postponed to the next week'. …'doctors' muddled plans' …'spent half a day planning with doctors' …	positive feedback on collaboration finishing planning in time clarification of action and training plan preparing action plan postponing plans and calculations muddled plans planning action with doctors	different plans and planning (2.2.)
…'backlog because of emergency patients…operations cancelled'. …'many patients in poor health…morning very hard'… 'Variable number of patients…either too few or too many'. …'extremely sick patients…with respect to number of staff'… 'We've had so many and so sick patients…everything's taken care of in time'. 'Many emergency patients'	backlog of patients high number of patients with poor health variation in the number of patients high number of sick patients good care due to adequate number of patients high number of emergency patients	overload and effects on patient care (2.3.)

'Work ran pretty well, although lots of work and substitute labour'	smooth work shifts with substitutes	substitutes from different occupational groups'and additional staff (2.4.)
'Staff dissatisfied with substitutes' contribution…all tired'.	staff's satisfaction with substitutes	
…'secretary on sick leave…no substitute…more work for others'…	workload of others due to lack of substitutes	
'totally helpless substitute…almost life-threatening to patients'…	helpless substitute	
…'responsibility for substitutes' work…who decides whether we are heard?'.	responsibility for substitutes	
…'no substitute for secretary…work piled up'…	backlog work due to missing substitute for secretary	
'Incompetent substitutes, ward overcrowded'	incompetent substitutes	
'Poor collaboration between staff nurses and substitutes'…	poor collaboration between substitutes and staff nurses	
…'tried to sort out the situation about substitutes… no hope of new appointment letter'	no extension of contract for substitute	
…'we've employed substitutes despite economy measures'…	substitute labour regardless of economy measures	
…'doctors also suffer from shortage of substitutes…	problems with organisation	
of operations '…	shortage of doctors' substitutes	
'Peaceful…a patient's named nurse was a great help'.	helpfulness of extra nurse	
…'named nurse left…caused extra work for permanent staff'	workload after departure of extra nurse	
'Extra nurse for two patients…time…better care'…	better patient care due to extra nurse's work contribution	

…'flexible shift arrangements'…	flexible changes in shifts	work shifts with effects on working (2.5.)
….'new plans for economy measures…new rota, no substitutes'…	new rota and shift planning	
…'positive…lots of morning shifts '	morning shifts	
…'hard week …long consecutive morning shifts and evening shifts'	long consecutive shifts	
'Confusing morning shifts…a mess'.	chaotic morning shifts	
'Patient discharge doesn't work…work left over from morning shift, chaotic evening'	chaotic shifts	
…'fragmentary shifts…no continuity, mere performance '.	fragmentary shifts	
…'short week after holiday…lost my pattern'…	pace of work week	
…'fragmentary week because of holidays'…	fragmentary week	
'Poor expertise when short work periods'.	low expertise due to short periods of work	
'A longer period…better concentration on comprehensive care'…	length of work period promoting concentration on care	
'part-time work does not enable continuity of work'…	poor continuity of care due to part-time work	
'part-time work: got to rest…better able to concentrate on patients' problems'	rest provided by part-time work	
…'one day off in two weeks…hard'…	number of days off	
'Morning shift after long holiday…confusing and difficult to get into pace.'	difficulty of getting back into pace after holiday	
'Only 1 workday in this week…holiday forthcoming … I feel enthusiastic'.	enthusiasm about work promoted through leisure-time	
'Regained my enthusiasm for work after a relaxing holiday'…	joy and desire to work after holidays	

…'doctors' 'boss' on sick leave…everybody performs solo acts'	chief physician on sick leave	sick leaves with effects on patient care (2.6.)
…'many sick leaves…poor continuity of care'	continuity of care complicated by sick leaves	
…'many staff on sick leave…'inadequate patient care'	inadequate patient care due to sick leaves	

…'training, bazaar, clinical supervision… on the same day'…	different events on same day	priority importance of issues and tasks (2.7.)
…'overlapping errands…must cut down… no substitute'…	cutting down overlapping events	
…'haste…unable to concentrate on patients' wishes…less important things ignored'	ignoring less important things	
…'we managed to do routine work…other things come first'…	managing priority issues	
…'had to prioritise tasks, high work tempo'…	prioritising duties	
'More work than is possible to handle…necessary duties just barely'…	finding time for necessary duties	

…'haste…forced to run 'food in mouth'…	haste at work and finding lunch time	haste with piling-up of tasks and effects on care (2.8.)
…'end of the week…no haste…time to perform normal duties'	lack of haste	
…'terrible haste…poor concentration…exhausted after work'…	poor concentration on work due to haste	
'You make tiny mistakes when you're busy and tired'	mistakes due to haste	
…'took care of arrears… work ran smoothly, although a lot of patients'…	smooth work	
…'extra secretary to help with dictation'…	clearing backlog with dictation	
…'all thing taken care of in time despite backlog'…	taking care of things in time within backlog	
'Arrears of work partly done '	doing arrears	
'Work piled up because of holidays and leaves'	duties piling up	
…'peaceful situation…time for patients'…	time for patients in calm situation	
…'busy…insufficient time for patients'…	insufficiency of time for all patients	
…'now that nurses' unnecessary errands are over …time for patients'	time for patients	
…'many patients needing basic care and reluctant patients…no time'	lack of time	
…'chaotic week… too many patients in spare beds, time for no-one…tenseness'	lack of time due to chaos	
…'weekend, peaceful…time to concentrate well on patient's affairs'…	time to concentrate on patient's affairs	
'The big exchange…especially in mornings, too little time per patient'	lack of time per patient	

…'collegiality…flexibility…different modules, same goals'…	inflexibility in modules	fluency of operations in modules (2.9.)
…'view of other module's problems reinforced…occasional complaints '	problems in module	

…'discussion about future policy plan from many perspectives'…	discussion about future policy	different meetings and assemblies (3.1.)
…'meeting about secretaries' overtime work and new arrangements'…	meeting about overtime and new arrangements	
…'planning meeting…decisions…positive spirit '…	decision-making in positive atmosphere	
…'annual plan and action plan for 1998: discussed at ward meeting'	discussion about plans in ward meeting	
…'joint meeting: wishes and summer schedule'…	meeting about summer schedule and wishes	
…'a clarifying account on Parse in nurse meeting'…	clarifying account in nurse meeting	
…'good case history in ward meeting'…	case history in ward meeting	
…'discussion in ward meeting! – about infections'	discussion about infections in ward meeting	
…'finally meeting with ward physician and decisions'	meeting with ward physician	
…'meeting - how to raise money for the conference'	meeting about fund raising	
…'ward meetings started again '…	reintroduction of ward meetings	

…'information breakdown…serious defects in patient monitoring '…	information breakdown of patient monitoring	problems with information flow (3.2.)
…'flow of information between shifts inadequate…could be better'…	inadequate flow of information	

…'very confused patients to look after, but other things to do'…	monitoring confused patients	difficult and complicated patient cases (4.1.)
…'restless patient, had to tie down because of safety'…	tying a patient down because of safety	
…'violent patient, had to call extra staff from emergency unit'…	need of extra staff due to violent patient	
'Confused and aggressive patient'	aggressive patient	
'Several restless patients during nights'	restless patient in night shift	
…'very difficult patient with whom all went OK'…	coping with a very difficult patient	
…'many weak patients…transferred quickly from ICU to the ward'…	weak patients transferred from ICU	
…'very speedy: very sick patient…received intensive care rapidly'	very sick patient admitted to intensive care	

…'patient with cancer pain on ward…poor pain management'…	poor pain management	medication: pain treatment (4.2.)

…'peaceful…familiar patients…decreased need for education'…	need of education for familiar patient	instructions for patients (4.3.)
'Diabetic…refused to follow instructions…took medications at random times'	patient's reluctance to listen to instructions	

…'language problems with foreign patient'…	language problems with patient	language and communication with patients (4.4.)
…'I felt I was unable to speak Swedish'…	inability to speak Swedish	
…'sign language…awkward…perhaps I trusted my interpretation too much'	exaggerated trust in own interpretation	

…'long-term patient recovering fast'…
'Young girl able to speak better after surgery'
'Difficult patients whose recovery not progressed'
'Even the difficult patients stayed alive'

recovery of long-term patient	patients' recovery (4.5.)
ability to speak after surgery	
halted of recovery	
survival of difficult patients	

…'very sick patients with no knowledge of a setting for continued treatment'…
…'many patients discharged and sent to continued treatment'…
'Long-term patient with tetraplegia found a setting for continued treatment'

non-realisation of aftercare	organisation of aftercare (4.6.)
discharge of patients and transferral to aftercare	
long-term patient's admission to aftercare	

…'personal praise from a number of patients publicly'…
…'patient praise for last week's arrangements'…
…'relatives and patients were satisfied'…
…'long-term patients dissatisfied…are they afraid of the transfer?'…
…'no complaints from patients…they seem happy and content'…
…'patients received poor care…were dissatisfied'…
…'satisfied patients…despite everything…flexible action'…
…'anguished patient… dissatisfied…distorts care relationship'…
'Much feedback from former patients at Christmas: post cards, calls'…
'Lots of positive feedback from patients'…
'Handling a complaint…what an experience'…

personal praise	patients' and relatives' satisfaction (4.7.)
praise from patients for arranging things	
relatives' and patients' satisfaction	
patients' dissatisfaction	
patients' positivity and satisfaction	
patient's dissatisfaction with poor care	
patient's satisfaction with flexible action	
anxious patient's dissatisfaction	
feedback from former patients	
positive feedback from patients	
dealing with complaint	

'Not one patient died of lack of care!'
'Patient rush settled down…everyone receives at least minimum care'…
…'terrible haste…poor attention to patients'…
…'haste…shows in not being able to fulfil all wishes'…
'All too much work…discharge of patients works poorly'…

lack of care	standards of care (4.8.)
minimum care	
inattention to patients	
unfulfilled wishes	
poor patient discharge	

…'many repeat operations, unable to meet our goals'…
…'patient had postoperative bleeding…repeat surgery and taken to ICU'…

| repeated operations | complications (4.9.) |
| repeated operation due to bleeding | |

'Patient's relatives in a breaking point…help from crisis unit'
…'family's quarrels were taken into consideration…encouraged them to sort it out'…
…'lack of resources for supporting a patient and relatives'
'Long-term patient's relatives in a crisis'

relatives in breaking point	support to families and relatives (4.10)
family quarrels	
lack of resources for supporting patients and relatives	
crisis of long-term patient's relatives	

…'patient died suddenly…resuscitation failed'
'Patient frightened of surgery…died…basic question of life: why?'

| patient's death | death of patient (4.11.) |
| patient's death during surgery | |

…'busy day…my poor health status: flu and cough'…
…'preception takes energy…I still have a cold and I'm tired'…
…'I've been healthy'…
…'I'm in poor condition…slows down my performance'…

own poor condition with flu	own physical health (5.1.)
flu and fatigue	
remaining healthy	
own poor condition	

…'many very sick patients…fed up with my inadequacy'
…'private life balanced, so I cope with my job'…
…'I feel unreal…difficulty concentrating…pressure from patients and unfinished jobs'
…'concentration on patients and tasks difficult…too many parties involved'
…'spring fatigue…concentration could be better'…
…'rest of the week peaceful…time to recharge'…
…'pause…able to take a deeper interest in patients' affairs '…
'Coping with work despite negative aspects'.

own inadequacy	sense of coping with work (5.2.)
coping with work	due to balance in life
concentration difficulties	
concentration difficulties with too many duties	
difficulty concentrating due to spring fatigue	
recharging in peaceful situation	
interest in patients' affairs after pause	
coping with work	

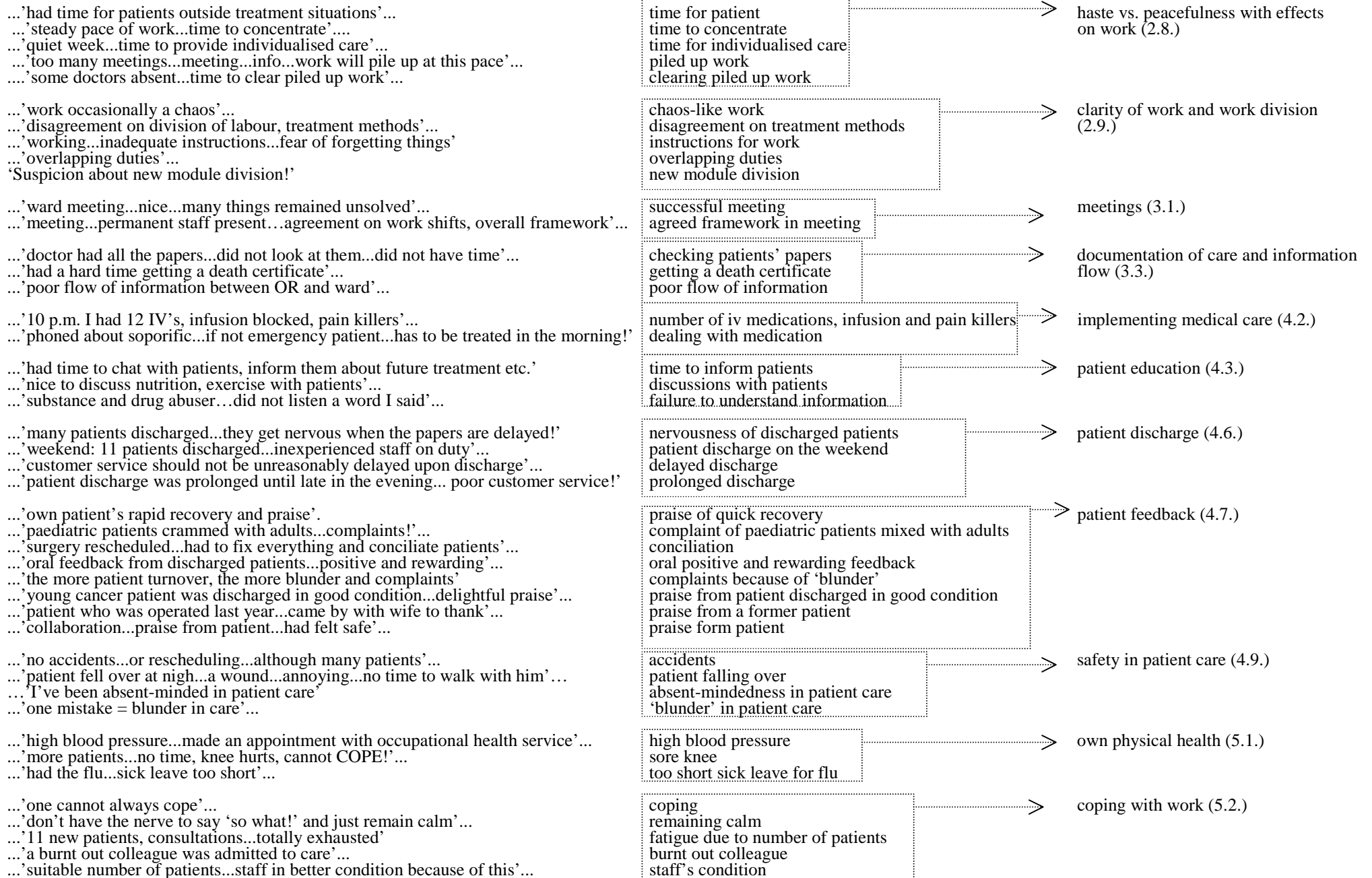| Quotes	Condensed	Category
'I'm losing my motivation in this chaos'…	loss of work motivation due to chaos	work motivation (5.3.)
…'interesting, thought-provoking ward meetings'… …'training in the afternoon…morning shift at a brisk tempo so as to make it'… …'leadership training cancelled…because of illness'… …'interesting training'… …'frustrating training…nothing new…no practical help'… …'visit to X's ICU: e.g. monitoring unit'. …'x-study days…excellent' 'Study days in Oulu…nurses from the whole Finland'…	interesting ward meetings finding time for training session cancellation of training interesting training frustrating training orientation visit excellent study days study day in nursing	participation in study days and in-service training (6.1.)
…'thank you for regional study day'… …'planning study days'	praise for regional study day planning study day	planning and organising study days (6.2.)
…'poor precepting …practical nurse has to bear responsibility ' …'positive preception…both gained something' …'handy student, great help'… …'students satisfied with preception'… …'able to put theory into preception and practice' …'heavy preception…did not know basics…last term student' …'arrears of work…unable to concentrate fully on preception of student' …'my student nurse is active and interested' …'steady stream of work…time to precept student'… …'precepted an exchange student…satisfied with study period'… 'Haste…precepted a new employee…no time to do it'.	poor preception mutual gain in student guidance help from handy student students' satisfaction with guidance putting theory into guidance and practice heavy preception with an unskilled student inadequate student preception active and interested student peaceful preception exchange student's satisfaction with study period complicated preception of a new employee	orienting and preceptiing new employees and students (6.3.)
…'CS…rewarding'… …'good relations…more open discussion for the first time'… …'was misunderstood…did not have the opportunity to fix it'… …'a colleague's problem was dealt with superficially in CS'… …'new things for me emerged in CS'… …'CS for nurses who have problems with patients'… …'doctor attended CS group'…	rewarding CS open discussion in CS misconception superficial discussion about problem new issues emerged in CS nurses' CS for patient problems doctor in CS	effects of clinical supervision (7.1.)
'Answering this survey… I hate these questions!'… …'when do we get feedback?…I have my doubts about the study'… …'too many surveys, once a month would be enough'…	tiring questions of survey dubious study frequency of surveys	motivation for laborious research (7.2.)
'ADP -system renewal causes confusion and vagueness' …'problems with computers, up-dating of statistics delayed and things pile up'… …'software had changed during holiday…spent lots of time learning it'… …'problems with system design…no time for patient affairs'… …'new software takes a lot of energy…room for development'… …'learning to manage computer software…training and advice from different wards'…	confusion caused by ADP system problems with ADP time-consuming software learning problems with system hamper focusing on patient affairs energy-consuming software managing software	changes with ADP systems with effects on operations (8.1.)
…'queries…vague information… uncertainty about the effects of strike' …'strike…had to give vague information over telephone' …'one doctor remained…impending strike…contradictory instructions'… …'relief… no strike…we can admit people from the queue'…	uncertainty about the effects of strike giving vague information about strike threat of strike with conflicting instructions cancelled strike	threat of strike with effects on operation (8.2.)
…'introduction of out-patient clinic makes people nervous'… …'clinic started to operate… people excited'…	nervousness due to new out-patient clinic enthusiasm due to starting of clinic	out-patient clinic activities (8.3.)
…'an interesting medical study is being launched'…	launched interesting medical study	launched study (8.4.)

Appendix 5 b. Examples of staff's positive and negative responses to the open-ended questions on ward B (n=124). The number of examples in this appendix is 32 and it represents 25.8% of all answers.

Example	Reduced expression	Category
'Negative feedback again...' …'verbal attacks for no reason = bureaucracy...'	negative feedback ungrounded verbal attacks	communication among staff (1.2.)
'Indifferent and patronizing attitude toward staff...' ....'peaceful at work... we had fun... superior on leave.' ...'ward sister (WS) 'bossed' one of us around... we were annoyed...' ...'WS's changing moods. For example...' ...'WS ignores problems...'	indifferent and patronising attitude peaceful at work while superior on leave 'bossing around' by WS WS's changing moods ignored problems by WS	relationship between ward sister and staff (1.3.)
…'difficult decision on filling a post... no support from director of nursing (DN).' …'Lack of support in the role of WS. '	lack of support from DN lack of support in the role of WS	support from colleagues to WS (1.5.)
…'haste... operations cancelled every day...' …' surgery schedules inaccurate... poor planning	cancelled operations unplanned action	scheduling operations (2.1.)
…'illness, no substitutes, fuss because of this'	'fuss' due to the lack of substitutes	substitutes (2.4.)
…'to be able to get people to come to work' 'All too much haste, long days and being on duty roster' 'I was able to be on duty the whole week at my own request…' ...'game/sauna evening with our team...' ...'after the holiday... difficult to start'... ...'it's Friday and the weekend starts...'	getting people to work haste and long days on duty at one's own request evening with the team difficult to return to work after holiday start of weekend	planning work shifts and free time (2.5.)
…'I was suddenly transferred to another theatre…' …'the same team gets the opportunity to work in peace.' 'Collaboration has been running smoothly' ...'the feeling that we are not trusted as a team... that we are not able to organise this'…	transfer to another theatre same team working together in peace smooth collaboration the team's ability to organise its work	collaboration of the team in OR (2.9.)
…'sad patient histories' …'aseptic behaviour... addressing a patient...' …'treatment not the best possible' ...'failed to enter the theatre during X, patient safety suffers'.	sadness of patient histories addressing a patient and aseptic behaviour low standard of patient care threat to patient safety	standard of patient care (4.8.)
…'I am able to attend study days in X' …'learning anaesthetics with another nurse' …'my experience of anaesthetics is insufficient…but I still have to do them in duty'... 'I have no skill to cope with difficulties.'	attending study days learning anaesthetics with another nurse insufficiency of work experience lacking skill to cope with difficulties	attending study days and gaining work experience (6.1.)
'Educational needs emerged in clinical supervision!' 'Anxiety caused by clinical supervision'	emergence of educational needs in CS anxiety	effects of CS (7.1.)

Appendix 5 c. Examples of staff's positive and negative responses to the open-ended questions on ward C (n=318). The number of examples in this appendix is 105 and it represents 32.7% of all answers.

Example	Reduced expression	Category
...'sometimes poor collaboration...depends on who you work with'...	poor collaboration depending on partner	collaboration between doctors, nurses and other occupational groups (1.1.)
...'busy day...'field gang' made it...smooth collaboration'...	good collaboration	
...'collaboration between different occupational groups OK'...	collaboration between different occupational groups	
...'collaboration with close colleague improved'...	improved collaboration with colleague	
...'treatment OK because smooth collaboration between patients and nurses'...	smoothness of collaboration	
...'doctors try to make nurses 'wait' on them...the senior ones make no exception'...	waiting on doctors	
…'thank god for a co-operative WS'…	WS's (ward sister) collaboration skill	
...'doctor's change simply announced... no prior discussion with staff'.	doctors' switch without informing staff	communication and feedback between doctors and nurses (1.2.)
...'lecture...doctor refused to share the information he had learned'...	sharing information	
...'negative discussions with doctors about quality of care'...	discussion about quality of care with doctors	
...'open expression of opinions...is taken as criticism'...	opinions taken as criticism	
...'atmosphere is more tense...gossiping made me feel bad'...	displeasure with gossip	
...'conflicts and the way to deal with them offended me'...	way to handle conflicts	
...'negative feedback from colleague was worse than…'….	negative feedback from colleague	
...'feedback from colleague...made me feel bad...unable to sleep afterwards.'	displeasure with feedback	
...'tense atmosphere in examination room... between patients and staff'...	atmosphere between patients and staff	atmosphere on ward and in patient care (1.4.)
...'patients in extra beds...stress between patients and staff...	stress between patients and staff	
...'good to see colleague out of uniform'.	colleague out of uniform	colleagues and their personal characteristics (1.5.)
...'night shift...with a nurse...seemed nice'...	nurse as a fellow colleague in night shift	
...'haste but nice colleagues, smooth work'.	nice colleagues	
...'friendly colleagues'...	friendly colleagues	
...'doctors' dull attitude towards patients and nurses'...	doctor's dull attitude	doctors' attitudes and personal characteristics (1.6.)
...'medical profession's attitude: nurses should take classes in 'good manners''...	doctors' attitudes	
'New house officers are bright, young people'.	new bright ward doctors	
...'5-6 patients constantly in extra beds...threat of economy measures!'	extra beds regardless of economy measures	patient load (2.3.)
...'part of beds 'closed down'... number of patients has not remained the same'...	patients on 'closed down beds'	
...'supposed to have 18 beds...exceeded by 170%...rapid patient turnover, haste'...	patient-bed ratio too large	
...'18 beds closed down, 21-28 patients...nurses laid off'...	nurses laid off regardless of patient number	
...'peaceful week...significantly fewer patients'....	peacefulness from small number of patients	
...'extremely high patient turnover...still things ran surprisingly smoothly'...	smooth work with high patient turnover	
...'occasionally too quiet...should have a steady flow of patients...no peaks'	unequal flow of patients	
...'too quiet...operations cancelled...OR fails to function properly!'	quietness because of cancelled operations	
...'rush...staff on sick leave...no substitutes'...	sick leaves without substitutes	contribution of substitutes (2.4.)
...'short-staffed...work suffers...annoying to see the same situation recur'...	shortage of staff	
...'substitute, co-operative and nice...hard week...went well'...	substitute's collaboration skill	
...'was not able to take my weekly short-time!'	taking short-time	work shifts and importance of holidays (2.5.)
...'few work days'...	small number of work days	
...'just finished holiday, I've regained my strength'...	coping after holiday	
...'soft landing to work after holiday'...	returning to work after holiday and calm situation	
...'soft landing to work after annual leave'...	soft landing after holiday	
...'autumn bazaar and sauna evening...everybody had fun... everybody involved!'	fun with bazaar and sauna evening	

...'had time for patients outside treatment situations'... | time for patient | haste vs. peacefulness with effects
...'steady pace of work...time to concentrate'.... | time to concentrate | on work (2.8.)
...'quiet week...time to provide individualised care'... | time for individualised care |
...'too many meetings...meeting...info...work will pile up at this pace'... | piled up work |
.....'some doctors absent...time to clear piled up work'... | clearing piled up work |

...'work occasionally a chaos'... | chaos-like work | clarity of work and work division
...'disagreement on division of labour, treatment methods'... | disagreement on treatment methods | (2.9.)
...'working...inadequate instructions...fear of forgetting things' | instructions for work |
...'overlapping duties'... | overlapping duties |
'Suspicion about new module division!' | new module division |

...'ward meeting...nice...many things remained unsolved'... | successful meeting | meetings (3.1.)
...'meeting...permanent staff present…agreement on work shifts, overall framework'... | agreed framework in meeting |

...'doctor had all the papers...did not look at them...did not have time'... | checking patients' papers | documentation of care and information
...'had a hard time getting a death certificate'... | getting a death certificate | flow (3.3.)
...'poor flow of information between OR and ward'... | poor flow of information |

...'10 p.m. I had 12 IV's, infusion blocked, pain killers'... | number of iv medications, infusion and pain killers | implementing medical care (4.2.)
...'phoned about soporific...if not emergency patient...has to be treated in the morning!' | dealing with medication |

...'had time to chat with patients, inform them about future treatment etc.' | time to inform patients | patient education (4.3.)
...'nice to discuss nutrition, exercise with patients'... | discussions with patients |
...'substance and drug abuser…did not listen a word I said'... | failure to understand information |

...'many patients discharged...they get nervous when the papers are delayed!' | nervousness of discharged patients | patient discharge (4.6.)
...'weekend: 11 patients discharged...inexperienced staff on duty'... | patient discharge on the weekend |
...'customer service should not be unreasonably delayed upon discharge'... | delayed discharge |
...'patient discharge was prolonged until late in the evening... poor customer service!' | prolonged discharge |

...'own patient's rapid recovery and praise'. | praise of quick recovery | patient feedback (4.7.)
...'paediatric patients crammed with adults...complaints!'... | complaint of paediatric patients mixed with adults |
...'surgery rescheduled...had to fix everything and conciliate patients'... | conciliation |
...'oral feedback from discharged patients...positive and rewarding'... | oral positive and rewarding feedback |
...'the more patient turnover, the more blunder and complaints' | complaints because of 'blunder' |
...'young cancer patient was discharged in good condition...delightful praise'... | praise from patient discharged in good condition |
...'patient who was operated last year...came by with wife to thank'... | praise from a former patient |
...'collaboration...praise from patient...had felt safe'... | praise form patient |

...'no accidents...or rescheduling...although many patients'... | accidents | safety in patient care (4.9.)
...'patient fell over at nigh...a wound...annoying...no time to walk with him'… | patient falling over |
… 'I've been absent-minded in patient care' | absent-mindedness in patient care |
...'one mistake = blunder in care'... | 'blunder' in patient care |

...'high blood pressure...made an appointment with occupational health service'... | high blood pressure | own physical health (5.1.)
...'more patients...no time, knee hurts, cannot COPE!'... | sore knee |
...'had the flu...sick leave too short'... | too short sick leave for flu |

...'one cannot always cope'... | coping | coping with work (5.2.)
...'don't have the nerve to say 'so what!' and just remain calm'... | remaining calm |
...'11 new patients, consultations...totally exhausted' | fatigue due to number of patients |
...'a burnt out colleague was admitted to care'... | burnt out colleague |
...'suitable number of patients...staff in better condition because of this'... | staff's condition |

...'attended an interesting training event'... ...'study day a positive experience...time to listen in peace'.... 'Study visit to Sweden'	attending an interesting training event listening in peace during study day study visit	attending in-service training and study days (6.1.)
...'unable to concentrate on guidance...but student was satisfied'... ...'holiday substitute...bright, quick to learn and good sense of humour'. ...'some...show no interest or independence...collaboration suffers'... ...'have to teach students...makes me nervous if busy'...	student's satisfaction with guidance substitute quick to learn lack of interest and independence teaching students in haste	factors affecting guidance of students and substitutes (6.3.)
...'19 new patients...no time for CS'... ...'good CS session'... ...'progress in CS...trying to deal with issues'... ...'felt bad about CS...unfinished business...hidden agitation'...	time for CS good CS session progress in CS unfinished business in CS	effects of CS and time for participation (7.1.)
...'I'm getting sick of responding to these surveys'... ...'this study is totally useless!'	responding to survey benefit from study	study motivation (7.2.)
...'some people still cannot master computers'... ...'new computer system, computer people cannot handle it' ...'computer system changed on the weekend...mild panic...on Monday'... ...'making appointments for aftercare very slow on computer'...	ADP matters not in order change in ADP system panic caused by change in ADP slow booking of aftercare appointments	ADP changes with effects on practice (8.1.)
...'decisions about the ward...did not hear about them…patients transferred to ward' ...'day surgery patients being transferred to ward'...	transferred patients day surgery patients transferred to ward	transferred day-surgery patients (8.3.)

Appendix 5 d. Examples of staff's positive and negative responses to the open-ended questions on ward D (n=621). The number of examples in this appendix is 166 and it represents 26.9% of all answers.

Example	Reduced expression	Category
...'collaboration...patients with many problems and very sick'... ...'poor collaboration...some avoid responsibility...annoying'... ...'collaboration got us through the 'circus''... ...'feeling of togetherness increased...discussed what to do'... …'colleague's birthday was the climax…enhanced feeling of togetherness'…	collaboration in patient care poor collaboration getting through with collaboration increased feeling of togetherness feeling of togetherness through colleague's birthday	smoothness of collaboration and feeling of togetherness (1.1.)
...'colleague gave positive feedback'... ...'way to interfere in things and give negative feedback'... …'feedback on smooth collaboration'. …'received positive feedback on interpersonal skills'… ...'direct feedback...they see me...as a positive person'...	positive feedback from colleague interfering in things with negative feedback feedback on smoothness of work praise for interpersonal skills direct feedback on positive attitude	communication and feedback between nursing staff (1.2.)
…'WS run me down…no chance to explain…I was hurt'… ...'WS gives impertinent feedback…not constructive, I'm feeling tense'... ...'feedback discussion with WS...positive feedback'. ...'constant minor 'carping...must be on the alert...' ...'substitutes are addressed impolitely…very unpleasant in our opinion'... 'WS lost her role...watching whether somebody is sitting'... 'Bosses' messing about hampers the work of rank-and-file nurses'. ...'presented suggestions for improvement in WS...immediate rejection'... 'WS back from holiday…dissatisfied with everything…wrong decisions'… …'lots of work...WS away...light atmosphere'... …'bosses fighting with each other…causes us distress and insecurity and depletes our resources'…	hurt by ward sister's (WS's) criticism WS's impertinent feedback WS's positive feedback constant carping unpleasant impolite form of address WS's watchdog role bosses' messing around hampered staff's work rejection of suggestions WS: dissatisfaction with wrong decisions lightness of atmosphere during WS's absence bosses' fighting with each other	WS's leadership style and relations with staff (1.3.)
...'haste and tense atmosphere because of it'. ...'general tenseness...work has not found its pattern yet'... …'tense relations between nurses…some conflicts'… ...'situation at deadlock...because of misunderstanding...no chance to explain'... ...'incident...there is 'agitation' on a larger scale…complaint to the management group'... ...'dealing with our joint problem...received tips on how to sort it out'... …'still problems that are not discussed'…	tense atmosphere tense atmosphere tense relations between nurses deadlocked situation due to misunderstanding conflict that led complaint to management group dealing with joint problem problems not discussed	atmosphere and conflicts (1.4.)
...'good work mates…helped me'... ...'10 o'clock shift received help without having to ask for it'. ...'empathetic and friendly colleagues'... ...'a colleague's behaviour...annoyed others...collaboration doesn't work'... ...'trouble with x...unfriendly and mean perhaps on purpose?'... …'the same partner the whole week'… …'support and understanding from a colleague in a difficult situation'…	getting help from good colleagues getting help without having to ask empathy and friendliness of colleague colleague's annoying behaviour difficulties with colleague same partner the whole week colleague's support and understanding	colleagues' helpfulness with other personal characteristics (1.5.)
...'female house officer was very rude to patients'... ...'female doctors 'peevish' to nurses...caused an unpleasant atmosphere'...	doctor's rudeness towards patient doctor's peevishness to nurses	doctors' behaviour (1.6.)

…'understanding patients…not operated because of economy measures'.	cancellations of operations for economical reasons	appointment times and time scheduling (2.1.)
…'operations rescheduled because of emergency patients…the rest delayed'…	cancelled operations	
…'being on call...cancelled operations...infections'…	cancelled and removed operation times	
…'examinations and operations rescheduled...patient not happy about it'…	rescheduling examinations and operations	
…'worker assigned to take care of patient summons...she's been sick for 2 weeks!'	worker assigned to patient summons on sick leave	
…'secretary responsible for appointments started work'.	secretary for appointments	
…'confusion between nurses and doctors about appointments'…	confusion about appointments	
…'errors in appointments...difficult to fix them'…	corrections of errors in appointments	
…'appointments devolved to nurses'…	appointments devolved to nurses	
…'summons organisation too heavy and time-consuming'…	heavy and time-consuming summons organisation	
…'planning failed...different picture appeared in talk.'	failure in planning work	planning and development work (2.2.)
…'genuinely multi-professional development work'.	multi-professional development work	
…'closed down for the summer and planning the 3rd OR'…	planning OR	
'Development work progressed well'.	progress of development work	
…'we are going to be evacuated during summer...challenging plans'…	plans for evacuation	
…'busy shifts, many patients...friction about division of labour'…	high number of patients	patient load (2.3.)
…'number of patients increased by 40%...number of staff remained the same'…	increased number of patients	
…'extra beds...many patients in poor condition...too little time'…	high number of patients in poor condition in extra beds	
…'many emergency patients and extra beds'…	high number of emergency patients and extra beds in use	
…'lots of work...shortage of staff'…	staff shortage	
…'busy week…staff/patient ratio too small'	lack of staff in relation to number of patients	
…'secretaries' increased workload'…	secretaries' workload	
…'her maternity leave started...no substitute...trying to figure it out'…	no substitute for maternity leave	lack of substitutes in unstable situation (2.4.)
…'flu and stomach disease...lots of work and too few workers...need for substitutes'…	need for substitutes	
…'three out of five shifts only substitutes...I was responsible for everything!'	substitutes on night shift	
…'substitutes not hired...they're economising'…	substitutes not hired for economical reasons	
…'situation with substitutes uncertain…distressing…not permitted to criticise'…	uncertainty about substitutes	
…'contracts possibly not extended'…	uncertainty about extending contracts	
…'no 'solo acts' and changes...changes in staffing'…	changed staffing through changes in work shifts	work shift planning with effects on working (2.5.)
…'she cancelled her annual leave...whole rota had to be rearranged'…	rearrangement of rota	
…'shift changes because of sick leaves'…	making shift changes	
…'haste and fragmented week…my contribution is dispersed'.	fragmentary week	
…'haste, an especially confusing and hard day'…	confusing and hard shift	
…'day surgery ward…flexible, convenient working hours'…	flexible and convenient working hours	
…'night shifts, able to calm down and compose my thoughts'…	calming down during shift	
…'6 days off, broke loose from work'…	breaking loose from work during days off	
…'adjustment problems after long Christmas holiday'…	adjustment problems after Christmas holiday	
'Waiting for holiday'	waiting for holiday	
'I'm feeling stronger after holiday'.	coping after days off	
…'many sick leaves...shift changes...collaboration still smooth!'	amount of sick leaves	effects of sick leaves on work shift planning (2.6.)
…'conflict and sick leaves'…	conflicts causing sick leaves	
…'sick leaves…too long shifts…fatigue'…	sick leaves initiated extra long shifts	
…'substituting sick colleagues…own work…a mess'…	substituting sick colleagues	

...'so busy that could have lunch only after my morning shift'.
...'busy pace of work...emergency patients, they phoned the instructions afterwards'...
...'we made it despite a tough situation'...
…'feeling of making it despite all the fuss'
...'doctor's round protracted...painful...impossible to be in two places'.
...'many very ill patients...rounds lasted until afternoon'...
...'new doctor interviewed...it took a long time...patients tired of waiting'...
...'positive...calm...had time to discuss with patients'...
...'ward has been full...no time to concentrate on patients'...

| haste postponed time for lunch |
| busy pace of work |
| elasticity in tough situation |
| coping despite fuss |
| protraction of doctor's round |
| rounds delayed until afternoon |
| time consuming interviews |
| peaceful conversations with patients |
| time to get to know patients |

> haste in work with limited time for patients (2.8.)

...'everything ran like a clock... and satisfied patients'...
...'work ran smoothly, no friction'...
...'clarity of action, although discharged 25 patients' ...
...'division of labour very confusing'...
...'primary nursing started rigidly, 'confusion'...
...'lots of traffic at report...5 nurses giving report...not always clear'...
…'confusing instructions'…
…'new system…ward X will be transformed into day ward…confusing'…
'Last day of week on another ward, impossible to get a clear picture of duties'...

| smoothness of work |
| smoothness of work without friction |
| clarity of action |
| confusing division of labour |
| confusion in primary nursing |
| confused reports |
| confusing instructions |
| confusing new system |
| getting a picture of work |

> smoothness of work through clarity of actions (2.9.)

...'people are not sticking to agreements...uncertainty'...
...'things are not going well...although everybody is committed'...
...'joint decisions: e.g. primary nursing'...

| sticking to agreements |
| poor progress through low commitment |
| joint decisions |

> joint decision-making in meetings (3.1.)

...'expectations and possibility to meet them...poles apart'....
...'many successful treatment episodes, excellent outcome!'

| discrepancy between expectations and outcome |
| successful outcome |

> outcome of care (4.5.)

...'patient's relative dissatisfied...patient was not'...
...'patients not satisfied...they have to wait for a long time'...
...'phone call...dissatisfied patient...felt bad about it'...
'A couple of dissatisfied patients. They made a written complaint'.
...'patient feedback: they've noticed our workload...does not show in quality yet'...

| relative's dissatisfaction |
| patient dissatisfaction with queuing |
| dissatisfied patient |
| patient dissatisfaction with form of address |
| patient feedback on staff's workload |

> patients' and relatives' satisfaction (4.7.)

...'not too many patients...they received individualised care'
...'impersonal work...30 patients per day...where's the individuality?'...
'Haste and ward fully packed…little time to orient to patients'.

| individualised care during night |
| impersonal care |
| inadequate orientation to patients |

> individuality of care (4.8.)

'It happens to the best of us'...
...'error...in patient care'...
...'severe complication due to local anaesthesia is being looked into'...
...'many complications...matter handled slowly'...
...'many post-surgery inflammations on ward'...
'Many complicated operations...a lot of explanation on ward!'

| errors |
| error in care |
| complication of local anaesthesia |
| high number of complications |
| high number of patients with inflammation |
| several complicated operations |

> errors and complications (4.9.)

...'patient died after a long operation...it shocked us all'...

| patient's death |

> death of patient (4.11.)

...'incipient flu makes me tired...no strength'
...'rehabilitation because of my back. It's better!'...
...'fatigue...had to work although not well'...
…'I was suddenly taken ill'…

| incipient flu |
| rehabilitation of back |
| own fatigue |
| sudden sick leave |

> own physical health (5.1.)

...'good feeling, I seem to be coping'.
...'too much work...I'm running out of my energy'...
...'mom died unexpectedly...new priority of life values'...
'Own life situation weakens contribution to work'.

| coping through own good mood |
| running out of energy |
| new priority of values |
| low contribution to work through life situation |

> sense of own adequacy and coping (5.2.)

...'talked about back pain...they ignored me...drives me mad and spils my mood'
...'primary nursing removed from practical nurses... weakens work motivation'
'Secretaries' motivation...reflects on others'

→ ignored back pain's influence on mood
decreased work motivation
reflections of low motivation
⟹ work motivation (5.3.)

...'study day...lots of new information...about strategies'...
'I learned new things...was able to practise...seems OK'.
'Was informed that I get to attend study days'...
…'training on Friday…relaxing and inspiring'…

→ information on new strategies during study day
learning new things
attendance of study days
inspiring and relaxing training
⟹ attendance at study days and in-service training (6.1.)

...'study day a success... positive feedback from outpatient care'.
'Planning study days'

→ positive feedback of successful study days
planning of study days
⟹ planning and organising study days (6.2.)

...'inadequate guidance to student...not enough time'...
...'guided a new employee...interesting.'
...'student on ward...easy because enthusiastic'...
…'they don't want to teach new employees…shortage of staff'.

→ inadequate guidance of student
interesting guidance of new employee
working with enthusiastic student
lack of teaching for new employees
⟹ guiding new employees and students (6.3.)

...'disappointment with CS...real issues not dealt with'...
...'CS clearly facilitated advancement'....
…'terrible feeling…assaulted at CS'…
…'no CS in autumn because of training and holidays'…
…'attacks at CS depressing'…
…'CS…distressed me'…
…'you should have the gift of setting boundaries'…
…'they did not manage the situation…turnover of participants…not safe'…

→ disappointment with CS
progress in CS
assault at CS
no CS sessions in autumn
depressing attacks in CS
anxiety caused by CS
skill to set boundaries
failure to control situation
⟹ progress in CS and working methods (7.1.)

...'not really motivated for these surveys'...

→ low motivation for surveys
⟹ motivation for study participation (7.2.)

...'ADP takes too much time'...
...'new software...confusing and failed to work as expected'.
...'new software...strikes me as very difficult to use'...
'Futile paper work because of ADP trouble'.

→ time taken by ADP
dysfunctional new software
difficult new software
confusion about ADP
⟹ ADP's impact on functioning (8.1.)

...'threat of strike...patient care slowed down'...
'Go-slow strike at the office...complicates work'...

→ patient care slowed down by threat of strike
'strike' complicating work
⟹ threat and effects of strikes (8.2.)

...'codes etc. reforms...had to dig up the information from papers, no-one to ask'...
…'3rd OR opened… easier access to surgery'
...'second floor started as a day surgery unit'....
'Started weekly nurse meetings'.
'Launch of the new named nurse project'...

→ reforms with missing information
new OR
launching day surgery ward
launching weekly nurse meetings
launching primary nursing project
⟹ new activities and projects (8.3.)

...'redecoration of office rooms...back from evacuation'...
...'new phones and alarm system out of order...patients disturbed by it'...

→ redecoration and 'evacuation' of ward
equipment out of order
⟹ redecoration of premises and equipment (8.4.)

...'enthusiasm about primary nursing...more experimenting required to establish it'
...'quarrel about launching the primary nursing system, uncertainty, turmoil'.
...'primary nursing poor...quality of care reduced'...
...'primary nursing...everything works for the first time...peaceful reports'
'A very tough week and work climate...conflict about primary nursing'...

→ starting primary nursing
problems with launching primary nursing
poor primary nursing
functioning of primary nursing
conflict about primary nursing
⟹ transfer to primary nursing (8.5.)

Appendix 5 e. Examples of staff's positive and negative responses to the open-ended questions on ward E (n=307). The number of examples in this appendix is 79 and it represents 25.7% of all answers.

Example	Reduced expression	Category
'We survived the week '... 'Team's support in an important issue' ...'everybody helps each other... a catching sense of well-being'.... ...'work went well... staff got along well together'... ...'very busy, but a good team in theatre'... ...'work goes well... no need for cancellations... smooth collaboration'... ...'new doctor... turned out to be co-operative...' ...'hard not to know... approaches... feeling that you do not cope with your job.' ...'glad that the new doctors... are not totally impossible'... ...'work with x not getting on... results in bad work... makes staff nervous'	survival support from team helping each other getting along among staff good team in theatre smooth collaboration new doctor's co-operative skill knowing others' approaches new doctors' accessibility poor collaboration	collaboration with doctors and among staff (1.1.)
...'we trashed the problem the whole week... without discussing it openly'... ...'misunderstanding... gave rise to negative feelings and disrupted work' ...'made a mountain out of a molehill... failed to admit mistake'... ...'we have too much time for idle talk'...	trashing a problem without open discussion misunderstanding with negative feelings exaggerated incident idle talk	communication and ways of processing problematic issues (1.2.)
'I have become the object of abuse for WS... splits hairs and aggravates me'... ...'unpleasant... took up unfinished business aggressively...' ...'staff-WS collaboration limps along'... ... 'free and easy-going atmosphere on ward, WS on leave!'.... ... 'leadership issue caused friction... who is the rightful substitute?...' ...'leadership again 'in the right hands''.	object of abuse for WS's (ward sister) unfinished business taken up aggressively poor collaboration between staff and WS easy-going atmosphere during WS's leave friction due to substitute leadership in the right hands	issues of leadership and WS's relationship with staff (1.3.)
...'Colleagues have supported me!' 'Awesome... 'best colleagues in the same theatre... great to work'... 'My partner in x is 'taunting' me, luckily we hardly meet.'	support from a colleague best colleagues in the same theatre taunting a partner	support and relationship between colleagues (1.5.)
...'stupid cutbacks... patients pay the price!' ...'perpetual economy measures, although our ward has not exceeded the budget!'	economy measures for which patients pay the price economy measures regardless of keeping budget	economy measures (2.1.)
...'terrible disappointment, not getting the third theatre. That's too much for me.' ...'new things revealed about planning perpetually'... 'Plans for the new theatre take much energy!' ...'interesting work because of new theatre'...	delayed opening of third theatre discovery of new things harming planning energy consuming planning interesting planning work	planning new operations (2.2.)
...'lots of regular staff absent - 50% substitute labour'... ...'we had a substitute, but not everybody is fit for work!' ...'hard to get substitutes... no reserve nowadays'... ...'absenteeism... many incompetent substitutes'... ...'similar situation as last week... not enough staff!' ...'we've been working nicely... despite shortage of staff'...	high number of substitute labour unsuitable substitute's for OR work difficulty getting substitutes high number of incompetent substitutes low number of staff shortage of staff	substitutes' work contribution in a situation of staff shortage (2.4.)
... 'fortunately came Easter and 4 days off. ' ...'I had a stimulating holiday in Lapland.' ...'wonderful dinner at a colleague's house!'... ...'party with colleagues'... ...'easy-going week, no big and demanding operations'... 'Fragmentary weeks with a few days off now and again'... ...'Christmas eve a hard day at work... unable to get in the mood for Christmas'… ...'emergency duty at night... disrupted my sleep pattern... still tired'...	Easter holidays stimulating holiday dinner at a colleague's house party with colleagues ease of work week fragmentary week hard day at work affecting mood disruption of sleep pattern due to emergency duty	works shifts, importance of free time and effects on working (2.5.)

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Original statement	Condensed	Category
..'stock supply improved'...	improvement in stock supply	clarity and functioning of operations (2.9.)
... 'microscope is old and starting to fail'....	failing microscope	
...'my duties have changed... at times... succeeded, at times at a loss'..	changed duties	
...'confusion because of duties, roles not completely clear'...	roles and confusion about duties	
...'confusing week... every day a different unit and always a different team'...	confusion due to working in different units and teams	
...'duty rosters will change... we don't know how... they didn't say'...	lack of information concerning duty roster	difficulty with information flow (3.2.)
...'patients complained... I'm tired of listening to needless complaints'...	complaints by patient	praise and positive feedback (4.7.)
...'positive feedback... it's heart-warming... provides motivation for new efforts'...	motivating positive feedback	
....'positive feedback from patients...'	positive feedback from patients	
...'praise from X...'	praise from doctor	
...'lots of new pages in quality manual'...	new pages in quality manual	standard of work (4.8.)
...'impersonal work... patients and we suffer'.	suffering due to impersonality of work	
...'lots of work... confusion...too much talk in front of patients'...	confusion at work	
...'many complications because of operations, infections, damage'...	high number of complications	complications (4.9.)
'My own good health, I go on and on...'	own good health promotes coping	own physical health (5.1.)
... 'my frequent illnesses have disturbed my 'mood'... unable to concentrate'.	illness harms concentration	
...'on sick leave because of rash... got to rest'	resting on sick leave	
...'my own affairs in a tangle... I can barely cope... results in absentmindedness'...	difficulties with coping due to own problems	sense of coping with work (5.2.)
...'sunny mood... removal... work progressed by itself'...	own sunny mood due to removal	
...'haste... but I felt I had accomplished something'...	feeling of accomplishment	
...'assisting went well, I enjoyed my success!'	enjoying success	
'Much haste and a feeling of inadequacy because of this'	feeling of inadequacy	
...'did not know how to fill in a report on leave... it felt embarrassing'...	embarrassment over inability to fill a report	
...'I had hoped to get feedback on congress x'...	unfulfilled hope of feedback from congress	participation in study days (6.1.)
'Argument over study days and participants'	argument over study participants	
... 'Study days in Helsinki. A uniting and stimulating thing.'	unifying and stimulating study days	
...'my lecture to students... went well'...	successful lecture to students	planning and implementing education (6.2.)
...'terrible programme of study day... preliminary programme unfinished'...	unfinished preliminary programme for study day	
...'too little time to precept substitutes'....	lack of time for precepting	precepting and teaching activities (6.3.)
...'lots of work with precepting a substitute'...	work overload of precepting substitutes	
...'is it really our job to teach doctors to operate the equipment?'...	teaching to operate a device	
... 'student public health nurse is positive'...	positive student	
'CS... we decided to identify the topics for the future'...	identify topics for CS	topics of CS (7.1.)
'Filling in these notices on overtime is not very sensible'	sensibility of filling in notices	motivation for research with associated effects (7.2.)
...'because of these inquiries... I have observed my work more closely'...	observing one's own action due to inquiries	

Appendix 6. Summary table and examples of patients' responses to the open-ended questions on wards on wards A, C and D

WARD A (n=493)	WARD C (n=371)	WARD D (n=401)
(I) the staff's competence and jointly created atmosphere		
1.1. staff's skills and behaviour 1.2. doctors' professional competence and adopted attitudes 1.3. nurses' professional caring skills 1.4. atmosphere on ward	1.1. staff's professional skills, attitudes and behaviour 1.2. doctors' professional competence and behaviour 1.3. nurses' caring skills 1.4. atmosphere and spirit on ward 1.5. students' developing skills and behaviour	1.1 staff's expertise and behaviour 1.2 doctors' professional competence and personal characteristics 1.3 nurses' professional and caring skills 1.4 atmosphere and spirit on ward
(II) overall quality of care		
2.1. getting help 2.2. care with attention 2.3. limited time for patients 2.4. perceived opinions and wishes 2.5. success of care episode	2.1 getting help 2.2. caring 2.3. haste with effects on patient care 2.4. wishes and opinions 2.5. success of care episode	2.1. getting help 2.2. caring 2.3. haste and associated problems 2.5. success of care episode
(III) medical technical care of illness and outcome of care		
3.1. diagnosis of illness and pain 3.2. operations, examinations and complications 3.3. restoration of health 3.4. medical care	3.1. identifying illness 3.2. success and pleasantness of examinations and operations 3.3. recovery and healing 3.4. medical care	3.1. diagnosis of illness and pain 3.2. success and pleasantness of care 3.3. recovery and healing 3.4. medical care
(IV) interaction and exchange of information		
4.1. collaboration in care 4.2. treatment and form of address 4.3. conversations and understanding listening 4.4. receiving and getting information	4.1. collaboration and social intercourse in care 4.2. treatment and form of address 4.3. discussions and communication 4.4. getting and receiving information and information flow	4.1. collaboration and social intercourse in care 4.2. treatment and form of address 4.3. communication and discussing 4.4. getting and giving information
(V) satisfied needs, changes in everyday traditions and one's values		
5.1. sleeping 5.2. food and eating 5.3. roommates and friends 5.4. visiting hours 5.5. feelings during hospital stay 5.6. changes in life values 5.7. interrupted study and work rhythm 5.8. changed smoking habits	5.1. rest and sleep 5.2. food and influence of illness on eating 5.3. roommates and new friends 5.5. feelings during hospital stay 5.6. changes in life values 5.7. interruptions in work and school 5.8. changes in smoking habits	5.1. rest and sleep 5.2. food, diets and having meals 5.3. roommates 5.4. visiting times 5.5. feelings during hospital stay 5.6. changes in life values and views 5.7. interrupted exercise interests
(VI) hospital environment and its comfort		
6.1. bed and patient room 6.2. facilities and equipment 6.3. tidiness and hygiene 6.4. pastime	6.1. bed and patient room 6.2. facilities and equipment 6.3. tidiness and cleanliness 6.4. entertainment	6.1. bed and patient room 6.2. facilities and equipment 6.3. cleanness of facilities 6.4. entertainment during hospital stay
(VII) factors related to different phases of care process		
7.1. access to care and treatment 7.3. length of care episode	7.1. admission to hospital 7.2. waiting at different points of care episode 7.3. duration of hospital stay and discharge	7.1. admission to care 7.3. duration of hospital stay and discharge
(VIII) the level of services and expenses		
8.1. quality and standard of services	8.1. grade of services 8.2. development of operations 8.3. cost level	8.1. quality and availability of services

Appendix 6 a. Examples of patients' positive and negative responses to the open-ended questions on ward A (n=493). The number of examples in this appendix is 161 and it represents 32.7% of all answers.

Example	Reduced expression	Category
...'pleasantly brisk and friendly staff'... ...'proficient and friendly staff, though busy'... ...'not all were friendly and competent'...	briskness and friendliness of staff professional skill and friendliness friendliness and expertise	staff's skills and behaviour (1.1.)
...'doctor in charge, operating and circulating physicians... all involved in care' ...'doctor was not interested in my wounds'... ...'doctors' positive attitude... relevant care'... ...'doctor X... matter-of-fact, gave time for patient'...	doctors' involvement in care lack of interest in wounds positive attitude with relevant care matter-of-factness and giving time	doctors' professional competence and adopted attitudes (1.2)
'Friendly nurses' ...'some nurses unfriendly and pretentious '... ...'received support from nurses in this difficult life situation'.... ...'nurses helpful and empathetic'... ...'immature nurse... I'm in this business, too... had to fill in the form myself"	nurses' friendliness nurses' unfriendliness and pretentiousness support in a difficult life situation helpfulness and empathy nurse's immaturity	nurses' professional caring skills (1.3.)
...'the ward had a positive atmosphere '... ...'hard work pressure, I could sense stress'... 'Yes, very friendly atmosphere.' 'Open and encouraging atmosphere on ward.' ...'busy atmosphere'...	positive atmosphere palpable stress on ward friendly atmosphere open and encouraging atmosphere palpable haste on ward	atmosphere on the ward (1.4.)
....'no help was offered, had to ask for it'... ....'help was always available'... ....'immediate help, no waiting'... ....'you had to ring a bell to get help... they did not offer it spontaneously'	asking for help help available at all times getting help without waiting no spontaneous help	getting help (2.1.)
...'I wanted more caring, attention.' 'Comprehensive attention to patients'... 'They took good care of you on the ward'...	need for attention and caring comprehensive attention good caring	attentive care (2.2.)
...'more nurses... they are forced to prioritise what they do.' ...'I wanted more time from nurses'... 'Nurses had time to discuss despite haste'... ...'nurses had no time for personalised care'...	prioritising duties lack of time from nurses nurses' time for discussion lack of time for personalised care	limited time for patients (2.3.)
'They listened to my opinion.' 'My wishes have been taken into consideration very well.'	listening to opinions considering wishes	perceived opinions and wishes (2.4.)
'A positive period as a whole.' 'Positive: whole care process'	positive whole positive care process	success of care episode (2.5.)

...'would they have sent me home?... first diagnosis false'...
'Positive thing: they discovered a hidden ailment'.
'Illness itself was a negative thing.'
 'Negative: pain.'
...'pain belonging to illness'...

wrong diagnosis
detection of a hidden ailment
illness
pain
pain as part of illness

> diagnosis of illness and pain (3.1)

'They discovered another illness... took vigorous measures immediately.'
'They rectified my vascular problems at hospital.'
...'both operations during the same visit'...
'Positive: removal of tumour.'
'I received all the examinations that I needed'...
...'X-ray moved to the next day... I don't know why'...
...'unsystematic care... factory-like, not personalized'...
...'it felt as though the care was well-planned'...
...'high-quality expertise and care... for my illness'...
...'good, mechanical treatment'...
...'sand sacks... old-fashioned from a layman's perspective'
'Germ in blood, urine and blood clot in leg'
...'neck loop... broken collarbone...interlocked bone ends'...
...'complication a negative thing, but got over it'...

starting treatment vigorously
rectifying vascular problems
operations during the same visit
removal of tumour
receiving necessary examinations
re-scheduling of X-ray
unsystematic and non-individualised care
good planning
high-quality care and expertise
mechanical nature of care
out-dated method in care
bacteria and blood clot
interlocked collar bones due to neck loop
complication

> operations, examinations and complications (3.2.)

...'the tediousness of recovery, that's all'...
'Quick recovery'...
'Yes... I got my life back!'
'Removal of ailment almost impossible.'
'Surgery did not give desired outcome.'
'Alleviation for chronic pain that had lasted for years'...

tediousness of recovery
quick recovery
getting life back
impossibility of removing ailment
undesired outcome of operation
alleviation for chronic pain

> restoration of health (3.3.)

...'constipation... night nurses kept putting off administering the capsules'
...'is cortisone a drug that causes hallucination?'...
'They had not given me any insulin on the day of surgery'...
'Negative: I received pain medication only when necessary'.
...'failed to receive medicine, although I could just barely tolerate the pain'

delayed medication for constipation
hallucinations caused by medication
no insulin injection
pain medication only when necessary
no medication for severe pain

> medical care (3.4.)

...'patient/doctor/nurse relationship worked well'..
...'on ward X staff collaboration good'...
...'staff collaboration worked wonderfully'...

functioning patent-nurse-doctor relationship
good collaboration
functional collaboration

> collaboration in care (4.1.)

...'treated me as an adult although I was unable to talk'...
...'impolite answers to telephone calls... was not put through'...
...'no humaneness!'...
...'treated me... as a human being... not as a sick person'...
...'You should not talk about private matters when strangers are around'

treating as an adult
impolite answers to phone calls
lack of humaneness
treating as a human being
talking about private matters

> treatment and form of address (4.2.)

....'discussions... positive and interactive... they listened to me'...
 'Free discussion about difficult issues'...
...'doctors knew Swedish... got to use my mother tongue'...

interactive discussions
discussing difficult issues freely
use of mother tongue

> conversations and listening (4.3.)

'My family were given misinformation... I was 'lost' for a moment'...
...'information does not flow between wards'...
'Got different information every time'...
'Anaesthetist... Finnish was bad... unable to ask questions'...
...'I'm Swedish-speaking... should receive information...and speak Swedish'
...'enough information, but you have to ask'...
...'you can ask freely about things that worry you'...
...'received much information about exercise, food, self-care'...

| wrong information |
| poor flow of information |
| inconsistent information |
| deficiency of information due to language |
| lack of information in Swedish |
| information has to be asked |
| asking about distressing matters freely |
| plenty of information |

> receiving and giving information (4.4.)

'Somewhat bad nights.'
...'restless nights'...
...'a disturbing roommate was taken away for the night'...
...'loud humming late at night... difficult to get to sleep!'

| bad nights |
| restless nights |
| roommate disrupted sleep |
| difficulty getting to sleep |

> sleeping (5.1.)

...'white bread at teatime... partly mouldy'...
'Too much fish on the menu.'
...'allergic to milk... no soy or acidophilus milk'...
...'they kept bringing in food, never hungry'...
'I wanted more vegetarian meals and fish.'
...'tablespoons... shape... difficult to eat with false teeth'.
'Meals too small in size.'
...'liquid... not allowed to drink... dying of thirst'...
'Hot meals too salty.'
'Enough food.'
'Meals could be bigger.'
...'fatty hospital food'...
...'good food and choice'...

| mouldy bread |
| high frequency of fish meals |
| missing milk allergy substitutes |
| abundance of food |
| longing for vegetables and fish |
| uncomfortable shape of spoon |
| smallness of meals |
| thirst due to restriction on liquid intake |
| salty hot meals |
| sufficiency of food |
| bigger meals |
| fatty food |
| standard of food with choice |

> food and eating (5.2.)

...'good spirit in patient room, nice roommates'...
...'a complaining roommate'...
'Nice roommates, free and easy.'
'Now you see who is a true friend.'
'To meet new people.'

| good atmosphere due to nice roommates |
| complaining roommate |
| relaxed atmosphere due to nice roommates |
| identifying real friends |
| meeting new people |

> roommates and friends (5.3.)

'Free visiting hours... wife was allowed to be present'....
'Unrestricted visiting hours.'

| free visiting hours |
| unrestricted visiting hours |

> visiting hours (5.4.)

...'someone was resuscitated at night... I felt daft... I'm a sensitive person'…
...'I felt bad in the recovery room... the patient opposite was doing really bad'…
'I felt safe... in competent hands'
...'epileptic fit... in my sleep and I'm deaf... It scared me'...
'Sense of security because of good care.'
...'insecurity... misunderstanding... different operation will be performed'…
...'felt unsafe... wanted to see the anaesthetist'...
...'hospital is a very lonely place'...
'My anxiety...'

| daft feelings due to resuscitation |
| bad feelings due to fellow patient's poor condition |
| sense of security |
| being frightened |
| feeling safe |
| feelings of uncertainty |
| insecurity |
| loneliness |
| own anxiety |

feelings during hospital stay (5.5.)
>

'Learned to value life.'
'Priorities for life in better order.'
...'there are other values than mine'...
...'maybe I learned to know myself better'...

learning to value life
getting priorities in order
others' priorities
learning to know oneself

⟩ changes in life values (5.6.)

...'Disruption of study pace'...
'I fell behind a bit at school.'
...'poorest possible time with respect to work'...
'Got to stay out of school.'

disrupted study pace
falling behind at school
poor timing with respect to work
staying out of school

⟩ interrupted study and work rhythm (5.7.)

'Did not smoke.'

without smoking

⟩ changed smoking habit (5.8.)

'Sweltering beds'...
'Bad bed... technically good but lousy to sleep in.'
'Bed felt hard, my back got sore.'
'Bed was too short'...
...'they made you lie down too much... my back cannot take it'...
'Small rooms... not too much hubbub'...
...'too crowded.'
...'poor ventilation in room'...
...'room for three... intimate functions awkward'...
...'negative thing... no WC and shower in room'...
'TV in the room, phone also'...
...'telephone system should be improved'...
...'negative: listening to radio... headphones and channels suck'…

sweltering bed
lousy bed for sleeping
sore back because of bed
short bed
sore back caused of staying in bed
quiet room
crowded ward
poor ventilation
limited intimacy in a room for three
lack of own WC and shower
own TV and telephone
poor telephone system
unsatisfactory radio equipment

⟩ bed and patient room (6.1.)

'The ward is too cramped.'
...'More new toilets'...
...'doors in toilets, toilet seats too low'...
'Ward is crowed... ventilation out of order.'
'they could provide toothpaste and hair dryers for patients'.
'One balcony for smokers... and they are so many.'

cramped ward
shortage of toilets
uncomfortable toilet facilities
crowded ward with dysfunctional ventilation
lack of toothpaste and hair dryers
number of balconies for smokers

⟩ facilities and equipment (6.2.)

'Toilet facilities untidy'...
'Positive thing: tidiness'
'WC hygiene could be more effective.'

untidy toilet facilities
tidiness
unhygienic toilets

⟩ tidiness and hygiene (6.3.)

...'it's boring'...
...'something to do as a pastime would have been nice.'
'Boredom'

boredom
pastime
boredom

⟩ pastime (6.4.)

...'access to care was really fast... didn't have to wait'...
'Fast access to care and immediate operation.'
...'the wait... twice as long as what the doctor said'...
'Long wait on admission day before going to room.'
....'waiting... waited for the bond'...
...'waiting and bossing about on the day of surgery'...

quick access to care
access to care and surgery without delay
doubled waiting time
long waiting time on admission day
waiting for treatment
waiting with bossing about

⟩ access to care and treatment (7.1.)

...'short and efficient treatment period'...
...'busy timetables apparent'...
...'I could have coped at home 3-4 days after surgery'...
...'they took care of my continued treatment'...

...'good service... they're in a hurry'...
...'good personal service'...
...'good quality services, humane and personalised'...

efficiency of care period
hasty schedule
coping at home after surgery
continued treatment

good service regardless of haste
personal services
high standard of services

length of care episode (7.3.)

quality and standard of services (8.1.)

Appendix 6 b. Examples of patients' positive and negative responses to the open-ended questions on ward C (n=371). The number of examples in this appendix is 133 and it represents 35.8% of all answers.

Example	Reduced expression		Category
...'professional skill... pleasant and skilled staff'... 'Nice and helpful staff' 'Staff very friendly.' ...'Rude staff at heart examination'.... ...'distant and formal staff.'	staff's professional skill pleasantness and helpfulness of staff friendliness of staff rude staff distant and formal attitude	⟩	staff's professional skills, attitudes and behaviour (1.1.)
...'doctor on duty incompetent and impolite!'... ...'knowledgeable, friendly and considerate doctor'... ...'it was obvious that the doctor wanted to perform quality work'... ...'stressed and unfriendly doctor... my own restlessness'	incompetent, rude doctors doctor's expertise and friendliness doctor's desire to perform quality work stressed and unfriendly doctor	⟩	doctors' professional competence and behaviour (1.2.)
...'hard-working, friendly nurses who are very, very busy'... ...'a cheerful, friendly nurse... makes me feel good'... ...'some nurses unfriendly... too formal'...	hard-working and friendly nurses cheerfulness and friendliness unfriendliness and formality	⟩	nurses' caring skills (1.3.)
...'staff seemed to have a good team spirit'... ...'in the beginning atmosphere really bleak... anaemic'... ...'open and warm atmosphere.' ...'free time... no predetermined bedtime, allowed to watch TV.'	good team spirit among staff bleak and anaemic atmosphere open and warm atmosphere free atmosphere	⟩	atmosphere and spirit on ward (1.4.)
'A really friendly student' ...'student's limping guidance... a nurse should always attend'...	friendly student poor patient education from student	⟩	students' developing skills and behaviour (1.5.)
'Rapid action within an hour relieved my discomfort'. ...'quick help for a serious illness'... 'I needed help and got it.' ...'received help for ailment that is hard especially psychologically.'	rapid action relieving discomfort getting help quickly getting help help for psychologically distressing ailment	⟩	getting help (2.1.)
...'I received caring and friendliness.' ...'caring despite haste'... ...'I felt they really took care of me'...	good caring and friendliness caring sense of genuine caring	⟩	caring (2.2.)
'Negative aspect: staff and cleaners bloody busy.' ...'nurses too busy to concentrate well on patient'... ...'nurses too busy... impersonal care.'	haste complicating concentration on patient impersonal care due to haste	⟩	haste with effects on care (2.3.)
...'nurse promised to wash my hair... forgot... I did it ' ...'wishes were not forwarded... especially those made at night' ...'my personal wish was fulfilled.' 'My opinions were considered.'	forgotten hair wash unforwarded wishes personal wish fulfilled considering opinions	⟩	wishes and opinions (2.4.)
'Good treatment on the whole'.... 'Standard of care excellent as a whole.'	success of treatment as a whole excellent standard of care	⟩	success of care episode (2.5.)

'They were able to ascertain the nature of my injury'...
'Clarity of the cause of ailment.'
...'they found another possible illness and started a treatment course.'
...'they found the disease I've been suffering from almost for a year.'

> ascertaining the nature of injury — identifying illness (3.1.)
> clarifying the cause of ailment
> diagnosis of another possible illness
> finding an illness that caused suffering

'Abdominal endoscopy failed.'
'It's difficult to breathe when your nose is blocked with tampons'....
'Dizziness after coming out of anaesthesia was awful!'
...'I received an extra injury in operating theatre.'
'The operation was quicker and easier than I expected'...
...'X surgery... thank you for making the quality of my life better.'

> failed abdominal endoscopy — success and pleasantness of examinations and operations (3.2.)
> uncomfortable nasal tamponage
> dizziness after anaesthesia
> additional injury in operating theatre
> swiftness and ease of procedure
> improved quality of life because of surgery

...'rapid recovery from illness'...
...'at least a hope of recovery'...
...'I could breathe normally again'...
...'my hand started to work again.'
...'got rid of pain in my throat.'

> rapid recovery — recovery and healing (3.3.)
> hope of recovery
> re-normalisation of breathing
> restored functionality of hand
> throat pain removed

...'once they forgot to install the afternoon infusion.'
...'unpleasant side-effects from medication.'
'A wonderful experience with pain killer'

> forgotten infusion — medical care (3.4.)
> side-effect of medication
> good pain medication

...'good collaboration with nurses'...
...'patient/nurse/doctor relationship now more humane.'

> smooth collaboration — collaboration and social intercourse in care (4.1.)
> humane patent-nurse-doctor relationship

...'no consideration for patients as frightened individuals'
...'treatment on ward X always very discreet'...
...'no one never said a bad work.'
...'director of nursing careless with words... not in the presence of others though'
...'nurses drive you home with how they talk'...

> non-consideration for patients — treatment and form of address (4.2.)
> discreet treatment
> polite way of addressing patients
> nurse's slip of the tongue
> nurses' impolite way of speaking

...'I wanted closeness and time... discussions with nurses'
...'communication, I was unable to speak and nurses were busy.'
...'some nurses and students... said something else than 'how are you?'…

> lack of time for discussions — discussions and communicating (4.3.)
> communication with busy nurses
> deeper level in communication

...'nurses could be better informed of patient care'...
...'staff not knowledgeable of treatment methods... 'guessing' !'
...'spent extra days in hospital... doctor was not informed.'
...'information breakdowns... between staff and patient'
...'information from doctor... nothing if you don't ask'...
...'poor and slow dissemination of information... everything's in Latin'
...'you had to squeeze the information out of them'

> nurses' poor knowledge of patient care — giving and receiving information and (4.4.) information flow
> lack of knowledge concerning treatment options
> extra days in hospital due to uninformed doctor
> poor flow of information
> no information unless asked
> slowness and incomprehensibility of information
> difficulty of getting information spontaneously

...'unable to sleep because of pain and snoring roommate'...
...'I got to rest properly... felt better every day'
...'difficulty sleeping... my own discomfort and strange bed.'

> difficulty sleeping — rest and sleeping (5.1.)
> proper rest
> sleep problems

...'only that liquid meals had no variety'. → lack of variety in liquid food ⇒ food and effects of illness on eating (5.2.)
...'enough food'... → sufficient amount
'Oatmeal gruel is not suitable for an operated throat.' → unsuitable oatmeal gruel for operated throat
...'had jaw surgery... I wondered... hard bread in the evening'... → hard bread after jaw surgery
...'nice coffee breaks. Nice choice of pastry'... → coffee breaks with variation in coffee bread
...'boring... every other day porridge and sour whole milk.' → bored with similar food
...'meals too small in size'... → smallness of meals
...'I got to eat ice cream!' → ice cream every day
...'More attention should be paid to the taste of liquid food.' → tastelessness of liquid food

'Nice to meet new people and to make new friends.' → getting to know new people ⇒ roommates and new friends (5.3.)
'You always meet nice roommates in hospitals'... → nice roommates
'Made new friends.' → new friends

...'I felt I was in good hands the whole time'... → sense of being in good hands ⇒ feelings during hospital stay (5.5.)
'I felt calm after realising that I was in good hands'. → calmness
'felt 'forsaken' before surgery... a young specialising doctor '... → feelings of being 'forsaken'
...'felt safe to get away from home and receive treatment'... → sense of security

'Re-organisation of life's priorities.' → re-organised life values ⇒ changes in life values (5.6.)
...'re-assessment from the point of view of my health.' → re-assessment of own health
...'Your priorities are worth thinking about'... → re-thinking of priorities in life

…'only negative thing: being away from school'… → away from school ⇒ interruptions in work and school (5.7.)
…'negative: absence from work'… → absence from work

'Smoked somewhat less.' → cutting down smoking ⇒ changes in smoking habit (5.8.)
...'did not smoke.' → no smoking at hospital
'Quit smoking' → quit smoking

...'hard mattress, poor pillows... back and neck got sore'... → sore neck and back due to mattress and pillows ⇒ bed and patient room (6.1.)
'Spacious, convenient room... nice and cool' → spaciousness and coolness of room
...'after surgery... table on the other side... could not turn to the right'... → place of table
...'quiet, small room'... → quiet and peaceful room
...'too crowded, too many patients in a small room'.. → crowding in a small room

'Good to have a TV set in the room' → TV in own room ⇒ facilities and equipment (6.2.)
...'radio had only two channels.' → two radio channels
'Proper hospital premises and facilities' → good facilities and equipment
'Day lounge could have more comfortable benches' → day lounge's uncomfortable benches
...'no place for smokers... should not be by the main entrance.' → no place for smokers
...'good patient library'... → good patient library
'Terrible draught from the windows.' → draught from windows
'Powerful mechanical ventilation... draught and blocked nose.' → too powerful ventilation and draught
'A cold place.' → coldness

'Cleanness leaves room for improvement' → improved tidiness ⇒ tidiness and cleanness (6.3.)
'Tidiness and excellent order e.g. in bathroom'... → excellent tidiness and order

...'tedious days... boring'
...'time passed quickly'...
...'time passed s-l-o-w-l-y... needed more stimulation.'

| boredom |
| time went quickly |
| time passed slowly with no stimulation |

⟹ entertainment (6.4.)

...'admission interview downstairs was quite confusing'...
...'no referral... phoned the doctor... helpful and admitted me.'
...'was allowed to come on the morning of surgery... no extra nights.'

| confusing admission procedure |
| admission after calling to doctor |
| admission on day of surgery |

⟹ admission to hospital (7.1.)

...'arrived early as summoned... expected to be admitted: report?! '...
...'waiting... understandable... urgent cases were treated first'...
'Wait for surgery a little bit too long.'
...'placed in queue in 1994... had surgery in 1996... unbelievable'...
...'didn't have to wait for a doctor'...

| waiting for admission |
| waiting due to treatment of urgent cases |
| waiting for surgery |
| waiting time too long |
| no waiting |

⟹ waiting at different points of care episode (7.2.)

'Permission to leave was given too late in the afternoon.'
'Slow examination at discharge.'
...'I felt I was discharged too early.'
...'waiting at admission and discharge.'

| delayed discharge |
| slow discharge |
| early discharge |
| waiting at admission and discharge |

⟹ duration of hospital stay and discharge (7.3.)

'Had my doubts... but service was skilled and friendly'...
...'self-service... they expect you to be independent'...

| skilled and friendly services |
| expectations of self-service and independence |

⟹ grade of services (8.1.)

'Compared with old times.... positive improvement!'
'Previous hospital stay in 1977... positive changes have occurred'

| development of actions |
| positive trend of change |

⟹ development of operations (8.2.)

'Moderate cost of care a positive surprise.'
...'coffee shop was really expensive!'

| moderate cost of care |
| expensive coffee shop |

⟹ cost level (8.3.)

Appendix 6 c. Examples of patients' positive and negative responses to the open-ended questions on ward D (n=401). The number of examples in this appendix is 145 and it represents 36.2% of all answers.

Example	Reduced expression	Category
'Friendly and helpful staff'... 'Pleasant and discreet staff'… 'Skilled and expert staff'… 'Not all staff are friendly and skilled'... ...'staff encouraged and provided hope'...	friendly and helpful staff pleasant and discreet staff expertise of staff unfriendly and unskilful staff staff's encouragement	staff's expertise and behaviour (1.1.)
...'despite their hard work... surgeons had a sense of humour'... ...'doctors were service-minded also while on duty.' ...'doctor on duty a bit too hasty'.... ...'best specialists you can find'...	surgeons with sense of humour doctors' service-mindedness while on call hasty doctor on duty expert doctors	doctors' professional competence and personal characteristics (1.2.)
...'one of the nurses was grumpy and rough'... 'Nurses were friendly despite haste.' 'One nurse smelled heavily of alcohol.' ...'one really sour nurse'... ...'friendly nurses despite haste'... ...'good-humoured and motivated nurses'... ...'one nurse had the 'we know best' attitude'...	grumpy and rough nurse friendly nurses nurse's alcohol smell sour nurse friendliness of nurses pleasantness and motivation of nurses nurse's attitude	nurses' professional and caring skills (1.3.)
...'compared with 1994... tense atmosphere... has an effect on care'. ...'relaxed and pleasant atmosphere '... ...'atmosphere at times tense'... ...'a few nurses fed up with their work... spoil the spirit'... ...'staff's good sprit... atmosphere influences patients.'	tense atmosphere sensed in care relaxed and pleasant atmosphere tense atmosphere fed-up nurses spoiled atmosphere good spirit among staff influences patients	atmosphere and spirit on ward (1.4.)
'Received help for eye disease.'	help for disease	getting help (2.1.)
'They took really good care of me.'	good caring	caring (2.2.)
...'nurses overworked... impossible to be friendly all the time'.... 'Too few nurses... old people would have needed more help.' 'Staff too hasty.' ...'transportation to the theatre... panic, rushing all over the place'...	nurses' work overload low number of nurses vs. need for help haste among staff transportation to theatre with panic and blundering	haste with associated problems (2.3.)
'As a whole a positive experience.' 'Everything ran smoothly.'	positive whole smooth operations	success of the care period (2.5.)
'Negative thing: illness' 'Illness in itself is an unpleasant and frightening thing.' 'Another ailment was found... examinations started right away.' 'Mild pain.'	illness unpleasantness and frightfulness of illness examination of another ailment pain	diagnosis of illness and pain (3.1.)

'Positive experience... operation was done under infusion anaesthesia.'
'Procedure itself was unpleasant.'
'All necessary treatment was given.'
...'they try to achieve efficiency... changeover to impersonal care'...
'Friendly and competent care'
'Poor diabetes care.'
...'daily questions about my bowel functions... no courage to tell'.
...'my fingertips got sore... too large syringes... blood sugar test'...
'Developed a bad rash.'
...'preparation for complications very good'...
'Coming out of anaesthesia was a really bad experience.'
...'my eye surgery failed'...

| positive experience of infusion anaesthesia | → success and pleasantness of care (3.2.) |
| unpleasant procedure |
| all treatment at the same time |
| impersonal care |
| friendly and competent care |
| poor expertise in diabetes care |
| inquiries about bowel functions |
| sore fingertips |
| rash |
| preparation for complications |
| unpleasant experience of anaesthesia |
| unsuccessful operation |

'Turnover of doctors... accuracy of monitoring progress?'
...'doctor checked... 3 days after surgery'...
'I got my eyesight back... that's the best thing'...
...'my problem was dealt with in the best possible way.'

| inaccuracy of monitoring progress | → recovery and healing (3.3.) |
| delayed check-up after surgery |
| regaining eyesight |
| dealing with problem in best possible way |

...'I asked for a pain killer... received a small pill... no effect'...
'Drips at random, when asked... timetables lagged behind'
...'received medication when necessary'...
'Regular eye-drips.'
...'haste... difficulty adhering to medication schedules'...

| ineffective pain killer | → medical treatment (3.4.) |
| unscheduled eye-medications |
| medication when necessary |
| regular medication |
| difficulty administering medication on time |

...'collaboration between ward and headquarters... room for improvement.'
...'collaboration among staff... is not very good.'
...'easy to interact with nurses.'

| room for improved collaboration | → collaboration and social intercourse in care (4.1.) |
| dysfunctional collaboration among staff |
| ease of interaction |

'Excellent treatment.'
'Positive and friendly treatment'...
...'how can they be so rude.. rude cleaners'...
'Doctor X... indiscreet address'....
'One of the nurses very rude.'
...'before anaesthesia... someone blurted out... a properly perforated eye!'
...'better sound-proof rooms... protection of privacy... it was a sensitive issue.'

| excellent treatment | → treatment and form of address (4.2.) |
| positive and friendly treatment |
| rude auxiliary staff |
| doctor's indiscreet verbal address |
| rudeness of nurse |
| inappropriate blurting |
| discussing sensitive issues |

...'nurses had time to discuss despite haste'...
...'inadequate communication with patients'...
...'communication has become easier with staff and doctors'...

| nurses' time for discussion | → communication and discussing (4.3.) |
| inadequate communication with patients |
| eased communication |

...'inadequate and curt answers'...
...'Estonian employee... had trouble understanding what she meant'...
'I received lots of new information about my illness.'
...'they kept me well informed, had time to explain.'
...'better guidance on how to find rest-rooms'...
...'guidance and instruction by some staff hopeless'...
...'referral should contain accurate instructions on what to do and where'...

| inadequacy of answers | → getting and giving information and guidance (4.4.) |
| difficulty of understanding |
| plenty of new information |
| keeping informed with explanations |
| better guidance on location of rest-rooms |
| hopeless guidance and instruction |
| imprecise instructions in referral |

'Had enough sleep'...
'I was able to rest in peace'...
...'it was impossible to rest... Noise of TV disturbed.'
...'a disturbing neighbour was moved away for the night'...

| getting enough sleep
resting in peace
noise of TV disturbed rest
disturbing neighbour moved away | ⟩ rest and sleep (5.1.) |

'Good food.'
'Bad and tasteless food.'
...'I missed coffee, because I was sleeping '...
'Enough food'...
...'snacks were really one-sided'...
...'Sometimes I would prefer stronger and more food'...
'Tasteless food, no salt or spices.'
...'they observed the diet I wanted'...
'Impossible to follow a special diet'...
'The chocolate biscuits my Mom brought me!'
'The food was often cold.'
...'as much coffee as you liked'...
'The food is good and wholesome'...

| good food
tasteless and bad food
missing coffee
enough food
one-sided snacks
lightness and smallness of meals without variation
tasteless and salt-free food
observing a diet
failing to follow a special diet
chocolate biscuits
cold food
getting enough coffee
good and wholesome food | ⟩ food, diets and meals (5.2.) |

...'other babbling patients.'
...'proper companions for a lonely person.'
'Communication with roommates helped psychologically.'
...'a smoking roommate... continuous headache.'
'Discussion with fellow sufferers... good therapy.'

| babbling fellow patients
proper people to talk to
communication with roommate
headache because of smoking roommate
therapeutic discussions with roommates | ⟩ roommates (5.3.) |

...'allowed my child visit me more frequently, no fuss about visiting hours.'

| flexible visiting hours | ⟩ visiting hours (5.4.) |

...'a positive feature: sense of security.'
'Information breakdown between operating theatre and ward... uncertainty'...
...'uncertainty because of constantly changing doctors'...
'We're in good hands.'
'Uncertainty of success of operation.'
'Hospital is a very lonely place.'
...'nervous about surgery and its success.'

| sense of security
uncertainty caused by information breakdown
uncertainty caused by doctor turnover
being in good hands
feelings of uncertainty
loneliness
nervousness | ⟩ feelings during hospital stay (5.5.) |

...'it broadened my mind in this sphere of life.'
'I learned humility and more service-mindedness.'

| broadening of views
learning humility and service-mindedness | ⟩ changes in values and views of life (5.6.) |

'I was able to take outdoor exercise.'
'Unable to take exercise like at home.'

| opportunity for outdoor exercise
taking exercise | ⟩ interrupted exercise pattern (5.7.) |

'They gave me the mattress I wanted because of back pain'...
'Back pain because of bed'...
...'softer pillows'...
...'twin rooms are convenient in size'...
'Room temperature too high.'
'Room a bit chilly and draughty.'

| mattress according to wishes
back pain because of bed
hardness of pillows
convenient size of room
too high room temperature
chilly and draughty room | ⟩ bed and patient room (6.1.) |

'Nice little ward.'....'no crowding'...
...'shared men's WC '
...'able to watch TV'...
...'TV in own room would have been very nice'...
...'radio was broken'...
...'the other channel could have been the national programme'...
...'telephone was far away and expensive'...
...'card phones... were out of order'...
...'considerable restlessness and noise on ward'...
...'ward was very peaceful'
...'inadequate equipment in room and lights out of order'...
...'room had everything I needed'...

| small, uncrowded ward |
| shared WC |
| watching TV |
| only one TV on the ward |
| broken radio |
| only two radio channels |
| distance to expensive telephone |
| dysfunctional card phones |
| restlessness and noise on ward |
| peaceful ward |
| inadequate room equipment and lights |
| well-equipped room |

> facilities and equipment (6.2.)

'Positive thing: tidiness.'
...'men's toilet should be cleaner'...

| tidiness |
| an-clean men's toilet |

> cleanliness of facilities (6.3.)

'I was bored to death.'
'It was boring because I was OK… unable to sleep all the time.'
'Why do we always have to wait?'

| boredom |
| boredom while waiting |
| waiting |

> entertainment during hospital stay (6.4.)

'Doctor admitted without referral as an old patient.'
'I'm happy to have received care'...
'Good admission procedure.'
...'flexible admission... night leave'...

| admission without referral |
| satisfaction with being admitted to hospital |
| good admission procedure |
| flexibility of admission |

> admission to care (7.1.)

...'I'd hope for a longer stay, but... no beds'...
'People over 80 should stay at least one day in hospital... while in pain.'
...'confusion upon discharge'...
...'examination by operating surgeon upon discharge is an absolute necessity'...

| short hospital stay |
| shortness of hospital stay for aged patients in pain |
| confusion at discharge |
| check-up by operating doctor at discharge |

> duration of hospital stay and discharge (7.3.)

'Good services.'
...'individual and swift service.'
...'slight bossing around in more special practical matters'...
...'waiting to receive services.'
...'no canteen services'....
'Poor turnover of books on the ward.'

| good service |
| individuality and swiftness of services |
| bossing around in practicalities |
| waiting for services |
| lack of canteen services |
| slow turnover of books |

> quality of services and availability (8.1.)

Appendix 7. Internal consistency of the instruments in the study

VARIABLES	INQUIRY I	INQUIRY II	INQUIRY III	INQUIRY IV	INQUIRY V
Atmosphere (AF1)	.7144	.8802	.8472	.8429	.8232
Team sprit (GF1)	.7016	.7818	.7456	.7402	.6049
Team's functionality (GF2)	.8480	.8460	.7675	.8283	.8405
Commitment to work and organisation (OC2)	.8687	.6319	.6362	.8280	.6852
Growth motivation (OC1)	.8678	.7762	.7800	.7754	.8559
Performance motivation (OC3)	.7456	.7835	.7472	.7599	.8564
Reflectivity (RF1)	.7050	.7513	.7135	.7958	.7352
Work's encouragement value (WF1)	.8612	.6697	.7260	.7228	.8067
Possibility to influence (WF2)	.7137	.8609	.8601	.8633	.8705
Participatory management style (MF1)	.9478	.9164	.9382	.9538	.9445
Performance orienting management style (MF2)	.8082	.9090	.9190	.8996	.9187
Task and goal systems (OF2)	.7988	.8725	.8457	.8249	.8271
Sufficiency of in-service education	.9339	.9350	.9193	.9220	.9257
Assessment of the impact of continuous work monitoring	.9418	.9515	.9329	.8921	.8571