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The lived supervision experience of healthcare support workers in primary care

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This study used Knowles's adult learning theory as a framework, to explore the meanings of the lived supervision experience of healthcare support workers in primary care. In this study, seven healthcare support workers participated in tape-recorded interviews, in which they described their supervision experience, yielding transcripts that were subjected to qualitative analysis. Four themes reflective of their supervision experience emerged from the data. These were *the beginning; creating the space; the supervisory relationship and outcomes of supervision*. The results of the study provided a clearer understanding of the meaning of supervision from healthcare support workers' perspective and additionally, support for Knowles's adult learning theory as a framework for adult learning. At the end, the findings were presented and recommendations were made in terms of primary health care practice and research.

Key words: adult learning theory; healthcare support workers; interpretative phenomenology; primary care and supervision

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Introduction

Long-standing efforts have been made to implement supervision in primary care that promotes personal and professional development and a more reflective workforce able to respond to complex, demanding situations. Definitions relating to supervision abound but those presented in the current study seemed apposite. Bond and Holland (1998) describe supervision as regular, protected time for facilitated reflection on clinical practice aimed to enable the supervisee to achieve, sustain and develop a high quality of practice through the means of focused support and development. Similarly, Bunton and Launer (2003) have described supervision as a particular kind of professional conversation, of the kind that happens when you provide space, time and support for practitioners so that they could reflect on their encounters with patients or clients. This sense of the word is recognized widely within many professions, including counselling, clinical psychology and social work. It is now starting to become familiar in primary care, where, as Bunton and Launer (2003) suggest it is taking over from the more traditional understanding of the word as something managerial or hierarchical. Proctor (2001) suggests that clinical supervision has three main functions (see Figure 1), which provided a useful starting point for the implementation of clinical supervision in primary care (Sood and Driscoll, 2004).

Healthcare support workers, like other nurses in primary care, are individuals who are constantly

Formative Function (Learning) – Clinical supervision concerned with developing skills, abilities and understandings of the supervisee/practitioner through reflective practice.

Restorative Function (Support) – Clinical supervision concerned with how the supervisee/practitioner responds emotionally to the stresses of working in a caring environment.

Normative (Accountability) – Clinical supervision concerned with maintaining and ensuring the effectiveness of the supervisor/practitioner's everyday caring work.

Figure 1 Three main functions of clinical supervision

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faced with new challenges in the workplace and this can only be sustained if they are properly supported (King's Fund, 2000). Adult learning theory aims to nurture and support the adult learner (in this case, the healthcare support worker) in the context of a new challenge and new ways of working. An overview of humanistic learning theories provides justification for using Knowles' Adult Learning theory (Kuchinke, 1999) to develop clinical supervision in the learning environment of primary care.

Theoretical underpinnings for the study

Humanistic theories have arisen from the philosophers Maslow and Rogers and are person-centred (Knowles, 1980). The underlying principle of adult learning is recognition that the adult learner is an autonomous and self-directed individual, who requires learning to be meaningful to his or her life situations (Rogers, 1969). The theoretical base rests on the belief that people are unique individuals with life experiences, strengths and resources, willing to learn and be responsible for their own development. Knowles (1990) proposes that learning, which is threatening to the self (eg, new attitudes or perspectives), is more easily assimilated when external threats are at a minimum. Positive reinforcement by the educator, acting as a facilitator, can enhance learning that is by establishing an atmosphere in which learners feel comfortable to consider new ideas. At the beginning of a new situation, which in the present context is the implementation of supervision in primary care, external organizational threats were perceived to be high. Thus, the teacher (in this case, the facilitator) needed to explain the purpose of supervision and to nurture, develop and motivate the learner and to give considerable direction in the early stages, so that they could embrace this new way of working.

Knowles' Adult Learning Theory bases its andragogical model, or the art and science of helping adults learn, on six elements (Kuchinke, 1999; Mitchell, 2004). In order for optimal learning to occur the following are deemed to be necessary:

- A need to know
- A responsibility for one's own learning
- The role of experience as a resource in one's learning
- A readiness or applicability of the information to one's life situation
- Motivation to learn
- Problem-centred learning with real-life problems.

These elements may not always occur together, particularly in a new area of learning (Mitchell, 2004). However, educational interventions that incorporate these features are more likely to positively affect learning outcomes (Brookfield, 1986). Thus, Knowles' Adult Learning theory was chosen as appropriate to provide the theoretical underpinnings for this study and links well with the three functions of Proctor's (2001) model of clinical supervision. In the context of the present study adult learning and clinical supervision were inextricably linked and was perceived as a method of supporting healthcare support workers, enabling them to use experiential learning to develop further knowledge about being a carer in primary care and increasing awareness of patient needs (Sood and Driscoll, 2004).

Rationale for the study

The Nursing and Midwifery Council (NMC) supports the establishment of supervision as an important part of clinical governance and in the interests of maintaining and improving the standards of patient and client care (NMC, 2003). In response to this directive, an East End of London Primary Care NHS Trust (PCT) made a commitment to implement a supervision programme, which assists with the clinical support and development of all health care practitioners employed by the Trust. This included healthcare support workers for the first time, which was an innovation across the Trust. The local University was commissioned to facilitate this undertaking, which entailed the implementation of supervision groups of qualified and unqualified staff including healthcare support workers. The groups, which included practitioners working in district nursing and health visiting teams, met together on a monthly basis for 90 min for supervision. The duration of the project was 18 months. Twenty-eight supervision groups, averaging six people for each group, were set up across the Trust, which were facilitated by five experienced supervisors from the University. The author was one of

the facilitators. The purpose of the study was to explore healthcare support workers' perspective of supervision in order to provide a basis for enabling them to reflect on their practice.

Research Design

For this study, the researcher chose a qualitative research design. Burns and Grove (2001) state that this type of research 'seeks to gain interest through discovering the meanings attached to a given phenomenon' (p. 75). Qualitative research is thus exploratory in nature. In a qualitative study, words and texts provide the database as the researcher seeks to explore, explain and describe the phenomenon of interest. The sample size in qualitative studies tends to be small because the subjects' experiences are examined in depth. The literature review is minimal at the beginning of the research process, so as not to influence the researcher's objectivity (Burns and Grove, 2001).

The research study reported in this paper used interpretive phenomenology to answer the question 'What is the experience of supervision like for healthcare support workers.' Interpretive phenomenology explicates meaning as they are lived in the life world of everyday human experience (Van Manen, 1994). The methodological structure of interpretive phenomenology is an interplay of the research activities of turning to the phenomenon, investigating the experience as it is lived, reflecting on essential themes, describing the phenomenon, maintaining a relationship to the phenomenon and balancing the research context by examining parts and wholes (Van Manen, 1994; Eifried, 2003). The researcher does not follow a prescribed set of steps or procedures but instead uses an approach that provides an optimum account of the text generated in the study (Benner, 1994). In the current study, careful hearing and listening to the participant's voices allowed the researcher to provide an account that represented the participant's world and articulated the meanings of the health care support workers' lived supervision experience (Moustakas, 1994; Spiegelberg, 1994).

Sampling

A recognized sampling procedure was followed (Procter and Allen, 2006). The population under study consisted of people employed in the PCT. Subjects were recruited from a pool of healthcare support workers who were currently participating in group supervision. A convenience sample of seven women, whose names were supplied by their line manager, was recruited to take part in the study. The age group of the sample varied between 37 and 59 years. Within the sample there was a rich mix of ethnic backgrounds, reflecting the diversity of the sample, including White UK, Black African and Black Caribbean. Four of the participants were employed as health care support workers within health visiting teams and three worked within district nursing teams. The sample was taken from four supervision groups across the Trust, which did not include a group facilitated by the researcher. All participants were recruited on the basis of their willingness to participate in the study.

Ethical considerations

Approval for the study was gained from the local research ethics committee and from the Director of the participating PCT. The purpose of the study was explained to the participants and when they were confident that they wanted to proceed, they signed a written consent form. Participants were assured that should they wish to stop the interview for any reason they would be free to do so. Furthermore, the healthcare support workers were guaranteed anonymity, and were informed that their names would not appear on any documents. The data for the study, which included interview tapes, were kept in a secure locked cupboard within the University. Participants were invited to ask questions and seek clarification before beginning the interviews.

Data collection

Data were collected in person through the use of face-to-face, in-depth, semi-structured interviews lasting approximately 1 h. Each participant was interviewed individually in the privacy of her workplace and they all appeared relaxed, comfortable and willing to talk about their supervision experience. A research question was formulated to guide the interview. The initial statement made to the participants was as follows: 'Please describe for me

in your own words as completely and clearly as possible what it feels like for you to be in supervision.' The participants were then invited to elaborate on the comment, and the interviewer's role was to help to facilitate the articulation of the supervision description. Examples of the interviewer's prompts for clarification and elaboration included 'Can you describe what it felt like' and 'How were you helped to move on in your thinking' and 'What kind of things did the supervisor say or do to help you to change.' A strong attempt was made to ensure questions did not lead the interviewee towards specific predetermined conclusions, but rather let them clarify and elaborate. When the researcher perceived that the experience had been fully articulated, the following question was asked 'Is there anything else that you would like to add that we have not already addressed.' Any further descriptions were explored and the interview was concluded.

Data analysis

The transcribed interviews were read and coded by the researcher into a classification system in the manner of Glaser and Strauss's Grounded Theory (Glaser and Strauss, 1967). The data was thematically coded, where themes or concepts from the interviews are grouped together to form a collective picture of responses. A computer software was used to organize the interpretative process: Qualitative Solutions and Research Non-numerical Unstructured Data Indexing Searching and Theorizing (QSR*NUDIST), into which all of the information that was gained from the semi-structured interviews was imported. Categories and subcategories emerged from the data and this was organized in a systematic way to enable further analysis. In the final stage of the data analysis for this study, the categories were clustered into themes observed to be emerging from the analysis, which although more abstract, still were based on the participant's own words and similar phrases. Exemplars that supported the interpretation of the themes were identified.

Following analysis of the text, a description of the lived experience was written and shared with the healthcare support workers. The participants verified the faithfulness of the descriptions and the interpretation of the experience and commented that the interpretation rang true for their experiences.

Issues of rigour

The researcher attended to reliability and validity issues (Guba and Lincoln, 1989) by seeking to work methodically and consistently throughout the entire data-gathering and analysis process. While collecting data, the researcher kept field notes to record personal observations that might influence findings. When the interviewing process was completed, the narratives for each interview were transcribed verbatim and became the text used in the analysis. All of the transcriptions were scrutinized and corrections were made to the text. An audit trail was generated by using QSR*NUDIST software to assist with data analysis. Systematic field notes were created to improve the reliability of the data. An experienced researcher (not involved with the study) undertook independent coding and interpretation of two of the transcripts. Any discrepancies arising were discussed and agreed.

Findings

On the basis of the analysis, the structure of supervision was viewed conceptually as involving four inter-related themes. These were labelled: *the beginning*, *creating the space*, *the supervision experience* and *outcomes of supervision.* The four themes are depicted (see Figure 2), and discussed along with illustrative examples in more detail.

Theme 1: The beginning

This was the phase when the meaning of supervision was explained to the healthcare support workers. In humanistic theories, the active search of the learner for meaning is stressed, with an emphasis on the social setting in which the learner operates, the engagement of which provides the learning *milieu* (Rogers, 1993). In the learning environment of primary care, attempts to implement supervision in the workplace could be described as disorganized and slow. The healthcare support workers, for whom this was a new undertaking, appeared to have little tangible knowledge of the nature of

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Themes	Description of categories
1. The beginning	First experience of supervision, lack of preparation, anxiety laden, demands on time, lack of guidance, feeling angry.
2. Creating the space	Ground rules, boundaries; instilling a sense of safety, feeling able to 'open up' in the group, feeling connected.
3. The supervision experience	Supervisory relationship experienced as emphatic, non-judgemental, supporting and validating. Having opportunity to reflect.
4. Outcomes of supervision	Strengthened confidence; refined professional identity, increased self-awareness. Feelings of being supported and connected with colleagues thus preventing isolation.

Figure 2 Four themes of lived supervision experience of health care support workers

supervision, so they felt that they were not able to assimilate its meaning or engage initially with the new structure imposed on them by the PCT:

> I have never had supervision before and did not know what supervision was about or what to expect. I had no idea what it was about, nobody explained anything to me so I was feeling anxious … powerless really.
>
> (Respondent 3)

The written information around supervision, which was provided by the Trust and delivered to the support workers' workplaces, did not seem to reach all them, or they had reviewed it superficially:

> I first heard about clinical supervision when we had a study day to talk about it, but like everything else I did not get to read up about it. Because I am so busy at times the leaflet got put on the table and you never get to read about it. I suppose it's my fault that I had not read it to get an understanding of what it was about.
>
> (Respondent 7)

According to Rogers (1969) adult learning is facilitated, when he or she participates completely in the learning process and has control over its nature and direction. For the participants in this study, they seemed to have little control over the new structure of supervision that was being implemented in the workplace. Instead, they were directed to attend a supervision group, at a given time and place:

> I did not have any choice … my name was just put on the list. I was not prepared for it. I was just told that I had to come for supervision … I feel I should have had some preparation … some say in it.
>
> (Respondent 2)

Theme 2: Creating the space

Creating the space was seen as the essential structure of supervision and involved the development of a purposeful relationship between the healthcare support worker and the group facilitator, which established a shared understanding in regard to roles and responsibilities. In this protected space, a contract was negotiated, which enabled boundaries to be established. The contract included structure factors such as confidentiality, continuity, responsibility and willingness to self-development. It also included climate factors such as genuineness, acceptance, empathy, support and challenge (Lindgren, 2005). Here, the adult learner (healthcare support worker) could be nurtured and helped to develop an understanding of what supervision entailed. This involved discussions about the nature of supervision,

the rules of engagement, objectives, methods and goals of supervision:

> I suppose most people appreciate rules. It was the confidentiality really. I suppose that's very important because we were saying things that should be confidential quite honestly.
>
> (Respondent 5)

Evidence suggests that a contract provides safety and clarity for the supervisee and offers the supervisor the freedom to take responsibility for his or her leadership (Freshwater *et al.*, 2001):

> She (the facilitator) explained the process to us. We were free to express in the group things pertaining to our work and that it would not be talked about outside the group. She explained that what was said in the room stays among us and stays with the supervisor unless she felt it should be taken further.
>
> (Respondent 6)

Theme 3: The supervision experience

Humanistic theories emphasize that the teacher and student work together to develop an effective relationship (McAllister, 1997). Fundamental aspects of the relationship are trust, mutuality and purposeful interaction (Rogers, 1969). The respondent felt that these qualities were conveyed by the facilitator:

> We felt we could talk about anything and somebody would be listening to what we had to say and things like that. So I started to open up about feelings that I had around work with colleagues and anything that was bothering me. I felt it was good. And even though it was a multi-skilled group I felt that everybody had something to offer.
>
> (Respondent 1)

The healthcare support workers felt that supervision provided a forum where they had a chance to be listened to with respect and where they could learn from others, look at issues from a wider point of view and learn from the skills and insights of the facilitator:

> She did explain to us, how she could see the session and she asked us, everybody how we were feeling and how we would like it to be. Everybody was prepared to be open and to bring his or her own problems for the session. That was a good experience as well. She explained it to us. When you are aware about certain problems and you are supported, the problems recede.
>
> (Respondent 4)

This set the stage for reflecting on practice with a view to changing practice:

> I am more aware now of what I am doing. Before I just went away and did the job, you don't think about it you know you just do the job without thinking about it. But now I reflect on what I have done and I find it very helpful. I write things down now and reflect on them.
>
> (Respondent 7)

Theme 4: Outcomes of supervision

According to adult learning theory (Knowles, 1984), the willingness to change is seen as the most important source of personal growth. In supervision, growth was facilitated by reflecting about feelings, thoughts and actions in the context of the participant's everyday experiences (Johns, 2002). The healthcare support workers reported that supervision had strengthened their identity and that a change had taken place in how they saw themselves in relation to their work:

> I am a perfectionist, so anything I do I like to do it to the best of my ability. So the thing supervision has really helped me with is to prove to me that what I am doing is right. It gave me that extra bit of confidence to go ahead.
>
> (Respondent 4)

Proctor (2001) has written about the restorative function of supervision. When asked to describe how supervision had been for them, the following comments were made:

> Supervision really makes you think. Because you are rushing about so much I have not got the time to think. To have that time out gives you a bit of refreshment to carry on. Yes it is

> only two hours, but if you can come along to supervision and then go away feeling better than when you came, then I think it is worth it.
>
> (Respondent 1)

When considering whether supervision has had any impact on practice, most of the respondents felt that they experienced both a strengthening and affirmation of their confidence, which impacted positively on their work. This links with Rogerian (1969) theory, which suggests that the adult learner should be challenged to move to increasingly advanced stages of personal development. An excerpt from the narratives described this:

> I think it helps me to be more confident. I feel also that I am more competent in what I do … I am more aware of that now. I hope we continue because it's a place to voice your opinion and an opportunity to talk about things that are concerning you away from the pressure of work.
>
> (Respondent 4)

The respondents felt that the development of a sense of togetherness was an important factor towards achieving the goals of supervision:

> I like the closeness and the sense of companionship. It feels like we are all working together. The supervisor comes across as one of us.
>
> (Respondent 6)

Some commented positively on the research study as a means of giving them an opportunity to voice their opinions:

> Support workers play quite an important part in the workplace, they should have their say as well and they should not be dumbed down.
>
> (Respondent 2)

Discussion

In the modern National Health Service practitioners work in a climate of endless change and with the expectation that they will continuously rise to the 'challenge' (King's Fund, 2000). Supervision, which was implemented in an East London NHS PCT, has been proposed as a key process which will help practitioners effectively manage and continually improve practice. It is evident from the study that the PCT has recognized the contribution of healthcare support workers to patient care. The provision of protected, paid time for supervision has demonstrated that this group of workers are valued and trusted to use this time effectively (Abbott *et al.*, 2006). Well supported and supervised staff are more likely to reflect on patient need and associated practice dilemmas, thereby ensuring best practice and personal development, a view endorsed by the NMC (2006).

One of the key findings that emerged from the study was the lack of a clear philosophy of supervision among the participants, whose knowledge and understanding of supervision was minimal. Although there was a policy document available at Trust level, much of the information did not seem to be disseminated to the level of the healthcare support worker. In particular, they felt that the information they required needed to be more specifically tailored to meet individual information needs. This is congruent with Knowles's (1984) adult learning theory, which contends that people are more ready to participate and learn when they realize that the information on offer is relevant to them. Moreover, a paucity of empirical research on the process of supervision with healthcare support workers in primary care resulted in a confusion concerning the purpose of supervision, its distinctiveness from other activities and the value of supervision for them. This indicated a need for the PCT to clarify and disseminate the philosophy of supervision more widely and for the education of all staff with respect to the principles and practice of supervision.

The findings confirm that group supervision had a systematic approach based on rules laid down in a contract between the group facilitator and the supervisees. The ultimate goal was high-quality patient care. The issues raised in supervision, were those that were pertinent to a non-professional group of healthcare support workers, which might have differed in content from that of a professional group. However, the fact that the group was multi-skilled did not seem to pose any significant problems for the healthcare support workers; rather they had come to value the chance to learn about each others' roles, which helped them in their day-to-day work. The research found that the various difficulties encountered by the group in the current study were concentrated in the initial phase

of the process, which was slowed down by inadequate knowledge of supervision, suspicion for the rationale for introducing group supervision and high turnover. Because of the diversity of their work, finding time for supervision sessions that would suit all participants turned out to be difficult. This led initially to a huge turnover in the composition of teams, which hampered the progress of supervision. It took on average 4 months for the groups to settle. Once this had happened, the participants began to engage with the supervision process and indicated that they liked the new ideas they obtained through being in supervision, especially having time to reflect on their work.

In each of the seven transcripts examined, participants referred to the quality of the supervisory relationship as crucial and pivotal, in particular the skills of the facilitator. These included interpersonal, explanatory and interpretative skills (Bond and Holland 1998). The provision of a meaningful supervision experience involved the use of adult learning theory, role modelling, support, guidance and shared experiences by the facilitator. Within this structure many of the themes and events were also generally consistent with previous studies around the supervisory experience. For example events, which reflected positive aspects of the supervisory relationship, included boundary setting and expression of warmth, respect, support and trust (Driscoll, 2000). There were gains from the project at a personal level and at a practice level. These gains may be summarized in terms of connectedness with and support from colleagues, increased self-confidence, self-awareness and personal growth.

Although the findings of the study are favourable there are a number of possible aspects, which must be considered. First, the study took account of the contextually grounded experience of supervision from the perspective of the healthcare support worker's only. It is likely that a different picture would emerge had this been an account of the professional nurse's experience of supervision been obtained. Second, although there has been no accurate means of comparing the supervision experience of the participants in this study with those of the general population of healthcare support workers, neither is there evidence to suggest that this sample was in any way different to the larger population. Third, the sample was small and was of a short-term nature; thus any conclusions drawn must be considered tentatively. Perhaps as Sweeney *et al.* (2003) suggested it is also important to acknowledge that the very act of participating in a study about supervision is likely to cause participants to think more about their own experience and to modify their account of their supervisory behaviour in accordance with what they feel is expected or desired of them. Thus, any conclusions drawn from this should be considered with this knowledge in mind.

Limitations to the study

This qualitative descriptive study builds on data from a relatively small population (seven subjects). The sample in this study was drawn to capture supervisory experiences of healthcare support workers in primary care. It may be held that the sample lacks sufficient variation and that research based on small a sample cannot be generalizable (Lincoln and Guba, 1985). While the researcher is aware of the possible limitations introduced by the homogeneity of the participants it is important to reiterate that the intent of this investigation was to describe and uncover the structures of personal meaning regarding the supervisory experience. As a result, the structure of supervision themes and events derived from the interviews is best understood as applying to the recalled experiences of the seven respondents and may be used to view experiences of other supervisees. There is no reason to assume that their experience would not be similar to others with the same demographic characteristics, nor based on the methods employed.

Conclusion and implications for primary care

The results of the study emphasized the need for supervision as support for healthcare support workers, as it has led to their acquiring a greater sense of self-esteem. The contribution of adult learning theory (Knowles, 1984; 1990) to the development of the participants has been highlighted and has demonstrated the importance of knowing how previous learning and experience may facilitate new learning, hands on or problem solving experience, and the immediate real world applicability. Seen from the perspective of Butterworth *et al.* (1996) adult learning theory enabled the participants to

become engaged in group supervision, which contained parts of all three functions of Proctor's (2001) clinical supervision model (see Figure 1). This means that its purpose was to increase healthcare support worker's knowledge, understanding and insights in clinical practice, to support them in their emotional needs arising from working daily with patients and their families and to help them explore the quality of patient care and understand how to achieve this (Lindgren, 2005).

The conclusion that can be drawn from this study is that the PCT with responsibility for the provision of supervision for healthcare support workers has acknowledged that these people work in stressful conditions and often work alone. Therefore, it has implemented a formal structure such as supervision in the workplace to support them in their work. The results of the current study are congruent with other research carried out independently in the PCT (Abbott *et al.*, 2006).

Introducing supervision in the workplace has resource, cost and time implications and managers need to be aware of this. In the implementation of supervision across an East London NHS PCT challenges emerged related to didactic, role function and organizational frameworks, which would need to be worked through to ensure that the difficulties encountered by the people in this study are not replicated in the future. The research indicated that further studies, in a wider perspective, are needed to identify factors that healthcare support workers have identified as influential on the development of their practice in primary care. A replication of this study addressed to professional nurses would be valuable. Lastly, the benefits of introducing this type of initiative is seen as contributing to the NHS as a whole and improving service provision, provided, financial, physical and educational support is made available from primary care Trusts.

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