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PARTNERSHIP OF CARE IN PEDIATRIC ONCOLOGY: PROPOSAL FOR A CLINICAL NURSING SUPERVISION PLAN

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Abstract: Caring for a child with cancer requires knowledge, resilience and adequate support networks. Clinical supervision of the family caregiver of a sick and/or dependent person enables them to provide care and support. Nurses have a responsibility to identify needs, teach, train, support and promote the performance of the role of caregiver, which requires skills in different areas, including clinical supervision. Anne Casey advocates the importance of partnership in care and highlights the participation and involvement of the family in the decision-making process, optimizing knowledge and skills for the development of the parental role. Brigid Proctor's model of clinical supervision contributes to a supervisory structure that strengthens competencies, establishes and maintains partnership relationships, reinforces professional practice and improves the quality of care provided, through formative, restorative and normative functions, which are essential for the successful care of children with cancer. This work consisted of drawing up and critically analyzing a clinical supervision scenario focused on accompanying a mother, a caregiver of a child with cancer, based on Anne Casey's care partnership model and Brigid Proctor's supervision model, supported by nursing ontology. Supervisory intervention with the mother facilitates the acquisition of knowledge, skills and abilities, particularly in managing the emotions that arise in this challenging context. Nurses' supervisory intervention is crucial to promoting the exercise of the caregiver's role effectively, safely and with quality.
Keywords: Clinical Supervision, Family Caregiver, Care Partnership, Supervision Model.

INTRODUCTION

Clinical supervision (CS) is a relevant strategy for the personal and professional development of nurses and plays a fundamental role in increasing motivation and professional satisfaction. In addition, CS contributes significantly to improving nurses' knowledge and skills, reducing anxiety, promoting critical and reflective thinking and, consequently, contributing to improving the quality and safety of the care provided (Abreu, 2007). In nursing, CS is understood as a collaborative and supportive process between two or more nurses, whose main objective is to develop personal and professional skills, reduce risks, promote quality standards and ensure quality and client safety (Abreu, 2007).

Clinical nursing supervision (CNS) establishes a supportive relationship between the supervising nurse and the supervisee. The former is responsible for the supervision process. He or she has the knowledge and mastery of the competencies of the nursing discipline, pedagogy and CNS. The latter is the target of the supervisory process and aims to develop professional skills within the scope of clinical teaching, internship or integration process in a clinical context (Regulation no. 366/2018, 2018).

In recent years, a new aspect of SCE has emerged in Portugal, which now considers the informal caregiver as the supervised subject. In this context, nurses are responsible for teaching, training, supporting and promoting the performance of the caregiver's role. Supervision of the informal caregiver is intended to train an individual who is not usually a health professional and who does not have health knowledge, to provide care for a family member with health problems and who is dependent on activities of daily living. The informal caregiver performs complex, emotionally challenging tasks that impact on their daily lives and require frequent adaptation and reorganization of their personal priorities. In this respect, the SCE plays an essential role because it ensures the provision of effective, safe and quality care to the dependent person, as well as valuing and dependent person, as

well as valuing and prioritizing support and emotional support for the caregiver (Teixeira *et al*., 2016).

The aim of this study is to develop SCE skills within the scope of informal caregiver supervision. It aims to present a clinical case whose objective is to provide informal caregivers with knowledge, skills and abilities in caring for children with cancer. In this way, a scenario was constructed which sets out an SCE plan, based on Brigid Proctor's Clinical Supervision Model (1986) and Anne Casey's care partnership model.

This document is structured in seven chapters. The first gives a brief introduction, the second discusses SCE, the third chapter describes the legislative framework for supporting parents as informal caregivers. The next chapter presents Anne Casey's care partnership model, Proctor's (1986) CS model and the relationship between the two. Chapter five describes the clinical scenario and operationalizes an OHC plan for an informal caregiver (mother) experiencing a health-disease transition in the face of a cancer diagnosis. Chapter six then provides a reflective analysis of the scenario presented and the proposed supervision plan. This document concludes with a report on the difficulties perceived and the implications for nursing practice.

CLINICAL SUPERVISION IN NURSING

The evolution of nursing as a profession, science and discipline reflects a significant transformation in the paradigm of care provision. This change implies the transition from a predominantly executive logic to a more conceptual approach, driven by investment in research and the implementation of practices supported by scientific evidence (Pereira, 2007). At the same time, there has been an improvement in the quality of care, promoted by OHS, which is a mechanism that generates new skills and promotes changes in attitudes, behaviors and professional practices (Sérgio *et al*., 2023). In Portugal and in developed countries, OHS is considered a central element in the programs that guarantee quality of care, reduce risks and optimize organizational management. It has proved to be a fundamental strategy for the evolution of healthcare.

ORIGIN OF EH&S

SCE is now recognized as a fundamental element in guaranteeing the provision of safe, quality healthcare. It is an essential resource for ensuring the accreditation and suitability of the services provided.

It was with Florence Nightingale, a pioneer in implementing strategies related to training and management, that the principles of SCE began to emerge. However, it is Hildegarde Peplau who stands out in the field of OHS, with her theoretical contributions on the epistemology of nursing education. In formulating the Theory of Interpersonal Relationships, Peplau argues that nursing is characterized by the development of interpersonal relationships between those involved in care, and that these relationships are fundamental to sustaining professional practice and thus promoting learning experiences and personal growth (Abreu, 2007; Almeida *et al*., 2005; França, 2013).

During the 20th century, several nursing theorists made significant contributions to the advancement of the profession. The multiple theories emphasize that the continuous improvement and professional training of nurses is essential for the evolution of nursing knowledge and practice. What is common to these approaches "is the effective articulation between clinical practice, professional development and the formation of emotional intelligence" (abreu, 2007, p. 178).

Although clinical supervision is intrinsically linked to the nursing training process, it

was in the 1990s in the United Kingdom that, in response to a period of crisis in the British health system (the case of nurse Beverley Allitt), there was a need to reflect on and reformulate the training of health professionals. This context highlighted the urgent need, on the one hand, to establish rigorous criteria for the selection of professionals and, on the other hand, to create a new system of training, on the other hand, to develop effective training and ongoing monitoring systems. Given the evidence that the safety of care and quality certification were fundamental, SCE stood out as the most effective strategy for guaranteeing these assumptions. It thus came to play a central and transversal role in the training process for professionals, and was essential for the care provided to be perceived by clients as safe and of high quality, which in turn contributed to satisfaction and trust in health organizations (Abreu, 2007).

THE CONCEPT OF SCE

The concept of supervision is intrinsically related to the learning process and therefore to human development. Throughout the life cycle, individuals experience various learning processes in which, in the early stages, they depend entirely on others. However, as they acquire skills, they gradually achieve autonomy.

In nursing, the supervision process is not a recent practice. In recent decades, there has been growing development and greater emphasis, recognizing it as a fundamental strategy to promote individual, professional, collective and institutional development (Abreu, 2007; Pires, 2018).

SCE is defined as "a dynamic, systematic, interpersonal and formal process between the clinical supervisor and supervisee, with the aim of structuring learning, building knowledge and developing professional, analytical and reflective skills" (Regulation no. 366/2018, 2018, p. 16657). From this perspective, SCE enhances the development of knowledge, critical-reflective thinking, involvement, decision-making capacity and autonomy of the supervisee. Although there are various definitions of SCE, the central objective in all of them is personal and professional development and the acquisition of knowledge and professional practice skills.

Scientific evidence affirms that SCE has significant benefits (Teixeira, 2021). It makes it possible to identify the challenges faced by the profession, it is a strategic tool to boost and strengthen the nursing discipline. Its central objective is to develop autonomous decision-making through processes of reflection and analysis of clinical practice. It is up to nurses to contribute in areas such as research, training and advice, with the aim of improving nursing care. New evidence is incorporated into the body of nursing knowledge, encouraging quality and continuous improvement (Ordem dos Enfermeiros [OE], 2015).

When contrasting the supervision process with the OE's quality standards, there is a convergence and complementarity of objectives with regard to "implementing systems for the continuous improvement of the quality of nurses' professional practice" (OE, 2001, p. 5). One of the main indicators of quality in nursing practice is the care provided by nurses. Quality in health, as defined in Order No. 5613/2015 (2015, p. 13551), argues that care should be "at an optimal professional level, which takes into account the available resources and achieves citizen adherence and satisfaction, presupposing the adequacy of care to needs and expectations". SCE is associated with greater satisfaction and personal and professional development, and promotes awareness of the roles of those involved, which strengthens professional identity. It also helps to increase self-confidence and reduce *stress* levels and the risk of *burnout*, which

promotes a positive and productive working environment. Professional skills are underpinned by critical reflection with an emphasis on critical-reflective thinking, which acts as a driver for decision-making and empirical reasoning. This process fosters the development of essential skills for promoting change, innovation and continuous improvement. The benefits of SCE in the context of the team are reflected in the strengthening of interpersonal relationships and improved conflict management (Abreu, 2007; França, 2013; Pires, 2018; Teixeira, 2021).

SCE establishes a relationship between two players, one with greater experience and skills, while the other seeks to to enrich their knowledge, foster autonomy and progressively assume responsibility and assertiveness in the process of autonomous decision-making. This process takes place in an environment that includes the physical space where supervision takes place, but is also influenced by the organizational culture, which can favor or disfavor the supervisee's development. For this process to be effective, it is essential to create a safe and trusting environment in order to promote learning, the exchange of experiences, knowledge and points of view (OE, 2015; Sérgio *et al*., 2023; Teixeira, 2021). Supervisor and supervisee establish an interpersonal and dynamic relationship, which is fundamental to the commitment and mutual responsibility of those involved in the process. In addition, it is imperative to implement effective monitoring, based on sharing objectives and assertive and clear communication. The relationship must be based on trust, empathy, collaboration and cordiality. However, it is essential to consider that this dyad is made up of singular and unique individuals, which highlights the importance of each one's personal characteristics.

The supervisor must have professional, human, communication and pedagogical skills that guide the development and construction of the supervisee's professional identity. The supervisor's duties are aimed at creating conditions and opportunities for learning, advising, collaborating and monitoring the supervisory process. In addition, the supervisor must promote reflection on the skills acquired, address the underlying ethical issues and encourage reflective thinking. For their part, the supervisee has the responsibility of being the driving force behind the supervisory process and promoting interrelationship during the supervision process.

SCE is a journey, based on scientific evidence and critical-reflective thinking, and not an end point (Abreu, 2007; França, 2013). The supervisory process aims to ensure that the supervisee achieves a high level of proficiency in the provision of nursing care. As Abreu (2007) points out, this process is structured in three interdependent and successive phases: initial, experimentation and autonomization and critical distancing.

In the initial phase, a relationship of trust is established between the supervisor and supervisee, based on learning by imitation, in which the supervisee tends to experience feelings of anxiety (Abreu, 2007). They need to develop greater personal security, confidence in their practices, autonomy and motivation. The experimentation phase is considered the longest and is characterized by the development of reflective learning; the supervisee experiences a continuous cycle of balance, imbalance and reflective rebalancing, which favours the integration of new competences and the improvement of skills Abreu (2007). This process involves constant evaluation of practices. Finally, the autonomization phase requires the supervisee to achieve autonomy, demonstrate independence in carrying out tasks and integrate the skills acquired throughout the pro-

cess, with the expectation that they will improve their professional performance, but also develop skills to act in contexts of uncertainty, complexity and diversity, in order to guarantee significant improvement in technical and personal aspects (Abreu, 2007).

Thus, SCE drives change through reflection and the restructuring of thinking. It fosters better nursing practices and, consequently, increases the quality and safety of care.

PARENTS AS INFORMAL CAREGIVERS

The term informal caregiver began to appear in the literature in the 1970s in the United Kingdom. Since then, it has been supported by government policies and legislation from the Department of Health and the social care system. It is mainly related to caring for patients with dementia, chronic illnesses and in palliative care (Tripodoro *et al*., 2008).

In Portugal, the informal caregiver statute was approved by Decree-Law No. 100 of 2019. It recognizes the essential role of informal caregivers and offers rights and benefits, such as:

- Recognition of the importance of the role of caregiver: their role is crucial in maintaining the well-being and quality of life of the person being cared for;
- Training and capacity building: access to training programs to acquire and develop the skills needed to provide adequate care, as well as the right to receive follow-up and advice;
- Access to information: from health professionals about the clinical condition of the person being cared for and from the social security system about economic and social support;
- Psychological support: access to psychological support to promote the emotional well-being of the caregiver;
- Reconciling the personal needs of the informal caregiver: the right to measures to harmonize personal and professional life with the provision of care.

Informal caregivers of children are also entitled to various forms of support and assistance, such as those presented in Decree-Law 70/2000 (2000), articles 18, 19 and 20.

- Special leave to care for the disabled and chronically ill: one of the parents is entitled to leave for a period of up to six months, extendable to four years, to care for their disabled or chronically ill child during the first 12 years of life;
- Economic subsidies: regulated financial support to ensure the family's subsistence;
- Professional reintegration: the parent is entitled to training and retraining after the end of the special leave.

The National Strategy to Fight Cancer, Horizon 2030, aims to reduce the incidence of preventable neoplasms, improve survival and the quality of life of patients, and increase equity i n access to health care. It includes a number of protective policy measures, such as educational support for children and young people with cancer during treatment.

Treatment (Ordinance no. 350-A/2017, 2017) and emphasizes the importance of psychological and social support. Organizations and support groups such as Acreditar, the Portuguese League Against Cancer, Operação Nariz Vermelho, groups such as "Sobbem-estars" and "Veteranos" have the mission of supporting children and families with cancer in order to promote their well-being and quality of life.

In nursing, the caregiver is considered "one who assists in the identification, prevention or treatment of illness or disability; one who attends to the needs of a dependent individual" (International Council of Nurses [ICN], 2019). Similarly, the parental role refers to the responsibilities associated with the role of mother and father. It involves the expecta-

tions of family, friends and society regarding appropriate or inappropriate behavior for this role, and reflects these expectations through actions and values, especially with regard to the promotion and full development of a dependent child (ICN, 2019). In the case of a child with cancer, the role of caregiver and the parental role are intertwined. Parents are challenged to balance their child's growth and development with the adversities imposed by the disease.

A child's cancer is a threat to the whole family, especially to the parents who see their plans for their child threatened and are deprived of the joys and rewards of seeing them become a healthy adult. The moment of diagnosis is especially critical and the family is faced with significant changes in their family dynamics. They are forced to develop strategies to meet new needs and challenges in order to reorganize and find a new balance (Mano, 2017; Pires, 2017; Pires, *et al*., 2020). Recognizing and valuing the role of the caregiver is crucial for the well-being of the child and the family. Caring for a child with cancer requires resilience, knowledge, adequate support networks and effective policies.

PARTNERSHIP OF CARE OF ANNE CASEY E MODEL OF PROCTOR'S CLINICAL SUPERVISION

Childhood cancer is experienced dramatically. It poses a threat to the whole family, especially the parents, who are deprived of the expectations and joys associated with their child's development into a healthy adult. This diagnosis is one of the biggest crises that parents can face when exercising their parental role. It requires significant changes in daily family life, reorganization of life and a reconfiguration of the family structure in order to respond to the child's treatment and hospitalization (Macedo *et al*., 2024). In this context, Anne Casey's model of partnership in care gains relevance, as it recognizes that the active participation of parents in the care process is fundamental to facing the challenges imposed by the illness, but also to maintaining stability and family cohesion.

Anne Casey's model of partnership in care is based on the premise that care centered on the family, with the family and by the family is the most appropriate approach to caring for children. The author argues that care should be based on protection, stimulation and affection, in order to preserve and promote the child's growth and development. At the same time, family roles and bonds are strengthened, which favors stability, cohesion and family normality during this period of adversity. This model favours the family's physical, emotional and social development and recognizes parents as active and essential partners in the care process (Casey, 1995).

Nurses establish a partnership with parents, recognizing them as the main caregivers for the child. Parents, being the ones who best know the child's needs and desires, are fundamental to the child's satisfaction, are the child's main source of comfort and are the mediators between the child and the outside world (Lee, 1998).

Two key elements facilitate the partnership approach: child- and family-centered care and negotiated care. Family-centered care aims to empower children and parents through shared information and knowledge, enabling them to make decisions and provide care. Negotiated care refers to the therapeutic relationship established between the nurse and the parents, based on trust and mutual respect, which results in the joint development of a care plan and active participation in the provision of care, according to the skills and wishes of each (Casey, 1995).

Nurses' responsibility goes beyond providing nursing care. It also includes emotional and psychological support, education, training, guidance and support for the child and parents during the health-illness journey (Casey, 1993). The main objective is the active involvement of parents in the care process. Nurse and family are key elements in this partnership model. Alongside these are the child, the environment and health.

Supervision and health education are fundamental concepts in the care process and play a central role in its effectiveness. Supervision must be continuous and adjusted to the specific needs of each family and take into account variables such as the social, economic and cultural context, since these factors can directly influence the way care is provided. The partnership model proposes a flexible approach which, by respecting the parents' choices and values, empowers them with the necessary resources to ensure the promotion of quality care, centered on the needs of the child and the family. In this sense, the challenge for nurses is to provide clear information about the therapeutic plan and adequately prepare parents for the continuity of care at home (Silva-Rodrigues *et al*., 2019). Supervision of parents should be an ongoing process, in which nurses should provide regular guidance. They should promote empowerment, guidance and support in order to achieve adherence, confidence and self-efficacy, which contributes to better care for children. A supervisory model is a conceptual framework that aids clinical supervision and acts as a guiding structure (Sloan & Watson 2002). It can contribute to an understanding of significant stages in the supervisory process, supervisory functions, roles of the supervisor and supervisee and propose focus of attention (Sloan & Watson, 2002). It is fundamental for individual development and for improving the quality and safety of the care provided (Silva *et al*., 2011).

Proctor's (1986) model integrates three key functions of CS: formative, normative and restorative.

The formative function focuses on education, developing and increasing knowledge, skills and abilities (Litherland *et al*., 2023; Silva *et al.*, 2011). It allows nursing thinking to be expressed in the design of care. It stimulates learning and the acquisition of knowledge supported by reflection and critical analysis of the supervisee's experience (Abreu, 2007; França; 2013; Pires, 2018).

The normative function includes actions aimed at increasing quality, safety and management standards (Silva *et al*., 2011). It involves the team in the training and suitability process (Abreu, 2007; França; 2013; Pires, 2018). It aims to improve the supervisee's ability to practice based on ethical and legal principles and *standards* (Litherland *et al*., 2023).

The restorative function is fundamental to building the therapeutic relationship. It focuses on emotional responses, support and well-being (Litherland *et al*., 2023; Silva *et al.*, 2011). It promotes the development of emotional intelligence, awareness of oneself, others and the context, as well as relationships between everyone (Abreu, 2007; França; 2013; Pires, 2018). It includes *stress* relief strategies, ways of dealing with emotional *stress* and maintaining emotions (Silva *et al*., 2011). It promotes the supervisee's emotional management, enhances conflict resolution, well-being, motivation and self-confidence. It reduces *stress*, anxiety and the risk of *burnout* and promotes client confidence in professional practices (Abreu, 2007; França; 2013; Pires, 2018).

From the above, the two models can be considered complementary. Casey focuses on the importance of partnership and highlights the participation and involvement of the family in the decision-making process. It assumes that parents receive the necessary guidan-

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ce to care for their children in the best possible way. in the best possible way. CS, supported by Proctor's model (1986), contributes a supervisory structure that strengthens parents' skills, establishes and maintains partnership relationships, reinforces professional practice and improves the quality of care provided. It offers continuous support and emotional support in situations of fragility. Collaboration, uninterrupted support and autonomy are essential for the successful care of children with cancer.

CLINICAL SCENARIO: INTERVENTION PROPOSAL FOR A SUPERVISION PLAN

E.M. is a three-year-old boy who was admitted to the pediatric oncology service in May 2023. His history of illness was one week of extreme tiredness, fever for three days, dry cough, anorexia and marked pallor. An analytical study revealed anemia, neutropenia and cells suggestive of blasts. He was given antibiotic therapy at the hospital on the outskirts of town and was referred to the above-mentioned service because of a suspicion of hemolymphoproliferative disease.

On arrival, E.M. was frightened, but cooperative and curious about the procedures. He was screened according to the service's protocol, fluid therapy was started, a unit of concentrated red blood cells was transfused, antibiotic therapy was continued and protective isolation care was started due to neutropenia. The mother was very distressed, distraught, tearful, fearful and in shock at her son's clinical condition.

She underwent various complementary diagnostic tests: blood tests, lumbar puncture, myelogram and bone biopsy under general anesthesia. On the same day, preliminary tests, specifically immunophenotyping of peripheral blood, showed the presence of blasts, 9.3% of which were B lymphoid blasts. She began chemotherapy according to the *ALL Together* protocol, which involves frequent lumbar punctures to collect cerebrospinal fluid and the introduction of intrathecal chemotherapy. Subsequently, the cytological examination of the cerebrospinal fluid showed there was no central nervous system involvement. However, the bone marrow was infiltrated with type B lymphoid blastic cells. These results are compatible with the diagnosis of acute lymphoblastic leukemia type B (ALL-B). In order to complete the initial study, additional diagnostic tests and consultations were carried out: abdominal and testicular ultrasound, electrocardiogram, echocardiogram and consultations with anesthesia, stomatology, ophthalmology, psychology, nutrition, social work and the teaching team.

There was no relevant personal history and the vaccination plan was up to date.

Mother 41 years old, healthy, administrative; father 39 years old, healthy, teacher. Parents not consanguineous; no history of hereditary-family illnesses. Good housing and health conditions; household of three people.

On admission, an initial assessment was carried out and written support documentation was provided: the service's welcome guide and regulations, the institution's welcome guide and a falls prevention leaflet.

After four days in hospital, E.M. remained collaborative and interactive with the multidisciplinary team. The mother was more aware of her son's clinical condition and the importance of her role in promoting his well-being. However, she still showed emotional lability and anxiety. She showed volition, involvement and a willingness to learn, but it was noted that she didn't comply with the rules relating to protective isolation or the visiting regulations.

E.M.'s vascular heritage was not compatible with chemotherapy and other treatments, so a central venous catheter had to be placed urgently in the central block. The mother had no

knowledge of this device, so it was necessary to intervene. In relation to the lumbar puncture procedure, there were gaps in knowledge and it was also the target of attention.

Although at this stage a large knowledge deficit was identified in different areas, the emerging nursing focuses were identified, and for the others it was considered not to be the right time to intervene.

Given the context of care presented, in which there is a need for constant and systematic monitoring, it is pertinent to include supervision dynamics aimed at education, the development of knowledge, skills and abilities, the improvement of capacities and the construction of the therapeutic relationship focused on emotional responses, support and well-being.

This scenario was analyzed based on the three functions of Proctor's Model (1986). *Nursing* ontology, *NursingOntos*, was also used to design the care inherent in the supervisory plan, by identifying domains, diagnoses and respective nursing interventions, as shown in Table 1.

REFLECTIVE ANALYSIS OF THE SCENARIO

Cancer in children is a threat to the whole family from an emotional, social and economic point of view. It is one of the biggest crises that parents have to face in the performance of their role. It implies significant changes in the family's daily life, reorganization of life and family structure. The diagnosis is complex and the treatment process long and aggressive. The risk to life is always present, not only because of the disease, but also because of the complications caused by the treatment.

In this scenario, the mother of a three-year-old child is exposed to a sudden and unexpected reality: hospitalization in a paediatric oncology institution due to a diagnosis of ALL - B. This event led to a rupture in family, personal and professional harmony and caused *stress* and anxiety. At an early stage of diagnosis, the family needs time and space to assimilate the health-disease transition and experience the first stage of transition awareness (Landier *et al*., 2016). The mother shows awareness of this process, understands the transition and expresses a desire to participate in the process of caring for E.M. It was noted that she is afraid of what the future may hold and fears that the treatments will not go well. She is aware that she has a long way to go to adapt. She is willing to learn and shows a willingness to get involved and collaborate with the nurses. They understand that many changes are going to happen, isolation is inevitable, but the new technologies will help bring them closer to their families, the main pillar in helping them get through this difficult time.

According to Landier *et al*. (2016), there are three key areas that should guide the education of the family of a newly diagnosed child with cancer: diagnosis and treatment, coping strategies and care. At an early stage, information needs are wide-ranging and varied. The transmission of information must be carefully structured in order to prioritize the most emergent care. The communication process must be gradual, clear and concise.

In view of the above, and taking maternal awareness into account, it is essential to structure the supervisory process in specific areas. These include emotion, with particular emphasis on anxiety management, medical diagnostic and therapeutic procedures - therapeutic attitudes [isolation regime and lumbar puncture] and medical diagnostic and therapeutic procedures/probes, drains and catheters [central catheter].

With regard to the domain of emotion, with a focus on anxiety, this was the subject of attention with the aim of promoting the mother's involvement and enabling her to become an active partner in the provision of nursing

<table>
<tr><td colspan="3">Client: Mrs. M. (mother)</td></tr>
<tr><td colspan="3">Domain: Emotion</td></tr>
<tr><td>Focus of attention/Diagnosis:
Anxiety;
Mother's potential to improve knowledge of anxiety control strategies;
Mother's potential to improve ability to use anxiety control strategies.</td><td>Objective:
Promote special parental role: anxiety management.</td><td>Data:
Mother's knowledge of anxiety control strategies: needs to be improved in order to progress to mastery; it is the right time to intervene;
Mother's ability to use anxiety control strategies: needs to be improved in order to progress to mastery; now is the right time to intervene.
time to intervene.</td></tr>
<tr><td>Proctor model: Formative function

Supervisory strategies:
Clarify; guide; observe; give positive feedback.</td><td colspan="2">Nursing interventions:
-Teach mother about anxiety control strategies;
-Teach, instruct and train mother in relaxation strategies;
-Evaluate the evolution of the mother's knowledge of anxiety control strategies;
-Evaluate the evolution of the mother's ability to use anxiety control strategies.</td></tr>
<tr><td>Proctor model: Restorative function

Supervisory strategies:
Support; pay attention; encourage; help find solutions to problems; give positive feedback.</td><td colspan="2">Nursing interventions:
-Manage physical environment (reduce environmental stimuli during anxious states; adjust lighting);
-Optimize communication (speak calmly and slowly, posture of serenity and closeness, respect moments of silence, maintain eye contact with the mother, provide comfort);
-Provide presence;
-Refer the mother to the psychology service;
-Convey optimism and realistic hope;
-Offer active listening;
-Promoting emotional support (staying close to the mother, providing feelings of security during periods of heightened anxiety, avoiding barriers to communication, encouraging verbal expression of feelings, perceptions and fears, showing empathy and understanding);
-Assist in identifying coping strategies (promote socializing with support groups such as: Acreditar, survivors group, volunteers, Operation Red Nose/Doctors Clown);
-Encourage relaxation techniques (use of warm baths, background music);
-Encourage periods of rest and distraction;
-Give positive praise;
-Encourage the mother to ask questions.</td></tr>
<tr><td colspan="3">Evaluation/expected result - The mother adopts anxiety management strategies.</td></tr>
</table>

Table 1 - Domain: Emotion

<table>
<tr><td colspan="3">Client: Mrs. M. (mother)</td></tr>
<tr><td colspan="3">Area: Medical diagnostic and therapeutic procedures -therapeutic attitudes [isolation regime]</td></tr>
<tr><td>Focus of attention/Diagnosis:
-Isolation regime;
-Potentialofmothertoimprove knowledge about isolation regime..</td><td>Objective:
To promote the special parental role: adherence to the isolation regime.</td><td>Data:
-Mother's knowledge of the isolation regime: needs to be improved in order to progress to mastery; this is the right time to intervene;-Carrying out the isolation regime according to the recommendation: themother does not follow the recommended isolation regime.</td></tr>
<tr><td>Proctor model: Formative function

Supervisory strategies:
Clarify; guide; observe; give positive feedback.</td><td colspan="2">Nursing interventions:
Teach mother about anxiety control strategies;
Teach, instruct and train mother in relaxation strategies;
Evaluate the evolution of the mother's knowledge of anxiety control strategies;
Evaluate the evolution of the mother's ability to use anxiety control strategies.</td></tr>
<tr><td>Proctor model: Restorative function

Supervisory strategies:
Demonstrate; clarify; guide; observe; give feedback.</td><td colspan="2">Nursing interventions:
-Teach the mother about the isolation regime;
-Provide institutional information leaflet on "Protective isolation for neutropenia";
-Teach and demonstrate the hand hygiene procedure to the mother, according to institutional standards;
-Demonstrate and explain personal protective equipment to the mother;
-Educate the mother about the importance of protective isolation;
-Explain to the mother the rules for using the toilet;
-Teaching about the care of the child's clothes;
-Explain the importance of selecting objects that can be disinfected/washed;
-Evaluate the evolution of the mother's knowledge of the isolation regime;
-Evaluate the evolution of the special parental role: adherence to the isolation regime</td></tr>
<tr><td>Proctor model: Normative function

Supervision strategies:
Demonstrate; clarify; guide; observe; condition; give feedback.</td><td colspan="2">Nursing interventions:
-Demonstrate hand hygiene procedure, according to institutional standard;
-Show a poster demonstrating the hand hygiene technique;
-Show information poster on the 5 moments of hand hygiene;
-Observe the mother during hand hygiene;
-Reinforce to the mother the importance of complying with the protective isolation regime;
-Explain personal protective equipment to the mother;
-Explain the importance of hand hygiene, according to institutional standards;
- Clarify the visiting regime.</td></tr>
<tr><td colspan="3">Proctor model: Restorative function

Supervisory strategies: Support; pay attention.
Nursing interventions:
Show willingness to clarify/help the mother;
Encourage the mother to ask questions;
Accompany the mother on her first admission to the isolation unit.</td></tr>
<tr><td colspan="3">Evaluation/expected result - Mother adopts isolation regime according to recommendation.</td></tr>
</table>

Table 2 -Domain: Medical diagnostic and therapeutic procedures -Therapeutic attitudes [Isolation Regime]

Client: Mrs. M. (mother)		
Domain: Medical diagnostic and therapeutic procedures - therapeutic attitudes [Lumbar Puncture]		
Focus of attention/Diagnosis: - Invasive procedure; -Potentialofmother/fathertoimprove knowledge about invasive procedure.	**Objective:** Promote special parental role: management of invasive procedure.	**Data:** Mother's knowledge of invasive procedure: needs to be improved to progress to mastery; it is the right time to intervene.
Proctor model: Formative function **Supervision strategies:** Provide guidance; observe.	-Nursing interventions: -Teach mother about circuit; -Teach mother about invasive procedure; -Teach mother about anesthetic procedure; -Inform about fasting; -Teaching about bed rest after the invasive procedure; -Educate about potential adverse reactions after the invasive procedure; -Provide institutional information leaflet; -Evaluate the evolution of the mother's knowledge of invasive procedure management.	
Proctor model: Normative function **Supervisory strategies:** Clarify; guide; give negative *feedback*.	**Nursing interventions:** -Verify informed consent; -Inform about the importance of bed rest for 2 hours after the invasive procedure; -Help the mother find strategies to promote bed rest after the lumbar puncture (create a sleep-promoting environment, use passive distraction strategies such as watching a movie or reading a story).	
Proctor model: Restorative function **Supervisory strategies**: Support; pay attention.	**Nursing interventions:** -Show willingness to clarify doubts; -Encourage questions/doubts; -Managing the physical environment; -Providing presence; -Offer active listening.	
Evaluation/expected result - Mother's satisfaction with the preparation for managing the invasive procedure.		

Table 3 - Domain: Medical diagnostic and therapeutic procedures - Therapeutic attitudes [Lumbar Puncture]

Client: Mrs. M. (mother)		
Domain: Medical diagnostic and therapeutic procedures - Probes, drains and catheters [central catheter]		
Focus of attention /Diagnosis: - Central catheter; -Mother's potential to improve knowledge about preventing complications related to the central catheter.	**Objective**: Promoteparental rolespecial: preventionof complications related tocomplicationso central catheter.	**Data**: Mother's knowledge about preventing complications related to the central catheter: needs to be improved in order to progress to mastery; it is the right time to intervene.
Proctor model: Formative function **Supervision strategies:** Provide guidance; observe; give positive *feedback*.	**Nursing interventions:** -Teaching about the central catheter; -Teaching the mother about preventing complications due to the presence of a central catheter; -Teaching the mother about monitoring the central catheter insertion site (signs of inflammation); -Teaching the mother about caring for the skin around the central catheter insertion site; -Teach mother about behaviors to avoid (immersion bath; dressing removal); -Provide institutional information leaflet on central catheter care; -To evaluate the evolution of the mother's knowledge about preventing complications due to the presence of a central catheter.	

Proctor model: Restorative function **Supervision strategies**: Support; pay attention.	**Nursing interventions:** -Show willingness to answer the mother's questions; -Encourage the mother to ask questions.
Evaluation/expected result - The mother adopts behaviors to prevent complications related to the central catheter.	

Table 4 - Domain: Medical diagnostic and therapeutic procedures - Probes, drains and catheters [Central Catheter]

care. Nurses play a crucial role in supporting the family's readaptation to the new context imposed by the child's cancer diagnosis. They also have a responsibility to help develop strategies that enable parents to manage the *stress* resulting from the situation, as well as to promote self-efficacy in exercising the parental role, especially in such challenging circumstances. Empowering the mother in this process is fundamental to ensuring an integrated and effective approach to caring for the child (Castanheiro, 2018; Mano, 2017; Pires, 2017; Pires *et al*., 2020). Bearing in mind that the mother demonstrates a need to improve her knowledge and skills in anxiety control strategies, and that the time is right, interventions were outlined within the scope of the formative and restorative function of the Proctor Model (table 1). These interventions aim to support the development of the mother's skills, to promote her ability to deal more effectively with anxiety and, consequently, to contribute to the child's well-being and the management of her role in family care.

The mother was instructed in anxiety management (formative function), using the following supervisory strategies: clarifying, guiding, observing and giving positive *feedback*. The aim of these interventions was to reinforce established nursing practices by teaching, instructing, training and evaluating the evolution of the mother's knowledge and ability to apply the knowledge acquired. At the same time, strategies were defined for adapting the mother to her new parental role (restorative role), for which the following supervisory strategies were used: supporting, paying attention, encouraging, helping to solve problems and giving positive *feedback*. These aim to sustain the emotional aspect and the support offered by the nursing team. According to Franco (2018), parents consider that effective communication contributes significantly to better understanding and cooperation and that it fosters a relationship of trust, while reducing uncertainty and decreasing anxiety. Family-centered care promotes parental involvement, which leads to greater knowledge about the child's state of health, a perception of greater control and reduced anxiety.

In relation to the essential aspects for the mother's learning, taking into account the diagnosis and safety of the care provided to the ME, the following areas were identified: diagnostic and therapeutic procedures - therapeutic attitudes (isolation regime and lumbar puncture); diagnostic procedures and medical therapy / probes, drains and catheters (central catheter). In pediatric oncology, the information provided in the initial phase should be restricted to the fundamental concepts needed to prepare the family for safe care. These include care related to "survival competence", which involves administering medication, handling the central catheter, recognizing health emergencies, among others (Landier *et al*., 2016).

With regard to the isolation regime, it was found that the mother needed to acquire and improve knowledge about the care required in this context. Neutropenia is understood as a decrease in the absolute count of circulating neutrophils in the blood, according to the standards of the service in question. This con-

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dition can be a manifestation of the disease or a consequence of chemotherapy treatment. Infection, an important cause of morbidity and mortality in neutropenic children, requires the implementation of strict infection prevention measures as well as strategies to reduce the risk of transmission of infectious agents.

In this service, the isolation units have a space called the antechamber, where the individual use equipment (gown, mask and cap) is located. (gown, mask and cap) for use by professionals and parents, to allow them to enter the space reserved for the child. In addition to this equipment, parents have their own uniform, which must be changed daily or whenever necessary. The use of this equipment is specific to the isolation area and should not be used outside it. Isolation units have positive air pressure and allow for a safe environment inside the unit (institutional standard).

As for specific care, the following are listed: the child's personal belongings must be washable and/or disinfectable with 70º alcohol; the child's clothes must be washed at 60º. Parents are the main caregivers and their substitution is allowed as long as it is duly planned; the parents' hygiene care must be carried out in the bathroom designated for this purpose and never in the child's bathroom; hand washing and disinfection must be carried out frequently; visits to children in protective isolation due to neutropenia are not contemplated. In view of the above, strategies were used within the scope of the formative function of Proctor's model, such as demonstrating; clarifying; guiding; observing; giving *feedback* (table 2).

In view of the plethora of information, it was found that the mother did not comply with the service's rules regarding visits and also those relating to protective isolation care due to neutropenia. She verbalizes that she understands the importance of complying with the isolation regime in order to protect her child and is motivated to comply with the rules taught. She demonstrates compliance with hand washing/disinfection, however, she doesn't do it at the essential moment, before entering the room. With regard to toys, there were several soft toys, which is not in line with the norm and with maintaining a safe and protective environment, so it was necessary to reinforce the teachings. Strategies were used in the context of the normative function of Proctor's model, such as demonstrating; clarifying; guiding; observing; conditioning; and giving *feedback*. There was also a need, through the restorative function of the Proctor model, to accompany the mother on her first admission to the isolation unit, to show willingness to clarify/help the mother and to encourage her to ask questions.

In order for this process to be fruitful, the supervisory strategies of supporting and paying attention were used (table 2).

In the context of diagnosis, various invasive procedures such as lumbar puncture and central venous catheter placement are carried out, so it is essential to provide information at key moments and throughout the different phases of care (Landier *et al*., 2016). Lumbar puncture allows intrathecal chemotherapy to be administered, as many of the cytostatics used do not cross the blood-brain barrier and make treatment and prophylaxis in the brain area unfeasible (Dias *et al*., 2019). As an invasive and potentially painful procedure, lumbar puncture requires the implementation of appropriate strategies to relieve pain and discomfort, as well as the adoption of interventions that minimize fear, anxiety, *stress* and suffering. After this procedure, it is essential that the child remains at bed rest for a period of two hours, in order to prevent adverse reactions such as headaches, nausea, vomiting, paresthesia and convulsions (Dias *et al*., 2019). It was observed that the mother's knowledge of this procedure was insufficient and needed

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to be improved. The mother was receptive to acquiring new knowledge. To fill this gap, supervisory strategies were used as part of the formative function of Proctor's model, namely guiding and observing (table 3). Given that the mother was not complying with the recommended rest, and taking into account the risks associated with this invasive procedure, teachings aimed at preventing complications and/or intercurrences were reinforced. To this end, supervisory strategies were used within the scope of the normative function of Proctor's model: clarifying, guiding and giving negative *feedback* (table 3).

The presence of a central venous catheter (CVC) allows for the safe administration of cytostatics, blood products and antibiotics, as well as facilitating the collection of blood samples. However, this device is not without its risks and complications, and specific care is required when handling and maintaining it. The nursing team plays a crucial role in preventing CVC-associated infections, and it is essential to teach children and parents about the care and aspects to watch out for in order to avoid complications (Pires, 2017). Complications (Pires, 2017). In relation to CVC, the mother's knowledge about preventing complications needed to be improved. She was receptive to receiving this information, which was conveyed using the training strategies of the Proctor model, namely: guiding, observing and giving positive *feedback* (table 4).

Finally, it is important to mention that for these invasive procedures, it was considered essential to adopt supportive supervisory strategies that would facilitate the readaptation of the parental role to the complexity of the care required by the EM. To this end, supervisory strategies were used in the context of the restorative function, such as supporting and paying attention (tables 3 and 4).

In drawing up this supervision plan, the domains of involvement in which Mrs. M. verbalized wanting and feeling able to collaborate and participate were negotiated. Anne Casey's care partnership model involves constant negotiation between the family and the nurse. It is a dynamic, systematic and partnership relationship and supervisory strategies are particularly important in the operationalization of this child care model.

CONCLUSION

This study made it possible to achieve the objectives initially proposed: to consolidate theoretical knowledge about CS, its applicability and importance for nursing practice. Specifically, we sought to deepen our skills in the area of CS for caregivers. As well as being a topical subject, this is also an area of intervention and interest for the working group.

The theoretical framework of the concept of supervision and its correlation with the supervision of parents as family caregivers was carried out, the essence of Anne Casey's care partnership model and Proctor's supervisory model were specified and a proposal for a supervisory plan for the parental role was developed, according to the scenario constructed. This work has made it possible to clarify the importance of supervisory processes for the quality and safety of care. Specifically, for the training of the mother/father as a caregiver (formative and normative function), and support (restorative function).

The main difficulties in carrying out the study were related to selecting the most suitable supervisory strategies for each phase of Proctor's model, prioritizing areas of intervention and differentiating between a supervisory plan and a care plan. Intrapersonal and interpersonal reflection was used to overcome these difficulties. The completion of this document helped to solidify my knowledge of EHC and promoted my personal and professional development.

The child and the family, in their process of adapting to this new reality, are challenged to develop strategies to achieve balance and family homeostasis (Castanheiro, 2018; Mano, 2017; Pires *et al*., 2020). It is therefore essential for nurses to intervene to support the proper performance of the parental role and promote the well-being of the child and the family.

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