A INFORMAÇÃO COMO SUPORTE À SUPERVISÃO DE PARES EM ENFERMAGEM

INFORMATION AS SUPPORT FOR PEER SUPERVISION IN NURSING

LA INFORMACIÓN COMO SOPORTE DE SUPERVISIÓN DE PARES EN ENFERMERÍA

Cecília Alves[1]
Artur Pacheco[2]

[1] Centro Hospitalar São João, UCI, Porto, Portugal
[2] Centro Hospitalar Alto Ave, UCI, Vila Nova de Gaia, Portugal

Cecília Alves - cecilia.m.alves@gmail.com | Artur Pacheco - ajc.pacheco74@gmail.com

Autor Correspondente
Cecília Alves
Alameda Prof. Hernani Monteiro
4200-319 Porto, Portugal
cecilia.m.alves@gmail.com

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RESUMO

Introdução: A qualidade dos cuidados é atualmente um foco de atenção de todos os profissionais de saúde, nomeadamente dos enfermeiros. A evidência tem vindo a demonstrar que a implementação de processos supervisivos entre pares é promotora do desenvolvimento de competências profissionais, permitindo aos enfermeiros exercer uma prática profissional adequada e critico-reflexiva, o que consequentemente terá repercussões positivas na qualidade dos cuidados de enfermagem. Decorrente das alterações demográficas, tecnológicas e científicas, a informação integra na atualidade o discurso dos profissionais de saúde.

Desenvolvimento: a informação é uma ferramenta essencial na orientação dos cuidados de enfermagem, pelo que importa averiguar qual a informação que sustenta a tomada de decisão dos enfermeiros. Esta indagação auxilia também a identificação das necessidades de formação destes profissionais, visando o desenvolvimento pessoal e de competências profissionais. Com a presente revisão narrativa pretende-se refletir sobre a pertinência da implementação de processos supervisivo de pares em enfermagem, bem como do suporte que a informação constitui para a identificação de áreas do conhecimento necessárias à transformação das práticas.

Conclusões: Como limitação na concretização deste artigo, evidenciamos a pouca bibliografia disponível principalmente no que respeita à evidência acerca da utilização da informação enquanto suporte à SC de pares em enfermagem, o que nos faz acreditar ser necessário o desenvolvimento de investigação que combine estas duas áreas.

Palavras-chave: supervisão clínica; cuidados de enfermagem; informação em saúde; qualidade da assistência à saúde; competência profissional.

ABSTRACT

Introduction: Quality of care is currently a focus of attention for all health professionals including nurses. Evidence has shown that implementing a supervisory process between peers, promotes the development of professional skills, allowing nurses to provide an appropriate professional and critical-reflexive practice, which in turn, will have positive impact on the quality of nursing care. Resulting from the demographic, technological and scientific changes today information integrates the discourse of health professionals.

Development: It is a fact that information is an essential tool in guiding nursing care and it is important to find out what information will be the basis for nurses' decision-making. This question also helps to identify of these professionals' training needs, in order to enhance personal development and professional skills and consequently to improve the quality of nursing care.

With this narrative review, we intend to reflect on the relevance of implementing a peer supervision process in nursing, as well as, the support that information provides to identify areas of knowledge that need to be addressed with a view to transforming practices.

Conclusions: It is worth noting that the dearth of literature available regarding evidence about the use of information, especially with respect to its support of peer CS in nursing is a limitation in implementing this article. This makes us believe that it is necessary to develop research that combines these two areas.

Keywords: clinical supervision; nursing care, health information; quality of health care; professional competence.

RESUMEN

Introducción: La calidad de los cuidados es actualmente un foco de atención de todos los profesionales de la salud, incluidas las enfermeras. La evidencia ha demostrado que la aplicación de los procesos de supervisión entre pares está promoviendo el desarrollo de las habilidades profesionales, permitiendo que las enfermeras ejercen la práctica profesional adecuada y crítica-reflexiva, que por lo tanto tiene impacto positivo en la calidad de los cuidados de enfermería. Derivada de los cambios demográficos, tecnológicos y científicos, la información incluye el discurso actual de los profesionales de la salud.

Desarrollo: la información es una herramienta esencial en la orientación de la atención de enfermería, y que debe averiguar cuál es la información para apoyar la toma de decisiones de las enfermeras. Esta pregunta también ayuda a identificar la formación de estas necesidades de los profesionales, la orientación del desarrollo personal y habilidades profesionales. Con esta revisión narrativa tiene como objetivo reflexionar sobre la pertinencia de la aplicación de los procesos de supervisión de pares en enfermería, así como el apoyo que la información da para identificar áreas de conocimiento necesarias para transformar las prácticas.

Conclusiones: Es destacable que la escasez de la literatura disponible a respecto de la prueba sobre el uso de la información, sobre todo con respecto a su apoyo entre pares CS en enfermaría es una limitación en la aplicación de este artículo. Esto nos hace creer que es necesario desarrollar la investigación que combina estas áreas.

Palabras clave: supervisión clínica; atención de enfermería; información en la salud; calidad de la atención de salud; competencia profesional

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INTRODUCTION

We live in an age of permanent change, with constant changes at the social, human and technological level, where knowledge has reached a provisional character. This represents a challenge for the individual because of the need to have to be prepared for the unexpected and thus, to keep up with change and to learn to change with those very changes (Alarcão & Canha, 2013).

Under this assumption, we can see the idea of a solid initial training being sufficient to ensure good performance of professionals throughout their career being abandoned. Moreover, this idea has been replaced by the assumption that living and practicing a profession implies personal involvement in a continuous process of personal and professional development, enabling the individual to build and reconstruct their knowledge and their behaviour throughout life (Alarcão & Canha, 2013).

Continuous training provides the updating of knowledge and practices, which nurses should follow throughout their careers, contributing to constructing/reconstructing their knowledge, training and professional development (Pires et al., 2004).

Indeed, it is ever more urgent the need to learn throughout life, particularly along professional life; so, it is also urgent to define new paradigms and training strategies. However, it is important that these are defined based on the training needs of the population for which it is intended, taking into account not only each nurse's individual needs, but also the collective needs of the group and the context in which they are found. Thus, we understand that this is the current challenge to professionals and health organisations in the field of clinical supervision in nursing (CSN).

Integrating nursing in higher education has been subjecting the profession to profound changes, whether by the need to expand the body of knowledge of this science through research or by the need to prepare more analytical and critical-reflective professionals (Pires et al, 2004; Pereira, 2009).

It is intended that nurses develop an analytical and reflective practice based on evidence, approaching the theory of practice and promoting the highest quality of nursing care in order to achieve gains in health. These professionals have therefore been called to participate more actively, not only in the training of future nurses, but also their peers' acquiring knowledge and skills (Silva, Pires & Vilela, 2011).

Clinical supervision (CS) of peers enhances improvement of care, providing nurses with the development of skills and knowledge and consequently the improvement of clinical practice. The large and rapid technological and scientific changes and the increased mobility of people due to globalisation, have been forerunners to new health needs, implying that professionals must constantly adapt to work contexts. In this sense, it is crucial that nurses continually reflect on their practices, seeking for continuous professional development.

It has been shown that in-service training has a positive impact on changing the attitudes of professionals in clinical practice (Cunha, 2008) as it emerges from the needs felt by them. At a time when Information Systems (IS) exist in Portugal, we believe that the information contained therein should be put to good use by peers in each context, and in particular by nurse managers, as a contribution to identifying target areas of specific training. In other words, we believe that the existence of clinical documentation systems, which contain information coming from the documentation of nursing processes, favour reflection regarding their actions and consequently identify areas of intervention. This is due to the fact that this documentation translates each nurse's knowledge, thought process and conception of care. It should therefore be understood by clinical supervisors to support identifying training needs, thereby supporting CS of peers in nursing.

With a view to maximising the professional development of nurses as well as the safety and quality of nursing care, peer supervision is clearly a necessity, perceived by health organisations, and included in their strategies (Rocha, 2014).

The aim of this narrative review is to reflect on the relevance of implementing peer supervision processes in nursing, as well as on the importance that the information provided to nurses from the IS, in identifying areas of knowledge that need to be addressed so as to transform practices.

1. CLINICAL SUPERVISION IN NURSING

Despite Clinical Supervision in Nursing (CSN) as a concept having recently emerged in the literature, its origin dates back to earlier times and it was Florence Nightingale who first opened its path (Abreu, 2002). However, and despite its origins in the past, this is an increasingly relevant and current topic, it is based on changes in education towards reflective practice (Garrido, Simões & Pires, 2008). This is a dynamic concept that has been changing in order to adapt to modifications occurring in society and to meet the needs of nursing students and professionals (Abreu, 2002).

In Portugal operationalising this concept in science of nursing, emerged in an attempt to meet new training demands to be more reflective at a time when this discipline began to assert itself as science and build up its own body of knowledge (Pires et al., 2004).

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Hyrkäs et al. (1999), cited by Silva et al. (2011) describe CS as a method of work and consulting, guidance, management, leadership and focused therapy in the development of clinical practice through reflection, guidance and professional support. Another definition by the UK Department of Health defines CS as a formal process of professional support and learning, which allows professionals to develop knowledge and skills in order to assume responsibilities for performance itself (Department of Health, 1993, cited by Lyth, 2000).

Transposing these definitions for nursing, it is understood that Abreu et al. (2015) argue that the CSN is a collaborative process and at the same time a support process between two or more nurses, to promote the development of their professional skills and naturally to promote and improve quality of practice standards in order to improve the quality and safety of nursing care. Moreover, the Portuguese Council of Nurses (OE) defines CSN as a formal practice of monitoring of nurses whose goal is to promote the effective decision-making through reflection and analysis of the practice of care (OE, 2009).

Thus, with the above definitions in mind, it is assumed that the CS, and CSN in particular, is oriented to the processes of peer supervision, relating to certification processes, quality and safety of care and nursing education (Silva et al., 2011).

Several authors cited by Abreu (2007) reinforce the nature of the CS as a process oriented to peers, a process of continuous training and professional development in adulthood, a supervisory process focusing on clinical practice and a process capable of creating the conditions necessary for professionals to discuss a variety of situations related to professional practice. This contextualisation is corroborated by Abreu (2007) describing the CS as a broad concept, because it is intended not only for the supervision of students, but also for training, professional development and to ensure quality of care provided by nurses. Thus, according to this broader view, CSN is "...a sustained formal process in the practice which allows professionals to develop skills and awareness of the responsibility of and related to the practice in a process of steady maturing and development" (Alarcão & Canha, 2013, p. 35).

For these reasons, it appears that this type of supervision proposes the construction of knowledge, which should be traced and threshed individually in the course of working life, given the constant need for redefinition, implying motivation, integration and orientation for this process (Garrido et al., 2008).

In this sense, and since it is consensual that the idea that CSN be oriented towards developing skills, knowledge and professional values, thereby promoting nurses' autonomy and conscious, responsible, supported, reflected and effective decision-making, we may conclude that peer supervision is a key aspect of nursing culture and life in environments of clinical practice, asserting itself as a tool to improve nursing care.

In fact, several benefits are associated with implementing this type of horizontal supervision, reflected in multiple studies highlighting in particular the willingness of nurses to reflect on the care provided to their clients, as well as promoting a sense of equality among themselves as a consequence of sharing and acquiring knowledge.

Walker (2009) validates this reflection indicating that this process allows nurses to perceive that they are not alone, feeling supported personally and professionally. Chilvers & Ramsey (2009) showed that the decrease in stress, the incentive for reflection on individual practice, improvement in quality of services and greater professional satisfaction and confidence are some of the advantages of peer supervision.

Brunero & Stein-Parbury (2008) assessed the effectiveness of CSN, concluding that its benefits relate to support from peers, to the relief of stress levels, promoting professional responsibility and to developing professionals' skills and knowledge. The authors categorised the findings according to the three functions defined by the Proctor CS Model. This model is characterised as developmental, focused on the functions of clinical supervision and centred on developing of the supervision relationship. For this model these functions are aggregated into three main functions: training, aimed at developing skills, understanding and knowledge; regulatory, promoting the development of a consistent practice among nurses, essential for the development of strategies to manage professional responsibility as well as quality management; and restorative, fostering colleagues' support each other, playing an active role managing emotions (Brunero & Stein-Parbury, 2008; Garrido et al., 2008; Lakeman & Glasgow 2009; Walker, 2009).

From the study by Brunero & Stein-Parbury (2008), several advantages for peer supervision were found. These were categorised according to the functions of the Proctor Model (Table 1).

Table 1- Benefits related to peer supervision

Function of the Proctor Model	Benefits of Peer Supervision
Training	Acquisition of new learning and knowledge; Development of creative capacity and innovation
Regulatory	Identifying and solving problems; Improving clinical practice; Development of professional identity; Organisation of care; Greater job satisfaction; Increased security for the client developed by improving the quality of nursing care
Restorative	Decreased anxiety levels; Ability to express thoughts; Reduction of conflict; Development of interpersonal relationships; Improved Coping Strategies

Source: Brunero & Stein-Parbury, 2008

Garrido (2004) also describes peer supervision in nursing as a structural condition of nurses, continuous learning process, providing continuous improvement to quality as well as effective risk management and performance. This author reinforces the conviction that the supervision contributes to efficiency and professional effectiveness by strengthening fundamental attributes, such as reflection and constructive critical analysis of practices.

In short, the above allows us to surmise that implementing peer supervision in nursing, provides support to the quality of clinical practice, encouraging self-assessment and the development of analytical and reflective skills.

2. CLINICAL SUPERVISION AND QUALITY OF CARE

The concept of "quality" has been gaining ground in the discourse of organisations, particularly when associated with health care. In fact, there is a growing appreciation on the part of healthcare organisations on issues associated with this concept, assuming that the quality of care, including nursing care, not only undergoes scientific and technological progress, but also transforms the very nurse as a person and the opportunity to reflect on the care provided.

The quality of health services is considered a goal to achieve by health organisations, attesting that the implementation of quality systems is now formally taken over by international organisations such as the World Health Organisation (WHO) and national organisations, such as the General Health Directorate (DGS). In Portugal, the basis of this concern by government entities was the need to establish strategic guidelines and implement interventions aimed at improving the quality of health services. Currently, at the national level quality is recognised in the 2012-2016 National Health Plan as a foundation for care, as one of its structural axes, with a view to obtaining health gains in the health care provided (DGS, 2012).

It is worth noting that despite the multiplicity of approaches to this issue, particularly with regard to its assessment, what is found is "...a common denominator which is the fact that these issues are inextricably linked in an explicit quality policy whose aim is to improve the performance of health services overall and, consequently, the results from the clinical and economic point of view as well as that perceived by patients (degree of satisfaction, preferences and expectations)" (Cunha, Eiras, & Teixeira, 2011, p.3).

Nursing has also been looking into this concept, which despite its current relevance, Florence Nightingale had argued about the need to analyse statistical results so as to be able to ascertain the quality of nursing practices (Cunha et al., 2011).

In 2001 the OE assumed a central role in indicating the creation of quality in health systems as a priority, defining quality nursing standards, categorised relative "...to customer satisfaction, the promotion of health, preventing complications , well-being and customer self-care, functional rehabilitation and the organisation of nursing services." (p.13). These are aimed at developing skills and are intended to clarify the social role of the nursing profession, establishing itself as a tool to help nurses to define their role with respect to their clients, other professionals and government agencies.

The aim of these standards is promote professional practice in terms of the highest standards of quality, thereby becoming a fundamental, essential and indispensable benchmark for the development of quality in nursing care. Its operation is linked to the achievement of continuous improvement in the quality of nursing care. It is not enough to just implement it, but it is necessary to identify problems and determine solutions a structured and systematic way (OE, 2009).

One of the most widely used mechanisms to operationalise the "continuous quality improvement" is the PDCA cycle which is comprised of four stages: *Plan* – analyse and define the areas/processes to improve; *Do* – implement the improvement/change; *Check* – monitor improvement/change; *Act* – assess the impact of the improvement/change in the quality improvement process (Deming, 1986, cited by Walley & Gowland, 2004).

It is interesting to note the parallels between this tool and the process steps of supervision recommended by Nicklin (1997), cited by Sloan (1999). According to this author, the process takes place in a cycle comprising six stages. They are: **Analysis**, practice of the objective, i.e. assessment of problem situations; **Identification** of the problem; **Contextualisation**, by defining the objectives of the interventions to be implemented to solve the problems; **Planning** an appropriate intervention for the problem situation identified; **Implementation** of the planned actions; and **Assessment** of results.

Analysing these steps and taking the definition of supervision by Alarcão & Tavares (2003), cited by Cunha (2008, p. 54) into account, it is a "...multifaceted, phased, continuous and cyclical action capable of contributing to developing knowledge, set of values and attitudes, as well as the capabilities and skills..." It appears that the supervisory process may fit into the PDCA cycle, and can be considered a strategy to be adopted in a process of continuous quality improvement.

In line with this idea, for some years healthcare organisations in Portugal have adopted processes to accredit institutions for quality. These processes include specific references to the need for CS in nursing in the rules (Abreu, 2007). To this end, the supervisory process must be effectively implemented and achieved with necessary recourse to critical reflection.

In short, we may infer from the literature that the peer CS in nursing supported by reflective critical analysis of practice, seems to promote nurses' personal and professional skills of with a view to continuous quality improvement. According to Alarcão (1996), "...the supervisor is the facilitator of reflection, raising trainees' awareness of their performance, helping to identify problems and planning strategies to solve them based on...responsibility for decisions that affect their professional practice" (p. 97).

This definition leads to a reflexive professional practice encompassing the need to: reflect on actions, that is, reflection occurs at the time of executing the action, resulting in reformulating it; reflect on the action, making a mental *a posteriori* reconstruction of the action; and reflecting on the reflection in action, promoting a meta-reflection developing new arguments, new ways of thinking, acting and identifying problems. Thus, "a reflective practice leads to (re)constructing knowledge, attenuating the separation between theory and practice and is based on building a circularity in which theory illuminates practice and practice equates theory" (Alarcão, 1996 , p.98).

Thus it is clear that peer CS develops a harmonious, dynamic and collaborative interaction between the various participants in the supervisory process, in which the concept of reflection is central, making it essential that those who are supervised reflect on the role they play in the action and with regard to the quality of their practices (Henriques & Oliveira, 2011).

For these reasons, it appears that the horizontal supervision is a valuable contribution for the quality of nursing care and consequently to obtain its respective health gains. However, for this end appropriate strategies should be defined for contexts, the people involved and the intended goals.

Based on the awareness that the supervisory process is a dynamic and interpersonal process grounded on the interaction between the professional and the action and among the professionals themselves, and with a view to its effective achievement, the need to include different strategies that provide an opportunity to examine, question and critically evaluate the practice is worth noting. Assistance, guidance, monitoring and reflection strategies are highlighted (Alarcão, 1996; Abreu, 2007; Alarcão & Canha, 2013).

Alarcão (1996) refers to reflection as a systematic investigation of practice. It can be seen as a means of supervision to enable identifying and understanding problems and needs that arise during the path of supervision. For this, and with a view to solving problems so as to improve the quality of care, it is essential that the reflective critical reflection of the practice happen by the supervisor and the supervised.

The evidence has shown that mobilising different areas of knowledge fosters the development of problem-solving, reasoning and reflective skills in nurses. A study by Serrano, Costa & Costa (2011), conducted in order to understand how nurses develop the skills of nursing care, concluded that this is a continuous interaction between three dimensions: actors, context and knowledge. These are affected by characteristics such as teamwork, reflection on practice, questioning, problem-solving, socialisation, CS, standards and health organisation procedures, organisation/working method, WHO guidelines and the institution's policies, values and mission.

Also along this line of thought, Fradique & Mendes (2013) concluded that leadership is key to continuous quality improvement, to promoting the development of skills and competencies of nurses, with a view the potential of each one.

These results reveal the idea that organisational knowledge "emerges out of active participation and the daily experience of work, which is conducive to a learning process," which occurs "informally," "is produced within the limits of each service" and "encompasses communication in many different ways – records, computerisation of data and interpersonal communication" (Serrano et al., 2011, p.21).

Currently, considering that nursing is a science with its own body of knowledge, it is undeniable that, associated with solid training, nurses should be facilitated in developing the skills of critical and reflective analysis and innovation founded on new CS strategies

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(Henriques & Oliveira, 2011).

Aware that technological advances have introduced changes in health organisations in terms of the care process (Serrano et al., 2011), in addition to the fact that nursing information systems (NIS) are now a reality, we believe we have a support tool for peer CS. This stems from the fact that the use of IS enables the supervisor to make judgments about the training needs of supervised nurses. Finally, it reinforces the concept of supervision based on a collaborative and supportive relationship between the supervisor and the supervised, with the goal of the personal and professional development of the latter, moving away from the traditional concept based on a power relationship which is usually associated with a punitive/penalising character.

3. TRAINING AND INFORMATION

In clinical practice, nurses collect data daily, making decisions based on these and on their own clinical judgment. However, it is emphasised that these can only be consistent when they are compiled and organised, thus becoming useful information for decision making. Only after being processed, organised and interpreted in each situation/context, do they take on meaning, guiding the nurse's decision-making. It is from the systematic collection of data that the remaining steps of the nursing process arise and are structured, with the objectives defined, health needs diagnosed, interventions planned and their impact on individuals' health assessed (Pereira, 2009; Jesus & Sousa, 2011).

Evidence has shown that when the data is organised in a structure that guides decision-making and are collected properly and in timely fashion for a particular purpose, the information derived from those data enables and develops the nurse for a given action in a given context, assisting in identifying needs. This organisation is usually achieved with recourse to an IS (Pereira, 2009; Jesus & Sousa, 2011), in particular from decision-making structures, known as decision-making support systems in nursing.

These support structures are intended to assist nurses in proper decision-making based on an organisation of data grounded in theoretical assumptions. From these, they can continuously scrutinise practices which is essential to transforming tacit knowledge into explicit knowledge (Teixeira, Soares, Ferreira & Pinto, 2012). Systematic literature review conducted by these authors, in order to analyse and reflect on the contributions of these structures, revealed that reflecting on the content and its suitability to each individual's health condition alerts nurses to aspects not normally perceived, thereby influencing the implementation of specific interventions. This study also indicates that nurses perceive that this information complements areas where their knowledge and expertise is scarce, increasing diagnostic accuracy.

Guimarães & Évora (2004), cited by Cunha Ferreira & Rodrigues (2010), also reinforce these assumptions to indicate that organised data structures are generating structured and accessible information, increasing efficiency in the process of care and support to effective decision-making. Analysis of this information facilitates scientific research and guides the production of new "knowledge."

Pereira (2009) corroborates these authors revealing that in recent decades the concept of "information" has evolved from a vision focused on documenting care, whose purpose was only to serve as documentary evidence indicating what had been executed, to a more analytical and critical-reflective view, where the information is understood as contributing to improving professional practice, revealing individuals' needs and focused on managing the quality of nursing care.

In fact, it is undeniable that "information is a central element in clinical decision-making and a key requirement for managing care." It should therefore be understood as enhancing quality care and managed as a resource (Marin et al., 2001, cited by Pereira, 2009, p. 32).

In short, in our view these conjectures justify the urgency of a structured peer supervision process, based on analysis of the information produced by nurses since it is thus possible to make inferences about nurses' real learning needs in each context from the critical reflection on practice.

For this, it is germane that from analysis and reflection of professional activities, health organisations create structures in order to support nurses (Cunha, 2008). Considering nurse managers are particularly important in leading the work team to guiding interventions to improve the practice of care, in institutions it is essential to identify which practices, when and how they should be targets for intervention (Fradique & Mendes, 2013).

In this sense, the improvement of clinical practice stemming from the specific training geared to the needs of each context is part of the concept of in service training, whose aim is excellence in nursing practice. Its definition refers to "...a planned process comprising preparation, guidance, updating and betterment for professionals in order to achieve and maintain the institution's effective and efficient standard" (Cunha, 2008, p. 68).

By way of CSN it is possible to improve clinical expertise, and the supervision processes allow nurses to reflect and modify their practice, discuss cases, review clinical guidelines and continuously update knowledge (Rocha, 2014). Thus, it is understood that it

is not possible to separate the concept of CS from the concept of continuing education, since in both supervisor and supervised "...engage in a collaborative process of analysis and assessment of practices, which forms the basis for change and for the reconstruction of context, attitudes and behaviour" (Cunha, 2008, p.70), implying a commitment on the part of both the clinical supervisor and the supervised to the process.

To sum up, we may infer from the above that the aim of continuous training is to continually improve quality of care, and for this purpose to be achieved, it up to health institutions to promote the conditions for the professional development of nurses. This is provided for in the definition and implementation of a training plan geared towards attitudinal changes in practices (Cunha, 2008).

Based on the fact that information is no more than a set of data organised from a given pattern of reading and that knowledge comes from analysis performed on this information (Pereira, 2009), it is vital that peer CS is based on the analysis of available information, in terms of identifying relevant operating areas for training. Thus, in our view, identifying training needs can and should emerge from the analysis of clinical documentation produced by nurses, since this information is a great pretext for both supervisors and the supervised to reflect on their practices (Rocha, 2014), thus defining an in-service training project for the development of these professionals.

CONCLUSIONS

The role of nurses should be guided by rigour and competence in order make it possible to obtain health gains arising from nursing care for individuals and populations. To that end, and with a view to changing behaviours, it is essential to perform systematic, structured and appropriate work for the target population. It is also necessary to raise the awareness of nurses and health organisations for their need to improve their professional performance progressively. In this sense, monitoring and continuous guidance throughout their working lives are essential aspects to achieving positive changes in practices, justifying, in our view, the need for continuing education in nursing.

In his study, Rocha (2014) found that nurses highlight the dimension of lifelong learning, considering it essential to the professional development of any nurse. However, it is emphasised that the areas proposed for intervention should emerge from reliable data and not from mere perceptions. They should arise from identifying a given population's true training needs. After that, it is necessary to define priority areas and intervention strategies. The aim of this strategy is nurses' personal and skills development, the assurance of quality health care and security in clinical practice.

However, as exposed here, inclusion of peer CS in daily practice implies not only the personal commitment of all professionals, but also on the part of health organisations. Only in this way can it provide and capitalise on the variety of experiences in different contexts, originating new practices, interactions and transitions, which are steps in personal and professional development.

Given the growing value by the health organisations regarding quality policies and continuous technological advances, peer CS is an instrument to promote skills development in nursing. In this context, we understand that in order to achieve excellence in care, a critical and reflective analysis of practices should be performed by both the supervisor and the supervised from the information produced by clinical documentation of nursing care, drawn from nursing information systems (NIS). Since this portrays these professionals' conception of care and their thought processes in decision-making, it is intended to be a reflection on their action.

It is worth noting that the dearth of literature available regarding evidence about the use of information, especially with respect to its support of peer CS in nursing is a limitation in implementing this article. This makes us believe that it is necessary to develop research that combines these two areas.

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