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CLINICAL SUPERVISION FOR THE DEVELOPMENT OF EMOTIONAL COMPETENCE

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Abstract

Nursing is a complex and highly demanding profession. Capabilities on Emotional Competence are crucial to overcome many constraints and achieve excellence in the care provided. Thus, the awareness of nurses regarding their place in the organization and in the continuous improvement politics, is essential. Clinical supervision plays an important role in professional development through the reflective practice. The aim of the study is to describe nurses' emotional intelligence capabilities in a hospital setting. To answer our research question, a convenience sampling strategy was employed. A total of 500 questionnaires were delivered using Veiga Branco Emotional Intelligence Capabilities Scale (VBEICS©) adapted version for nurses. From the questionnaires delivered, 259 questionnaires were returned. The data were collected between April and July 2017 and processed using the SPSS© version 24.0. The results showed that nurses perceived themselves emotionally intelligent. Self-Awareness and Emotions Management had a higher correlation with the total score of Emotional Competence. Social skills were less developed in our sample. Academic degree and workplace context can be potential predictive factors of Empathy and Managing Relationships in Groups. According to these findings, the implementation of a nursing clinical supervision model adapted to a specific context can be crucial to the development of strategies ensuring the continuous improvement of these capabilities.

Keywords: Clinical supervision, emotional competence, nursing.

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1. Introduction

The concept of emotional intelligence is relatively young. Three trends can be distinguished in literature; the Abilit Model by Salovey and Mayer, the Trait Model by Golem and the Mixed Model by Bar-On (Van Dusseldorp, Van Meijel, & Derksen, 2011).

The term "Emotional Intelligence" was first formally defined in the early 1990s by Salovey and Mayer (1990) as "the ability to control feelings and emotions in oneself and in others, to discriminate between them and to use information to guide actions and thoughts" (p. 189). They divided emotional intelligence into four areas of abilities/skills: (1) perceiving emotions, (2) using emotions to facilitate thoughts, (3) understanding emotions and (4) managing emotions in a way that enhances personal growth and social relations. According to Goleman's model (1995, 2010), Emotional Intelligence is based on five great capabilities (table 01): Self-awareness, Self-Regulation, Internal Motivation, Empathy and Social Skills.

Table 01. Skills of Emotional Competence (Goleman 2010) – adapted

Personal Skills These skills determine how we manage ourselves	**Social Skills** These skills determine how we deal with interpersonal relationships
Self-awareness ▪ Emotional self-awareness, self-assessment, and self-confidence. **Self-Regulation** ▪ Self-mastery, inspire confidence, be conscientious, adaptability and innovation. **Internal Motivation** ▪ Will to succeed, commitment, initiative and optimism.	**Empathy** ▪ Understanding others, developing others, service orientation, enhancing diversity and understanding the emotional currents. **Social Skills** ▪ Influence, communication, conflict management, leadership, catalyst for change, building bonds, collaboration and team capabilities.

In a progressive and multi-authorial way, the concept of Emotional Competence was thus constructed from the initial concept of Emotional Intelligence. According to Bisquerra (2008), Emotional Competence is "the set of knowledge, skills, abilities and attitudes necessary to properly understand, express, and regulate emotional phenomena". Therefore, in the daily practice, the set of Emotional Competencies allow to understand, express and regulate in an appropriate way the emotional phenomena, facilitating the learning processes, problem-solving, interpersonal relationships and adaptation to different contexts including cross-cultural ones. Veiga-Branco (2005), who also studied the concept of Emotional Competence based on the initial concept of Emotional Intelligence, developed by Goleman (1995, 2003), distinguishes the concept of EC from EI. The author considers that it refers to be more grounded on the concept of intelligence, more "virtual", in the domain of the broad axes of structuring a knowledge.

The Emotional Competence is relevant in the context of health care, since it can highly influence the quality performance among health professionals. Modern demands of nursing draw on the skills of emotional intelligence to meet the needs of direct patient care and multidisciplinary team. The significance of this needs to be recognized in nurse education. The link between emotional intelligence and emotional labour is considered to be an important area for future research (McQueen, 2004), as emotional labour is important in establishing therapeutic nurse–patient relationships but carries the risk of 'burnout'. To prevent

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this, nurses need to adopt strategies. To achieve a good professional performance, it is necessary that the nurse integrates the specific competencies inherent to the profession, alongside with other transversal competencies, which include flexibility, creativity, autonomy, a sense of responsibility, teamwork, adapting to change, critical thinking and decision-making. Emotionally competent nurses give an important contribution to their workplace by expressing concerns such as quality, improvement in patient care outcomes, staff recruitment and management (Cadman & Brewer, 2001).

Health organisations are ever-changing, and nursing turnover is globally high. Leaders who provide inspiration and maintain motivation within their workforces are important for staff retention and changing practices. EI has been linked to relational models of leadership, such as transformational leadership, which in turn are related to improved outcomes for patients (Cummings et al., 2010; Spano-Szekely, Griffin, Clavelle, & Fitzpatrick, 2016). They are thus able to promote knowledge and innovation as well as create therapeutic work relationships, which are critical for facilitating knowledge utilization that leads to more evidence-based nursing practice (Edgar et al., 2006).

In Portugal, clinical supervision in nursing is now a daily practice, but there are still few national studies conducted in this area. Nurses in clinical practice need to show flexibility and be prepared to complex and demanding situations. According to the literature review, clinical supervision is essential for the quality of nursing care and it is an important mechanism to support nurses in their clinical practice. Health benefits can be achieved through clinical supervision since nurses are able to develop their expertise, improve and develop the quality of the care they provide to their clients, reduce stress, optimize their coping resources and emotional intelligence capabilities. According to Nightingale, Spibyb, Sheena, & Slade (2018) in their integrative literature review, they provide evidence that developing emotional intelligence may positively impact on certain caring behaviours. But there are still few studies that correlate the impact of a clinical supervision model and the development of emotional competence. Cruz, Carvalho, & Sousa (2015) implemented a clinical supervision model in nursing (six months) but even though, their study pointed out that when the supervisees were more ‘self-motivated’ they discussed less ‘personal issues’.

Therefore, we decided to conduct this research which is a part of a larger study, the “Clinical Supervision for Safety and Care Quality” (C-S2AFECARE-Q). In the first phase, we identified and assessed nursing capabilities of emotional competence. In the second phase, clinical supervision teams will be organized and we will implement the clinical supervision model. In the last phase, we will assess the same indicators with the same instruments of the first phase and compare the results.

2. Problem Statement

When faced with change, nurses will have to deal with many demands and the need to reflect on the complex and often difficult reality, compelling them to develop intrinsic competences in the sense of maintaining a good biopsychosocial structure. Massey, Chaboyer, & Anderson (2017) reported negative emotional responses hampered by the escalation of care. Moreover, it is possible that assisting nurses to develop EC capabilities and the application of these capabilities in clinical reasoning may be a strategy to enhance clinician’s capacity for considered clinical reasoning and decision-making in challenging and complex environments.

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Taking into account this approach, it was considered pertinent to study and deepen this theme in the sense that Emotional Competence is relevant in the healthcare context since it has a major importance for quality performance among professionals, reflected in the quality and safety of care they provide. Considering that clinical supervision plays an important role in professional development, it is crucial the assessment of Emotional Competence capabilities in this context, so that a clinical supervision model tailored to the needs of nurses can be implemented.

3. Research Questions

This research intended to respond to three main questions:

- What is the Emotional Competence profile of the study sample?

Which variables influence nurses' Emotional Competence

4. Purpose of the Study

This study set out to describe the nurse´s emotional competencies in a clinical context, specifically:

- To study the variables that characterize the nursing population;
- To study the profile of Emotional Competence in the nursing population;
- To identify variables that influence the nurses' Emotional Competence.

5. Research Methods

We conducted a quantitative, descriptive-correlational study. In order to answer our research questions, a convenience sampling strategy was employed to deliver 500 questionnaires in several units of the context under study.

The data collection instrument used was a questionnaire mostly composed of closed questions and divided in two parts, the first one intended to characterize the participant in the study, the second one was constituted by Veiga Branco Emotional Intelligence Capabilities Scale (VBEICS©) adapted version for nurses. This version includes 85 – items with a Likert – type scale (1-7) ranging between “never” to “always”. The items are divided into five subscales, namely: ‘self-awareness’ (20 items), ‘emotions management’ (18 items), ‘self-motivation’ (21 items), ‘empathy’ (12 items) and ‘managing relationships in groups’ (14 items). The data were collected between April and July 2017 and processed using software SPSS 24 version, with a 0.05 significance level.

6. Findings

A total of 259 questionnaires were obtained with a VBEICS© Cronbach’s alpha value for the total score of 0,919. The response rate was 51.8%, indicating the positive nurses' receptiveness to this study. In our sample, 79.2% of the respondents were female, with an average age of 37.1 years and mean of years of practice of 13.9 years. In addition, it also showed that 32.6% had a specialization course in this area and 32.4% had a postgraduate course. Socio demographic data are shown in table 02.

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Table 02. Socio demographic data

	n=259	%
Gender		
Female	205	79.2
Male	54	20.8
Professional Category		
Nurse	173	67.1
Specialized Nurse	84	32.6
Other	1	0.4
Academic degree		
Other	4	1.5
Bachelor	105	40.5
Postgraduate	30	11.6
Specialization	84	32.4
Master	35	13.5
Ph.D	1	0.4

Nurses self-perceive themselves by norm emotionally intelligent, with a 4,82 weighted average score. Descriptive analysis of total score and each dimension are presented below.

Table 03. Descriptive analysis

	n	Min	Max	X	SD
Total	227	275	504	405.1	37.5
Self-Awareness	252	70	138	102.6	12.0
Emotions Management	250	56	108	81.3	9.4
Self Motivation	250	67	140	106.0	11.1
Empathy	254	25	84	59.8	9.1
Managing relationships in Groups	254	13	91	57.3	9.4

The Pearson correlation coefficient was used to assess the significant relations between the variables. The total dimensions are positively and significantly correlated with each other and with the full scale ($p<0.001$ for all calculated correlations). The dimensions that present a higher correlation with the total scale are dimensions Self-Awareness (R=0.790) and Emotions Management (R=0.782). The dimensions Self-Awareness and Self-Motivation (R=0.657) and the dimensions Empathy and Managing Relationships in Groups (R=0.658) are those that present a higher correlation between each other. In the study conducted by Vilela (2006), Empathy was also correlated to Managing Relationships in Groups, showing the highest score (R=0.653). Empathy and Managing Relationships in Groups were also the dimensions with lowest correlation with the total score. These findings are important for further interventions in context, showing that Empathy and Managing Relationships in Groups are dimensions with lowest correlation with total EC score. The dimensions Self-Awareness and Managing Relationships in Groups (R=0.253) and dimensions Self-Motivation and Managing Relationships in Groups (R= 0.282) show lower correlation between each other.

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The identification of potential predictive factors (gender, age, professional practice time, legal status, academic degree and workplace) of the total scale, as well as of each of the dimensions was performed using simple linear regression. Finally, adjusted linear regression models were used in order to identify factors independent from each of the dimensions and the total scale. Considering these results, for total EC score and dimensions: Self-Awareness, Emotions Management and Self-Motivation, none of the predictive factors remain statistically significant in the adjusted models. In the dimension Empathy, 8,6% of variability can be considered from academic degree and workplace. Nurses with a higher academic degree showed higher scores of Empathy. In addition, nurses from surgical unit showed lower scores comparing with those from psychiatric and mental health (table 04). Predictive factors (academic degree and workplace) also remain statistically significant in the adjusted model for Managing Relationships in Groups, showing that nurses with higher academic degree also performed higher scores of this dimension. Managing relationships in groups, in emergency and intensive care, midwifery and medical unit, showed higher scores than for those nurses working in the psychiatry and mental health unit (table 04). Only, 5,9% of variability can be considered from the variables of this model.

Table 04. Adjusted Models for Empathy and Managing Relationships in Groups

	Empathy			**Managing Relationships in Groups**		
	Adjusted Model			**Adjusted Model**		
	β	**IC 95%**	***p***	**B**	**IC 95%**	***p***
Gender						
Female	(ref)	-	-	(ref)	-	-
Male	-0.05 (1.4)	-2.9 – 2.8	0.972	1.9 (1.5)	-1.0 – 4.9	0.199
Age	0.001 (0.3)	-0.5 – 0.5	0.996	0.01 (0.3)	-0.5 – 0.6	0.961
Professional practice time	0.04 (0.3)	-0.5 – 0.6	0.890	0.06 (0.3)	-0.5 – 0.6	0.824
Academic degree						
Bachelor's degree	(ref)	-	-	(ref)	-	-
Postgraduate studies	1.9 (2.0)	-1.9 – 5.8	0.321	2.0 (2.0)	-1.9 – 5.9	0.312
Specialty	1.0 (1.4)	-1.8 – 3.9	0.484	1.3 (1.5)	-1.6 – 4.1	0.394
Masters or PhD	4.2 (1.9)	0.5 – 7.8	0.027	3.2 (1.9)	-0.5 – 7.0	0.089
Legal status of employment						
Public functions contract	1.6 (1.8)	-1.9 – 5.1	0.356	-0.4 (1.8)	-3.9 – 3.2	0.834
Individual contract for an indefinite period	(ref)	-	-	(ref)	-	-
Individual contract for a fixed period or other	-1.8 (2.9)	-7.5 – 3.8	0.526	-4.4 (3.1)	-10.6 – 1.8	0.162
Workplace context						
Paediatrics	-0.7 (2.4)	-5.4 – 4.0	0.784	4.5 (2.4)	-0.3 – 9.3	0.066
Emergency and intensive care units	-4.1 (2.4)	-8.8 – 0.5	0.082	5.2 (2.4)	0.5 – 9.9	0.031
Surgery unit	-5.6 (2.8)	-11.1 – -0.1	0.047	3.1 (2.8)	-2.4 – 8.7	0.269
Medical unit	-3.7 (2.2)	-8.1 – 0.7	0.097	4.5 (2.3)	0.04 – 9.0	0.048

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Midwifery	-1.8 (2.6)	-6.9 – 3.3	0.488	6.1 (2.7)	0.8 – 11.3	0.025
Psychiatry and mental health unit	(ref)	-	-	(ref)	-	-

7. Conclusion

Attention should be given to developing nurses' EC as an important factor in escalating care for the deteriorating patient and voicing concerns regarding patient safety. Our study pointed that nurses self-perceived themselves *by norm* emotionally intelligent. Social skills had the lowest scores, which is relevant for team performance regarding patient safety and quality of care provided. Workplace and academic degree can be considered predictive factors for empathy and managing relationships in groups. For these leaders and managers have a pivotal role in the development of an organizational culture that values strategies for the development of these capabilities and emotional literacy. Emotional Competence should be recognized as a relevant construct underlying the nursing practice and in continuous education policies. In clinical practice, the emotional competence can be trained and developed over time. The implementation of a clinical supervision model adapted to nurses' EC needs and workplace context can make an important contribution for its development towards quality of care and patient safety.

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