An Interpretative Phenomenological Analysis study of the lived experiences of health care assistants / support workers receiving clinical supervision within acute mental health inpatient settings in the UK.

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A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy. The candidate has already achieved 180 credits for assessment of taught modules within the blended learning PhD programme.

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I declare that this thesis is my own work and has not been submitted for the award of a higher degree elsewhere.

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This work is dedicated to all health care assistants and support workers. My hope is that this work will contribute something, no matter how small, to help them in their endeavours. The final dedication is to my Dad, who sadly, could not complete this journey with me. I miss our conversations, but you will always be in my thoughts.

Abstract

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Clinical supervision is a process which has been adopted as part of nursing practice for the past 30 years. Its purpose provides a formal arrangement for professional support, guidance and development through reflective practice. The literature around clinical supervision in nursing is extensive and continues to grow. However, despite this, very little is known about health care assistants' / support workers' experience of clinical supervision and particularly their experience of this within inpatient mental health settings. This is especially pertinent as health care assistants / support workers represent the largest number of practitioners within these settings and have more face-to-face contact time with the service user. The literature review in this thesis alludes to this point by highlighting the scarcity of available research on clinical supervision with this group of people in this setting.

This thesis has utilised Interpretative Phenomenological Analysis as a methodology to explore the experiences of the health care assistant / support worker of clinical supervision within inpatient mental health ward settings. Eight participants were involved in individual semi-structured interviews. These recorded experiences formed the data which were analysed and provided two over-arching themes. These were: (1) ''*One of the things that could help is the…, is that it happens basically I suppose and that it doesn't keep getting called off…''*: Trying to engage with the ongoing challenges. (2) ''*Because of supervision, the way it's structured and the way it works, it's kept me within the NHS''*: Placing value on clinical supervision. These overarching themes consisted of three subthemes each.
This study offers an original contribution to knowledge through the discussion, which explores how health care assistants/ support workers can meaningfully contribute to clinical supervision and become empowered in the process. The limitations of this study are also discussed and suggestions for future research.

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List of abbreviations

CASP	Critical Appraisal Skills Programme
CBT	Cognitive Behavioural Therapy
CQC	Care Quality Commission
DH	Department of Health (United Kingdom)
HCA / SW	Health Care Assistant / Support Worker
HEE	Health Education England
NHS	National Health Service
IAPT	Improving Access to Psychological Therapies
IMHTF	Independent Mental Health Task Force
IPA	Interpretative Phenomenological Analysis
NICE	National Institute for Health Care Excellence
NMC	Nursing Midwifery Council
PRISMA	Preferred Reporting Items of Systematic reviews and Meta Analysis
RCN	Royal College of Nursing
RN	Registered Nurse
RCPsy	Royal College of Psychiatry
TS	Thematic Analysis
UK	United Kingdom
UKCC	United Kingdom Central Council
USA	United States of America

Chapter One: Introduction to the research

1.1 Introduction

The primary focus of this thesis is to gain an understanding of what clinical supervision means to health care assistants /support workers (HCA/SWs)[1] based on inpatient adult acute mental health wards in the United Kingdom (UK) National Health Service (NHS). The thesis is set within the context of frequent and unprecedented changes which have directly impacted on several aspects of mental health services. The most notable direction of change has permeated across health policy, introducing strategic changes (DH, 2011; Independent Mental Health Task Force, 2016; NHS England, 2019) and workforce changes impacting on the development of the health care assistant/ support worker role (Durcan et al., 2017; NHS England/Health Education England, 2017).

To understand what clinical supervision means to the HCA/SW within mental health inpatient settings, consideration was given to how knowledge of clinical supervision, is constructed and attributed meaning. This approach was vital to gain insight into the personal and complex phenomenon of clinical supervision and also consider an alternative knowledge construction to the influential positivist research approach to clinical supervision (Kühne et al., 2019). Within the positivist research paradigm, the researcher assumes the position of the existence of an objective, measurable reality. This can be observed and justified by methods such as experiments and surveys yielding quantitative data to test a

[1] There are several terms used to identify a non-registered nurse. The terms, health care assistant and health care support worker, are the most common used to describe this role (Cavendish, 2013; Unison, 2016). In the context of this information, the terms that will be used in this thesis will be health care assistant/ support worker (HCA/SW) or the plural (when necessary), health care assistant / support workers (HCA/SWs), to identify with this role.

hypothesis. This approach is evident in several international studies (Gonge & Buss., 2011; Long et al., 2014; Martin et al., 2021) and reviews of clinical supervision (Kühne et al., 2019; Rothwell., 2021; Teasdale., 2001).

1.2 Personal interest development in clinical supervision

My own interest into clinical supervision began as a registered nurse in the mid 1990's while working between inpatient and community mental health services. At that time, clinical supervision had a relatively obscure profile in mental health nursing but had received political support (DH, 1993; DH, 1994). In the UK, this political identification of clinical supervision in nursing was proposed by the Department of Health, who endorsed a managerial responsibility contributing risk management aspects within clinical supervision. This had followed a national report (Clothier et al., 1994) which had investigated contributing factors into tragic circumstances involving murder and injury of children by a nurse within an NHS children's unit in 1991. The decision to adopt clinical supervision for nurses was challenged by a confusing myriad of models with no consensus on the delivery of it (Edwards et al., 2005; White, 2017). At this time, I had received clinical supervision from a senior nurse. Unfortunately, this was inconsistent and was delivered in a similar way to appraisal with an emphasis upon the assessment of risk. Following this initial exposure to clinical supervision, I encountered a different experience of clinical supervision over time through professional development and training as a psychotherapist. This involved receiving clinical supervision from clinical professionals who had received training as psychotherapists or clinical psychologists. It was notable that working within a setting such as psychological therapies, clinical supervision was afforded an unconditional, reserved position as part of the role which assured its quality and consistency.

This experience contributed to my role development. This was not always immediately evident but through the reflective process of clinical supervision my care delivery was enhanced. In my experience, however, it remained that clinical supervision within inpatient settings and across mental health services as a whole presented anomalies and inconsistencies with policy implementation, interpretation, understanding and delivery. Curiosity drew me to try to understand the experience of clinical supervision and what this experience was like for staff such as HCA/SWs. It appeared that this group of staff, within mental health inpatient settings, experienced more direct face to face contact time with service users than any other care staff. However, they did not appear to have access to clinical supervision or, if they did, it was inconsistent or delivered as a single session response following a serious incident. This presented a research opportunity to develop a clearer understanding of clinical supervision by HCA/SWs within mental health inpatient settings.

1.3 Conceptualising clinical supervision

The literature around clinical supervision is extensive and has continued to grow exponentially, with growth nationally and internationally, over the past thirty years (Howard & Eddy-Imishue, 2020). Many definitions of clinical supervision exist and tend to be influenced by their respective schools of philosophical understanding and subsequent models of clinical supervision (Farrington, 1995). Farrington (1995) argues there are broadly three schools with many models and definitions falling into these. The first school adopts a psychoanalytical philosophy focusing on analysis of transference and counter transference within the relationship between supervisor, supervisee, and client, and is reflected in

models of clinical supervision such as the triadic model (Milne, 2009). Clinical supervision defined in this way is:

> *"An intensive, interpersonally focused, one to one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person"* (Loganbill et al., 1982, p.4)

A second school adopts a humanistic philosophical understanding and views clinical supervision as the development of supervisees' understanding of self, increased awareness and emotional growth, with the supervisee having responsibility for the content and their own learning within the supervision. Such a definition is:

> *"An exchange between practising professionals to assist the development of professional skills".* (Butterworth & Faugier, 1992, p.12)

This definition is reflected in models such as the growth and support model advocated by Butterworth and Faugier (1992) and Proctor's three function Interactive model (Proctor,1987). White (2017) argues Proctor's interactive model is the most commonly adopted approach to clinical supervision in nursing and consists of three interactive functions which are reflected in clinical supervision. These are a normative function, considered to be a managerial aspect, a formative function, an educational aspect and a restorative function, a supportive aspect (Proctor, 1987).

The third school is based on a behavioural philosophy which views clinical supervision as a process to facilitate the development of the supervisee's skills by the supervisor. In this approach the supervisor has the responsibility for the content, focus and learning (Farrington, 1995). This approach is reflected in models such as an adaptation of John Heron's six category intervention model (Heron, 1990). This model has been advocated for clinical supervision within nursing, with some limited success and with an acknowledgement for more research (Solan & Watson, 2002). Hawkins and Shohet (1989) have suggested consideration for integration of these theories and models. They suggest that different forms of clinical supervision are all connected to make up clinical supervision. For example,

> *"Supervision can be an important part of taking care of oneself, staying open to new learning, and an indispensable part of the individual's ongoing self-development, self-awareness and commitment to learning".* (Hawkins & Shohet, 1989, p.48).

Since this definition, Hawkins and Shohet (2012) have integrated the theories further, to include the role of the relationship and context within clinical supervision. Other clinical supervision definitions and explanations have been articulated in a similar way since (Bernard & Goodyear, 2014; Driscoll et al., 2019; Van Ooijen, 2000).

Although many definitions have had dimensions added over time, a broad consensus has emerged that clinical supervision essentially consists of a formal, accountable and supportive arrangement within a confidential environment (Driscoll et al., 2019; Pollock et al., 2017). Despite this broad consensus there is dissenting literature when identifying individual components of the process of clinical supervision. Lister and Crisp (2005), Milne

(2007) and Cleary et al. (2015) argue that the process lacks clarity with the term clinical supervision often used interchangeably with reflective or restorative supervision or management supervision, with a suggestion of organisations misappropriating the meaning and practice of clinical supervision, to align with their own interpretations (White & Winstanley, 2021).

Koivu et al. (2010) and White (2017) question how learning and knowledge acquisition takes place, while White and Winstanley (2009) and White (2017, 2018) assert that the development of the supervisor / supervisee relationship is left largely to inference in the absence of any research to provide a rigorous evaluation of this. Not surprisingly, the lack of clarity and consensus around specific key components, such as what and how content should be discussed, impacts upon the supervisory relationship development and how this should be purposely facilitated (Bernard & Goodyear, 2014; Cleary et al., 2015; Edwards et al., 2005; Ellis et al., 2017; Lister & Crisp, 2005; Milne, 2009). As clinical supervision has evolved, it has also taken on different meanings within different professions which have been reflected in terms of understanding and development (Carroll 2007; White & Winstanley 2010, 2014).

1.4 Clinical supervision in nursing: background and development

Busse (2009) argues that a broad meaning of the term supervision has been around for centuries within professions and trades. Some evidence suggests that clinical supervision has had a presence in nursing since the 1920s (Sloan, 2006), however, it is only in the past three decades that a formal interest in clinical supervision within nursing, in the UK, has occurred. Butterworth and Faugier (1992) reported that clinical supervision in disciplines

such as psychology and social work has been established considerably longer. Indeed, Carroll (2007) maintains that clinical supervision within nursing has been developed based on models that prevail in clinical psychology, psychotherapy, and social work. When considering the different fields that constitute nursing, Butterworth et al. (1997) suggest that mental health nursing has arguably adopted clinical supervision more comprehensively than the rest of nursing as a whole because of a closer alignment with other non-nursing disciplines, in particular psychology, psychotherapy, and social work.

Clinical supervision within nursing, including mental health nursing, is reflected by models which generally adopt humanistic approaches. The most popular model is Proctor's three function interactive model (Proctor, 1987) which has sustained its popularity since its inception (Markey et al., 2020; Sloan & Watson, 2002). The model, briefly identified earlier, has three components which are elaborated on further here and are: A normative (managerial) function which includes the development of standards and compliance with policies and procedures; a formative (educational) function which includes learning and enhancing skills; and finally, a restorative (support) function which includes the understanding, recognition and management of emotional stress. The model has received criticism in relation to its vague structure (Sloan & Watson, 2002). However, for others, it is the very composition of the model that allows for adaptability and change, and it is this that has sustained the model to meet the contemporary complexities of nursing care (Markey et al., 2020). The formative and restorative components of the Proctor model sit comfortably with the many definitions of clinical supervision as discussed above.

It was notable that initial directives involving clinical supervision and nursing (UKCC, 1992; DH, 1993; DH, 1994; UKCC, 1996), associated the implementation of clinical supervision within nursing, as a way of enhancing standards and quality while impacting upon clinical issues such as managing risk.

However, it has been argued, that this endorsement has occurred with seemingly little evidence of its efficacy within nursing in the UK (White, 2018). The UK, however, does not appear to be alone as White (2017, 2018) suggests the international literature identifies clinical supervision being published in health policy and health care organisations advisory documentation on the widespread benefits of clinical supervision, rather than sufficient research-based evidence to support such claims. It is possible that this suggestion proposes that clinical supervision has been influenced more by rhetoric rather than research.

Over the past decade in the UK, clinical supervision has been embroiled within health policy, possibly because of health care failures receiving national attention, such as those detailed in the Winterbourne View Hospital serious care review (Flynn, 2012) and the Mid-Staffordshire NHS Foundation Trust public inquiry[2] (2013). Recommendations from these publications identified the lack of supporting mechanisms for staff through appraisal, supervision, and professional development. The Care Quality Commission[3] (CQC, 2013) has taken a similar view, which they set out in their guide *Supporting information and guidance:*

[2] The Winterbourne View Hospital revealed systemic and multiple care failures within an independent learning disability hospital leading to 11 criminal convictions. The Mid-Staffordshire NHS Foundation Trust Inquiry revealed systemic care failures at multiple levels between 2005 – 2009. There were poor standards of care and leadership among the 290 recommendations.

[3] The Care Quality Commission (CQC) is an independent regulator of health and adult social care providers in England. The CQC monitor, inspect and regulate services. They publish their findings and have powers from issuing cautions to prosecutions.

Supporting effective clinical supervision (CQC, 2013). The CQC (2013) assert that the guidance is designed to be used by legally responsible care providers in relation to regulatory requirements. White (2018) identifies that a significant number of NHS Trusts in the UK utilise this guidance as a reference and refer to it in their policy on clinical supervision suggesting that policy, rather than research-based evidence, justifies the benefits to implementation of clinical supervision.

1.5 Context of mental health services and policy impacting upon clinical supervision

Mental health services are constantly changing due to influences from political, social, cultural, and professional role initiatives and directives. They are also increasingly influenced by the service user voice, diversity, rapidly changing treatment, and technological advances. There is, therefore, a complex interrelated synergy between the politico-social, cultural, and professional components that shape the context of mental health services. This impact, on UK mental health services, has contributed to changes over the past decade that have had a profound effect, directly and indirectly, on the interrelated components that form the context of addressing contemporary mental health services (Kings Fund,[4] 2018).

A notable political change over this period has been the manifestation and influence of political ideology reflected in legislation and policy strategy. This has resulted in radical and frequent changes in the fundamental structure, funding, administration, and the reconfiguration of UK health care services (DH, 2012; Independent Task force Mental

[4] The King's Fund is a charitable and highly influential organisation that claims to improve health care in England and frequently reports Government health care policy.

Health, 2016; NHS, 2019). It has been argued that the changes have been initially driven by a political ideological view of austerity-driven measures used to justify the rationale for change (Durdy & Bradshaw, 2014; Hemingway et al., 2013; Kings Fund, 2018). Moreover, the Kings Fund (2018) demonstrated a consistent underfunding of mental health services that was disproportionate to any other service, resulting in staffing resource issues.

This appears evident in the early part of the previous decade which saw a sustained trend in reducing the capacity of mental health nurse training places and a significant change to bursary funding (Palmer et al., 2023). This appears to have had some effect on the latter half of the decade which shows that although the number of mental health nurses in the UK NHS workforce had grown slightly, this was still 7% less than expected and it is only in the past year that the numbers are beginning to meet expectations (Palmer et al., 2023). The combination of these issues and the potential issues of leavers have led the current funders of UK nurse training, Health Education England (HEE), to express concerns of a risk of vacant mental health nursing posts which may need to be filled by new roles, creating mentoring and clinical supervision implications for HCA/SWs (HEE, 2022).

Clarke (2019), however, suggests that the fall in the mental health nursing workforce over the early part of the previous decade may not be attributed to a reduction in funding and leavers of the profession alone. Clarke (2019) adds that over this period, a significant number of mental health nurses have made a transition from posts such as acute inpatient settings to community-based posts within psychological therapies, in particular the improving access to psychological therapies (IAPT) programme. This, Clarke (2019) argues, perpetuates an increased turnover for staff in acute services as therapy specific posts may

be viewed as a more attractive opportunity for mental health nursing staff to develop their role and skills further. This, however, simultaneously creates the loss of valuable experience (including clinical supervision experience) on wards, which may become unsustainable in the future.

The IAPT programme is a national initiative for England that commenced in 2008 supported by evidence of the efficacy of cognitive behavioural therapy (CBT) in the treatment of 'common' mental health problems such as anxiety and depression. The approach has been endorsed by the National Institute of Health and Care Excellence (NICE) and the service has continued to expand adopting new pathways around the country (DH, 2019). Clarke (2019) adds that mental health nurses are an obvious solution to remedy the demands of providing a high intensity therapist service on a large scale with most already equipped with the prerequisite skills and knowledge of the CBT model. A successful approach supported by clinical evidence and addressing waiting times for psychological support has been considered attractive by Government and an economically viable investment. However, the success of IAPT could also be viewed as an unintended consequential impact of reducing experienced staff (who would also have the role of clinical supervisor) in areas such as acute inpatient services and contribute to a high turnover rate and retention issues (Durcan et al., 2017). For example, Durcan et al. (2017) found that mental health acute inpatient adult beds fell by 15% and staffing levels by 20% between 2012 and 2016. Admission numbers, however, did not change, meaning that bed occupancy levels, on average, demonstrated a 94% increase. By contrast during the same period, access to psychological therapies rose, reaching 900,000 people a year by 2015/16, a figure which has continued to grow. Crisp et al. (2016) have also drawn attention to the issue of the continued reduction of available

inpatient beds, which has resulted in considerable pressure for demand on remaining inpatient beds resulting in frequent out-of-area placements. The pressure due to the lack of available beds has also impacted upon other aspects of acute inpatient care such as a sustained high threshold for service user presenting problems on admission. This sustained intensity is thought to contribute to high workforce stress and burnout rates among staff, the inability to introduce therapeutic interventions for patients and adequate clinical supervision for staff (CQC, 2019; Laker et al., 2019).

Acute inpatient mental health settings continue to encounter difficulties despite the *Five year forward view for mental health* (Independent Mental Health Task Force, 2016) which recommended a care delivery focus on innovations around several mental health services but with little on acute inpatient services. NHS England have, however, introduced *The NHS Long term plan* (NHS, 2019) which sets out a ten-year plan for the NHS, including mental health services in England with a planned £20.5 billion investment. The NHS long term plan overlaps with *the Five year forward view for mental health* and consolidates the existing recommendations raising concerns from The British Medical Association and the Royal College of Psychiatrists who both stress their own concerns for funding to reach frontline services, such as acute inpatient mental health care.

It is clear from the discussion above that there is a coalescence of changes to which it could be argued that inpatient mental health services are at the centre of the impact. One of the common outcomes of the transformation of services outlined above has been the attention drawn to the concept of clinical supervision, as a process and its possible ameliorative effects, which has reignited the debate around its role and influence (Markey et al., 2020).

1.6 The development of the health care assistant / support worker

The *Five year forward view for mental health*, *NHS Long term plan* and *NHS Long term workforce plan* (NHS England, 2023) identify reconfiguration for the mental health workforce, with a greater commitment to the use of health care support assistants and the development of apprenticeship schemes and trainee nurse associates across all services (Durcan et al., 2017; NHS England, 2023).

The health care assistant/ support worker (HCA/SW) is a non-registered[5] clinical nurse whose role has expanded from delivering personal care only (washing, feeding and, in mental health settings, taking service users out and organising social activities). Over the past decade, the HCA/SW role has become more complex with extended responsibility, with additions of many of clinical interventions and responsibilities that had previously been undertaken by registered nurses. With registered nurse numbers lower than a decade ago, both nationally and internationally, a greater emphasis has been placed upon the HCA/SW filling the void, despite no national formalised training programme for all HCA/SWs (Unison, 2016).

Indeed, the Trade Union Congress (2016) argued that the HCA/SW typically delivers 60% of patient care, yet only 5% of the NHS education and training budget is spent on them. The same report also identified widespread inconsistencies in job titles, roles and responsibilities and a general perception of them feeling undervalued in the workplace by managers and

[5] A registered nurse (RN) has successfully completed a specifically designed formal programme of nurse training, approved by the nursing and midwifery council (NMC), which meets the standards and requirements set by the NMC and is registered with the NMC. These nurses are sometimes colloquially referred to as ‘qualified’ nurses. Non-registered nurses have not had any such formal training and are therefore unregistered and sometimes colloquially referred to as ‘unqualified’ non-registered nurses.

other practitioners and confusion for the service user. The HCA/SW has increasingly more service user contact time, increasing clinical skills, yet no formalised training and are also much less likely to receive clinical supervision, although the actual figure for the number of HCA/SWs in receipt of clinical supervision is not known (Cavendish, 2013).

Receiving clinical supervision was among the recommendations to address the care failures from the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013), were the inclusion of national mandatory training and education standards and a code of conduct and mandatory registration for the HCA/SW. In 2017, Health Education England set out the introduction of a national two-year generic training programme for trainee nursing associate apprentice role (HEE, 2017). The programme would run between the place of work and a local higher education programme, resulting in an entry to the appropriate part of the Nursing and Midwifery Council register. The role is viewed as a bridge between HCA/SWs and registered nurses with the aim of providing a career pathway for the HCA/SW (HEE, 2020, 2022). It is not clear, however, what happens to the HCA/SW who does not want this pathway or who does not meet the entry criteria. Although Callaghan and Butler (2017) acknowledge that the registered mental health nurse role within inpatient settings has become more managerially administrative and strategically orientated, leaving more clinical and therapeutic duties to the HCA/SW, there is no acknowledgement of the role of clinical supervision, particularly its educational role, to facilitate the increase in clinical responsibilities for the HCA/SW.

The issue of the development of skills is acknowledged by Foye et al. (2020). They report the absence of meaningful therapeutic activities on inpatient mental health wards, impacts

upon the development of therapeutic skills drawn from therapeutic relationships, and the absence of clinical supervision is disadvantageous for staff and patients. More recently, Wilberforce et al. (2017) and Health Education England has made a clear recommendation that educational development for therapeutic interventions for all concerned; '*should be incorporated into the formative function of clinical supervision'.* (HEE. 2022: p14.). This would suggest clinical supervision becomes a focus in terms of it being available for all staff and further research required around its function.

While a growing body of literature has emerged around clinical supervision, research into clinical supervision within inpatient mental health settings involving the HCA/SW role is clearly under-represented, and what is available does not focus exclusively upon the HCA/SW. For example, studies by Buss et al. (2011) and (2018) involving clinical supervision in mental health inpatient settings in Denmark and which included HCA/SWs in their participants, were 50% of the sample. Tuck (2017) described a team approach to clinical supervision in the UK but this included four other types of practitioners other than HCA/SWs. Howard and Eddy-Imishue (2020) conducted an integrative review of 14 studies of factors influencing adequate and effective clinical supervision for inpatient mental health nurses' personal and professional development and did not identify solely HCA/SW involvement or representation in any of the included studies.

Significant challenges remain for mental health services in respect of increased demand for the quality, recruitment and retention of high-quality staff. If the recommendations in contemporary mental health policy are to become reality, then the need for a well-supported and trained workforce to respond to the complex and changing needs of service

users and mental health services cannot be underestimated (NHS England, 2023). Changes to the HCA/SW level of working would be welcome, however would take considerable time and there remain questions around a generically trained approach to a speciality such as mental health. HCA/SWs are gradually increasing in number and both new and existing HCA/SWs continue to be exposed to the challenges presented in acute mental health. Clinical supervision has been advocated as an ameliorative process for all mental health nursing staff to engage in such challenging settings, for the HCA/SW (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013; Cavendish, 2013; HEE 2017, 2022). Given the direction for policy transformation impacting upon the HCA/SW, the expanding role and duties at the HCA/SW level and the challenges presented by rapidly changing inpatient mental health services, clinical supervision, would appear a necessary process with which to engage, and for organisations to make available (McCarron et al., 2017).

1.7 Rationale for this study

Pilgrim (2014) defines acute mental health inpatient services as those which are accessed by people who are very distressed and present in a disturbing and / or perplexing way and are viewed as requiring immediate containment to assess their need. Occasionally such services are imposed legally on people which can complicate an already complex and stressful situation.

Set within this context, acute mental health inpatient settings require care which aims to establish collaborative partnerships between service users and health care staff, which focuses on the promotion of self-determination and dignity (Wyder et al., 2017). Care

delivered in this way adopts a person-centred recovery model approach[6]. This approach promotes individual care, partnership, hope and resilience through open communication. This is possible by establishing a therapeutic alliance and trust through direct clinical exposure and adequate clinical supervision (Jacob, 2015; McKenna et al., 2014). Not being able to develop and explore the skills to adopt a person-centred recovery model approach, through clinical supervision, places the HCA/SW in an already difficult position.

Nursing experiences in delivering care in acute mental health inpatient settings have been captured in a narrative synthesis review of the literature by Wyder et al. (2017). The reviewers suggest that to establish therapeutic partnership working, all nurses need to be supported and develop greater self-awareness and reflective skills through structures such as clinical supervision. Clinical supervision, however, does not currently appear to be implemented in acute NHS mental health inpatient settings with any consistency (Cleary et al., 2010; White, 2017).

The lack of available literature suggests little is known about the experiences of clinical supervision exclusively from HCA/SWs within acute mental health settings or how any sense is made of clinical supervision, or how, if at all, it makes any impact upon HCA/SWs' practice. This represents a research opportunity confirming the need for exploration to gain a clear understanding of the experience of the HCA/SW within such settings and providing this rationale.

[6] The recovery model, in the context of mental health, aims to encourage people with mental health to work beyond surviving their problems to moving forward by setting new goals and developing meaningful relationships.

1.8 Research study aims and question

Gaining an understanding of what the clinical supervision experience means to the HCA/SW based within acute inpatient mental health wards needs to be viewed in the context of the conceptualisation of clinical supervision, mental health services, policy, and development of the HCA/SW. To explore this phenomenon a qualitative research study would be considered appropriate. The study aims, therefore, are as follows.

(i) To explore the HCA/SW perspectives of clinical supervision within acute NHS mental health inpatient settings.
(ii) To interpret how HCA/SW form an understanding of their experience of clinical supervision within acute NHS inpatient mental health settings.
(iii) To ascertain how HCA/SW experiences of clinical supervision impact upon their practice.

The study focuses upon the question:

How do health care assistants / support workers make sense of their experience of clinical supervision within acute mental health inpatient settings?

1.9 Reflexivity

Qualitative research has been described as subtle and complex, created in part, by the unavoidable researcher presence within the research and throughout it (Holloway & Biley, 2011). Qualitative research also often engages participants with powerful emotions from their experience which they are asked to discuss or reflect upon at length. To address this,

reflexivity, has emerged as a concept which can assist. Qualitative researchers, therefore, must be open to the view that reflexivity can enhance the position of self- awareness, and the balance of employing self-knowledge without becoming over emotive (Doyle, 2013).

Reflexivity is often understood as a process of a researcher's continuous internal dialogue and self-evaluation of their personality while explicitly acknowledging that this position may impact upon the research process and outcome (Berger, 2015). Moreover, Berger (2015) suggests this would include being attentive to the researcher's own history and their own understanding of the issues in question and self-understanding of participant reactions. This would help to recognise the balance of involvement and detachment of the researcher and the researched to demonstrate rigour, credibility, transparency, and trust (Doyle, 2013).

Engaging in the process of reflexivity revealed two key areas around my research positionality. The first area involved my personal experience of clinical supervision over 15 years of direct and indirect involvement in acute inpatient mental health settings, as a clinical supervisor, and supervisee. This experience indicated that the HCA/SW, within these settings, appeared to have little to no clinical supervision. Having personally experienced clinical supervision that was both effective and ineffective, I was mindful of how this experience could impact upon the research. I reflected upon how my history of trying to introduce a more effective clinical supervision experience, along with a personal enthusiasm for clinical supervision and how this could bias my perception on what participants may identify as clinical supervision. I was also mindful of how my own reactions could be if participants stated they did not receive, want, or value clinical supervision, given that this is contrary to my own view that clinical supervision can potentially impact positively on the

service user, the supervisee and the organisation. I reflected on how transparent I needed to be and to record this in my reflective journal and in my initial noting (discussed further in chapter three).

The second key area exposed some anxiety around my research approach which would impact upon my research position. To address the research question and subsequent aims, this needed to be a qualitative study. My reflections not only raised issues of my inexperience with qualitative research but the challenges to my research worldview and position. My exposure to research had been largely influenced by a positivist approach which will be discussed further in chapter three.

In this context, I reflected on the challenges of developing a different positionality on research, which evolved over time. A research philosophy module, reading, reflecting and previous qualitative research participation all contributed to this. Reflection included careful consideration of the alignment of the research question for the appropriate method selection. Reflections on the chosen methodology also appeared to illuminate similarities between the chosen research methodology and clinical supervision around the dynamic of the relational and interpretative qualities involved.

Positionality in qualitative research (discussed further in chapter three) requires the researcher to be explicit about their position and includes biases and assumptions as it is acknowledged that the researcher has considerable influence on the research process (Austin & Sutton, 2014). To be transparent, and articulate about personal biases and assumptions, a personal reflective process included questions exploring my interest in

clinical supervision. This revealed the strength of my enthusiasm for clinical supervision, due to personal positive experiences and the desire to see this work in what is perceived to be the most difficult of clinical environments for meaningful clinical supervision to become sustained. Other reflections included noting personal thoughts on potential assumptions on the outcomes of this study and being aware of these to enable the voice of the participants.

1.10 Chapter summary

To conclude this chapter, it is acknowledged that clinical supervision is of national and international research interest and features significantly in practice and policy involving mental health nursing around the word (White, 2018). There has, however, been a distinct lack of qualitative research in clinical supervision that involves HCA/SWs working within mental health inpatient settings (discussed further in chapter two). In addition, there is also little evidence of interpretative phenomenological analysis (IPA) used as a research method (discussed further in chapter three) to investigate the experience of clinical supervision and what this means specifically to HCA/SWs, the findings of such (discussed in chapter four), and potential implications and impact for the future (discussed in chapter five). This study has taken this opportunity to address this gap in the research in this area.

Chapter Two: literature review

2.1 Introduction

This chapter presents the results of a systematic review which also served to inform the empirical study (chapter 4). The review, along with the study, are set within the qualitative paradigm and aimed to review systematically, both national and international, qualitative studies.

2.2 Rationale and justification of the review

In considering the focus for this review an initial scoping exercise was performed to gain a broad perspective of the literature available on qualitative studies involving the experiences and perspectives of mental health nursing staff and HCA/SWs on clinical supervision within mental health settings. To assist this, the SPIDER search strategy (discussed in the search strategy at 2.4.2) was adopted (Cooke et al., 2012). Following this scoping exercise, two key issues were considered: The volume of qualitative literature available on the many aspects of clinical supervision (models, methods of implementation etc.) and qualitative literature involving clinical supervision within inpatient mental health settings and the HCA/SW.

Several studies had been conducted since the mid 1990's on aspects of clinical supervision involving nursing. These included broader components such as models. There were also several substantive international literature reviews of clinical supervision involving nursing. For example, a literature survey of mixed methods studies from 2001 - 2007 was conducted by Butterworth et al. (2008). This was a thematic analysis involving 92 studies and found that clinical supervision may offer potential benefit to patient outcomes and that health care organisations need to develop and sustain clinical supervision. The study concludes

that further investigation of clinical supervision is needed in relation to patient safety, professional development, and enhanced clinical outcomes.

Moreover, a systematic review of empirical evaluations of clinical supervision, was appraised by Cutcliffe et al. (2018). They used a grading system to grade a total of 28 qualitative and quantitative studies conducted between 1995 and 2015. They concluded, as did Butterworth et al. (2008), that a further investigation of clinical supervision was needed due to a lack of a competency-based framework for clinical supervision and clinical supervision was poorly defined.

An integrative review conducted by Howard and Eddy-Imishue (2020) explored factors influencing effective clinical supervision for inpatient mental health nurses and its impact on personal development. A thematic analysis was applied to 14 studies using qualitative, quantitative, and mixed methods designs conducted between 1997- 2017. The review concluded a lack of attention and investigation given to inpatient mental health settings and different forms of clinical supervision were required.

A scoping review of peer-reviewed research explored the barriers and facilitators to nurses accessing clinical supervision within organizations and skills required to facilitate clinical supervision (Mashama et al., 2022). The authors applied a qualitative data analysis to 87 papers of mixed designs with five themes identified as barriers, including definitions, trust, alternative forums, costs, and skills. The review concluded that these persistent barriers to clinical supervision must be addressed if clinical supervision is to be successfully implemented.

In addition to these barriers, a rapid evidence review involving a systematic search of barriers and enablers to clinical supervision was conducted by Rothwell et al. (2021). This

review examined 135 papers from 2009 – 2019 and examined the data using thematic qualitative synthesis. Papers were qualitative, quantitative, and mixed methods in design. The review concluded that the effectiveness of clinical supervision was dependent upon a shared understanding of its purpose, access to a range of types of supervision and training for supervisors.

The scoping exercise also suggested a limited focus on studies of clinical supervision specifically within inpatient mental health settings. This is particularly so when compared to community mental health settings. This is not just exclusive to the UK but a feature internationally (Howard & Eddy-Imishue, 2020; Masamha et al., 2022; Long et al., 2014; Carthy et al., 2012). This may be explained by global mental health policy over the past 30 years. This policy has been focused on the move from inpatient settings to specialist community provision (McDaid & Thornicroft, 2005; Royal College Psychiatry, 2011). Despite the lack of research, inpatient mental health settings, nationally and internationally, also appeared to have unique and specific problems, with the implementation of clinical supervision (Roche et al., 2015; Cleary & Freeman; 2005). The problems included a limited focus on the HCA/SW experience (no studies could be found solely involving HCA/SWs experience) of clinical supervision within inpatient mental health settings involving qualitative methods, as only half the total sample size on studies found, consisted of HCA/SWs (Buss et al., 2018; Buss et al., 2011; Cleary & Freeman; 2005).

Consequently, a decision was made to conduct a systematic review with a specific focus on understanding the experience of clinical supervision from the inpatient HCA/SW and/or mental health nurse perspective, within the literature available, given there were not enough studies available to support a review purely on HCA/SWs. Moreover, to maintain

the richness of human interpretation of experience, only qualitative studies were included, to enable participants' voices of their experience to be heard (Burr, 2015; Creswell, 2013; Ludvigsen et al; 2015).

This review may be considered timely given the rise of new roles for HCA/SWs to consider, such as, nursing associates and nursing apprentices and the potential impact of clinical supervision on these roles (NHS, 2019). Internationally a similar empowerment of the HCA/SW has also been suggested (Travers et al., 2020). To develop an understanding of the HCA/SW experience of clinical supervision within mental health inpatient settings, and what it means to them, a qualitative literature review of the existing studies was considered necessary.

2.3 Aim

The aim of this systematic review was to synthesise qualitative empirical studies of mental health nurses and HCA/SWs perspectives and experiences of their clinical supervision within mental health inpatient settings. The research question formulated utilised the SPIDER search strategy components (**S**ample, **P**henomenon of **I**nterest, **D**esign, **E**valuation and **R**esearch type) (Cooke et al., 2012). The justification for using the SPIDER search strategy was utilised due to its sensitivity and specificity for searches (Methley et al., 2014) and clarity to assist in the formulation of questions. It is also considered more appropriate for qualitative research (Cooke et al., 2012).

The review question was *'How do health care assistants/ support workers and mental health nurses, within mental health inpatient settings, understand clinical supervision in the context of their practice?'*

2.4 Methods

For this review the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) framework was utilised (Moher et al., 2009). This framework moves through identification, screening, eligibility, and inclusion and provides transparency for each stage of the review.

2.4.1 Search Strategy

To assist the production of a systematic, replicable search, a consultation with an academic librarian took place initially. A systematic literature search was conducted using the following databases: CINHAL, PsycINFO, PubMed, EMBASE, MEDLINE, Scopus and Discover More. These databases were chosen due to their association with nursing and health care research. No date exclusions were applied.

The database search utilised a combination of terms relating to the aims of the review, including 'wildcards' represented by **(?)** or truncations to words represented by **(*)** or **($)** which enable part of a word and other similar words, various spellings and plurals (psychiart***** = 'psychiatrist' **and** 'psychiatry'). Boolean operators such as '**AND**' '**OR**' and '**NOT**' were also used to combine key words and free text words. The search terms included: 'inpatient Setting' **OR** 'Psychiatric Ward' **OR** 'Inpatient services' **OR** 'Mental Health Setting' **AND** 'Mental Health Nurse' **OR** 'Psychiatric Nurse' **OR** Mental Health Professional' **OR** 'Health Care Assistant' **OR** 'Non-Registered Nurse' **OR** 'Support Worker' **OR** 'Support Staff' **NOT** 'Students' 'Clinical Supervision' **OR** 'Reflective Supervision' **OR** 'Professional Supervision' **AND** 'Factors' **OR** 'Obstacles' **OR** 'Barriers' **OR** 'Limitation' **OR** 'Facillitat*****' **OR**

'Promot*****' **OR** Enhance **AND** 'Qualitative' **OR** 'Perceptions' **OR** 'Attitudes' **OR** 'Experience' **OR** 'Lived Experience' **OR** 'View' **OR** 'Interpretative Phenomenological Analysis (IPA)' **OR** 'Phenomenology' **OR** 'Grounded Theory' **OR** 'Interviews' **OR** 'Perspectives' **NOT** 'Randomised Control Trial'

Evidence suggests that locating qualitative literature by electronic database searches alone can risk relevant studies being missed (Ring et al., 2011). Therefore, other strategies were also utilised such as manually searching and citation pearl-growing, in which within a relevant article, which meets the criteria (pearl), free text terms and reference lists from included studies were also searched. The searching of key journals such as '*The Clinical Supervisor', 'Journal of Psychiatric and Mental Health Nursing', 'International Journal of Mental Health'* etc. were also considered to be appropriate in this context. Additional systematic searches took place in grey literature such as NICE Guidelines and NHS Evidence to ensure that a reference to a potential study would not be missed, although grey literature itself did not meet the inclusion criteria. The search results were imported to Refworks (a reference management software) to assist with the elimination of any duplicate studies. Two searches were performed to keep the review relevant. The first search took place in May 2018 with the second one covering the period from May 2018 to July 2023. The same procedures as described above were followed for both searches (appendix I).

2.4.2 Inclusion and Exclusion Criteria

The inclusion and exclusion criteria were based on the research question's aims and objectives. The criteria were also influenced by the components of the SPIDER research tool. (Sample, Phenomenon of interest, Design, Evaluation, Research type).

Inclusion Criteria

- Studies which included HCA/SWs and nursing staff receiving or having received clinical supervision and who were based on inpatient mental health settings. Studies which included staff on inpatient mental health settings and other settings also included (Sample).
- Studies which explored the experiences, perceptions and perspectives on HCA/SWs and nurses and the impact of clinical supervision on them within inpatient mental health settings (Phenomenon of interest).
- Studies which included qualitative methods of data collection including interviews and focus groups and qualitative methods of analysis using interpretive forms of data analysis, including grounded theory, ethnographic and phenomenological analytical methods (Design).
- Qualitative studies. Mixed method designs were considered where qualitative data could be isolated and analysed (Design).
- Studies where half or more of the total participants in the study were mental health nurses (including HCA/SWs) (Sample).
- Studies where half or more of the total participants (as identified above) in the study were based within mental health inpatient settings (Sample).
- Published peer reviewed studies (including any peer reviewed studies referenced from the grey literature).
- English Language articles in peer reviewed publications were considered. It was not within the scope of the review to provide translation of other languages into English.

Exclusion Criteria

- Studies where mental health nursing staff and/or HCA/SWs were excluded.
- Studies where mental health nursing staff and/or HCA/SWs had never received clinical supervision.
- Studies that did not include any staff from inpatient mental health settings (Sample).
- Studies which did not explore the experiences, perceptions and perspectives on HCASWs and nurses and the impact of clinical supervision on them within inpatient mental health settings (Phenomenon of interest).
- Quantitative studies, editorial, opinion pieces, and conference papers (Design).
- Studies utilising quantitative methods and mixed methods studies where the qualitative data could not be separated. (Design).

2.4.3 Appraisal of quality

The critical assessment of quality in qualitative research can be viewed as a contested area with limited consensus on how this may be achieved (Thomas & Harden, 2008). To compound this, utilising criteria for appraisal can be subject to bias as the application of such criteria by different reviewers to the same study, can produce different results (Sandelowski & Barroso, 2002). Moreover, it has been argued that quality assessment for qualitative reviews should not be done on the same basis as for quantitative papers and instead has developed a focus on contextual value and trustworthiness (Burls, 2015).

Critical appraisal, however, can provide a useful focus to ensure the quality of qualitative research, providing the checklist is appropriate. For this review, the Critical Appraisal Skills Programme (CASP) (Critical Appraisal Skills Programme, 2013; 2018) appraisal checklist tool

was applied. Justification for the use of the CASP was its ease of implementation and facilitation of assessment on issues such as trustworthiness and relevance of published papers (Jones, 2006).

The CASP covers 10 items, consisting of two initial screening questions followed by eight further detailed questions on the research design, data collection, ethics, analysis, implications and reflexivity (appendix II). This tool is well established and can be applied to many qualitative research methodologies (Long et al., 2020). While providing a numerical assessment of quality can be controversial, such an approach, using the CASP, has been developed. For example, Duggleby et al. (2010) applied a method of quantifying comments from the CASP to obtain an overall score for quality. A three-point rating was applied to eight CASP questions (excluding the two screening questions) to produce a CASP score range of 0-24 with higher scores indicating higher quality. This process was also utilised in this review for each study. The details for the CASP assessment and score criteria applied to the final review studies are outlined in table 1. Following the use of the CASP and the numerical ratings (Duggleby et al., 2010), all studies passed the initial screening questions. The CASP scores awarded ranged from 22 (Gardner et al., 2010) to 18 (Begat & Severinsson, 2001).

There is, of course, an acknowledged risk of inherent subjectivity, so an experienced reviewer cross checked three (20%) of the studies and agreed with the ratings of the initial reviewer (myself). As all studies passed the initial screening questions, no study was considered for exclusion based on quality (Bondas & Hall, 2007).

Table 1 *Assessment of quality of the studies using the CASP*

Study Number	Studies Included in the review	CASP Question										
		1	2	3	4	5	6	7	8	9	10	CASP Score
1	Arvidsson *et al* (2001)	✓	✓	✓	?	✓	?	x	✓	✓	✓	20
2	Begat & Severinsson (2001)	✓	✓	✓	✓	?	✓	?	✓	✓	?	21
3	Berg & Hallberg (2000)	✓	✓	?	?	✓	✓	?	✓	✓	?	20
4	Buss *et al* (2011)	✓	✓	?	✓	?	?	?	✓	✓	?	19
5	Buss *et al* (2018)	✓	✓	✓	?	✓	?	✓	✓	✓	?	21
6	Cleary & Freeman (2005)	✓	✓	?	?	✓	?	✓	✓	✓	?	20
7	Gardner *et al* (2010)	✓	✓	?	?	?	X	✓	?	?	?	16
8	Hyrakas & Paunonen-Ilmonen (2001)	✓	✓	✓	?	✓	?	x	✓	✓	?	19
9	McCarron *et al* (2018)	✓	✓	✓	✓	?	✓	✓	?	?	?	20
10	Olofsson (2005)	✓	✓	✓	?	?	?	x	?	✓	✓	18
11	Scanlon & Weir (1997)	✓	✓	✓	?	✓	?	x	✓	✓	?	19
12	Hamilton et al (2023)	✓	✓	✓	?	?	?	✓	?	✓	✓	20
13	Thomas & Isobel (2019)	✓	✓	?	?	✓	?	?	?	✓	✓	19

Key for CASP score (Based on Duggleby et al. (2010).
Yes (✓) Strong 3 marks: Extensively justified and explained issue at hand
Cannot tell (?) Moderate 2 Marks: Addressed the issue but did not fully elaborate justification using comparisons. Procedure not fully explained.
No (×) Weak 1 Mark: Little or no justification.

2.5 Data synthesis using thematic synthesis

In recent times, several methods have been developed to synthesise qualitative research findings. Barnett-Page and Thomas (2009) suggest that there is a need for researchers to select the most appropriate method for their topic. For this review, thematic synthesis (Thomas & Harden, 2008) was used. Thematic synthesis has been used in reviews with similar aims (e.g., Nowell et al., 2017) and used in other qualitative reviews examining individuals' views and experiences (e.g., Morton et al., 2010; Thomas & Harden, 2008).

Thematic synthesis is now an established method for synthesising qualitative studies (Ryan et al., 2018) and was selected as overlapping and divergent themes can be abstracted across studies, which can enlighten interpretation beyond the original analysis (Thomas & Harden, 2008).

Meta-ethnography (Noblit & Hare, 1988) contains some similarities to thematic synthesis. It is an interpretative approach to synthesis which aims to generate new theory and understanding by bringing together primary qualitative research to contribute to new, higher order constructs (Flemming & Noyes, 2021). This was considered as an alternative approach to thematic synthesis, however, meta-ethnography presents a complex methodology and synthesis process to provide translation towards theory development and may require greater methodological experience (Atkins et al., 2008; Flemming & Noyes, 2021). Thematic synthesis, therefore, was selected for its accessible form of synthesis, clarity and transparency and it enabled synthesis of the studies without specific focus on the concepts involved in translation found in the synthesis processes of meta-ethnography.

2.5.1 Conducting data synthesis using thematic synthesis

Three stages of conducting thematic synthesis were followed based on Thomas and Harden (2008). The first stage involved reading and re-reading each line from the results and other sections of the identified studies, including all the themes generated by the authors, direct participant quotations and the authors' interpretations. This enabled a line-by-line coding which was achieved by salient points being simultaneously noted and codes developed. The coding was conducted by the researcher (first reviewer) and discussed with a second reviewer which enabled further reflection. Each study was coded and new codes added as

necessary. Thomas and Harden (2008) refer to this task as a translation of concepts from one study to another. This first stage of the process is outlined in a stage one code development table (appendix III). In the second stage, codes and overlapping codes, were identified and compared from the original findings across all the studies. Similarities and differences were examined to group them into a structure and resulted in eight descriptive themes. This process is outlined in appendix IV.

The third stage has been described as the most difficult and controversial as it is dependent upon the judgement and insight of the reviewer and aims to 'go beyond' the findings of the studies to generate additional concepts and understanding (Thomas & Harden, 2008). To facilitate this stage the descriptive themes that had emerged from stage two were used to explore how to answer the review question. The first reviewer in this review made inferences on obstacles, facilitators, and interventions on clinical supervision within inpatient settings from the views of the participants in the studies. Studies which also referred to theory as part of their discussion were also discussed. These were reflected upon and checked with the second reviewer and four analytical themes began to emerge. Each change that was made to the analytical themes was reflected upon and recorded in a reflexive diary by the first reviewer and then checked again with the second reviewer. This was repeated until each analytical theme was able to address sufficiently the descriptive themes, inferences and the salient points of the review question and therefore moving beyond the synthesis at stage two which was still close to the original findings (Thomas & Harden, 2008) (appendix V).

2.6 Reflexivity

The influence from the researcher on the review process can present several problems (Palaganas et al., 2017). Previous experience of being a clinical supervisor and supervisee had the potential to influence the review in terms of selection, analysis, and interpretation of the studies. To limit the impact of the threat, a reflexive diary was maintained and contained prompts for entries to allow for biases and assumptions. The prompts included questions on similarity of the studies to personal experience which would increase awareness of potential influences. Discussions around such points with doctoral colleagues and during PhD supervision assisted the reflective process (appendix VI).

2.7 Findings

2.7.1 Study Selection

The first literature search (conducted in May 2018) searched literature available from 1995 up until May 2018. Clinical supervision became more established within nursing nationally and internationally from the mid-1990s (Milne, 2008). This search yielded a total of 968 articles from the databases and other sources. Once duplicates were removed from the first search, this total became 488. All the titles and abstracts from the 488 articles in the first search were screened, which left 28 to be assessed by full text scrutiny for eligibility. For several reasons, 17 articles were excluded, resulting in 11 articles which were included in the final review. Figure 1 identifies the PRISMA flow chart for this search process. The two reviewers identified earlier reviewed all 11 articles in the final review for suitability and meeting the inclusion and exclusion criteria.

In the second search (conducted in July 2023) literature was searched from the point where the first study ended (May 2018) and searched up to July 2023. A total of 936 articles were yielded from the databases and other sources. Following the removal of duplicates this total became 914. All titles and abstracts were screened, which left 13 to be fully assessed for eligibility. From the 13 articles, 11 were excluded for several reasons resulting in 2 articles included in the final review. The same two reviewers as identified earlier reviewed the 13 articles including the two which were included in the final review. Figure 2 identifies the PRISMA flow chart for this search.

2.7.2 Study characteristics

In the first search the final review included 11 studies which were conducted in 5 different countries: Sweden (*n*= 4), Denmark (*n* = 2), Australia (*n* = 2), UK (*n* = 2), and Finland (*n* = 1). These were published between 1997 and 2018. The design of the studies were qualitative, although two studies utilised a mixed methods approach (Berg & Hallberg., 2000; McCarron, et al., 2018). All the studies were conducted within inpatient settings, although the study by Scanlon and Weir (1997), contained four participants out of a total of ten (40%) who were registered mental health nurses working in a community setting. All studies included at least 50% or more staff from inpatient / residential mental health settings, including HCA/SWs. All studies are detailed in table 2.

The second search added two studies, both conducted in Australia and published between 2019 and 2023. Both these studies utilised a mixed methods approach, both utilised inpatient mental health settings and included HCA/SWs.

Figure 1 *The First search conducted in 2018. PRISMA flow chart of selection process (Taken from Jakimowicz, S., Stirling, C. & Duddle, M, 2015).*

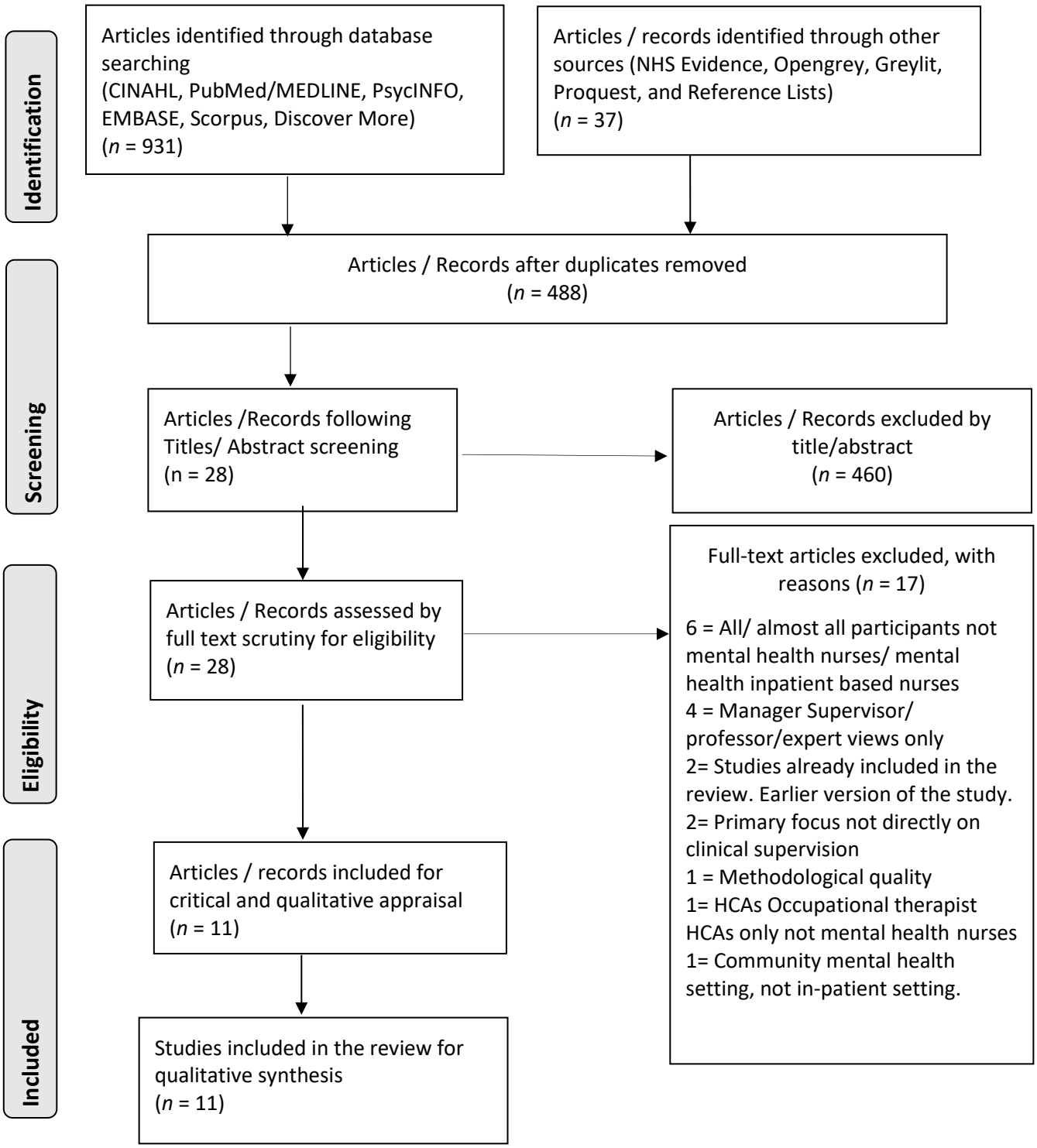

Figure 2 *Second search conducted in 2023. PRISMA flow chart of selection process (Taken from Jakimowicz, S., Stirling, C. & Duddle, M, 2015).*

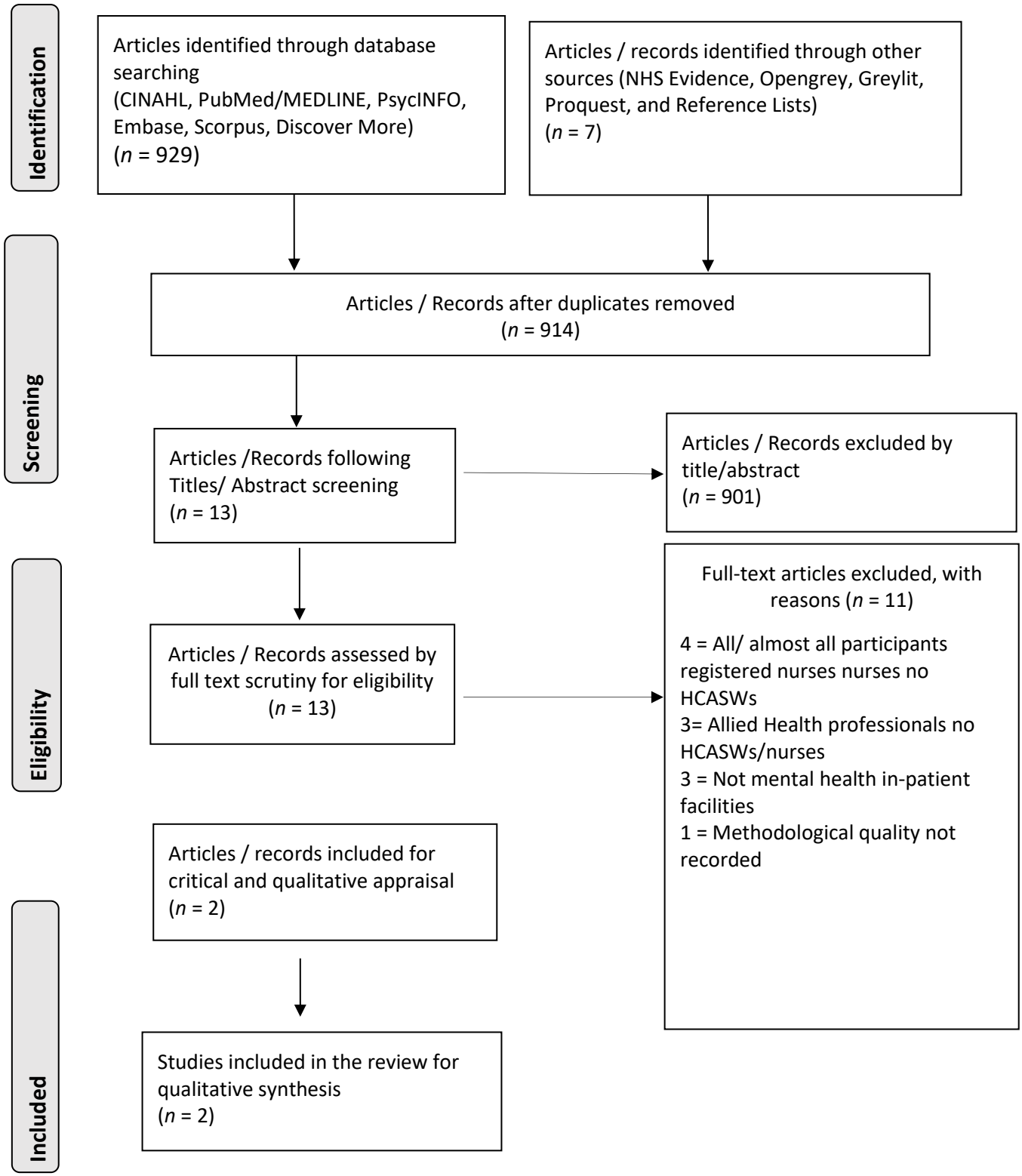

Table 2 *A summary of the Studies Included in the review*

Study	Author(s)	Country of study	Study Aim(s) / Question(s)	Sample	Methods Design	Methods Data Collection	Analysis	CASP Score
1	Arvidsson *et al* (2001)	Sweden	Psychiatric nurses' conceptions of how a 2-year group supervision programme within nursing care had influenced professional competence.	10 mental health nurses, who had all participated in group supervision in nursing care programme. All worked in mental health in-patient settings in Sweden.	Qualitative Phenomenography	Semi-structured interviews	Phenomenography analysis	20
2	Begat & Severinsson (2001)	Sweden	To investigate nurses' reflections and interpretations regarding their provision of care.	46 nurses (from 8 clinical supervision groups equally from medical and psychiatric in-patient settings in Sweden). All nurses had 1.5-hour group clinical supervision each week.	Qualitative Descriptive exploratory design	Open ended unstructured interviews. Collected through personal interviews during the clinical supervision session. Narrated experiences of practice.	A four-stage hermeneutic analysis	21
3	Berg & Hallberg (2000)	Sweden	Understand the meaning and significance of the psychiatric nurses' lived experience of systematic group clinical supervision combined with supervised individually planned nursing care.	22 nurses (10 registered nurses (mental health), 10 licenced mental health practice nurses, 1 licenced practice nurse and 1 nursing aide). All worked in mental health in-patient settings in Sweden.	A pre- to post-test study design. Investigation of clinical supervision combined with documented, planned and individualised care.	Semi-structured interviews	Interpretive analysis	20

4	Buss *et al* (2011)	Denmark	Psychiatric Hospital nursing staff reflections on participating in clinical supervision.	22 nursing staff members (11 Registered Nurses, 11 Health Care Assistants). Experience of group clinical supervision In-patient psychiatric setting in Denmark	Qualitative interview study design exploring inpatient mental health nurses' reflections on their participation in clinical supervision.	Semi-structured interviews	Interpretive analysis involving Ricoeur's hermeneutic method	19
5	Buss *et al* (2018)	Denmark	Examine the resistance of clinical supervision by exploring perspectives on clinical supervision of mental health staff members who did not participate in group clinical supervision.	24 staff (10 registered nurses, 13 health care assistants and 1 occupational therapist). All worked in mental health in-patient settings in Denmark.	Qualitative interview study design	Semi-structured interviews	Discourse analysis, to develop themes. Open coding identified views of clinical supervision, constructing themes and sub-themes. Theme content warranted attention in this study	21
6	Cleary & Freeman (2005)	Australia	Explore nurses; perceptions of professional attitudes and support to gain a better understanding of the cultural realities of clinical supervision in acute in-patient mental health settings.	10 nurses all based in acute mental health in-patient settings in Australia.	Qualitative. Ethnographic approach design.	Observation of practices and work of nurses. Discussion groups, Field notes and Face to face interviews.	Ethnographic analysis. Four cognitive processes (comprehending, synthesising, theorising and re-contextualising) following Morse (1994).	20
7	Gardner *et al* (2010)	Australia	Explore the concept of 'superficial supervision'	15 mental health nursing staff based in mental	Qualitative. Grounded Theory Approach	Semi-structured interviews	Constant comparative	16

				health in-patient settings in Australia			analysis. Constructivist grounded theory	
8	Hyrkas & Paunonen-Ilmonen (2001)	Finland	The effects of clinical supervision on the quality of care. Measuring the impact upon quality of team supervision within a hospital organisation	5 clinical supervision teams based on 5 wards. 82 practitioners in total. These included 23 specialised nurses, 19 other nurses, 14 assistant nurses and 10 other auxiliary staff. Of the initial 82 total, 62 staff were interviewed.	Qualitative Phenomenographic research design	Semi-structured group interviews	Phenomenology using a phenomenographic method.	19
9	McCarron *et al* (2018)	United Kingdom	The experience of clinical supervision for nurses and health care assistants in a secure mental health adolescent service. Experience of access and perceptions of clinical supervision for both nurses and HCASWs. Identifying any consequences of inadequate clinical supervision.	92 bed inpatient mental health facility. Study involved 64 registered nurses and 131 HCASWs.	Qualitative. Grounded Theory Approach	2016 survey of registered nurses and HCASWs. Comparison following a previous survey. Descriptive open questionnaire for all	Mixed methods approach. Questionnaire utilised a grounded theory approach	20
10	Olofsson (2005)	Sweden	Describe nurses' experiences of participating in reflection groups focused on the use of coercion, as	21 nursing staff members (14 from acute mental health and 7 from elderly mental health. 7 were registered nurses (mental	Qualitative Reflective group design	Structured interviews	Content analysis	18

			related to their views of systematic supervision and staff support.	health), 14 enrolled (mental health) nurses. All worked in mental health in-patient settings in Sweden.				
11	Scanlon & Weir (1997)	United Kingdom	To what extent do mental health nurses experience clinical supervision as helpful? What are the hindrances to effective clinical supervision? How might the provision of effective clinical supervision be further developed?	10 Nursing Staff (4 in-patient ward registered nurses, 2 in-patient residential nurses, 4 community registered nurses) in the UK	Qualitative Constant comparative design associated with grounded theory	Semi-structured Interviews to address experiences of CS	Constant comparative analysis. Grounded Theory	19
12	Hamilton *et al* (2023)	Australia	The impact of clinical supervision on practice using a model (*Safe wards*) of care delivery.	3 wards based within one inpatient mental health unit. Study involved 84 nursing staff including registered nurses, enrolled nurses and clinical nurses.	A sequential mixed method explanatory study Qualitative design element of the study included interpretative phenomenological analysis (IPA) approach.	Manchester Clinical Supervision Scale and semi structured interviews with 8 staff interviewed, 5 of which were clinical nurses.	Semi-structured interviews used an interpretative phenomenological analysis (IPA) approach.	20
13	Thomas & Isobel (2019)	Australia	Evaluation of reflective practice groups for nurses within a mental health inpatient setting.	Adult mental health inpatient setting. Study involved running 12 reflective practice clinical supervision groups over 12 sessions. These were open to any 'front line' staff. Any staff who had attended the sessions were asked to complete	A concurrent mixed methods evaluation using thematic qualitative analytical techniques of open coding, creating categories and themes	Descriptive evaluation questionnaires and semi-structured interviews.	Thematic analysis used for semi-structured interviews.	19

				an evaluation questionnaire. A total of 91 completed. Open invitation for a semi structured interview for all who attended the sessions. 4 staff Participated				

2.8 Theory

For each of the studies included in this review, the use of theory varied. Several studies did use existing theories to explore their findings or inform them. Existing theories were also used in the discussion of these studies usually to provide context to the discussion of findings and to articulate a point. These included drawing upon reflection theory (Schön, 1983) in the studies by Begat and Severinsson (2001) and Scanlon and Weir (1997). Reflection theory (Johns, 1995) was also identified by Olofsson (2005). Resistance theory (Hollander & Einwohner, 2004) was drawn upon by Buss et al. (2018), systems and change theory (Watzlawick et al., 1967) drawn upon by Berg and Hallberg (2009) and boundary theory (Collins, 1989) drawn upon by Gardner et al. (2010).

2.9 Analytical thematic synthesis

The analytical themes emerged as a result of the three stages of the thematic synthesis discussed earlier in 2.4.6. The four analytical themes emerged from eight descriptive themes in the process (appendix V).

2.9.1 Theme one: Clinical supervision facilitating personal development of competence and confidence

In this theme, participants appeared to understand their experience of clinical supervision in the context of facilitating their personal development. There appeared to be several components to developing competence and this was the most prominent discussion in all included studies. There was a consensus in almost all the studies that participants attributed

clinical supervision to their increased competence through the development of professional qualities which, in turn, developed confidence.

The components of competence were reflected in several studies (Arvidsson et al., 2001; Begat & Severinsson, 2001; Berg & Hallberg, 2009; Cleary & Freeman, 2005; Hamilton et al., 2023) which identified developing knowledge, insight, and a deeper understanding of care delivery. An example of this was expressed by a participant (informant 3) in Arvidsson et al. (2001):

> *"Theoretical knowledge puts words to what one has done... One takes one day after the other and sometimes sees results, but not always, but actually clarifying what method I am using, how I work and what makes people better or worse, those are things that are not highlighted in the daily work. That's what one does in supervision."* (Arvidsson et al., 2001, p. 165).

This example captures how knowledge in clinical supervision develops over time. It also suggests how competence grows by clarifying practice which appears to be part of increasing self-awareness. None of these aspects appeared to be referred to as part of clinical duties on a day-to-day basis.

Competence, self-awareness, and confidence featured considerably in the studies and the construction of this theme (Arvidsson et al., 2001; Cleary & Freeman, 2005; Hamilton et al., 2023; Olofsson, 2005; Scanlon & Weir, 1997). These aspects related to quality improvements in care delivery through knowledge acquisition, both shared knowledge and theoretical knowledge and the effects of this on change and the implementation of change (Hyraks & Paunonen-Ilmonen, 2001). Developing a skill through clinical supervision over

time, appeared to develop more reflective thinking on practice, as explained by this participant in Hamilton et al. (2023):

> *"…it [clinical supervision] can help you structure your conversation with (patients), to get the most out of it, so that you keep that rapport...it's just slowly got better with time, just by a kind of feeling, building, that confidence that it works by a sense of seeing 'oh that actually went better than I thought' makes me feel less anxious about dealing with those scenarios (in the future)"* (Interview 2, Hamilton et al., 2023, p. 808).

The influence of reflective practice was a feature in all studies. The HCA participants particularly appeared to value the opportunity to reflect (McCarron et al., 2018; Olofsson, 2005; Thomas & Isobel, 2019). Moreover, the influence of reflective practice was also considered as a prerequisite for the development and sustainability of clinical supervision and possibly as an alternative (Thomas & Isobel, 2019). This suggestion is illustrated in a participant's comments from the study by Thomas and Isobel (2019) below.

> *"…it's also a really good stepping stone…I mean there's heaps of people that I know who cringe at clinical supervision. So, if there is an offer of something like a reflective practice group then they suddenly have this realisation that this is really awesome, then they might want to take that actual step…."* (Thomas & Isobel, 2019, p. 156-157).

Additionally, when the influence of reflection is experienced by participants, it appeared enlightening and unexpected for some as the quotation from participant two from Olofsson (2005):

"…we talked about old incidents, both of us had the same experiences, which we had not talked about before, it was good to talk about it" (Olofsson, 2005, p263).

This comment appears to suggest that opportunities to reflect and / or develop reflective practice may be limited. However, content of clinical supervision sessions identified within the studies, appeared varied. Although this theme draws upon examples that facilitate development, this facilitation frequently coexisted with the concept of support enabling development. Support appeared to be interpreted in different ways with several examples involving people, behaviours, and events across all studies. Despite the different interpretations and examples, support, appeared to be a catalyst in all aspects of development in all the studies.

2.9.2 Theme two: Calibrating the characteristics of a good clinical supervisor

This theme examined the importance of what was viewed by participants as positive specific supervisor characteristics that were considered vital for clinical supervision to be effective. Contributions to this theme came from the following studies: Berg and Hallberg (2000); Buss et al., (2011); Cleary and Freeman (2005); Olofsson (2005); Scanlon and Weir (1997); Thomas and Isobel (2019).

It was clear that, for many participants, a valued clinical supervisor was understood as being adequately trained, person-centred, supportive, clinically focused and who could facilitate reflection. Not having the qualities, outlined above, was also viewed as a barrier to effective clinical supervision (Olofsson, 2005; Scanlon & Weir, 1997). Having support and

understanding from a supervisor was considered important for providing a way forward in difficult situations as illustrated by a participant in this example in Berg and Hallberg (2000):

> *"We had a patient, who used to spit on the walls a lot, but then the supervisor told us how to treat the patient and after a time he suddenly stopped spitting. We treated him in a different way. We didn't go in and tell him he shouldn't spit. Instead, we asked him why he did it and we told him we knew he wanted to tell us something by behaving like that"* (Berg & Hallberg, 2000, p. 120).

A valued supervisor also appeared to have the qualities to act as a source of guidance and inspiration to some supervisees possibly due to their style of facilitation and ability to build trust. This was reflected in this participant's comments in Scanlon and Weir (1997):

> *"…Basically, she sits and listens, she is there for me, if I get stuck she will bring out things and say to me had you thought of this… I am given the chance to explore the way I am functioning. It gives me a chance to talk about and to work through some of the difficulties that I am having about what is being said to me. So, I suppose there is an element of improving skills and my own competence, as well as getting support for the feelings that might come up…"* (Scanlon & Weir, 1997, p. 298).

The choice of supervisor was an important factor in ensuring a successful relationship and was discussed in several studies (Buss et al., 2011; Berg & Hallberg, 2000; Gardner et al., (2010); Olofsson, 2005; Scanlon & Weir, 1997). A supervisor taking the dual role of the participant's line manager as well as clinical supervisor was strongly objected to, as this was thought to compromise the supervisory relationship and likely to be seen as a barrier.

Some nurse participants had mixed opinions on a preference for the supervisor's background / discipline. Some nursing participants preferred individuals from their own discipline to be supervisor but were content with a supervisor from another discipline as a temporary arrangement. The comment from this participant summarises the situation in Scanlon and Weir (1997):

> *"… probably the best people to supervise mental health nurses would be other mental health nurses but we still need more of them and they'd have to be trained - in the meantime I think that it is unrealistic not to use counsellors from other sections of the helping profession… my supervisor at the moment is a psychotherapist and it's excellent"* (Scanlon & Weir, 1997, p. 300).

By contrast, one study finding (Olofsson, 2005) suggested a supervisor for nursing staff from a different discipline may be viewed as a way of gaining new perspectives.

This theme has synthesised what were considered positive supervisor characteristics. These characteristics appeared to depend upon competence, training, and ability of the supervisor, whatever their discipline.

2.9.3 Theme Three: Building unity and collaboration through team approaches to clinical supervision

This theme explored participants' perspectives of sense of unity and collaboration during clinical supervision which was valued in team approaches such as group clinical supervision. The findings for this theme were represented in all studies.

Group clinical supervision was mostly viewed as a collaborative, unifying process which offered the group an identity developed through relationships, and which facilitated trust. Two participants explain this point in Arvidsson et al. (2001):

> *"It's a feeling of belonging to the group... One does not look at them in the same way as before we were in supervision together. One sees much more the person behind the mask. One sees the immense warmth within people"* (Arvidsson et al., 2001, p. 167).

and

> *"One feels it when one meets the group and knows that we have something in common. It feels as if it is something we have and carry with us..."* (Arvidsson et al., 2001, p. 167).

In most studies (Arvidsson et al., 2001; Begat & Severinsson, 2001; Berg & Hallberg, 2000; Buus et al., 2011; Hamilton et al., 2023; McCarron et al., 2017; Olofsson, 2005; Thomas & Isobel, 2019) participants recognised group clinical supervision within inpatient mental health settings was also vital to unify the care delivery approach and pragmatic enough to manage the logistical challenges presented by inpatient settings. These studies presented findings that appeared to suggest that sharing information and problem solving together on clinical issues made approaches for effective and safer practice.

Collaboration within group clinical supervision appeared to bring with it a greater sense of courage to share knowledge, problem solve and contribute to, and make, decisions. (Arvidsson et al., 2001; Begat & Severinsson, 2001; Berg & Hallberg, 2000; Buus et al., 2011; Hamilton et al., 2023; Hyraks & Paunonen-Ilmonen, 2001; Thomas & Isobel, 2019).

Autonomy and conviction about decision-making appeared to grow and be accompanied by a sense of courage, as explained by this participant in Hyraks and Paunonen-Ilmonen (2001):

> *"Although we've always been able to discuss everything. These sessions helped us to express our views more freely. We acquired a certain courage to say what we think. If you compare, we've made decisions about certain lines of action and discussed these things before but now we make decisions and commit ourselves to a line of action. We plan things together*" (Hyraks & Paunonen-Ilmonen, 2001, p. 495).

The concept of better collaboration also appeared to form part of personal practice decision making. These decisions appeared to be more informed and rewarding. This was captured by a participant in Begat and Severinsson (2001):

> *"I have worked with a patient and it worked very well for her. The patient and I made a care plan and I handled all the contacts with the social workers and created a well-functioning co-operation, which has been very good for the patient. She feels much better and has hope for the future. In this case, I really felt that I had done something for the patient"* (Begat & Severinsson, 2001, p.75).

Although this theme has focused on the collaborative and unifying effects of group and team approaches to clinical supervision, this was within the context of a belief in almost all studies that group supervision was the only realistic method of delivery for inpatient settings. This view of group supervision, however, was not held by everyone and appeared to depend upon if the focus of the group was on personal issues or knowledge based reflective problem solving. A participant in the study by Olofosson (2005) reported the group approach feeling 'meaningless' and 'contrived'. This finding was also similar to the comments from several participants in the study by Buss et al. (2018), who stated they felt

'uncomfortable', 'out of control', 'stripped' and 'vulnerable' when the focus was on personal issues.

2.9.4 Theme Four: Systemic and procedural difficulties implementing clinical supervision

This theme summarised participants' views on systemic and procedural difficulties such as allocating appropriate time, delivery, priority for clinical supervision and the challenges of inpatient settings. These issues were represented in all the studies.

The challenges of inpatient settings were multifaceted and were considered unique. The challenges presented a sense of frustration and feelings of being torn as participants recognised the value of clinical supervision but the implementation of it was dependent upon issues such as the ward environment, planning, who was available to attend and / or deliver the sessions. Participants questioned priority for clinical supervision, consistency, quality and its sustainability (Arvidsson et al., 2001; Buss et al., 2018; Buus et al., 2011; Cleary & Freeman, 2005; Gardner et al., 2010; Hamilton et al., 2023; McCarron et al., 2018; Olofsson, 2005; Scanlon & Weir, 1997; Thomas & Isobel, 2019).

These challenges consolidated the issue of lack of time for clinical supervision. This appeared in all the studies with three exceptions (Begat & Severinsson, 2001; Berg & Hallberg, 2000; Gardener et al., 2010). In the context of lack of time, clinical supervision did not appear a priority, which led to cancellations and problems sustaining the process. These issues were reflected in the sense of frustration for many participants and were captured in the comments from participants in Thomas and Isobel (2019) and Buss et al. (2011):

> *"…time is always a problem…but there's just a huge problem with nurses handing over responsibility…and it wasn't just because it was reflective practice groups, it's just a common problem with all education and training"* (Thomas & Isobel, 2019, p. 156).

> *"Well, you are a little torn about it. I know with my head that it is very important we have supervision. You go and it's been healthy and you speak about it afterwards. You usually gain something, but if we are only four at work and everything is in flames, I start thinking we need to cancel. It is so annoying and you have been frustrated about it and think: 'That damn supervision"* (Buss *et al.*, 2011, p. 99).

Participants prioritised what care could be delivered in a limited timeframe and clinical supervision appeared to take a reduced priority. It was not explicitly clear why this happened but this situation created the tension of wanting to participate in supervision but being unable. No study, however, identified clinical supervision being prioritised or time protected as a regular feature.

Along with the issues of time and priority, participants also identified the lack of staffing in ward settings, which for some participants was also a risk to safety. These issues are illustrated by participants in the studies by Hamilton et al. (2023) and McCarron et al. (2018):

> *...it is hard to get off the ward sometimes, just because of lack of staff and lack of time to cover the ward.* (Hamilton et al., 2023, p. 813).

> *Staffing numbers is the main concern working with our patient group. The low numbers compromise our and the patients' safety.* (McCarron et al., 2018, p.149).

One participant in the study by Cleary and Freeman (2005) viewed time and staffing levels with such pessimism that they questioned the feasibility of safely delivering inpatient setting clinical supervision in a sentence:

> *In reality it just isn't feasible and doesn't work* (Cleary & Freeman, 2005, p. 498).

In one study the issue of staffing levels appeared to be experienced more acutely by HCAs. For example, McCarron et al. (2018) found that HCAs experienced more personal concerns, related to staffing levels, safety, and clinical duties. HCAs therefore, valued clinical supervision opportunities more than other staff. This study, however, also argued that organisations should be mindful of the need to provide clinical supervision for HCAs as well as registered nurses as provision for them lacked equity.

The findings in this theme suggested systemic and procedural issues were at the root of most obstacles to clinical supervision, risking the development of a culture where clinical supervision could not be considered as routinely standard.

2.10 Discussion

The aim of this review was to explore HCA/SW and mental health nurses' perspectives and experiences of clinical supervision within mental health inpatient settings. The review included 13 studies across five different countries. The analytical themes identified here are consistent with existing evidence across many research studies, using many types of methodological approaches involving clinical supervision and nursing. For example, the fact that clinical supervision offered much to a practitioner in terms of professional development, stress reduction and enhanced quality of care also accorded with systematic

reviews conducted by Cutcliffe et al. (2018), Howard and Eddy-Imishue (2020), Pollock et al. (2016), Rothwell et al. (2021) and Tullners et al. (2023). The themes suggest that clinical supervision is inherently a good initiative, however, several factors require further consideration.

The findings suggested participants valued personal development which associated clinical supervision as a positive experience. Participants discussed development through interpersonal and intrapersonal skills, which were both valued equally. Interpersonal skill development drew upon knowledge acquisition and problem solving which were commonly expressed in all studies. Reflective practice appeared to introduce more subtle cognitive skills and active listening which were underpinned with reflective theory and distinguished in the discussion of some studies (Begat & Severinsson, 2001; Olofsson, 2005; Scanlon & Weir, 1997; Thomas & Isobel, 2019). HCA/SWs do not usually receive training in areas such as reflective practice (Wallang & Ellis, 2017) which may suggest a reduced likelihood to engage in clinical supervision (Long et al., 2014). This was referred to in two of the studies (Gardener et al., 2010; McCarron et al., 2017) which suggested HCA/SWs did not gain the full benefit of clinical supervision consequently.

Participants identified increased self-awareness and self-esteem which appeared to develop a sense of safety and confidence. This finding appeared to accord with the systematic reviews conducted by Cutcliffe et al. (2018), Howard and Eddy-Imishue (2020), Pollock et al. (2016), Rothwell et al. (2021) and Tullners et al. (2023). As many HCA/SWs did not receive any training on developing self-awareness skills (Unison, 2016), it is possible that access to clinical supervision becomes even more imperative. Studies by Gardener et al. (2010) and

McCarron et al. (2017) and an evaluative descriptive study by Tuck et al. (2017) all used predominantly HCA/SWs as participants and reflected this point.

The findings also emphasised how the positive experiences of clinical supervision were accentuated further when the supervisor facilitated trust in relationships. This appeared to bring a supervision group together but was problematic if this could not be achieved (Buss et al., 2011; Kovic & McMahon, 2023; Saxby et al., 2015; Tulleners et al., 2023). This appears to be consistent within inpatient settings as there are many logistical issues such as shift patterns and environmental unpredictability (Hamilton et al., 2023; McCarron et al., 2017; Roche et al., 2011). While the reviewed literature identified the positive qualities of the supervisor, it was unclear who this should be. Nursing, as a profession, appears to view clinical supervision as a hierarchical process which on inpatient settings maybe seen as a necessity to assist with the logistics of implementation (Cleary & Freeman, 2005). This does, however, have implications for the supervisor relationship (Olofsson, 2005; White & Winstanley, 2021). Some participants, from some of the studies, identified their supervisor as also their line manager. For many participants this was unsatisfactory and influenced their perception of the supervision process as less effective (Buss et al., 2018), with issues of trust, understanding the process and a superficial approach to delivery identified (Gardener et al. 2010; Scanlon & Weir, 1997). A clinical supervisor as a line manager has also been discouraged in different examples of guidance on implementing clinical supervision (e.g., Bond & Holland, 2011; Scaife, 2019) and viewed as a barrier in systematic reviews on clinical supervision (Rothwell et al., 2021; Snowdon et al., 2020). None of the studies reviewed offered a solution to this issue.

A further finding which made the experience of clinical supervision positive was the sense of unity and collaboration in group / team approaches to clinical supervision. Unity appeared to give a sense of identity to the group which revealed a collective strength in the supervisory relationship. This aspect appeared to contribute to changes in the dynamics of the supervisory relationship, building trust and cohesion. This aligned with the findings in a systematic review (Tullners et al., 2023), an integrative review (Howard & Eddy-Imisue, 2020) and a descriptive analysis survey study (Fakalata & St Martin, 2020). Group supervision also offered a type of informal peer support which, for some participants, extended beyond the supervision sessions (Cleary & Freeman, 2005). This finding was also identified in studies by Whitehead et al. (2013) and Cleary and Freeman (2005) who suggest that this approach of reflective peer support may be useful for newly qualified staff to build confidence and self-esteem. While these findings suggest this approach is valued, questions remain if this approach can address the more formalised components of clinical supervision with its sense of objectivity.

It is possible that the dynamics of group clinical supervision may provide a greater sense of democracy, sharing and the power that comes from sharing experiences without any fear of feeling judged (Tulleners et al., 2021). The findings from the participants in this review also discussed how group supervision developed the courage to challenge practice assumptions and ask questions; moreover, sharing with other participants with similar experiences appeared to reduce professional isolation (Lakeman & Glasgow, 2009). The sharing of experiences within group supervision, to arrive at a sense of collaboration and unity, appears to need commitment to the process and to the membership of the group which suggests that a concerted effort must be made for supervision to be sustained (Gardener et al., 2010; Scanlon & Weir, 1997; Tulleners et al., 2023). These findings identify with the

theory of psychological safety proposed by Edmondson (1999). Edmondson suggests that psychological safety describes individual's perceptions of the consequences of taking risks with interpersonal skills in contexts such as a workplace. Edmondson and Lei (2014) add that psychological safety explains why information and knowledge is shared between employees as trust and confidence is developed for an organisation's improvement.

In all studies reviewed, the sustainability of clinical supervision appeared to depend on overcoming several organisational issues identified as obstacles. Some of these were logistical such as time, priority and workload. Other issues were resource related, such as staff availability. Many of the obstacles appeared to be constant over time as they were identified in the oldest (Scanlon & Weir, 1997) and most recent study (Hamilton et al., 2023). These findings are also consistent with an integrative review by Howard and Eddy-Imishue (2020) and systematic reviews conducted by Cutcliffe et al. (2018), Pollock et al. (2016), Rothwell et al. (2021) and Tullners et al. (2023).

The Cleary and Freeman (2005) study suggests that traditional nursing culture has been viewed as one that does not seek formal support and maybe somewhat confused in the interpretation and implementation of clinical supervision as a process. For example, while organisations recognise the process has much potential, it also appears to be perceived as a dispensable non-necessity, possibly due to unfamiliarity with the process resulting in ambiguity around its purpose (Cutcliffe et al., 2018; Saab et al., 2021). These findings are similar to Dilworth et al. (2013), who suggest that an ambiguity towards the purpose of clinical supervision in nursing, risks a culture resistant to change and accentuates obstacles such as time, logistics, and resource issues.

This discussion has raised issues around the positive experiences of clinical supervision and obstacles. However, within these two areas, the discussion has raised some subtle issues of staff circumventing their situation to gain access and attendance to supervision. This was reflected in staff using alternative approaches of using group and peer supervision to ensure the benefits of clinical supervision were gained and how they avoided having a line manager as a supervisor. While this finding demonstrated a determination to participate, it also highlights the inadequacies of how clinical supervision is being implemented and sustained within mental health inpatient settings.

2.11 Review limitations

This review included, and/or focused on, studies using qualitative methods within the context of inpatient mental health settings, which appeared, to limit studies available for selection with this search combination. Many studies had mixed participants with some participants registered nurses and others non-registered nurses with different roles and abilities, resulting in evidence being less specifically focused on HCA/SWs.

More than half the studies were conducted in Scandinavian countries. All the studies included countries which have Western values, which will not reflect nursing care or clinical supervision as part of that nursing care, within other cultures. The mental health care systems in each country represented in the studies also differed from each other. Provision of services and opportunities for mental health nursing staff also differs.

The synthesising process within this review effectively produces a secondary analysis and it is possible that the interpretation and understanding of the original authors' views may be limited in their representation in this review (Sandelowski, 2008).

2.12 Clinical implications

Analysis of this review suggested issues such as understanding clinical supervision, logistical issues, implementation, engagement, and commitment from the organisation in the process. Clinical implications have been implicitly acknowledged earlier by discussing how the role of the HCA/SW has expanded and how clinical supervision can assist this. This review suggested that clinical supervision has the potential for exploration, reflection, learning, and development for HCA/SWs and other nurses. The clinical implications for the service user, supervisee, supervisor, and organisation appear to be significant if the barriers to clinical supervision, identified in this review, can be overcome.

2.13 Conclusion

The review suggests that most mental health nurses within inpatient settings view clinical supervision as an effective process to offer personal and professional development. However, the review also suggests that a cultural change and several obstacles are to be overcome to if it is to be accessible and sustained rather than viewed as a low priority indispensable process.

If clinical supervision is to become a priority and sustained, then a deeper understanding is required from all involved with its purpose of developing and supporting staff and its ultimate improvement intention to improve patient care. Understanding clinical supervision needs to be embedded within an organisation's culture and values from senior managers to supervisees. Without this, confusion and ambiguity appear to contribute to the obstacles which are experienced (Featherbe, 2023). The review has also demonstrated how nurses

have utilised group /team and peers approaches to their clinical supervision to facilitate collaborative reflection, identity, trust and finding the time. Offering both group and peer clinical supervision and having different supervisors may resolve unpopular issues, such as having a supervisor who is also a line manager.

As a profession, nursing, in the UK is entering a new era with the development of new nursing roles in many areas including inpatient mental health (HEE, 2020). The roles are being created to increase competencies such as the level of skill, knowledge, accountability, and responsibility and will impact on the largest group of nursing staff (the health care assistant population). New roles promise to offer progression and opportunity to develop skills and knowledge to levels not previously encountered. Clinical supervision can clearly assist these competences within these new roles and contribute to the development of them as some of the findings in this review have identified. However, this review has also identified the lack of research that focuses solely upon the HCA/SW experience of clinical supervision within inpatient settings and how little is known or understood about this role in this context. More research in this area is therefore imperative if any benefits are to be achieved.

Chapter Three: Methodology and methods

3.1 Introduction

This methodology chapter is presented in two parts. Firstly, this consists of the development of this research opportunity, encompassing personal philosophical, ontological and epistemological views. These views have been developed over time and, along with extensive reflection, have formed part of the reflexivity process within my experience of this research study. These points facilitated transparency and assisted the rationale to employ interpretative phenomenological analysis (IPA) as the qualitative approach adopted.

The second part of this chapter will provide a justification for the research design, including the recruitment process, the sample, issues relating to sample selection, data collection and method of data analysis. The integrity of the study in terms of the identified ethical issues and considerations will also be raised.

3.2 Personal development of a research position

My world research view and research position has been developed and influenced over several years of experiences working as a registered nurse in various settings. Early exposure to research was within the context of a medical model-influenced programme of nurse training in the 1980s (Burnard & Chapman, 1990). This training was strongly aligned to positivist approaches as training and practice were considered 'scientifically evidence based'. This was reflected through objective data measurement and reductionist approaches to clinical presentations and the constant association of scientific and medical knowledge with little consideration of any other research approach. These early experiences

facilitated a research position that ontologically created a belief that reality is the same for each person, suggesting the existence of one external reality which can be discovered by experimental testing, objective measurement, and deductive reasoning (Ryan, 2018). Practice examples reinforcing this view were clinical observations and measurements. Epistemologically the belief was that the world exists irrespective of the presence of the researcher and knowledge can therefore also be collected objectively. Holding such entrenched beliefs on this position made reflection on any limitations of it difficult until my knowledge of the philosophical positioning of research expanded.

The value of understanding the role of philosophy to develop different ontological and epistemological positions in research was not an area that I initially understood well. However, with specific exposure to this aspect, understanding the value of research philosophy was a crucial part of my exploration of different research positions and personal development.

Moreover, qualitative research offered a very different position. Qualitative research can take the form of several approaches, each supported by their own theoretical and philosophical base. My personal positionality was drawn towards interpretivism which argues that subjectivity is central to knowledge and truth based on individuals' experiences and their personal understanding of them. From an ontological perspective, reality is constructed by the individual and understood by socially constructed meanings. This reflects the concept of multiple realities due to individual perception, which can assist understanding of subtle and complex nuances and meanings in life experiences through language (Ryan, 2018). Ryan (2018) suggests that this reflects the view that researchers will inevitably inform the research process, as they cannot achieve total separation from their

own values and beliefs. In all qualitative research approaches, this is accepted, with reflexive exploration encouraged throughout the research process.

3.3 Research Paradigms and philosophy

It is considered a necessity for many researchers to develop a philosophical foundation to their research, through philosophical questioning, to gain clarity defining a research paradigm (Pritchard, 2010). There are several definitions of a research paradigm offered (Khaldi, 2017). Fundamentally a research paradigm represents the researcher's world view in terms of their beliefs, values, their definition of the world and how they operate and work within it. In addition, a research paradigm is thought to contribute to facilitating and shaping the concepts of being, structure and reality and in turn the development of knowledge (Kivunja & Kuyini, 2017). The type, number and components of paradigms are a contested issue. It has been argued, however, that there are essentially four popular research paradigms: positivism, interpretivism, critical realism and pragmatism, with each paradigm consisting of four components, ontology, epistemology, methodology and axiology (i.e. research ethical issues and considerations) (Bowling, 2014; Saunders et al., 2009). Outlined very briefly, positivism suggests that reality is external, objective, and independent of social actors. Interpretivism is considered to be socially constructed, subjective and may change. Critical realism argues a reality independent of human thinking or scientific measurement and that human observations are fallible. This leaves any derived theoretical principles questionable in terms of credibility by being critical of the claim that knowledge has an assured certainty (Bhaskar, 2010). Finally, it has been suggested that pragmatism (considered to be the fourth paradigm) is a hybrid of the first three (Tashakkori & Teddlie, 2003), in which reality can be viewed as external and objective but also provides that

individuality may impact people's perception of the world, therefore, research in this sense is also subjective.

The researcher arrives at an appropriate research paradigm through philosophical questions, which create uncertainty. Philosophical questions also create a curiosity within the researcher's own worldview and assumptions and enable a more critical approach by creating questions around the nature of reality and what can be known (Pritchard, 2010). These types of questions engage ontological, epistemological and methodological enquiry. Understanding and embracing research philosophical questioning is crucial to the researcher. It allows for the development of a worldview that facilitates the exploration of the relationship between ontological and epistemological beliefs in the context of the research paradigm and of developing appropriate research methods and methodologies for a research study (Darlaston-Jones, 2009).

All research methodologies are based on their respective research philosophical paradigms which are considered to facilitate and shape the concepts of being, structure and reality and in turn the development of knowledge underpinned by their respective ontology (the nature of reality) and epistemology (the nature of knowledge) (Al-Ababneh, 2020).

Ontology is generally accepted as being concerned with the concept of 'being' such as beliefs about the structure and existence of reality and social reality (Crotty, 1998; Snape and Spencer, 2003). Conceptualising ontology presents research with some complex philosophical questions but questions which are crucial in the shaping of research paradigms. For example, ontology has been viewed as questioning if there is a social reality

that independently exists from what humans conceptualise or interpret (Ormston et al., 2014). To briefly summarise, ontology therefore, concerns the complexity of human beliefs and what kind of reality and the nature of that reality which exists.

Willig (2013) describes epistemology as how we know what we know. An epistemological position can therefore determine underpinning knowledge belief assertions. Crotty (1998) and Al-Ababneh (2020) essentially suggest three epistemological positions, objectivism, constructionism, and subjectivism, with each of these positions articulated through their relevant theoretical perspective. Objectivism is often aligned with the theoretical perspectives of positivism. These perspectives create assumptions which view the existence of objectivity by following experimental methods that follow the natural sciences. This assumption implies that research would be objective and value free. Positivism would also view the human mind as an object of investigation with the acceptance of universal laws of objectively. Knowledge is acquired through empirical methods of deduction such as surveys and experiments, which aim to measure and demonstrate objectivity. This knowledge is conveyed through language and articulated as a 'truth' to explain, prove, or provide evidence (Morrow, 2007).

Constructionism can be viewed as an alternative epistemological position. Crotty (1998) and Burr (2015) suggest constructionism is articulated through the theoretical perspective of interpretivism. This can be represented by of a range of approaches. The concept centres around an alternative belief from objectivism, refuting the assertion of an objective truth or an externality to the social world that can be objectively measured. The suggestion offered is that the social world offers multiple realities, which are socially constructed, and language

and culture facilitate this. This is viewed as a continuous process and facilitates meaning and understanding by individuals within their political, cultural, and social societies (Gergen, 1999). Constructionists therefore are drawn to the process of detailed interactions between individuals in context specific situations and what happens in this arena of the lived experience of this relationship and its construction (Pearce, 1994; Shotter, 1995). Burr (1995) adds to this concept by suggesting that the process of social interaction develops knowledge of individuals' understanding of the world and is influential in articulating historical, cultural, and societal ideas. The value of this position became clearer when I was exposed to the detailed interactions that took place in the clinical supervision process and drew me towards this paradigm. Ryan (2018) suggests an alignment between the values and principles of interpretivism and nursing with examples of personal centred and holistic care. In addition, Alase (2017) suggests an interpretive and /or critical theory paradigm would be suitable for approaches such as IPA which explore the lived experiences of research participants.

One other epistemological position is subjectivism (Crotty, 1998). Bryman (2012) argues that theoretical perspectives of this position such as critical inquiry are modified forms of positivism or post positivism. Indeed, Robson (2011) has suggested that subjectivism can be viewed as an alternative to both objectivism and interpretivism as approaches such as post positivism accept that evidence in research is always imperfect. However, the approach advocates following cause-effect concepts, influenced by positivist approaches, while simultaneously interpreting information and constructing theories, with consideration to the researcher's values and beliefs to facilitate explaining social realities.

3.4 Methodological Approach

Phenomenology, originally a philosophy, has also been used as the basis of various qualitative methodological approaches which provide a thorough explorative examination of the lived experience and an interrogation of the qualities that contribute to that experience and its 'essence' (Balls, 2009). Phenomenological investigation can take the form of different approaches. The approach for this study considered the researcher's philosophical ontological and epistemological position, the study's aims and research question. Reflection on these aspects led to the conclusion that Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) was considered the most appropriate approach within phenomenology.

3.5 Interpretative Phenomenological Analysis (IPA)

IPA was initially developed in 1996 within the discipline of psychology as a potential qualitative research methodological approach (Smith, 1996). Since then, IPA has become more widely used and continues to grow across health and social sciences (Miller & Barrio-Minton, 2016; Peat et al., 2019). IPA attempts to provide a detailed and systematic exploration of how an individual's personal experience is made sense of through attached meanings of that experience (Smith, 2019; Smith et al., 2022). Enabling that experience to be expressed in its own terms makes IPA phenomenological and aligns it to some of the core ideas unifying some phenomenological philosophers (Smith, 2019; Smith et al. 2022). IPA theory has, in essence, been largely developed around three component theoretical aspects: phenomenology, hermeneutics and idiography.

3.5.1 Phenomenology

Phenomenology has been described as an alternative to the positivist paradigm by offering a way to inquire into phenomena that positivism may overlook such as lived experiences and the subjective qualities of these (McConnell-Henry et al., 2009). As a philosophical approach, phenomenology, can be applied to the study of meaning and used to understand experience as it is perceived by an individual or group (Patton, 2015). Moreover, Patton (2015) further qualifies this by claiming that phenomenology questions what meaning is, i.e. the structure and essence of the lived experience of the phenomenon experienced by a person or group. As a fundamental component of IPA theory, Smith et al. (2022) identifies phenomenology questioning of what meaning is as a distinctively human element of phenomenology, by adding how the study of phenomenological thinking acts as a guide to the experience of being human. This is explained in terms of what makes meanings to humans and the importance of reflecting upon an experience, by engaging in reasoning and the influence of emotional state. Smith et al. (2022) described this as 'hot cognition', and the process of trying to make sense of it.

The challenge of applying phenomenology to research presents a diverse and conflicting range of ideas when attempting to access and convey a subjective experience with authenticity. To demonstrate this, phenomenology has essentially two approaches, both of which have inspired IPA. These approaches are: transcendental (descriptive) phenomenology and interpretive hermeneutic phenomenology.

Transcendental phenomenology was initially developed by Edmund Husserl (Husserl, 1927) in response to his view of the failure of natural science as a means of studying human

experiences (McConnell-Henry et al., 2009). Husserl could not accept the Cartesian concept of the subject-object dichotomy, which dominated science for centuries. This led Husserl to conceptualise the concept of reality as a personal construct, based on personal internal interaction and the external interaction within the social / cultural context of the world in which one exists (Matua, 2015).

Despite this thinking, Husserl attempted to preserve objectivity to assure credibility for methodological advancement. This was reflected in two key aspects, these being, intentionality of consciousness and 'époche' or bracketing. Intentionality involved the belief that the mind was directed outwards away from the self towards objects, with this directedness being termed intentionality (McConnell-Henry et al., 2009). Wertz et al. (2011) suggest that this concept implies that reality has an inseparable connection to an individual's consciousness and therefore consciousness is unable to exist independently of its object. Époche arose from Husserl's belief that it was necessary for the researcher to suspend any presuppositions they may have in relation to the phenomena under investigation within their data. Data obtained would therefore be a descriptive account of the experience with no attempt to ascertain meaning from the experience (Charlick et al., 2016; McConnell-Henry et al., 2009).

Interpretive hermeneutic phenomenology (a combination of rich descriptions of a lived experience with interpretations of their meanings through reflection) was developed by Martin Heidegger, a former student of Husserl. Heidegger held the view that it was important to move from description of an experience to interpretation, with a focus on developing meaning from being (Heidegger, 1962). Heidegger rejected the concept of

'époche' or bracketing, claiming that the researcher does not operate in a vacuum and is an integral part of the research by being in the world of the participant, with prior understanding facilitating interpretation. The concept of *being in the world* relates to what Heidegger described as *Dasein* (Heidegger, 1962). McConnell-Henry et al. (2009) suggest that the meaning of *being* is dependent upon the context of that being, but meaning will always exist and the aim should be to discover meaning or uncover the structures of being as they manifest themselves in the phenomena. Smith et al. (2022) acknowledge the significance of Heidegger's influence on IPA and adds that knowledge of an experience lived can only be possible through interpretation. This interpretation is subject to relationships and language in the context of that individual's world view. Smith et al. (2022) adds that IPA involves the interpretation of how individuals construct meaning which must inevitably be relational in the perspective of the researcher. Heidegger's influence on IPA theory is further evident, with the suggestion that the only way the researcher can conduct a hermeneutic approach would be to ensure questions are pertinent and the questioning and re-examining the text will produce an interpretative, ever-expanding circle of ideas of meaning, described as the hermeneutic circle (Heidegger, 1962; McConnell-Henry et al, 2009).

Although Smith et al. (2009) acknowledge the influence upon IPA theory of Heidegger as a key interpretive philosopher, they also recognise the influence from Merleau-Ponty (1962) and Sartre (1956), who, along with Heidegger (1962), have differing contributing concepts but essentially hold the underpinning view that no knowledge is revealed without interpretation.

The influence of Merleau-Ponty (1962) on IPA also considers the self. Merleau-Ponty (1962) also presents a particular focus on the self, in that the individuals view themselves as uniquely different in the world due to the sense of self and view of the world leading to a perception of interpretation from an individual's own perspective. Smith et al. (2009) suggests that this influence on IPA is manifest in the researcher being able to engage, observe and empathise with participants but the phenomenon is viewed from the researcher's perspective and can never be shared in its entirety. Sartre (1956) was also focused on the self but from the perspective of becoming oneself as a continuous development throughout life. Therefore, continuous engagement with one's world and ultimately constructing meaning is ongoing. Charlick et al. (2016) adds that this concept is reflected in the unfolding nature of the researcher and the researched, the influence on IPA theory being the development of understanding the experience and this being subject to interpretation by the researcher and individual participant.

3.5.2 Hermeneutics

Along with phenomenology, hermeneutics is also considered to be of theoretical significance in the development of IPA theory. Dallmayr (2009) and Ricoeur (1981) maintain that hermeneutics concerns itself with the theory of interpretation while recognising the process of making meaning. Historically, Smith et al. (2009) note that hermeneutics was developed to interpret biblical texts and has been adopted for use in such areas as history and literature as well as in more recent times, science research. Charlick et al. (2016) identifies three hermeneutic theorists who have strongly influenced IPA theory, these being, Heidegger (1962), Gadamer (1990), and Schleiermacher (1998).

Heidegger (1962) claimed that unless someone has anything revealed to them as something, within the context of that individual's world view interpretation and applied meaning, then nothing can be revealed. Smith et al. (2022) maintain that analysis within IPA always involves interpretation and align with Heidegger's concept of the appearance of a phenomenon by acknowledging that a phenomenon is ready to 'shine forth'. Smith et al. (2022, p.22) suggest that at this point the researcher needs to apply 'detective work' to facilitate this 'shine forth' and 'make sense' of the experience once it has happened. In addition to this concept, Heidegger (1962) also draws attention to the researcher's potential impact on interpretation due to prior experience assumption and preconceptions. Heidegger (1962) goes on to suggest that this is inevitable but can be acknowledged and worked with and as such departs from Husserl's (1927) concept of bracketing.

Gadamer (1990) takes a similar view to Heidegger (1962) suggesting that any preconceptions from the researcher only become known when interpretation is happening. As part of IPA theory, Smith et al. (2022), identifies with this as a complex relationship between the researcher interpreting and what is interpreted as the experience or phenomenon that influences the interpretation process. Gadamer (1990) argues that the separation of what is being researched from the researcher cannot be achieved because engaging with the world by individuals creates change within them. Smith et al. (2022) capture this by acknowledging the importance of awareness of personal bias, particularly during analysis.

Schleiermacher (1998) has focused on the process of interpretation by suggesting the involvement of a range of skills and intuition taking place simultaneously. This process

engages literal and grammatical meaning and psychological interpretation of the individual, indicating that a greater insight can be achieved. The influence of Schleiermacher (1998) can arguably be apparent in what Smith and Osborne (2008) have referred to as the double hermeneutic process. In IPA the researcher is attempting to interpret the participant (and/ or text), while the participant is trying to make sense of their own experience of their personal and social world (Smith, 2004).

The double hermeneutic in IPA can be illustrated through the concept of the hermeneutic circle on two levels. Firstly, this relates to an ongoing interpretation that exists between the part and the whole. To gain some understanding of the part, this would need to be initially viewed in isolation, then viewed in relation to the whole. The same pattern is also applied to developing an understanding of the whole, which would initially be viewed in isolation then viewed in relation to the part. Secondly, this potentially perpetual circular style of interpretative analysis in IPA facilitates the deeper interpretation of enabling the researcher to engage and reflect on the part or whole on different levels such as interviews (within, between and after interviews) and transcripts (during and between analysis of transcripts from words in a sentence to the transcript in its entirety). On another level, Smith et al. (2009) suggest that the starting point of the cycle is influenced by the researcher's own preconception and experience. From this point the researcher pivots between positions of attempts to be fully aware of the potential impact of their own preconception and experience, while working on the participant's position of identifying elements of their experience as it is conveyed. It is inevitable, however, that this is in the context of the researcher's own views and experience.

In IPA theory, the movement between these interpretative positions resembles Ricoeur's (1970) conceptual interpretive positions of hermeneutics of empathy, which according to Smith et al. (2022; p.30) involves two aspects. These are a reconstruction of the original experience in its own terms and hermeneutics of suspicion, which suggest the involvement of 'outside' theoretical perspectives to increase understanding of the phenomenon. Larkin et al. (2006) and Smith et al. (2022) adopt this concept by suggesting that IPA takes a centre ground position, where the interpretative approach can be viewed as appropriate as long as it attains the meaning of the experience. Larkin et al (2006) and Smith et al. (2022) suggest that IPA in practice requires the researcher to adopt and combine both empathic (hermeneutics of empathy) and questioning styles during interpretation (hermeneutics of suspicion, re-phased as 'hermeneutics of questioning'). The hermeneutics of empathy facilitate an 'insider's perspective of what it is like for the researcher to see what it is like for the participant, while the hermeneutics of questioning facilitate analysis in making sense of something. Consequently, IPA does not move through fixed stages but allows for deeper interpretations of meaning (Smith et al., 2022).

3.5.3 Idiography

Idiography has been defined as having concern for individuality and the particular through a commitment to rigorous analysis of unique phenomena and how that perspective has been understood or made sense of within a particular context from particular people involved (Charlick. et al., 2016; Noon, 2018). To achieve this, IPA utilises small samples which are usually purposive and relatively homogenous. In IPA each single case has justification, as the researcher aims to understand as much as possible before moving to the next case (Noon, 2018).

Smith et al. (2022) maintain that each case is revised by the researcher, allowing for reflection and modification of thinking as the next piece of evidence is assessed. Single cases can also be matched together culminating in more analysis before moving to broader claims. Smith et al. (2022) suggest the value of IPA studies offer analysis that is detailed and nuanced with particular instances of the lived experience. This allows for a deeper exploration of the particular in each case which brings the general features of a phenomenon into focus. The contribution of a detailed idiographic analysis allows IPA to illuminate existing nomothetic research (research that generalises in a context to identify trends and predictions), which in turn facilitates the process of theoretical transferability (Smith. et al., 2022).

3.6 Consideration of other approaches

Several qualitative methodological approaches exist, e.g., phenomenology and grounded theory and analysis approaches such as discourse, narrative or thematic (Creswell, 2013). IPA as a phenomenological method was selected above other types of phenomenological approaches as the question and aims of this study appeared more suited and aligned with key features of the question focusing upon personal meaning and making sense within a specific context (Smith et al., 2022).

However, a phenomenological approach as proposed by Giorgi (1997) was given some consideration. Giorgi's phenomenological approach is influenced by transcendental /descriptive phenomenology (Husserl, 1927) and is reflected in the descriptive approach taken. The approach aims to describe phenomena as they present themselves precisely as

they emerge, with nothing to detract or add to them. Any previous knowledge or understanding from the researcher's perspective is suspended or bracketed to facilitate the meaning of the phenomenon as it was experienced. Giorgi (1997) argues that the researcher does not need to interpret the data beyond description, with the aim being to construct a picture of the phenomenon by drawing on commonalties of what was experienced by participants.

This contrasts with IPA, which aims to use interpretation through hermeneutics and does not support the concept of the researcher bracketing previous knowledge or experience. However, this is only to a point, as initial drafts and coding are less influenced by what is already known. Another contrast is the way IPA utilises detailed analysis of divergence and convergence patterns across participants (cases) with the aim of capturing the rich data of each participant (Smith et al., 2009). The philosophical underpinnings of Giorgi's (1997) approach and IPA are also contrasting and while there is an appreciation of both philosophical viewpoints, my personal view aligns with the view that interpretation accounts for an inevitable structure of understanding and being in the world. With this view, research cannot operate in a vacuum, questioning the concept to what degree it is truly possible to bracket any prior knowledge and preconceived ideas (McConnell-Henry et al., 2009).

Finally, the research question and aims for this study was to utilise idiography to facilitate understanding of meaning through analysis of individual experience (and as also summarised at the group level) in contrast to gaining clarification, in more general terms, of the phenomenon.

3.7 Limitations of IPA

IPA's progress, since its inception more than 20 years ago, has been significant and influential (Smith, 1996). IPA's place as an established experiential qualitative approach has, for some time, been widely recognised in UK psychology and in recent years this has been paralleled by its growth internationally. Moreover, researchers are now using IPA in fields beyond psychology, such as humanities, sports science, and organisational studies. The development of IPA has led to views on its limitations with variations in the way IPA has been applied (Clarke, 2009). Giorgi (2010), Rettie and Emiliussen (2018), and Van Manen (2017) argue that IPA lacks standardisation and is insufficiently interpretative, with a lack of clarity of interpretation and general guidance present issues with application. However, Smith and Nizza (2022) have responded with further guidance and application including providing more clarity on theories, practical approaches, and the purpose of IPA characteristics.

Moreover, Tuffour (2017) questions if IPA can capture experiences and the meanings created of these experiences other than opinions. Tuffour (2017) qualifies this by arguing that phenomenology as a philosophy is associated with introspection, allowing for the exploration of experiences. Phenomenology as a research approach, however, requires methods sufficiently robust to explore participants' accounts and the researcher's own experience. For Tuffour (2017), this raises critical questions around whether both the researcher and participants have the requisite communication skills to attain the nuances of an experience being accounted for, and if this can be achieved in situations where levels of articulation and fluency may be a challenge.

In addition, both Noon (2018) and Willig (2013) have raised the issue of language and how this is conveyed. Noon (2018) asserts that IPA presupposes that language provides participants with the necessary method to articulate their experiences. This view of language and articulation, however, has been questioned. For example, Rose et al. (2019) conducted a systematic review examining 28 published studies looking at the appropriateness of using IPA in research with people who have intellectual disabilities, with a particular focus on quality. The findings rated 6 studies as 'good' quality, 16 as 'acceptable' and 6 as poor. This ratio was comparable to assessments of IPA papers in non-intellectual disability domains, suggesting that quality issues reflect researcher competence, rather than possible challenges of participants with more limited communication. Rose et al. (2019) concluded that IPA is an appropriate methodology, however they argued for more detailed analysis and more transparency in sample strategies and sample characteristics as the ability to articulate an experience can vary widely in participants with an intellectual disability.

There are also theoretical debates around IPA around its underpinning theory and if IPA can claim to be phenomenological in its nature and level of interpretation (Van Manen, 2017), especially if it is limited by participants' abilities to deliver acceptable insights (Chamberlain, 2011; Van Manen, 2017; McCormick & Joseph, 2018).

3.8 Reflexivity points on philosophy and methodological approach

It has become clear, through my lived experience of clinical supervision, that knowledge can be created through jointly constructed interaction, where there is the potential for multiple realities conveyed through representations of individual realities. This appeared to be

particularly so for health care professionals who had more direct clinical involvement with service users, who would express this through their thoughts, behaviours and emotions. However, it was not clear from my own experience of practice of, and the literature on, clinical supervision how these health care professionals developed personal meaning with their clinical supervision and how they made sense of it. Over time, reflexivity on this point concluded that for this phenomenon to be examined in this way, it could not be appreciated or evidenced by adopting positivist assumptions (Findlay, 2011, 2009) including the associated ontology and epistemology. To understand how sense and meaning are made, it became clear that any research study would not involve proving or disproving a theory utilising hypothesis testing with an 'objectively detached' researcher.

Clinical supervision presented in the literature is vast, yet finding empirical investigations around clinical supervision and mental health inpatient settings were rare. This became rarer still if this involved practitioners such as HCA/SWs. While there is a presumption that clinical supervision is inherently good, there appears to be little consensus on the conceptual interpretative understanding and practical implementation of clinical supervision.

From a personal philosophical positional perspective, interpretivism appears consistent with IPA in trying to gain an understanding of the nuances of the experience and how meaning was reached. This position does not aim to seek the facilitation of questions of 'why' but 'how' or 'what' to explore and clarify the lived experience description. This positional approach would also explore the experience of meanings of social interactions through by utilising language to develop insight into this (Gergen, 1999; Morrow, 2007).

3.9 Method

3.9.1 Design rationale

Flick (2014) and Crotty (1998) emphasise the importance of alignment of a research study's aims, objectives and question with the most appropriate methodology and methods. To achieve this fundamental principle, it was, therefore, important to understand the methodological underpinnings to IPA.

IPA aims to enable the researcher to explore the detailed account of a participant's meaning given to an experience through their thoughts and emotional responses by a process of interpretation (Noon, 2018). For interpretation to be facilitated it is thought that semi-structured interviews with individual participants are considered the most preferable means of data collection, with analysis of the transcripts of the interviews following a process informed by IPA approaches to analysis (Smith et al., 2009; Pietkiewicz & Smith, 2012). This will be discussed further in 3.9.4 data collection.

3.9.2 Participants, sample and recruitment

It has been suggested that IPA targets samples that are homogenous and require a purposive sampling approach which includes participants with a similar demographic outline to each other (Peat et al., 2019; Smith et al., 2009). Smith et al. (2009) also added that the question must have meaning to homogenous participants who have experienced the phenomenon in question as this assists the researcher to capture the necessary detail from

individual participants, while being able to examine and analyse any emerging convergence or divergence across the whole group.

Regarding the number of participants, Smith et al. (2009 p.51) argue that 'there is no right answer to the question of sample size'. In IPA commitment to the process and analysis of individual cases is emphasised. Noon (2018) concurs but notes that the idiographic commitment usually results in smaller sample sizes. Although Smith et al. (2009) do not provide a precise number, they do suggest a default sample size of three for Masters level and four to ten for professional doctorates. They go on to emphasise this point further by adding that to meet the commitments of IPA, larger sample sizes are 'more problematic' than ones that are 'too small' Smith et al. (2009 p.51). Recent studies have used sample sizes of 8 (Armitage et al., 2020), 9 (Chua et al., 2022) and 11 (Murphy et al., 2022).

For this study, a purposive sampling method was applied, with eight HCA/SWs recruited. The aim, as outlined in the ethics proposal, was to recruit between six and twelve. It was also important to consider the potential of being overwhelmed by the volume of data and the threat this may have posed on time dedicated to each individual case. Of the eight participants, 5 were female and 3 male (see table 3). All participants were employed by one NHS trust in the UK and were based between three different acute mental health admission inpatient wards. The total length of NHS healthcare experience ranged from between 1 year and 4 months to 35 years, with an average of 14 years. Experience specifically in acute inpatient mental health settings ranged from 1 year, 4 months to 28 years, with an average of 9.6 years. It was notable that despite a wealth of experience in acute mental health inpatient settings, availability and accessing clinical supervision provision, was historically

inconsistent for all participants. For example, six participants had received clinical supervision within the past month, while for two participants it was longer than two months. The relevant trust policy stipulated that the frequency of receiving clinical supervision should be every two months. Interviews with participants were very variable in range and unusual for IPA interviews (Smith et al., 2009) with the shortest duration being just 12 minutes, while the longest was 1 hour, 3 minutes. Seven participants were receiving group clinical supervision, while one participant was receiving one to one clinical supervision. All participants had a registered nurse as their clinical supervisor. For some participants the clinical supervisor was a different registered nurse for each session. Seven participants had, during their experience, taken part in both one to one and group clinical supervision.

Table 3 *Details of participants*

Participant (Pseudonym)	Gender	UK NHS Health Care and Acute inpatient experience	History of supervision and type attended previously	Type of supervision currently attending	Last supervision attended
Wasim (P01) Transcript 01	Male	12 years total	Inconsistent provision	Group	< 1 month
		2.5 years acute inpatient	1:1, Group		
Linda (P02) Transcript 02	Female	35 years total	Inconsistent provision	Group	< 1 month
		28 Years acute inpatient	1:1, Group		
Louise (P03) Transcript 03	Female	11 years total	Inconsistent provision	Group	> 2 months
		10 years acute inpatient	1:1, Group		
Amita (P04) Transcript 04	Female	16 years total	Inconsistent Provision	Group	< 1 month
		4.5 Years acute inpatient	1:1, Group		
Noel (P05) Transcript 05	Male	12 years total	Inconsistent Provision	1:1	> 2 months
		11 Years acute inpatient	1:1, Group		
Ann (P06) Transcript 06	Female	3 years total	Inconsistent Provision	Group	< 1 month
		3 Years acute inpatient	1:1, Group		
Cala (P07) Transcript 07	Female	1 year 4 months total	Inconsistent Provision	Group	< 1 month
		1 Year 4 Months acute inpatient	Group		
Adrian (P08) Transcript 08	Male	22 years total	Inconsistent Provision	Group	< 1 month
		17 Years acute inpatient	1:1, Group		

3.9.3 Recruitment process

Prior to recruitment a research proposal and application for ethical approval was submitted to Lancaster University ethics committee (Reference: FHMREC16126, appendix VII). A further ethics approval was also sought from the relevant Trust's research committee

through the Health Research Authority (appendix VIII). Following successful approval, a request via an e-mail letter (appendix IX) was made to a senior trust member to act as a local collaborator and take the responsibility for research on trust premises. The letter also contained an example recruitment flyer (appendix X), and participant information sheet (appendix XI). The recruitment of potential participants was gained by initially contacting service and ward managers to inform them of the study.

This initial contact with service and ward managers enabled access to potential participants directly following handover to introduce the study. It also gave the opportunity to draw attention to the flyer and information sheets (placed on notice boards in staff rooms). Interested participants were provided with written participant information (appendix XI) as well as detail about the study. Participants were requested to read the information and consider the study over a 24-hour period. This allowed for participants to reflect upon the information with no pressure or influence to take part (Hammersley & Traianou, 2012). Participants were also requested to read the consent form (appendix XII) and, if in agreement, sign two copies of the form. One was retained by the participant, the other by the researcher, which was stored securely. At this point participants were also informed of their right to withdraw from the study one month following the audio-recorded interview (Robson 2011; Guillemin & Gillam, 2004). However, participants were also made aware that once data had been analysed and included in themes, it would have been impossible to withdraw the data. Informed, voluntary consent required participants to understand the purpose and participation of their involvement. Participants were also informed that the researcher's supervisors would be included in all parts of the research process through research supervision. Participation was voluntary and no incentives were offered.

3.9.4 Data Collection

Qualitative research offers several methods of data collection, and it was important to find an appropriate way of collecting data that would align with the study aims and allow for participants to talk openly about their experiences spontaneously and flexibly. It was thought therefore that questionnaires would be inappropriate for this. Focus groups and existing data such as blogs are also considered a method of data collection for qualitative research. However, Smith et al. (2009) acknowledge that while focus groups have been used in IPA, they are less suitable for IPA researchers. This is because while focus groups allow for multiple voices to be heard, the presence of several participants and the consequent interactional complexity makes it difficult to develop the phenomenological aspects of IPA. On this basis focus groups were rejected.

Smith et al. (2009) describe two possible interview approach options for data collection: unstructured or structured. Unstructured interviews are non-directed, and the questions asked are not restricted in any way, ensuring that the interview process remains to remain without boundaries. Unstructured interviews also require an excellent grasp of interviewing skills, and that the interviewer remains completely focused on the topic (Denscombe, 2014). Smith et al. (2009) suggest that unstructured interviews are not recommended for people new to IPA and should be considered more appropriate as an interviewer becomes more experienced. The second option of semi-structured interviews requires questions that are broad enough and that can be articulated sufficiently to develop a conversation, with the aim to facilitate the exploration of experiences (Flick, 2014). Marlow (2010) further suggests that semi-structured interviews should aim to be reciprocal to facilitate an understanding of

the experience. Semi-structured interviews are frequently used and evident in IPA studies because of their ability for deeper exploration and open-ended questioning style allowing the participant to engage at their own pace (Smith et al., 2009). Based on the discussion above, around possible data collection methods, semi-structured interviews were thought to be more appropriate to meet the abilities and skills of the researcher and take into consideration the limited experience of using IPA. Semi-structured interviews were therefore chosen as a data collection method.

3.9.5 Interview schedule

Participants took part in a one-to-one semi-structured interview, for which the researcher had developed an interview schedule (appendix XIII) which was piloted with a HCA/SW, who had specifically volunteered for the pilot only. The interview questions were developed prior to meeting the participants and were influenced by the literature review from the clinical supervision studies and the study aims and objectives.

Questions were open-ended to encourage description and encourage the participant to discuss their experiences of clinical supervision with the most minimal interaction from the researcher as possible (Pietkiewicz & Smith 2012; Smith et al., 2009). The schedule also contained a range of prompts and probes which allowed for following the participant's responses and to encourage participants to reflect on and articulate their experiences of clinical supervision.

Participants were offered a choice of times, dates, and venues across the Trust's many geographical locations. There was also the opportunity to meet at a venue not connected to

the Trust (i.e. the researcher's place of work) but this option was not accessed by any participant. As the interviews took place on Trust premises, health and safety and other related trust and university policies, procedures, and research ethical approval procedures such as lone working, were followed.

Prior to the interview, participants were informed that the format that would include a pre-interview stage, the interview stage, and the post interview stage. The pre-interview stage was approximately 10-15 minutes and consisted of reviewing the participant information, including being digitally audio recorded, anonymity and confidentiality, the right to withdraw, consent and generally ensuring the participant's comfort. Participants were also informed that should there be any concerns arising during interviews, the researcher would suggest stopping the interview and follow a distress protocol (appendix XIV) (Draucker et al 2009) and attention was also drawn to additional support and a debrief following all interviews (Israel & Hay, 2006).

Adhering to the approach described by Smith et al. (2009), each participant interview was digitally audio-recorded, and the recording was transcribed exactly, including noting non-verbal sounds and pauses. The Interview schedule consisted of open questions and deeper probing questions where experiences were discussed. The aim was to follow the hermeneutic cycle as much as possible while simultaneously being aware and noting any pre-existing theoretical knowledge and assumptions within the researcher's own experience. The HCA/SW did not usually have opportunities to be interviewed, present or discuss openly their experiences of events such as clinical supervision. This inexperience was apparent through some of the interviews, with participants struggling to elaborate on their

experiences and expressing feelings in the debrief that at times they did not know what they thought they should say, despite reassurance. For the duration of the interview stage, approximately one hour was allocated and 30 minutes allocated post interview stage (Burns & Grove, 2011).

Following the interview, the recording was stopped, and participants were taken through a debrief. They were encouraged to reflect and ask questions on their thoughts and feelings on any difficulties or issues that may have arisen during the interview. Participants were again reminded of their right to withdraw, how the data would be used and stored and any further support and contacts, should any future difficulties or issues be encountered as a result of participating in the interview. All participants were sent a transcript of their interview, and all participants contacted the researcher to confirm they had read it and were happy for the information to be analysed.

3.10 Data analysis

The process of IPA research has been described as flexible in its approach to data analysis (Smith et al., 2022). The process aims to examine aspects of an individual participant's experience as it is lived by them and also how that experience may be shared by other participants. The process can be considered an inductive cycle of line-by-line analysis of a participant's transcript reflecting the hermeneutic cycle (Smith et al., 2009; Smith et al., 2022). The researcher needs to be aware of the emergence of themes from individual participants and across all participants. The researcher also requires awareness of data interpretation that connects any psychological interpretation of contextual meaning for the participant, how themes are structured and developed, and to account for the participants'

data and researcher's own reflection and interpretation. The researcher aimed to achieve this by implementing stages[7], based on and adapted from, the six steps outlined by Smith et al. (2009) (appendices XV - XIII).

3.10.1 Data Analysis: Stage one

The initial stage involved listening to the audio recording while reading and re-reading a hard copy of the transcript. This was done several times as the process revealed the rhythm and flow of the interview, which enabled a deep immersion with the participant's view. Any field notes taken from the time were also reflected upon.

Each transcript had a margin to the left (reflecting on initial ideas of any emerging theme) and to the right (reflective comments identifying the researcher's own influence and any preconceptions) (appendix XV).

3.10.2 Data Analysis: Stage two

Another hard copy of the transcript was produced, again with left and right margins. The left-hand margin reflected upon initial ideas on themes, while the right hand margin assisted the process of the researcher noting by a line by line examination. This included any aspects of concern for the participant and comments that were considered descriptive, linguistic, and analytical/ conceptual (Smith et al., 2009). These were each allocated a colour to distinguish them. The aim for the researcher was to develop an immersive approach to

[7] The four stages in this study are based on and adapted from the six steps set out in chapter five of Smith et al. (2009) rather than chapter five of Smith et al. (2022) as the study had progressed too far to consider the latest work.

try to gain a deeper understanding of the participant and their account in relation to the experience. This essentially iterative process allowed for locating where interpretations were and their alignment with the original data (appendix XVI).

3.10.3 Data Analysis: Stage three

This stage of individual analysis took the form of three parts. Firstly, the data from the transcript's line by line analysis and notes were examined to identify any emerging themes. This included the identification of what was considered important from the transcript line by line statements and notes. This process reflected both the concise words of the participant and the researcher's conceptualised interpretation of those words which resulted in an initial list of developed themes. Experiential statements were also compiled to check that emerging themes were corresponding.

The second part involved mapping the themes into a structure which involved processes to facilitate patterns and connections. Smith et al (2009; p.96-99) identifies in detail these processes as 'abstraction' 'subsumption' 'polarization' 'contextualisation' 'numeration' and 'function'. Smith et al. (2009) stress that these methods are not prescriptive but are ideas to assist. For this study, all these processes were considered, with some (abstraction, subsumption and numeration) used more than others. From this point, themes were clustered and arranged under potential grouped themes, which brought a key aspect that represented the participants' accounts. For the third part, a table of potential grouped themes was constructed which identified their location within the transcript. In addition, all identified themes were recorded so they could be tracked and compared with all the cases to follow (Appendix XVII).

3.10.4 Data Analysis: Stage four

The stages, as set out above, were applied to every transcript, so that analysis could be applied to each individual case in this way. Following analysis of all the transcripts, all the potential grouped tables were set out from all the cases. This facilitated the identification of patterns, comparisons, contrasts and any shared features or idiosyncrasies. From these tables, a matrix theme table was created to represent all participants (appendix XVIII). This consisted of over-arching themes, superordinate themes with subordinate-themes and abstracts from participants' transcripts to illustrate the relevance of that theme.

3.11 Confidentiality and Anonymity

As the study aimed for a small number of participants from one NHS trust, combined with how qualitative research conveys detail through the participant's own words, it was possible that anonymity in this context could be considered fragile (Bryman 2012; Hammersley & Traianou, 2012). The researcher expressed in the pre-interview discussion and in the participant information sheet (appendix XI) that although every effort was to be made in this context, the guarantee of complete and total anonymity could not be assured.

Limits to confidentiality were also made clear to participants as confidentiality would not be maintained if a participant disclosed information that made the researcher believe that the participant or others were at risk of harm. Participants were also informed that they would all have their identities protected using pseudonyms (chosen by the participants) and there would also be a separation of personal details from all coded identified data and any participant's verbatim quotations would be edited to eliminate identifiable material and any

indirect identification of people and locations (Robson, 2011). Participants were also informed that all the transcription was completed by the main researcher only (appendix XI).

Miller et al. (2012) suggest that the subjective, emergent character of qualitative research indicates that not all risks can be foreseen. Although the researcher was not anticipating the study to create any distress or discomfort to any participant, the researcher was mindful that, within interviews, the experiences of clinical supervision may have presented some emotive experiences such as strong opinions or a sense of embarrassment.
To reduce these possibilities, two examples of the interview questions were contained in the participant information and contact details of the researcher and information for additional support. The information also contained contact details of the PhD supervisors, director of the PhD programme and the appropriate contact for any complaints or concerns about the study.

3.12 Ethical issues

The approach to this study was influenced by key ethical principles which included autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 2001). These principles provided the foundation for other key aspects such as reflection and reflexivity. Research ethical approval was obtained from Lancaster University's research ethics committee and the NHS Trust's research ethics committee by the NHS Health Research Authority were adhered to, along with the research governance framework (DH, 2008). The researcher also followed the suggestion by Miller et al. (2012) to enhance the researcher's research integrity, ethical responsibility should extend to the institutions involved and their

population. The researcher always adhered to their own code of professional conduct but was particularly sensitive to the relevant research and research ethics sections (NMC, 2018; NMC 2018a).

3.13 Reflexive point/note on method and design

Several stages of the methods presented challenges. Recruitment was difficult and a lengthy process. The literature review (Chapter two) demonstrates that it is rare for HCA/SWs to be participants in research involving clinical supervision. The data collection stage presented many challenges as the acute mental health inpatient wards were constantly busy and the HCA/SWs were at the forefront of this. Although HCA/SWs were released to be interviewed, there was perceived pressure on time from some HCA/SWs, who would indicate that they needed to get back on the ward as soon as it was possible.

There was initial interest in participating in the study but many potential participants expressed reservations which broadly fell into two categories. These were to a minor extent, a sense of scepticism and, to a greater extent, a perception of inferiority.
Scepticism related to confidentiality was reflected in statements such as *'Who else hears about this'.* Such responses gave me the impression that there was a concern about a wider sense of recrimination for unfavourable comments about the organisation. For those participants who did take part, this was not reflected in their interviews.

A perceived sense of inferiority appeared to be a greater issue and was reflected in some responses such as *'I'm just a HCA, I don't know that much about clinical supervision'* or *'I don't have anything worth saying or use any fancy words'.* This view continued for some

participants despite my reassurance, prior, during and following the interview. Prior to the interview participants would comment *'I can talk about what I know and that is not much'* or *'Let's get this over with'.* I would explain that there was no pressure to take part and take the time to review the pre-study information. There were also comments such as *'I don't want to mess this up for you'* or *'I don't think I know enough about clinical supervision'.* During the interview, two participants mimed they did not know or shrugged their shoulders. At this point I would pause the voice recording and provide any re-assurance if necessary and following the interview participants made comments such as *'I'm glad that is over'* or *'I'm no good at this kind of thing'.* Two participants who expressed these views had the shortest interview duration times. My thoughts were that some participants perceived that their contribution did not have worth or value, possibly due to their status.

Chapter Four: Findings

4.1 Introduction

The findings of an IPA study can result in different levels of analysis and subsequently there is no one definitive way of presenting IPA findings (Smith et al., 2009). The findings presented here are influenced in their presentation by the work of Murray and Wilde (2020), who suggest that novice IPA researchers can sometimes produce findings that can appear fragmented. With consideration for this, the approach was to capture how meaning is made from the complexity of the participants' experience. To achieve this, an interpretative approach was utilised to present the participants' understanding and meaning making. This took the form of discrete themes in which aspects of relevant experiences, and the development of the meaning of these, were presented as an interpretative narrative, with the intention of forming a deeper understanding of the experience and meaning. Appendices XV to XVIII demonstrates the journey of the development of the interpretative approach of meaning.

4.2 Identifying the overarching themes and sub themes

The findings consist of two overarching themes which were formed from subthemes of related clusters of interpretations from HCA/SWs and their experience of clinical supervision on an inpatient mental health ward. The overarching themes and sub themes are illustrated in the theme table (Appendix XIX).

The two overarching themes were:

Overarching theme one:

Trying to engage clinical supervision amid ongoing challenges: '*One of the things that could help is… that it [supervision] happens basically I suppose and that it doesn't keep getting called off…'*

Overarching theme two:

How clinical supervision created value: *'Because of supervision, the way it's structured and the way it works, it's kept me within the* NHS'

4.3 Overarching theme one

Trying to engage clinical supervision amid ongoing challenges: '*One of the things that could help is the…, is that it [supervision] happens basically I suppose and that it doesn't keep getting called off…'*

All participants discussed and reflected upon various challenges in accessing supervision and how they tried to work with them. Several factors were considered challenges, which were perceived as inhibiting access to, and taking part in, effective clinical supervision. These factors included systemic barriers at local and organisational levels within the organisation. A perceived indifference from registered nursing staff and the marginalisation of HCA/SWs were considered driving factors for this.

All participants considered inpatient mental health wards to be very challenging environments and discussed their experience of clinical supervision as an event that *'doesn't happen often due to shift patterns and time and one thing and another'* (Amita, line 34-35). The sustainability, logistics and the difficulty of receiving this in an inpatient setting was, for

some, related directly to the busy, sustained pace of the ward, resulting in no available time. The intensity of the challenges the ward presented was emphasised with words such as *'chaotic'* (Cala, line 117-118 and Adrian, line 393). It was also notable how sustained the challenges were, with words such as *'constant'* and *'always busy'* (Linda, line 68-70 and Ann, line 134-135).

For example, Noel commented:

> *P: "Err…. because of time constraints and…what could help? Errm….(Pause)…er one of the things that could help is the…(pause), is that it [clinical supervision] happens basically I suppose and that it doesn't keep getting called off, that's the only thing. On the ward it's like I say, it's the time constraints, really…when it doesn't happen and I'm sure in other departments, If you work like… like I say when I worked on the community police thing, you know it [clinical supervision] happened no problem and I'm sure if you were in the XXXX, err oh sorry another department, but if it happened elsewhere in other community teams they've got…it seems to be a bit more relaxed and it [clinical supervision] happens doesn't it?....because of the nature of inpatient services, you've got to sort out patients' demands all at the same time and you can't just go, 'yeah I'll leave you to it' and do our supervision, you know what I mean? it doesn't work like that does it…if only"* (Noel, Line 230).

The challenge of available time appeared to be one of the most pressing issues for most participants. It is notable how Noel uses the term *'time constraints'* twice and *'patients demands'* as if to emphasise the level of engagement within inpatient settings.

For Noel, the lack of time for clinical supervision was acknowledged with a sense of irony in that it needs to *'happen basically' (*Noel line 231-233). There was a considered, linguistically stressed emphasis upon the word *'happens'* and this finished with the word '*basically'* as an almost fundamental request. This compounded the next sentence and with an underlying sense of a controlled frustration, with *'and it doesn't keep getting called off'.*

Noel's contribution also afforded an opportunity to examine the hermeneutic cycle. As Noel discussed clinical supervision not happening, he presented the question *'what could help?' to* which he appeared to reflect on his own question with two pauses and then continues '*…and I'm sure in other departments, If you work like…'* This seemed to steer him into thinking why previous clinical supervision in a different environment was made available and how in other settings such as *'community'* clinical supervision was more available due to the less frantic nature compared with inpatient settings. The question of *'what could help?'* appeared to trigger a sense of self-discovery as, at this point, Noel considered how clinical supervision was possible and consistent in previous settings but not in his present working environment, which had a sense of inevitable acceptance about it.

For some participants a sense of resignation of accepting infrequent or no clinical supervision was clear. However, some interesting differences emerged in how this was conveyed. There was generally a sense of pessimism and sometimes irony. This was summed up by Noel ending his excerpt above with '*it doesn't work like that does it?…if only'.* While others were more pragmatic with *'…just say right, we'll plan it for another day if we can…'* (Cala, line 119-120). For the participants who did not receive any clinical supervision at the time, but had received it in the past, the sense of a resigned acceptance appeared to convey a mood of exasperated hopelessness.

For participants who received clinical supervision more frequently, it was often discarded at busy times. This suggested clinical supervision was afforded a lower priority in relation to other ward duties and cancellation was often justified as this was preferable to *'taking people off the ward, so it's usually staff shortages'* (Louise, line 77).

Other participants who had received infrequent clinical supervision felt a sense of inequity and gave the impression that HCA/SWs were not given time that registered nursing staff were. This was reflected in comments such as: *'If it's important for qualified staff, then it must be important for all'* (Wasim, line 168-169). Other participants described inserting clinical supervision when and where possible, which would vary the time spent within it. This gave the impression that any clinical supervision, regardless of place and duration, was better than none and it appeared proactive: '*yeah you have about fifteen minutes sometimes, it depends on what time hand over finishes'* (Carla, line 55-56).

For some participants, the time available impacted upon the quality and sustainability of clinical supervision. This was notable when a direct comparison was made with previous clinical supervision delivery of better quality, as in non-inpatient settings. Wasim comments how clinical supervision was delivered in a previous setting:

> *'The young lady [clinical supervisor] would have had things she'd want you to deal with and help me, you know, to help me along because, I'm quite... err a force at times to speaking and I'm quite prepared to tell what I feel. Yeah, she was quite prepared to let me drive, drive the meeting' (Wasim, line 121-124).*

When discussing the present inpatient setting, some participants questioned the clinical supervisor's competence, for example, *'I don't think she [clinical supervisor] knew what she was doing'* (Linda, line 42-46) or one supervisor was described as *'clueless'* (Wasim, line 316)

when delivering sessions. Some participants described managerial rather than clinical supervision by recalling questions such as, *'…there's usually like bullet points of like…err… any problems...err what you're doing, where do you want to be, you know, where do you want to go, training things like that.'* (Noel, line 40-41). This could be interpreted as supervisors resorting to the clearly defined structure of management supervision. This is set out in a step-by-step manner and could be considered less challenging, as it did not require the spontaneity and time for discussion, facilitating clinical supervision.

All participants perceived a general lack of interest in them, as HCA/SWs, in receiving clinical supervision from the organisation and in particular if they were attached to inpatient settings. Perception varied between participants and was expressed in several ways. For some participants the frustration at the lack of clinical supervision was expressed clearly as *'There is no clinical supervision on adult mental health inpatient wards, because nursing assistants [HCA/SWs] are not focused upon on adult in-patient wards'* (Wasim, line 59-60). This appeared to indicate that HCA/SWs were somehow not worthy of clinical supervision from the organisation. For other participants who received clinical supervision more frequently, there appeared to be justification for clinical supervision by appealing to the concept of collaboration and inclusivity as the team as a whole: *'we all here for the best interest of the patient and should be working together'* (Amita, line 171-172).

This perceived lack of interest at an organisational level appeared to be confirmed by all participants who noted the lack of explicit time allocation for clinical supervision, leading to little or no priority or guidance to receive clinical supervision. Again, all participants had a view on this aspect. It was interesting to note how three participants circumvented the lack

of clinical supervision by identifying an alternative approach; for them, clinical supervision took place over a 30-minute period following the handover and change of shift period.

This initiative was possibly due to maximising the number of people who could attend clinical supervision as, at the handover period, the ward had its highest numbers of staff present than any other time. However, it was notable how even this time was conditional on the length of the handover report. This could be interpreted that staff valued their clinical supervision with a determination to make it happen in the absence of a prioritised time.

It was apparent how any approach was valued by the participants with one participant discussing how they worked on the bank/pool within the organisation and how they witnessed apparent inconsistencies across the organisation in relation to HCA/SWs within inpatient settings receiving clinical supervision.

> *"As I say, I work on quite a few [shifts] on bank, I don't just stay in my local area, I go out of area as well. I can go to other wards and think, I'm equipped, should anything happen, most scenarios I've probably been through or been in. A lot of wards are not the same. I don't feel that confident on other wards…that I probably feel on the [ward] that I'm working"* (Ann, line 208-213).

This was interpreted that being in receipt of clinical supervision, for this participant, gave a sense of security and confidence in their own practice when in areas were clinical supervision occurred.

All participants discussed organisational provision in terms of how the organisation facilitated or communicated the delivery of clinical supervision for HCA/SWs. This was

generally perceived as *'a tick box exercise'* (Wasim, line 177-179, Noel, line 86-88). The sense of tokenism was also evident in appraisals of its quality. The following view from Linda alludes to her perception of this issue.

> *"..I didn't find it beneficial at all, I felt like I was doing it because she'd been told she had to do it and that why can't we do something that would help... y' know and like I say I tend to ventilate my…I'm a great ventilator*[8]*… but it does, then it eases the atmosphere…but, no.. and I can't even say again there was no structure to it really, because I don't think she knew what she was doing…and that's no disrespect. It was no disrespect to the nurse what so – ever. I think they were all at a loss all of a sudden, you've got to do this supervision…well, no I don't think they knew"* (Linda, line 35).

Linda's perception of her experience of clinical supervision is clearly not what she expected as she stated that she thought the supervisors are 'told' what to do. There appeared to be a suggestion that everyone was following a particular directive so the organisation may be viewed as addressing a particular issue without any meaningful conviction. Two other participants described similar interpretations accompanied by gestures which referred to 'ticking off' a task that needs to be achieved by the organisation (Wasim, line 318, Noel, line 88); this naturally excluded elements to facilitate their own development or support. The meaning indicated one of an automated mechanical process that forced HCA/SWs to '*go through the motions*' (Noel, line 88).

[8] Being very good at venting in clinical supervision sessions

All participants discussed, to varying extents, their perceptions around experiencing a sense of division between themselves and registered nursing staff. Experiences appeared to coalesce around not feeling valued, characterised by a lack of recognition of the HCA/SW's contribution and role and a reluctance for collaborative working. As Amita commented:

> *"I feel as though we don't get involved, it's like them and us, you know, it's like when ward rounds are going on, we don't get invited into the ward rounds, which I think with us being on the ward seven and a half….the full shift, we have more contact with patients. We see more of the day experiences and how they are engaging with other peers and how bright they feel for the day, err and as they are getting ready for ward round day you can see a dramatic difference in the presentation. Err… So I just think that they are not seeing the true patient when ward round is happening to what we see all week, so I do think we should be more involved instead of them and us, we are a team and we should work together"* (Amita, line 118).

Amita's use of dichotomous terms, with the phrase of *'them and us'* emphasises the divisions between staff which were understood to lead to unequal provision. Amita's comments also suggest that HCA/SWs have more direct contact *'…we have more contact with patients. We see more of the day experiences and how they are engaging with other peers…'* when in comparison with registered nurses. Other participants also acknowledged this but seemed to view this as a problematic disconnect (Linda, line 140-143, Adrian, line 506-508) which was perceived as a further division with registered nurses making decisions without any consideration or collaboration with HCA/SWs.

A further division perceived by half of the HCA/SWs was reflected in a perceived attitude of registered nurses, in particular, newly registered, who were thought to have *'got career minded rather than having a genuine interest'* (Wasim, line 185). Amita's comments below appeared to portray subtly, how registered nursing staff, missed opportunities to value contributions by HCA/SWs in clinical situations: *'I just think that they are not seeing the true patient when ward round is happening to what we see all week'* (Amita, line 124-125). These missed opportunities of inclusivity of the HCA/SWs by the registered nurses were perceived as meaning HCA/SWs were not appreciated *'Sometimes now you do feel undervalued'* (Linda, line 145) and thus compounding a sense of friction with registered nurses (supervisors).

This was interpreted by most participants as impacting upon the relationship dynamics in clinical supervision, as commented on by Carla (line 213-221):

> *P: "Yeah, then our decision gets shunned off, and whatever, it's a bit pointless sometimes when you've just had a meeting at supervision…then that isn't agreed with by one or two staff".*
>
> *R: "How does that make you feel"?*
>
> *P: "It's annoying… because we're doing it for our benefit because we're the ones that, like I said… spend most time with the patients".*

The dynamics of the relationship between registered nurses and HCA/SWs on the ward and within clinical supervision were complicated further with the HCA/SWs' perception that the registered nurse's university education was viewed, by registered nurses themselves, as more valuable and superior to any practical experience HCA/SWs could contribute. In turn

this was interpreted as emphasising a sense of inferiority expressed as: '*I suppose I'm not as important like, you know what I mean, because I've not spent that three years at…[university]* (Wasim, line 193-194). While others commented: *'The door closes at a band two, unless you have been to university, then the door opens'* (Ann, line 157). This aspect clearly drew emotional responses, with participants reporting feeling *'miffed'* (annoyed) because HCA/SWs had a '*wealth of experience'* that supervisors '*do not take account of*' or *'it's [experience] not valued'.*

For all HCA/SWs clinical supervision was perceived to be primarily about self-improvement and '*a patient or it could be something that has happened on the ward*' *(Ann, line 32-33).* To contribute to clinical supervision, HCA/SWs viewed their experience as key to this *'one thing you can't buy. When you've a lot [of experience] you can deal with a lot more situations.'* (Wasim, line 201-202). Experience was interpreted as an attribute that should mean being valued or at least acknowledged by registered nurses but this seldom happened. Adrian (line 785-787) comments:

> "*but they [registered nurses/ clinical supervisors] don't seem to give a shit but they've never experienced some of the experience I've had and it's sort of like well, I'll pass it on to somebody else…but if you want to change something, everything's going to cause… if you're going to bring everything up in clinical supervision."*

For some participants, clinical supervision appeared to have a strong teaching element, to which knowledge acquisition appeared to be the focus for the inexperienced clinical supervisor at the expense of acknowledging the informal knowledge gained through experience of the HCA/SW. Interpretation of this aspect was twofold. Firstly, the inexperienced clinical supervisor was possibly using a teaching approach to help them

structure and guide the clinical supervision sessions in the absence of experience. Secondly, the lack of recognition of the HCA/SW's knowledge development through their experience, in and outside of the organisation, appeared to antagonise some HCA/SWs. For example, Linda (line 185-192) commented:

> *"But I'm God, I've read the book, who do you think you are? Well, I'm God as well, and I've got more experience than you'll ever have… or they try teaching you about the…'oh they've got bi-polar'…. no they've not. They've been shoving cocaine up their nose for the last three weeks and that's why they are coming down. I've got bi-polar, my father had it, please don't patronise me, walk a mile in my shoes. So… they… would benefit from some clinical supervision…they really would, because to me they want to go back to…'bring us a drink in on the tray'…or they'll blank you, that's another belter[9]".*

In this comment the sense of exasperation is notable possibly because it was difficult to restrain. An underlying sense of frustration from many HCA/SWs was indicative of the disrespect they encountered, not only for their role but for them as people.

Overall, the theme suggests that HCA/SWs find clinical supervision useful when it is pragmatic (learning from, and working with, issues that directly impact on them). HCA/SWs also broadly believed that their experience could form a helpful contribution but this was often overlooked and marginalised.

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[9] 'belter' is a slang word used as an outstanding example of something. In this context it was used with sarcasm.

4.4 Overarching theme two:

How clinical supervision created value: *'Because of supervision, the way it's structured and the way it works, it's kept me within the* NHS'

All participants contributed, discussed, and reflected upon several factors important to how clinical supervision created value. This was determined by facilitating access to, and taking part in, effective clinical supervision which also created a sense of belonging. These factors included a commitment to the process, the facilitation of learning and development and being supported. Participants also discussed developing opportunities for the HCA/SW to contribute to and shape the process of the clinical supervision, which appeared to give a positive sense of identity.

All participants expressed being committed to clinical supervision when it was perceived as having purpose and meaning. For most participants, this was interpreted as the supervisor demonstrating an approach that appeared to understand the role and potential contribution of the HCA/SW. This seemed to be facilitated further when participants viewed a sense of pragmatism to the approach.

Pragmatism was demonstrated in words such as 'structure' and 'solution' which were thought to have provided practical help to work with service users/ patients and difficult clinical situations. HCA/SWs appeared to value the supervisor's approach when it was perceived as coming from: *'Somebody who can listen, understands, and has got knowledge' (Amita, line 57).*

Adrian's comment below also captures these aspects well which possibly permits him to commence with *'she's brilliant'* about his supervisor.

"she's brilliant, you know she came as a band 6 but a bit after she became sort of a promoter sort of thing, she did a splendid job, we had a… even ward manager signed it off, we had a whole afternoon and all we did… we were going to do blood pressure, do you know they paid for that, do you know we were supposed to be on the ward but no, she took us off the ward, everything was all wrapped up, we did the hand one [manual sphygmomanometer to measure blood pressure] and all the rest of it, what all the range means and they took you through it all and she does a bloody good job and I think what we were saying about all the qualities you need, I think she's… she's got em…" (Adrian, line 724-731).

Adrian appeared to value this commitment to clinical supervision, as demonstrated by the supervisor's enthusiasm and investment both in time and expertise in developing the HCA/SW role. Investment in the HCA/SW appeared to be based on an understanding of their role which brought value and appeared to be a key requirement in being a supervisor for all HCA/SWs.

It is worth considering that Adrian also uses the terms *'promoter'* and *'splendid job'* possibly suggesting the supervisor was not only able to promote clinical supervision but through their understanding of the HCA/SW was able to present as an influential role model who gave clinical supervision a sense of meaningfulness. However, the influence of the supervisor and ability to understand the HCA/SW, for some participants, appeared to be based on a perception that it could be better achieved from a nurse who had lived experience of being based within inpatient settings and understood *'what happens on the wards'* with their working environment and unpredictability. For others it was important for the supervisor to have an experience of being a HCA/SW themselves. This shared experience

could be interpreted as believing that this would endow the supervisor with greater empathy to understand. This identity was reflected by one participant with the use of words such as *'us'* and *'who we are'* which seemed to have a sense of wanting to be understood as a HCA/SW and appreciated for their role.

Adrian also appeared to suggest his value in a supervisor with practical knowledge. '*We had a whole afternoon'* and *'we were supposed to be on the ward but no, she took us off the ward',* indicating time was given up for this and '*they took you through it all'* indicating a problem-solving pragmatic style of teaching from a thorough knowledge base.

Other participants also referred directly to the knowledge base of the supervisor, while others referred to this as *'… the wisdom of their [supervisors'] experience, might bring something up that you've probably overlooked' (Noel, line 149-150)* which can be a guide to better practice. The facilitation of knowledge from the supervisor appeared to be enhanced when this was pragmatic and structured. This was valued by all participants, even participants who were not receiving clinical supervision frequently, but who reflected on a desire to receive this.

As Wasim commented:

> *"…but if it's [clinical supervision] structured, you know, you go to that, you have that meeting and you might not think you need a supervision then, you come out of the supervision, you've unloaded a lot" (Wasim, line 159-161).*

Pragmatism for some participants was determined in how adaptable some supervisors within inpatient settings became when trying to explore unconventional approaches to clinical supervision. Three participants indicated that the implementation of clinical

supervision was utilised at the handover period which was pre-prepared (with guides) for 30 minutes. Thirty minutes consistently appeared to be sufficient for HCA/SWs to allow key aspects of clinical supervision to develop such as reflection, skills development, and personal growth.

Personal growth and self-development appeared to have been facilitated by the process of reflection during clinical supervision. Participants commented in a way that implied the reflective nature of deeper level thinking of different perspectives from others was quite profound and sometimes made participants question their own thinking and ideas. This was reflected in the comments made by Louise.

> *"[The psychologist] Probably spoke about them [the clients/patients] for about forty-five minutes and I think it's great for staff to engage with each other and reflect and improve standards of care…as we can face many challenging people on the ward. (pause) err…basically just to talk about a client and I think it helps other people's point of view. Plus, it gives you time to go into the background of the person which gives you a greater understanding. Sometimes we don't always get the chance to read the case notes in depth, so it gives you a better understanding and I think it helps because it made you see it differently and different people's points of view"* (Louise, line 22-26*).*

Louise refers to being able to *'engage'*, *'reflect'* and *'improve standards of care'* as she '*can face many challenging people on the ward'.* This suggested that clinical supervision provided an opportunity to reflect, develop and meet the challenges. Louise also identifies how reflection can give a full picture of the service user to develop a *'better understanding'*. This

appeared to suggest that clinical supervision was one of the only opportunities when HCA/SWs could participate in reflection and be encouraged to think more deeply about the personal impact of their decisions, which created a perceived value in clinical supervision.

Reflection, as part of clinical supervision, also appeared to have an influence on the participant's learning process. This was valued by participants as an important way to learn. For some participants there appeared to be a sense of why and how learning was taking place. From a 'why' perspective, clinical supervision appeared to offer a safe sanctuary where the difficulties of the role on the ward could be reflected upon. This was reflected in words used by all participants, such as *'difficult', 'challenging'* and *'continuous'* and metaphors such as *'there are no easy rides',* were used frequently. However, for many participants, there was a sense of gratitude for the invitation to reflect. Reflecting on how learning had taken place appeared to suggest a sense of being prepared for some participants while, for others, learning appeared to be about not repeating any mistakes.

Whichever way the learning and development was achieved, there was a sense that it contributed to the growth of competence and confidence. Ann's comments were typical of other participants' but they provided an insightful view on the impact for her.

> *"It [clinical supervision] just gives you a lot more confidence… more confident and competent, to go out there. You know, you all sit in the office, you know, you do your handover and this has happened,… and this is a new patient…You feel, I can go out there,…I can do a job. I wouldn't like to go on a ward and think…er (pause) I don't know what I'm doing…(pause) as you know, I say it just makes everybody uneasy, if you don't know what you are doing, we all have to basically be on the same page, if*

we can. It doesn't always work but we try to be on the same page…same level" (Ann, line 293-300).

Developing confidence and competence was considered inspiring and added to Ann's self-esteem and belief in herself as competent within her role: *'You feel, I can go out there, I can do a job'*. This increased personal growth, confidence and created a sense of value. It was also interpreted as validating what was perceived as good and safe practice. Ann's concerns for safe practice were reflected by her uncomfortable thoughts of potential incompetence '*… it just makes everybody uneasy, if you don't know what you are doing'*. It is also notable how Ann includes all her HCA/SW colleagues '…*we all have to basically be on the same page, if we can'.* It is possible Ann was thinking of good and safe practice in relation to a consistent approach but also acknowledged the unpredictability of acute care, as this is difficult to gage from day to day. This appears evident in Ann's comment '*It doesn't always work but we try to be on the same page…same level'* (Ann, line 299-300).

Ann's comment appeared to be an example of the hermeneutic cycle as she considered the impact of confidence and competence, then paused while she thought and considered the alternative of not being confident or competent. She then, reflected upon this to the point of this being identified and expressed on how uncomfortable this alternative would have been. With the thought at the forefront of Ann's self-awareness, she then returned to consider the impact of confidence and competence, but extended this to the team, as the idea of sharing and equality appear to be significant.

Most participants commented on a sense of belonging through the perceived support clinical supervision provided, whether that was currently or historically. Support seemed to

involve being able to '*vent'* feelings and the recognition of the HCA/SW as a colleague who was individually and collectively listened to.

An aspect around being supported in clinical supervision which Ann valued was accessibility to others to discuss worries or concerns. This was accessibility to *'anybody'* involved and appeared to give a sense of autonomy to seek reassurance, as and when necessary, which was valued by all the participants who commented on this aspect.

> *"I don't want to be on the ward and not know what I'm doing. I need to know what I'm doing. Err…the supervision that we get is fantastic, we get in our practice, it is written in the diary, so it's never missed, you know, I'm aware of nurses in other hospitals, that don't get the support we get from the manager that we do. Err…You know we get group supervision and individual supervision. You can always speak to anybody if there is anything worrying you, anything concerning you. You can always say 'can I have a quick word with you' and there's always someone there". (Ann, line 19-26)*

Several participants appeared to express a sense of gratitude for a perceived 'permission' for the time in clinical supervision for a sense of *'release'* of pressure and the support available for this. Other participants used other similar metaphors around releasing pressure such as '*the weights off your shoulders'* and *'holding all that'.* An interpretation of these comments, collectively, could have also suggested how there was a release of the emotions that had built up, possibly through transference[10], in the difficult day to day

[10] Transference in this context could viewed as the HCASW re-directing some of their emotions, from the challenges of their duties, to the researcher during the interview.

challenges of the role and how clinical supervision as a process offered a sanctuary to unload such emotions.

Most participants appeared to want to feel valued and listened to, as they believed they had much to offer but this was not considered. When the value of the HCA/SW was acknowledged in some way (in the past or present), this was interpreted as meaning appreciation.

Two participants identified feelings of being valued when distinguishing between previous clinical supervision experiences and present ones. Phrases such as *'you didn't feel like an unqualified member of staff'* appeared to mean their band / grade did not matter and the participant's previous working environment had more inclusivity as everyone's participation and contribution was valued, regardless of grade.

Being supported, for many HCA/SWs, appeared to go deeper than practical support with their role; there appeared also to be a desire to be acknowledged and feel a greater sense of belonging through the inclusivity and equality that clinical supervision represented. For some participants this appeared to be how they contributed to the development of opportunities for clinical supervision to happen more frequently and shape the process to facilitate a sense of support and belonging.

Cala was one of four participants who utilised pragmatic approaches to ensure that their supervision sessions took place. This type of arrangement took place for approximately 30 minutes following handover between two-day shifts. This approach was very popular with Cala and other HCA/SWs who were involved.

> *"Erm… here we tend to do it as like a team meeting so all the NA's [nursing assistants] go into a room and one person is allocated on what they want to bring up in that particular session, so to me it's just kind of a team meeting where we all discuss something. It's like an issue or something that we can work on or something like that or what we've found hard or what we all think we've done well on. It doesn't have to be what you can improve it can be what we all think we have done good at. If there has been an incident, how did we react and did we do it well"* (Cala, Line 28-34).

Here Cala talked about all HCA/SWs being in a room and how presentations were allocated. It was notable how the words *'team meeting'* appeared twice and it appeared to be viewed this way rather than clinical supervision. This may give the impression of clinical supervision presented with greater informality, which was an aspect that other participants appeared to prefer. Cala appeared to identify a collaborative team approach with regular reference to the words *'we'* or *'we've'* which appeared to suggest the identity of the team was recognised and heard. Collaborative approaches appeared to be applied to how practice issues were *dealt with* and how supervisees worked towards a *common ground about a subject in the end* (Adrian, line 192-193). This was interpreted as meaning the HCA/SW's contribution was recognised. There also appeared to be a preference for group supervision by most participants, which was viewed as '*better as a group so everyone can air their views, and you can hear different people's points of view'* (Louise, line 106-107).

By contrast, Linda was one of the participants whose ward had not utilised any pragmatic approach to ensure that HCA/SWs received clinical supervision and only ever received infrequent clinical supervision.

"It shouldn't be just teaching somebody, again I'm back to the ventilating, it should also be able to ask them something that's relevant …questioning why we are doing that… Ok I'll hold my hands up…I am a thorn in the side because I will question [frequently]…not being afraid to question. Give the support workers the confidence to have a voice and to say 'Well look, there's a team down here, can you listen to us all…It's giving us that voice and that….[helps] us to develop it in the right way if you will, you know " (Linda, Line 225-231).

Linda gave the impression that when her clinical supervision took place, it appeared quite fixed in structure, content, and delivery with the word *'just'* in the sentence of *'It shouldn't be just teaching somebody'*. This appears to be confirmed in the next sentence with *'should also be able to ask them something that's relevant …questioning why are we doing that…'* This implies little autonomy and maybe an inexperienced clinical supervisor with limited understanding of how to facilitate clinical supervision. Linda appeared to make a request for the identity of her peers to be recognised and worked with more collaboratively: *'Well look, there's a team down here, can you listen to us all….'.* Within Linda's comment she appeared to suggest that HCA/SWs need to feel empowered and a need to be listened to with recognition for what can be offered, rather than a contribution whose reception was influenced by grade or role.

It was clear in this theme that clinical supervision created a sense of value that was appreciated by all HCA/SWs. Value was represented in many ways but was often underpinned by the HCA/SW feeling acknowledged or being the focus in the way their contribution was accepted. The creation of value from clinical supervision was appreciated

by some HCA/SWs to the extent of their determination to be part of clinical supervision despite the challenges of the clinical setting.

4.5 Reflexivity and Positionality

Thinking reflexively on this, it was difficult not to feel a sense of admiration for the HCA/SWs who were trying to address the challenges they encountered. It appeared they wanted to receive meaningful clinical supervision and be included as a valued team member with ideas of their own. I developed a sense of how much they wanted to be viewed for their experience and contribution rather than perceived within the confines of their role. The challenges encountered by the HCA/SWs appeared to bring a sense of determination to engage in clinical supervision, which only appeared to build their identity and sense of belonging when participating in it.

Understanding these nuances of the HCA/SWs' experience and how meaning was interpreted from those experiences confirmed my interpretivist approach. The approach confirmed questions of 'how' and 'what' and provided insight into those lived experiences, which was facilitated by the method of IPA.

4.6 Chapter Conclusion

This study's primary aim was to examine HCA/SWs' experience of clinical supervision within an acute mental health inpatient setting. This chapter has provided interpretation and given meaning to participants' descriptions of this experience. The first of the two overarching themes explored the narratives of engaging in clinical supervision with a series of ongoing

challenges. The participants' narratives described issues of consistency and unpredictability within inpatient settings. Other aspects included the organisational challenges of operational logistics (e.g., time and supervisor availability/competence). The supervisor and supervisee relationship were also interpreted as a challenging terrain to navigate successfully given the perceived lack of status and respect given to the HCA/SW. The second overarching theme explored how clinical supervision created value. The participants' narratives described the value and meaning of commitment to clinical supervision and how valued professional development and a sense of belonging were. To conclude, the meaning of clinical supervision, which has emerged from the findings, will now be discussed in more detail in chapter five alongside the literature discussed in chapter two.

Chapter Five: Discussion and conclusion

5.1 Introduction

The presentation of this chapter is divided into two parts. The first part will discuss and reflect on the findings from the IPA analysis in the context of the previous chapter, the literature reviewed in chapter two, other related literature and established theory with consideration given to the study's original contribution. The perspectives presented by the HCA/SWs in this study essentially demonstrate two broad features. Firstly, the meaning of the challenges they interpreted from their encounter on a personal, professional, and organisational level and, secondly, the meaning of the value they placed on clinical supervision to address those challenges.

The second part will provide a critical review of the research process for this study and IPA as a research method. The chapter concludes with the role of reflexivity and discussion on individual, professional, service and policy implications. Finally, further research and a conclusion will be presented.

5.2 Relating the findings

In the previous chapters, the application of IPA and the underpinning theory attempted to capture what it meant to be an HCA/SW experiencing clinical supervision within a mental health inpatient setting. The literature search in chapter two, a recent qualitative research literature review (Coleiro et al., 2022) and other research literature reviews involving qualitative studies (Avrill et al., 2022; Howard & Eddy-Imishue., 2020; Rothwell et al., 2021), have not delivered any detailed interpretation of meaning making and what it means

specifically for HCA/SWs to experience clinical supervision within an inpatient setting, as there appears to be no qualitative research study that focuses solely upon HCA/SWs within mental health inpatient settings. This study addresses this gap.

The themes presented in the findings reflected the lived experiences of clinical supervision by the HCA/SWs and contextualised the experience as a whole. There were two overarching themes.': Trying to engage clinical supervision amid on-going challenges: *'One of the things that could help is… that it [supervision] happens basically I suppose and that it doesn't keep getting called off…'* and How clinical supervision created value: *'Because of supervision, the way it's structured and the way it works, it's kept me within the NHS'*. Each theme comprised of three sub-themes each (appendix XIX). The interpretations from each theme impacted upon each other and were reflected in how participants' accounts of their experiences converged and diverged. These themes will now be discussed in relation to the literature in chapter two, other relevant published findings and how these finding accord with existing established theories.

5.3 Theme 1: Trying to engage clinical supervision amid ongoing challenges: 'One of the things that could help is… that it [supervision] happens basically I suppose and that it doesn't keep getting called off…'

The first subtheme, '*trying to find some consistency in a place of unpredictability',* reflected the recognition that working in a UK acute mental health inpatient ward continues to present several challenges within these unpredictable settings (Avrill et al., 2022; McAllister et al., 2021). Within the findings of this study, concerns over unpredictability, safety and lack of managerial support impacting upon clinical supervision within the setting were evident.

This was also in the findings in a Danish study by Buss et al. (2018), an Australian study by Cleary and Freeman, (2005) and a UK study by Scanlon and Wier (1997) (discussed in chapter two). Similar issues were also raised in international literature reviews involving clinical supervision of nurses and other health care professionals by Wyder et al. (2017) and Howard and Eddy-Imishue (2020).

The interpretations from the analysis in chapter four suggested that HCA/SWs wanted to engage with clinical supervision but did not always get the opportunity, possibly due to the unpredictability of inpatient settings. This reflects the similarities noted by Cleary and Freeman (2005) and Cleary et al. (2010). In this thesis, however, the analysis and interpretation of meaning appeared to suggest that infrequent engagement in clinical supervision might have impacted on how HCA/SWs viewed their clinical priorities based on perceived responsibilities of their duty. For example, clinical supervision appeared to be a process which could not be prioritised over HCA/SW duties. HCA/SWs interpreted the meaning of responsibility as a duty to respond immediately, whatever the situation, to inpatient service user events and prioritise the response to these above any other concern such as infrequent supervision.

The interpretation of the meaning of how the HCA/SW's valued their sense of duty appeared to be viewed as valid if they were direct pragmatic interventions. This finding did not appear in any other review and might suggest that clinical supervision was not viewed as direct or pragmatic enough to have equal priority with direct interventions of care giving duties. This appeared to suggest that clinical supervision was therefore viewed as a lower priority activity and could be dispensed with or moved, if time was not available or in competition with care giving duties. This linked with the inconsistency of clinical supervision

with little thought for any contingency plan for missed or cancelled sessions, which appeared to be accepted as a frequent occurrence.

This lack of priority and inconsistency were similar themes identified in several international studies discussed in chapter two (Arvidsson, et al., 2001; Buss, et al., 2011; Cleary & Freeman, 2005; Scanlon & Weir, 1997). All these studies identified the lack of priority for clinical supervision to the point of similar phrases being used by participants in this study, such as *'not prioritised' 'ward too disturbed' 'no time' 'sometimes it gets cancelled'*. However, these studies did not use IPA methodology and did not identify the exclusive perspective of the HCA/SW and the interpretation of meaning in prioritising their duties of care giving. This context presented a challenging paradox of parity. For example, on one hand, the view from the participants was that clinical supervision was important enough to be considered as an integral part of the role and duty of the HCA/SW as this would promote a better understanding of the functions of clinical supervision and create enhanced skills. Yet, on the other hand, the role and duty had to take priority over clinical supervision because of the unpredictability of the setting.

For some HCA/SWs in this study, the infrequency of receiving clinical supervision was interpreted from meanings based on questioning some supervisor's ability to deliver, due to lack of experience, poor knowledge and understanding of clinical supervision. These findings were consistent internationally with those from Berg and Hallberg (2000), Olofsson (2005), and Scanlon and Wier (1997) (discussed in chapter two). A mixed methods study conducted in the USA reported that inexperienced supervisors who were disinvested tended to be poor communicators and / or inflexible, resulting in challenging supervisory relationships and inconsistent clinical supervision (Kemer et al., 2019). Although none of the 22 participants in

the study by Kemer at al. (2019) were HCA/SWs, registered nurses or worked within inpatient mental health wards. This thesis also found inexperienced supervisors were perceived to be poor communicators and disinvested in clinical supervision by the HCA/SWs. These experiences were interpreted as a lack of respect from the supervisor for some the HCA/SWs and their role.

The confusion around understanding clinical supervision from clinical supervisors has been evident in research studies for some time. It appears to validate the view within mental health nursing of a conceptually confused understanding of clinical supervision, with its many definitions and varying models of implementation (Cleary, et al., 2010; Masamha et al., 2022; Storey & Minto, 2000; Yegdich & Cushing, 1998). This lack of clarity appears to be particularly evident for inexperienced supervisors and inpatient-based mental health nurses (Storey & Minto, 2000; Cleary, et al., 2010).

This point could suggest possible issues around the supervisors' competence and ability to access sufficient and appropriate clinical supervision training. This view was interpreted by some HCA/SWs in this study, based on the meaning of their experience, to be a contributory factor in the inconsistency of delivering clinical supervision. Three HCA/SWs reported their experience of clinical supervision as very similar to managerial appraisals. This may be because inexperienced supervisors may lack the training to implement a structure that is more abstract than an appraisal.

The second subtheme from the overarching theme, *'wanting more than a tick in the box'*, reflected participants' views of piecemeal clinical supervision arrangements as an extension of the organisation's lack of commitment to clinical supervision. Participants considered that the organisation did little, if anything, to facilitate clinical supervision in terms of making it a

priority or allowing protected time for it to take place. This appeared to lead to a general sense of clinical supervision being viewed as a tokenistic exercise happening in name and policy only. This was disappointing for the HCA/SWs as many had experienced what they perceived as 'good' clinical supervision and wanted this to continue.

The perceived lack of commitment and understanding from the organisation was interpreted by some participants as being responsible for some clinical supervision sessions being a misinterpretation of what they thought should be happening. The dissatisfaction with the provision of clinical supervision was also borne out by some studies included in the literature review. Studies by Buss et al. (2018), Cleary and Freeman (2005), Gardner et al. (2010), Scanlon and Wier (1997) identified participants who were dissatisfied with the inconsistencies in terms of time being available, implementation and the perceived lack of commitment to clinical supervision generally which appeared to affect morale. These studies were not solely focused on HCA/SWs but registered nurses also, which raises questions on the impact of this on the profession as a whole, and the complexities of implementing sustainable clinical supervision within inpatient settings.

Factors which affected medical, nursing, psychology and occupational therapy staff morale on seven inpatient mental health wards in England was the focus of a qualitative study involving group interviews (Totman et al., 2011). Although the study did not focus on clinical supervision, it presented a similar finding to this study in relation to staff believing they had limited or no voice or influential control. Totman et al. (2011) suggested benefits to morale when staff believed their views were considered for any decision making. HCA/SWs in this thesis, interpreted their role and status as the reason as to why they were not listened to, believing that their views were not considered. For the HCA/SWs with experience of 10

years or more, this was a particularly sensitive issue, as they interpreted their experiential knowledge as potentially helpful in difficult situations. However, this was interpreted as not being valued and was reflected in such terms of themselves as *'dogsbody'* interpreted as meaning menial, undervalued and with no participation or influence in decision making. These HCA/SWs believed that they had the experience to influence and a contribution to make but this was overlooked based on their role.

Considering these findings theoretically, this lack of influence and disconnect, was interpreted from participants as meaning a sense of no control. These interpretations appear to fit with the theory of locus of control, and particularly HCA/SWs' experience of external locus of control. The concept of locus of control was developed by Rotter (1966) and categorises how individuals perceive control over events in life which affect them and determines individuals' responses to those events. People who attribute their own efforts to their success or failure are described as having internal locus of control, while those who believe events are determined by external factors, which they have no or limited ability to influence are described as having external locus of control (Joseph & Keating, 2023). The impact of external locus of control on wellbeing, motivation, and commitment to an organisation by nursing staff has been demonstrated in a quantitative study by Kalil et al. (2019). This concluded that two fifths (75 of 129 staff nurses) of the sample, expressed external locus of control, which was considered too high by the researchers and was associated with negative outcomes. External locus of control in the context of this thesis appeared to be perceived by most HCA/SWs as also negative and was exemplified by comments such as *'you just feel worthless, I'm only a support worker, what does it matter?'* (Louise, line 68-69).

The third subtheme focused upon the role of *'difficult dynamics in the supervisory relationship'*. One of the key components of clinical supervision is its managerial aspects of quality assurance and ethical consideration, which places the supervisor and supervisee in a hierarchical relationship from the outset (Bernard & Goodyear, 2014). Ellis et al. (2017) argues that the hierarchy in the supervisory relationship places the supervisee in a vulnerable position that could expose them to emotional or psychological harm through no or inadequate supervision. Ellis et al. (2017) reported on the narratives of harmful clinical supervision and suggested that this was increasing as supervisors appeared to be unaware of or unable to acknowledge the potential of their actions. Difficult dynamics of the supervisory relationship involving some HCA/SWs and their supervisors were evident in this study as was reflected in HCA/SWs believing that they were not understood and their experience in situations was not considered.

In a qualitative study of power dynamics in clinical supervision with psychology counsellors, De Steffano et al. (2017), found five general categories. These were: how power resides with the supervisor's expertise, failure of the supervisor to recognise their own errors, the misuse of power to illicit self-preservation in the supervisee and how power can be shared when trust, transparency and nurturing is established (De Steffano et al., 2017). Some of these findings resonated with the HCA/SWs in this study, as supervisees were implicitly aware of their power disadvantage in the supervisory relationship, attributing this to the supervisor being viewed as an expert with expert knowledge. This, however, did not extend to inexperienced staff who were clinical supervisors. In these situations, HCA/SWs interpreted inexperienced nurse clinical supervisors as being more concerned with personal career development. This was further interpreted as meaning an HCA/SW has nothing to contribute towards a registered nurses' career development pathway and that the HCA/SW

experience was irrelevant to this. In addition, HCA/SWs interpreted the registered nurse status of the inexperienced supervisor as a means of exercising power to compensate for their lack of experience. This issue was compounded by HCA/SWs not being able to choose their own supervisor.

The exercise of power appeared to illustrate some similarities with French and Raven's power bases theory around coercive power, the use of legitimate power and expert power (French & Raven, 1959). French and Raven's theory has contributed to the understanding of power in therapy and the supervision dyad (Steffans et al., 2022) making this theory relevant to the findings in this study. Some HCA/SWs interpreted having their line managers as clinical supervisors as a conflict of role resulting in a difficult relationship dynamic to navigate. This was interpreted as increasing the likelihood of encountering issues around the supervisor implementing what was interpreted as expert power, and sometimes a sense of coercion, being used as legitimate power.

The issue of managers also being clinical supervisors and the subsequent challenges has been raised by some of the studies discussed in the literature review (Cleary & Freeman, 2005; Scanlon & Weir, 1997) which also conclude that clinical supervision provided by a line manager was not preferable for the risks outlined. More recently Howard and Eddy-Imishue (2020) found that supervisees found it difficult to establish trust when the supervisor was also a line manager which was a finding similar to this study. Despite these findings, there has, however, been an accepted hierarchical form of delivery of clinical supervision since it became a recognised feature of health care practice.

5.4 Theme 2: How clinical supervision created value: 'Because of supervision, the way it's structured and the way it works, it's kept me within the NHS'

This second overarching theme also comprised of three subthemes. In the first subtheme, the findings were focused around *'establishing a commitment to the process of clinical supervision that was implemented with purpose and meaning'*. All participants valued their clinical supervision sessions when they considered the clinical supervisor demonstrated commitment and a sense of purpose and meaning. This was interpreted as the clinical supervisor demonstrating positive attributes which were identified as a professional attitude, focus, knowledge, competence, enthusiasm, and an inspiring manner. The studies discussed in the literature review, e.g., Scanlon and Weir (1997), Berg and Hallberg (2000), Arvidsson et al. (2001) and Olofsson (2005), also focused on perceived 'good' supervisors as being able to motivate, inspire, acknowledge, and attentively listen to the supervisee. While the findings in these studies were similar to those in this study, HCA/SWs in this current study interpreted only experienced clinical supervisors as having such positive attributes. The experienced HCA/SWs interpreted supervisors with several years' experience as being more understanding and empathic towards them and their role with a sense of humility. These interpretations appeared to be based on meanings that experienced supervisors had life experiences, clinical experience, and a respect for the HCA/SW role which accentuated a mutual respect.

The role of clinical supervisor humility has been the subject of a discussion paper by Watkins et al. (2019) using case studies to argue for its necessity for effective supervisory practice. Within their discussion they examined different types of humility and proposed that it had a positive impact upon clinical supervision by enhancing the relationship, increasing receptivity from the supervisee, creating more opportunities for uninhibited feedback, and

fostering engagement with peers. Although the term humility was not referred to by HCA/SWs in this study, it was possible to interpret the meaning of this quality as being potentially perceived by some of the HCA/SWs who discussed the qualities of their experienced and effective clinical supervisors as being *'good supervisors'*.

Within the supervision sessions themselves, HCA/SWs' interpretation of a good supervisor also involved developing collaborative, empathic approaches combined with sessions being structured, organised and consistent. This appeared to mean the supervisor was understanding, confident and proficient. This aspect was supported in the findings by studies (Buss, et al., 2018; Cleary & Freeman 2005; Kemer et al., 2019; Scanlon & Weir, 1997) and reviews (Masamha et al., 2022; Snowdon et al., 2020).

One study from the literature review (Buss et al., 2011) found that supervisees who identified positive previous experiences of clinical supervision, influenced engagement and participation and without such experiences, barriers to clinical supervision were more likely to be evident. This was similar for some HCA/SWs who had experienced what they considered good clinical supervision sessions, based on the approaches discussed above. For the HCA/SWs without a positive experience of clinical supervision, not all perceived these experiences as barriers to clinical supervision. This made some HCA/SWs more determined that they could find a way to achieve a good clinical supervision experience.

In the second subtheme, '*self-development and learning to become a better practitioner*', participants appeared to value clinical supervision sessions perceived as being pragmatic. 'Pragmatic' was interpreted as learning tangible skills with direct instruction that developed new or existing knowledge and self-awareness and applied a problem-solving, self-directed

approach. Problem-solving and self-directed approaches were also found to be a dominant aspect when discussing clinical issues in other studies (e.g., Buss et al., 2011).

For some HCA/SWs, valued supervision sessions were also thought to result in positive self-development and knowledge acquisition by developing transformative learning through reflection. In a review of factors influencing effective clinical supervision for inpatient mental health nurses, Howard and Eddy-Imishue (2020) reported that reflection and learning was highly valued in clinical supervision across all the studies reviewed. Clinical supervision was also considered a formal opportunity for reflection and transformative learning. These findings were similar to those in studies discussed in the literature review (e.g., Buss, et al., 2011; Cleary & Freeman, 2005; Severinsson & Hummelvoll, 2001). For HCA/SWs, however, learning reflective practice skills was not considered to be part of the required mandatory skills within the participants' organisation. HCA/SWs also usually have no formal training programme and therefore have seldom encountered reflective practice skills until they take part in clinical supervision. The interpretation from most participants was that reflection, when combined with modelling and feedback, also gave meaning to confirmation and validation of their practice. For some HCA/SWs clinical supervision was a transformative learning experience as described by Watkins et al. (2019), which was described as developing new ways of thinking and behaving which can then be applied to different situations to learn from. An example of this would be how HCA/SW participants would take this new way of thinking into conversations on good clinical practice into discussions outside of clinical supervision.

Effective clinical supervision, in the context of this second subtheme, has been described as having four learning mechanisms embedded within it. These are: direct instruction, self-

direction (viewed as a pragmatic approach by the HCA/SWs), modelling and feedback (Bernard & Goodyear, 2014). It is notable how these mechanisms were interpreted by the HCA/SWs in this study, as a valued learning process and how this relates to Dewey's theory (Dewey, 1938) of learning, which combines experience plus reflection (Nel & Fouche, 2017). A further aspect of Dewey's theory relevant to this study's findings and the process of clinical supervision, is an individual's meaning making processes which emanate from the learning experience, and which are enhanced by collaboration and interaction. Building on Dewey's theory is Mezirow's theory of transformative learning (Mezirow, 2000), which advocates critical reflection of experience, collective practice, and rational discourse. Mezirow (2000) argues that people learn by trying to make sense of their experiences and form deeper meanings based on the interaction of new and previous knowledge. This is achieved by thinking in a more critically reflective way that examines the experience facilitating change in self-understanding, revision of beliefs and subsequent changes in behaviour. Almost all HCA/SWs had a significant body of experience accumulated in their clinical setting to provide them with a point of reference that could be utilised. A positive supervisory relationship can act as a vehicle that can facilitate being listened to, critical reflection of experiences and interpret meanings providing them with transformative learning and a developing autonomy (Nel & Fouche, 2017).

The final subtheme focused on *'feeling a sense of belonging as an HCA/SW'.* This was a positive aspect of clinical supervision that all participants valued. The sense of inclusivity and acceptance was particularly valued, as was being listened to and emotionally supported. This was interpreted as endowing respect for the HCA/SW's role, contribution,

and experience. The interpretation of a sense of belonging appeared to facilitate feelings of trust and empowerment to participate in clinical supervision without a fear of judgement.

The participants also valued the support and a sense of belonging from a supervisor who was perceived as approachable, experienced and gave a sense of validation to the HCA/SW role. A good supervisor has been defined as having the qualities identified above and the ability to follow any concerns and provide guidance for difficult clinical situations, which may be external to the clinical supervision session (Greer, 2003).

Many HCA/SW participants found guidance and support from each other. This gave them a sense of belonging and trust in each other within their group/ peer supervision sessions. This appeared to give a strong sense of cohesion, validity, and identity, leading to the development of a peer clinical supervision approach for some.

The concept of a peer/ group clinical supervision approach was reflected in some of the studies from the literature review. Most studies identified a sense of identity within a group while the studies by Buss et al. (2011), Gardner (2010) and Cleary and Freeman (2005) all identified a form of peer or informal style of clinical supervision, which had similarities to the interpretations and meanings expressed by the participants in this study. A more recent study into a service evaluation of a model of clinical supervision on an acute admission ward by Tuck (2017) also reported increased ownership, attendance, and commitment through team clinical supervision. Howard and Eddy-Imishue (2020), however, accept the benefits of peer supervision but argue that formalised structures with the objectivity of professional challenges should be instead of or as well as.

The findings from the HCA/SWs on their interpretations and meanings of belonging to a team or group strongly relate to the theory of psychological safety in teams, proposed by

Edmondson (1999). Edmondson examined medical errors through communication and team dynamics and found that teams who communicated better still made errors but were more likely to report them and use the experience as an opportunity to learn and improve. By contrast, teams with poor communication were more likely to under-report for fear of recrimination and punishment. These findings enabled Edmondson to develop the concept of psychological safety in teams. Edmondson (1999) argued that teams need to aim for inclusivity and to feel safe to contribute and challenge without a fear of being rejected, humiliated, or marginalised in some way. This would increase trust, acceptance, and respect, increasing a team's performance. The HCA/SW participants in this study all discussed a desire for their clinical supervision to embrace the components of Edmondson's theory. For some HCA/SWs this direction had been developed with positive effects.

5.5 Critical review of the research process and limitations of this study

As discussed earlier in chapter three, my research positionality has developed and become clearer over the development of this study. An understanding of the alignment of my ontological and epistemological position drew me towards an interpretivist approach which involved trying to gain an understanding of the nuances of the experience and how meaning was reached. The approach has facilitated questions of 'how' and 'what' and helped clarify the lived experiences of HCA/SWs' clinical supervision within inpatient mental health settings and their meanings of social interactions. This positionality influenced the choice of research method and is reflected transparently throughout the research process in this study. The following, therefore, provides a critical review of the various aspects of the research process. The critical review will inevitably expose the limitations of the study and

this review discussion, therefore, will embody observations and reflections. The critical review includes a critique of the research methods, IPA as a research method, the scope of clinical supervision within this study and a discussion on the role of reflexivity.

The quality of qualitative research of any form is dependent upon the methods used to ensure the rigour and trustworthiness of its findings. Several contributions have been made to determine criteria to demonstrate quality within qualitative research (e.g., Yardley, 2000; Roulston, 2010; Lavee & Itchakov, 2021) as its growth and influence continues. Yardley (2000) outlined four broad assessment principles for qualitative research generally and these were referred to as a guide for this study along with Smith et al. (2009) and Nizza et al.'s (2021) guidance specifically for IPA research. Yardley's (2000) first principle considered sensitivity to the context, which is concerned with the process of how the interviews are conducted, data handling and how interpretations are supported by literature. The second principal aimed for commitment and rigour, which is achieved through the attentiveness of the researcher towards the participants and also applied to data handling and the analysis and levels of interpretation. Yardley's third principal drew attention to the importance of transparency and coherence demonstrated by the clarity of the study and a coherent development of the phenomenon. Finally, Yardley (2000) stressed the impact of imparting an outcome that would be considered important, interesting, and useful, with future possibilities. In this study these principles were followed in the context of IPA.

IPA continues to establish itself as a qualitative method that involves the deep exploration of an individual's lived experience and making meaning (Smith et al., 2009). Assessing quality, specifically within IPA studies, has frequently focused on theoretical transferability of representative participant experience within themes (Smith et al., 2009). More recently,

however, Nizza et al. (2021) have suggested four quality indicators for IPA: constructing a compelling unfolding narrative, developing a vigorous experiential and / or existential account, analytic reading of participants' words and attending to convergence and divergence. In addition to Yardley's criteria above, these quality indicators proposed by Nizza et al. (2021) were also considered as guidance.

In this study, the methodological process and findings address Nizza et al.'s (2021) four quality indicators as the study constructs a compelling unfolding narrative in a group of participants who are seldom represented in the clinical supervision literature. The narrative development in this study aimed to convey a desire to change clinical supervision for it to become more meaningful. This was demonstrated in the expression of the hermeneutic cycle which was reflected upon in part and as a whole by individual accounts within and across the themes by each individual participant. This generated a narrative, while additional accounts from other participants took the narrative further usually offering a different perspective. The application of the methodological process also increased a personal awareness to draw a deeper attention to the hermeneutic cycle. Attempts were constantly made to travel back and forth through the data from the different perspectives on different levels in a non-linear way.

This process was very reminiscent of reflection which is a primary goal of clinical supervision. This perspective gave a further confirmation of the justification of using IPA to explore the experiences of HCA/SWs in clinical supervision. In keeping with the central aspect of IPA, the study also focused on capturing, transparently, experiential meaning and a close analysis and interpretation of the participant's words to give meaning to how the experience was described. An example of this was illustrated in the analysis presented in the

development of the themes and how these changed and developed in appendices XV to XVIII.

There was also a concerted attempt to address convergence and divergence by exploring comparisons between participants. This was demonstrated through their experiences compiled into matrix tables. An example of which is illustrated in appendix XX, demonstrating patterns of individual idiosyncrasies and similarities.

5.5.1 Recruitment, sampling and interviewing

The aim of IPA is to illuminate an individual's lived experience, which is achieved through purposive sampling. This also provided a justification for the sample size in this study (Smith & Nizza, 2022). Further reasons for the sample size were the time necessary for analysis and detail required for each participant. This strategy also aligned with the principles and quality indicators that were used as a guide for this study and discussed earlier.

Interviews are considered a key aspect when assessing quality within qualitative research (Nizza et al., 2021; Lavee & Itzchakov, 2021). The semi-structured interviews in this study were designed to allow participants to explore their own experiences at their own pace and discuss areas of importance and significant meaning to them. Interviewing can also present assumptions in that everyone has tacit knowledge of interviewing and interviews can be similar to a natural communication situation (McClelland, 2017). In addition, Morse (2020) adds the research interview is not at all as natural as a communication exchange would be. Indeed, this appeared to be experienced by three of the HCA/SWs, who indicated at the end of the interview how relieved they were it was over, as they felt their responses should have

contained more information but could not think of what to add. This may have been a contributing factor to some interviews being shorter than usual for an IPA study (Smith & Nizza, 2022). This was also in the context of reassurance that this was about their experience and there were no 'right' or 'wrong' answers. HCA/SWs have no formal training in interviewing skills, which appeared to be reflected by some, seeking a form of reassurance. This also indicates that the participants (and researcher) may slip into what Lune and Berg (2016) refer to as expectant 'roles' and 'perform' interactions.

Regarding IPA, it has been argued that the researcher has significant influence on the interview and should aim to be an equal producer of a successful interview outcome (Lavee & Itzchakov, 2021). To achieve this the researcher needs to master good listening skills, which, they maintain, can be identified within three main elements. These include: attention, comprehension and relational facets. The speaker needs to be always fully attentive which was demanding for two interviews due to background noise distractions from the ward. The location for all the interviews was usually in or close to the ward. This was the preferred choice of all the participants as they believed they needed to be close to the ward in case they were needed. This belief appeared to underline how the HCA/SWs viewed their role, one of duty and to be always present.

The second element, comprehension, is indicated by how the listener conveys that they understand the speaker, to which non-verbal cues and positive facilitation were emphasised to keep the interview unfolding. The final element, relational facets, include empathy, a non-judgmental approach and acceptance to which I was particularly sensitive towards, drawing on my own ward management experience and the respect I recall having for the HCA/SWs with whom I worked. This sensitivity was reflected upon following the pilot

interview, which was useful to give an understanding of the required subtlety to appreciate the sensitivity of the interaction and direction of the interview. There was a suggestion, even at this stage, that the HCA/SW requested reassurance in relation to the interview, hence I became acutely sensitive to this aspect. This point was reminiscent of Yardley's principle of sensitivity to context (Yardley, 2000) and I believed that, as an experienced clinician with acute mental health experience, this enhanced the facilitation of such sensitivity, through emanating trust and transparency.

Despite the personal perception of facilitating sensitivity, through trying to develop trust and transparency, the interviewing strategy could be viewed as a limitation of this study. The initial recruitment strategy was devised with the aim of identifying HCA/SWs who had experienced clinical supervision on their mental health ward. Although initial interest was strong, recruitment proved to be difficult, with many potential HCA/SWs deciding not to participate as they believed they did not feel 'sufficiently qualified' to comment in any depth in an interview situation or did not have any 'research interview experience'. This raised potential questions about the possibility of feeling inferior and having to demonstrate some form of evidence of this to the contrary. This was articulated by some HCA/SWs as a culmination of tacit knowledge through experience and life experiences. A copy of the interview schedule was given to each participant prior to the interview and was briefly explained. On reflection, there did not appear to be sufficient time for the participants to comprehend fully the questions or potential sub-questions. Also, an explanation of the aims of IPA was not explained, possibly not allowing the methodology or the terms 'Interpretative phenomenological analysis' to be rationalised, which may have potentially created a feeling of inaccessibility and uncertain expectations from a participant with no previous research involvement. Another limitation in this area which could be considered

was the way limited responses to some questions could have been encouraged further. IPA demands a deep questioning style with an aim to reveal the essence of an experience and, to develop this, IPA considers the contribution by Merleau-Ponty (1962) to explore and consider the embodiment of an experience, which may be achieved through prompt questions exploring associated emotions. Although prompt questions were applied where possible, for some participants the sense of being needed on the ward was strong enough to respond with limited answers and behaviours such as to check the time or pausing when hearing a possible disturbance on the ward.

5.5.2 IPA as a method

The application of IPA as a research method enabled the development of an intense insight and knowledge into the experiences of HCA/SWs' clinical supervision but its use also raised concerns and considerations, throughout the analysis. A presentation of the theoretical position of IPA was discussed in chapter three along with a discussion around its limitations. In addition to that discussion, using IPA as a method also raised other considerations.

IPA has attracted criticism for its lack of scientific rigour, in particular relating to the risk of variance of interpretation within the themes as they emerge within the analysis process. Pringle et al. (2011) argue that the interpretation of findings by a reader may not conform with those proposed by the researcher as interpretation is employed by readers themselves and that such conclusions may change over time as experience changes. More recently, the issue has been argued by Rettie and Emiliussen (2018) and Van Manen (2017) who have also raised questions of the interpretation process and how this can be varied. Rettie and Emiliussen (2018) argue that Smith et al. (2009) can demonstrate analysis within their six-

step approach to IPA but interpretation of meaning is less clear which can lead to confusion and misunderstanding. Although Smith (2011) suggests that the quality of interpretation improves over time as more flexibility is developed, Rettie and Emiliussen (2018) argue that a clearer explanation of interpretation would be of great benefit to all, especially the novice IPA researcher and encourage transparency about how the findings they present have been interpreted.

Improving interpretation through the articulation of language of an experience has been considered by Noon (2018) and Taffour (2017). Both have raised concerns over IPA presupposing participants have the necessary language to articulate their experiences. This aspect was reflected upon and considered with some of the participants who questioned their own articulation of their experience conveyed in the interview. However, this aspect was reflected upon and discussed in academic supervision, in the context that HCA/SWs have no formal training in how to conduct or participate in an interview and the limited experience of myself as an interviewer within an IPA study.

The methodology could be considered to have some limitations to this study, as it may not be able to be applied to other mental health inpatient settings as each setting has its unique operational dynamics. IPA, however, does not aim to provide generalisable findings equally applicable to other NHS mental health wards. However, it can provide insights into an experience and interpretation of meaning to clinical supervision as a phenomenon with an underrepresented group of practitioners within their contextualised environment. Meanings created through IPA analysis and subsequent knowledge production are not intended to represent an objective reality. Knowledge production in this context can be understood as

part of the position of interpretivism and the social construction of reality (Smith et al., 2009).

5.5.3 The scope of clinical supervision in this study

All participants had received clinical supervision, which facilitated them to talk about their experiences of it but this was without directing any discussion explicitly to a mode or model of clinical supervision. This could be viewed as a limitation of this study and criticised for not capturing this aspect. Discussing clinical supervision models, modes of delivery and their underpinning theories, may have given additional direction to this study. The freedom, however, to talk openly about experiences allowed a greater understanding of the HCA/SW clinical supervision phenomenon as it emerged. It also revealed the diversity of the mode of clinical supervision in terms of the benefits and challenges. For example, almost all participants had a strong preference for a group approach because of a sense of identity, safety and belonging. As previously identified, this led to some HCA/SWs circumventing ward activities such as shift handover periods to accommodate their clinical supervision sessions. The challenges this presented to supervisors was difficult to gauge as this was not an intended focus of the study. This may be considered a further limitation of the study in terms of its scope. The study set out to examine HCA/SW practitioners' experience of clinical supervision. By definition of the HCA/SW role they will be supervisees only, the focus therefore, excluded half of the clinical supervisory relationship and the study only presents the supervisee perspective.

This critical overview is focused on this study and arguably the criticisms highlight the short falls of the study rather than the IPA as a research method and the larger picture of the

intrinsic nature and complexities involved in qualitative research. IPA aims to get as close as possible to the lived experience, so that the detail of this can be examined. This aims to bring the researcher insight into that experience from the individual by capturing the rich description and emotions associated with the experience. This also involves how the experience is understood, made sense of, how meanings are made of this and how this relates to that individual's view of their world and their relationships. IPA, therefore, attempts to reflect what may be viewed as certainties and uncertainties in the complexity of human experiences (Smith & Nizza, 2022).

5.6 Reflexivity

Smith et al. (2009) argue that the aspect of transparency must be determined largely by those who read the research and they then determine if the analysis is compelling based on the 'data' (i.e. quotes) with which they are presented. In this study, this is achieved through transparency by addressing issues such as reflexivity.

Reflexivity underpins the credibility of qualitative research as it brings to the researcher's attention the potential influence of researchers' views, experiences, and beliefs about a topic on their findings (Braun & Clarke 2019; Clancy, 2013). The reflexive process does not perceive the researcher in a neutral data-collecting role but allows the researcher to consider and understand their impact on their research and how the effects of the impact could be minimised or at least acknowledged. Issues such as researcher influence and transparency, therefore, are brought into focus which can enable the researcher to address these issues to produce a more transparent interpretation of participant accounts, increasing trust and credibility (Clancy, 2013).

In this study, the reflexive process was primarily operationalised by working with a reflexive diary. The reflexive diary was used throughout the whole study but was particularly useful prior to collecting data and analysing the data. This allowed for meaningful questions to be raised and addressed along with questioning any possible assumptions made (for example, questions raised and discussed during supervision). Recording reflexivity adopted a three-fold approach. Firstly, ideas and preconceptions prior to the interviews were recorded to try to reduce the possibility of asking leading questions or resisting any urge to express agreement, disagreement, or judgement. Secondly, following the interview, a pragmatic reflective style was adopted documenting what happened during the event. An example included documenting personal thoughts, feelings, behaviours and how improvements could be made. Key words were also noted in the context of a participant's sentence, and how they were expressed along with any non-verbal accompaniment. Thirdly, there was the need to explore my own understanding, influence, and world view to examine the possibility of why and how interpretations were being developed. This was done before the documentation of any possible reflexive comments, conclusions, or contribution to the development of the interpretations throughout the analysis process. Possible conclusions and contributions were then discussed openly with my supervisor during supervision. This proved very valuable and enabled further exploration and consideration.

5.7 Implications to consider from the study

The findings presented in this study suggest there are implications across individual, professional, service and policy dimensions. On an individual level, Greer (2003) raised the issue of rights for supervisees including the right to choose a supervisor, documented

feedback and a supervision contract. A more formal approach may set out, with clarity, expectations of standards, collaboration, specific goals and ethical standards. This may include a model of clinical supervision and mode of delivery (i.e., group clinical supervision). The clinical supervision rights or charter and contract may address the specific needs of the HCA/SW. This may reduce the potential of what was discussed earlier around the risk of harmful supervision (Ellis et al., 2017).

Implications from an international professional perspective may include the consideration of clinical supervision to be championed more explicitly in undergraduate nurse training (Sundler et al., 2014). In the UK, the nursing associate role gives HCA/SWs the opportunity to aspire to this role and registration with the Nursing and Midwifery Council [NMC], opening future career progression. The standards set by the NMC, in the publication *Standards for Nursing Associates* (NMC, 2018) however, do not identify clinical supervision. Unfortunately, this appears to be a similar situation for UK undergraduate nursing students as their standards also do not explicitly identify clinical supervision (NMC, 2018a).

The findings in this study suggest that inpatient service leaders, i.e. middle and senior managers, need to recognise the value of clinical supervision and consider prioritisation of the process within inpatient settings. Clinical supervision needs similar parity afforded to risk assessment and clinical handover, which would require adequate staffing and time resources. These findings complement several studies discussed in chapter two (Buss, et al., 2011; Cleary & Freeman, 2005; Scanlon & Weir, 1997) and a comprehensive literature review involving five countries which examined clinical supervision in the workplace in which these aspects were all found to be barriers to effective clinical supervision (Rothwell et al., 2021).

White and Winstanley (2009) have suggested that conceptualising clinical supervision as a regular part of nursing, by not viewing it as a burden resulting in barriers, presents a considerable challenge to quality. It has been suggested that the quality of health care and organisational performance is determined by leadership which needs to be inclusive to enable staff to feel supported, valued and respected to change culture and behaviour (Kline, 2019). Leadership approaches common in many health care settings and organisations have top-down approaches and have, internationally, been found to be the least effective way to implement cultural change and manage healthcare systems (Aasland et al., 2010). Despite this, they continue to prevail due to reasons of denial, failing to be honest with mistakes and poor behaviour, the mismatch between demand and resources and failure to tackle issues such as discrimination and bullying (Kline, 2019). The lack of priority for initiatives such as clinical supervision are argued to be part of a wider problem of improving and sustaining a positive organisational culture. Sustaining cultures to improve the quality of compassionate health care is dependent upon inclusive leaders who inspire and operationalise initiatives, with clear objectives, engagement and a focus on innovation and quality through team working (Dixon-Woods et al., 2014).

Theories of organisational change can contribute significantly if organisations are to identify and promote change to enable initiatives such as clinical supervision to become effective. There are several organisational change theories including diffusion theory of change (Rogers, 2003) and organisational learning theory (Argyris & Schön, 1996). Batras et al. (2016), however, suggest a popular organisational change theory that complements the desired change. One of the most popular adopted change theories is that of Lewin's theories of change (Lewin, 1997). This theory can embrace the concepts of clinical supervision which adopt a team approach or implementing a change such as introducing

clinical supervision for a team. Lewin essentially suggests three themes. The field theory theme is considered to be a way of working with groups in a particular setting to map their behaviours. Another theme describes group dynamics which note individuals influences such as conformity and decision making. These two themes are implemented by introducing a third theme that is represented by a three-step guide that helps to mitigate setbacks in change. The three-step guide involves: unfreezing a process which challenges the present status quo, creating dissatisfaction and reviewing how the benefits of change can counter potential negatives associated with it. The next step is moving, which involves implementing the change. Finally, refreezing occurs to realign culture, practice, and policy to support the change, which provides a unification of all three themes (Batarus et al., 2016). Implementing an appropriate organisational theory, such as the above, must be a consideration if organisations are genuinely committed to positive changes.

This study demonstrated that when clinical supervision can take place, more flexibility may be required in terms of a different model of clinical supervision and a more flexible mode of delivery (group, one to one or peer). Jones (2006) suggests that there is room for inpatient mental health nurses to align to different processes or models of delivery of clinical supervision, rather than a 'one size fits all' approach.

Content for HCA/SWs can be more pragmatic if delivered in a peer style, as some participants in this study demonstrated. Educational and safety elements of clinical supervision could be more prominent and delivered in shorter peer sessions and more abstract concepts such as reflection and formulation can follow in more formal group arrangements as argued by Tuck (Tuck, 2017). This, however, would require decisions to invest in other facilitating factors such as organisational change, as discussed above and

training and updates. Consideration could be given to pre-clinical supervision participation development. HCA/SWs who are new to the process would then have an opportunity to develop crucial skills such as reflection and formulation which could be developed through mandatory training around risk assessment and management.

In this study, as well as other reviews (Cloeiro et al., 2023; Snowdon et al., 2020; Brooker & White, 2020), more broader issues such as training and development were identified. Brooker and White (2020), in their scoping review of 52 mental health NHS trusts in England, identified that over a third reported that clinical nurse supervisors were not specifically trained in the provision of clinical supervision. Snowdon et al. (2020) found allied health professionals would like organisations to provide formal clinical supervision training to ensure a competency in both supervisee and supervisor. Participants in this study were also in agreement with this and may assist in a clearer definition and understanding of the process. Cloeiro et al. (2023) reviewed 29 studies from ten different countries and reported insufficient knowledge in supervisors.

Findings from this study suggest that there are considerations for local and national UK clinical supervision policy. At a local UK policy level, White and Winstanley (2021) found that clinical supervision policies were considerably influenced by Care Quality Commission [CQC] guidance on clinical supervision (CQC, 2013), which, at the time of White and Winstanley's review, was already eight years old. White and Winstanley (2021) also argued that local policy should also consider an annual evaluation of effectiveness of clinical supervision rather than just recording frequency of attendance.

At a national UK level, it would be worth consideration if clinical supervision could be linked to national and international directives, such as providing a professional duty of candour

and the *Compassion in Practice* agenda (Cummings & Bennet, 2012). This may accentuate the contribution of clinical supervision to reflect on compassionate and ethical care. An international clinical supervision committee would be a worthy consideration as this would assist regular updated clinical supervision guidance. This would assist the development of operational definitions and become a reference point for the development of local policy rather than relying upon guidance as and when it arrives. It would also be a useful consideration for clinical supervision policy development and steering groups to consider having HCA/SW representation.

5.8 Conclusions and further research

This study indicates that clinical supervision has long been viewed as one way of addressing issues that arise in clinical practice through supportive, educational, and administrative functions. Two recent extensive literature reviews of clinical supervision studies reviewing a combined total of 164 of mixed methods studies from 15 countries (including the UK) (Coleiro et al., 2023; Rothwell et al., 2021) demonstrate that clinical supervision is effective and helpful. However, this is dependent upon several factors, many of which have been discussed within this study, such as the power and training of the supervisor, organisational commitment, and cultural change. Although there is a plethora of research on clinical supervision, it was clear that the combination of qualitative research on clinical supervision, involving mental health inpatient settings and HCA/SWs was almost non-existent on the national or international stage. Given this context, it became an intriguing challenge to explore what the experience of clinical supervision was actually like for HCA/SWs and the impact, if any, of clinical supervision experience on them. It was personally considered that

the reflective approach of clinical supervision and the reflexive process of IPA could complement each other well. The interpretative and analytical process of IPA gave a subjective and unique interpretation of an experience that is rare to find in the clinical supervision literature.

Clinical supervision research that is considered to have stronger scientific rigour and more useful to accommodate supervision competencies, has been largely shaped by a positivist approach, which projects a synonymous alignment with an evidence base practice discourse (Kühne et al., 2019). While this approach is welcome, it is possible that there may be a risk of loss and limitation in the actual understanding of the phenomena of the lived experience of clinical supervision. Although non-positivist clinical supervision research is evident within the literature, clinical practitioners are influenced to demonstrate their competence through evidence based practice. It could be argued that the positivist approaches are viewed as synonymous with the evidence based practice discourse and that such approaches prioritise a preference for an understanding of a phenomenon, such as clinical supervision, to be viewed in this way. This in turn could be understood as a series of attainable skills which can be developed as competences for standardising training and assessment. Such approaches are merited and acknowledge the complexities of the clinical supervision relationship (Cutcliffe & Sloan, 2014). Aspects involving personal and interpersonal experiences however, appear to be less evident, and more difficult to objectify. The risks with such a dominant positivist approach to clinical supervision research are that other forms of gaining an understanding of clinical supervision become overlooked.

This is particularly relevant for HCA/SWs as there is an argument for understanding this group of practitioners and their participation and engagement in, and perception of, clinical

supervision much further, given the sparse research available. A consideration for the HCA/SW role, experience, understanding and contribution to clinical supervision would complement any future training or competence development. However, for this to be a reality, nursing as a whole, from its professional body to its workforce, needs to prioritise the development of a positive culture towards authentically valuing clinical supervision and not the piecemeal approach that is evident within the clinical supervision research in the UK and internationally. It is imperative, therefore, that all forms of clinical supervision research, seriously consider a much greater involvement of HCA/SWs and other non-registered nurses. This needs to be in all types of settings, especially inpatient / residential settings, to continue to gain a broader understanding of this complex phenomenon. HCA/SWs form the largest number of clinical staff in acute mental health inpatient settings in the UK. Despite this the research on clinical supervision involving them within this setting is rare. This study has attempted to explore that rarity and give a voice to the HCA/SW of their experience of clinical supervision within an acute inpatient mental health setting. This study is timely, if clinical supervision is to be considered seriously, to form an integral part of the development and contribution for HCA/SWs to progress within their role. This study has also made a specific contribution to knowledge by providing a detailed analysis of what the experiences of clinical supervision mean and what are understood by them, to the HCA/SW, within acute mental health inpatient settings.

This study suggests that, in the UK and internationally, the understanding of clinical supervision and the motivation to implement it within nursing, and in particular for HCA/SWs, could be better. If clinical supervision is delivered poorly, or not at all, then opportunities for improvement for the service user, the supervisee, supervisor and organisation could be missed indefinitely.

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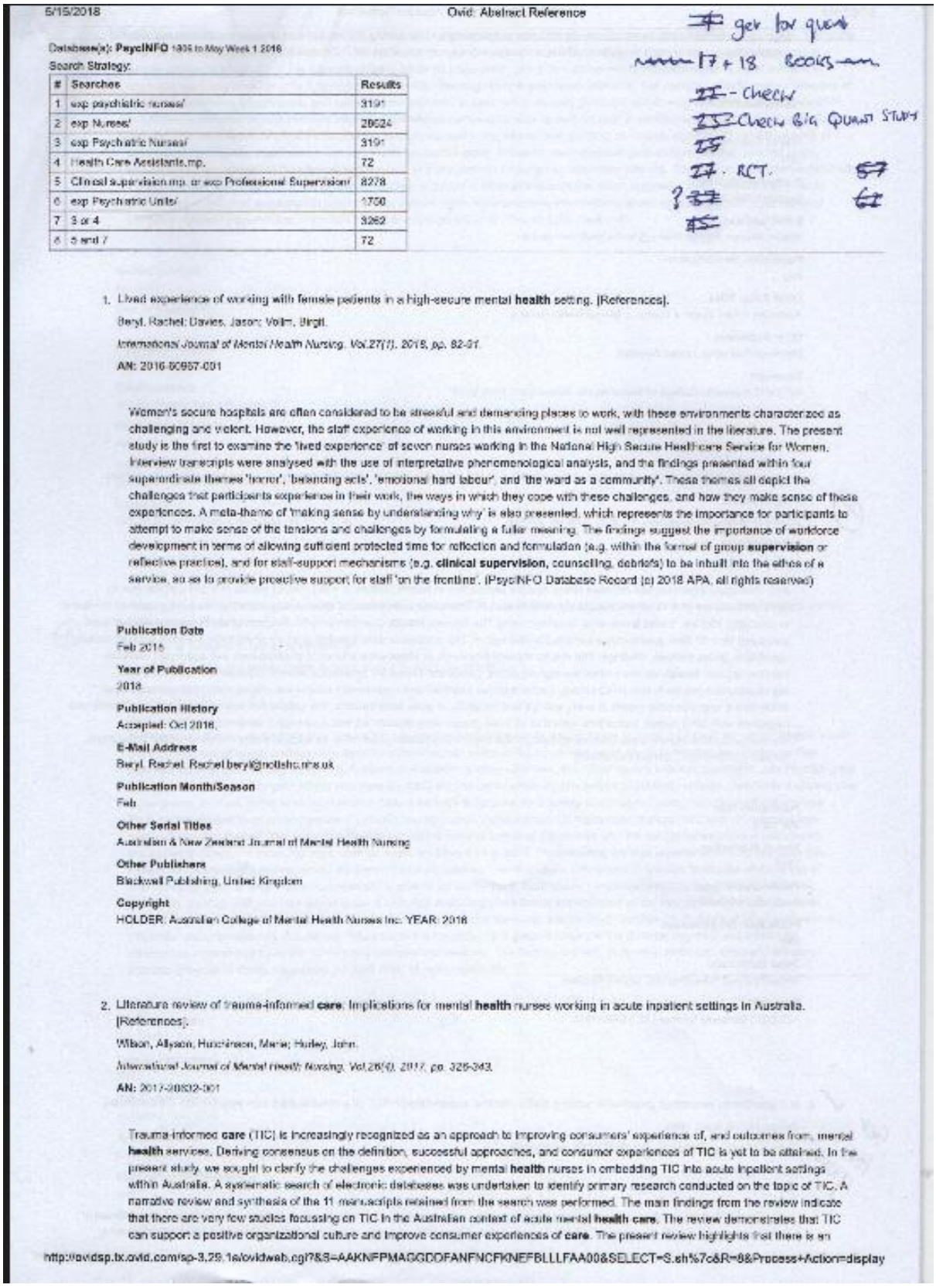
Appendices

Appendix I: Search Scree print examples (May 2018 search)



5/15/2018 Ovid: Abstract Reference

Database(s): PsycINFO 1806 to May Week 1 2018

Search Strategy:

#	Searches	Results
1	exp psychiatric nurses/	3191
2	exp Nurses/	28624
3	exp Psychiatric Nursing/	3191
4	Health Care Assistants.mp.	72
5	Clinical supervision.mp. or exp Professional Supervision/	8278
6	exp Psychiatric Units/	1750
7	3 or 4	3262
8	5 and 7	72

1. Lived experience of working with female patients in a high-secure mental **health** setting. [References].

Beryl, Rachel; Davies, Jason; Vollm, Birgit.

International Journal of Mental Health Nursing. Vol.27(1). 2018, pp. 82-91.

AN: 2016-60957-001

Women's secure hospitals are often considered to be stressful and demanding places to work, with these environments characterized as challenging and violent. However, the staff experience of working in this environment is not well represented in the literature. The present study is the first to examine the 'lived experience' of seven nurses working in the National High Secure Healthcare Service for Women. Interview transcripts were analysed with the use of interpretative phenomenological analysis, and the findings presented within four superordinate themes 'horror', 'balancing acts', 'emotional hard labour', and 'the ward as a community'. These themes all depict the challenges that participants experience in their work, the ways in which they cope with these challenges, and how they make sense of these experiences. A meta-theme of 'making sense by understanding why' is also presented, which represents the importance for participants to attempt to make sense of the tensions and challenges by formulating a fuller meaning. The findings suggest the importance of workforce development in terms of allowing sufficient protected time for reflection and formulation (e.g. within the format of group **supervision** or reflective practice), and for staff-support mechanisms (e.g. **clinical supervision**, counselling, debriefs) to be inbuilt into the ethos of a service, so as to provide proactive support for staff 'on the frontline'. (PsycINFO Database Record (c) 2018 APA, all rights reserved)

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E-Mail Address
Beryl, Rachel: Rachel.beryl@nottshc.nhs.uk

Publication Month/Season
Feb

Other Serial Titles
Australian & New Zealand Journal of Mental Health Nursing

Other Publishers
Blackwell Publishing, United Kingdom

Copyright
HOLDER: Australian College of Mental Health Nurses Inc. YEAR: 2018

2. Literature review of trauma-informed **care**: Implications for mental **health** nurses working in acute inpatient settings in Australia. [References].

Wilson, Allyson; Hutchinson, Marie; Hurley, John.

International Journal of Mental Health Nursing. Vol.26(4). 2017, pp. 326-343.

AN: 2017-28932-001

Trauma-informed **care** (TIC) is increasingly recognized as an approach to improving consumers' experience of, and outcomes from, mental **health** services. Deriving consensus on the definition, successful approaches, and consumer experiences of TIC is yet to be attained. In the present study, we sought to clarify the challenges experienced by mental **health** nurses in embedding TIC into acute inpatient settings within Australia. A systematic search of electronic databases was undertaken to identify primary research conducted on the topic of TIC. A narrative review and synthesis of the 11 manuscripts retained from the search was performed. The main findings from the review indicate that there are very few studies focussing on TIC in the Australian context of acute mental **health care**. The review demonstrates that TIC can support a positive organizational culture and improve consumer experiences of **care**. The present review highlights that there is an

http://ovidsp.tx.ovid.com/sp-3.29.1a/ovidweb.cgi?&S=AAKNFPMAGGDDFANFNCFKNEFBLLLFAA00&SELECT=S.sh%7c&R=8&Process+Action=display

			Search Database - CINAHL Complete	
S4	S1 OR S2 OR S3	Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	13,376
S3	AB healthcare support workers	Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	1,014
S2	AB Health care assistants	Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	2,267
S1	AB mental health nurses or psychiatric nurses	Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL Complete	10,231

July 2023 search


biomedicine
humans 349
Language
Sort
Language Filter
English 911
Português 19
Français 3
Deutsch 2
Español 2
Database
Nursing assistants' experiences of...
by Kodua, Michael; Mackenzie, Jay-Marie; Smyth, Nina
International journal of mental health nursing, 12/2020, Volume 29, Issue 6
Journal Article
PDF
Full Text Online
More Options
Citations
Cited by
Cites
Scopus 2
5
Factors influencing adequate and effective clinical supervision for inpatient mental health nurses' personal and professional...
by Howard, Vickie; Eddy-Imishue, Gesi-ere Kindah
Journal of psychiatric and mental health nursing, 10/2020, Volume 27, Issue 5
Journal Article
PDF
Full Text Online
More Options
Citations
Cited by
Cites
Scopus 4
6
The Experiences of Psychiatric Mental Health Nurse Practitioners with Clinical Supervision...
by Lee, Sung-Nam; Kim, Hyun-Jin
International journal of environmental research and public health, 11/2022, Volume 19, Issue 23

Appendix II: Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (CASP 2013)

The following demonstrates how one of the articles from the review was used using the CASP checklist.

Article number 11: Scanlon, C. & Weir, W.S. (1997) Learning from practice? Mental health nurses' perceptions and experiences of clinical supervision. *Journal of Advanced Nursing*. 26, 295-303.

Screening Questions

1. Was there a clear statement of the aims of the research? **Yes** Can't tell No
HINT: Consider
What was the goal of the research?
Why it was thought important?
Its relevance

The aim of the study was to explore mental health nurses' perceptions and experiences of clinical supervision. The study was thought important as it asserts that mental health nurses are becoming better able to reflect upon their own learning needs and utilise this in their professional support as they improve therapeutic relationships with service users/ patients. There were also no studies at the time exploring mental health nurses experiences and perspectives using a qualitative methodology only.

2. Is a qualitative methodology appropriate? **Yes** Can't tell No
HINT: Consider
If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
Is qualitative research the right methodology for addressing the research goal?

The study used interviews and analysed these using a constant comparative method, usually associated with grounded theory. The approach would be considered appropriate, due to accounting for in-depth lived experience of multiple realities.

IS IT WORTH CONTINUING? Yes

Detailed Questions

3. Was the research design appropriate to the aims of the research? **Yes** Can't tell No
HINT: Consider
If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

The authors identify that qualitative inquiry does not adhere to a rigidly determined schedule but can be more flexible through which can be directed by emergent themes. And be developed and tested throughout the data collection process. As the study is seeking to explore experiences then the design would fit the aims.

4. Was the recruitment strategy appropriate to the aims of the research? **Yes** Can't tell No

HINT: Consider

If the researcher has explained how the participants were selected

If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study

If there are any discussions around recruitment (e.g. why some people chose not to take part)

A purposive sample of mental health nurses was adopted with 10 participants. 4 in community settings, 6 in in- patient settings. All participants had recent experience clinical supervision. . The average post qualification experience of the participants was 15 years. The study makes no reference to the amount of supervision experience.

5. Was the data collected in a way that addressed the research issue? **Yes** Can't tell No

HINT: Consider

If the setting for data collection was justified

If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)

If the researcher has justified the methods chosen

If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?

If methods were modified during the study. If so, has the researcher explained how and why?

If the form of data is clear (e.g. tape recordings, video material, notes etc)

If the researcher has discussed saturation of data

The study aims and methods justified the data collection method and this was clearly explained. Interviews were minimally structured and each began with a general question seeking to elicit background information, which then proceeded into a purposeful convention style discussion. This style was guided by the participants' responses. Data from the interviews was audio recorded and transcribed.

6. Has the relationship between researcher and participants been adequately considered?

Yes **Can't tell** No

HINT: Consider

If the researcher critically examined their own role, potential bias and influence during (a) Formulation of the research questions (b) Data collection, including sample recruitment and choice of location

How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Both authors were nurses by profession and both worked in an honorary capacity within an NHS trust. It is not made clear in this is the same Trust. Both authors recognised a potential for bias, but this is not explained or explored any detail.

7. Have ethical issues been taken into consideration? Yes **Can't tell** No
HINT: Consider
If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
If approval has been sought from the ethics committee

The discussion around ethical issues was generally poor and explicit identification of obtaining ethical approval was not obvious. This was also a similar situation for the way any issues were raised around informal consent and the effects on participants during or after the study. Confidentiality was acknowledged, but again lacked detail.

8. Was the data analysis sufficiently rigorous? **Yes** Can't tell No
HINT: Consider
If there is an in-depth description of the analysis process
If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data? Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
If sufficient data are presented to support the findings
To what extent contradictory data are taken into account
Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

For the most part the elements of sufficient rigour for the data analysis was evident. Three main measures were adopted to ensure rigour. There were to seek inter-rater reliability by cross checking emerging themes and categorizations. A technique of continuous checking was also adopted, during which the agreement of meanings of participants disclosures during the interviews themselves. The use of selective quotations allowed the participants to represent themselves, making the interpretation of the data open to direct scrutiny.

9. Is there a clear statement of findings? **Yes** Can't tell No
HINT: Consider
If the findings are explicit
If there is adequate discussion of the evidence both for and against the researchers arguments
If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
If the findings are discussed in relation to the original research question.

The findings are clear and the discussion raises some very poignant questions. Four key themes were identified and the researchers presented a reasonably balanced discussion in relation to their findings and theses are also discussed in relation to the original research questions.

10. How valuable is the research? **Yes** Can't tell No

HINT: Consider
If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. Do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
If they identify new areas where research is necessary
If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

The research is very valuable as it is conducted with a population based with a setting that is under-represented in the research as a whole. The researchers identify the issues of resources, structure (of in-patient settings) and the need for greater direction. The researchers also identify how clinical supervision needs to viewed as a priority. The discussion suggests that clinical supervision can offer a better quality in terms of care delivery, but there needs to be changes. The researchers also call more a better understanding of clinical supervision with this population and setting and further research.

Appendix III: Stage one code development table: Code identification and descriptive theme development (Example of Article 1)

Article 1. Arvidsson, B., Lofgren, H. & Fridlund, B. (2001) Psychiatric nurses' conceptions of how a group supervision in nursing care influences their professional competence: A 4-year follow up study. *Journal of Nursing Management,* 9, 161-171.	**Initial thoughts for codes based online by line sentences**	**Potential codes (underlined) and Possible descriptive theme**	**Reflexive thoughts**
Line by Line from the Results and discussion section of the article Results Sharing experiences This conception confirmed that the nurses recognized themselves in each other's work situations and that they took part in solutions which they themselves could use. Interview occasion 1 *'... our problems within the different activities are largely the same. We work with the same things and towards the same goal. I think that is the most important, that I also feel part of situations that are far removed from the activity that I'm used to'* [informant 3]. Interview occasion 2 *'I think that this knowledge is so difficult that you can't just read about it and integrate it but you have to talk about it and ventilate it again and again in order for it to become personal knowledge'* [informant 1]. Being confirmed The participants stated that much of their work was problematic and that they reflected upon their way of thinking and acting. They conceived that, in supervision, their feelings, thoughts and actions were confirmed to be valid. Interview occasion 1 *'I often receive confirmation during supervision that my way of thinking and looking at things is not entirely wrong, through for example the participants nodding their agreement. I often nod in agreement when somebody else is*	Authors analysis Activities similar Working towards the same goal Different kind of knowledge gained from the process of supervision Author's analysis Confirmation of thoughts From others and supervisor Confirmation from self to others Permission to react Author's analysis	**Development of engagement skills** Shared experiences Sharing experiences **Content of supervision** Expression during supervision process **Skill of the supervisor/ Competence development self-awareness** **Formal supervision** Confirmation of self-reflections to and from others Validation Skill of the supervisor to facilitate **Courageous approach**	My own clinical mental health nursing experience has included both in-patient settings and community settings. From this experience I can empathise with the concept of the shared experience of direct work with the patient/ service user. As on an inpatient setting, the whole team are working with the same group of people. By contrast with community settings the focus is on an individual caseload. The shared direct experience can bring the in-patient team to focus on one goal and work together in a more collective way. This participant made me reflect on my own experience of group supervision and how one of its

talking ... in all situations discussed, I feel that I have been confirmed or that I have been able to confirm somebody else' [informant 4]. Interview occasion 2 *'I thought that it felt really good to talk about what had happened and to receive confirmation that it was okay to react and think as I did. I didn't do anything wrong, and the members of the supervision group were able to understand'* [informant 1]. Being independent The nurses' area of responsibility was nursing care. This conception showed that the nurses experienced that their professional role was more clearly defined. Interview occasion 1 *'I never thought that it would be possible to strengthen my professional identity through nursing theory. I have never felt the need to stress the distinction between nurses and carers. I have my area of responsibility; I haven't felt the need to strengthen it'* [informant 5]. Interview occasion 2 *'I have thought about it in the last few weeks ...* I feel much more content now *with my work than I did 2 years ago. I find that I'm more content and that it's an effect of the supervision'* [informant 9]. Gaining energy The nurses perceived themselves to be overworked and worn out. Gaining energy meant that the participants conceived that they gained increased strength and had the power to carry out the care work. Interview occasion 1 *'In my work I feel less burdened and burnt out compared to previously, especially as I felt last autumn'* [informant 6]. Interview occasion 2	Reflective power of supervision Content with own work Author's analysis Less Stress Less burnout Strength Author's analysis Sense of security with the group allows for questions	**Possible descriptive theme:** *Increasing competence and professional qualities through clinical supervision* **Group Supervision valued** Permission to express Support in group Validity through numbers **A sense of fellowship** **Possible descriptive theme:** Group clinical supervision **Reflection** Identity **Clinical Focus** Confirmation of responsibility **Confidence development** **Stress Relief** **Develops self** **Value of supervision / reflection** **Stress Relief** Revitalised **Develops self** **Reflection – self awareness** **Courageous approach**	strengths are the validation in numbers This discussion made me reflect on the focus of my study. There are many quantitative research-based papers that are available that investigate issues around burnout, stress, increased competence and clinical supervision. The measures for these studies are usually questionnaire based and examined for statistical significance. According to these studies, clinical supervision can impact upon the reduction of stress, burnout and increase competence and confidence and this contribution is clearly welcome. However, studies which examine the actual experience of clinical supervision as a process are limited. This limitation extends further if the focus moves to mental health nurses within inpatient settings and further still if the nurses are non-registered. This is surprising for several reasons as mental health is considered to be one of the most stressful areas to work in.

'The supervision has given me the strength to work at things which I perhaps would have refrained from doing otherwise' [informant 5]. A feeling of fellowship The participants were all from the same professional background. This conception was concerned with giving and taking in the communication with others in the same situation. Interview occasion 1 *'We are a secure group, and it gives you the courage to feel that you don't have to be so sure that you know things, and you dare to make mistakes and ask questions'* [informant 2]. Interview occasion 2 *'I'm very dependent on those around me, if I'm to function or be able to share with others. This has been a first-rate group'* [informant 4]. Gaining insight The nurses' experiences and frames of reference were expressed in the descriptions of special situations. This conception expressed how nurses acquired new insights through supervision. Interview occasion 1 *'I have learnt not to take people for granted because if you are like B, who is very much liked by the patients, it is easy to become burdened with a lot of work. I have learnt that it is important to talk with B about it, ... I'm aware of that in a different way now when I ask for things'* [informant 4]. Interview occasion 2 *'... I didn't think that it would be possible to apply nursing in outpatient care, but I believe that now and that very much depends on the supervision'* [informant 7]. Handling the terminology This conception showed that the nurses frequently encountered nursing terminology that was unfamiliar to them. However, the nurses perceived that they gradually became more familiar with the terminology over time.	Importance of sharing with others and trust Authors analysis New insight Supervision potential Increased understanding Articulation and expression Change requires time Management perspective on supervision Perception of nursing Self -reflection- exposure to linking theories to practice	**Possible descriptive theme:** *Increasing competence and professional qualities through clinical supervision* **Group Clinical Supervision** **Security** **Fellowship** Freedom of clinical exploration **Personal effect of attending** **Power of the group** Sharing Trust **A sense of fellowship** **Possible descriptive theme:** Group clinical supervision **Competence development** **Courageous approach – skills to dare** **Reflection** **Self-awareness** New insights Potential ability of supervision **Philosophical nursing viewpoint** **Courageous approach** **Possible descriptive theme:** *Increasing competence and*	The Royal College of Nursing and the BBC (2017) noted that there had been an increase of 7,580 mental health nursing staff in 2012-13 to 9,285 in 2016-17, following freedom of information requests (Higher than any other area of nursing). Most assaults (casing stress) happen within in-patient mental health settings and the most front-line nurses are non - registered. Clinical supervision appears to offer so much, yet the actual understanding of the experience appears somewhat limited. The information from participants in this study made me reflect on my own clinical supervision and the significance of the supervisor characteristics. It made me think of how important it is for the supervisor to simultaneously develop insight within supervisees, reflection and facilitate so many other skills to begin to produce a sense of trust. In my own experience and involvement with clinical supervision within UK mental health settings, I became aware of how difficult it is to find training on clinical supervisor development skills. So much

Interview occasion 1 *'I have been a novice when it comes to the terminology. It feels good in the supervision sessions, many of the words are used there. The supervisor uses them and somehow they stick'* [informant 3]. Interview occasion 2 *'The supervision has provided me with a language for the job that I do. It has given me another language that speaks more directly to me'* [informant 5]. Changing perspectives The nurses' conception showed that the supervision influenced their thinking in the direction of a nursing perspective. Interview occasion 1 *'It takes time to change things and to become secure. I would like to have this supervision together with my colleagues at the ward. You have to start somewhere when you want to change things and I think that you have to start with the managers'* [informant 4]. Interview occasion 2 *'I am realizing more and more that nursing is the right way of working. I enjoy working in this way'* [informant 7]. Understanding the essence The conception showed that the introduction of nursing theories enhanced the understanding of the essence of nursing. Interview occasion 1 *'I can use the nursing theories and the process as such, I can take it in, evaluate and plan'* [informant 8]. Interview occasion 2 *'I have thoughts about the importance of nursing for the clinic, I don't think that I would have thought about that if the supervision hadn't provided scope for that'* [informant 9].	Value of supervision from a wider philosophical nursing viewpoint Authors analysis The supervisor's ability to dare. Supervisor questions supervisee's thinking Authors analysis Reflection Self-awareness Increased understanding Developing empathy Clearer focus person centred	*professional qualities through clinical supervision* **Adequately trained supervisor** Understanding through articulation **Appropriate supervisor** Supervisor expression **Reflection and self-awareness** **Development of wider philosophical questions** **Development of engagement skills**	appears to focus on the development through experience. The issues raised by participants around security, change and managers changing, made me reflect on my own experience and how many UK NHS trust policies follow a hierarchal approach to clinical supervision in nursing. This is where the line manager becomes clinical supervisor also and clinical and managerial supervision are sometimes merged. The points made around reflection by participants in this study caused me to reflect on how supervision enables a questioning process around oneself, the care delivery, evidence-based practice, and the profession as a whole. Reflection also questions the evidence for ritualistic practice, which has a long history in mental health nursing which as a

Having a role model The conception showed that the nurses had different strategies for exercising nursing. This inspired admiration and a wish among those involved to acquire the same knowledge. Interview occasion 1 *'She dared go against the whole staff. She just carried the tray into the patient's room. She broke our rigidity; she dared do exactly the contrary'* [informant 3]. Reflecting upon personal opinions This conception showed that the participants pondered upon different viewpoints within nursing and wished to improve their ability to give the patients the nursing they required. Interview occasion 1 *'I gained a better understanding through talking about what one was allowed to give the patients, how much love, if it was okay to hug them. There has been much talk within psychiatry that one must not give too much of things like that'* [informant 6]. Interview occasion 2 *'I ask questions to try to understand the opinions of the patients, instead of thinking aha, this is the problem, like I did before. When you have thought that, then you stop listening and the work is focused on trying to get the patient to understand what the problem is'* [informant 9]. Being attentive This conception showed that the nurses sought to under-stand the patients' innermost thoughts and wishes. Interview occasion 1 *'It is important to feel what the patient wants ... feel the patient's need for human kindness. To offer oneself in some way ... pure love of mankind'*	Empathic understanding Deep level of reflection Clinical focus Importance of engagement encounters Courage Self-awareness Independence Permission Patient focused	**Develops Self** **Reflection and self-awareness** **Ability of the supervisor** Supervisor challenges Supervisor role model **Supervisor Facilitation** **Possible descriptive theme:** *The importance of specific clinical supervisor characteristics* **Clinical focus** **Development of engagement skills** **Patient /service user satisfaction** **Courageous approach** **Patient /service user satisfaction**	field of nursing has a long history of institutionalisation. This made me think about how reflection is maintained or developed following graduation to a registered nurse. The nursing profession has traditionally followed a medical /

[informant 3]. Interview occasion 2 *'The supervision has clearly given me room for reflecting upon the depth of human beings, the spiritual dimension, ... the patient's needs and our needs'* [informant 10]. Realizing the importance of the encounter This conception was concerned with creating a good relationship between carer and patient. Interview occasion 2 *'I have become still more convinced that the first encounter with a patient is extremely important, and I try hard to get that message across in the ward ... because you create a relation at the first encounter which is important for the future'* [informant 4]. Gaining trust in oneself The participants conceived that the supervision sessions contributed to their having the courage to trust their own feelings. They felt pride and perceived that they felt more assured in their nurse role. Interview occasion 1 *'... I thought that I would build up courage ... I don't know why I don't have courage. Am I afraid of becoming brave, or of losing my foothold? What is it that makes me a little faint-hearted or cautious like that?'* [informant 3]. Interview occasion 2 *'I have become more courageous, daring more, and perhaps also a little less dependent ... I feel that I work a little more independently. It's not so important what the others think'* [informant 1]. Achieving personal development In the first year of supervision the participants conceived that something had happened to them personally. They were later able to express, in more concrete terms, how this development had influenced them.	Supervision as a process develops Supervision requires / brings patience Permits questions	**Competence development** **Reflection** **Increased self-awareness** **Development – Self** emotional intelligence Reflection allows for challenge of traditional thinking in mental health **Courageous approach** **Development of engagement skills** Person centred Creating independence **Development of reflection** **Skills of reflection** **Development of engagement skills and interactions** Ability to challenge **Development of courage** Increased self-awareness to **develop courage** Increased independence – self, role and profession **Develops self**	disease model approach to care. In my mental health experience, I have seen the focus in mental health nursing move from a medical model towards a recovery – person centred model. Deeper reflection allows for challenges to traditional approaches and increases awareness to question oneself, in terms of competence, ability and giving the permission to dare to question. This was a recurring point from the participants when they discussed reflection within this study. As I have stated, my nursing experience has taken me from a position of strong and influential

Interview occasion 1 *'This supervision involves much more than I first thought, suddenly something had happened. It is not something one notices at first, it starts to happen, and then one just notices it'* [informant 3]. Interview occasion 2 *'The supervision has taught me to be patient, to wait and see, and to dare to wait and see, not to go for things blindly'* [informant 2].		Supervision process needs time **Reflection and self-awareness** **Competence development** **Possible descriptive theme:** *Increasing competence and professional qualities through supervision*	medical model dominance and subservience to developing a nursing identity with a changing philosophy. The changing philosophy is developing a sense of independence and liberation. Reflection and increased self-awareness provide a platform to dare, question and challenge. While the clinical supervision process and can facilitate this, a deeper understanding and exploration of the clinical supervision process itself would help.

Appendix IV: Code identification and descriptive theme development into eight descriptive themes (example for Article 4)

Article 4: Buss, N., Angel, S., Traynor, M. & Gonge, H. (2011) Psychiatric nursing staff members' reflections on participating in group-based clinical supervision: A semi structured interview study. *International Journal of Mental Health Nursing.* 20, 95-101.		
Potential codes from stage one for development following the line by line examination of this study	**Developed codes to formulate the descriptive theme following comparison across all the studies in this review**	**Comments and Reflexive thoughts**
Increasing competence – benefits supervision can bring awareness of organisational issues. Insufficient resources Forced prioritisation **Value Reflection in supervision** leadership More focused on clinical problems In-depth Personal development **Competence Development** Positive purpose Beneficial Deadlock risk New perspective **Increasing confidence from competence** Competence reflection New insight highly valued Reflection development and competence Increasing confidence from competence	**Develops Self** and is restorative with a range of inter-related benefits **Problem solving qualities** Can reduce deadlock risk, frustration and offer new perspectives that can be powerful **Develops confidence** to challenge **Contribution to descriptive theme 1: Supervisee Development**	The potential codes were transported across from stage one. These codes were then developed following comparison across all the studies. Some of the codes in this study were compared with the other studies. Repetition and /or similarity was noted. The essence of the codes collectively indicated the importance of competence development, which appeared evident as professional self- awareness grows
Stress relief Reinvigoration	**Stress relief** provides reinvigoration **Alternative Approaches (Group) support** – less intense- less systematic- - Less exposing -Formal supervision for complicated situations. Unstructured approaches, however, can lack leadership and experience interruption. **Contribution to descriptive theme 2: Supervisee Support**	Participants referred to supervision as a process of relieving stress. This was more notable in group situations.

clinical supervisor skills Abilities Problem solving Importance of Reflection Supervisor skills	**Appropriate Supervisor** Someone who is adequately trained **Importance of Reflection** – Supervisor ability to teach and facilitate **Supervisor facilitation skills** – Several skills including facilitation **Formal supervision** Model gives structure and not controlling Good supervisor leadership. **Contribution to descriptive theme 3: Supervisor Competence**	From my own experience the role the clinical supervisor has is very significant in how clinical supervision is developed, conducted and ultimately sustained. The essence of the codes collectively indicated the importance of the clinical supervisor characteristics which are vast
Quality of the clinical focus	**Clinical focus** – Purely a clinical focus based on quality which is valued. **Contribution to descriptive theme 4: Supervisor Commitment**	Supervisor commitment was reflected in how much attention to the quality and detail of the clinical supervision session.
Group dynamics Interactions are trusting Group dynamics and interaction **Group cohesion** Sharing experiences Trust	**Group dynamics interaction** – More open and honest **Sharing experiences** – Working as peers/ colleagues increases trust **Contribution to descriptive theme 5: Relationship Dynamics and Trust**	Interaction dynamics The essence of the codes collectively indicated the importance of group clinical supervision
Group CS Power Valued joint input **Possible descriptive theme:** Group clinical supervision **Alternative group supervision** Alternative supervision - Socialising valued Support for alternative approach Many advantages of informal supervision Alternative – less intense- less systematic- Less exposing	**Valued elements of the Group** - Brings together elements of clinical supervision **Power of the group** – collective power – increased sense of belonging **Skills of the group** – reflection **Development of competency within the group** – guided reflection **New perspective** – viewed from numerous positions **Alternative group / parallel supervision advantages** - Socialising valued – supervision in different forums other than clinical forums –	From my own experience and the findings within the literature, group clinical supervision appears more common in inpatient settings. Some participants do not like group situations. This made me consider and reflect on what happens to supervisees to supervisees within inpatient settings who are left with very few alternatives to group clinical supervision.

	Contribution to descriptive theme 6: Supervisee identity	
Organisational issues Logical problems shifts Supervision in own time High workload – prioritising **Organisational issues** creates doubt around supervision Consequences of organisational issues / limited supervision **Frustration with organisation**	**External supervisor** – Valued in specific situation – offer new insights. **Organisational operational issues –** Not enough staff – leading to limited supervision – downward spiral – undermines outcomes of supervision. **Negative experiences** **Contribution to descriptive theme 7: Logistics of operationalising clinical supervision**	Reflecting on my own experience and other clinical supervision literature reveals that workplace organisational issues are many. In-patient facilities by their design and function do offer unique situations that are different from community based settings. These can be viewed as both a strength and weakness in my own experience. This also appeared evident in the findings within this study.
Consequences of limited supervision. **Formal supervision** for complicated situations Formats **Two models** Contrasts with formal supervision Appeal of informality	**Two types of models** preference for alternative/ informal formats. Contrast with formal supervision. **Inpatient specific** - Logical problems shifts- Having to participate on days off- time off more valued- Supervision in own time. **Frustration-** Recognition of the importance of clinical supervision- considered health and open, but frustration at not being able to implement it. **Lack of CS Consequences -** Consequences of limited supervision – burnout- poor work lack of efficiency- no continuous supervision – never making enough impact. **Contribution to descriptive theme 8: Inconsistent availability**	The literature (and my own experience would concur with the concept of alternative forms of clinical supervision, in particular within in-patient settings. The essence of the codes indicates supervisee's desire for supervision and a realisation of the potential benefits. It also gives an indication of the frustration from supervises who may be looking for an alternative form of clinical supervision.

Completed code tables following comparison across all the studies resulting in eight descriptive themes

Descriptive Theme 1: Supervisee Development	
1. Competence development – Development of competence in ability and role- competence as a measure – engagement-time – necessary skills – emotional intelligence **2. Clinical focus** – Clinical focus is valued **-** creates ability to reflect - Increased self-awareness – creates value through shared experience. **3. Develops self** Competence, skill and feeling supported - Importance of developing and maintain the relationship. - Restorative with a range of inter-related benefits - Build into career structure- Self –awareness Creates curiosity. **4. Development of engagement skills** – **multidimensional interactions** – empathy-person centred - independence Confirms many positive emotions (Safety / hope) with both the care giver and care recipient - Relationship skills	**5. Problem solving qualities** Can reduce deadlock risk, frustration and offer new perspectives that can be powerful. **6. Reflection and self -awareness** Many opportunities - Reflection can develop other supervision avenues Challenge of traditional thinking in mental health - Reflection – deeper knowledge- increased awareness – commitment & understanding Develops role & Professional skills - new insights Decreases apprehension- Wider focus to include other aspects – such as ethical discussion. analysis of own needs/ skills/ deficits and requirements Relationship skills produce acceptance by patient-Relationship skills require knowledge & experience- Relationship conveys self –insight from confidence- Relationship skills - The significance of empathic understanding.

Descriptive Theme 2: Support (of the supervisee)	
1. Courageous approach **Skill to dare** The support of reflection on self-development and courage. A supportive process. **2. Stress relief / Responsibility** Provides reinvigoration Stress reduces willingness to take responsibility Nurses accept stress as their responsibility in supervision Stress in the context of organisational issues perceived differently More attentive – supporting colleagues- **3. Alternative support** – less intense- less systematic- - Less exposing -Formal supervision	**4. Nurses preference** for other nurses or clinicians. Feel more supported. Training an important requirement for the desired supervisor characteristics. Nurses understood by each other more supported. **5. Fellowship – not alone** **Group timing** – topic of discussion near to time Wider focus (in this study) to include other aspects – such as ethical discussion. **6. Personal Effect on attending of group supervision** Better understanding and connection between more detailed oral information Thorough logical approach

for complicated situations. Unstructured approaches however, can lack leadership and experience interruption. **–**Much support for alternatives forms. Greater trust.	Self-reflection discussed through the patients care – less threatening Increases participation Develops confidence and competence Contribution from all collective.

Descriptive Theme 3: Supervisor Competence	
1. Content of supervision session Structured better allows for clearer expression during supervision process- Provides purpose/aim – Educational - Ability to challenge outdated practice -Reflection valued **2. Philosophical nursing viewpoint T**hrough supervision - Development of wider philosophical questions. Linking theory to practice Increased independence – self, role and profession- Merciful to self **3. Formal supervision gives structure** - systematically works through aspects of care presented **4. Adequately trained supervisor** Supervisor adequately trained has these skills and characteristics. - Supervisor training (a significant feature) Ensures quality and promotes respect and trust.	**5. External supervisor** **Supervisor can offer new / different perspective** Supervisor development of self-awareness skills **6. Person centred Supervisor Skills** – Empathic understanding- Deeper level of reflection Confirmation of self-reflections to and from others **7. Reflection** – **Importance of** –Supervisor ability to teach and to facilitate this skill **8. Supervisor- ability to provide facilitation skills** – Several skills including facilitation Encouragement Inspiration Reflection Permissive atmosphere Safe environment Permission of expression Problem solving **9. Competency development in group CS** within the group – guided reflection- competency in the role **10. Model of delivery of supervision –**Suitable to all in inpatient settings.

Descriptive Theme 4: Supervisor Commitment	
1. patient/service user satisfaction validation **2. Responsibility essential for safety** Taking responsibility – dependent on- knowledge and skill- Taking responsibility – dependent on the possibilities the organisation **3. Quality through Standards**	**4. Clinical impact aspects of Group Supervision** Commitment from all members Former experience influence. Opportunities Collective approach

	Relief about Distinction of not 'being' but focus on 'Doing' Easier to discuss own feelings and reactions Deflects personal focus Positive contribution by all valued New perspective. Effective work with patient Qualities of group work

<u>Descriptive Theme 5:</u> Relationship Dynamics & Trust	
1. Hope as an inner force Dimensions of hope- importance of – relationships **2. Appropriate supervisor** Structure model Implementation Supervisor as a role model Skills and support in many forms –Role of questions Supervisor inspiring Not forced Supervisor personality **3. Liberation – A sense of** No inhibition Supervisor personality and skill **4. Control** Colleagues set the focus, tone and pace of the alternative to supervision **5. Continual supervision** with peers drawing on each other's experience	**6. Value / validation from the supervisor** Sense of approval, demonstrated by work output. Awareness of wanting to be taken seriously by the supervisor Skill of the supervisor to facilitate **7. Challenges to participation in-direct (personal)** Content of the session not always relevant- Perceived Lack of relevance - Perceived no value in process by negative experiences - Uncomfortable with situation - Expression of emotion uncomfortable - In particular with group CS situations - Commencing CS uncomfortable- Avoidance strategies. Strategies to aim for cancellation **8. Dynamic interaction Group Supervision** - Cohesiveness, brings together elements of clinical supervision Trust – Sharing More open and honest Time for self –expression Permission to discuss events not previously discussed. Being understood

<u>Descriptive Theme 6:</u> Supervisee Identity	
1. Supervisor group Facilitation - dynamics of a group provide contribution - group collectiveness shares the problem - Collaborative approach- Cohesiveness- Empathic awareness – being Understood and	**4. Power Group Supervision** collective power – sense of belonging, security Skills of the group – reflection Confirmation and validity by colleagues

Satisfied- structured supervision provides values with group **2. Alternative Formats** Accessing supervision- Many formats of informal supervision - Professional consultation - Free from management focus - offers flexibility, relevance and focus organisational obstacles. **3. Alternative / parallel supervision advantages/ appeal -** Gives more authentic with external supervisor – more skilled. - Socialising valued – supervision in different forums other than clinical forums – Alternative models - Speed to which something can be discussed. Informal supervision/ Peer CS more aligned to clinical reality- Informal valued Risks of informal CS Timing flexible- structured agendas do not always allow for deeper reflection – valued – freedom in structure – cohesiveness – clinical focus – check things instantly. Conversations - As and when – Convenience	**5. Valued elements of group / Team CS** Team cohesiveness Collective approach Good communication Working relationships Culture of inpatient settings Gives new perspective Support and satisfaction Some mistrust and lack of openness. Unclear expectations Development and change Clinical exploration Recognition
<u>Descriptive Theme 7:</u> Organisational logistics	
1. Reflection on organisational issues of lack of time- Lack of support- lack of Reflection - Self-awareness **2. Individuals concerns** - Lack of time- Recorded process - Unaware of the need to reflect **3. Personal perception and assumptions of manager Supervisor** Risky challenging questions Fear of exposure Lack of trust – colleagues and supervisor **4. External supervisor** – Valued in specific situation – offer new insights Gaining knowledge and support **5. Informal supervision contrast with formal clinical supervision** – Formal supervision most valuable for long term growth – Most valuable for difficult cases- deep reflection	**10. Organisational operational issues** CS should not be mandatory Timing- Frequency In work time Difficult to prioritise due to work constraints logistics - Need for time **-** Appropriate Setting clinical supervision policy – enforcement of supervision and supervisor – devalues clinical supervision Supervision not given priority. - Too detached - A version of supervision. No audit Need more supervisors. Poor value of CS reflected in giving it a low priority - Prioritising problems - Logistical issues Not enough staff /resources– leading to limited supervision – downward spiral – undermines

7. Two types of supervision – Need of – Consensus for **8. Inpatient specific -** Logical problems shifts- Having to participate on days off- time off more valued- Supervision in own time **9. Rhetoric of organisational policy** Does not match the reality of actual availability and delivery of CS - Forced/ induced participation by workplace - Participation too challenging/ induced/ false -	outcomes of supervision. Constraints make CS difficult to sustain **11. Negative experiences -** Cancellations leaving lasting negative perceptions - Minimise benefits and need – CS not worth it**.** Accentuated difficulties 'too challenging' therefore cancel **12. Organisation – Need for external supervision -** Need for supervisor respect (two way) **-**Removes organisational confines – Outside hospital setting – respect. **13. Unfamiliar group concerns** - Attention focus- Unwanted exposure - Analysis not always wanted Impact of Organisational issues Logistical constraints = difficulties in CS presentation

<u>Descriptive Theme 8:</u> Inconsistent Availability/ Delivery	
1. Inpatient settings unique presentations clinical focused and effective Inpatient services. Unique challenges Rewarding, Team cohesiveness Informal supervision valued in this environment **2. Organisational approach** to supervision producing inappropriate supervisors viewed as not skilled enough. **3. Sensitive topics** Alternative to supervision **4. Frustration-** Recognition of the importance of clinical supervision- considered health and open, but frustration at not being able to implement it	**5. Impact of lack of CS** Consequences of limited supervision – burnout- poor work lack of efficiency- no continuous supervision – never making enough impact. **6. Night staff CS issues** CS orientated for day staff Continuity and Content in CS sessions issues for night staff **7. Not Receiving CS Inpatient MH settings** - The problem of not receiving supervision appears to be evident in nursing and particularly acute in ward based/inpatient-based settings. - Mental health nursing different than other nursing – needs outlet **8. Responsibility of supervision implementation** ward managers / senior responsibility **-** Nurses responsible to identify own needs**-** Group creation by organisation contrived

Appendix V: Overview of the formation of the codes and the development of the descriptive and analytical themes

The codes which were developed from the code identification stages 1 and 2 (appendices III and IV)

Codes

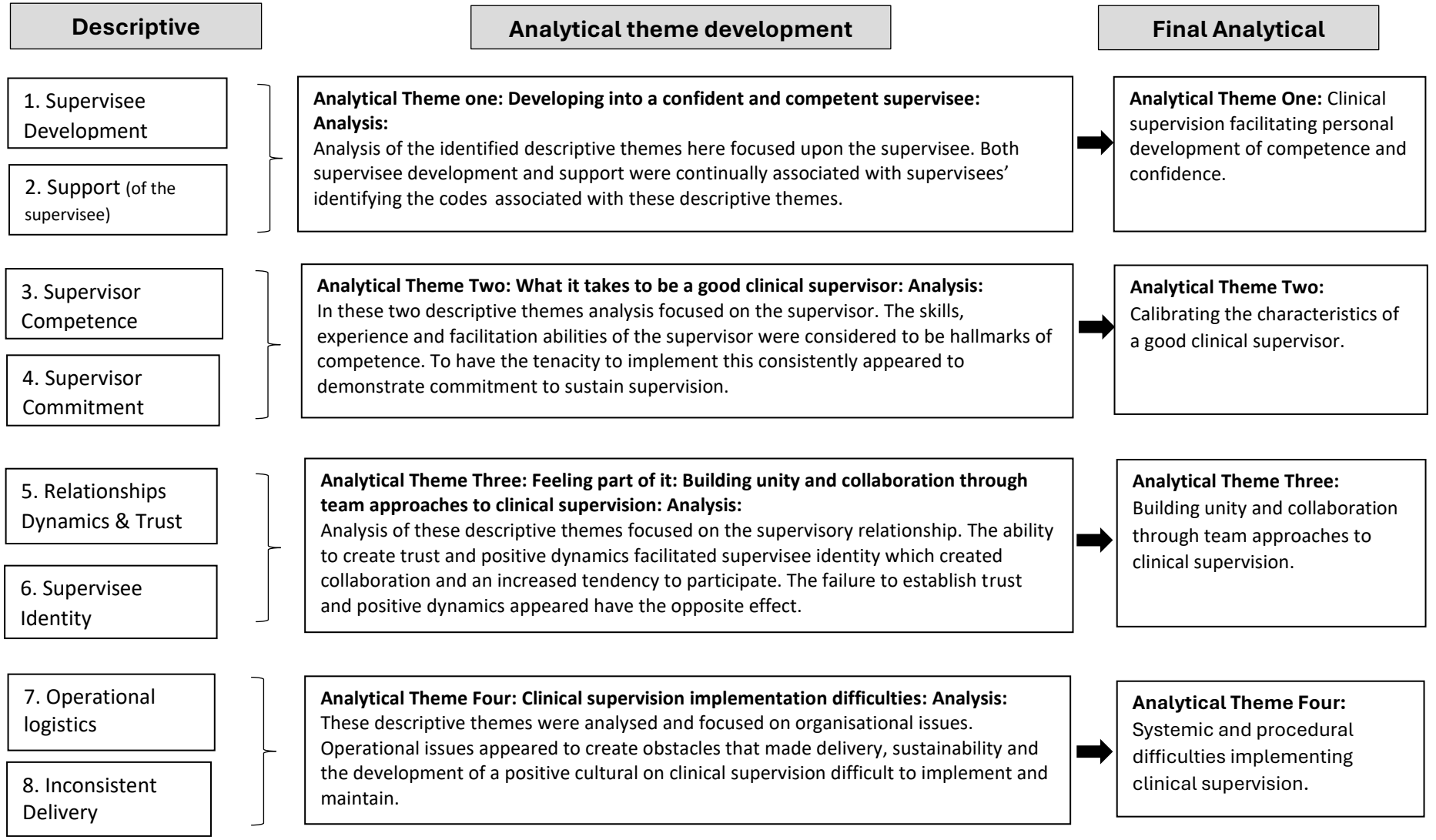
*Competence development *Content of supervision session *Courageous approach /to dare*Develops Self *Development of engagement skills *Formal supervision *Hope as an inner force*Individual's concern *Patient/service user satisfaction *Problem solving qualities * Philosophical nursing viewpoint * Quality standards *Reflection and self-awareness Responsibility safety * Confidence *Compassionate care * *Adequately trained supervisor * External supervisor * Liberation * Manager Supervisor perception of * Person centred supervisor skills *Reflection importance of supervisor facilitation skills *Supervisor Group facilitation process *Validation from supervisor * Experience *Skills * Resolve dynamics issues *Alternatives – formats* Alternative / parallel supervision advantages/ appeal *Alternative support *Control *External supervisor * Informal supervision appeal * Organisational approach to * Nurses preference *Sensitive topics * Two types of supervision *Teamwork *Peer support *Collegiate*Competency development in group supervision * Clinical impact aspects of supervision * Dynamic interaction of group supervision * Model of delivery * Power of group supervision * Personal effect of attending group supervision * Unfamiliar group concerns * Valued elements of group supervision. *Frustration * Inpatient specific resources * Impact of lack of supervision * Organisational issues Line managers * External supervision need * Organisational operational needs * Rhetoric of Organisation policy * Negative experiences * Challenges to participation personal * Challenges to participation organisational * Night staff issues * Responsibility of supervision implementation * Not receiving supervision in inpatient mental health settings * Poor / untrained supervisor *Lack of time * Topics not explored *Disruptions

The descriptive themes were developed from the codes. This process is as documented in appendix IV

Descriptive Themes

1. Supervisee Development
2. Support (of the supervisee)
3. Supervisor Competence
4. Supervisor Commitment
5. Relationships Dynamics & Trust
6. Supervisee Identity
7. Operational logistics
8. Inconsistent Delivery

This diagram illustrates the development of the analytical themes.



Appendix VI Extract from reflexive journal

Reflexive thoughts and discussion

A reflexive journal was maintained throughout the research journey. This is an extract commenting on the article below. Some of the comments also appeared in the column on the reflexive notes of the code tables (appendices IV and V).

Article: Cleary, M. & Freeman, A. (2005) The cultural realities of clinical supervision in an acute inpatient mental health setting. *Issues in mental health nursing.* 26:5, 489-505.

Prompt reflexive questions considered were,

- 1. To what extent is my involvement within this client group in this study?
- 2. What is the extent of my personal experience of this phenomenon?
- 3. Are there any salient assumptions in this data set?
- 4. Could my analysis of this data reproduce existing inequalities?
- 5. How does my evidence / influence reflect my biases?

Extract

My own experience involves working as a registered nurse (Adult) and registered nurse (mental health). In mental health I have worked in many inpatient settings and have both received and conducted clinical supervision. I have also read a great deal of literature around clinical supervision and nursing. I am, therefore, very conscious of the process of my involvement with clinical supervision with mental health nurses in mental health inpatient settings and the wider literature which has influenced my view of clinical supervision over 20 years. **This first paragraph entry considered questions 1 and 2.**

The value of supervision appears well recognised both in my experience and in this article. No dissenting participants recorded. **My own clinical practice involves clinical supervision, and this is viewed as a valuable part of clinical practice. This comment on how clinical supervision is well received in the study, compliments my own views and bias towards this. This comment also engages question 5.**

Alternatives to supervision are a very interesting and appear to be a growing concept. A concept that I have experienced in different mental health inpatients in different trusts in the UK. Alternative supervision takes many different forms, which the study outlines. Professional consultations do have several advantages on high turn-over acute wards. In my own experience informal supervision is becoming increasingly popular. However, there is the question of depth and time to reflect. Informal clinical supervision in this study, appears more valued, which is also the situation in my own practice experience. However, like my own experience there is the risk of cancellation of this due to organisation issues, so informal supervision happens more frequently. **This paragraph considers questions 1, 2, 4 and 5. Again my own involvement and experience is highlighted (questions 1 and 2). My initial analysis based on my experience reflects some of the inequalities viewed in relation to organisational issues. The awareness of my potential bias of being drawn to this issue needs to be transparent (question 5)**

Also, in my own experience with some UK mental health trusts, the supervision policy can operate an enforced approach, which tends to always be hierarchical and particularly so in nursing. Supervisees

in my experience, prefer a choice of supervisor and can have issues with their manager also being their supervisor. A hierarchal structure in management supervision is logical in an organisation, but it is unclear why there must be the same for clinical supervision. This has left me to question is clinical seen as an adjunct or add on to managerial supervision and/or what is the perception of the value or quality of clinical supervision if it can be included in organisational policies in this way. I have experience of practitioners who believe they have been driven away from their organisation to seek external supervision which they believe is the most appropriate. **This paragraph, like the one above considers questions 1, 2, 4 and 5. Again my own involvement and experience is highlighted (questions 1 and 2). There is also the same issues of potential inequalities and bias. Awareness of these issues however needs to be transparent and evident.**

Appendix VII: Lancaster University Ethics Approval

Applicant name: William Jackson
Supervisors: Jane Simpson and Ian Fletcher
Department: Health Research

13 November 2017

Dear Bill

Re: Health care assistants experience of inpatient clinical supervision

The University of Lancaster undertakes to perform the role of sponsor in the matter of the work described in the accompanying grant application. As sponsor we assume responsibility for monitoring and enforcement of research governance. As principal investigator you will confirm that the institution's obligations are met by ensuring that, before the research commences and during the full term of the grant, all the necessary legal and regulatory requirements are met in order to conduct the research, and all the necessary licenses and approvals have been obtained. The Institution has in place formal procedures for managing the process for obtaining any necessary or appropriate ethical approval for this grant. Full ethical approval must be in place before the research commences and should be reviewed at all relevant times during the grant.

Yours sincerely,

PP Professor Roger Pickup
Associate Dean for Research
Chair Faculty of Health and Medicine Research Ethics Committee.

Appendix VIII: Health Research Authority Ethics Approval

Mr William Jackson
Lecturer Practitioner Nurse Education
Edge Hill University
Faculty of Health and Social Care
St Helens Road, Ormskirk
Lancashire
L39 4QP

18 December 2017

Dear Mr Jackson

Letter of HRA Approval

NHS
Health Research Authority
Skipton House
80 London Road
London SE1 6LH

Tel: 0207 104 8010
Email: hra.approval@nhs.net

Study title:	**The Experience of Clinical Supervision in mental health inpatient settings in the UK: Health Care Assistants' Perspectives**
IRAS project ID:	**226114**
REC reference:	**18/HRA/0382**
Sponsor	**Lancaster University**

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities

Appendix IX: Email/ letter of participation

Expression of interest - Initial Correspondence – Letter/E-mail

Research Project Title: The Experience of Clinical Supervision in mental health inpatient settings in the UK: Health Care Assistants' perspectives

Dear…….

I am a part time student with Lancaster University, undertaking a PhD thesis which aims to explore the impact of clinical supervision on practice from the perspective of the Health Care Assistant (HCA). I would welcome the opportunity to ask the health care assistants who work within your respective inpatient settings and who meet the requirements above about their experience of clinical supervision. My aim is to develop understanding of the experience of clinical supervision in mental health inpatient settings from the perspective of the Health Care Assistant as little known about this particular area of practice. I am looking to recruit participants who meet the following requirements for the study. These are;

Health Care Assistant,

Employed full or part time with the Trust,

Male or female,

Based on an inpatient mental health ward

Must be receiving and have received clinical supervision

I have attached a recruitment flyer which contains an outline of the study, for which I would be very grateful if you could display on staff notice boards. There is also contact details and a participant information sheet which contains further details about the research study. If you have any questions or would like to find out more, then please do not hesitate to contact me. Alternatively or as an addition arrangement, I would be happy to meet in you and any potential participants in person to discuss the research study further. I would also be grateful to have permission to attend after handovers, meetings and answer any further or specific questions.

Many thanks for your kind consideration. Yours
Sincerely,

William Jackson (PhD student Principal Researcher)

Tel: 01695 650983

mail: W.Jackson2@lancaster.ac.uk

Appendix X: Recruitment Flyer

Health Care Assistants

Could you help with a research project?

Research Project Title: The Experience of Clinical Supervision in mental health inpatient settings in the UK: Health Care Assistants' perspectives.

DO ANY OF THESE STATEMENTS APPLY TO YOU?

- Employed Full or Part time by the Trust?
- Based on a mental health inpatient ward?
- Receiving or have received clinical supervision while in your role on a mental health inpatient ward.

If all these apply to you and you wish to participate, then please do not hesitate to contact me.

William Jackson (PhD student Principal Researcher) Tel: 01695 650983

E-mail: W.Jackson2@lancaster.ac.uk

Health & Medicine | Lancaster University

What would taking part involve?

- A one to one, face to face interview with my-self about your experiences of clinical supervision in an inpatient mental health setting.
- Interviews will last up to one hour at a time and choice of NHS Trust locations convenient to you.
- The aim of this research is to give a greater insight into what clinical supervision means to health care assistants.

Appendix XI: Participant Information

PARTICIPANT INFORMATION (1 of 4)

The experience of clinical supervision from the perspective of health care assistants (HCA) who are based within a mental health inpatient setting.

Introduction
Thank you for taking the time to read this. My name is William Jackson and I am conducting this research study as a part time student on the PhD Mental Health programme with Lancaster University in the UK.

What is the purpose of the study?
The study sets out to explore how clinical supervision is experienced by HCAs and how this impacts upon practice. The study aims to create greater clarity, and a deeper understanding of how clinical supervision works in practice. Through listening to your experiences of clinical supervision, it is hoped to identify this.

Why am I being approached to consider participation?
You are being approached to consider participation because the research study focus is the experiences of clinical supervision in mental health inpatient settings from the perspective of the health care assistant.

Do I have to take part?
No. Taking part is purely voluntary. It is your decision whether you wish to take part or not. If you wish to withdraw prior to a digitally recorded interview, you may. However if you have taken part in the interview, you can withdraw from the study one month after the interview has taken place, but data that has been analysed, this analysis may be included in the study.

What will be requested of me if I decide to take part?
If you agree to consent to take part you will be requested to meet with the researcher for one face to face, one to one interview. The interview will be digitally audio recorded and may last up to 60 minutes or less. The interview will present an opportunity for you to describe your experiences of clinical supervision in your setting. It will contain some loosely structured questions and at the start of the interview there will be a request not to name people (Staff, service users etc.) or locations. Question examples from the interview will include questions such as:

(I) *Can you describe in your own words your understanding or ideas of the term 'clinical supervision'*

(II) *In your own words can you describe the general structure of your clinical supervision sessions?*

Your participation is completely voluntary. You do not have to answer any questions you do not wish to. You can withdraw from the study one month after the interview has taken place, but data that has been analysed, this analysis may be included in the study.

PARTICIPANT INFORMATION SHEET (2 of 4)

All interviews will take place in offices that are mutually agreeable to yourself and the researcher on your NHS Trust site or the researcher's work base, Edge Hill University. The Trust has many premises over a large geographical area and has many suitable offices for interviews which are not based on your direct geographical place of work and you will be offered a number of locations to choose from. You will also be offered a choice to be interviewed away from the Trust locations entirely at a location on my own place of work, which is Edge Hill University, Ormskirk, Lancashire L39 4QP.

Will my information be confidential?

Every possible attempt will be made to ensure that the Information provided by you will be confidential and anonymised. There are some limitations to this, and it may not be possible to ensure complete anonymity if you decide to be interviewed on a Trust location, even if this is a separately geographical location from you place from your direct place of work.

Data information collected will be securely stored. Only the researcher conducting the study will have access to the secure storage area and secure filing system containing the data.

Data will be protected in the following ways:

(i) All personal data is confidential and will be separated from any interview recordings and interview transcriptions.

(ii) Digital audio recordings: When the study has been examined and submitted these recordings will be destroyed.

(iii) Hard paper copies: Copies of interview transcripts and consent forms will be stored securely in a locked filing system and stored for 10 years. All hard copies will be securely destroyed at the end of this time period.

(iv) Electronic Computer Files: Files including recorded interviews will be stored for 10 years on the computer and all will be encrypted (Access to the files is by the researcher and the researcher's supervisors only). The computer is password protected.

(v) Transcripts of the interviews: This is a typed version of the interview typed by the main researcher. Transcripts will be coded and pseudonyms applied removing any type of potentially identifying information. Some anonymised quotations from the interview will be used in the thesis or other outputs such as publications or reports, but no names or locations will be attached. Although transcripts will be anonymised, you should also be aware that they will be read by the PhD supervisors and examiners as part of the requirements of the PhD thesis and parts of them may be included in the final report which will be retained by Lancaster University.

PARTICIPANT INFORMATION SHEET (3 of 4)

Confidentiality does have some limitations. If something is revealed in the interview that the researcher believes that yourself or someone else are at significant risk of harm then confidentiality will not be held and this information will be shared with the researcher's PhD supervisors. If it is possible the researcher will inform you if this should happen. This is also a requirement of the researcher's professional code of conduct (NMC Code of Conduct, 2015).

What will happen to the findings from the study?
The findings form part of the requirements for the PhD thesis and therefore although all data will be anonymised it will be read by examiners. You will be contacted from the contact that you wish to give and be asked if you would like a summary report of the findings which will be made available for you. Findings may also be submitted for journal publication or other forms of dissemination such as conference presentations.

What are the potential benefits of participating in the study?
There are no direct benefits from participating in the study, however taking the opportunity to discuss your experiences of clinical supervision, it may help to increase your own self- awareness of how clinical supervision can enhance practice or improve the process itself. It would also be a contribution that would be valued in an area of research with a group of practitioners who have historically received little attention.

What are the potential risks of taking part?
No risks are anticipated with the study, however If you experience any distress during the interview or following participation in the study you are encouraged to consider informing the researcher and contacting the resources provided at the end of this participant information.

Has the study been reviewed?
Yes. The Faculty of Health and Medicine Research Ethics Committee has reviewed the study and this has been approved by the Research Ethics Committee, Lancaster University and also by the local NHS ethics committee.

If I need further information, where can I get it?
If you require any further information, clarification or have questions, then please contact the main researcher:
William Jackson (main principal researcher) Tel: 016895 650983
E-mail: W.Jackson2@lancaster.ac.uk

PARTICIPANT INFORMATION SHEET (4 of 4)

PhD supervisory team

Dr Jane Simpson (Director of Education) Division of Health Research,
Lancaster University LA 4YG Tel: 01524 592858
E-mail: J.Simpson2@lancaster.ac.uk

Dr Ian Fletcher (Senior Lecturer, Clinical Psychology) Division of Health Research,
Lancaster University LA 4YG Tel: 01524 593301
E-Mail: I.J.Fletcher@lancs.ac.uk

Complaints
If you wish to raise concerns or make a complaint about this study as a whole or any part of it and do not want to speak to the researcher, you can contact the researcher's PhD supervisors (above) or one of the contacts (who are not part of the research team) below:

Division of Health Research: Dr Mark Limmer Tel: 01524 593015
Email: m.limmer @lancaster.ac.uk Division of Health Research Lancaster University
Lancaster LA1 4YG

If you wish to speak to someone outside of the Mental Health Doctorate Programme, you may also contact:

Professor Roger Pickup Tel: 01524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk Faculty of Health and Medicine
(Division of Biomedical and Life Sciences) Lancaster University
Lancaster LA1 4YG

Thank you for reading through this participant information.

Resources available if you require support
If you are experiencing distress as a result of your participation in the study either during or following the study, then please contact any of the following.
Occupational Health and Wellbeing Service:
Tel: 0161 720 2727 or 0161 604 5214
e-mail: occupational.health@pat.nhs.uk

Open Monday – Friday 8am – 4pm: Thursday late night clinic until 6pm
Healthy Minds: Tel 0161 419 5725
Opening Hours Monday – Friday 9am – 5pm NHS Direct. Tel – 0845 4647

Appendix XII: Consent Form

Consent form (page 1 of 2)

Study Title: The Experience of Clinical Supervision in mental health inpatient settings in the UK: Health Care Assistants' perspectives

We would like to ask if you would like to participate in a research study which aims to explore the impact of clinical supervision on within mental health inpatient settings from the perspective of the health care assistant. Before you consent, please carefully read the participation information and if you have any further questions or require further information then please contact the principal researcher, **William Jackson.**

Contact: William Jackson: Tel 01695 650983 E-mail William.Jackson2@lancaster.ac.uk

If you have followed the above and are satisfied to participate can you place your initials in each box below following the statement if you are in agreement with it.

Please initial each statement

1. I confirm that I have read the information sheet and fully understand what is expected of me within the study. ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript. ☐
4. I understand that audio recordings will be kept until the research project has been examined. ☐
5. I understand that my participation is voluntary and that I am free to withdraw before the interview or up to one month after the interview without reason and without my legal and employment rights being affected. ☐
6. I understand that once my data has been anonymised and incorporated into themes it will not be possible for it to be withdrawn. ☐
7. I understand that the information from my interview will be pooled with other other participants' responses, anonymised and may be published. ☐
8. I consent to information and quotations from my interview being used in reports, conferences and training events. ☐

9. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will need to share this information with his research supervisor.

10. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.

11. I consent to take part in the research study as identified above

Name of Participant……

Signature……..

Date……

Name of Researcher…….

Signature……..

Date……

Appendix XIII: Interview Schedule

Interview Schedule

Interview questions to explore the Experience of Clinical Supervision in mental health inpatient settings in the UK from a Health Care Assistants' perspective.

Introduction (prior to interview)

- Introduction of self and explain role.
- Set out a broad agenda by outlining the main question and timeframe: Over the next 60 minutes or less, I would like to ask you about your experiences of clinical supervision while you have been working in mental health inpatient settings'
- Highlight that it is important that the study is about personal experience and that there are no correct or incorrect answers.
- Establish that throughout the interview a number of aspects of clinical supervision will be asked about and you will be given opportunities, through questions, to see if there is anything that has not been covered, captured satisfactorily or missed.
- Outline the distress protocol.

Opening introductory questions

2. Can you tell me about yourself, how long you have worked in mental health impatient settings and what you think about your role in this setting?
3. Please describe in your own words your understanding of what the term 'clinical supervision' means to you in your role and setting where you are?

Specific Questions

4. In your own words can you describe the general structure of your clinical supervision sessions?

Further Prompts: Can you describe to me how the session is set out from start to finish? How long does the session last and do you think this is too long/short or about right? How often does your clinical supervision happen and do you think this is about right/too long/too short?

5. What kind of things do you discuss or raise in your clinical supervision session?

Further Prompts: Who decides what topics are to be discussed? How is this done?

6. What do you think would be the qualities required for a good clinical supervisor? *Further Prompts: Understands Good listener, knowledgeable, understands the service user/patient issues very well, empathic, and approachable.*

7. Have there been times when clinical supervision has not happened?

Further prompts: What were the reasons for this? What happens then? What do you think about that? Does that affect you in any way?

8. For the remaining questions I would like to ask you about the different aspects of the impact of your clinical supervision on your work. How, if at all, does your clinical supervision experience impact upon your work with service users?

Further prompts: How does that happen? Can you give any examples? What does that mean to you? Can you tell me more about that?

9. How, if at all, does your clinical supervision experience impact upon your work with other professionals?

Further prompts: How does that happen? Can you give any examples? What does that mean to you? Can you tell me more about that?

10. How, if at all, does your clinical supervision experience impact upon your own self-development?

Further prompts: How does that happen? Can you give any examples? What does that mean to you? Can you tell me more about that?

11. How, if this happens at all, does your experience of clinical supervision help or hinder your practice or do you think it makes no difference to your practice?

Further prompts: How does that happen? What does that mean to you? Can you tell me more about that?

Closing Question

12. Is there anything you wish to add or anything that you think is important about the clinical supervision experience that you think has not been covered?

Concluding Statement

Just before we finish the interview is there anything that you would like to add? I would like to sincerely thank you for your time, Thank you.

Appendix XIV: Distress Protocol

Distress Protocol for managing distress during the study interview

Research Project Title: The Experience of Clinical Supervision in mental health inpatient settings in the UK: Health Care Assistants' perspectives

The study is not expected to create distress or discomfort to any participant; however the subjective, emergent character of qualitative research indicates not all risks can be foreseen. Within interviews the experiences of clinical supervision may present some emotive experiences such as strong opinions or a sense of embarrassment. To reduce these possibilities the following distress protocol will be adhered to.

Introduction: Explanation prior to commencing the interview that should any concerns arise during interview, the researcher may suggest stopping the interview and following the distress protocol.

Stage One - Indicative or perceived distress

- The participant indicates that they are experiencing stress OR
- Participant exhibiting behaviours that are indicative that the interview is becoming stressful (Example, crying, frequent fidgeting, frequent anger)

Stage One - Response

- Stop the interview
- Researcher (a mental health professional) to offer immediate support
- Assess mental status (*Example, tell me what are your thoughts at the moment? Tell me what are your feelings at the moment? Do you feel safe?* Do you think you are able to continue with the interview? *Do you feel that you can continue to go on with your day?*

Stage One – Review

- If the participant thinks and feels that they are able to continue then resume the interview.
- If the participant is unable to continue, then go to stage two.

Stage Two- Response

- Terminate the interview. If possible and with consent from the participant suggest relocating the participant to a quite area and accompany the participant.
- Encourage the participant to contact their GP or utilise further support and resources detailed in the participant information.

Stage Two – Follow up

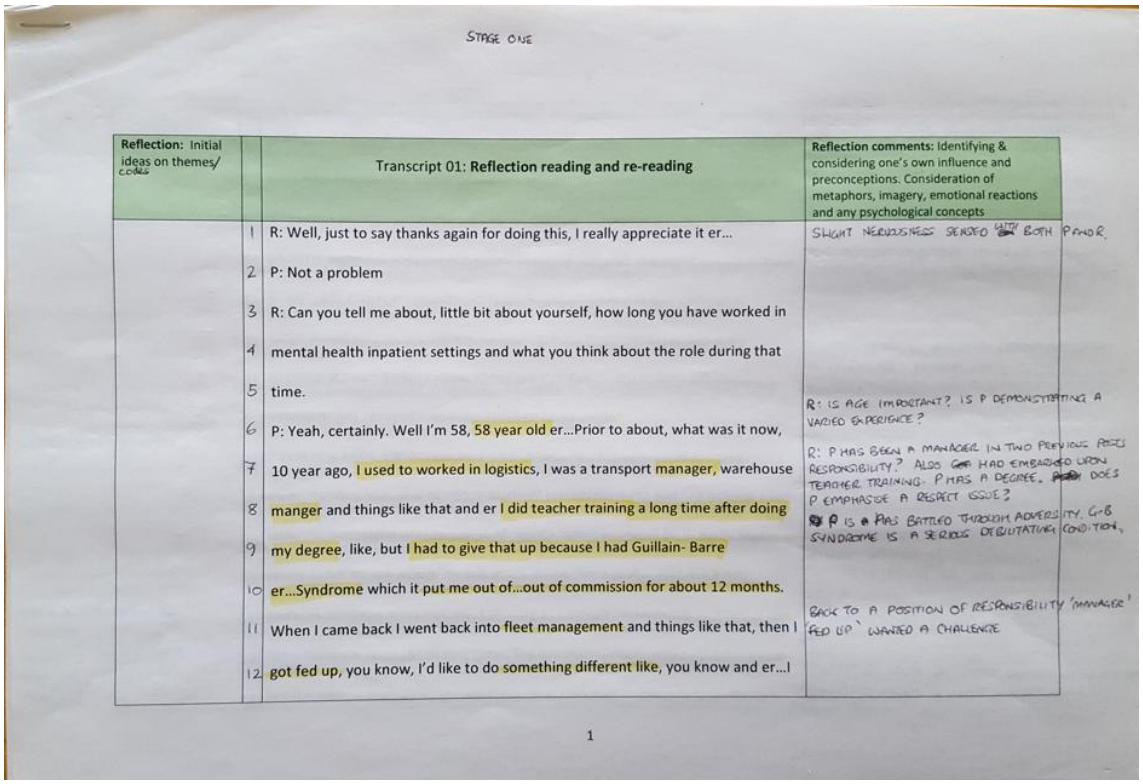
- If participant consents, follow up with courtesy call.
- Encourage the participant to call if they experience an increase in stress in the hours/days that follow the interview.

Appendix XV: Data Analysis stage one

Stage 1: Reading the transcript.

The transcript was read and re-read several times. The voice recording was listened to closely to enter the participant's world to gage the flow and rhythm of the interview. Additional brief notes were taken at the time, which were kept separate from the account of the experience and were reflected upon. Reflective comments identified personal influence and preconceptions. Consideration for metaphors, imagery, emotional reactions and any psychological concepts were noted.

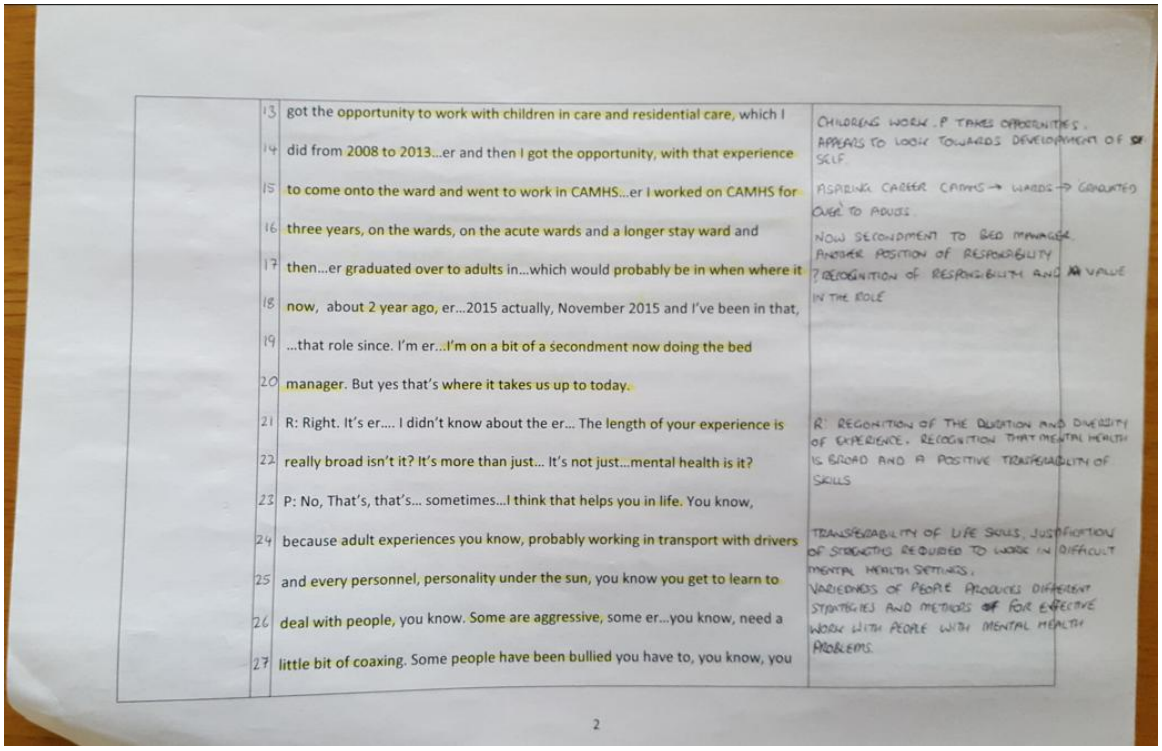
Each transcript had margin to the left (reflecting on initial ideas of any emerging theme and to the right (reflective comments identifying the researchers own influence and any preconceptions. The example below shows pages one and two of a stage one transcript (TR01).



STAGE ONE

Reflection: Initial ideas on themes/ codes		Transcript 01: **Reflection reading and re-reading**	**Reflection comments:** Identifying & considering one's own influence and preconceptions. Consideration of metaphors, imagery, emotional reactions and any psychological concepts
	1	R: Well, just to say thanks again for doing this, I really appreciate it er...	SLIGHT NERVOUSNESS SENSED WITH BOTH P AND R.
	2	P: Not a problem	
	3	R: Can you tell me about, little bit about yourself, how long you have worked in	
	4	mental health inpatient settings and what you think about the role during that	
	5	time.	
	6	P: Yeah, certainly. Well I'm 58, 58 year old er...Prior to about, what was it now,	R: IS AGE IMPORTANT? IS P DEMONSTRATING A VARIED EXPERIENCE?
	7	10 year ago, I used to worked in logistics, I was a transport manager, warehouse	R: P HAS BEEN A MANAGER IN TWO PREVIOUS ROLES RESPONSIBILITY? ALSO [redacted] HAD EMBARKED UPON TEACHER TRAINING- P HAS A DEGREE. [redacted] DOES P EMPHASISE A RESPECT ISSUE?
	8	manger and things like that and er I did teacher training a long time after doing	
	9	my degree, like, but I had to give that up because I had Guillain- Barre	P IS A PAS BATTLED THROUGH ADVERSITY. G-B SYNDROME IS A SERIOUS DEBILITATING CONDITION.
	10	er...Syndrome which it put me out of...out of commission for about 12 months.	
	11	When I came back I went back into fleet management and things like that, then I	BACK TO A POSITION OF RESPONSIBILITY 'MANAGER' FED UP` WANTED A CHALLENGE
	12	got fed up, you know, I'd like to do something different like, you know and er...I	

1



got the opportunity to work with children in care and residential care, which I did from 2008 to 2013...er and then I got the opportunity, with that experience to come onto the ward and went to work in CAMHS...er I worked on CAMHS for three years, on the wards, on the acute wards and a longer stay ward and then...er graduated over to adults in...which would probably be in when where it now, about 2 year ago, er...2015 actually, November 2015 and I've been in that, ...that role since. I'm er...I'm on a bit of a secondment now doing the bed manager. But yes that's where it takes us up to today.

CHILDRENS WORK. P TAKES OPPORTUNITIES. APPEARS TO LOOK TOWARDS DEVELOPMENT OF SELF.

ASPIRING CAREER CAMHS → WARDS → GRADUATED OVER TO ADULTS.

NOW SECONDMENT TO BED MANAGER. ANOTHER POSITION OF RESPONSIBILITY

? RECOGNITION OF RESPONSIBILITY AND VALUE IN THE ROLE

R: Right. It's er.... I didn't know about the er... The length of your experience is really broad isn't it? It's more than just... It's not just...mental health is it?

P: No, That's, that's... sometimes...I think that helps you in life. You know, because adult experiences you know, probably working in transport with drivers and every personnel, personality under the sun, you know you get to learn to deal with people, you know. Some are aggressive, some er...you know, need a little bit of coaxing. Some people have been bullied you have to, you know, you

R: RECOGNITION OF THE DURATION AND DIVERSITY OF EXPERIENCE. RECOGNITION THAT MENTAL HEALTH IS BROAD AND A POSITIVE TRANSFERABILITY OF SKILLS

TRANSFERABILITY OF LIFE SKILLS, JUSTIFICATION OF STRENGTHS REQUIRED TO WORK IN DIFFICULT MENTAL HEALTH SETTINGS. VARIEDNESS OF PEOPLE PRODUCES DIFFERENT STRATEGIES AND METHODS OF FOR EFFECTIVE WORK WITH PEOPLE WITH MENTAL HEALTH PROBLEMS.

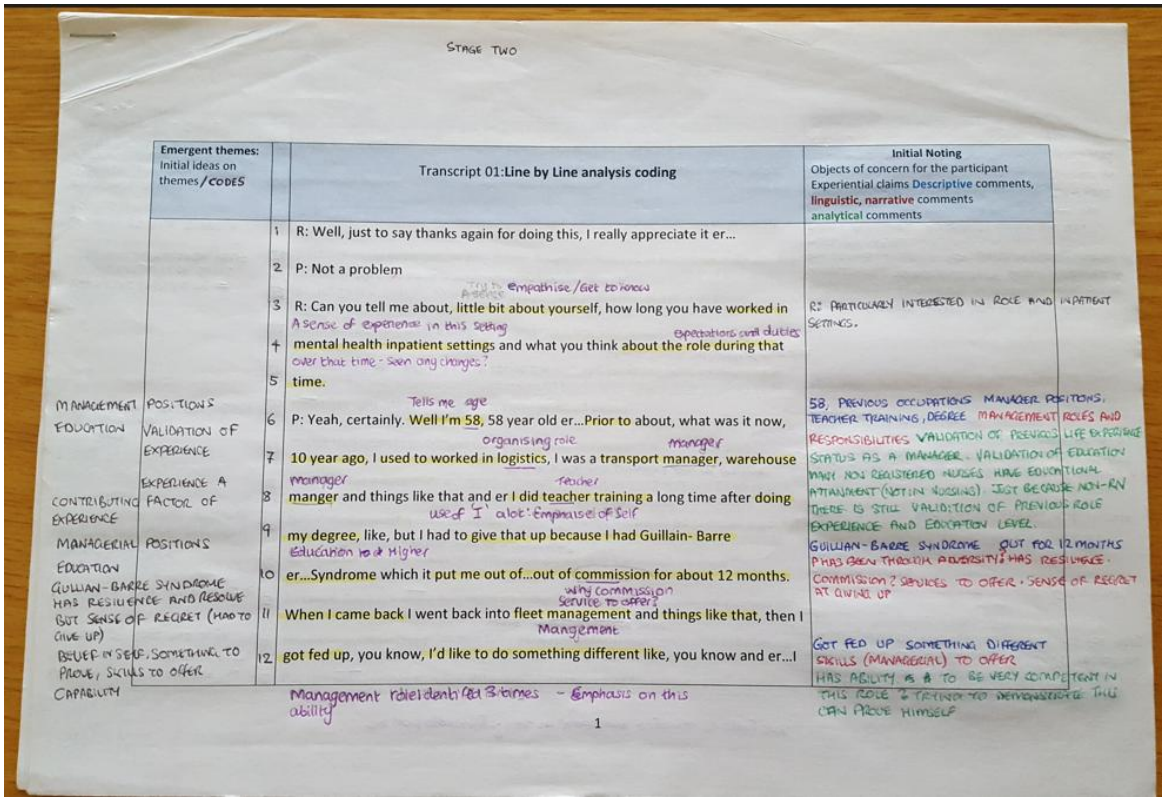
2

Appendix XVI: Stage two data analysis

Stage 2: Noting – Line by line examination

A hard copy of the transcript was produced again (following on from stage one). The left-hand margin reflected upon initial ideas on themes. A line by line examination of the content was developed using the right hand margin for **descriptive, linguistic** and **analytical** / conceptual comments. These were written in colour for distinction (see photographed example page below).

The objective was to become immersed in the participant's world and engage with the data analysis to make sense of the participants view through the iterative process of description and interpretation. Interpretations in this way could be traced to the original data. The example below illustrates pages one and two of this process.

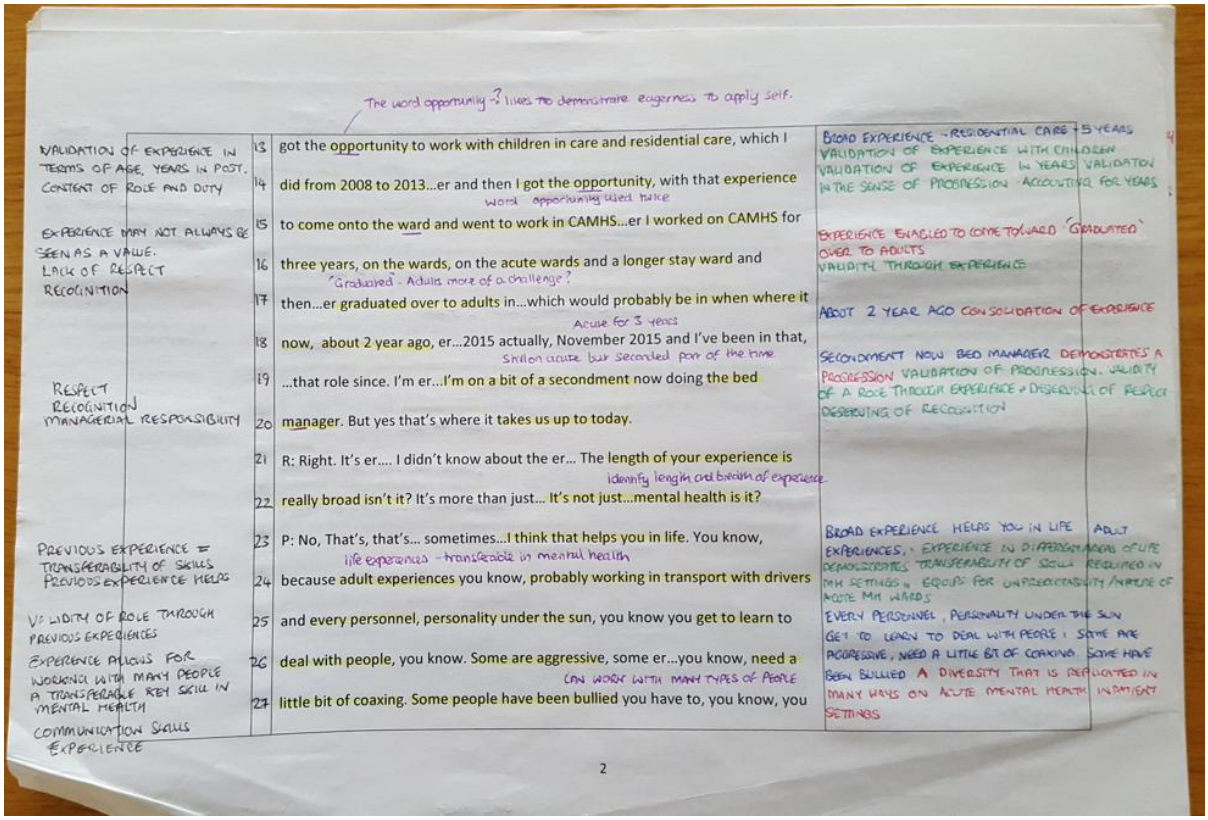


STAGE TWO

Emergent themes: Initial ideas on themes / CODES			Transcript 01: Line by Line analysis coding	Initial Noting: Objects of concern for the participant; Experiential claims Descriptive comments, linguistic, narrative comments; analytical comments
		1	R: Well, just to say thanks again for doing this, I really appreciate it er...	
		2	P: Not a problem	
		3	R: Can you tell me about, little bit about yourself, how long you have worked in	R: PARTICULARLY INTERESTED IN ROLE AND INPATIENT SETTINGS.
		4	mental health inpatient settings and what you think about the role during that	
		5	time.	
MANAGEMENT POSITIONS		6	P: Yeah, certainly. Well I'm 58, 58 year old er...Prior to about, what was it now,	58, PREVIOUS OCCUPATIONS MANAGER POSITIONS, TEACHER TRAINING, DEGREE MANAGEMENT ROLES AND
EDUCATION	VALIDATION OF EXPERIENCE	7	10 year ago, I used to worked in logistics, I was a transport manager, warehouse	RESPONSIBILITIES VALIDATION OF PREVIOUS LIFE EXPERIENCE STATUS AS A MANAGER. VALIDATION OF EDUCATION
CONTRIBUTING FACTOR OF EXPERIENCE	EXPERIENCE A	8	manger and things like that and er I did teacher training a long time after doing	MANY NON REGISTERED NURSES HAVE EDUCATIONAL ATTAINMENT (NOT IN NURSING) JUST BECAUSE NON-RN THERE IS STILL VALIDITION OF PREVIOUS ROLE
MANAGERIAL POSITIONS		9	my degree, like, but I had to give that up because I had Guillain- Barre	EXPERIENCE AND EDUCATION LEVEL.
EDUCATION				
GUILLAN-BARRE SYNDROME HAS RESILIENCE AND RESOLVE BUT SENSE OF REGRET (HAD TO GIVE UP)		10	er...Syndrome which it put me out of...out of commission for about 12 months.	GUILLAN-BARRE SYNDROME OUT FOR 12 MONTHS PHAS BEEN THROUGH ADVERSITY? HAS RESILIENCE. COMMISSION? SERVICES TO OFFER. SENSE OF REGRET AT GIVING UP
BELIEF IN SELF, SOMETHING TO PROVE, SKILLS TO OFFER		11	When I came back I went back into fleet management and things like that, then I	
CAPABILITY		12	got fed up, you know, I'd like to do something different like, you know and er...I	GOT FED UP SOMETHING DIFFERENT SKILLS (MANAGERIAL) TO OFFER HAS ABILITY & TO BE VERY COMPETENT IN THIS ROLE ? TRAINED TO DEMONSTRATE THAT CAN PROVE HIMSELF

Management role identified 3 times - Emphasis on this ability

1



The word opportunity -? lives to demonstrate eagerness to apply self.

VALIDATION OF EXPERIENCE IN TERMS OF AGE, YEARS IN POST, CONTENT OF ROLE AND DUTY

EXPERIENCE MAY NOT ALWAYS BE SEEN AS A VALUE.
LACK OF RESPECT
RECOGNITION

RESPECT
RECOGNITION
MANAGERIAL RESPONSIBILITY

PREVIOUS EXPERIENCE = TRANSFERABILITY OF SKILLS
PREVIOUS EXPERIENCE HELPS

VALIDITY OF ROLE THROUGH PREVIOUS EXPERIENCES

EXPERIENCE PLAYS FOR WORKING WITH MANY PEOPLE A TRANSFERABLE KEY SKILL IN MENTAL HEALTH

COMMUNICATION SKILLS EXPERIENCE

13 got the opportunity to work with children in care and residential care, which I
14 did from 2008 to 2013...er and then I got the opportunity, with that experience
Word opportunity used twice
15 to come onto the ward and went to work in CAMHS...er I worked on CAMHS for
16 three years, on the wards, on the acute wards and a longer stay ward and
'Graduated' - Adults more of a challenge?
17 then...er graduated over to adults in...which would probably be in when where it
Acute for 3 years
18 now, about 2 year ago, er...2015 actually, November 2015 and I've been in that,
Still on acute but seconded part of the time
19 ...that role since. I'm er...I'm on a bit of a secondment now doing the bed
20 manager. But yes that's where it takes us up to today.
21 R: Right. It's er.... I didn't know about the er... The length of your experience is
identify length and breath of experience
22 really broad isn't it? It's more than just... It's not just...mental health is it?
23 P: No, That's, that's... sometimes...I think that helps you in life. You know,
life experiences - transferable in mental health
24 because adult experiences you know, probably working in transport with drivers
25 and every personnel, personality under the sun, you know you get to learn to
26 deal with people, you know. Some are aggressive, some er...you know, need a
CAN WORK WITH MANY TYPES OF PEOPLE
27 little bit of coaxing. Some people have been bullied you have to, you know, you

BROAD EXPERIENCE - RESIDENTIAL CARE - 5 YEARS
VALIDATION OF EXPERIENCE WITH CHILDREN
VALIDATION OF EXPERIENCE IN YEARS VALIDATION IN THE SENSE OF PROGRESSION - ACCOUNTING FOR YEARS

EXPERIENCE ENABLED TO COME TOWARD 'GRADUATED' OVER TO ADULTS
VALIDITY THROUGH EXPERIENCE

ABOUT 2 YEAR AGO CONSOLIDATION OF EXPERIENCE

SECONDMENT NOW BED MANAGER DEMONSTRATES A PROGRESSION VALIDATION OF PROGRESSION. VALIDITY OF A ROLE THROUGH EXPERIENCE + DESERVING OF RESPECT DESERVING OF RECOGNITION

BROAD EXPERIENCE HELPS YOU IN LIFE ADULT EXPERIENCES, EXPERIENCE IN DIFFERENT AREAS OF LIFE DEMONSTRATES TRANSFERABILITY OF SKILLS REQUIRED IN MH SETTINGS + EQUIPS FOR UNPREDICTABILITY / NATURE OF ACUTE MH WARDS
EVERY PERSONNEL, PERSONALITY UNDER THE SUN GET TO LEARN TO DEAL WITH PEOPLE : SOME ARE AGGRESSIVE, NEED A LITTLE BIT OF COAXING. SOME HAVE BEEN BULLIED A DIVERSITY THAT IS REPLICATED IN MANY WAYS ON ACUTE MENTAL HEALTH INPATIENT SETTINGS

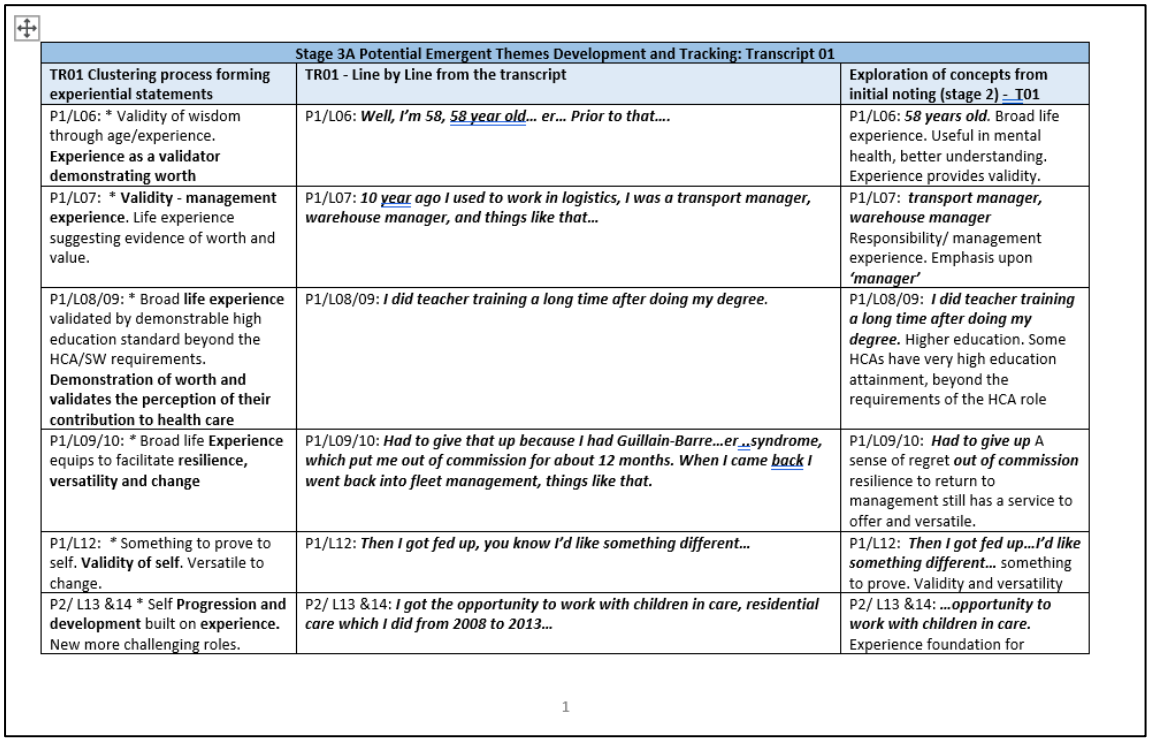
2

Appendix XVII: Stage three: Emergent theme process

Stage 3: Emergent Theme Process (part one)

This process took the form of three parts. Firstly, working from the transcript and line by line examination, there was an attempt to chronologically identify emerging potential clusters taking place based on participants experiences. This consisted of using concise statements, identifying what was important in that part of the transcript and accompanying notes. These statements reflected the participant's original words (in bold) and experiences and the researcher's interpretations of those words on a contextual level.

Experiential statements were also constructed based on this process to continually check that the experiences reflected the participants words and meaning. (see examples below).



Stage 3A Potential Emergent Themes Development and Tracking: Transcript 01		
TR01 Clustering process forming experiential statements	**TR01 - Line by Line from the transcript**	**Exploration of concepts from initial noting (stage 2) - T01**
P1/L06: * Validity of wisdom through age/experience. **Experience as a validator demonstrating worth**	P1/L06: ***Well, I'm 58, 58 year old… er… Prior to that….***	P1/L06: ***58 years old.*** Broad life experience. Useful in mental health, better understanding. Experience provides validity.
P1/L07: * **Validity - management experience**. Life experience suggesting evidence of worth and value.	P1/L07: ***10 year ago I used to work in logistics, I was a transport manager, warehouse manager, and things like that…***	P1/L07: ***transport manager, warehouse manager*** Responsibility/ management experience. Emphasis upon ***'manager'***
P1/L08/09: * Broad **life experience** validated by demonstrable high education standard beyond the HCA/SW requirements. **Demonstration of worth and validates the perception of their contribution to health care**	P1/L08/09: ***I did teacher training a long time after doing my degree.***	P1/L08/09: ***I did teacher training a long time after doing my degree.*** Higher education. Some HCAs have very high education attainment, beyond the requirements of the HCA role
P1/L09/10: * Broad life **Experience** equips to facilitate **resilience, versatility and change**	P1/L09/10: ***Had to give that up because I had Guillain-Barre…er…syndrome, which put me out of commission for about 12 months. When I came back I went back into fleet management, things like that.***	P1/L09/10: ***Had to give up*** A sense of regret ***out of commission*** resilience to return to management still has a service to offer and versatile.
P1/L12: * Something to prove to self. **Validity of self**. Versatile to change.	P1/L12: ***Then I got fed up, you know I'd like something different…***	P1/L12: ***Then I got fed up…I'd like something different…*** something to prove. Validity and versatility
P2/ L13 &14 * Self **Progression and development** built on **experience.** New more challenging roles.	P2/ L13 &14: ***I got the opportunity to work with children in care, residential care which I did from 2008 to 2013…***	P2/ L13 &14: ***…opportunity to work with children in care.*** Experience foundation for

1

Experience in years (A measure) **Evidence of worth**		Progression and validity. New direction valued challenging role
P2/L14-15: * **Experience facilitates progression.** Transferable skills. Caring authenticity	P2/L14-15: ***With that experience to come to the ward and went to work in CAMHS for three years.***	P2/L14-15: ***With that experience… went to work in CAMHS for three years.*** Progression and consolidation in time.
P2/L16-18: * **'Graduated'** earned progression. Validated by progression/**Caring authenticity** deserving of respect?	P2/L16-17: ***Three years on acute wards and a longer stay ward and then…er graduated over to adults.*** **'Graduated' progression.**	P2/L16-18: ***Three years on acute wards and a longer stay ward and then…er graduated over to adults.*** **'Graduated'** earned progression. Considerable experience. Validity
P2/L19-20: * Demonstration of **progression -validity experience.** Reflection on experience and achievement Respectful. Versatile **contribution**	P2/L19-20: ***I'm on a bit of a secondment now doing the bed manager, where it takes us up to today.***	P2/L19-20: ***bed manager, where it takes us up to today.*** Demonstration of progression. Further validity experience and respect.
P2/L23: * Emphasis on **previous life experience** helpful. Transferable skills / life skills. **Evidence of worth**	P2/L23: ***I think it helps you in life. You know, because adult experience, you know probably working with transport drivers.***	P2/L23: Previous life experience helpful. ***I think it helps you in life. You know, because adult experience.*** Transferable experiences
P2-3/L24-29: * **Life skills that can transferable** in MH In-patient ward settings. Something to offer in any situation. **Versatile.**	P2-3/L24-29: ***You've got what you'd get on the ward in a more expanded version.***	P2-3/L24-29: ***You've got what you'd get on the ward in a more expanded version.*** Life skills that can transferable in MH In-patient ward settings.
P3/ L35-37: * **CS facilitates self-awareness**, self-development, development of others. Developing competence. CS examines your	P3/ L35-37: ***Looking at your actual role…on the ward, dealing with other people er… trying to guide using your own personality Getting rid of the rough edges and gaining the experiences in the areas that you are good at and to move on with that….***	P3/ L35-37: ***Looking at your actual role…*** CS examines your role, influences your own personality to set example… ***Getting rid of the rough edges***

2

Experiential statements developed from the emergent themes development table (above)

Experiential statements from TR01 (Wasim) Transcript

Experience as a validator demonstrating worth.

Broad life experiences validate and contribute to health care role.

Experience brings valued caring authenticity

Good clinical supervision develops self and invests in the supervisee, which empowers and liberates.

Clinical supervision needs to be organised with direction and structure with pragmatic outcomes.

Clinical supervision differs across services. Inpatient services have very little or none at all.

HCASWs are not valued enough to receive clinical supervision.

A positive competent and knowledgeable approach from supervisor is key to good supervision.

Good clinical supervision does not happen on the inpatient wards. It is really needed as the HCASW role is difficult enough.

Clinical supervision creates learning opportunities and improves reflection.

A good clinical supervisor provides trust, professionalism and inspiration.

Protected time for clinical supervision demonstrates commitment and value for all.

No value in / respect for the clinical supervision process within inpatient settings.

A tokenistic process that needs to be completed for the organisation, but no value in it.

The clinical supervisor needs to listen and allow for the HCASW to contribute.

Clinical supervision on in patient settings does not happen. There appears to be no justification for this as it does happen in other service areas.

HCASWs not worthy of clinical supervision

Inequitable availability of clinical supervision between HCASWs and RNs.

Need for clinical supervision as this can be underestimated. Issues can go undetected.

A tick- box exercise for the organisation.

Organisation not clear on clinical supervision. This allows for inequalities between staff.

New RNs are too career focused. Clinical supervision viewed only as a goal for career advancement. HCASWs not important.

Inexperienced RNs not equipped to deliver clinical supervision.

HCASW skills and experience not valued in the RN relationship.

Experience not viewed as valuable by RNs.

Division between career and caring for RNs. RNs focused on ambition. RNs to achieve their goals at any cost.

HCASW contribution is worthless.

Reflection increases self-awareness.

Formulation is a valuable process in clinical supervision.

Clinical supervision facilitates professionalism and increases self-awareness.

Clinical supervision introduces skills, formulation and problem solving.

Clinical supervision develops insight and objectivity and assists in the reduction of transference.

HCASWs face more challenging events, therefore clinical supervision needs to be available and frequent.

Clinical supervision provides a validation and confirmation of good practice which is supportive and re-assuring.

A good supervisor can resolve personal issues.

A good supervisor is able to address the most sensitive problems competently with support and objectivity.

Supportive supervisor is valued.

Clinical supervision provides confidence to challenge and gives an understanding of own role and development needs.

Before clinical supervision there was no opportunity for problem resolution or professional development.

HCASW identity and support of each other.

Clinical supervision influences practice.

Poor supervisor attitudes diminish respect.

Narrow organisational approach to clinical supervision allows for poor interpretation of clinical supervision.

Poor clinical supervision processes viewed as management led.

Blanket approach to clinical supervision is organisational led and does not allow for individual approaches.

Unclear process of clinical supervision results in confusing and variable delivery.

Variability of supervisor delivery allows for inconsistent clinical supervision and there is little respect for the process.

Clinical supervision is dependent on the supervisor ability. This leads to misinterpretation of the process.

Supervisors not viewed as competent. Poor misunderstanding of the clinical supervision process.

Inequality of the delivery between inpatient services and non-inpatient services.

HCASWs access to clinical supervision is marginalised.

Life experiences can contribute positively to clinical supervision.

RNs do not lead by example. This gives a sense of resentment in the HCASW.

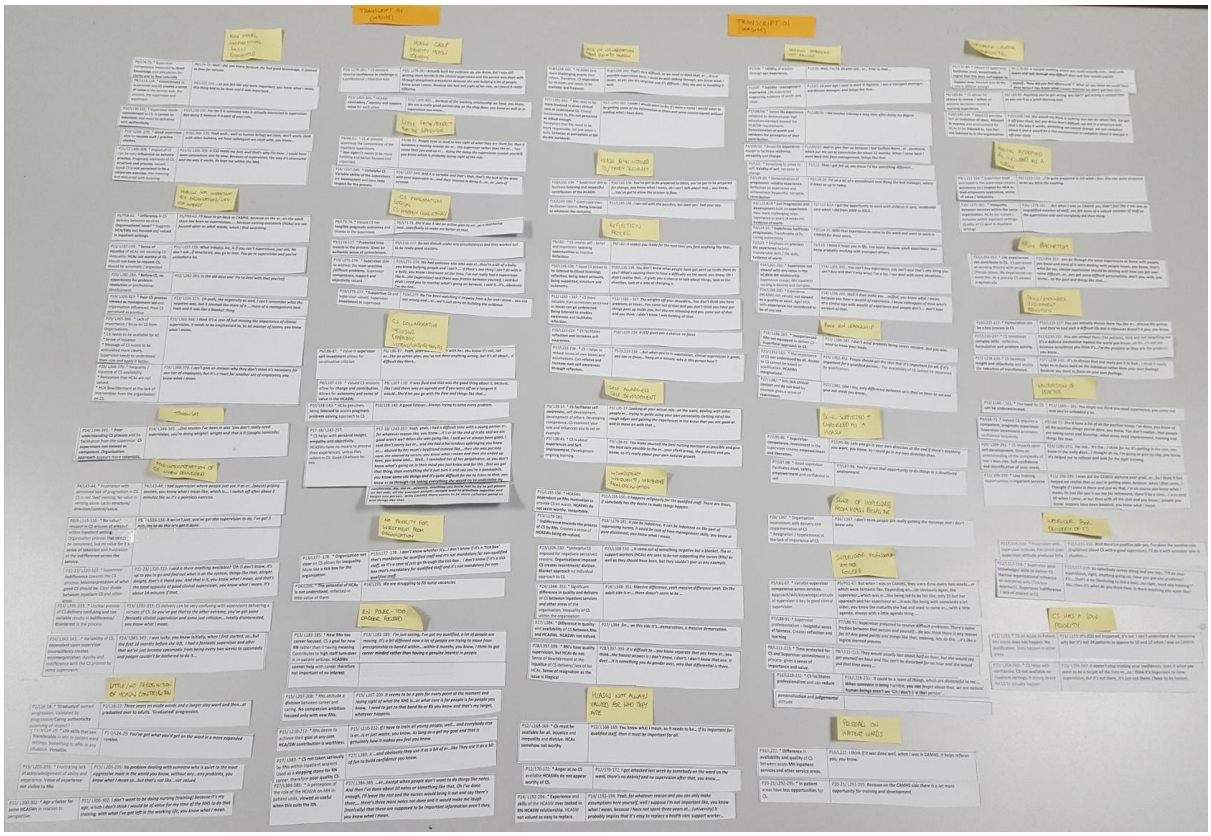
Inequality. Difference between in quality, availability and access to clinical supervision between RNs and HCASWs.

RNs need more clinical involvement to understand clinical supervision.

Sense of resignation over absence of clinical supervision and / or poor quality clinical supervision

Stage 3 (continued): Emergent Theme Process (part two)

The second part of this process attempted to identify emerging potential themes by using a table top exercise, involving cutting up the statements from the emergent themes development table (identified above) into clusters and mapping them out. This part of the process followed the strategies of using, abstraction, subsumption etc (Smith et al, 2009). (See examples below)



Each cluster statement was noted and this contributed to cluster tracker and later, matrix (see appendix XVIII stage 4) with key statements emerging as potential themes.

Stage 3 (continued): Emergent Theme Process (part three)

The third part to this process used the table top exercise again using the mapped clusters to develop potential emerging themes further. The pictures of this process below demonstrate on this case six broad themes were developed from the clusters (three noted with green post-it notes with headings and three pink post-it notes with headings.

The picture above is also represented by the tables (see below) which demonstrate the potential themes emerging following this table top exercise.

Statement clustering following 'table top' exercise (Photos above) showing potential emerging themes from transcript 01

Potential theme group A
Statements/ clusters grouped following 'table top exercise'
Good clinical supervision
• A good clinical supervisor has professionalism, a good attitude, they are focused and competent. • A good clinical supervisor is a good role model, is inspirational and committed to clinical supervision. • Good clinical supervision is collaborative, inclusive and empathic. • Clinical supervision works best when it is pragmatic, logical and happens consistently

Potential theme group B
Statements/clusters grouped following ‘table top exercise’
learning and reflection improves practice
• Clinical supervision and the development of reflective skills • Clinical supervision and skills and knowledge acquisition • Clinical supervision as a process to safely offload and ventilate • Clinical supervision and increasing self-awareness and self-development • Clinical supervision as a validator for practice
Potential theme group C
Statements / clusters grouped following ‘table top exercise’
Feeling valued
• Being listened to • Feeling supported and empowered • Feeling accepted and included • HCASW pragmatism • HCASW Group identity and HCASW identity
Potential theme group D
Statements/ clusters grouped following ‘table top exercise’
Supervisor issues
• Poor clinical supervision delivery from clinical supervisor • No / little respect for the clinical supervisor • A sense of hopelessness from the HCASW at the situation • Low priority and the lack of clinical supervision • Pressures and challenges on inpatient wards
Potential theme group E
Statements/ clusters grouped following ‘table top exercise’
Organisational issues
• Inconsistency and inequality of clinical supervision • HCASWs not seen as important by the organisation for clinical supervision • No/ little priority for investment in clinical supervision by the organisation • Misinterpretation of clinical supervision when it is delivered • Tokenism/ tokenistic process
Potential theme group F
Statements / clusters grouped following ‘table top exercise’
Difficult supervisory relationships
• HCASWs experience not valued • Little recognition of HCASW contribution • HCASWs not valued in their role • Registered Nurse (RN) power, too career focused and self-serving • Poor RN leadership • RNs lack of collaboration and empathy with HCASWs

These three parts in stage 3 were repeated for every participant.

Appendix XVIII: Stage four

Stage 4: Repetition of the process for the remaining transcripts

Stages one to three, outlined in appendices XV, XVI, and XVII, were repeated for each 'case' (transcript from each participant) and was analysed this way. Reflection was ongoing throughout the stages, and this drew attention to what was mindful of the structures and knowledge from previous transcripts. This allowed for new clusters, then themes, to emerge.

When all 8 transcripts were analysed and themes were established, patterns were noted across all cases by spreading out all the super-ordinate theme tables from all cases to allow for comparison and contrast, while noting any idiosyncrasies and shared qualities from the cases.

To assist this a tacker table of clusters was developed to record what was common and new in each case. As each theme developed potential themes were added, merged and grouped with the clusters in the tracker table. Below are the final tracker tables demonstrating the clusters that were evident with each participant and how these formed the sub themes and superordinate themes.

Tracker table of clusters and cluster groups

Key Theme: Facilitation of the clinical supervision process within Inpatient settings								
SUPERORDINATE THEAME: The Value of CS	**Participants 1-8 identification of clusters**							
	P1	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**
Subordinate Theme 1: Commitment to the purpose of CS								
Professional attitude and focus / would like to see professional attitude and focus	✓x2	✓	✓	✓	✓	✓x2	✓x2	✓
Supervisor as role model/ Influential / Inspirational / Would like more inspiration	✓x3	✓	✓	✓	✓x2	✓x1	✓	✓x3
Competent supervisor/team you can trust / Would like more trust/ Someone who knows the inpatient wards	✓x2	✓	✓	✓x3	✓	✓x1	✓x2	✓
Supervisor commitment /investment meaningful / Would like more meaning/more listening	✓x2	✓x3	✓	✓x	✓x2	✓	✓x3	✓
Autonomy (in groups) (or freedom to choose the subject)	✓	✓x2	✓	✓x3		✓x3	✓x4	✓x2
Can empathise/understand / Would like more empathy	✓x2	✓x2		✓x2	✓	✓	✓x2	✓x10
Collaborative/inclusivity	✓	✓	✓	✓	✓	✓x1	✓x4	✓
Consistent	✓			✓	✓	✓x2	✓	✓
Exploration of content	✓		✓	✓	✓	✓x2	✓	✓
Pragmatic action (outcome time focused) and structure- easy to follow		✓	✓	✓x4	✓	✓x10	✓x9	✓x4
CS is about being able to say what is wrong / question	✓x2	✓x2		✓	✓x6		✓x2	
CS is about clinical issues competency / helping the HCA to develop	✓	✓		✓		✓x2	✓	✓
Sub-Theme 2: Better practice with developmental skills & Learning								
Self-Development: Belief/awareness/ evaluation /own and others perspective / confidence/competence	✓x6	✓	✓x3	✓x2	✓x4	✓x10	✓x8	✓x6
learning experience as a challenge	✓					✓x2	✓	✓x6
Increasing knowledge and skills /Formulation/reflection/ empathy/value development	✓x2	✓	✓x2	✓x2	✓	✓x4	✓x2	✓x2
Conformation/validation/Empowerment and trust of ones' own/other HCA skills	✓		✓	✓	✓	✓2	✓x2	✓x4
Support / Someone to talk to/ supporting each other	✓	✓	✓x2	✓	✓	✓x5	✓x2	✓
Reflection skills/ empathy/value development formulation skills	✓x2	✓	✓x2	✓x2	✓	✓x5	✓x2	✓x2
Off-loading / Ventilating	✓x2	✓	✓	✓	✓	✓x10	✓	✓
Relief of stress /pressures	✓			✓	✓	✓		✓
Hope of achievement through unity/validity by making you think of your actions	✓			✓	✓	✓x5	✓	✓
Validity through communication support (group or otherwise)	✓				✓	✓x3	✓8	✓

HCAs possible a career structure (Associate nursing)					✓			✓
Autonomy with experience as a justification	✓x2	✓x3	✓	✓	✓	✓		✓x4
A new / more valued career direction (Consolidation & Progression)	✓X3			✓	✓	✓		✓
Transferable skills/ Adapt to contrast and change/ HCA role expansion	✓x2	✓	✓	✓x7	✓x2			✓x11
Sub-Theme 3: Being valued as a HCA in CS								
Inclusivity / Accepted Role / identity recognition validated	✓	✓x4	✓x2	✓	✓x4	✓x4	✓x3	✓x3
Empowered participation	✓x2		✓	✓	✓	✓	✓x4	✓
Belief in self/ self confidence and competence	✓x2		✓2	✓2	✓2	✓3	✓x2	✓2
Comradery with other HCASWs	✓	✓	✓	✓x2	✓x3	✓x2	✓2	✓x2
Autonomy and freedom of expression with experience as a justification		✓x3				✓x3		✓x3
Commitment /contributory role/ helping others. A purpose/ There for other HCAs	✓	✓	✓	✓x2	✓x3	✓x3	✓2	✓x3
Being listened to in CS/ Empowerment and liberation in group	✓	✓x2	✓x2	✓x2	✓x4	✓x4	✓x7	✓x2
HCA contribution valued/identity recognised in CS - group	✓x2	✓x2	✓	✓3		✓x2	✓x3	✓x2
Group responsively agile varied and novel content / creative hybrid methods		✓	✓	✓x2	✓x3	✓x6	✓x2	✓x4
Trust in HCA / Role model	✓	✓	✓	✓	✓	✓	✓	✓x2
Supervisor approachable	✓x4	✓	✓x2	✓x2	✓x3	✓x2	✓	✓
Meaningful direct help to validate practice/ Reduced anxiety / feeling safe	✓	✓x2		✓	✓	✓x2	✓x	✓x7

Theme Clusters: Key Theme: Inhibition of the clinical supervision process within Inpatient settings								
SUPERORDINATE THEAME: Challenges within Inpatient settings	**Participants 1-8 identification of clusters**							
	P1	**P2**	**P3**	**P4**	**P5**	**P6**	**P7**	**P8**
Subordinate theme 1: Supervisor issues and the challenges of inpatient services								
No faith in/ respect for supervisor / process/ Boredom and pointless with CS	✓x3	✓x2			✓			✓x3
Delivery incompetence. Inconsistent, too ridged, confusing	✓x2	✓x2		✓x3	✓x6		✓x2	✓x5
Not real work or pragmatic duty		✓	✓		✓			✓
Unique pressures around stressful events and time		✓x3		✓x2	✓x5	✓x9	✓x11	✓x10
No/ Low priority Lack of significance/importance of CS		✓	✓	✓x3	✓x8		✓x2	✓x7
Resignation hopeless situation acceptance		✓x2	✓	✓	✓x7		✓	✓
Without impact					✓x3		✓x3	
changes with inpatient services / Poor understanding of inpatient services by others								✓x6
Wanting to be included more	✓2	✓3	✓	✓	✓x3	✓	✓	✓x3
HCA delegated more challenging events	✓2	✓4	✓4	✓2	✓	✓	✓x4	✓x6

Subordinate theme 2: Organisation tokenism & indifference								
Organisational lack of interest in CS for HCAs	✓x3	✓x2			✓x3		✓x2	✓x2
Meaningless. CS a tokenistic exercise. Tick box exercise.	✓x2	✓	✓	✓	✓x4			✓x2
Inequality between service areas	✓			✓	✓2	✓		
A contrived misinterpretation of the process. Hopelessness / Futile	✓	✓	✓		✓x3	✓	✓	✓
Organisational inconsistency approach. Confusing	✓x2	✓	✓x2	✓	✓x2	✓x6	✓	✓x2
No significance to the importance			✓x2	✓	✓	✓	✓	✓
Emphasis on process only lack of organisational investment in people or training	✓	✓	✓	✓	✓	✓x2	✓x4	✓x2
CS too superficial / tick box/ CS in the past was better – more natural	✓x4	✓x2	✓	✓	✓		✓	✓x2
Supervisor needs to listen meaningfully and empathically/ Trust in the HCA/Role model	✓x2	✓x2	✓	✓x2	✓x2	✓	✓x3	✓x4
Supervisor needs to be approachable / demonstrable qualities	✓x2	✓x4	✓	✓			✓x2	✓x4
Subordinate theme 3: The indifference and power of supervisory relationships								
Not valued/listened to because of role/Marginalised	✓	✓x4	✓x3	✓x3		✓x3	✓x3	✓x13
Resigned acceptance of devalue	✓	✓x2	✓	✓		✓	✓x2	✓x2
No/little recognition / interest in the HCA/ HCA contribution is worthless	✓x2	✓x7	✓x2	✓x3		✓x2	✓x6	✓x10
Inequality (Injustice) between registered and non-registered	✓x4			✓x2		✓	✓	✓x5
RN too career focused/self-serving	✓			✓				✓x3
RN power /status focused. Some duties now below RN	✓	✓		✓x3		✓	✓	✓x4
HCA delegated more perceived challenging events	✓					✓		✓x3
Poor leadership/ justification/ Lack of resilience / experience with new RNs	✓x2	✓x2		✓		✓	✓x6	✓x8
Lack of /empathy / understanding/ collaboration	✓	✓x2		✓x3		✓x2	✓x5	✓x4
Life experience / responsibilities not considered (confidence, versatility, Empathy)	✓ x5	✓x3		✓	✓	✓x2		✓
Experience not considered by some RNs. Deserves more respect / acknowledgement	✓x2	✓						✓x2
Personal resilience through experience not always considered	✓	✓	✓					✓x2
Validation of duty/ contribution valued/ Education achievement validation not considered	✓x5	✓x6	✓	✓x2	✓	✓	✓	✓
Varied clinical experience gives a caring authenticity not considered	✓	✓x2	✓	✓	✓	✓	✓	✓x2
Clinical setting experience 'shop floor' understanding competence not considered	✓	✓	✓	✓x3	✓	✓x2	✓	✓1

Each individual participant case followed these stages. A final table demonstrating the clusters within their theme was developed for each case (participant) to demonstrate how this linked to the original text from the transcript. The example below illustrates this with transcript 01 (Wasim).

Table of super-ordinate themes from TR01

Table of super-ordinate themes from TR01		
Themes from clustering exercise developing experiential statements	**Page/Line**	**Key words/ quotes**
Potential Sub-theme: *The Value of clinical supervision – Good Supervision – Establishing a commitment to the process*		
Supervisor as a role model/ inspiration committed to the clinical supervision process	P5/L62-67	***Depending on obviously again, the supervisor…the maturity… always with a little agenda*** Supervisor competence marked by professionalism maturity and organisation
Supervisor approach: Professionalism of attitude/ focus/ competence	P6/L73-74	***An action plan to err…as a monitoring tool…specifically to make me better at that.*** Tangible pragmatic outcomes. Targeted outcomes easy to follow.
Supervisor collaborative, inclusive and empathic	P6/L74-75	Supervisor competence measured by ***Good knowledge.*** Articulation and clarity ***flowed naturally.***
Pragmatism. Logically organised and consistent	P6/L86-87	***Yeah, yeah she brought it with her, you know…like an action plan, you've not done anything wrong, but it's all about a difficult day there….*** Investment from the supervisor. A preparation demonstrating pragmatism
Supervisor approach: A professionalism of attitude/ focus/ competence	P7/L88-91	Supervisor professionalism and approach – Insight to question, sense of fairness. ***There's some friction between that person and yourself… do you think there is any reason for it?***
Supervisor approach: A professionalism of attitude/ focus/ competence	P8/L107-110	***It was fluid… She would let you go with the flow.*** CS sessions have structure. Supervisor approach
Supervisor approach: A professionalism of attitude/ focus/ competence	P8/L111-113	Supervisor professionalism. Personal investment in the CS process ***You can't be disturbed for an hour.*** Prioritised ***This thing had to be done and it was important.*** *Priority equal to other duties.* ***Undisturbed sense of importance.*** Valued commitment.
Supervisor as a role model/ inspiration committed to the clinical supervision process	P8/113-114	***…so you felt like you were important, you know what I mean, this thing had to be done it was important…*** Commitment to the process
Supervisor approach: A professionalism of attitude/ focus/ competence	P8/9-L115-116	***It wasn't just let's get this done now, I've got three minutes to do this, let's get it done.*** Contrast between previous supervisor and present situation. This supervisor was professional in approach

Supervisor approach: A professionalism of attitude/ focus/ competence	P9/L116-117	***She'd (previous supervisor) time it, an hour,*** Professional commitment ***do not disturb under any circumstances.*** Protected time for CS a valued the supervisee.
Supervisor role model. Inspirational and committed.	P10/L130-131	Supervisor commitment to CS –***actually interested in supervision.*** Must believe in it or risk of tokenism. ***For me it is someone who is actually interested in supervision.*** Meaningful ***Not doing it because it is part of your role.***
Pragmatism. Logically organised and consistent	P10/138-140	***A good listener…Always trying to solve problems.*** Pragmatic approach logically organised
Supervisor approach: A professionalism of attitude/ focus/ competence	P16/L228-232	Supervisor needs to maintain professionalism. ***It could be a ream of things, which are distasteful to me. When someone is being horrible, you can forget about their problems.***
Supervisor approach: A professionalism of attitude/ focus/ competence	P17-18/L243 257	Role of insight, empathy and objectivity found in CS
Supervisor approach: A professionalism of attitude/ focus/ competence	P19/ L268- 270	***As human beings we clash, don't we…we have colleagues we clash with.*** CS and a good supervisor able to address this.
Supervisor as a role model/ inspiration committed to the clinical supervision process	P19/ L271-274	Able to address the most sensitive and difficult problems. ***I've not really had a supervision like it.*** Competence valued and commitment to the process.
Supervisor as a role model/ inspiration committed to the clinical supervision process	P19/L275-277	***We'll just carry on building the evidence.*** Supervisor role modelling on Professionalism Skills to develop professional objectivity.
Pragmatism. Logically organised and consistent	P21/22 L306 - 308	CS – can be profound. ***It made me feel, well that's why I'm here…I could have been somewhere else by now.*** CS can be very influential in terms of career development. ***Because of supervision, the way it's structured and the way it works, it's kept me within the NHS.*** CS delivered in a professional focused way.
Potential sub theme: *Developing to be your best through learning and self-development*		
Self-development through self-awareness and building confidence	P3/ L35-37	Consolidation of experiences. ***Looking at your actual role…*****using your own personality to set example…** ***Getting rid of the rough edges and gaining experiences.*** A self-development process
Increasing knowledge and skills	P3/ L38-41	Personal experience valuable. CS is about experiences. ***You make yourself the best nursing assistant as possible.*** ***best care possible to the er…your client group*** Client focused **Own natural growth** Development ongoing increasing knowledge and skills.

When all cases were developed a matrix table was created to map all cases against the themes that had emerged. This was set out in a table (see below)

Matrix table

Overarching Theme 1: *'One of the things that could help is… that it [supervision] happens basically I suppose and that it doesn't keep getting called off…'*					
Super-ordinate Theme: Trying to engage clinical supervision amid ongoing challenges					
Sub-ordinate Theme 1: Trying to find some consistency in a place of unpredictability: *'We didn't have it the other week because something happened on the ward…it was too chaotic and the ward was disturbed'.*					
Sub Theme	**Supervisor delivery of CS**	**Unique pressures on inpatient wards**	**Low priority / lack of significance of CS**	**Resignation / Disillusioned acceptance of hopelessness situation**	**No faith in / respect for supervisor**
Participant and transcript number *'Wasim'* Tr 01	***'I'll do your supervision, right, anything going on, have you got any problems? that's a no (Gesturing to tick a box) any training?'*** Supervisor poor understanding of the process. HCASW questions the ability and poor facilitation skills. RN not interested, too superficial. L315-319.	Difference in availability, pressures and quality of CS between MH inpatient services and other service areas. ***'If it was done well, like when I was in CAMHS, it helps refocus you'.*** CS can be very effective. Should be an equality about CS availability. L222-223.	CS on Acute In-Patient MH wards. ***'It's not happened, it's not. I can't understand the reasoning'*** No priority for a process which underpins care. L153.	***'I think it's important to have supervision,*** Recognition of the need ***but it's not there,*** Desperation ***It's just not there. I have to be honest'.*** Frustration and hopelessness. A sense of resignation. L359-360.	Supervisor attitude produces a frustration and irritability in the supervisee. ***'I've done the positive side (Explained about CS with a good supervisor). I'll do it with someone who is' clueless.*** Little respect with supervisor. A belief that caring values are not shared with HCASW. L315-316.
Participant and transcript number 'Linda' Tr 02	***'I didn't think she knew what she was doing…I think they were all at a loss'.*** The introduction of CS was not thought through. Poor conceptual understanding. L43-46.	***'It doesn't happen regular and again is down to pressures on the ward'*** acute admission wards are unpredictable, and CS is not considered with any priority. L95-97.	Unique pressures ***You're always busy…it [CS] does not happen that I know of'*** Demands are continuous on acute inpatient settings. L70-72.	***'You would like some constructive criticism, if need be, but not demolishing your confidence.*** Supervisor (RN) misinterpretation more harmful? Hopeless? ***but not demolishing your confidence'.*** L87-88.	'***It was literally waffle. I know it sounds silly but I felt like I had wasted 20 minutes'.*** Meaningless. Imposed CS misinterpreted by supervisor that does not understand the process. infringement on time that could be better spent. L64-65.
Participant and transcript number 'Louise' Tr 03		In-patient challenges including time to implement CS effectively with unique in-patient challenges. Need CS to help. '***We can face many challenging people on the ward'.*** L24-27.	Viewed as luxury adjunct in the context of Logistical difficulties of inpatient settings. ***'Well it's taking people off the ward, so it's usually staff shortages'.*** Not prioritised. L77-78	Categorically CS does not happen frequently. '***No it doesn't happen…no'.*** Emphatic response in 'no'? It should happen. L175-176.	
Participant and transcript number 'Amita' Tr 04		***'…On an inpatient ward you have got X amount of patients,*** Logistical challenges are significant on	***'it doesn't happen often due to shift patterns and time and one thing and another'.***	***'You're all here for the best interest of the patient, we should be working together'.*** Disillusion	

		inpatient settings. ***where as in the community, I think you'd be dealing with one on one more than a number of patients together'.*** Challenges identified as being different. L67-69.	Challenges of inpatient settings interpreted as priorities above all for HCASWs. L34-35.	as CS can be helpful for all, should be available for all. Does not believe there is a collaborative approach. L172-173.	
Participant and transcript number 'Noel' Tr 05	***'…Your supervisor will probably just give you some, like advice how to cope a bit better'.*** Superficial approach with no clear expectation. CS not considered that significant. ***'Probably just' 'advice'*** '***cope a bit better'.*** Approach lacks depth of exploration. L72-73.	***'…usually when the time is a bit stretched,*** CS does not happen when busy ***like err when which always seems to happen, 'always'*** challenges of inpatient settings ***you've got to tread wood,*** resignation to the situation ***you know what I mean'?*** CS not viewed as a priority or with any contingency due to priorities and challenges. L198-100.	***'It all goes out of the window,*** No priority for CS. Dependent on ward environment. ***you know what I mean, so then it's another time isn't it? (pause)*** CS has to be moved ***But that's to be expected in a ward, do you know what I mean'.*** Resigned to the challenges of in-patient facilities. L226-227.	***'…one of the things that could help is that it happens basically,*** Irony. Stressed emphasis upon the word 'happens' A starting point for implementation would be for CS to happen. ***I suppose, and it doesn't keep getting called off, that's the only thing'.*** No priority. L231-233.	***'I can't remember the last time we had it, but I'm sure it's probably due, I'd have to ask'***. Not a positive culture towards CS. Supervisor does not appear proactive. Interest from each party not strong as a result. L138-139.
Participant and transcript number 'Ann' Tr 06	RNs not cognisant of HCA limitations ***'…Words and terminology of things just can be baffling sometimes'.*** Delivery approach can produce feelings of inferiority. L162.	Unique challenges of inpatient wards present consistent stresses. '***From walking in at half past seven… and going on until half past nine tonight, it's constant'.*** Challenges do not seem to stop ***It's constant*** matches the constant pace of inpatient services. L120-121.	Challenges of inpatient wards present consistent stresses. '***From walking in at half past seven… and going on until half past nine tonight, it's constant'.*** CS not seen as any kind of priority.	Take a long time to develop for all. Not optimistic '***…as you get back to that, to our level…it's going to be a long road,*** not hopeful of any change ***it's going to be a long way off'.*** L324-325	
Participant and transcript number 'Cala' Tr 07	Supervision allows interchangeable supervisors that are not always an RN. '***…especially if the qualifieds that aren't in our supervision,*** Frustration ***we've had this so many times when they're not in our supervision, they don't agree with what we've come up with…'*** Would prefer	Unpredictable inpatient setting work derails planned '**CS. …** ***didn't have it the other week because something happened on the ward…it was too chaotic and the ward was disturbed'.*** For many HCASWs CS did not view any kind of priority and the most easily dispensed with. L117-118.	The CS process not considered significant enough and has to be flexible and fit the challenges of the ward. '***… we'll just say right, we'll plan it for another day if we can or we'll just say we can't have it today, we need to go and do this.'*** L119-120.		Outcome focused. Pragmatism requires a ***'conclusion'*** Frustration when ***'going around in circles'*** solution not found. ***'…like when we haven't been able to come up with a conclusion…we're are going around and around and around in circles'.*** Supervisor could intervene more if supervisor is RN. L257-258.

	consistency. L197-199.				
Participant and transcript number Adrian Tr 08	***'… it is lacking because since we've started…, nobody was saying anything good'.*** Supervisor did not appear to have any structure. Delivery of CS needs improvement to recognise and support HCA practice. L257-259.	***'… quite disruptive or unsettled or there's 1:1's or bed baths to be done'.*** Occasionally CS does happen not priority to the challenges of inpatient service. L378-380.	***'…we've had a massive handover …so we haven't been able to'.*** Handover always has priority. CS does not have a dedicated place. L381-383.	***'…but if you want to change something … it would cause chaos for one… it will fall really…'*** Not optimistic of the CS process appears to need to be less sanitised and raise more difficult issues. L787-793.	***'Some of the staff nurses on our ward that I would not go to…'*** CS not good from some staff. No faith or trust. Experienced RNs have better qualities. L347-350.
Subordinate theme 2: Wanting more than a tick in the box: *'….I think it gets kind of brushed under. …..'*					
	Lack of interest / importance in CS for HCAs	**Tokenistic exercise**	**Organisational inconsistency confusing/ inequality**	**Misinterpretation of the process**	**No priority/ investment from the organisation**
Participant and transcript number *'Wasim'* Tr 01	***'No CS on adult mental health inpatient wards, because nursing assistants [HCASWs] not focused upon on adult in-patient wards'.*** HCASWs marginalised. Sharp difference in how CS is delivered on in-patient settings between RNs and HCASWs. HCASWs not considered important enough. L59-62.	***'That's mandatory for qualified staff and its not mandatory for non-qualified staff.*** Frustration with RNs and organisation being implicit on a tokenistic exercise. L177-178.	CS delivery can be very inconsistent with supervisors delivering a version of CS. '***So you've got some fantastic clinical supervision and some just criticism….totally disinterested'.*** Finding it difficult to justify the *disinterested* in their role. All care givers should hold the same values. L331-332.	***'One session I've been in was 'you don't really need supervision, you're doing alright!- alright… And that's it! '*** misinterpretation. Too superficial and a question of the ability of the supervisor and organisation to let this happen. L344-345.	***'I think it's a case of just moving the importance of clinical supervision needs to be emphasised to all manner of teams…*** HCASWs needs do not appear to matter. There is little interest for CS for all. L364-366.
Participant and transcript number 'Linda' Tr 02	***'They have got to try to put themselves into your shoes and if they are trained staff [RNs] they can't always do that***. Trained staff [RNs] really should understand empathy. Empathic understanding would lead to better understanding of the HCASW. L20-21.	***'Staff themselves didn't seem to know…. it was like the blind leading the blind'.*** Appeared tokenistic, doing something but with no clarity. L20-21	***'A few years ago they [the organisation] tried to do it [clinical supervision] again …So I just said immediately, I need to tell you about such a person, because I thought it was to ventilate and help me…but …oh no we are not talking about that'*** Poor training from the organisation to implement CS more appropriately. L33-39.	***'I think it's got to be more about the patient….but it was 'well no it's more to do with work…work related…I wanted to say I was struggling at the time'.*** Organisation's misinterpretation of CS is not really CS at all. L56-59.	***'I felt like I was doing it because she'd been told she had to do it'.*** Corporate organisation lacking clarity on implementation and what CS is and what its purpose is for. L39-41.

Participant and transcript number					
'Louise' Tr 03	Staff need to be engaged in the process and this needs to be introduced appropriately by an organisation. ***'….if staff are willing to undertake it.'*** L89-92.	Tokenistic approach to CS '***….I think it gets kind of brushed under'.*** L78-80.	***Well it's taking people off the ward, so it's usually staff shortages***. Confusing inconsistencies across the organisation. L77-78	***Two types of supervision…***Informal (personal staff members) and formal supervision by a psychologist.***'…when we had a psychologist come in…'*** No 'formal CS' at present, more of a blurring of 'informal CS' L18-22.	***'…just staff shortages and taking people off the ward to have it and making time to have it'.*** No positive organisational culture towards CS. Not prioritised. L126-127.
'Amita' Tr 04	'***We are a team, it should be everybody and not what band you're at'.*** Status judgement perceived to be used as a determinant of availability of CS. L171-172.	***'…The clinical supervision has not been ward based, it's been someone coming from the community or off the ward….'*** disconnect with understanding of inpatient setting. Tokenistic. L85-86.	CS needs to be consistent. ***'I think so, yeah…yeah'.*** Not viewed as a priority to work with resolving logistical difficulties. L89-90.	No consistency of supervisors. ***'…and again with the same person, that helps'.*** Inconsistency and misinterpretation of process. L91.	'***Just better training'.*** Investment in training does not appear evident CS. L139.
'Noel' Tr 05	***'To be honest I can't remember when I last had supervision'. 'Err…not of the top of my head'.*** CS not frequency. As part of appraisal only. ***'I'm sure it's noted somewhere'.*** Lack of interest. L110-111.	***'It seems like (demonstrating a ticking sound) let's get this done…bum, done, so you know what I mean'.*** A mechanical routine of appraisal / managerial supervision, more to satisfy the organisation. CS can be tokenistic. L88-89.	***'But then it was alright because there was only two of us… that means you could easily step aside for half an hour and do that.*** Inconsistency and logistical challenges of inpatient settings. ***Obviously on the ward it's a lot different'***. Justification of the present situation by the challenges of in-patient wards, but not priority attributed to CS. L130-132.	***'Any problems? What are you doing? Where do you want to be, where do you want to go'***. Appraisal / management style of CS, superficial, a misinterpretation of CS? L41-42.	***'Something pops up like…I don't know…Like an incident or something like that, do you know what I mean'?*** No priority. CS is dispensable due to the challenges of in-patient settings. CS does not appear to have a structure. L102-103.
'Ann' Tr 06	Lack of interest for CS and or collaboration from organisation in some inpatient settings. Possible that the organisation does not see the importance '***There's not that mix, It's not there'.*** L319.	Concerning that CS is not available or appears to be tokenistic on some in-patient settings, feeling unsafe. ***'I walk in some wards and think, this is only bank and now I'm scared on some wards'***. L316-317.	CS is not available or not known about in some in-patient settings. '***…I've noticed people go 'What's supervision'?*** Concerning that CS is not known about. L321-322.	***'but sometimes, I'd like to have a little bit more…if I had that understanding of it'.*** Process can be misinterpreted and difficult to follow. Needs to be presented in a way that is understandable. L170-172.	***'Actually putting it into play is a different ball game again'***. No formal training, the link between practice and theory is difficult to understand. L174.

Participant and transcript number 'Cala' Tr 07	A challenge for the group when no RN present to be supervisor is trying to find a consensus within a limited time frame. ***'It's hard to find that one topic sometimes that everyone can have an in-put in'.*** Leaving HCAs to their own CS. L173.	Handover time always takes priority… '***…sometimes it's not always half an hour, sometimes its fifteen minutes'.*** Tokenism? CS under variable time constraints to be completed. CS always has the lowest priority. L49-50.	Enforced logistical arrangements can cause inconsistency and confusion with decisions. '***If you have missed it and you're in the next day and you say oh yeah and it's not what we discussed'.*** CS does not appear to be recorded with any plan. L164-165.	Frequency of CS is a consequence of responding to logistical problems. Can make CS appear too frequent, superficial and be misinterpreted '***…sometimes, you think oh, no offence like, oh I've got it again'.*** L138-139.	Handover dictates the pace and duration of CS. '***…you have about fifteen minutes sometimes,*** CS is secondary. ***it depends on what time hand over finishes'.*** No dedicated time from the organisation to prioritise. Organisation do not see the value or HCASW not worth it. L55-56.	
Participant and transcript number Adrian Tr 08	***'…Like I was saying about sections, we can diffuse situations by just knowing a little bit more…but then we're getting, well sort of we're busy or like it being it's us and them'.*** Knowledge acquisition in CS is valued. Interest in the HCA is not always present. Knowledge acquisition must be available for all HCASWs. L506-508.	***…we weren't allowed to do that but then we were and sometimes it gets misconstrued what our actual role is…we were supposed to be doing this you know.*** HCA role is confusing, changes are frequent and can be viewed as tokenistic. No control or say in role. L466-469.	***It's a management thing, It's like trying to distinguish between a management and clinical but they do sort of cross over.*** Organisation do not give a clear understanding of the CS. Results in confusion and inconsistencies. L773-774.	***'It lasts about half an hour, basically we all get into a big group with the NAs…'*** CS organised in this way open to misinterpretation. Also a response to logistical inpatient issues of implementation on inpatient wards. L176-179.	***'Including clinical supervision, they come second really'.*** low priority for CS. L399.	
Subordinate theme 3: Difficult dynamics in the supervisory relationship: '*Them & Us'*						
	Not valued / marginalised	**Little recognition of HCASW contribution**	**RN power –too career focused/self-serving**	**Lack of collaboration and empathy with HCASW**	**Poor RN leadership/ resilience.**	**HCASW Experience not considered / valued**
Participant and transcript number *'Wasim'* Tr 01	***'I suppose I'm not important.*** HCASW of no value of contribution. An assumption attributed to ***not having spent three years at….'*(university).** Experience and skills of the HCASW over looked. L193-194.	HCASW contribution is worthless. ***'Everybody*** all other non-registered nurses ***else is just waste, you know.*** Valueless ***As long as a get my goal*** RN Self focus only ***and that is genuinely how it makes you feel'.*** A sense of injustice and that HCASWs are true	***'I think its got career minded rather than having a genuine interest'.*** HCASWs cannot help with career- not important. RNs less commitment to care. L184-185.	CS must be available for all, not just RNs. ***'If it's important for qualified staff, then it must be important for all'.*** Little collaboration/ understanding of the HCA. L168-169.	Frustration at why RN staff cannot see the need to lead. ***'I would have made it happen if I was in charge'.*** CS process needs commitment. HCASWs link CS to better care delivery, not career progression. L172-173.	***'You can't buy experience…that's one thing you can't buy. When you've a lot you can deal with a lot more situations.'*** HCASW experience can make a significant contribution, but this is ignored. A belief that qualifications cannot match. L201-202.

		custodians of care. L210-220.				
Participant and transcript number 'Linda' Tr 02	***'Sometimes now you do feel undervalued'.*** HCA Marginalised. ***'Who do you think you are' 'I've read the book' 'Well have you?'*** Resentment and no respect. RNs use their knowledge (through their training) to marginalise HCASW. L144-145.	RN recognition attitude…***'how dare you say it to me, I'm the nurse and you're not' and you still get that'.*** Division. Status a weapon. L125-126	***'…but I've come across it frequently, really…really very, very status conscious some people'.*** Anger division ***very, very status conscious'*** RN divide no value of the HCASW. L148-150.	***'They (gesturing to offices) will ignore you, never mind ask for your opinion'.*** Anger with RN Indifference No recognition or collaboration with HCA. L196-197.	***'…they're up in the office, you're on the shop floor'.*** HCASW role not understood distant disconnect. Poor collaborative leadership. Cannot be empathic with this approach. L21-24	***'I've got more experience than you'll ever have'.*** Justification. HCASWs validation for feelings of being marginalised. L185-187.
Participant and transcript number 'Louise' Tr 03	HCASWs view not always listened to due to status. '***Sometimes you feel like you are not always listened being to as a support worker'.*** L58-59.	HCASW position perceived as low status. HCASW contribution not worthy. '***You just feel a bit worthless, you think I'm only a support worker, what does it matter?'*** L68-69.				***Basically I've done everything around care…personal care with patients, assisting them in everyday life, supporting families*** Care commitment. Demonstrating that HCASWs are capable of diverse roles. L11-14.
Participant and transcript number 'Amita' Tr 04	Marginalised because of HCASW status. '***I feel like we don't get involved, it's like them and us, you know'. 'them and us'*** Not invited to question implementation of CS due to status. Views status as a divide between HCASWs and RNs. L118.	HCA contribution not valued. '***It's like when the ward rounds are going on, we don't get invited to the ward rounds…'*** Lack of collaboration compounds a valueless status. L119.	Them and us, them; '***Anyone that is above band two, it's them and us'.*** A clear distinction based on grade. L130.	***'I do think that once they are qualified they forget the basics…*** RN role qualities/ hierarchy interpreted as placing basic care in a lower position. Compounded by reduced direct clinical contact ***…where they started'.*** Lacking empathy with HCASW. L177-178.	***'Certain jobs…*** Direct clinical contact duties ***are out of their role now….*** Better leadership reduce disconnect? …***you should just come in and do what is expected'.*** Greater collaboration required on direct care. L180-181.	***We see more of the day to day experiences…*** More direct clinical contact than RNs. Not always considered. ***So I just think they are not seeing the true patient…*** HCASWs can offer a more accurate insight, due to direct exposure. L124-125.

Participant and transcript number						
'Noel' Tr 05	***'Not yet, not for me. Not so far,*** No CS, lack of interest / value ***…but you do hear from others',*** Inconsistent approach, needs to be more consistent if any impact is to be made. L95-96.	Indifference ***'I actually don't know of the top of my head how long, how often it's supposed to be,*** indifference, ignorance of policy. Little recognition. ***… is it six monthly or is it monthly?*** CS not embedded as a culture. L136.	***'I haven't personally I don't know if anybody else has…'*** HCAs have no training on CS from supervisors. Do not appear to share? L196.	***'Like I say, a lot is down to 'well say something then'*** Supervisees expected to request their CS. Lack of collaboration / empathy towards HCA. L141.	***'If it's just a sort of tick box exercise…or routine…well just going through the motions aren't you'***? Sceptical about meaning of present CS process. Poor leadership on this. L86-88.	***I've been on 11 years…I used to work in factories before this, so it's a massive change.*** Patient and broad life experiences. L8-9.
'Ann' Tr 06	The limitations of the HCA conflict with a wide and expanding role. Needs to be recognised. '***The door closes at a band two, unless you have been to university, then the door opens'.*** Perceived distinction based on grade. University viewed as a difference. L157.	***'Then you think you're backed up a little bit*** Awkward position ***and you think, no I don't know what you mean'.*** RNs must balance recognition of HCAs limitations and contribution. RNs cannot always empathise with HCASW with their contribution. L159-160.	***The qualified are in the office, doing paperwork,…*** RNs focusing on their work/ progression***…we're on the shop floor and it's constant from coming in to going home*****.** HCAs greater risk of exposure to stress. A disconnect between the two. L134-135.	***'…Have I done that, did I sign that, did I do the obs bit, the paper lead, so its constant when you get off,*** stressful rumination ***so this is why you don't sleep until 12 o clock'.*** Clear collaborative CS would be better agreed outcomes. L97-98.	Need for clear leadership and recognition of HCA role. '***We are on a good ward, we like to be pushed and directed, that's where we should be going and we do get to where we get, but we are not up there'.*** RN's leadership could be by example? L155-156.	***I can de-escalate that. I've seen this happening before.*** Experience enables understanding of the environment HCASW experiential learning enables skills, but this is not always acknowledged. L220-222.
'Cala' Tr 07	HCA decision not valued ***'Shunned off'*** CS can feel like a waste of time ***'pointless sometimes'*** Devalued contribution ***'…then our decision gets shunned off, and whatever, it's a bit pointless sometimes, when you've just had a meeting at***	Final decisions made by RNs without explanation causing frustration. '***…we've had a meeting…and you're disagreeing, what do we do'?*** Absence of reflection no recognition of HCA contribution. L206-207.	Decision making influenced ultimately by RN's power and position. '***…It's going against the decision that we discussed, sometimes it's hard, I think it's confusing for the service user when that happens'.*** L166-168.	Need more collaboration and understanding of the HCA. RNs need to understand the CS process better. '***…so then we end up arguing…NAs and qualified because they don't agree with what we've said...'*** L199-201.	Leadership could be more objective. Some RNs not experienced enough to control the CS sessions. '***…what's going on, why are they snapping and do not agree, why are they saying it in that tone'.*** L315-316.	Care experience is valued and considered necessary prior to training. ***'…because I thought I want to get the experience before I go to uni'.*** L5-7.

	supervision'. L213-214.					
Participant and transcript number Adrian Tr 08	***'Makes me feel ******* horrible because… I'm a good NA. I know my faults and I know what I'm good at'.*** No value in HCASW. Accepts limitations of HCASW role, but within these limitations there are strengths, but these are not recognised. L516-517.	***'I was thinking well what the **** are we here for…'*** Frustration. Contribution not valued or considered. HCASW knowledge and skills through experiential learning not considered because of grade/ role. L601-602.	***'… 35 years' worth of experience…and 1 years' experience from the staff nurse'.*** Power of decision making based on position and not valuing a HCASW experience. L490-494.	***'why weren't they listening? They're the staff nurses… I will always be there'.*** Lack of collaboration and rejection of HCASW contribution. HCASW not considered skilful/ knowledgeable enough. L621-623.	***'… nurses in the station and another country sending us orders type of thing'***. A disconnect of RNs communication. Poor RN leadership remote from direct clinical contact. RNs lack understanding of clinical work due to being remote. L130-131.	***'…they don't seem to give a ****, but they've never experienced some of the experience I've had'.*** Irritated by RNs lack of understanding of HCA role and the value of HCASW experience. L785-787.

Appendix XIX: Final table of themes and cluster development

Final table demonstrating the development from some clusters to keys themes resulting in the final tables below.

Overarching Theme: *'One of the things that could help is… that it [supervision] happens basically I suppose and that it doesn't keep getting called off…'*		
Overarching theme / Super-ordinate theme	**Sub-ordinate themes**	**Sub-theme Clusters**
'One of the things that could help is the…, is that it happens basically I suppose and that it doesn't keep getting called off…' **Trying to engage clinical supervision amid ongoing challenges**	**Sub-theme 1**	**Clusters**
	Trying to find some consistency in a place of unpredictability *'We didn't have it the other week because something happened on the ward…it was too chaotic, and the ward was disturbed'.*	No faith in/ respect for supervisor / process/ Boredom and pointless with CS
		Delivery incompetence. Inconsistent, too ridged, confusing
		Not real work or pragmatic duty
		Unique pressures around stressful events and time/ not enough time/ staff
		No/ Low priority Lack of significance/importance of CS
		Resignation hopeless situation acceptance / too busy
		Without impact
		changes with inpatient services / Poor understanding of inpatient services by others
		HCA delegated more perceived challenging events
		Wanting to be included more
	Sub-theme 2	**Clusters**
	Wanting more than a tick in the box *…. I think they were all at a loss all of a sudden, you've got to do this supervision…well, no I don't think they knew.*	Organisational lack of interest in CS for HCAs
		Meaningless. Tick box exercise.
		Inequality between service areas
		A contrived misinterpretation of the process. Hopelessness / Futile
		Organisational inconsistency approach. Confusing
		No significance to the importance
		Emphasis on process only lack of organisational investment in people or training
		CS too superficial / Tick box /CS in the past was better/more natural
		Supervisor needs to listen meaningfully and empathically/ Trust in the HCA/Role model
		Supervisor needs to be approachable/demonstrable qualities/
	Sub-theme 3	**Clusters**

	Difficult dynamics in the supervisory relationship: *'I feel as though we don't get involved, it's like them and us, you know'*	Experience not valued/ not listened to because of role/Marginalised
		Experience not considered by some RNs. Deserves more respect / acknowledgement
		Resigned acceptance / devalued
		No/little recognition / interest in the HCA/ HCA contribution is worthless
		Inequality (Injustice) between registered and non-registered
		RN too career focused/self-serving
		RN power /status focused. Some duties now below RN
		Poor leadership/ justification/ Lack of resilience / experience with new RNs
		Lack of /empathy / understanding/ collaboration
		Being able to say what is wrong / question/ Needs to be prioritised better

Overarching Theme: *'Because of supervision, the way it's structured and the way it works, it's kept me within the NHS'*		
Overarching theme / super-ordinate theme	**Sub-ordinate themes**	**Sub-theme Clusters**
'Because of supervision, the way it's structured	**Sub-theme 1**	**Clusters**
	Establishing commitment to the process of clinical supervision that was implemented with purpose and meaning: *'… she does a bloody good job, and I think what we were saying about all the qualities you need, I think she's… she's got em…'.*	Professional attitude and focus
		Supervisor as role model/ Influential / Inspirational
		Competent supervisor/team you can trust / Someone who knows the inpatient wards
		Supervisor commitment /investment meaningful
		Autonomy (in groups) (or freedom to choose the subject)
		Can empathise/understand / Would like more empathy
		Collaborative/inclusivity
		Consistent / Exploration of content
		Logical/ Organised / pragmatic guide
		Pragmatic action (outcome time focused) and structure- easy to follow
	Sub-theme 2	**Clusters**
	Self-development and learning to become a better practitioner: **'***Anything you get wrong, you do not*	Self-Development: Belief/awareness/ evaluation / perspective / confidence/competence
		learning experience

and the way it works, it's kept me within the NHS' **How clinical supervision created value**	*get wrong a second time, you use it as a great learning experience'.* *You can always speak to anybody… there's always someone there'.*	Conformation/validation/Empowerment and trust of ones' own/other HCA skills
		Support/ someone to talk to/ supporting each other
		Reflection skills / empathy/value development Formulation Skills
		Comradery with HCAs
		Being listened to
		Varied clinical experience gives a caring authenticity
		Clinical setting experience 'shop floor' understanding, importance and competence
		Life experience / responsibilities provide many positives (confidence, versatility, Empathy) – personal resilience
		Autonomy and freedom of expression with experience as a justification
	Sub-theme 3	**Clusters**
	Feeling a sense of belonging as an HCA/SW: '*when we tell them something it's not to be smart, even medication is to pre-empt somebody absolutely exploding, if you can't de-escalate by talking, It's all it's about'*	Inclusivity / Accepted Role / identity recognition validated
		Enabling off-loading / Ventilating/ Relief of stress
		Hope of achievement through unity/validity
		Being listened to/ collaboration/ Empowerment and liberation in group
		HCA contribution valued/identity recognised and inclusion in CS - group
		Responsively agile varied and novel content / creative hybrid methods
		Belief in self-increases confidence and competence in practice delivery and changes
		Meaningful direct help to validate practice/ Reduced anxiety / feeling safe
		Trust in the HCA/Role model
		Supervisor approachable/demonstrable qualities

Appendix XX Final matrix table

Overarching Theme 1 / KEY THEME 1: The Inhibition of the clinical supervision process within Inpatient settings					
SUPERORDINATE THEAME: Trying to engage clinical supervision with ongoing challenges					
Subordinate Theme 1: Trying to find some consistency in a place of unpredictability: '*We didn't have it the other week because something happened on the ward…it was too chaotic and the ward was disturbed'.*					
	Supervisor delivery of CS	**Unique pressures on inpatient wards**	**Low priority / lack of significance of CS**	**Resignation / Disillusioned acceptance of hopelessness situation**	**No faith in / respect for supervisor**
'Wasim' Tr 01	***'I'll do your supervision, right, anything going on, have you got any problems? that's a no (Gesturing to tick a box) any training?'*** Supervisor poor understanding of the process. HCASW questions the ability and poor facilitation skills. RN not interested, too superficial. L315-319.	Difference in availability, pressures and quality of CS between MH inpatient services and other service areas. ***'If it was done well, like when I was in CAMHS, it helps refocus you'.*** CS can be very effective. Should be an equality about CS availability. L222-223.	CS on Acute In-Patient MH wards. ***'It's not happened, it's not. I can't understand the reasoning'*** No priority for a process which underpins care. L153.	***'I think it's important to have supervision,*** Recognition of the need ***but it's not there,*** Desperation ***It's just not there. I have to be honest'.*** Frustration and hopelessness. A sense of resignation. L359-360.	Supervisor attitude produces a frustration and irritability in the supervisee. ***'I've done the positive side (Explained about CS with a good supervisor). I'll do it with someone who is' clueless.*** Little respect with supervisor. A belief that caring values are not shared with HCASW. L315-316.
'Linda' Tr 02	***'I didn't think she knew what she was doing…I think they were all at a loss'.*** The introduction of CS was not thought through. Poor conceptual understanding. L43-46.	***'It doesn't happen regular and again is down to pressures on the ward'*** acute admission wards are unpredictable, and CS is not considered with any priority. L95-97.	Unique pressures ***You're always busy…it [CS] does not happen that I know of'*** Demands are continuous on acute inpatient settings. L70-72.	***'You would like some constructive criticism, if need be, but not demolishing your confidence.*** Supervisor (RN) misinterpretation more harmful? Hopeless? ***but not demolishing your confidence'.*** L87-88.	'***It was literally waffle. I know it sounds silly but I felt like I had wasted 20 minutes'.*** Meaningless. Imposed CS misinterpreted by supervisor that does not understand the process. infringement on time that could be better spent. L64-65.
'Louise' Tr 03		In-patient challenges including time to implement CS effectively with unique in-patient challenges. Need CS to help. '***We can face many challenging people on the ward'.*** L24-27.	Viewed as luxury adjunct in the context of Logistical difficulties of inpatient settings. ***'Well it's taking people off the ward, so it's usually staff shortages'.*** Not prioritised. L77-78	Categorically CS does not happen frequently. '***No it doesn't happen…no'.*** Emphatic response in 'no'? It should happen. L175-176.	

'Amita' Tr 04		***'…On an inpatient ward you have got X amount of patients,*** Logistical challenges are significant on inpatient settings. ***where as in the community, I think you'd be dealing with one on one more than a number of patients together'.*** Challenges identified as being different. L67-69.	***'it doesn't happen often due to shift patterns and time and one thing and another'.*** Challenges of inpatient settings interpreted as priorities above all for HCASWs. L34-35.	***'You're all here for the best interest of the patient, we should be working together'.*** Disillusion as CS can be helpful for all, should be available for all. Does not believe there is a collaborative approach. L172-173.	
'Noel' Tr 05	***'…Your supervisor will probably just give you some, like advice how to cope a bit better'.*** Superficial approach with no clear expectation. CS not considered that significant. ***'Probably just' 'advice'*** '***cope a bit better'.*** Approach lacks depth of exploration. L72-73.	***'…usually when the time is a bit stretched,*** CS does not happen when busy ***like err when which always seems to happen, 'always'*** challenges of inpatient settings ***you've got to tread wood,*** resignation to the situation ***you know what I mean'?*** CS not viewed as a priority or with any contingency due to priorities and challenges. L198-100.	***'It all goes out of the window,*** No priority for CS. Dependent on ward environment. ***you know what I mean, so then it's another time isn't it? (pause)*** CS has to be moved ***But that's to be expected in a ward, do you know what I mean'.*** Resigned to the challenges of in-patient facilities. L226-227.	***'…one of the things that could help is that it happens basically,*** Irony. Stressed emphasis upon the word 'happens' A starting point for implementation would be for CS to happen. ***I suppose, and it doesn't keep getting called off, that's the only thing'.*** No priority. L231-233.	***'I can't remember the last time we had it, but I'm sure it's probably due, I'd have to ask'.*** Not a positive culture towards CS. Supervisor does not appear proactive. Interest from each party not strong as a result. L138-139.
'Ann' Tr 06	RNs not cognisant of HCA limitations ***'…Words and terminology of things just can be baffling sometimes'.*** Delivery approach can produce feelings of inferiority. L162.	Unique challenges of inpatient wards present consistent stresses. '***From walking in at half past seven… and going on until half past nine tonight, it's constant'.*** Challenges do not seem to stop ***It's constant*** matches the constant pace of inpatient services. L120-121.	Challenges of inpatient wards present consistent stresses. '***From walking in at half past seven… and going on until half past nine tonight, it's constant'.*** CS not seen as any kind of priority.	Take a long time to develop for all. Not optimistic '***…as you get back to that, to our level…it's going to be a long road,*** Not hopeful of any change ***it's going to be a long way off'.*** L324-325	
'Cala' Tr 07	Supervision allows interchangeable supervisors that are not always an RN. '***…especially if the qualifieds that aren't in our supervision,***	Unpredictable inpatient setting work derails planned '**CS. …** ***didn't have it the other week because something happened on the ward…it was too chaotic***	The CS process not considered significant enough and has to be flexible and fit the challenges of the ward. '***… we'll just say right, we'll plan it for another day if***		Outcome focused. Pragmatism requires a ***'conclusion'*** Frustration when ***'going around in circles'*** solution not found. ***'…like when we haven't been***

	Frustration ***we've had this so many times when they're not in our supervision, they don't agree with what we've come up with…'*** Would prefer consistency. L197-199.	***and the ward was disturbed'.*** For many HCASWs CS not viewed any kind of priority and the most easily dispensed with. L117-118.	***we can or we'll just say we can't have it today, we need to go and do this.'*** L119-120.		***able to come up with a conclusion…we're are going around and around and around in circles'.*** Supervisor could intervene more if supervisor is RN. L257-258.
Adrian Tr 08	***'… it is lacking because since we've started…, nobody was saying anything good'.*** Supervisor did not appear to have any structure. Delivery of CS needs improvement to recognise and support HCA practice. L257-259.	***'… quite disruptive or unsettled or there's 1:1's or bed baths to be done'.*** Occasionally CS does happen not priority to the challenges of inpatient service. L378-380.	***'…we've had a massive handover …so we haven't been able to'.*** Handover always has priority. CS does not have a dedicated place. L381-383.	***'…but if you want to change something … it would cause chaos for one… it will fall really…'*** Not optimistic of the CS process appears to need to be less sanitised and raise more difficult issues. L787-793.	***'Some of the staff nurses on our ward that I would not go to…'*** CS not good from some staff. No faith or trust. Experienced RNs have better qualities. L347-350.
Subordinate theme 2: Wanting more than a tick in the box: *'….I think it gets kind of brushed under. …..'*					
	Lack of interest / importance in CS for HCAs	**Tokenistic exercise**	**Organisational inconsistency confusing/ inequality**	**Misinterpretation of the process**	**No priority/ investment from the organisation**
'Wasim' Tr 01	***'No CS on adult mental health inpatient wards, because nursing assistants [HCASWs] not focused upon on adult in-patient wards'.*** HCASWs marginalised. Sharp difference in how CS is delivered on in-patient settings between RNs and HCASWs. HCASWs not considered important enough. L59-62.	***'That's mandatory for qualified staff and its not mandatory for non-qualified staff.*** Frustration with RNs and organisation being implicit on a tokenistic exercise. L177-178.	CS delivery can be very inconsistent with supervisors delivering a version of CS. '***So you've got some fantastic clinical supervision and some just criticism….totally disinterested'.*** Finding it difficult to justify the *disinterested* in their role. All care givers should hold the same values. L331-332.	***'One session I've been in was 'you don't really need supervision, you're doing alright!- alright… And that's it! '*** A misinterpretation. Too superficial and a question of the ability of the supervisor and organisation to let this happen. L344-345.	***'I think it's a case of just moving the importance of clinical supervision needs to be emphasised to all manner of teams…*** HCASWs needs do not appear to matter. There is little interest for CS for all. L364-366.
'Linda' Tr 02	***'They have got to try to put themselves into your shoes and if they are trained staff [RNs] they can't always do that***. Trained staff [RNs] really should understand empathy. Empathic understanding would lead to	***'Staff themselves didn't seem to know…. it was like the blind leading the blind'.*** Appeared tokenistic, doing something but with no clarity. L20-21	***'A few years ago they [the organisation] tried to do it [clinical supervision] again …So I just said immediately, I need to tell you about such a person, because I thought it was to ventilate and help me…but …oh no we are not talking about***	***'I think it's got to be more about the patient….but it was 'well no it's more to do with work…work related…I wanted to say I was struggling at the time'.*** Organisation's misinterpretation of CS is not really CS at all. L56-59.	***'I felt like I was doing it because she'd been told she had to do it'.*** Corporate organisation lacking clarity on implementation and what CS is and what its purpose is for. L39-41.

	better understanding of the HCASW. L20-21.		***that'*** Poor training from the organisation to implement CS more appropriately. L33-39.		
'Louise' Tr 03	Staff need to be engaged in the process and this needs to be introduced appropriately by an organisation. ***'….if staff are willing to undertake it.'*** L89-92.	Tokenistic approach to CS '***….I think it gets kind of brushed under'.*** L78-80.	***Well it's taking people off the ward, so it's usually staff shortages***. Confusing inconsistencies across the organisation. L77-78	***Two types of supervision…***Informal (personal staff members) and formal supervision by a psychologist.***'…when we had a psychologist come in…'*** No 'formal CS' at present, more of a blurring of 'informal CS' L18-22.	***'…just staff shortages and taking people off the ward to have it and making time to have it'.*** No positive organisational culture towards CS. Not prioritised. L126-127.
'Amita' Tr 04	'***We are a team, it should be everybody and not what band you're at'.*** Status judgement perceived to be used as a determinant of availability of CS. L171-172.	***'…The clinical supervision has not been ward based, it's been someone coming from the community or off the ward….'*** disconnect with understanding of inpatient setting. Tokenistic. L85-86.	CS needs to be consistent. ***'I think so, yeah…yeah'.*** Not viewed as a priority to work with resolving logistical difficulties. L89-90.	No consistency of supervisors. ***'…and again with the same person, that helps'.*** Inconsistency and misinterpretation of process. L91.	'***Just better training'.*** Investment in training does not appear evident CS. L139.
'Noel' Tr 05	***'To be honest I can't remember when I last had supervision'. 'Err…not of the top of my head'.*** CS not frequency. As part of appraisal only. ***'I'm sure it's noted somewhere'.*** Lack of interest. L110-111.	***'It seems like (demonstrating a ticking sound) let's get this done…bum, done, so you know what I mean'.*** A mechanical routine of appraisal / managerial supervision, more to satisfy the organisation. CS can be tokenistic. L88-89.	***'But then it was alright because there was only two of us… that means you could easily step aside for half an hour and do that.*** Inconsistency and logistical challenges of inpatient settings. ***Obviously on the ward it's a lot different'***. Justification of the present situation by the challenges of in-patient wards, but not priority attributed to CS. L130-132.	***'Any problems? What are you doing? Where do you want to be, where do you want to go'***. Appraisal / management style of CS, superficial, a misinterpretation of CS? L41-42.	***'Something pops up like…I don't know…Like an incident or something like that, do you know what I mean'?*** No priority. CS is dispensable due to the challenges of in-patient settings. CS does not appear to have a structure. L102-103.
'Ann' Tr 06	Lack of interest for CS and or collaboration from organisation in some inpatient settings. Possible that the organisation does not see the importance	Concerning that CS is not available or appears to be tokenistic on some in-patient settings, feeling unsafe. ***'I walk in some wards and think, this is***	CS is not available or not known about in some in-patient settings. '***…I've noticed people go 'What's supervision'?*** Concerning that CS is not known about. L321-322.	***'but sometimes, I'd like to have a little bit more…if I had that understanding of it'.*** Process can be misinterpreted and difficult to follow. Needs to be	***'Actually putting it into play is a different ball game again'***. No formal training, the link between practice and theory is difficult to understand. L174.

	'***There's not that mix, It's not there'.*** L319.	***only bank and now I'm scared on some wards'***. L316-317.		presented in a way that is understandable. L170-172.	
'Cala' Tr 07	A challenge for the group when no RN present to be supervisor is trying to find a consensus within a limited time frame. ***'It's hard to find that one topic sometimes that everyone can have an in-put in'.*** Leaving HCAs to their own CS. L173.	Handover time always takes priority… '***…sometimes it's not always half an hour, sometimes its fifteen minutes'.*** Tokenism? CS under variable time constraints to be completed. CS always has the lowest priority. L49-50.	Enforced logistical arrangements can cause inconsistency and confusion with decisions. '***If you have missed it and you're in the next day and you say oh yeah and it's not what we discussed'.*** CS does not appear to be recorded with any plan. L164-165.	Frequency of CS is a consequence of responding to logistical problems. Can make CS appear too frequent, superficial and be misinterpreted '***…sometimes, you think oh, no offence like, oh I've got it again'.*** L138-139.	Handover dictates the pace and duration of CS. '***…you have about fifteen minutes sometimes,*** CS is secondary. ***it depends on what time hand over finishes'.*** No dedicated time from the organisation to prioritise. Organisation do not see the value or HCASW not worth it. L55-56.
Adrian Tr 08	***'…Like I was saying about sections, we can diffuse situations by just knowing a little bit more…but then we're getting, well sort of we're busy or like it being it's us and them'.*** Knowledge acquisition in CS is valued. Interest in the HCA is not always present. Knowledge acquisition must be available for all HCASWs. L506-508.	***…we weren't allowed to do that but then we were and sometimes it gets misconstrued what our actual role is…we were supposed to be doing this you know.*** HCA role is confusing, changes are frequent and can be viewed as tokenistic. No control or say in role. L466-469.	***It's a management thing, It's like trying to distinguish between a management and clinical but they do sort of cross over.*** Organisation do not give a clear understanding of the CS. Results in confusion and inconsistencies. L773-774.	***'It lasts about half an hour, basically we all get into a big group with the NAs…'*** CS organised in this way open to misinterpretation. Also a response to logistical inpatient issues of implementation on inpatient wards. L176-179.	***'Including clinical supervision, they come second really'.*** low priority for CS. L399.

Subordinate theme 3: Difficult dynamics in the supervisory relationship: '*Them & Us*'						
	Not valued / marginalised	**Little recognition of HCASW contribution**	**RN power –too career focused/self-serving**	**Lack of collaboration and empathy with HCASW**	**Poor RN leadership/ resilience.**	**HCASW Experience not considered / valued**
'Wasim' Tr 01	***'I suppose I'm not important.*** HCASW of no value of contribution. An assumption attributed to ***not having spent three years at….'*(university).** Experience and skills of the HCASW over looked.	HCASW contribution is worthless. ***'Everybody*** all other non-registered nurses ***else is just waste, you know.*** Valueless ***As long as a get my goal*** RN Self focus only ***and that is genuinely how it makes***	***'I think its got career minded rather than having a genuine interest'.*** HCASWs cannot help with career- not important. RNs less commitment to care. L184-185.	CS must be available for all, not just RNs. ***'If it's important for qualified staff, then it must be important for all'.*** Little collaboration/ understanding of the HCA. L168-169.	Frustration at why RN staff cannot see the need to lead. ***'I would have made it happen if I was in charge'.*** CS process needs commitment. HCASWs link CS to better care delivery, not career progression.	***'You can't buy experience…that's one thing you can't buy. When you've a lot you can deal with a lot more situations.'*** HCASW experience can make a significant contribution,

	L193-194.	***you feel'.*** A sense of injustice and that HCASWs are true custodians of care. L210-220.			L172-173.	but this is ignored. A belief that qualifications cannot match. L201-202.
'Linda' Tr 02	***'Sometimes now you do feel undervalued'.*** HCA Marginalised. ***'Who do you think you are' 'I've read the book' 'Well have you?'*** Resentment and no respect. RNs use their knowledge (through their training) to marginalise HCASW. L144-145.	RN recognition attitude…***'how dare you say it to me, I'm the nurse and you're not' and you still get that'.*** Division. Status a weapon. L125-126	***'…but I've come across it frequently, really…really very, very status conscious some people'.*** Anger division ***very, very status conscious'*** RN divide no value of the HCASW. L148-150.	***'They (gesturing to offices) will ignore you, never mind ask for your opinion'.*** Anger with RN Indifference No recognition or collaboration with HCA. L196-197.	***'…they're up in the office, you're on the shop floor'.*** HCASW role not understood distant disconnect. Poor collaborative leadership. Cannot be empathic with this approach. L21-24	***'I've got more experience than you'll ever have'.*** Justification. HCASWs validation for feelings of being marginalised. L185-187.
'Louise' Tr 03	HCASWs view not always listened to due to status. '***Sometimes you feel like you are not always listened being to as a support worker'.*** L58-59.	HCASW position perceived as low status. HCASW contribution not worthy. '***You just feel a bit worthless, you think I'm only a support worker, what does it matter?***' L68-69.				***Basically I've done everything around care…personal care with patients, assisting them in everyday life, supporting families*** Care commitment. Demonstrating that HCASWs are capable of diverse roles. L11-14.
'Amita' Tr 04	Marginalised because of HCASW status. '***I feel like we don't get involved, it's like them and us, you know'. 'them and us'*** Not invited to question implementation of CS due to status. Views status as a divide between HCASWs and RNs. L118.	HCA contribution not valued. '***It's like when the ward rounds are going on, we don't get invited to the ward rounds…'*** Lack of collaboration compounds a valueless status. L119.	Them and us, them; '***Anyone that is above band two, it's them and us'.*** A clear distinction based on grade. L130.	***'I do think that once they are qualified they forget the basics…*** RN role qualities/ hierarchy interpreted as placing basic care in a lower position. Compounded by reduced direct clinical contact ***…where they started'.*** Lacking empathy with HCASW. L177-178.	***'Certain jobs…*** Direct clinical contact duties ***are out of their role now….*** Better leadership reduce disconnect? …***you should just come in and do what is expected'.*** Greater collaboration required on direct care. L180-181.	***We see more of the day to day experiences…*** More direct clinical contact than RNs. Not always considered. ***So I just think they are not seeing the true patient…*** HCASWs can offer a more accurate insight, due to direct exposure. L124-125.

'Noel' Tr 05	***'Not yet, not for me. Not so far,*** No CS, lack of interest / value ***…but you do hear from others',*** Inconsistent approach, needs to be more consistent if any impact is to be made. L95-96.	Indifference ***'I actually don't know of the top of my head how long, how often it's supposed to be,*** indifference, ignorance of policy. Little recognition. ***… is it six monthly or is it monthly?*** CS not embedded as a culture. L136.	***'I haven't personally I don't know if anybody else has…'*** HCAs have no training on CS from supervisors. Do not appear to share? L196.	***'Like I say, a lot is down to 'well say something then'*** Supervisees expected to request their CS. Lack of collaboration / empathy towards HCA. L141.	***'If it's just a sort of tick box exercise…or routine…well just going through the motions aren't you'?*** Sceptical about meaning of present CS process. Poor leadership on this. L86-88.	***I've been on 11 years…I used to work in factories before this, so it's a massive change.*** Patient and broad life experiences.L8-9.
'Ann' Tr 06	The limitations of the HCA conflict with a wide and expanding role. Needs to be recognised. '***The door closes at a band two, unless you have been to university, then the door opens'.*** Perceived distinction based on grade. University viewed as a difference. L157.	***'Then you think you're backed up a little bit*** Awkward position ***and you think, no I don't know what you mean'.*** RNs must balance recognition of HCAs limitations and contribution. RNs cannot always empathise with HCASW with their contribution. L159-160.	***The qualified are in the office, doing paperwork,…*** RNs focusing on their work/ progression***…we're on the shop floor and it's constant from coming in to going home.*** HCAs greater risk of exposure to stress. A disconnect between the two. L134-135.	***'…Have I done that, did I sign that, did I do the obs bit, the paper lead, so its constant when you get off,*** stressful rumination ***so this is why you don't sleep until 12 o clock'.*** Clear collaborative CS would be better agreed outcomes. L97-98.	Need for clear leadership and recognition of HCA role. '***We are on a good ward, we like to be pushed and directed, that's where we should be going and we do get to where we get, but we are not up there'.*** RN's leadership could be by example? L155-156.	***I can de-escalate that. I've seen this happening before.*** Experience enables understanding of the environment HCASW experiential learning enables skills, but this is not always acknowledged. L220-222.
'Cala' Tr 07	HCA decision not valued ***'Shunned off'*** CS can feel like a waste of time ***'pointless sometimes'*** Devalued contribution ***'…then our decision gets shunned off, and whatever, it's a bit pointless sometimes, when you've just had a meeting at supervision'.*** L213-214.	Final decisions made by RNs without explanation causing frustration. '***…we've had a meeting…and you're disagreeing, what do we do'?*** Absence of reflection no recognition of HCA contribution. L206-207.	Decision making influenced ultimately by RN's power and position. '***…It's going against the decision that we discussed, sometimes it's hard, I think it's confusing for the service user when that happens'.*** L166-168.	Need more collaboration and understanding of the HCA. RNs need to understand the CS process better. '***…so then we end up arguing…NAs and qualified because they don't agree with what we've said...'*** L199-201.	Leadership could be more objective. Some RNs not experienced enough to control the CS sessions. '***…what's going on, why are they snapping and do not agree, why are they saying it in that tone'.*** L315-316.	Care experience is valued and considered necessary prior to training. ***'…because I thought I want to get the experience before I go to uni'.*** L5-7.
Adrian Tr 08	***'Makes me feel ******* horrible because… I'm a good NA. I know my faults***	***'I was thinking well what the **** are we here for…'*** Frustration.	***'… 35 years' worth of experience…and 1 years' experience from the staff***	***'why weren't they listening? They're the staff nurses… I will always***	***'… nurses in the station and another country sending us orders type of***	***'…they don't seem to give a ****, but they've never experienced some of the***

	and I know what I'm good at'. No value in HCASW. Accepts limitations of HCASW role, but within these limitations there are strengths, but these are not recognised. L516-517.	Contribution not valued or considered. HCASW knowledge and skills through experiential learning not considered because of grade/ role. L601-602.	***nurse'.*** Power of decision making based on position and not valuing a HCASW experience. L490-494.	***be there'.*** Lack of collaboration and rejection of HCASW contribution. HCASW not considered skilful/ knowledgeable enough. L621-623.	***thing'***. A disconnect of RNs communication. Poor RN leadership remote from direct clinical contact. RNs lack understanding of clinical work due to being remote. L130-131.	***experience I've had'.*** Irritated by RNs lack of understanding of HCA role and the value of HCASW experience. L785-787.

KEY THEME 2: The Facilitation of the clinical supervision process within Inpatient settings				
Superordinate theme: How clinical supervision created value				
Subordinate Theme 1: Establishing commitment to the process of clinical supervision that was implemented with purpose and meaning: *'Because of supervision, the way it's structured and the way it works, it's kept me within the NHS'*				
	Supervisor approach: professionalism attitude/focus/competence	**Supervisor role model Inspiration/ committed**	**Collaborative, inclusive, empathic**	**Pragmatic / logically organised, consistent**
'Wasim' Tr 01	***'An action plan to err…as a monitoring tool…specifically to make me better at that'.*** Tangible pragmatic outcomes. Targeted outcomes easy to follow. A preferred structure for HCASWs. L73-74.	***'She used to come er…with a little agenda. Always a little agenda thing like that (gesturing towards the size of a sheet of paper) and er…she'd have a list of all the positive things I've done'.*** Investment from the supervisor. A preparation demonstrating commitment to process and the HCASW. L66-69.	Reflection- ***'How did you feel afterwards' What do you think we could have done better'?*** Facilitation of inclusion through a questioning style for improvement. Collaborative and inclusivity promote feelings of feeling valued. L79-80.	***'Because of supervision, the way it's structured and the way it works, it's kept me within the NHS'.*** CS delivered in a pragmatic, focused way. L307-308.
'Linda' Tr 02	***'Done correctly'.*** Needs to be meaningful. This includes frequent, professional facilitation of CS. L201-202.	***'Ones that had done the support workers roles themselves don't forget'.*** RNs previously HCAs better role model/ understanding. L24-27.	***'You want someone that will say 'yes. I take your point on that ….or so why do you feel like that'?*** Respect understanding, empathy and inclusion. L82-85.	***'I would have found more useful to be given some hints how to deal with it'.*** CS needs to be more pragmatic. L59-61.
'Louise' Tr 03	***'Because she** [the psychologist] **had a structured time and it was more a structured session'.*** Dedicated time, focused, inclusive of the HCASWs and meaningfully valued. L34-36.	***'Just like a group discussion, probably with the psychologist again'.*** HCA group inclusivity inspires and demonstrates a commitment to HCAs. L135.	Collaboration. ***'I do think it brings staff together definitely….*** HCA identity and acceptance stronger through collaboration. …***Helping patients, patient focused'.*** L100-103.	Structured CS appears more pragmatic with direct help for HCAs ***'If they have been struggling in certain areas or with patients that they can't connect with'.*** L39-41.
'Amita' Tr 04	***'Somebody who can listen, understands, has got knowledge'.*** Competence, commitment and credibility demonstrable through skills and ability. More respect for this type of supervisor. L57.	***'Someone who actually knows the impatient wards…*** A role model who Understands '***actually knows'*** Empathy with **'inpatient wards'** is an important value. ***what happens on the wards…'*** Interpretation that experience will give empathy? L58-59.	***'I think if you know each other,*** collaborative and inclusive ***you know what the staff member is doing correctly and what she or he can change…'*** validation and change through trust. Trust based on understanding. L73-74.	***'Then I'll get feedback off whoever's been in the clinical supervision*** Pragmatism. Logically structured feedback constructive ***on what I could possibly change…'.*** Outcome orientated approach valued with tangible outcomes. L50-51.
'Noel'	***'…because sometimes they…*** Authority with '***they'*** the supervisor***…can raise***	***'Because that's what they want you to do, that's what the management want,***	***'….Through the wisdom of their experience, they might bring something***	***'Like I said before, you might be err…have a little bit of a problem with***

Tr 05	***something that you might be doing a bit wrong and don't realise'.*** Instructional managerial approach. Opportunity to develop competent practice. L77-79.	***they want you to develop….*** Managers/ supervisors as role models to develop. L217-219.	***up that you've probably overlooked'.*** Guided ***'wisdom'*** inclusive and collaborate with supervisee through use of experience. L149-151.	***one particular patient…who's maybe grating on you dare I say it…'*** Impact of organised CS can be of value in pragmatic challenging in-patient settings. L147.
'Ann' Tr 06	A supervisor needs to be able to understand. '***Understanding…You've got to understand us, who we are'.*** Need to have empathy with the HCA role to understand. Understanding forms greater trust and inclusivity. L152.	Clinical line manager/supervisor committed to the process, inspires difference. ***'I'm aware of nurses in other hospitals that don't get the support we get from the manager that we do'.*** More aware and empowered. L22-23.	***'There's always something that everybody says…*** Opportunity for all to contribute. ***'Well what did you think about that?' 'hmm, bit iffy wasn't it?'*** Collaborative safe sharing of ideas and opinions with peers who can empathise with situations. Creates feelings of validity. L89-91.	Commitment to CS from staff team promotes attendance. '***There's never 'Oh we've not done it this month so we'll do it next month' no it's in the diary'.*** Consistency enables commitment and more logical arrangements that are easier to understand. L181-182.
'Cala' Tr 07	HCA responsibility to follow the plan and outcomes. Emphasis upon attitude to maintain commitment and focus on CS. '***We're prompted, especially if you miss it, if you're not in on a Tuesday, we're prompted to look at it'.*** L375-376.	Communicating the sessions in a pragmatic way that tries to inspire and promote commitment '… ***it's how you communicate with your team. I think it should be handed over at handover over the next two days maybe just as a reminder we all came up with this idea, this decision'.*** Good communication enables respect irrelevant of grade. L181-183.	Alternative CS is collaborative and aims for a pragmatic outcome. '***…one person brings up their topic what they want to discuss…we all have our own input*** collaboration ***…then …a conclusion type of thing at the end'.*** HCASWs ownership is deeper with alternative arrangements to CS. L50-52.	Pragmatic arrangement maximises staff availability. '***We do it after hand over…between two and three…they stop hand over at half two and let us have half an hour'.*** Acceptable for HCAs. No protected time. L47-49.
Adrian Tr 08	***'…she's brilliant …she came as a band 6 but a bit after she became sort of promoter thing, she did a splendid job…'*** RN demonstration of professionalism, enthusiasm and investment in HCA is valued and more likely to encourage engagement in CS. L724-725.	***'… she does a bloody good job…qualities you need, I think she's got em…'*** A valued supervisor that Invests in the HCA with commitment and acts as a role model. L729-731.	***'…everybody worked together, this patient eventually did sort of calm down…'***The importance of collaboration and consistency HCA integral to the team. Makes HCASW feel more valued. L241-243.	***'… that next half an hour is the only time we can have clinical supervision….'*** CS part of handover. Pragmatic use of time to tackle the logistics of inpatient settings. Ownership with alternative arrangements. L383-384.

Subordinate theme 2: Self-development and learning to become a better practitioner: '*Anything you get wrong, you do not get wrong a second time, you use it as a great learning experience'.*					
	Self-development Awareness/ confidence	**Learning through reflection**	**Increasing knowledge and skills**	**Confirmation and validation Of practice**	**Offloading / ventilating Relief of stress and pressure**

'Wasim' Tr 01	CS – Provides self-awareness for the role/ practice. ***'I thought oh know...I'm going to give up.*** It gives a sense of confidence and purpose. ***It's helped me to refocus and look for the right training'.*** L290-291.	**The weights off your shoulders, you know what I mean. Because you don't think you have any problems at times.** Ventilating and support through communication, vital as this can be missed. Appreciation that that this is possible to protect personal mental health. L163-167.	Opportunity for learning experiences. ***'Anything you get wrong, you do not get wrong a second time, you use it as a great learning tool'.*** An opportunity to review practice decisions and improve the care delivered. L83-84.	Develops insight and reflection into personal practice. ***'I think it really helps to re-focus back on the individual'.*** Empowers practice to allow for HCASWs to express their care with confidence. L238-240.	The need for CS can be underestimated. '***You might not think you need it you've unloaded a lot'.*** The environment can be stressful. Mindful of personal mental health. L160-161.
'Linda' Tr 02	***'We used to work more as a team years ago….*** RN supervisors disconnected, more distant from direct care ***…they worked alongside you, they valued you'.*** Increased own self development. L140-144.	***'Lets step back'.*** Use of reflective practice. No formal training for HCAs can be challenging. L116-120.	***'You learn to reflect on your practice and you do that automatic'.*** Experiential learning and learning in CS. L175-178.	***'Certain ones that are willing to listen and ask your opinion'.*** Some RNs will treat HCASWs with respect. L181-182.	***'Not a pre-planned. If you pre-plan something, you're psyching yourself up'.*** CS to be more spontaneous to ventilate openly. L96-97.
'Louise' Tr 03	***'…It gives you a greater understanding of a person and I think it makes you think about the care you give'.*** Self-awareness development for better care delivery. Liberating. L101-102.	Reflective process influential in changing thinking. ***The fact that you discuss the patients and it makes you think differently.*** Allows for reflection. L113-116.	CS can only be a process for the good. ***'It can't hinder in any way, I get more knowledge about the patients'.*** Knowledge acquisition. L124.	***'We don't always get the chance to read the case notes in depth, so it gives you a better understanding'.*** A sense of confirmation of duty/practice that enables empowerment. L28-30	Time and structure allow for reflection and permission to ventilate. Valued by HCASWs ***'…It gives you a chance to, you know…get it off your chest'.*** L143.
'Amita' Tr 04	***'If I brought up, like a case…whatever we've discussed I'd try to take a step back*** allow for reflection and collaboration in others ***and let somebody else deal with the situation'.*** Learning through self-awareness and limitations. L101-102.	***'….it gives you a chance to reflect…'*** Opportunity ***chance*** to gain an understanding. Reflection opportunities are unusual for HCASWs. L18.	***'….also you can learn a little bit and you can reflect back…'*** Development opportunities to learn and understand through reflection. L22-23.	***'…but with supervision that's taught me to do'.*** Developmental learning brings empowerment and confirmation and validation of practice approach. L161-162.	***'You can release that little bit of pressure that you might have yourself'.*** Allow/ permission for relief of pressure recognition in a safe environment. L21-22.
'Noel' Tr 05	***'I suppose it gives you that little bit of…a boot up the backside…'*** Motivation to think	***'…. you sort of see it from someone else's point of view, you sort of like 'Ah, Yeah***' 'Use	***'…makes you re-think… which is very helpful'.*** Value of reflection and improving skills	***'I'm showing some interest in these err… what's it called at the moment, these***	***'….You might have err…like I say, it's like sounding off as well'.*** Sounding off/ ventilating

	about one's own self-awareness to develop. An urgency to develop? L214-216.	of reflection as learning and developing. Acknowledgement of reflection qualities. L79-80.	for practice. Reflection opportunities are rare for HCASWs. L153-155.	***apprentices'.*** Confirmation of new skills and role in CS empowers to believe in personal career progression. L203-204.	thoughts and feelings a forum to do this. L69-70.
'Ann' Tr 06	CS assists personal development around confidence and competence. ***'It just gives you a lot more confidence, more confidence and competence to go out there'.*** Being part of a process that validates practice and safe care delivery. L293-294.	***'It could be an incident that's happened on the ward…*** CS gives choice ***how do you reflect on it, how to stop it happening again'.*** Reflective skills applied in a pragmatic way. A review of practice in a pragmatic way. L34-36.	***'…if they are not trained they are not competent…*** Association competence and training ***everybody has to do what is expected of them'.*** Confidence promotes competence through knowledge and skills. Concerns over other staff not receiving CS. This may compromise safety. L283-285.	***'If you don't know what you are doing, everybody is wide open…*** Risk ***Everybody has to be on the ball, basically'.*** Supervisees sense of validation of competence to empower provision of safe care. L286-287.	***'…there might be things that you are holding in yourself and you might be thinking 'I've got to offload, it's got to, because it's a stressful job'.*** Recognition of the stressful role in inpatient settings. A process to unload and feel supported. L118-119.
'Cala' Tr 07	Self-development is a choice made by the HCA. ***'…what you take from that supervision, what you all discussed then*** Choice ***it's your own self development. If you don't want to take anything from it then that is fine'.*** Having a choice is part of thinking HCASWs have some value. L244-245.	The CS process can enhance practice learning through listening and reflecting. ***'…it depends what you take from it.*** Personal application ***…if you listen and you take everything in from it and what you can do for the service user, then you're going to get on better with them…'*** For the greater good. L159-161.	An eagerness to learn. This approach offers skills development and learning. ***'…I think…we're so eager on this ward, we want to learn everything like…*** Enthusiasm ***we all wanted to go on wound care training and stuff like that'.*** A sense of ownership for the HCASW. L342-344.	***'Sometimes, it's good when it's weekly…when the ward was that chaotic we had something to help us every week to learn things'.*** The approach validated and empowered practice at difficult times. L150-151	Approach to CS is transparent, with opportunity to offload. ***'…you can say what you want and then we all either agree or disagree with it….'*** A freedom to express. An alternative way for CS appears to encourage more willingness to participate. L76.
Adrian Tr 08	***'I've been in situations where someone has took an overdose and you know because of all the things I've learned…'*** Additional learning builds self-development, competence and confidence in challenging situations. A sense of being better prepared now. L80-82.	***'Dealing with a patient that was horrible and nobody knew how to deal with it…like somebody constantly ligaturing… there was how does everybody feel? do you know'.*** Frequent exposure to difficult situations. The process of reflection in CS can allow for	***'I will say this though, a lot of the skills and especially mental health and sections…has not necessarily been passed to you'.*** Previously, no learning but now present clinical supervision. CS used to discuss / learn skills. A sense of some	***'But that was because of me.*** Confidence to make the decision. ***They didn't have to be telling everybody but if we didn't know that in the first place…'*** Learning has given confidence that validates decisions that HCAs would not have previously made. L89-90.	***'…but then it was explained to them why and 'yeah I understand your point' but 'who cares', 'I'd leave the door open if I could all day' but there is a reason why we do these things…'*** CS allows for open discussion, transparency and an exchange of views, even

		exploration of difficult emotions. Providing reflection to peers, even if not aware of the process. HCAs not trained formally in reflective practice. Being able to express is helpful. L220-221.	skills should have been made clear prior to CS. L90-92.		if there is disagreement. L567-570.
Subordinate theme 3: Feeling a sense of belonging as a HCASW: '*when we tell them something it's not to be smart, even medication is to pre-empt somebody absolutely exploding, if you can't de-escalate by talking, It's all it's about*'					
	Inclusivity/ accepted	**Being listened to**	**Being supported and Empowered**	**Alternative ideas and approaches through HCASW Pragmatism**	**Individual and group HCASW identity**
'Wasim' Tr 01	***'On CAMHS*** Not inpatient setting ***you didn't feel like a you was an unqualified member of staff,*** A true sense of belonging ***you felt more of a valued member of staff on the supervision side'.*** valued due to the CS process and competence of the supervisor. L379-381.	***You've*** **[the supervisor]** ***got to be prepared to listen and change.*** ***'It was fluid… She would let you go with the flow'.*** CS sessions structured but balanced with autonomy. Feelings of being listened to so important for identity and recognition of HCASW contribution. L132-134.	HCASWs have a will of their own, but need to feel integration. '***I'm quite prepared to tell what I feel. …quite prepared to let me drive the meeting'.*** Autonomy / empowerment. ***'She'd want you to deal with and help me, to help me along'.*** Empowers to arrive at one's own decisions. L123-124	The environment is difficult and clinical supervision should be fit for purpose by content and delivery. ***'We are dealing with people issues, you know, that's what for me, clinical supervision should be dealing with. How you get over some difficult personalities.*** As a process CS needs to be pragmatic and address difficult situations which involve unpredictable behaviours to alleviate feeling of personal vulnerability. L355-357.	HCAs value each other. '***We are a really good partnership on the shop floor, you know as well as in supervision, you know'*** Trust in each other as HCASWs. A belief in what they are doing as a group. L304-306
'Linda' Tr 02	***'When we tell them something, it's not being smart, even medication is to pre-empt somebody from absolutely exploding'.*** HCA contribution	***'It's nice of one of the nurses actually comes and asks you, that to me means they're not afraid of learning something'.***	***It's giving us that voice and that….helping us develop it in the right way if you will, you know (pause)*** Allowing HCASWs freedom of expression respects	***'Being able to even say what's wrong with the wards' You see things and you should advocate for the patient to the trained staff.*** Clinical	***I know when to use humour with wisdom and that works so many times…*** HCA demonstrate value and experience. ***'wisdom'*** with strategies. L129-132.

	just about being accepted. Inclusion. L162-167.	Desire to be respected ***nurses actually comes and asks you*** valued ***they' re not afraid of learning something*** Empowers the HCASW. L124-125. ***'They* (medical consultant) *would value it and ask you right in front of trained staff and it makes you feels so much…your self-esteem was so much better'.*** Support comments by valuing HCA actions. L182-184.	and empowers inclusivity. L229-231.	information given to RNs from HCAs this should be respected and valued. L156-157. ***'We've got 30 minutes, right let's go'.*** Alternative CS allows for advantages within in-patient settings. 30 minutes is possible. L98-100T.	
'Louise' Tr 03	CS allows for collaboration and time, that the HCASW would not usually have, to gain a deeper understanding of the patient. '***It gives you the time to go into the background of the person which gives you a greater understanding'.*** L24-27.	***'Just listen to people and listen to their points of view'. 'Just'*** Stressing the word a desire to be listened to and understood. '***Very good listening skills, empathy, understanding…..Just listen to people and listen to their points of view'.*** A strong desire to be listened to and feel included and valued. L57-58.	Being accepted and included. '***…It does you good to get your own point of view'.*** Empowered and valued when this happens. L61-62. ***'…I actually did an NVQ three within my workplace'.*** Validation, recognition and support through achievement. L13-14.	***Because she*** *(the psychologist)* ***had a structured time and it was more a structured session.*** A hybrid approach. Inclusivity, autonomy and patient focused. L34-36. ***…discuss difficult people and I think that would help.*** Dedicated time, content and more meaningfully valued. L138. ***Well you went into the background of the person and we kind of discussed why they would act in a certain way*** Patient focused with time for reflection. L49-50.	Peer contribution and stronger in numbers to contribute and support. ***I think it's better as a group so everyone can air their views.*** L106-107.
'Amita' Tr 04	***I've had clinical supervision with the same person…'*** Trust established. Developed through consistent approach preferred. '***The only clinical supervision***	***'We've got to know each other,*** Formation of trust ***this person knows my strengths and what I'm capable of doing'.*** Understanding and being	***'I explain my strategies*** Time to express explanation ***and the way I try to communicate with the patient ….'*** Empowered participation. Demonstration	***… But there is structure.*** Pragmatic logical approach. CS valued when it happens. L36. ***It's just about understanding what is going on and what's***	***'…we are a team we should work together.'*** Two teams within a team. RNs should collaborate more with HCASWs.

	I've had which were very relaxed'. Confidence in the CS process because of acceptance and trust. L31-32.	listened to. Valued in developing the trusting relationship. L32-33.	that HCASWs have the skill and ability. L48-49.	***happening around you.*** CS becomes meaningful. An alternative approach, such using handover periods, offers pragmatic learning improving self-development L103-105.	Divide based on grade/ status. L125-127. ***'You can just express your concerns that you've got…''Just'*** allows for freedom of expression. Gives a permission to express. L20-21
'Noel' Tr 05	***'It flicks that light bulb on and makes you go 'Oh yeah' makes you re-think where you could be going wrong which is very helpful'.*** Reviews own practice through inclusivity, which is unusual for HCASWs. Acceptance of exposure of own practice, then how it can be changed for the better. L153-155.	Investment in the process from the clinical supervisor is a necessity for collaboration and feel valued. ***I think the qualities are…obviously err…their listening skills and a genuine concern or interest in whatever…*** L85-86.	***'Because that's what they want you to do, that's what the management want, they want you to develop….'*** Managers supportive and interested enough to empower participation for progression. ***'…makes you realise where you might be making a mistake or doing something wrong, or doing something right, do you know what I mean'?*** Confirmation of validation of practice sufficient enough to change actions in own practice. L161.	***It's usually goals, structured, like one bullet point at a time….*** CS managerially structured easy to follow …***You know, organised and straightforward.*** Appraisal/managerial content less abstract than CS easier to interpret. L43-44. ***…all I'm thinking of is basically you get the one to one, how are you doing? have you got any problems?*** CS reflects only managerial elements of supervision. L26-27. ***…what you could then cascade to other team members and things like that.*** Instructional for other team members, not necessarily inspirational but provides safety ***Myself, personally I like to just, get to the point and get it done.*** Viewed as routine. An alternative way of implementing CS reduces time. L174-175.	***I think the supervisor usually starts it off and then leaves you to it…*** Structured control with the RN, but then identifies with the HCA group. L59-61.
'Ann'	CS approach involves an inclusiveness for everyone.	Open listening and expression. '***You start on one and it opens***	Seeks validation from each other prior to presentation. ***We***	***Get what you need across, that's your point and that's***	Diverse HCASW group adds strength to the group CS

Tr 06	***'…we have a good team…we do discuss between us everything'.*** Team make it possible to discuss. Teams bring a more even process to the CS sessions. L241-243.	***the gateway to everything…*** Exploration of ideas ***then we all come back together, but everyone has an opinion'.*** Autonomy and listening to others confirms decisions and belief in the care given. L258-259.	***all have a natter to each other.*** *Reassurance* ***There might be somethings that you push to the front more than other things.*** Approach empowers to participate. L264-265. Informal discussions inform presentation content for CS based on actions and events. '…***what do you reckon? 'well yeah, we'll discuss that' so we do…we talk among ourselves'.*** L262-263.	***what we are discussing.*** Alternative supervision is succinct, direct, pragmatic and popular. ***So fifteen of that and fifteen on the other.*** Pragmatic. CS viewed in terms of competence in clinical practice. L179-181. ***Clinical supervision means being able to do the job, to my potential.*** Understanding of CS ? Training issues. L18. ***Yes after handover and like I say…there's always time anyway with any of the staff to say 'I don't quite get that'*** Approach allows for reassurance/ development. L56-58.	sessions. ***…that's what we've got on here, it's a mixture of both, from all walks.*** L112-113. A supportive HCASW culture which is communicated across all staff members. ***'You can always speak to anybody… there's always someone there'.*** L24-26.
'Cala' Tr 07	Team approach has collaboration and inclusivity. '***…but at least we come up with something together …rather than one person making a decision and we all have to follow it'.*** The process of HCASWs having time to be together and discuss as a group. L362-364.	Identity of the HCA group, transparent and open with other's opinions. Being listened to. ***'...but now we just say it as it is in one room, we all have our own ideas and opinions…'*** Greater acceptance. L258-259. A good supervisor quality must include being approachable. ***I think they've got to be approachable.*** Someone to be able to talk to without inhibitions. This type of supervisor will be inclusive irrespective of band/ grade. L104.	HCA group empowers to participate due to transparency, collaboration and ability to challenge. ***'You talk more as a team, because if you have got anything to say it kind of comes out there and then'.*** L304-305. CS impacts when collaboration adopted. Approach facilitates trust and achievement through actions undertaken '***…as a team you've all been there,*** Shared understanding ***you're all gonna say you all make a decision and follow that'.*** L161-162.	***'To solve it'*** a pragmatic solution considered by HCAs. ***…I think to solve it, I don't know the right person to solve it…*** A team of HCAs has unity, trust and democracy. … ***we tend to do it as like a team meeting…*** unity …***the NAs go into a room and one person is allocated on what they want to bring up that particular session.*** Clinically focused. L28-30. Drawn to pragmatic approach, reflection influences thinking, learning to increase confidence and safety and easier to understand. '***…because you***	HCA team supervision approach favoured by HCAs as a whole. ***I think it does help more as a team.*** HCA team identity. No individual is stronger than the team. '***…it's important that everyone gets involved*** sense of cohesion, ***and everyone has their input*** Collaboration ***rather than just one person all the time chipping in'.*** A sense of validity to the support through communicating ideas. L111-112.

				think next time I'm in that situation, well this happened last time, it didn't go right, let's do this approach…' L249-251.	
Adrian Tr 08	***'…we had a whole afternoon …going to do blood pressure…we were supposed to be on the ward, but no she took us off the ward…everything was all wrapped up…we did the hand one and everything…'*** Interest, inclusivity and investment in the HCASW, with planning and preparation of the session. L726-729.	***'I will say…the charge nurses and the ward manager are brilliant at wanting to develop that staff and they're really understanding as well…'*** Senior staff, with their experience appear to instil a sense of listening to and understanding the HCASW and want to develop the ward as a team. ***'that's what makes a good supervisor… an empathetic group'.*** key supervisor quality listening /understanding the HCASW. L.711-714.	**' I found that was brilliant because it sort of like erm… it got us more involved and we didn't have to go to university to do that type of thing and then like, physical health checks, we've always sort of had to do them and but they just seem to be ploughing us with different skills,.** HCASW challenges are intense. Empowered to raise issues and support colleagues during participation in CS. Inclusivity. Making HCASW feel valued. L70-71.	Alternative CS is a pragmatic '***…all gets written down …stuff is either dealt with or …common' ground*****.** Outcome focused similar to a clinical huddle. ***'…all gets written down by the band 6 with what we've decided …stuff is either dealt with or we've got a common ground about a subject in the end'.*** Clinical outcome focused, pragmatic. Strong preference by HCASWs for pragmatism and tangible outcomes. L191-193.	***'…somebody comes up with a topic… we all basically argue about it…'*** comfortable with HCA group identity to express. L779-780. ***'…it was an horrific situation, but somebody led it and they did what everybody else was saying and people took initiative as well and did this…'*** Issues in CS discussed /communicated to validate how well HCAs work in challenging situations. L239-241.