AN EXPLORATION OF STROKE CARE NURSES' MEANINGS AND EXPERIENCES OF CLINICAL SUPERVISION

PhD Thesis of

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The learning achieved through a PhD can be easily mistaken as cognitive, academic, about a chosen topic. Mistaken, because alongside the intended growth of knowledge in the topic (the cognitive/ academic gain), a wealth of experiential and relational learning takes place by design and by chance. I need to thank the major contributors to this stupendous experience.

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ABBREVIATIONS

BMA British Medical Association
CLAHRC Collaboration for Leadership and Applied Health Research and Care (of the National Institute of Health Research, UK)
CQC Care Quality Commission
CS Clinical supervision
DH Department of Health (UK)
HCPC Health and Care Professions Council
HSE Health and Safety Executive
IPA Interpretative Phenomenological Analysis
NAO National Audit Office
NHS National Health Service (United Kingdom)
NMC Nursing and Midwifery Council
NSS National Stroke Strategy
R & D Research and Development Departments of NHS Trusts
RCP Royal College of Physicians
SSNAP Sentinel Stroke National Audit Programme
SRU Stroke Rehabilitation Unit
SU1 Stroke Unit 1
SU2 Stroke Unit 2

ABSTRACT

Background: Clinical supervision (CS) is a mechanism supporting clinical governance, quality assurance and staff development and wellbeing. There is abundance of publications about CS practised in psychological therapies and mental health services. In the UK, CS became a focus for nurses' practice development in the 1990s following recommendations in publications issued by government and professional nursing organizations. However, much of the research about CS in nursing focuses on trainee or auxiliary nurses. Our knowledge of CS for post-qualification adult nursing is limited. No references were found about CS for nurses in stroke care.

Aims: To contribute to knowledge about CS in stroke nursing care by exploring and understanding experiences and meanings of CS from the perspective of post-qualification nurses in stroke care services. To contextualize understandings with data about workplace and organizational characteristics.

Objectives: To form an understanding of the experiences and meanings of post-qualification stroke care nurses about CS through a mixed methods approach, primarily through interviews.

Methods: In-depth interviews were carried out to explore qualified nurses' experiences and meanings of CS in stroke care, analyzed using Interpretative Phenomenological Analysis (IPA). Site observations, questionnaires completed by stroke care nurses about characteristics of CS they received, and a pro forma completed by service leaders in interview sites about their service were used for contextual information.

Findings: The study found provision of CS was inconsistent across stroke services. Staff nurses in acute stroke units rarely received CS, and when they did, it was usually part of performance related measures. Four superordinate themes were identified through Interpretative Phenomenological Analysis: Psychological impact, Reflection as personal growth, Relational factors, and Participants' meanings of CS.

1. INTRODUCTION

I age forever taught by the best (Plato, *Laches*, 188b)

This thesis describes a study about clinical supervision (CS), a mechanism of lifelong learning, development, and support for clinicians in any healthcare discipline and specialty. Clinicians in this study were qualified nurses in stroke care. The research was funded through a studentship from the Workforce stream of NIHR CLAHRC's Stroke theme administered by the School of Nursing and Midwifery of the University of Sheffield. These parameters provided the initial focus of the inquiry: to examine CS in stroke nursing. This chapter introduces elements of the study including CS and learning, stroke, the impact of care on carers, nursing and stress, and provides an outline of the structure of the thesis.

1.2 Clinical Supervision and Learning

Learning is complex and multi-dimensional. Learning new things often requires repetitive rehearsal correctly, followed by feedback, and perhaps reward, before application in routine contexts. Other learning, as in clinical practice, develops from experiences and insights when using skills and knowledge in real life situations, "case-studying" them, reflecting on processes and outcomes. CS has roots in this learning (Milne, 2009). Flyvbjerg (2001) notes that experts are often unable to describe the minutiae of what they have done. He emphasises Aristotle's intellectual excellence of *phronesis*, meaning *the ability to judge the right end of action in a particular situation and make a wise choice* (Svenaeus, 2003:409), which underpins and demonstrates case-by-case ethical expertise. Due to the nature and purpose of CS, Aristotle's model of wisdom, especially the concept of phronesis (in Aristotle's Nicomachean Ethics: Broadie & Rowe, 2002; Flyvbjerg, 2001; Lear, 1988) is useful in conceptualizing and operationalizing CS.

Performing complex tasks is difficult to verbalize or even notice. Becoming competent is a process from unconscious to conscious sense of incompetence, then from conscious to unconscious competence (Scaife, 2009). Phronesis is relevant to supervising competent ethical clinical practice (Benner, 2004) because CS aims to develop capabilities in applying knowledge from training, research and generic guidelines to particular circumstances, tailoring decisions and actions in specific

situations while maintaining clinician's wellbeing. Acknowledging the complexity of interventions to improve performance, Oxman et al (1995) found that dissemination-only strategies alone (brief training, workshops, conference attendance, mailings) had little effect on improving clinicians' performance.

Beginners' learning usually entails developing competence in procedural and technical knowledge which can be described formally and explicitly (Aristotelian *techne,* Broadie & Rowe, 2002). An *excellent practitioner* (Benner, 2004:189) uses phronesis developed through applying scientific knowledge (episteme) in practising technical skills, producing experience for reflection to fine-tune future applications of knowledge and make ethical choices (Svenaeus, 2003). Research/ evidence-supported clinical interventions may prove unsuitable for some 'real-life' individuals. Such cases challenge knowledge about the suitability of interventions and improve learning about which patient, when, and how (they) may react to the intervention. Interweaving cognitive and experiential learning refines and customizes clinicians' responses/ performance, leading to expertise and excellence. Here, we enter a debate whether healthcare practices are of technical or phronetic excellence, which is not the purpose of this thesis. As Sveneaus (2003) concludes, technical knowledge must be combined with phronetic, situated ethical application.

To varying degrees of severity, mistakes occur in most clinicians' work (Scaife, 2009). Mistakes are not necessarily 'good' in themselves or their consequences but for the learning opportunities they provide (Levy, 2001). To avoid mistakes, one must have experience, but to gain experience one must make mistakes. Significant learning occurs through experiencing discomfort and challenges to habits and thoughts. Such learning usually requires a supportive context that facilitates understanding, reflection and construction of meaning. The quality of support available enhances awareness and can turn mistakes into learning experiences (Casement, 2002) by offering shared mental space for *learning* and *unlearning* (Wilmot, 2011:69) for understanding and sense-making towards consolidation of learning. This indicates the importance of relationships in learning (Adamson, 2011; Carroll, 2011). CS is a professional development mechanism encompassing the aforementioned, a confluence of expertise from professional guidelines, clinicians' knowledge and experience, and patients' preferences. It is a confidential, supportive professional relationship within which learning -in its broadest meaning- can be customized, optimized, and made useful. Literature suggests that CS is fundamental to the integrity of a clinical profession (Everett & Koerpel, 1986; Morgan & Sprenkle, 2007).

This thesis explores nurses' experiences and meanings of CS in stroke services. It interweaves various concepts, including the promotion of best practice, strategies for improving the health and wellbeing of healthcare staff, and the forum that CS provides towards reflective equilibrium. Established in documents of the Department of Health emphasising its importance in clinical practice (1993, 1998), CS has been widely acknowledged as essential activity of NHS clinicians. However, its meaning varies among stakeholders (Cutcliffe, 1997; Driscoll, 2000; Fowler, 1996; Hall & Cox, 2009; Milne, 2009; White and Winstanley, 2010) due to ambiguity (Morgan and Sprenkle, 2007) and conceptual overlaps with clinical leadership, mentoring, coaching, teaching, reflective practice, managerial supervision and appraisal, psychological therapy, and generally concepts and processes of learning for and from clinical practice (Yegdich, 1999). An ambiguous construct (Milne, 2007 & 2009) invites interpretations in its operationalization and challenges about the validity of research on its frameworks/ models and outcomes.

1.3 Stroke

By analogy to a heart attack, stroke is *'a brain attack' caused by a disturbance to the blood supply in the brain* (National Stroke Strategy [NSS], 2007:10). There are three types of stroke: Ischemic, when blood supply to the brain is thwarted by a blood clot, leading to anoxia and necrosis in the brain; haemorrhagic, when a burst vessel in the brain causes damage; and transient ischemic attacks (TIAs) or minor strokes, which resolve by themselves within 24 hours. Temporary or permanent disturbance may result in the body parts and functions controlled by the affected brain section.

The impact of stroke is *devastating and lasting* (NSS, 2007:11), a sudden, overwhelming and fundamental change with a background of loss, uncertainty and social isolation for the survivor (Salter et al, 2008). It is the largest cause of disability, and the third largest cause of death in England, with 20-30% of sufferers dying within a month. Metasyntheses suggest that stroke has significant psychological impact on survivors (Satink et al, 2013), including to memory, attention, concentration, and emotion. Approximately 20% of survivors experience anxiety disorders (Campbell Burton et al, 2011) and 37% of subarachnoid stroke survivors posttraumatic stress disorder, four times higher incidence than in the general population (Noble et al, 2008 & 2011). Consistent with these impacts and the resulting dependency needs (Rudd et al, 2009), the financial costs to survivors and their families are considerable (McKevitt et al, 2009), as are socioeconomic costs due to disability, which ascend to millions for the NHS, lost productivity/ work, thus to the economy.

Staffing gaps in stroke services and crucial time lapses between onset of stroke and professional interventions (House of Commons Public Accounts, 2010, National Audit Office, 2005; Rudd et al, 2009) are associated with poorer stroke outcomes in the UK compared with other countries in terms of avoidable disability and mortality (NSS, 2007). The Survey of Stroke Unit Staffing and Patient Dependency (2007) found only 25% of hospital units adequately staffed. UK clinicians had less contact time with individuals than in other countries: 75% of stroke patients received less than four hours of nursing input over every 24 hours period. The picture was similar in rehabilitation, which was not available to a number of stroke patients requiring it: 75% received an hour of physical therapy input a day available mostly during office hours. Only one in four units had access to clinical psychology. The NSS proposed service redesign to optimize investment, improve outcomes and develop a workforce with *the appropriate level of knowledge, skills and experience to ensure capability, capacity and collaborative working both within stroke teams and across providers and commissioners so that there is an overall focus on delivery of high quality stroke care and services* (2007:50). The Intercollegiate Stroke Study (2012) provided figures for adequate staffing of stroke services.

In the decade prior to this study, stroke services developed as specialist units (hyperacute wards, acute stroke units, rehabilitation, and community stroke services) with positive outcomes on mortality, rehabilitation and discharge (Bernhardt et al, 2008). However, a report by the Care Quality Commission (2011) criticized the quality of stroke care highlighting major deficits in the care older people received in the NHS generally. The Parliamentary Health Service Ombudsman (2011) reported a lack of reflection, planning and implementation of care, and a lack of compassion in services for older adults.

1.4 Impact of Care on Professional Carers

Caring can be intrinsically and extrinsically rewarding, but also demanding, draining, underpaid, overwhelming and unsatisfactory. Care for someone experiencing the effects of stroke may be complex and complicated due to the psychological impact of stroke on patients and their families. *We have often seen very competent workers reduced to severe doubts about themselves and their abilities to function in the work through absorbing disturbance from clients.* (Hawkins & Shohet, 1989:3). The term vicarious traumatization describes the psychological impact on the helper from caring for someone dealing with a psychologically disturbing experience (Pearlman and Saakvitne, 1995). The personal histories of helpers as wounded healers (Wheeler,

2007) may predispose them to vicarious trauma, as can the capacity for deep empathy (Black and Rhys, 2004). Obholzer and Roberts (1994:129) argue that we use unconscious psychological defences against overwhelming fear when our beliefs of a fundamentally logical and safe world are threatened.

Learning and emotional availability are more likely when learners' emotional arousal is optimal (James et al, 2004). Physiological, psychological, and social effects of work-related stress are likely to interfere with workers' attention, perception, capacity to relate, capacity to process, reflect on, and learn from experience, therefore, their performance. Literature suggests that performance is related to the experience of psychological pressure and stress. There is also a wealth of literature about stress in the nursing profession. The next section gives some details.

1.5 Nursing and stress

A number of studies address nurses leaving the profession early, many as early as in their first year post-qualification (Cummins, 2009; Flinkman et al, 2013; Kirby, 2017; MacKusick and Minick, 2010). Highlighting nurses' level of commitment to nursing, research found that their efforts to meet expectations and maintain compassion led not only to stress and burnout but also to investigatory and disciplinary procedures of their actions (McGrath et al, 2003). These were associated with contextual factors that impeded work satisfaction (*to care for patients properly*, McGrath et al, 2003:556), poor professional relationships, communication, continuing professional development, socioeconomic status, staffing, lack of autonomy and time (ibid.). White and Winstanley (2010) report high levels of psychological morbidity in participants of their study. The physiology of stress is also implicated in statistics showing nurses' life expectancy close to miners' life expectancy (Mc Grath et al, 2003). While the contributing factors continue to be researched, stress and burnout in nursing are well established (Stordeur et al, 2001; Walsh and Walsh, 2001; White and Winstanley, 2010). However, stress is also a matter of personal interpretation: one person's stress is another's challenge (Gilboa, et al, 2008): personal factors, for example coping skills and support networks, are also important (AbuAlRub, 2003).

Bamber and McMahon (2008) report occupation-specific maladaptive schemata developed from early life as predisposing nurses to occupational stress, burnout, and general psychiatric morbidity. This links to research suggesting that occupational choice is related to personal characteristics developed during childhood (Arthur, 2000; Merodoulaki, 1994; Roberts, 1994; Roe, 1961): people choose work they are already

"qualified" for as a result of early life experiences. For example, a child acting as peacemaker between the parents may become a mediator; one brought up nursing a family member may choose nursing or medicine. Research on psychotherapists' relational styles has developed these ideas further (Obegi & Berant, 2009; Parpottas, 2012; Pistole & Watkins, 1994; Wallin, 2007).

Psychodynamic understandings of psychological processes at interpersonal and organizational level highlight the inter-relationship between personalities (and psychopathologies) of individual staff and the state of the organization, including dynamics between staff, and the effects on service provided. Stokes discusses *the idea of an organization or institution 'in the mind'* (1994:121)*,* explicating the interaction between the sense making of employees about their organization and dynamics within the organization (also: Obholzer & Roberts, 1994). Psychological defences to anxiety have been described as operating within individual staff and in the culture of healthcare organizations (Menzies-Lyth, 1959), compromising capacity to relate to patients as whole persons. Defences are understood as staff unconsciously avoiding awareness of intense conflicting emotions (eg. care and disgust) about witnessing patients' vulnerability and death, managing the pressure from the amount of tasks to be completed, and their relationship with organizational processes and hierarchies (Flinkman et al, 2013; McGrath et al, 2003).

Apart from the effect of personal history and the impact of patients' traumata, healthcare workers may suffer from witnessing dying, disability, and from routine emotional costs due to the intensity of *emotional labor* (Hochschild, 1979; Smith, 2011c) required in their professional relationships. Aldridge (1994) challenges the emphasis on developing close, holistic relationships in nursing care, due to the potential costs to the profession and to individual nurses and the low social value of nursing skills. Walsh & Walsh (2001) conclude that mental health work puts the mental health of its practitioners at risk due to its high demands and low socioeconomic value. The quality of professional relationships, such as continuity of care, is a major contributor to clinical outcomes (*partnerships in care:* Nolan et al, 2003; Patterson et al, 2011). The quality of staff's psychological availability influences relationships with patients and in a reciprocal manner. For example, job strain has been found to co-vary with challenging behaviour in dementia services, while there was an inverse relationship between emotionally warm environments and challenging behaviour (Edvardsson et al, 2008). Linking this with Benner's (2004) ideas, excellent practice is unlikely where staff experience job strain.

1.6 The NHS as the context of care

Staff with good relational and technical skills are assets of healthcare organizations. Their retention is important, especially in frequently understaffed specialties, such as care of older adults. Engaging staff in decision making, facilitating their sense of control over work, and developing them further are highlighted in reports about staff wellbeing, in the HSE's management standards (2007) and the European Agency for Health and Safety at Work (2001). In *Shifting the Balance of Power,* the Department of Health (2002) promised organizational changes that would empower the voice, knowledge and skills of frontline staff in their workplaces. The NHS Health and Wellbeing report (Boorman, 2009:31) recommended that *Trusts need to go beyond simply meeting their legislative obligations to embrace a wider concept of staff engagement.*

Providing staff with working conditions that capitalize on intrinsic motivation to care facilitates excellence in practice. Admasachew & Dawson (2009) found that NHS patients' experiences were linked with how staff experienced their work: Shared influence over decision making in teams was associated with lower levels of patient mortality. Staff involvement and improved job satisfaction led to improved team satisfaction which, in turn, led to improved patient satisfaction. A more emotionally engaged employee is also more productive, more customer focused, safer, and more likely to be retained in the workforce (op. cit.). An inclusive culture is a vital ingredient in the way people work together to be productive and flexible enough to meet new challenges (Staff involvement, Department of Health, 2003).

Central in enabling staff to experience how their role is linked to the organization's mission, CS helps combine research evidence, clinical and professional guidelines, the needs and wishes of patients, and professional judgment while enabling the person of the supervisee to be acknowledged in the process. However,

An implicit assumption of clinical supervision is that regularly engaging in the process will enhance existing practice. In many respects, this will depend on what practitioners perceive such a process to be and more importantly why they should consider taking part in it. (Driscoll, 2000:4)

This highlights the importance of the meanings practitioners hold about CS.

1.7 Structure of the Thesis

Following this introduction, this thesis consists of:

Chapter 2 examines literature on CS, including in psychological therapies and nursing. At the time of the original literature search (2011) the only reference found on CS in stroke care was focused on a trainee psychologist. Therefore, a search on CS in related specialties was carried out the results of which are discussed in this chapter.

Chapter 3 presents methodological elements, epistemological background, design, and 'what happened' in the planning and carrying out data collection and analysis.

Chapter 4 contains the findings of the analyses.

Chapter 5 contains discussion that synthesizes findings with the literature reviewed and more recent sources, and discussion on implications and reflections on this study.

The appendices contain the ethics permission letter, tables of literature reviewed the research pack used in this study, details about the settings where data were collected, and a pictorial sequence of the IPA process.

2. The Literature

2.1 Introduction

There are thousands of papers and books covering various aspects of CS across health and social care disciplines including about theoretical elements, the purpose/ functions of CS, models/ frameworks guiding it, modes of delivery, its effects on clinicians, the systems in which they work, and patients. They include opinion pieces, research from various methodological paradigms, meta-analyses and meta-syntheses of existing literature, and policies. In this chapter some of this literature is discussed giving:

- Background ideas about CS, mainly within psychological therapies, where it has been long established and written about, to illustrate some core themes and issues
- Issues presented in literature of CS in nursing
- Findings of the literature focused specifically on CS in stroke care including services for older people and dementia.

2.2 BACKGROUND: CLINICAL SUPERVISION

Professional conduct guidelines of organizations regulating health and social care professions, such as the Health and Care Professions Council, British Psychological Society, Nursing and Midwifery Council, British Medical Association, British Association for Counselling and Psychotherapy, British Association for Social Work encourage or require their members to take part in CS and reflective practice. Disciplinary proceedings published on the website of the Health and Care Professions Council indicate that regular CS is both a mitigating factor, if occurring before the disciplinary investigation, and a remedy recommended in outcomes of hearings for regaining or maintaining the right to practise.

Scaife (2009) draws distinctions between conceptualizations of CS in the USA, where it is seen as primarily for trainee practitioners, and in the UK, where CS is ongoing for the duration of clinical practice. Much of the research has focused on CS for trainees. However, given the differences in supervisee competence levels, needs, workplaces, and the emphasis for supervision to accommodate these (Spence et al, 2001), this sampling tendency limits generalizability mainly to prequalification professionals. In Stoltenberg and Delworth's (1987) developmental model of CS, this is around the early

levels of supervisee's clinical competence, involving heavy reliance on the supervisor for guidance and advice in managing the clinical work and the anxieties associated with it. What about CS beyond training?

There is some evidence to suggest that access to clinical supervision varies between staff groups and types of units. In the main it is in mental health and learning disability trusts/ units that clinical supervision appears to be more established. (Gilmore 2001:126)

CS has evolved in psychological therapies, a context with a focus on subjective experiences and meanings as reality and clinical data. In physical health contexts reality is usually constructed through data from the physical world (pulse, levels of sugar and other substances in the body) with associated technology that obtains and processes experiences numerically and "objectively". This epistemological distinction may affect the current situation vis-à-vis CS in physical compared to psychological care in that clinicians may seek CS to understand intersubjective processes in mental health, which may not be considered necessary in a context of "objectivity".

Considered one of the most important influences on developing practice (Lucock et al, 2006), CS has been long established in psychological therapy and counselling (Driscoll, 2000). Examples of summative works include: Wheeler and Richards' (2007) systematic review of the literature on the effects of CS on counsellors' practice. Scaife (2009) details different frameworks of CS and issues encountered in its practice. Milne (2009) and Milne & Reiser (2012) provide systematic reviews of definitions and research towards an evidence-based model of CS in psychological therapies.

CS has also been established in social work (Hawkins and Shohet, 1989; Pack, 2009) and nursing (Butterworth et al, 2008; Cutcliffe et al, 2001; Cutcliffe and Proctor, 1998; Department of Health, 1993; Driscoll, 2000; Faugier and Butterworth, 1993; Gilmore, 1999; Nursing and Midwifery Council, 2011; White and Winstanley, 2014). Varying levels of nurses' engagement with CS have been identified (Butterworth et al, 2008) due to ambivalence, avoidance, poor understanding of the purpose of CS, and fear of criticism (Fowler, 1996; Major, 1992; White & Winstanley, 2010).

Defining CS has been a challenge. Arguments that a tight definition restricts contextualization and local implementation have been countered with the need to address lack of clarity about CS, especially in nursing, and suggestions for guidance on "being a supervisee" during nursing training (Cutcliffe, 1997; Cutcliffe and Proctor, 1998). The absence of and resistance to a firm definition of CS (Kelly et al, 2001) have been associated with *the conceptual muddle* (Sloan et al, 2000:515) and lack of models of providing CS in nursing (Sloan et al, 2000), and criticized for their effects on quality of research and implementation in practice (Milne, 2009).

There is agreement among authors that CS is based on a collaborative professional relationship (Holloway, 1995; Milne, 2009; Proctor, 2001; Scaife, 2009) of usually unequal but shared power between the parties, containing conscious and unconscious elements, including emotions from the clinical encounter that re-emerge during CS (Frawley-O'Dea & Sarnat, 2001; James, 2007). Unarticulated major issues and emotions are reproduced in the CS encounter, often in a similarly unarticulated way, where they may be made explicit and worked with (known as parallel processes). Sloan (2005) proposes that factors associated with the professional relationship in CS of nurses would improve through training supervisors in providing good quality CS, a view supported by Milne (2009).

CS is aimed at enhancing professional (Milne, 2009) and personal development (Casement, 1985, 2002). Its purpose is learning: cognitive (planning, strategic intervention), technical (using specific assessment tools or intervention techniques), and experiential (using oneself to understand, work with and enhance the helping process). Emphasising the role of experiential learning cycles, Carroll (2011) describes CS as transformational rather than transmissional/ informational learning. For this, attention is required to supervisee's current professional proficiency and development needs (Spence et al, 2001), competences already acquired (Stoltenberg and Delworth, 1987), professional aspirations, client characteristics, the system/ institution within which the supervisee practises, and supervisor's skills and competences (Holloway, 1995). The needs and wishes of a trainee professional differ from those of a post-qualification senior clinician or healthcare manager (Spence et al, 2001). The former may require more honing of cognitive and technical elements of supervision (James et al, 2004), while the latter's needs may include reflection on quality assurance and management issues (Hyrkäs et al, 2005; Hyrkäs, Koivula et al, 2003; Spence et al, 2001).

The various elements of CS are elaborated in models or frameworks. Generally, these acknowledge that CS is a process, for example, a *cyclical process* (Page & Wosket, 2001). It often involves a contract between participants, a focus (issue/s for consideration), space for thinking, feeling, reflection, a link between discussion and planning future action, and a summary of issues presented with feedback on the overall experience of supervision. Scaife's (2009) General Supervision Framework consists of a focus on feelings and personal qualities, knowledge, thinking and planning, and actions and events associated with the work; a medium for eliciting these in CS (narration, live, recorded); and tasks and skills of the supervisor (to listen, reflect, enquire, assess, and inform the supervisee).

In their CS alliance model which is widely known and used, Inskipp and Proctor (in Proctor, 2001) propose three major tasks or functions: The formative function refers to supervisor's and supervisee's responsibilities in relation to the professional growth of the supervisee, the role of CS in enhancing the awareness, knowledge, skills and general personal and professional development of the supervisee. The normative function refers to responsibilities to supervisee's clients, the employing organization, and safeguards against bringing the profession into disrepute. It is guided by organizational policies and procedures, codes of ethics and conduct, research on good practice and empirically supported work. The restorative function refers to supervisor's and supervisee's responsibilities regarding the supervisee's physical and psychological wellbeing, which is ultimately a responsibility to the client, the organization and the profession. Compromised wellbeing is likely to interfere with both normative and formative functions and with the quality of the helping process. Proctor (2001:31) considers the restorative function of supervision the foundation for the other two, emphasizing that without it, ***the other tasks will not be well done*** (highlight in the original).

2.3 Description of Clinical Supervision

As already discussed, definitions of CS vary, and *'the essence' of CS is complex and […] the effects are individual and based on the meaning given by the supervisee* (Hyrkäs, Koivula et al, 2003:51). Milne (2009:8) traces the earliest evidence of practices like CS to the handing down of healing rituals from Heron to Asclepius and priests in ancient Greece. Heron, a centaur, contains the ambiguity of whether he was a God or just an intelligent, considerate, civilized, socially skilled centaur with expertise in healing. This metaphor encapsulates the varying perceptions of the professional relationship in CS, with the supervisor personifying authority and power in a professional relationship to impart wisdom.

Other metaphors of CS include: a map of the clinical terrain; the eye of the hawk surveying and advising (Bolton, 2001, in Scaife, 2009:1); a constructive 'mental space' in supervisor and supervisee alongside the physical and diary space/ time (Merodoulaki et al, 2003; Page & Wosket, 2001). In practice, CS is a confidential in-depth conversation in a quiet space and time, face to face or on the telephone/ internet without interruptions or intrusions.

Overlapping partly and sharing the same noun with other kinds of supervision, CS is distinct from managerial, research, or training/ assessment supervision (Merodoulaki et al, 2003; Scaife, 2009; Yegdich, 1999a). It is also distinct from but shares common

elements with mentoring, coaching, leadership, peer support, and psychological therapy (Faugier and Butterworth, 1993; Milne, 2009, Yegdich, 1999b). The conceptual complexity of CS is reflected in the "slices" of it captured in frameworks of its delivery. Milne (2009) observes that existing definitions of CS have not been empirically established and empirical research in CS has tended to bypass the issue of definition and concentrate on outcomes instead, undermining shared understanding and attempts to replicate findings. Definitions tend to focus on CS of prequalification clinicians, which includes formal and academic assessment of competence. Milne (2009:15) proposes an empirically derived definition of CS containing specification, functions and operationalization, to differentiate it from other activities:

The formal provision, by approved supervisors, of a relationship-based education and training that is work-focussed and which manages, supports, develops and evaluates the work of colleague/s […]. It therefore, differs from related activities, such as mentoring and therapy, by incorporating an evaluative component […] and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisee's performance, teaching, and collaborative goal-setting […]. The objectives of supervision are 'normative' (eg, case-management and quality-control issues), 'restorative' (eg. encouraging emotional experiencing and processing) and 'formative' (eg. maintaining and facilitating the supervisee's competence, capability and general effectiveness) […]. These objectives can be measured by current instruments.

To ensure it happens, CS is usually pre-booked. In some contexts, ad hoc CS is available, for example when a clinician requires guidance urgently. Clients/ patients are usually not present in the supervision discussion. In most psychological therapy models, CS usually happens after or in preparation for the clinical appointment. In systemic psychotherapies, the supervising team and the therapist are usually in contact while therapy happens. The supervisor may work with supervisees individually or in a group format. Peer supervision refers to a group of professionals who meet regularly without a designated facilitator to discuss and reflect on their work. Apart from conversation, facilitation may include creative media, images, sounds, poetry/ prose, audio- or video-recordings (Scaife, 2009), and written material produced with the client during the appointment, such as a shared formulation of the issues/ problems.

In summary, literature on CS in psychological therapies where it has been long established has identified:

The need for clarity in defining CS and as distinct from other supervisory and supportive mechanisms to enable clarity in research planning and findings

The learning that takes place within/ through CS is mainly experiential, of a transformational nature, and may include informational/ didactic elements

Supervisees may have different needs from CS depending on their stage of professional development and seniority (trainee, qualified, senior)

The professional relationship between supervisor and supervisee is of paramount importance.

2.4 Clinical Practice and Clinical Supervision

The NHS is a constantly changing area of clinical practice where major changes occurred in policies and procedures about care delivery over the past 25 years. These aimed at increasing the involvement of service users and their loved ones and balancing the power between professionals and service users (Department of Health, 2004). Government publications emphasized the desirability of planning and delivering care in ways that are acceptable to service users, and shaped by them at every stage, including their carers and communities. Examples are:

- Public and Patient Experience and Engagement. Putting people at the heart of care (2009)
- Now I Feel Tall (2005)
- Creating a Patient–led NHS. Delivering the NHS Improvement Plan (2005)
- Results from a programme of consultation to develop a patient experience statement (2003)
- Essence of Care Guidance. Patient focussed benchmarks for clinical governance (2001)

Since 2000, there has been a gradual move towards giving patients more power over their own health and care. The NHS Constitution, which raises awareness of the rights that people have in determining their own care, and the increasing ability of patients to choose which service they use are just the latest signs of this trend.

(Public and Patient Experience and Engagement. Putting people at the heart of care. Department of Health, 2009: 6)

Although the ideas in these documents align with the ideals and training of healthcare professionals, interpreting and implementing them in a sensitive and individualised manner requires not only advanced clinical skills to avoid “one size fits all” practices and patients’ experiences of conveyor belt service, but also interpersonal clinical skills to explain rationales for care (Benner, 2004), especially where guidance, clinical judgment and a patient’s preferences diverge. Research indicates that despite these,

in practice, service uses have remained dissatisfied with care. Reviewing the relevant literature on stroke, Brereton & Nolan (2003:51) conclude:

what emerges most clearly from the available studies is the importance of focusing on the values, goals, aspirations and meanings of stroke survivors and their families.

Using the term "system induced setbacks", Nolan et al (2003:260) acknowledge the complexity of this aim and the importance of conditions at work, as they summarize relationship breakdowns between staff and patients/ patients' families resulting from situations where individuality is compromised through attempts to fit service-users into existing service provision with inadequate regard for personal preferences, circumstances, or culture. Dissatisfaction is reported with services that ignore patients' strengths and efforts, failing to tailor input accordingly. Nolan et al (2003) conclude that system induced setbacks can be prevented through reviewing how staff manage their professional status as experts, to facilitate the development of trust between services and patients and their families. This requires awareness of how professional power is used, the importance of the professional relationship to outcome quality, and the role of CS in restoring the worker's personal resources, encouraging review and balance of power differential, and enhancing the experience of personal and professional learning and its transmission into practice.

While access to CS for qualified and/or experienced clinicians is well organized in some specialisms, such as mental health and psychological therapies, this is not universal, as evident in some acute services: *The ability of junior staff to seek advice and appreciate urgency, and their supervision by senior staff were rated as very poor in 20-30% of cases considered [by the National Confidential Enquiry into Patient Outcome and Death]* (Olsen and Neale, 2005:1219). There is limited literature regarding CS in privately funded healthcare.

How can services and supervisees pursue learning that, as Carroll (2011) and others have suggested, transcends the usual conception of CS as transmission of technical knowledge (the "what to do" of caregiving), by incorporating the experience of being in a professional relationship that models the "how to be" aspect of caregiving? Worrall (2001) views the primary task of CS as the facilitation of supervisee's capacity to offer empathic understanding to the client. Empathy is considered an observable and trainable skill, possible to record for reflection and feedback in CS thus training in communication skills should include simultaneous training in empathic understanding, in order to cultivate capacity for relational depth.

Edvardsson et al (2008) indicate that in residential services with a better care climate and less job strain, residents with dementia tended to exhibit lower levels of

"behavioural symptoms" associated with staff experiencing low levels of job strain independently of job-related knowledge. Carroll (2011) posits that in certain conditions, we automatically move into a physical (brain) state that enables transformational learning which is based on reflection that facilitates the expression of what the supervisee is thinking and, at a meta-cognitive level, the frameworks that guide the meaning they create about clinical experiences. This claim is supported by research on the physiology of memory and emotion (LeDoux, 1994) and on emotional regulation (Schore & Schore, 2008).

Nolan et al (2003) proposed the "Senses Framework" of a relationship-centred approach in the context of care, which can usefully provide the backdrop for delivering care: the sense of security, of continuity, of belonging, of purpose, of achievement, of significance. The senses apply to workers, clients, and client's carers/ families. Applying the senses framework to understanding and supporting staff may be facilitated through the restorative, formative and normative functions of CS.

2.5 LITERATURE ON CS IN NURSING

[…] clinical supervision found its way into the vocabulary of nursing without having a significant impact on the reality of nursing practice or education (Faugier and Butterworth, 1993:2)

This quote speaks to CS as receiving lip service in nursing. White and Winstanley (2010:162-3) juxtapose *merely 'having' CS (and being seen to 'have' it)* vs organizing *demonstrably efficacious CS* - the latter being likely to produce positive clinical outcomes. Despite consensus about the functions, purpose, usefulness and necessity of CS in clinical practice (Kelly et al, 2001), variations exist in understandings of its nature (Hall & Cox, 2009) and the level of engagement across professions and countries (Koivu et al, 2011). In DH guidance (2004), CS is seen as promoting and developing the ten shared capabilities in delivering professional and accountable clinical practice. *A Vision for the Future* describes CS as

a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex clinical situations (Department of Health, 1993:15)

Supervisee restoration, an important function of CS (Bowles and Young, 1999; Brunero and Parbury, 2008; Cutcliffe, 1997; Koivu et al, 2012; MacLaren et al, 2016; Pearce et al, 2013; Proctor, 2001), is absent here. However,

Significant changes in the formative domain (development of skills and knowledge → impact on patient outcomes) may only become demonstrable after significant changes to restorative (personal wellbeing) and normative (promotion of standards and clinical audit issues) domains have become established, caused by sustained and efficacious CS. (White and Winstanley, 2010:160)

CS has remained loosely conceptualized (White and Winstanley, 2014) to preserve flexibility in local implementation. Despite regular reviews of research (Butterworth et al, 2008; Cummins, 2009; Fowler, 1997; Gilmore, 1999; Spence et al, 2001), questions remain: What exactly is CS in nursing? 'How' does it work, especially when it works well? What happens in the supervisory meeting and process - and is it supposed to happen? What is the correlation of CS with clinical outcomes? What is the specific contribution of each party to the process and outcome of supervision? What develops the supervisory relationship? How is the learning and development that the supervisee gains conveyed into the care of clients/ patients? Is it true that: *It is possible that some patients in treatment with student therapists/ analysts could say, if they were asked, which session in the week follows immediately after the weekly supervision* (Casement, 2002:45)?

Some conceptual variations may be traced to the origins of CS in education (Kelly et al, 2001; Scaife, 2009) from where many CS studies have drawn their participants, and whether CS is perceived as primarily of a formal instructional nature (Milne, 2009). In nursing literature, implementation of CS is emphasised and encouraged across seniority levels (Bassett, 1999; Butterworth et al, 2008; Cutcliffe et al, 2001; Faugier and Butterworth, 1993; Fowler, 1996; Gilmore, 1999, 2001; Kelly, 2001). Critical reflection and CS can be effective in empowering clinical leaders to define their roles, put their ideas into action, and improve their self-confidence (McCormack and Henderson, 2007; Hyrkäs, Koivula et al, 2003).

Nurses' varied understandings about its nature and purpose, and the barriers associated with accessing CS are also acknowledged (Butterworth et al, 2008). Misconceptions include CS being a casual chat with a colleague during breaks to help staff who struggle at work or are at risk of burnout; criticism or micromanagement by an authority figure; assessment or preceptorship arrangements, and conflation with other supervisions, most commonly managerial (Kelly et al, 2001; White and Winstanley, 2010). In mental health practice, CS is encouraged beyond initial training as:

a dynamic, interpersonally focussed experience which promotes the development of therapeutic proficiency. One of the primary reasons for all supervision is to ensure that the quality of therapeutic work with clients is of a consistently high standard in relation

to the client's needs. Consequently, supervision must be acknowledged as a cornerstone of clinical practice. (CPNA, 1985, in Kelly et al, 2001)

The importance of the supervisory relationship has been highlighted, especially its alliance characteristics (White and Winstanley, 2010), but the effects of dual roles (clinical and managerial supervision) remain unclear, as studies included managers as clinical supervisors. One of the distinguishing features of CS is to provide opportunities for nurses to feel sufficiently comfortable to verbalise, reflect, and learn from their professional actions and non-actions and the processes that guide their decision-making. This requires an empathic and accurate understanding of and feedback to the supervisee and their clinical role (Hawkins and Shohet, 1989; Scaife, 2009). The relationship may take account of supervisee's anxiety, motivation, autonomy, their view of the supervisor's expertise, the supervisor's training in CS, the authority and interpersonal power dynamics (between supervisor and supervisee). Although the purposes may differ depending on where in the range of competence development and professional identity supervisees find themselves (from early in training to experienced practice) the empathic element of the CS relationship is necessary.

Reviews of studies found recurring evidence of the restorative function of CS for nurses engaging in it (Brunero and Parbury, 2008; Butterworth et al, 2008; White and Winstanley, 2010). However, conceptualization challenges have produced barriers. Further clarity is required about the extent of addressing the personhood of the supervisee in order to limit misconceptions of CS as psychotherapy (Yegdich, 2009), to challenge splitting of the personal and professional self, to highlight the restorative function of CS, and to produce more clarity on the role and importance of the nature and quality of the supervisory relationship (ibid, also Scaife, 2009). Faugier and Butterworth (1993), Gilmore (1999), White and Winstanley (2010) provide ideas about overcoming barriers and establishing organizational structures so that all nursing practitioners receive adequate and efficacious CS.

Nurses are required to demonstrate reflective practice rather than participation in CS (Benbow & Jordan, 2007). Although CS is recommended by the Nursing and Midwifery Council and potentially all good CS is reflective practice, not all reflective practice is CS. It becomes clear that the nature and importance of the professional relationship provides definition for the process and content of CS. Bounded by agreements, this is an openly negotiated relationship between supervisee and supervisor, providing direct experience for negotiating the nature of other professional relationships. Within the definition of this relationship, clinicians portray, construct, reconstruct and enhance their understanding of their work and the interaction between their personal world with

their professional identity and activities. Transformation during CS occurs through forming the professional relationship (Carroll, 2011).

2.6 SUMMARY

Stroke is a significant cause of disability and death, necessitating development in clinical knowledge and skills to respond to it in efficient and effective ways, making it a healthcare specialism (rather than part of general healthcare services). CS supports and develops clinical practice. There is extensive professional literature on CS in different healthcare disciplines. Its content is diverse, covering CS specific to clinical interventions, constituent elements of CS (contract, professional relationship, confidentiality, development), effects on practitioners, their contexts and –to a limited extent- their patients/ clients.

There has been a proliferation of literature since the 1990s and a drive to implement CS structures at all levels of nursing seniority. Implementation appears to have been achieved in mental health services. Studies emphasise the continuing problems associated with the range of understandings of CS and their consequences. Within those limitations, there are reports of CS being useful in developing practice, but especially in restoring the supervisee's personal resources (eg. managing stress). I now turn to the review of literature specifically on CS in stroke care, dementia, older people and similar clinical contexts.

2.7 LITERATURE ON CLINICAL SUPERVISION FOR NURSING OLDER PEOPLE

Within the broader literature already discussed, material specifically about CS in stroke care and in related services has been sought. For this purpose, a search of databases was conducted, the method and results of which are presented here.

2.8 Search strategy

The databases CINAHL, PsychInfo, Scopus, Cochrane and Google Scholar were searched, and the websites of the Department of Health, Health and Care Professions Council, Nursing and Midwifery Council. Using Boolean operators, keywords/ search terms were a pair of 'clinical supervision' AND

'stroke'

'neuro*'

'elderly'

'older people'

'gerontol*'

'dementia'

In addition, names of well-known authors on CS were searched in Google for relevant publications. To improve findings, some of the searches were performed with a librarian who suggested the term 'older people', and some with a research supervisor.

2.9 Inclusion and exclusion criteria

Inclusion: I included items if they detailed aspects of CS in relation to contexts of the clinical problems and populations included in key-terms: if they examined a combination of clinical supervision AND stroke or neurological conditions. The search was for publications from 1980 (to capture any articles prior to the resurgence of CS in nursing in the 1990s) to 2011 (when the search was performed). As approximately 75% of people who suffer a stroke are aged over 65 (National Stroke Strategy, 2007:11), the terms: elderly, older people, gerontological, dementia were also explored. Papers on managerial supervision, mentoring and related terms were not included. Only papers that utilised and stated a research methodology were included.

Exclusion: Opinion items were excluded. Papers about CS of patients, for example assessment of independent living, were all excluded. Papers on managerial supervision, mentoring and terms of other types of supervision, references that used the adjective "clinical" to define some process other than CS and items that refer to CS

in services other than the aforementioned were excluded unless reference was made that these included services to people with the specified clinical presentations (stroke, dementia, and similar conditions). These criteria were applied first to the title of each reference, then the abstracts of items that appeared relevant, before downloading the full article. The quality of these studies is discussed later.

2.10 Results

Initial database searches using only the term 'clinical supervision' identified in excess of 40,000 items. Subsequent searches pairing the terms 'clinical supervision' and 'stroke' produced 16 references, of which 15 were about the supervision of patients and one about CS of trainee psychologist in stroke services. In total 18 references were identified from the searches pairing CS with other specified terms. Appendix 2 contains the table summarizing these references.

2.11 The nature of the literature

There were various types of literature examining CS from the perspective of nursing care, but also from psychology and occupational therapy. The items selected were related specifically to CS in nursing patients with stroke/s and other cognitive dysfunctions associated with advancing age. I read each included item in full more than once, to understand each study in detail and depth. There were seven quantitative studies, five qualitative, four with mixed methods, one case study and one audit. Fifteen studies took place in services providing care to older adults in Scandinavian countries, in state-funded services increasingly subjected to budgetary reductions. Three UK studies were included: one case study, one mixed methods, one audit. The authors were mainly academic researchers with a clinical background.

The table of focused literature review (appendix 2) contains information about each study arranged by author, year and aim, methodology, participants' characteristics, setting, design, reported outcomes, any change mechanisms reported, and a brief appraisal. I have used the general principles outlined in Fothergill and Lipp (2014) as explained next, to comment on quality of each and then synthesized their conclusions thematically.

2.12 THE LITERATURE

2.12a General Opinion and Discussion about the Literature

Although several references contained both “clinical supervision” and “stroke”, only one, a psychology case study, addressed clinical supervision in services delivering stroke care. The rest referred to the clinical supervision of stroke patients. This was an early indicator of the level of knowledge about CS in stroke services and consistent with findings by Ashmore et al (2002) that despite the coverage of CS in nursing journals in the 1990s, items on CS in services for older adults were few.

Fothergill and Lipp (2014) provide a guide to critiquing a CS research paper, using an article they had authored as an example. They distinguish between believability and robustness, each with specific criteria. Believability pertains to how well written the paper is, the credentials of the authors, and the accuracy of representation in the title and abstract in relation to the actual content. Robustness pertains to the purpose of the research, logical consistency in the report, availability of a logically organized literature review, the existence and accurate description of the paper’s theoretical framework (for quantitative studies), clarity of aims and objectives, sampling details, ethical considerations, clarity of operational definitions, methodology and analysis, and whether the discussion follows from the rest of the contents. Although these are suggestions for a quantitative paper, its general principles apply to other methodologies as well, and I have used some of their criteria here.

Regarding believability, 15 of the articles were co-authored by well-known Scandivanian academics associated with research in CS. Believability was compromised in some papers due to robustness issues. All papers contained a literature review justifying the research. Writing in a language different from that in the place of the study, and using measures that had been validated and standardized elsewhere, some authors had translated measures but not provided information about validity and reliability in their own language (Begat et al, 1997; Berg et al, 1994; Hyrkas et al, 2006) exposing the study to threats of internal validity (Edberg & Halberg, 2001). Occasionally, the language was unclear (Haggstrom et al, 2010). Few of the studies provided a definition of CS. There was an implicit assumption that CS was beneficial. In some reports, clarity of logical cohesion between effects and CS was compromised, for example, reporting outcomes of CS even though the results are not specific to CS, because studies combined CS simultaneously with training or with the introduction of a specific philosophy and practice of care.

Information about the training and competences of participants was rarely provided. Sampling indicated assumptions of similarity of need for and response to CS by participants regardless of skill or seniority (some studies included both assistants and qualified nurses). Where skills varied, conclusions did not consider possible differences in learning and support needs or possible effects of socio-economic factors on results. For example, reporting commitment to the job due to emotional factors (attachment to patients) without acknowledging the socioeconomic context of high unemployment where staff may have few alternative employment options (Flackman et al, 2007).

Information about training and competences of supervisors providing CS was usually not available or clear. Where information was provided, it was not always directly translatable to a UK context due to differences in the terms used for job titles. There are issues of translation and interpretation in Scandinavian studies reporting in English. For example, Hallberg and Norberg (1993:1867) report on negative emotional reactions, *dissociation rather than association.* This is not defined, allowing ambiguity whether dissociation was the psychiatric symptom or disconnection from work/ patients. Recent studies were closer to Fothergill and Lipp's criteria (perhaps consistent with the formal appraisal of studies).

More specifically, Begat et al (1997) found their participants' self- awareness and self-value improved after CS, as did communication and exchange of information, and nurses felt "confirmed'. However, the validity of the measure used is not known, compromising the believability of the inferences drawn in the interpretations of the data. Berg et al (1994) used experimental interventions, training, CS and patient centred care to examine tedium, burnout and conflict in nursing homes caring for people with dementia. They reported that tedium, burnout and conflict decreased in the experimental condition while in the control condition it had not changed. There are various methodological and design problems with this study including the (non) definition of tedium, variable levels of staff competence at the start of the study, using questionnaires about which little information is known, and not accounting for the effects of major organizational changes concurrent with the study and high levels of unemployment locally.

Berg & Welander (2000) implemented group CS and individualized care on a dementia ward and reported their effects using interviews and questionnaires. They found that the interventions helped "confirm" the nurses as persons and professionals and "confirmed" the patient as a unique human being (from task-orientation to person-orientation). This is an interesting study for the message it provides about possible co-

variation between staff and patient wellbeing, but it is difficult to establish which intervention was most potent.

Berggren & Severinsson (2000) used interviews analysed through a "hermeneutic transformative process" to examine the effects of group CS on 15 nurses working on dementia and stroke wards. Nurses reported increased self-assurance and autonomous decision making regarding care quality; improved support to patients; improved empathic relating; and being better able to discharge their responsibilities with very dependent patients. Through CS, nurses had time to think/ reflect, sought clarification and affirmation about their job, and experienced better containment of their emotions.

There is a set of studies reporting on the introduction of training and CS on dementia wards and examining the effects of this on different variables: Edberg and Hallberg (2001) used mixed methods (questionnaires and interviews) to examine the occurrence of patient actions that staff viewed as demanding after the introduction of individualized patient care and CS in a nursing home caring for people with dementia. They reported that challenging behaviour and seclusion decreased in the experimental ward, and staff perceptions improved regarding job satisfaction, tedium, creativity, and burnout, while on the experimental ward, incidence of challenging behaviours was reported as increased, and that training alone did not effect change. This study suffered from small sample size and unspecified staff variables. The reliability and validity of the measures used were not reported and there were threats to internal validity. Olsson, Bjorkhem & Hallberg (1996) attempted to explore care home staff's content and reasoning about dementia care by tape recording CS sessions and research interviews with supervisors. They found that CS helped supervisees gain a better understanding of patients and to clarify their philosophy of care. Hallberg et al (1996) examined the effects of 2-day training and supervised implementation of individualized patient care on dementia wards (experimental) vs routine care. They reported interesting results, where from similar levels of cooperation between nurses and patients across the wards, cooperative behaviour from both sides increased in the experimental condition (training and CS). Staff were more empathic, better able to self-regulate their emotions and communicate effectively. Less anger was reported from staff and patients appeared less fearful. This very interesting study seems related to the one reported by Edberg and Hallberg above. It suffers from poor design: the experimental ward had one more qualified nurse than the control ward, which had three untrained staff (experimental ward had one untrained person).

Edvardsson et al (2008) extracted data from previous studies to examine the co-variation between behavioural symptoms of residents of a home for dementia patients and care home emotional atmosphere, staff job-strain and knowledge. They found that self-reports of job strain correlated positively with residents' behavioural symptoms but inversely with caring climate at work and that staff level of knowledge was unrelated to occurrence of residents' behavioural symptoms. A weakness of this study is that, to minimize participant fatigue, data were extracted from another study. Additionally, there are more general questions of accuracy of self-reports used.

In a well-researched, conducted and reported study, Soini and Valimaki (2002) used questionnaires with home care and nursing staff to examine which of the interventions used they found helpful. Consultations with colleagues, CS, and managerial supervision were reported to be most helpful. Hansebo and Kihlgren (2004) used mixed methods to illuminate changes in carers' approach after CS was introduced with a sample of qualified nurses and aides working on wards with older people with cognitive impairments. They used video recordings as part of the intervention and data collection and found that feedback from the recordings was powerful in improving staff self-awareness and practices towards greater comfort for patients.

From the UK context, Dinshaw (2006) used the NMC definition for CS as one aspect of an audit of in-patient services for older people in England. She found that CS was "not fully implemented", with mainly ward managers having monthly CS. This was reported to be due to lack of time and resources, Trust policy guidelines, and their interpretation by management. In Northern Ireland, Galinagh et al (2000) carried out a study that appears to have started as an audit and developed into an experimental design. They offered an one-day course in CS to examine the concept of CS held by their post-qualification nursing colleagues working on a rehabilitation ward for older people. After the course, they "audited" participants' knowledge and understanding about CS and again three months later. They reported that at baseline, most staff were unable to say what CS or its purpose was. Although this improved after the course (three months later), it was still inadequate.

2.13 SYNTHESIS OF THIS LITERATURE

Emerging themes

Only one study was found specifically about CS in a stroke context (James et al, 2004). This is a well-designed case study (n=1) of CS of a trainee psychologist working with stroke patients. It addressed competence in clinical assessments used in stroke contexts and examined supervisee's emotions in the supervisory process. This study provides an account of supervisor and supervisee interactions over a number of sessions and their post-hoc reflections on the supervisory process. Although there is much useful information about the management of anxiety of pre-qualification supervisees, the focus is on the early stages of competence and identity development as a professional, and therefore not necessarily generalizable to all levels of competence or other professions.

Several Scandinavian studies involved stroke survivors as part of the work-context, which was usually in-patient or residential care for people with dementia, but there was no clarity or differentiation about any issues specifically to do with stroke care. Generally, conceptualizing and implementing the construct of CS across professions/ disciplinary frontiers was problematic, as a definition of CS was not included in several studies. Methodological and design problems were also evident, for example, introducing a variety of variables but reporting results as applicable to CS only.

The interpretation in some studies using qualitative methodologies indicated overstated claims. For example, in a study with no definition or measure of "tedium" the conclusion was that CS was *a very effective way of improving the quality of care [reference]. It is interesting to notice that although both individualised care and systematic clinical supervision focused on the patient and the nursing care provided, it affected nurses' degree of creativity, tedium and burnout.* (Berg et al, 1994:747)

These limitations notwithstanding, certain themes emerge from this literature:

- The application and applicability of CS in services caring for older adults with cognitive (and physical) disabilities.
- The effect of CS on the work context of staff
- The effect of CS on clinical practice (change, modernisation)
- The effect of CS on staff self concept
- The effect of CS on service users
- The mechanisms whereby the outcomes found in the studies are effected.

2.13a Application and applicability

Despite strong arguments for the benefits of CS implementation to clinical practice (Hyrkäs et al, 2006), CS is not part of routine nursing work in services caring for older adults with cognitive disabilities (Berg & Welander Hansson, 2000; Dinshaw, 2006; Edberg & Hallberg, 2001; Edberg, et al, 1996; Fläckman et al, 2007). CS is the variable/ intervention introduced for examination. Some participants had little or no knowledge or experience of CS and were unlikely to seek it (Gallinagh et al, 2000). Where CS was available, difficulties were reported finding cover for duties and arranging time to attend (Dinshaw, 2006). Some studies specified that participants were from day-time shifts. CS of night staff is not addressed explicitly. Some participants reported experiencing guilt for increasing colleagues' workload. Recommendations include that managers should encourage staff to participate in CS to ameliorate the obstacles and emotions experienced (Dinshaw, 2006).

Some participants declined the offer to participate in CS. This was due to the aforementioned work-context reasons, but also because they did not feel that they wished to learn anything more. Although this was attributed to older age, it also raised the question of perceptions of such learning as professional but also personal development, as comments included their ideas of own worthiness and intelligence (Häggström & Bruhn, 2009).

In summary, there are various reasons for the absence of CS in these services, including organisational, practical, perceptual, emotional, and personal choice.

2.13b The effect of CS on the work context and practice

Edberg et al (1996) found that through CS, staff changed their attitude and practice, pursuing relationships of respect and cooperation with residents resulting in more cooperation and change in the organizational culture. A helpful perceptual shift from task-focused care about the body (washing, feeding) to the mind of the patient (emotions, preferences) was reported in some studies. There was a change in the attribution of symptomatic or challenging behaviour from it being viewed as caused by "disease" to being related to the person's feelings and preferences; an acknowledgement of patients as sentient beings whose minds are still partially active and responsive. This shift towards empathy has wider implications: For example, there is evidence that CS can generalize positive effects on staff relationships to their interactions with organizations external to their work context (Edberg et al, 1996).

Edvardsson et al (2008) found positive correlations between staff self-reported job strain with behavioural symptoms of patients/residents, while a positive and caring work climate was inversely correlated with behavioural symptoms and job strain.

In summary, there may be an impact of CS on staff's skill and capacity to relate in an emotionally intelligent and effective manner that has positive results in clinical practice and beyond.

2.13c The effect of CS on clinical practice (change, modernisation)

Training is an obvious way to update and change clinical practices, but alone, it is not sufficient for change to be maintained- or perhaps even initiated (Häggström & Bruhn, 2009; Milne, 2009; White and Winstanley, 2010). Edvardsson et al (2008) report that level of knowledge was unrelated to reported incidences of "behavioural symptoms" while associations were reported with job strain and emotional climate of work. So, although staff may have a cognitive understanding of the latest technical knowledge, their habits and avoidance of risk may mitigate against action on this.

Edberg et al (1996), Häggström & Bruhn (2009), Hansebo & Kihlgren (2004) report that CS facilitates engagement with change, seen as an opportunity to examine decision making, plan interventions with foresight and manage risks, thus limiting the factors contributing to avoidance of change implementation. The provision of feedback on the experience of practising in a different way can reinforce and maintain change. This would be even more likely if, in the process, staff discover things relevant to themselves (transformational learning in CS, Carroll, 2011). This is applicable with staff learning new skills, but may be even more important for experienced staff who practise in 'established' ways.

2.13d The effect of CS on staff self concept

Several of the studies identified that among the benefits of CS reported by participants was "feeling confirmed", although this was not always explained adequately (Bégat et al, 1997; Berg & Welander Hansson, 2000; Berggren & Severinsson, 2000; Häggström et al, 2010). There are various ways to understand this, including confirmation about the suitability of clinical decisions and actions (professional autonomy). Such confirmation may have various effects, including relief from doubt/ uncertainty, satisfaction about professional efficacy, or increased confidence about one's knowledge, skills and applications of them. "Confirmation" can lead to more autonomous practice (Berg & Walender Hansson, 2000). With application of

knowledge and skills in practice, positive results confirm their usability and suitability, while negative results can be reflected upon for further learning, with potential benefits on the supervisee's self-confidence and esteem (Bergrren & Severinsson, 2000).

The (complex) mechanisms and processes involved in CS were also associated with enhanced personal awareness, ie. staff understanding themselves and their reactions to their work better. A sense of mastery over one's work has been associated with job satisfaction and limiting job-stress (HSE, 2007), both of which are associated with staff retention, the latter being a major concern in services for older adults with cognitive impairments (Fläckman et al, 2007; Hallberg & Norberg, 1993; Olsson et al, 1998).

2.13e The effect of CS on the recipients of care

There were indications that CS enhances knowledge and skills but also staff capacity to initiate and establish good and appropriate professional helping alliances (Berg & Walender Hansson, 2000; Berggren & Severinsson, 2000; Edberg & Hallberg, 2001; Edberg et al, 1996; Fläckman et al, 2007). These were important factors in determining patient satisfaction with services received, including the patient themselves and their family. Although no studies were sourced to indicate direct links between CS and satisfaction of patients' family/ carers, it was reported that CS facilitated a shift in staff's approach towards more person-centred care (Berg et al, 2000), staff were better able to pay closer attention to the histories, needs and preferences of patients/ residents and this resulted in more harmonious, cooperative, reciprocally warm relationships between staff and service users (Berggren and Severinsson 2000; Edberg et al, 1996; Fläckman et al, 2007).

2.13f Mechanisms whereby the outcomes found in the studies are effected

A variety of mechanisms and complex processes were evident in the effects of CS mainly associated with the psychological benefits for staff, which resulted in improved quality of care. By narrating experiences of care, staff became more aware of the different factors involved in their work, including their own attributes. Through CS, staff had an increased opportunity to observe the dynamics operating between them and service users (Hansebo & Kihlgren, 2004), the effects of organisational variables, and the general benefits and liabilities involved in providing care. The supportive/ restorative function of CS meant that such awareness was translated into more empathic understanding not only of the people they cared for, but also of themselves (Berggren & Severinsson, 2000; Edberg et al, 1996; Edvardsson et al, 2008; James et

al, 2004). Conveying this understanding improves the emotional climate of work and the burden that care is often associated with, facilitates better relationships with care-recipients, colleagues and factors external to the immediate work context, perhaps creating a beneficent cycle, by enabling a sense of mastery, competence, affirmation, and limiting the level of job strain and stress.

2.14 Supplementary literature

Additional searches of post-2011 literature were carried out in 2016. These searches were on CS in stroke care and no more references were found.

2.15 Summary and Research Questions

There is an abundance of literature about CS in various fields of health care. The summary earlier in this chapter is indicative rather than exhaustive. It indicates that CS is a system to support reflective clinical practice and the reflective practitioner. The mechanisms with which this support occurs include learning within a supervisory relationship characterized by trust built within the boundaries of respect and confidentiality that facilitate openness to accountability. Aims include: integration of knowledge from research, training, guidelines and policies with the particular characteristics and needs of the patient in the context of care where s/he is, bridging the best interests of the patient, the care organization, and the practitioner.

The focused literature review indicates that through CS, accountability is facilitated through feedback. The purpose and value of the practitioner's work are acknowledged. The relationship between practitioner and care recipient is reinforced through strengthening the practitioner's psychological resources. Greater understanding, a sense of purpose and control in the work, professional self-confidence and autonomy are developed. The practitioner and the work were the focus of CS. Where CS was implemented even as an experimental condition, the beneficial results reported transcended the immediate clinical encounter into the work context and wider organization. The literature suggests a scarcity of CS implementation. Additionally, staff have limited understanding of what CS is and its purpose, especially for their benefit. Some declined to participate in CS. This indicates the importance of personal meanings of CS in nurses' attitude towards using it. When CS is available, ultimately, personal meanings determine its use.

Taking all this into account, the acronym strategies PICOC (Population/ Problem, Intervention, Comparisons, Outcomes, Context) and SPICE (Setting, Perspective,

Intervention/ Interest, Comparison, Evaluation) were used to focus the research question. The intervention/ interest is clinical supervision from the perspective of qualified nurses employed in the context/ setting of stroke care. This is not a study of outcomes or structured evaluative comparisons but an exploration of stroke nurses' meanings and experiences of CS due to their importance in informing participation in CS.

The question of this study is:

What are stroke care nurses' experiences and meanings of CS?

To answer it, I employed the following methods of data collection:

1. Individual interviews to understand nurses' experiences and meaning of CS
2. A questionnaire to obtain basic numerical indicators about current availability and arrangements for CS in stroke services.

To understand contextual influences on the meanings and experiences of CS, I used

3. Field observations (unstructured notes) at interview participants' workplaces
4. A pro forma to obtain numerical descriptions of each service where interview participants worked (Nancarrow et al, 2009).

3. METHODOLOGY

3.1 Introduction

Methodology refers to the theoretical, philosophical, and data analytic parts of a study. It includes a description of the design and the approach used. Design refers to the actual structure or framework that consists of the time frame for data collection/ when and how they were analysed, when a treatment was implemented or not, and what method or combination of methods was involved. Approach refers to the theoretical model of how the data were collected and in what configuration- single case, or one or more other methods (Edmonds & Kennedy, 2013). This chapter reports on the methodological considerations, decisions and philosophical underpinnings of this study.

Following the section Positioning the Researcher, descriptions are provided of methodological considerations, philosophical underpinnings, and 'what happened' during collection and analysis of data. Given the absence of literature on CS in stroke nursing, the main approach was qualitative supplemented with quantitative data to capture a holistic picture. The following description is in order of weighting, not sequential:

- Semi-structured interviews aiming at understanding stroke nurses' experiences and understandings of CS (the "how" and "why", Willig, 2008).
- A questionnaire to elicit practical information about how CS is organized/ delivered, in what circumstances, how often, etc.
- Field observation visits to add contextual depth
- A pro forma for structured descriptions of the contexts of the interview data (Nancarrow et al, 2009).

The design was sequential with overlaps. Informal visits elicited early observations prior to data collection and facilitated prospective participants' understanding of the study and recruitment. Most interviews were arranged after receiving a participant's completed questionnaire that included contact details. Questionnaire completion was not a prerequisite for interview participation. Overall, questionnaire and interviews overlapped partly across sites, due to variable authorisation time lapses in different NHS R&D departments. Field observation visits during data collection produced observations that enhanced understanding of the context. The final stage was completion of a pro formaby contacts at interview sites, offering numerical descriptions of service context. Thus the sequence of data collection was:

1st Informal visits

2nd Research packs delivered

3rd Questionnaires received

4th Interviews and Field Observations conducted

5th Pro forma

3.2 Positioning the researcher

Researchers' experiences and personal characteristics (background, current position, prior knowledge) influence all aspects of the research process (Gemignani, 2011). Although in quantitative research this is viewed as bias to be avoided, in qualitative research such [b]*ias is essential and must be used if qualitative research is to be done well* (Morse, 2003:891). This highlights the importance of reflexivity, *an attitude of attending systematically to the context of knowledge construction, especially to the effect of the researcher, at every stage of the research process* (Malterud, 2001:484). Thus, reflexivity contributes to the quality of a study.

This study is a continuation of my professional and personal interests. Consistent with the importance of CS in my profession, counseling psychology, I have experienced it as a supervisee, supervisor, developer of clinical supervisors, and as past Head of an NHS counseling service for staff. Having worked in a brain injury service, I am interested in how staff experience CS in services for 'the injured brain'. The literature indicates that through CS clinicians develop intellectual, emotional and moral capabilities: observation, understanding, empathy, compassion, reflection, strategic thinking, ethical and practical decision-making towards optimal professional functioning. These have been my motives and experiences as supervisee and as supervisor. The professional alliance necessary in CS, assumes non-threat, trust, openness to experience, reciprocal feedback, factors related to facilitating understanding and learning. Experiencing understanding in CS improves my capacity to understand clients. I call this 'sequential containment'.

Applying knowledge and skills in practice, reflecting on the experience, and taking the lessons back into practice results in expertise and phronetic practice (Benner, 2004). In a climate of risk avoidance for fear of litigation, CS helps maintain safe practice and may be a legal defence. However, fear may leave little room for innovation or personalization of services to specific patients, degrading clinical practice to following a checklist, thus raising ethical dilemmas. CS facilitates thinking about and working towards best practice.

Coyle's (2007) acquaintance with research as a psychology student in the 1980s resembles my own experiences. Quantitative research has been dominant in psychology's struggle to achieve academic status as *respectable 'natural' science* (Smith et al, 1995:2), resulting in much research being quantitative (Munley et al, 2002; Brocki & Wearden, 2006) and debates about shifting from the measurement of observable phenomena to understanding experience and humans as creators of the meanings involved in psychological phenomena (Bryman, 2006 & 2012). These debates followed psychology into the 21st century, raising questions about identity and practice (Spinelli, 2001; Thompson & Russo, 2012).

The teachings of Ernesto Spinelli about phenomenological psychology and counseling offered me tremendous insights into my subjectivity and the effects of familial and sociocultural influences. Having taken "Abnormal Psychology" and "Phenomenological Psychology" in the same semester, I experienced the tension between nomothetic and idiographic paradigms in the contrast between classifying people's experiences on a diagnostic system of supposed diseases without understanding their subjective experiences or meanings of symptoms. Phenomenological approaches would seek the latter. Experiencing phenomenology and hermeneutics as personal transformation informed my career subsequently.

My postgraduate education was focused on quantitative methods. Even interviews and observations were taught as pre-codified for quantification (Bryman, 2008/12). I used the State-trait anxiety inventory (Spielberger et al, 1983) and Rotter's (1966) internal and external locus of control scale for my Master's dissertation (Merodoulaki, 1987). My second Master's dissertation (Merodoulaki, 1994) was also questionnaire based: participants' experiences fitting into my predetermined categories. Analyzing the data, I reflected privately on attempting to explain before I understood (Cohn, 2005): looking for explanations in the data, but how well did I understand and represent responders? Sensitive construction of the questionnaire had elicited extensive personal comments, meaning that large amounts of data found no place. As advised, I used some comments to embellish statistical findings. Here was yet another research adventure that filled me with excitement at inception but left me dissatisfied in the reporting. I needed other ways of inquiry, not yet widely used in psychology (Yardley, 2000).

Practicing psychology, I have attended courses about various types of interviews. Therapeutic interviews that help a person disclose personal and sensitive information, be listened and responded to therapeutically towards psychological relief form the core of my work. I consider CS an inter-view situation, constructing a professional alliance that has different purposes from therapy but similar features. In research, I have learnt

about structured, semi-structured and unstructured interviews, the contribution and shortcomings of each type and how to conduct them fruitfully. In preparation for the conduct of the study, I attended several courses to improve my knowledge and skills regarding qualitative research methods (semester course, autumn 2011) and IPA in particular. IPA training included a day course with Drs Gil-Rodriguez and Hefferon, a conference on qualitative methods at Derby University (2013), a workshop with Dr. Michael Larkin where other IPA research-in-the-making was also presented, a monthly IPA researchers' group (2-3 hours each) where published IPA researchers visited to present their work (Drs Catherine Berry, Cheryl Hunter, Jeanne Broadbent) and epistemological and technical issues were discussed extensively. I also attended ethnography meetings organised by Sheffield University and a session on evaluating mixed methods research with professor Bryman.

Clinically, I work mostly in the idiographic domain, evaluating my work with tools such as the Clinical Outcomes in Routine Evaluation scale. However, I struggled with the concept of 'evidence based practice' and clinical guidelines. Spinelli (2001) eloquently summarizes these nomothetic issues in counseling psychology. Rolfe (2005) critiques the philosophy of evidence-based practice. Flaming (2001) acknowledges the necessity of clinical research but proposes that Aristotelian phronesis is more appropriate than research-based practice because it permits more sources of knowledge, including ethical, to inform clinical actions, enabling clinicians to be more than competent technicians. My views that paradoxes fertilize knowledge, that knowledge is more than information retention or following manuals/ guidelines, and my preference for thinking through rather than complying challenged colleagues whose expressed realities were about numbers and logistics (not lessons from inter-subjective realities). I argued for psychosocial contextualization of clinical outcomes (Moloney & Kelly, 2004) and presented casework to illustrate. CS contained my reaction to 'evidence based' therapies and helped me use guidelines phronetically.

I experience words as both liberating and imprisoning. Liberating in symbolizing 'reality', and imprisoning in the limitations of inhabiting linguistic 'realities' (categories, order, 'certainty') and their consequences. For example, beyond the idea of skill as mastery through mechanistic repetition, skill and competence can be conceptualized as primarily ways of being, including therapeutically with another person: Aristotle's distinction between 'making' and 'doing' (Flaming, 2001). CS relies on my capacity for openness to and articulation of what is accessible to consciousness, how I experience the impact of my practice, my anxieties, ambitions, inhibitions, career plans, and learning needs, therefore, engagement with care ethics, including self-care.

In counselling psychology, CS is emphasized as transformational learning beyond what can be taught didactically (Carroll, 2011), including the idea of the use of therapist's self (Rowan and Jacobs, 2002) and psychological restoration (Wheeler, 2007). This contrasts with widely held views elsewhere that CS is for trainee/ inexperienced clinicians and that after a period of practice, "you work autonomously", where "autonomy" means conceptual and practical limitations imposed on the availability of CS (Merodoulaki et al, 2003). This PhD elucidated my belief- supported by literature- that CS is beneficial. I accept that CS can also be experienced as having negative effects. I see these as the result of misuse (of power or attention) rather than the nature of CS. In this study, as in clinical practice, I aimed to explore others' experiences, understandings, meanings of CS, and prioritise them when making sense of them or comparing them to mine. To balance this potential bias, I enquired explicitly through the questionnaire and the interviews about damaging effects of CS.

Reading on epistemology reacquainted me with an aspect of myself I usually treat as 'neutral'/ 'irrelevant': ethnicity. IPA's pedigree is traced to classical philosophies, particularly Aristotle's Nicomachean Ethics. I observed experiencing philosophy in clinical practice and CS; rediscovering these ideas during this PhD was comforting during the recent economic turmoil in Greece. Philosophy became my comfort (Boethius, 525/ 1969) and my antidote to the shame and humiliation projected on Greeks, illustrating that:

Not everything that can be counted counts. Not everything that counts can be counted (Cameron, 1963:13).

3.3 Epistemology

Epistemology *is that part of philosophy concerned with the nature, sources and justification of knowledge.* (Ladyman, 2002:265)

Our lay and professional beliefs and theories involve meta-knowledge (knowledge about knowledge) that even we may not know. The appetite for knowledge is as old as humanity; theorizing about knowledge is more recent and can be traced to classical philosophies. Epistemological concerns are important parts of all inquiry; more explicitly in qualitative research with regard to methods, validity, and scope, and inform the distinction between justified belief and opinion. Here I discuss epistemological aspects of conducting this study. A section detailing the criteria of validity and quality and how this study meets them is provided in the Discussion.

Participating in CS may be a personal and professional choice. However, as the literature suggests, it may be difficult to choose to participate, if CS is not available or not 'legitimate' or if it is imposed. Therefore, this study explores stroke nurses' experiences and meanings in the context where the experience is lived.

3.4 Decisions about choice of methodology

Formed through various contextual, interpersonal, and intrapersonal factors, the range of understandings and experiences of CS is likely to be specific to person and context, therefore vary considerably within and between professional groups and even in the same person in different contexts. The literature on CS in dementia services suggests that CS has beneficial effects on clinicians as a process that facilitates accountability, professional development and psychological restoration. However, there are also accounts that CS is resisted when perceived as managerial performance management, when staff feel they are not good/ intelligent enough for CS (Edvardsson et al, 2008), or experience it as surveillance. This highlights the divergence of meanings and experiences of CS that may be held by stroke nurses, and the lack of research on the mechanisms whereby CS is perceived as helpful or to be avoided and the importance of personal meaning in deciding how/ whether to use CS. A qualitative approach was most appropriate due to insufficient (published) knowledge about the topic from which to specify and test hypotheses. In seeking to engage with the data to gain new insights into the ways participants experience their world and construct meaning, the qualitative part of this study provides the main findings while quantitative information provides an overall picture of the use of CS in stroke nursing and contextualizes the interview findings with descriptions of the particular ethos in participants' services in this geographical area at this point in time.

3.5 Mixed methods

Understandings vary about what a "mixed methods" study is, whether the use of different types of methods requires a philosophical underpinning that deals with all aspects of the methodology to address and resolve internal conflicts in the study, how data are integrated and how results are presented. This study uses both qualitative and quantitative data within a predominantly qualitative approach. Data from each method have been analysed separately and integrated narratively at the end of the Findings chapter. Shannon-Baker (2016:321) views

mixed methods research as a type of inquiry that is philosophically grounded where an intentional mixture of both qualitative and quantitative approaches is used in a single research study.

Focusing on philosophical considerations to approach paradigmatic issues, she emphasizes the importance of paradigmatic perspective throughout a study. Other authors focus on the practical integration of fundamentally different types of data and the need for a good level of knowledge and skill in qualitative, quantitative and mixed methods approaches, the integration of which shows in various aspects of a study, from philosophical position, to design, data analysis and interpretation (Bergman, 2008; Creswell and Plano Clark, 2011; O'Cathain, 2010).

This study posed no hypothesis to be tested. The quantitative part provided a bird's eye view of the state of CS in stroke nursing in this region. Quantitative data were conceptualized and used as "scoping", simple descriptive ways to enhance understanding of context rather than explain statistical relationships, and were aggregated, not analysed or used in a way that would make the approach meaningful in terms of integration of methods. Philosophical integration exists in the chosen paradigmatic perspective, dialectics, which allows for convergence, divergence and even conflict of ideas and theories to co-exist (Shannon-Baker, 2016). It also provides continuation with IPA's inclusion of multiple voices within a homogenous sample as well as the essence of CS. The discussion brings the quantitative results into the conclusions to support and elucidate qualitative findings.

3.5 Qualitative approach

The absence of literature specifically on CS in stroke nursing makes the topic suitable for qualitative methodology (Willig, 2008), constructivist approaches to an exploratory process to deepen our understanding (Creswell, 2009). Qualitative methods emerged as part of a linguistic and interpretative turn in the social sciences (Willig & Stainton-Rogers, 2008:3) away from assumptions of objectivity associated with quantitative research, and with *the systematic and self-conscious intrusion of broader philosophical issues into discussions about methods of research* (Bryman, 1988:3). Qualitative methods involve the systematic collection, organisation and interpretation of usually text data (Malterud, 2001:483) with the aim of describing and understanding social phenomena (Willig & Stainton-Rogers, 2008:9) and emphasis on meaning (Edmonds & Kennedy, 2013).

Schwandt (2000:190) asserts that qualitative inquiry is better understood as *a site or arena for social scientific criticism than as any particular kind of social theory, methodology or philosophy*, a continuous process of acting and thinking, practice and theory, critical reflection and transformation. Its approach to the definition and

production of knowledge is marked by seeking detailed answers to 'how', rather than 'how many', description and understanding rather than explanation (Cohn, 2005; Edmonds and Kennedy, 2013) - although inductive explanation is an aim of grounded theory (Willig, 2008).

There are various types of qualitative methods with various epistemologies and methods even within the same broad methodology (Smith et al, 2009; Yardley, 2000). Navigating the literature, similarities and differences emerge between them, an exciting and bewildering process (Lyons, 2007a) in the search for answers about choice, about the *tool for the job* but more importantly *what the job is* (Smith et al, 2009:45), the research question (purpose of the research), ontological and epistemological considerations, but also pragmatic considerations (Willig, 2008). I decided to use Interpretative Phenomenological Analysis, as I explain here.

Within the range of discursive approaches (F/DA), focus would be on the social role of language in describing individuals' experiences (Biggerstaff &Thompson, 2008), critically interrogating the status quo by destabilizing taken-for-granted ways of categorizing (Lyons, 2007b) or how a concept is construed in the language during social interactions and for what purpose, or the perpetuation of power relations (Yardley, 2000). However, my focus was on experiences and meanings. Additionally, with its preference for naturalistic data, potential recruitment difficulties, and that it is *very labour intensive* (Willig, 2008:98), DA appeared too risky to the entire study. However, F/DA could be suitable for later research after some understanding had been gained of how CS was experienced and construed.

As I was not looking for systematic categorization of the phenomenon of CS in stroke care or to produce theory, but to gain insights into individual nurses' experiences of CS, grounded theory (GT) was not suitable. As already mentioned, due to my long experience of CS, I hold various preconceptions about it. Although the researcher may manage this by choosing to be reflexive, I considered the risk of bias greater if using GT due to the low level of reflexivity required (Willig, 2008:46).

Narrative and phenomenological methods have similarities in their hermeneutic epistemology (Willig, 2008:144). Narrative methods explore associations that create the plot in participants' story, a biographical narrative, from the perspective of structure and form ("story grammar"), generating insights into the structure of the narrative, its functions and its social-psychological implications in participant's biography (Willig, 2008:133). I was mindful of the lack of personal distance from the research in narrative analysis (Willig, 2008:145), that I was interested in discovering participants' experiences and meanings and keeping them separate from mine, retaining enough

control over my personal involvement while exploring participants' experiences. I was not looking for reappraisals of CS experiences (although these may happen inevitably through conversations).

Apart from its relevance to the research question, practically, IPA offered a well-described methodological package and process (Smith et al, 2009) with clear epistemological positions and concerned with how participants experienced an event and the meaning they made of it. Peer support systems (email group and regular regional meetings) to learn from other newcomers and established IPA researchers were also part of the decision-making. IPA studies have contributed extensively to research in mental and physical health, detailed in IPA evaluations by Brocki & Wearden (2006) and Smith (2011). Through this idiographic, inductive approach, analytic depth is developed of particular instances/ cases that may lead to inferences about general laws from "black swan" cases (a single case that questions, falsifies, or proves a hypothesis or law, Flyvbjerg, 2006:224) with the potential of adding to the richness of divergence and convergence in the data and to deeper understandings of CS. This is described more in the Idiography section. IPA is concerned with participants' lived experiences of a phenomenon and the meaning they make of it, in this case, stroke nurses' experiences and meanings of CS. A relevant example of the usefulness of IPA in examining nurses' lived experiences of a phenomenon and their meanings is a study by Carradice et al (2002) in which IPA was used to explore theoretical models guiding mental health nurses' assessment of family caregivers of people with dementia.

The following Methodology Table (3.6) summarizes considerations about approaching the research question based on a comparison table provided by Smith et al (2009).

Table 3.6 Methodology Table (modified from Smith et al, 2009:45)

Research Question	**Key features**	**Suitable approach**
How do nurses in stroke care experience and make sense of CS?	Personal meaning and sense-making of nurses who share the experience of CS in stroke context	Interpretative Phenomenological Analysis
What are the main experiential features of nurses' CS in stroke care?	Focus on common structure of CS as an experience	Phenomenology
What story structures do nurses use to describe CS in stroke care?	Focus on how narrative relates to sense-making via genre or structure	Narrative Psychology
What factors influence how stroke nurses experience CS?	Developing an explanatory account (factors, impacts influences)	Grounded theory
How do stroke nurses talk CS into being?	Not seeking to describe or understand the nature of the phenomenon but how it is constituted in talk as social action	Discursive psychology
How is CS constructed in verbal reports of nurses in stroke care?	Not seeking to describe or understand the nature of the phenomenon but how particular versions of it are constructed through language	Foucauldian discourse analysis

3.7 Participant involvement

Regardless of epistemological approach, researching in human sciences involves researcher's subjectivity and interpretation (Rolfe, 2005). This is stated explicitly in qualitative approaches, where participants are considered experts. Consciousness and description of "the other" involves interpretation with resulting questions about political and social implications of research, issues of power and privilege, the importance of how participants are represented in reports, and how reports are representative of participants (Lyons, 2007b). This is associated with otherness and "othering" (ibid) and the role of the researcher and of the research in relation to the participant and the data. In previous sections, I position myself in relation to this research. Lyons (2007) reflects on the power inherent in questions, the impact of (re)presenting answers, and to whom, and discusses ways for critical engagement with the self-other relationship and strategies towards a reflexive approach.

In health research, patient and public involvement (PPI) refers to consultation activities about the study with people sharing important characteristics with the study's sample. PPI usually refers to people accessing a service to monitor or improve their health condition (patients, clients). This study, however, is about those who deliver these services, not the recipients. Attempting to consider how my participants could be more influential in the study, I sought advice from INVOLVE at a conference (2011) explaining that participants were NHS staff. I understood that this group had not received much attention. Seeking such consultations with participants is not explicitly required in IPA. However, within the time limitations of this study, I made specific efforts to involve stakeholders, believing this would improve the viability and quality of the study. As my PhD upgrade panel had highlighted recruitment risks, it was important that the study was meaningful, appealing and easily accessible to potential participants.

I sought advice from a nurse about the user-friendliness of the questionnaire and from a layperson about the comprehensibility of the language. During informal site-visits, I consulted stroke nurses of various levels of seniority about the best ways to approach data collection, starting with delivering the research packs. In one acute unit, staff explained they had little time online. In general, paper packs were preferred, to be delivered to individuals by research nurses, ward managers, or coordinators (site contacts). During data collection, another unit asked for the pack (already distributed in paper) to be emailed to nurses via the ward manager. During interviews, participants named specific nurses whose meanings of CS they felt should be incorporated in the study due to their influence on strategic and executive decision-making, including

about CS. I expanded the sampling plan by inviting their participation. So, although I had devised plans at the outset, there was flexibility and responsiveness to participant involvement.

The meaningful involvement of NHS staff in all/ any stages of research about them requires more consideration, including engagement with research outputs. I plan for the results of this study to inform policies, procedures, practices, availability/ accessibility of CS, so that stroke nurses find them agreeable and helpful, facilitative in their responsibilities, development and restoration. I will seek opportunities to feed back the results to all stakeholders through local events, publications, and conferences. A summary of the completed study will be sent to all site contacts for dissemination across hierarchical levels encouraging them to consider formal dissemination activities (presentations in routine and special meetings/ events and as continuing professional development). This improves the probability of the study to effect change for individuals and their context.

3.8 Philosophical Background of IPA

Smith et al (2009) describe the philosophical foundations of IPA as being phenomenology, hermeneutics and idiography. Its concern with understanding the meaning of the lived experience of individuals positions IPA in qualitative methodology. Philosophically, IPA is based on phenomenology and hermeneutics (Smith et al, 2009; Smith & Eatough, 2006). IPA's endorsement of the idea that *understanding **is** interpretation* (Schwandt, 2000:194) and that the researcher's subjectivity in the process of understanding is not bias to be eliminated but necessary to engage with for understanding, positions IPA's epistemological stance in philosophical hermeneutics. Idiographic refers to the importance of the experience of the one individual, which is the focus of IPA. A brief description of these follows.

3.8a Phenomenology

IPA is concerned with *understanding the thing as it shows itself, as it is brought to light* (Smith et al, 2009:24) and this usually means *the lived experience* (ibid). Lived experience is a description of a phenomenon, the phenomenon in itself, our awareness of experiencing, and the meaning we make of experiencing. This dual nature of human experience is at the core of phenomenology and hermeneutics in proposing a new, human science (alongside natural sciences). As Giorgi (1995:28) explains,

[…] while the thing itself may be subject to such analyses [in natural sciences], the perception of the thing, or the perceived thing, is not. While the act of perceiving may belong to consciousness, and the thing itself is wholly outside of consciousness, the perceived thing is neither the act of perceiving nor the thing itself. Consequently, new terminology has to be introduced to account for it, and one such term is that the 'thing as perceived' is a 'phenomenon'.

Another way to understand this is Magritte's painting "The Treachery of Images" ("*Ceci n'est pas une pipe*"): It is the *image* of a pipe, or whatever the observer construes the image as, not a pipe.

Phenomenology, in its different versions, is concerned with subjective first person experience (Finlay, 2009) posited as the source of all knowledge, and with the structures of consciousness, how we become aware of phenomena (how things appear to us). Phenomenologists propose that consciousness is directed to the objects of which we become aware (intentionality). Objects take on meaning by which they are represented in our experience, and our experience of that experience also obtains meaning (within the limits of our sensorium, we notice what has significance for us). Finlay (2009:8) defines phenomenological research as involving *rich description of the lifeworld or lived experience, and where the researcher has adopted a special, open phenomenological attitude which, at least initially, refrains from importing external frameworks and sets aside judgments about the realness of the phenomenon.*

In historical context, Husserl's phenomenology arose at a time of significant intellectual activity in Europe (Vienna Circle, Psychoanalysis Circle). Husserl was a contemporary of Sigmund Freud whose case studies founded psychoanalysis; and of Einstein, whose ideas had a great impact on the philosophy of science. Husserl's search for the 'essence' of conscious experience is similar to the Platonic and Aristotelian 'form', defined as *the structure or essence of a thing as opposed to its matter or substance* (Ladyman, 2002:265). In other words, what exists beyond and/or behind the appearance.

Husserl also developed phenomenological epoché and bracketing from the ideas of Greek skeptics, to describe the practice of identifying, questioning and suspending assumptions, preconceptions, and judgments, and blocking them in a particular moment so as to understand a phenomenon of consciousness in its essence. This became one of the points in the development of hermeneutics as different from Husserlian/ transcendental phenomenology. Phenomenology is not a unified field but consists of variants developed since Husserl (Yardley, 2000), including Heidegger's hermeneutics.

3.8b Hermeneutics

Qualitative methods acknowledge researcher's position as affecting the research process and, to varying degrees, make it an explicit part of the process (Malterud, 2001). Hermeneutics, developed by Heidegger, a student of Husserl's, is a marriage of phenomenology with Aristotelian philosophy, *carried out **with** Husserl but also **against** him* (Volpi, 2007:35 emphasis in original).

*We can also understand Heidegger's choice of the term hermeneutics over such alternatives as interpretation when we remember that implicit in the Heideggerian project is the effort to regain a grasp of being that has been lost in modern times and indeed since the time of Plato and Aristotle. One seeks the "hidden weight" of ancient words precisely in order to go **behind** what is self-evident in modern thinking. This special and intense listening Heidegger calls for is necessary in order to break away from the confines of the modern world view. Hermeneutics, it will be remembered, is the discipline concerned with deciphering utterances from other times, places, and languages- **without imposing one's categories on them** (the hermeneutic problem).* (Palmer, 1980:7, emphasis in original)

Hermeneutics is an extension of phenomenology based on the idea that all forms of awareness and understanding are interpretative (Edmonds and Kennedy, 2013). Cohn (2005) distinguishes between interpretation as explanation and as understanding, linking the former with the physical sciences and the latter with human/ social sciences. In its interpretative part, IPA involves a double hermeneutic: the researcher interprets the participants' experiences and meanings (interpretations) of a phenomenon as they are contained in the data and the themes emerging from transcribed interviews (Smith et al, 2009).

As Figal (1994:236) states*: A characteristic of philosophical hermeneutics is always also to be hermeneutic in itself.* I interpret this as a reminder for reflexivity. Hermeneutics is part of Interpretative philosophies derived from the interpretation of classical philosophies and of biblical texts. In the context of IPA, the main influence has been from philosophical hermeneutics, represented by the work of Heidegger and 20th century existentialism.

Philosophical hermeneutics argues that understanding is not, in the first instance, a procedure- or rule-governed undertaking; rather it is a very condition of being human. Understanding is interpretation. (Schwandt, 2000:194)

It has been my clinical experience that by paying close attention to someone's sense-making of experience, the attender's understanding may become more extensive than the experiencer's (although the extent and accuracy can only be tentative until confirmed by the experiencer). This includes a risk of the researcher imposing their own meanings rather than capturing the experiencer's, raising the issues of "representing the other" in research, mentioned earlier. Smith et al (2009) emphasize

the importance of researchers' awareness of their own meaning-making systems operating in the double hermeneutic process, the pre-understandings they bring to understanding participants' experiences and meaning making. In hermeneutics and IPA, researcher's subjectivity is acknowledged and its influence becomes part of the process of progressive abstraction from recurring and/ or salient themes to superordinate themes.

3.8c Idiography

A commitment to an idiographic psychology is obviously closely linked to the rationale for case studies. (Smith, 1995:63)

There is overlap between CS and IPA. IPA is idiographic, concerned with the particular rather than the general, and employs in-depth case studies (Smith & Osborn, 2007). Idiographic means focusing on the particular and the individual. IPA data contain a large amount of personal information provided by the participant regarding an aspect of their lived experience and the meanings and interpretations they assign to it. Therefore, the data become in-depth case study that *lends itself to the exploration of meaning of the lived experience of some phenomenon* and to phenomenological approaches (Edmonds & Kennedy, 2013:137).

CS can also be seen as a process of reviewing, developing, and evaluating a clinician's work through the oral presentation of one or more case studies the focus of which may be a patient/ service user, a group, or (an aspect of) the organization. Smith (1993) sees the collection of patient data in clinical work as very similar to the construction of case studies. In contrast to nomothetic approaches to knowledge that use large samples the purpose of which is to generalize to the wider population, idiographic research does not average out individual variation (Willig, 2008) but instead facilitates the systematic production of exemplars (Flyvbjerg, 2006).

A case contains a detailed set of information about a person or a group of people (an organization or a social unit) obtained through various qualitative and quantitative methods. Willig (2008:74) clarifies that the case study is not considered a research method as such but *an approach to the study of singular entities*, analyzed with various methods. It demonstrates existence rather than incidence of a phenomenon. Thus although they are considered rigorous when carried out thoroughly, case studies are usually not generalized to the wider population (Smith et al, 1995).

Willig (2008) describes five core characteristics of case studies:

- Their idiographic perspective focuses on the individual, the particular rather than the general.
- Attention to contextual data is required by the holistic nature of case studies. Smith et al (1995) state that case studies may highlight the necessity to account for factors they reveal but which may have been overlooked or not identified when studying large groups.
- Integration of a range of data collection and analysis techniques through triangulation, which facilitates diversity in the vantage points from which to consider the case.
- A focus on change and development which means that there is a temporal, processual element to case studies.
- Facilitation of theory generation and development through detailed exploration of the particular, leading to validation or falsification of existing theory.

Case studies demand a great deal of self-reflection from participants (Smith, 1993; Willig, 2008). This gives a case study 'depth' which can aid understanding of data from "black swan" cases (Flyvbjerg, 2006:224); question or falsify existing theories; show directions for further elaboration and refinement (Smith et al, 1995, Flyvbjerg, 2006; Willig, 2008). So, a *good case-study usually either 'disconfirms' our expectations, or reveals things that were not expected* (Smith et al, 1995:64).

Data from the detailed examination of a combination of case studies which have been subjected to as little preconceived categorization as possible can be used to test or contribute to existing theory or formulate new theory. This does not involve statistical generalization, it does not estimate frequencies in a population; it offers analytic generalization to expand and generalize theory through new insights (Smith, 1993; Willig, 2008). Beyond the exploratory role in under-researched topics to identify specific issues or characteristics and their associated hypotheses, case studies offer practical, context-dependent knowledge that facilitates and demonstrates achievement of high levels of expertise (Flyvbjerg, 2006). *The role of the researcher is that of a witness or* a reporter (Willig, 2008:88) who provides a detailed, accurate, and neutral description. Although researcher's own thoughts and theoretical background are also important and made explicit in the report, interpretations of the observations require a high degree of fidelity to the original data.

Flyvbjerg (2006) argues that extensive oversimplification of the purpose and usefulness of case studies has led to misunderstandings. He highlights that, depending on the case and how strategically it is chosen (2006:225), it may be possible to generalize, and discusses historical overturns of accepted knowledge

through case study work. He points out that social science has failed to produce context-independent knowledge, while case studies have provided information to challenge accepted theories, as they lend themselves to falsification, not verification.

I close this section with discussion about IPA in relation to the three epistemological questions pertaining to methodologies that Willig (2008:12-14) proposes:

3.9 Epistemological questions about IPA

3.9a What kind of knowledge does IPA produce?

IPA is an idiographic method. This means that it is concerned with the meanings and experiences of the individual. Epistemologically, IPA is situated in phenomenology and philosophical hermeneutics (discussed earlier). Essentially, this means that IPA is used in *the detailed examination of human lived experience* (Smith et al, 2009:32), the meaning an individual creates of life experiences that are *bigger and more significant* to him/her, at deliberately reflective and pre-reflective or intuitive levels (Smith et al, 2009:188). IPA also examines the way this meaning is made, participants' thoughts, feelings and beliefs about the phenomenon.

The main objective in IPA is to understand and make sense of participants' meanings of the phenomenon under investigation through the researcher's attempt to gain insider's views by attending closely to the participant's accounts of experiencing the phenomenon. The focus is on how things are understood from a personal, subjective point rather than on what happened as description of events (Larkin, 2011). A dual process of interpretation, known as a double hermeneutic (Smith & Eatough, 2006) is identified and reported on: one aspect of the duality is the participant's perception and meaning of their lived experience; the other is the researcher's interpretation of how the participant is making sense of that particular experience, how the researcher understands the participant's understandings and meanings of an experience. The double hermeneutic is an acknowledgement that direct, unmediated access to another's personal meanings is impossible (Willig, 2008: 69).

By working towards interpretations close to the original transcript of a participant's account through the researcher's own subjectivity, IPA honours Schleiermacher's view of hermeneutics as *the art of avoiding misunderstandings* (Cohn, 2005:221). Hermeneutics of empathy is the lens filtering the researcher's understandings rather than any formal theory, such as psychoanalysis (Smith et al, 2009). IPA's position regarding interpretation is that it emphasizes inter-subjective understanding rather than (theoretical) explanation.

The knowledge that can be produced through IPA is *reflexive* (Willig, 2008:69) as it is acknowledged that the interpretations are influenced by/ dependent upon the researcher's own beliefs and views. Privileging subjectivity through its idiographic character, IPA presents an additional direction to research, particularly in cognitive psychology (Larkin et al, 2011; Smith et al, 2009; Smith & Eatough, 2006), and a research method described in helpful detail for in-depth understanding of individual meaning-making processes in the form of case study.

3.9b What kinds of assumptions does the methodology make about the world?

IPA can be seen as aligned with *relativist ontology* (Willig, 2008: 70) as it assumes that there are as many realities about an event as individuals experiencing the event. Facts depend on the perception of the individual who experiences them. Different individuals experience the same phenomena/ events of the external world in entirely different ways. Interpretations vary according to factors affecting how they perceive, process, experience them (prior learning, preconceptions, beliefs).

Smith et al (2009:196) develop this towards

a less strong form of social constructionism than discursive psychology and FDA. […] *While IPA studies provide a detailed experiential account of the person's* ***involvement*** *in the context, FDA offers a critical analysis of the structure of the context itself and thus touches on the resources available to the individual in making sense of their experience* (emphasis in original).

Perceptions of reality, as held and recounted by individuals, change over time and in response to personal and social/ environmental factors. In IPA, individuals' subjective perceptions, meanings, experiences of the world are prioritized rather than objectivity in description or the external world as determining experience. A symbolic interactionist perspective is adopted, acknowledging that perceptions and meanings are not developed in a vacuum but are mutually influenced by the place, historical time, and sociocultural, linguistic and relational context in which the individual has been living and interacting (Smith et al, 2009:194; Willig, 2008:70). This includes the perspective of the researcher.

3.9c How does the methodology conceptualize the role of the researcher in the research process?

The IPA researcher is part of the double hermeneutic: His/her own preconceptions, judgments, beliefs, and meanings enter data analysis in the attempt to understand the participant's sense-making. However, the initial task is phenomenological description, to become aware of and suspend (bracket), to the extent possible, researcher's own ways of constructing meanings in order to capture the richness of range of interpretations possible in line by line reading of transcripts as well as within the hermeneutic circle. The researcher pays detailed attention to the particular meaning and place of words in the narrative but also in relation to the whole transcript, and the reverse: how the meaning of the whole account is understood through specific meanings of words/ lines within it. This is accomplished by starting the analysis with repeated readings of the participant's account withholding interpretative activity on the transcript while noting researcher's reactions elsewhere.

The researcher records his/her own cognitive processes whereby understanding is attempted. Awareness of one's own beliefs, preconceptions, judgments, etc. are acknowledged and the extent they contribute to understanding the participant's meanings and ways of arriving at these. This process is similar to phenomenological attempts to arrive at the essence, 'the thing itself', the phenomenological experience of the participant (Smith et al, 2009: 188) to fundamental truths beyond appearance.

Although Smith et al (2009) describe the method systematically, they discourage using IPA as if following a manual when dealing with the data. Researchers' individual and creative ways of IPA, allowing their own reactions to the participant's accounts to be acknowledged and worked with in relation to the transcript, provides part of the interpretative aspect of IPA (Larkin et al, 2006). Smith et al (2009:189) emphasise the importance of reflexivity for the purpose of data collection (how the interviews are conducted) and during data analysis, describing *layers of reflection* that analysis may undergo (pre-reflective reflexivity; pre-reflective experience; attentive attention on the pre-reflective, and deliberate or controlled reflection).

3.10 Data in IPA

Most of the instructive works about IPA present the analysis of spoken (interviews) or written accounts (diaries) and more recently focus groups that evolve by describing the researcher's reflective journey into the transcript during analysis. Semi-structured interviews are commonly used for data collection. Interviews are conceptualized as very loosely semi-structured (Biggerstaff & Thompson, 2008). The purpose is to give participants ample opportunity to provide their account of an experience of a phenomenon and the meaning/s they created. Although there is an interview schedule (appendix 3), its purpose is for guidance rather than adherence, as the participants' meandering in the narrative is more important than the topics on the schedule. Interpersonal rapport is emphasized to facilitate the attainment of rich data that will allow in-depth understanding of the participant's meanings

In data analysis, IPA allows the gradual infiltration of the researcher's meanings into his/her understanding of participant's meanings, moving from a phenomenological stance to an interpretative one: *understanding requires the engagement of one's biases* (Schwandt, 2000:195). Once the early awareness-oriented reading of transcripts has occurred, the participant's account is interrogated in a dance between the hermeneutics of empathy and hermeneutics of suspicion (Smith et al, 2009:107), that is from understanding the account as presented by the participant, to asking questions of the data and potentially reaching understandings that the participant may not have been aware of. Individuality of the account is maintained through treating each participant's account as a case study to be understood without interference from other participants' accounts.

3.11 Sample size in IPA

IPA studies are conducted on relatively small sample sizes, and the aim is to find a reasonably homogeneous sample, so that, within the sample, we can examine convergence and divergence in some detail. (Smith et al, 2009:3)

However, later (p.51) the authors state: *There is no right answer to the question of the sample size.* This is a frequently appearing issue in the electronic IPA discussion group, demonstrating conceptual difficulties perhaps involving oversight of the significance of IPA's idiographic nature, which requires time-consuming, in-depth interpretation of data for each participant individually.

In their review of literature regarding qualitative non-probabilistic purposive sample sizes, Guest et al (2006) report various numbers offered by various authors. They indicate that for phenomenological research, the minimum recommended sample size

varies from six (cf. Morse, 1994:225) to 25 (cf. Creswell, 1998). The matter is complicated further due to importing concepts such as saturation from other qualitative methods. Saturation derives from grounded theory and pertains to the number of interviews necessary until no more new themes emerge from the analysis of interviews (Guest et al, 2006). Saturation is not a predictive concept or mechanism, it occurs in the process of the analysis rather than during the planning of the research - which renders it of limited use when planning a study. The closest such concept in IPA could be termed within-case saturation, the point when the researcher can stop searching for themes within one transcript.

When employing IPA, a single case may be used or a small number of them (Smith et al, 2009:51). *Yin* [1989] *makes the important claim that case-studies do not follow a sampling logic. He suggests that each case is equivalent to one study in a chain of experiments rather than one of the participants in a single experiment* (Smith et al, 1995:67). IPA presents various considerations and options regarding how to manage analysis and the level of commitment to depth of analysis for each case when the number of cases is large. Brocki & Wearden's review of IPA studies (2006) found that sample sizes ranged from one to 30 while Smith and Eatough (2007) state that IPA samples have ranged from single case study to 42. They warn of the risks of the researcher becoming overwhelmed by the analysis where the sample is so large and of compromising the quality and depth of the analysis to fit the timeframe of the research. Recommendations about sample size have included: one to three cases for a Masters level IPA study, and 3-6 for a professional doctorate study (Smith, et al, 2009; Thompson et al, 2011) with PhD more difficult to explicate. Hefferon and Rodriguez (2011) consider IPA misunderstood and misapplied, not least in terms of meaningful sample size (*More is not always more*, p. 757) with pressure being exercised on research students about the size of the study's sample and its respectability, meaning large enough.

In the present study, sample size was considered during planning but also during data collection. At planning, the alert (at upgrade viva) about this population being difficult to engage especially for a whole hour was heeded, including the potential risk to depth (in short interviews). The early interviews indicated that the experience being made sense of was about *not* having CS. A small sample size would have limited the opportunity to capture the richness sought in the research question. Later interviews provided information of participants' experience and meaning of CS as it was understood in the literature. Although fifteen interviews could be considered a large number for an IPA study due to data overwhelm (Wagstaff et al, 2014), here, this led

to capturing more fully the divergence of understandings participants associated with their experience of CS, including its absence.

3.12 DESIGN

The study aimed to find out:

What are stroke nurses' experiences of CS? What does CS mean to stroke nurses?

To achieve this, the following methods of data collection were employed:

5. Individual interviews to understand their experiences and meaning/s of CS
6. A questionnaire to obtain basic numerical indicators about current availability and arrangements for CS in stroke services.
7. Field observations at interview participants' work contexts
8. A pro forma describing each service from which participants were interviewed (Nancarrow et al, 2009)

The sequence in which these methods were employed was based on what seemed the best way to introduce the study and invite participation. The study was initially discussed with service leaders/ managers who managed how participants would be informed, including researcher presenting the study at formal meetings, and how the research packs were distributed. Using the questionnaire before interviews served as a formal/ written introduction to the study. An invitation to participate in the interviews was enclosed with the questionnaire. This allowed participants time to consider participating. Consideration was given to whether this order/ the questionnaire content would prime or bias participants' accounts during interviews. As the key topic was about participants' experiences and understandings, it was decided that the questionnaire could trigger reminiscence and reflection processes contributing to richness of data.

Expecting that the questionnaires would be returned before interviews were conducted, replies to the questions could have informed the interview schedule (in addition to original schedule). This strategy was of limited value, due to the coinciding times that completed questionnaires arrived and interviews occurred. To monitor priming effects, interview participants were asked whether they had completed the questionnaire. Most interview participants had. One linked the questionnaire with the interview, saying she had provided similar responses in both about a specific issue. Others just confirmed that they had completed the questionnaire but did not discuss any effects of this on the interview.

Observations were noted after each visit to a site. A formal observation visit was arranged with each of the sites from where staff volunteered for participation in interviews. In appendix 5, selected relevant information from the notes is provided with descriptions of each context where interview participants worked.

Finally, the service pro forma was sent to the contact people in sites where interview participants worked. Numerical information from these is included in site descriptions.

3.13 ETHICAL ISSUES

Here, I present ethical considerations in the design of the study, how I had planned to manage them and what happened. Following the upgrade viva, the following reviews and permissions were obtained:

- Independent Scientific Review from CLAHRC
- University of Sheffield Ethics committee of the School of Nursing and Midwifery
- Patient and Public Involvement (PPI) review
- The Research and Development department of each of the five NHS Trusts approached to participate.

Ethical considerations were included in the study protocol sent to reviewers.

3.13a Incentives

No material incentives for participation were available, but participation could be reflected upon and used as part of participants' continuing professional development activities.

3.13b Voluntary participation

The information sheet made clear the voluntary nature of participation, which was also discussed with site-contacts. It was also made clear that it was not possible to withdraw one's questionnaire data after it had been returned because questionnaires were not personally identifiable (only marked with code for workplace).

3.13c Psychological impact of data collection methods on participants

Although CS is a topic unlikely to cause upset, discussing experiences and working on meanings may (Thompson & Russo, 2012). In the case of the questionnaire, participants could choose to stop completing it at any point and even withdraw by not returning it. The same was the case for interviews. Beginning the interviews, I discussed with participants that if they felt negatively affected by the interview experience, they should inform me and consider the options of taking a break or discontinuing, or withdraw from the study altogether. If participants were distressed, I would have a discussion about sources of help such as their staff counselling service or GP. To prevent untoward emotional impact, I maintained an empathic inquiring approach.

At the end of each interview, I asked participants how they felt and if anything about our conversation had disturbed or upset them. None reported any adverse reactions, and several expressed gratitude for the opportunity of a rare reflective experience (one spoke of the interview as similar to CS) affording insight into their understanding of CS and appreciation that they had more knowledge than they initially thought.

3.13d Measures to ensure participants' anonymity

Anonymisation is the default position and one of the ethical issues addressed in various papers about ethical standards in qualitative research (Allmark et al, 2009; Hadjistavropoulos & Smythe, 2001; Thompson & Russo, 2012; Walker, 2007). In the present study, no option was offered for participants to be personally identifiable. The questionnaires only had a site identifier to enable reminders to be sent through the site-contact and for summarising data per location; no other identifying details. For clarity during inputting, upon receipt, questionnaires were given a number identity to avoid repeated entries and confusion. This number was the order of input, thus unrelated to any of the participant's personal details.

For the interviews, personal/ contact data, including consent forms, were separated from questionnaires immediately when they were received and kept separately from transcripts in a locked cabinet. Transcripts were identified by respondents' codenames and as per guidance on the UK Data Archive website (accessed 25/6/2012) about keeping data as accurate as possible. Pseudonyms, replacement terms, vague descriptors of job titles or systems of coding were used to retain maximum content while protecting participants' identity. Where participants identified colleagues by name and the section of the transcript was quoted in analysis, the job title was used instead of the name to maintain comprehensibility of data. Some transcripts were shared with my research supervisors in the course of analysis to seek feedback and improve the study's validity. Participants had been informed (via information sheet) about this and about using transcript excerpts in writing up. To protect anonymity, transcripts will not be publicly available. Any other identifying data were kept in password protected memory devices and lockable cabinets, in accordance with University guidance.

3.13e What happens to the data after the study ends?

The recordings of the interviews will be destroyed after the final version of the thesis has been accepted post viva. The transcripts will be kept on a password protected memory device. The memory device and the returned questionnaires will be kept in a locked cabinet in the University for seven years, then they will be destroyed.

3.14 RECRUITMENT AND DATA ANALYSIS

3.15 Sampling strategy

Once permissions were received from R&D departments, I met with the contact person on each site, reminded them of the research and discussed how they could help. The site contacts were service managers, clinical leaders, research nurses, or stroke coordinators. All had previous involvement in CLAHRC research, having recruited to other studies. Many were acquainted with my research supervisors. They had different preferences: For Hyperacute, Stroke Rehabilitation 1, Stroke Units 3 and 4, the contact persons asked for the research packs and distributed them (I did not meet prospective participants for recruitment purposes). In Rehabilitation 2 and Stroke Units 1 and 2, the contact persons received the packs from me and distributed them. Then, they arranged meetings with prospective participants for me to discuss the study. This was how questionnaire participants were recruited.

Participants for interviews were primarily recruited through invitations enclosed in the research packs. One person (new to the research site) asked to be contacted after an informal conversation with a colleague who mentioned this study. I emailed her the research pack and arranged the interview a week later. Another interview participant was recruited after a participant suggested that participation from the strategic level of hierarchy would be illuminative to experiences and meanings of CS in their organization. I contacted the office of Chief Nurse, explained about the study and requested an interview; the interview participant was someone from that hierarchical level (but not the Chief Nurse).

Three contacts from the interview sites provided information describing their services on a pro forma sent them.

3.16 Recruitment: process and participants

All participants were qualified nurses of various levels of seniority working in NHS Trusts in four urban centres in northern England. To enable homogeneity, all except one worked in a context providing care to stroke survivors, consistent with the need identified earlier for research in this particular topic. No students or auxiliary staff were recruited, as they are not autonomous practitioners, their roles and functions are different and so (perhaps) their needs from clinical supervision. The nurse who was not directly involved in stroke care was a high ranking executive recruited after a

participant's recommendation that this would enhance contextual understanding due to their powerful influence on decisions in the Trust.

In visits before data collection, I met clinical leaders, managers, medical consultants and potential participants while acquainting myself with the context. I attended several service meetings to introduce the study and invite participation. The number of meetings varied according to the availability of staff time. However, I visited all sites at least twice, once prior to the research being locally approved and once for the delivery of the research packs. I visited sites of interview participants more than this, for observations of the context. After authorisation was given by each Trust, I delivered the research packs to site-contacts (managers, clinical leaders, or research nurses) who handed them out. The packs contained the questionnaire, an introduction letter/ invitation, participant information sheet, pre-paid reply envelope, and invitation to interview.

Where attendance at service meetings was not possible, I liaised with site contacts to deliver the questionnaires, clarifying that their role was to inform staff of the study and distribute the questionnaires and that no pressure should be placed on staff to participate. I made it clear that no material incentives for participation were available, but participation could be reflected upon and used as part of participants' continuing professional development activities. A response time of two weeks was given to return questionnaires. Following this, reminders were sent to site-contacts where recruitment had been low to remind (prospective) participants on that site. Questionnaires arriving after the deadline were still included, and the last one was received a few months later.

In what follows, I describe methods in chronological order used, to facilitate coherence, starting with field visits, then questionnaires, interviews, and proforma.

3.17 Observation visits

Bannister et al (1994) argue that all psychological research methods include some element of observations from simple measurement instrument readings to observations of group interactions. I arranged to visit sites before and after study authorisations. The main purposes (but not exclusive of each other) were: before, to facilitate recruitment, and after to observe the context in which participants' meanings and experiences occurred. The effectiveness of these as recruitment strategies varied. Some managers who had agreed to meet me were absent on the day (without notification). There was usually no specific format how to meet potential participants

(service managers and leaders varied in their organisational abilities). I attended twelve meetings where I discussed the purpose of the study and data collection strategy with stroke nurses. During these, nurses made it clear that they would prefer a paper questionnaire to a web-based one. Later, some asked for the document to be emailed to them via the site-contact to enable access and printing if they lost their paper copy.

I made unstructured notes of naturally occurring behaviours, the most relevant of which I have included in the descriptions of each site's context in data analysis. Bannister et al (1994) suggest headings to guide observations including: description of context, of participants, of the observer, of participants' actions, and search for meanings of these, including alternative meanings, using observer's feeling (reflexive analysis). The purpose of observations was to understand some of the context of participants' experiences and meanings of CS. My role during these visits varied, and if I had an ID card, it would describe me as a visitor or external researcher.

According to Junker's typology of field observation (1960/ 2004), in rehabilitation –and to a smaller extent, in SU2- I was initially a visitor, then *observer as participant* (p. 224) once I was a face known to the staff as a researcher. In SU1, my role was usually the *complete observer* (ibid). Although Junker suggests that this role is not found naturally, this would be the closest description of me occupying a plastic chair in the middle of the ward's long corridor, observing and writing notes, having informed some staff of my role, but not all of them and certainly not the patients or their relatives by whom I was surrounded. When the matron emerged from a door, I felt I was completely obvious and quite hidden at the same time, as I had been for the rest of the people for most of the observation time. At meetings, I was a visitor, there to discuss an issue and depart.

3.18 Questionnaire

I developed a questionnaire to map availability and quality of CS. This was delivered to qualified stroke nurses for anonymous completion (part of the research pack). To minimize bias, care was taken to be specific and avoid jargon and leading questions (Fife-Schaw, 2006). Its construction has been guided by definitions and descriptions of CS (eg. Milne, 2009). I discussed the questionnaire with research supervisors and checked for linguistic clarity through seeking feedback from a layperson who speaks English as a second language, and from a nurse unrelated to this study. Feedback

was very positive about its comprehensibility and user-friendliness with few phraseological or conceptual changes suggested (final version, appendix 3).

In the introduction, issues of response-tracking and confidentiality were explained. Questions had "tick box" answers beginning with demographics: participants' gender, age and position/ grade. This information was important, as CS in nursing gained most publicity in the past 20 years. Positions of leadership and supervision require sufficient clinical experience, therefore, some senior staff may or may not have reflected on the debates; this would influence their views and actions about CS. Participants were then asked about their status (supervisee, supervisor and whether trained in CS) and invited to continue the rest of the questions regardless of whether they had CS arrangements.

A section about arrangements follows (questions 7-13), to find out about frequency, duration, format, how time for CS is obtained, and about the respondent's supervisor. The next section (questions 14-20) is about the effect of the supervisory relationship/ alliance on the respondent and perceptions of activities that may meet the formative, normative and restorative functions of CS. There is space after each question for respondents to give more information, exploring the possibility that even if no formal arrangements for CS exist in a service, to some extent, CS functions may still be met through other means.

Questions 21-25 invite the respondent to reflect on qualitative aspects of their CS and evaluate it. Positive and negative effects and the direction of feedback about the supervisory process are addressed. The questionnaire closes with a free text box and an invitation to participate in interviews.

Completing and returning the questionnaire was interpreted as consent to participate in the questionnaire part of the study.

3.19 Interviews

As CS in stroke care is a complex and minimally researched phenomenon and its uptake likely associated with subjective perceptions of it, accounts of nurses' experiences and meanings are best elicited through semi-structured interviews (Breakwell & Rose, 2006) that offer rich descriptions and opportunities for clarification. Focus groups were also considered. Interviews were preferred for the privacy afforded to participants to share their views without the possibility of censorship due to fear of work-related consequences from speaking openly among colleagues.

Most interview participants were contacted after returning the interview invitation with their contact details and we arranged interview appointments. Two participants came forward to be interviewed, with their manager's permission, on days when I was visiting the site. Interviews took place at mutually convenient times and in a comfortable and confidential environment (Millar et al, 1992) in participant's workplace or the University. Interview duration varied from 20 minutes to over an hour. The most frequent duration was approximately an hour. One interview that took place at the end of the day lasted about two hours. Some staff offered to be interviewed during their break times, meaning that the interviews were short, about 20 minutes. I had reservations about depth of data, but discovered the importance of interpretation in informing questions during interviews and data analysis.

As discussed under Recruitment, to monitor priming effects, I asked interview participants whether they had also read the questionnaire. Thirteen of the fifteen had. However, it was not possible (and in retrospect, perhaps not necessary) to monitor such effects, as participants gave specific examples from their own experiences. In line with IPA, interviews were minimally structured, allowing participants plenty of opportunity to express their views and experiences. I facilitated by asking clarification questions on the material provided by the participant, checking my understanding of the material. Near closure, I consulted the interview schedule for any remaining questions.

Quality of interviews is a fundamental factor in study validity. Conducting interviews is complex, labour-intensive activity where uncertainty and tricky issues abound (Bannister et al, 1994). The introduction included a discussion of the interview purpose, inviting participants to seek any further clarification. Confidentiality issues were discussed clarifying that the researcher would take no action regarding grievances or complaints that participants expressed regarding their work circumstances, and that although unlikely, it may become necessary to breach confidentiality, if instances of criminal activity, abuse or risk to life were disclosed. All participants had read the information sheet at least 24 hours prior to the interview and had no questions. After checking this, they were asked to sign the consent form. The interview questions started with demographics information (on a form), then, with the participant's permission, the recording device was switched on.

I encouraged participants to say as much as they felt was safe and comfortable for them, making it explicit again that they could stop any time, for any reason, and this would have no adverse consequences. I sought depth in the content of the interview through empathic responses, summarising my understanding, and sensitive curiosity/

questions. Two participants asked me to stop the recording to share specific instances in absolute confidentiality. In the event of any adverse psychological effects from the interviews, I would have discussed potential sources of help such as the staff counselling service or their GP. None of the participants reported any negative effects.

Establishing rapport is important when conducting in-depth interviews. I often reflected on the nature and boundaries of such rapport and my obligation to honour the trust (Bondi, 2013; Cohn and Doyle Lyons, 2003). Starting with minimizing anxiety through briefing the respondent about the purpose and nature of the interview, how it would be conducted, and with openness in replying to respondent's questions to help them feel at ease, I maintained and enhanced rapport by being both personable and professional, listening carefully and conveying and checking the accuracy of my understanding of the respondent. I also noted paralinguistic elements like tone and volume of voice as also important (Berry, 1999).

My role was that of facilitator mindful of the personal and potentially sensitive nature of the data, the power inherent in questions and the possible impact of asking them, and the power dynamics in the interview interactions (Bannister et al, 1994). The interviews were minimally structured and flexible. I attempted to be as responsive as possible to the participant (Bannister et al, 1994), prioritising the material they brought, asking clearly phrased, open-ended, single questions and giving the respondent time to consider and answer them; following a sequence of behaviour/ experience first, and opinion/ feeling after; using "funneling" (moving from broad to specific questions), probes and follow up questions, seeking clarification and confirmation of accuracy of understanding; and managing the range between participants' experience of freedom to talk and maintaining relevance to the topic (Boyce and Neale, 2006; Berry, 1999).

Allmark et al (2009) consider ethical issues in the use of in-depth interviews and present themes of: privacy and confidentiality; informed consent; harm; dual role and over-involvement; politics and power. I also considered these and accommodated or managed them in preparation and while conducting the interviews. Participants' good interpersonal skills and friendliness made it easy to establish rapport. At no point was I in dual role (researcher and friend or immediate colleague).

3.20 Sample size

The questionnaires were contained in research packs distributed to 149 qualified nurses working in stroke services in seven research sites across four geographical areas.

Recruitment to interviews was via an invitation at the end of the questionnaire. Although not opposed to larger samples and the possibility of generalising for larger populations (Brocki and Wearden, 2006), IPA's idiographic approach allows small samples, including N=1, for in-depth understanding and analysis of individual's meanings about the phenomenon being researched. The minimum sample for a professional doctorate study is 3-6 (Thompson et al, 2011; Smith, et al, 2009). Smith et al (2009) address the question about IPA size for a PhD but do not answer it numerically. Instead, they suggest adding depth to the analysis by treating each interview/ participant as an in-depth case study. I had planned to interview 15-20 participants to ensure there would be enough transcripts with rich data for in-depth analysis and to enable exploration of convergence and divergence. In total, I conducted 16 interviews. The recording of one of these (the 3rd in the series) was lost due to undetected battery failure in the instrument, leaving 15 for analysis. This amount of interviews enabled a picture of the diversity of meanings and experiences that stroke nurses have not only of CS but also its absence.

3.21 ANALYSIS

3.21a Interview data

The transcript of each interview in the present study was analysed using Interpretative Phenomenological Analysis (IPA) following Smith et al (2009) who encourage an individualistic approach and creativity in the use of the method. I kept research journals which proved invaluable: I recorded a variety of topics, including site descriptions, observations and my emotional responses to them, points of "stuckness" and frustration in the research process and associations of these with events in my past, helpful references, websites, and online videos that would be useful immediately or later; and my reactions to some of my reading. For example I found Willig's (2008:2) metaphor of research as a cooking recipe empowering, not because I follow recipes but because I enjoy cooking, a helpful metaphor in the battle with my sense of incompetence as a qualitative/ IPA researcher early on. Thus I restored my enjoyment and, in the process, adapted the metaphor to PhD research as a banquet.

The journal also contained my observations of my reactions to some of the experiences reported by participants, for example, the distress of nurses witnessing patients' deaths, and which they were expected to manage -at best- by having time alone in an office. This was not so much about my own reactions to death but about what I perceived as lack of care and compassion for staff. I also recorded some of my reactions to specific participants. For example, while analysing "Steve's" interview, which was also the first one, I discovered through the notes in the journal that his laughter added to the ambiguity of his communication style and potentially had adverse effects on his communication and relationships with the staff he managed. This led to my returning to the transcript having overcome an obstacle, and adding one more category and colour to the descriptive, conceptual and linguistic characteristics that Smith et al (2009) suggest: the paralinguistic, acknowledging the power of this in the interview/ relating to me, and its manifestations in the experiences "Steve" discussed in the interview.

Initially, I read each transcript at least twice to ensure an overall sense of what the participant said, noting my observations in the research journal. During readings of the transcript afterwards, I noted my understandings in the large margin of the transcript, using colour to mark descriptive, conceptual, linguistic, and paralinguistic elements, working towards identifying themes emerging from my understanding of the participant's meanings of their experience (double hermeneutic), bearing in mind the

general sense from the entire transcript and revising my understanding of it through particular meanings of particular words or lines (hermeneutic circle). Photograph 1 illustrates this (appendix 4)

When I thought internal (in-case) saturation had been achieved, that enough themes had emerged, I wrote them out as small paper notes. I placed the theme-notes in a container, mixed them up and arranged them randomly on a large surface, like a table, and sought conceptual links between themes. The names of such links became superordinate themes under which theme-notes, which had that concept in common, found a conceptual roof (cumulative coding, Larkin et al, 2006). Photographs 2 and 3 illustrate this (appendix 4). I analysed transcripts one by one to preserve the idiographic nature of the methodology by limiting the influx of interpretations from analyses of other transcripts. When analysis of one transcript was complete, I moved on to another.

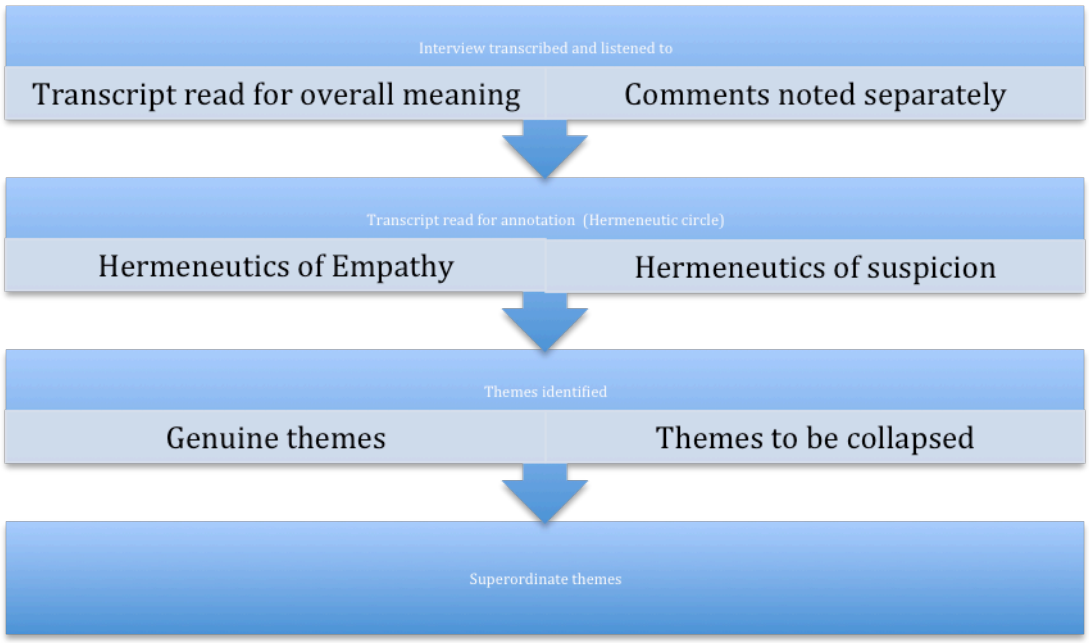
In preparation for the conduct of the study and throughout, I sought to improve my knowledge and skills regarding mixed methods, qualitative research (autumn 2011) and IPA in particular. These included IPA training with Drs Elena Rodriguez and Kate Hefferon, a workshop with Dr Michael Larkin where other IPA research-in-the-making was also presented, a monthly IPA researchers' group (3 hours each) where various IPA researchers presented their work (Drs Catherine Berry, Cheryl Hunter, Jeanne Broadbent) and issues pertaining to epistemology were discussed extensively (Dr Michelle Bastian). I also attended a qualitative methods conference in Derby University (2013), ethnography meetings, a session on evaluating mixed methods research with prof Bryman.

Attendance at monthly regional IPA meetings, membership of an IPA online group, and discussions with my research supervisors not only expanded my understanding of specific IPA issues, but also facilitated awareness of my own preconceptions and validated or challenged my interpretations and themes. They also improved my confidence as a qualitative researcher. When I had analysed all the transcripts, my supervisors and I met for two hours, discussed issues of divergence and convergence and arrived at summative themes across cases (integrative coding, Larkin, 2006). Photographs in appendix 4 illustrate this process.

I chose to do the analysis manually rather than using a computer programme such as Nvivo because I attended a course in the use of Nvivo early in the second year of the PhD. After the first two interviews, which occurred several months after the course, there was a period of more than two months when no more participants came forward for interviews. I anticipated that the final sample would have been too small to use of

Nvivo which was incompatible with Apple computers that I was using at the time (Wagstaff et al, 2014). Additionally, I keep informed about environmental issues and avoid wasting electricity. Apart from these practical reasons, I felt that I needed to be personally involved in this process and experience all dimensions of the bigger picture as it was developing for each case, with the themes spread out on a large area so that not only could I see them clearly, but also be comfortably in control moving them around in creating superordinate themes.

Diagram 3.21a: Analytic process of each interview



3.21b Questionnaire data

Data from the questionnaire were processed through SPSS to provide frequencies of responses for each answer about the current situation regarding clinical supervision in stroke services. Although Excel could manage this work, I chose SPSS over Excel because SPSS is designed for statistical analysis. I treated its availability through the University as an opportunity to refresh my knowledge of it.

SPSS keeps the data separate from the output, which helps prevent accidental overwriting of data. SPSS allows for further statistical analysis in future, if the data can be used beyond this study (with necessary permissions).

3.21c Service pro forma

The service pro forma developed by Nancarrow et al (2009) was used to understand service context through descriptions of interview sites. This instrument enables detailed quantitative description of the components of complex services, including delivery and organization, thus enabling contextual comparisons. It was originally constructed for use in intermediate services for older adults, which are heterogeneous, and captures a variety of important information that facilitates comparison.

4. FINDINGS

4.1 Introduction

This section contains the findings of the study presented in three parts:

The first part contains the quantitative analysis from the questionnaires created to allow a general view of clinical supervision (CS) in stroke nursing in this region and a general understanding of current practice of CS in relation to ideas found in the literature. Questionnaire data were organised and presented as frequencies.

The second part contains the qualitative analyses of all 15 interviews from verbatim transcripts. Each transcript was analyzed in depth, respecting participants' willingness to contribute their time and voice. Descriptions of each participant are followed by tables of themes and subthemes with keywords or phrases for the subthemes. Participants' names are pseudonyms and when other people's names are mentioned, they have been replaced with [name] or their job title (if known). For contextualization, the themes and subthemes for each participant are presented under the title of their workplace. After looking for patterns across cases, superordinate themes were identified (Smith et al, 2009:101). These are presented and discussed after the individual case analyses and include quotations from interviews to elucidate their construction.

In the third part, information from the quantitative and qualitative analyses is combined to enhance understanding and inference.

4.2 QUANTITATIVE RESULTS

This section presents the results from the survey. As stated previously, the purpose of these data was to give a general idea about clinical supervision (CS) in the participating stroke services rather than examine any relationships between variables. Summary tables describe the results in frequencies, starting with demographic information, then data about specific elements of CS.

In total, 149 questionnaires were provided to contact persons in seven stroke care services: four acute stroke units (106 sent, 26 returned: return rate 25%), two rehabilitation units (30 sent, 21 returned, 70% return rate, mainly from the service that participated in the interview part of the study), and one hyperacute unit (13 sent, two returned: 15%). Forty-nine questionnaires were returned containing varying degrees of completion. One questionnaire (50) was returned completely blank. Although the meaning of this gesture warrants consideration, it has not been taken into account in

the quantitative analysis. The responses in the remaining 49 questionnaires were processed through SPSS with the purpose of examining frequencies in aspects of clinical supervision provided in stroke care nursing.

4.3 QUESTIONNAIRE DATA

The first page of the questionnaire elicited demographic information, and is the only page that has been most fully completed across the sample. This was because several participants did not have clinical supervision arrangements as such and therefore did not answer many of the questions in the rest of the questionnaire.

Table 4.4 Summary table of questionnaires returned by site

Site	**Delivered**	**Returned**	**%**
Stroke Rehabilitation 1	19	17	89%
Stroke Rehabilitation 2	11	4	36%
Stroke Unit 1	42	9	21%
Stroke Unit 2	20	1	5%
Stroke Unit 3	19	3 (+1blank)	16%
Stroke Unit 4	25	12	48%
Hyper acute Unit	13	2	15%
Total:	**149**	**49**	**33%**

4.5 DEMOGRAPHIC INFORMATION

4.5a Age

Participants' ages ranged from 23 to 71 years. This question was answered in 47 of the 49 questionnaires. Data were grouped into decades as shown in table 4.5a. The majority, 70% of the respondents, were over 40 years old.

Table 4.5a : Participants' age

Age group	Number of participants	%
23-30	7	15%
31-40	7	15%
41-50	18	38%
51-60	12	26%
Over 60	3	6%
Total	**47**	**100%**

4.5b Job Title

Forty-five participants gave information about their job titles. Eight of these (18%) chose "Other". Of these, four specified: One stroke coordinator, one ward sister, one stroke nurse practitioner, and one research nurse.

Table 4.5b: Participants' job titles

Job title	Number of participants	%
Staff nurse	25	56%
Senior nurse	9	20%
Ward manager	2	4%
Nurse consultant	1	2%
Other	8	18%
Total	**45**	**100%**

4.5c Nursing experience

Data indicated that most respondents had long experience in nursing.

Table 4.5c: Years of nursing experience

Years	Number of participants	%
Less than a year	4	9%
1-3 years	13	29%
4-7 years	5	11%
Eight or more years	23	51%
Total	**45**	**100%**

4.5d Stroke nursing experience

There was a wide range of length of stroke-specific nursing experience. Data were grouped into number of years of stroke nursing experience below:

Table 4.5d: Years of stroke specific nursing experience

Number of years	Number of participants	%
Less than 1 year	4	9%
1-3 years	13	29%
3-6 years	5	11%
6-10 years	11	24%
10-20 years	12	27%
Total	**45**	**100%**

4.5e Formal arrangements for CS

Table 4.5e: Receiving and offering supervision & supervisor training

Question	Yes	%	No	%
Do you have formal arrangements for CS of your work?	22	47%	25	53%
Do you offer CS in an NHS context?	21	46%	25	54%
If yes, do you have any training in CS?	19	65%	10	35%

4.6 Results about specific aspects of supervision

The main body of the questionnaire examined three areas of clinical supervision: Practical arrangements respondents had in place (multiple choice questions: 7-13), the supervisory relationship and content of CS ("yes"/ "no" questions: 14-20), and how respondents evaluated CS received ("yes"/ "no" questions: 21-25). A final section for "other comments" respondents wished to make was also provided.

4.6a Arrangements

Fewer participants answered the main body of the questionnaire than the demographic part. It started with questions about the participants' arrangements for CS. Question 7 asked about the frequency of CS meetings. Three participants added "Never".

Table 4.6a: How frequent CS meetings are

Interval	No. of participants	%
Weekly	3	10%
Monthly	10	32%
Quarterly	6	19%
3-6 months	2	6%
Annual	7	23%
Never	3	10%
Total	**31**	**100%**

4.6b Duration of CS meetings

Table 4.6b: Duration of CS meetings

Duration	Number of participants	%
Less than an hour	12	40%
One hour	15	50%
90 minutes	2	7%
None	1	3%
Total	**30**	**100%**

4.6c Format of CS

Table 4.6c: Format of CS

Format	Number of participants	%
One to one	12	44%
Small group	10	37%
Large group	3	11%
Peer group	2	8%
Total	**27**	**100%**

4.6d When does CS take place?

Table 4.6d: When does clinical supervision occur?

Time	Number of participants	%
Work time	26	96%
Personal time	1	4%
Total	**27**	**100**

4.6e Is there a nominated clinical supervisor?

Twenty-eight (57%) participants replied whether they had a nominated clinical supervisor. For 20 of those (71%) this was a nurse.

Table 4.6e: Nominated clinical supervisor

Nominated?	Number of participants	%
Yes (nurse)	28 (20)	57% (71%)
No	8	29%
Total	**28**	**100%**

4.6f Who is the supervisor?

Twenty-six (53%) participants answered who their clinical supervisor was.

Table 4.6f: Who is the supervisor

Supervisor's position	Number of participants	%
Participant's manager	19	73%
Participant's colleague	6	23%
External supervisor	1	4%
Total	**26**	**100%**

4.6g Choice of supervisor

Twenty-seven (55%) participants answered whether they had choice of supervisors.

Table 4.6g: Choice of clinical supervisor

Choice	Number of participants	%
Assigned supervisor	12	44%
Chosen from a range	7	26%
Respondent's choice	8	30%
Total	**27**	**100%**

4.6h Relationship and Content of Supervision

The next set of questions was about respondents' professional relationship with their clinical supervisor and the content of CS. This was through a series of "Yes"/ "No" questions with opportunities for textual comments.

14. Does clinical supervision help you manage your work? (28 responses, 57%)

Yes: 18 (64%) No: 10 (36%)

15. Does your working relationship with your clinical supervisor support and develop your work? (28 responses, 57%)

Yes: 19 (68%) No: 9 (32%)

16. Does your working relationship with your clinical supervisor help you learn skills related to your role? (28 responses, 57%)

Yes: 15 (54%) No: 13 (46%)

17. Does your clinical supervision help you set goals in your clinical work? (28 responses, 57%)

Yes: 12 (43%) No: 16 (57%)

18. Does your clinical supervision help you keep your work within ethical and legal boundaries? (26 responses, 53%)

Yes: 21 (81%) No: 5 (19%)

19. Does clinical supervision help you identify gaps in your knowledge and skills? (27 responses, 55%)

Yes: 20 (74%) No: 7 (26%)

20. Does clinical supervision help you to think about the good and not-so-good effects of work on yourself? (28 responses, 57%)

Yes: 13 (46%) No: 15 (54%)

4.6i Evaluating Clinical Supervision

The third part of the questionnaire examined the effect of CS on the supervisee and the exchange of feedback from supervisee to supervisor about the CS process. As in previous, this part consists of a series of "yes"/ "no" questions with space for comments.

21. Are there things about clinical supervision that you would like to be different? (26 responses, 53%)

Yes: 12 (46%) No: 14 (54%)

22. Have you ever felt or thought that something about or during clinical supervision was damaging to yourself or to your clinical work/ to patients?

(25 responses, 51%)

Yes: 2 (8%) No: 23 (92%)

23. Does your clinical supervisor ask you for feedback on whether and how supervision is working for you? (27 responses, 55%)

Yes: 13 (48%) No: 14 (52%)

24. Do you feel comfortable enough to discuss with your supervisor whether supervision works for you? (24 responses, 49%)

Yes: 21 (87.5%) No: 3 (12.5%)

25. Have you ever raised such issues with your supervisor?

(21 responses, 43%)

Yes: 6 (29%) No: 15 (71%)

4.7 SUMMARY

The return rate was 33%, as 49 of the 149 questionnaires were returned (one was returned with no replies, total 50). Of these, one third of respondents were from the same rehabilitation service, with a high response rate (89%) the majority of whom completed the questionnaires beyond the demographics page. Overall, respondents were mature (age) and experienced, with 70% being over the age of 40. They had lengthy nursing experience: 51% had more than eight years of nursing experience, and between 6 and 20 years in stroke care. More than half were basic grade ("staff") nurses. Only 47% reported having formal arrangements for their CS. Almost half (46%) of the respondents (21) offered CS in an NHS context, and most (19) had some training in it.

Thirty-one respondents (63%) continued beyond the demographic questions. This may indicate that the rest did not have CS. After the first two questions about CS this fell to maximum of 28 replies to the questions that followed. 'Never' was not among the options to be ticked. Three respondents wrote "never" in the questionnaire. Approximately half of the respondents (48%) had CS in small or large group format, 44% had one-to-one arrangements, and two (8%) had peer supervision. These arrangements occurred mainly at work (96%), with one respondent reporting CS occurred in personal time. The majority (71%) had a nominated clinical supervisor, usually their manager (73%) who was a nurse (71%) or a colleague (23%). The supervisor was usually assigned (44%) or chosen from a range (26%), with 30% (8) reporting that they had a supervisor of their own choice. One had CS external to their service.

More than a third responded that CS does not help them manage their work or support and develop it, while only 54% responded that CS helps them learn job-related skills and 43% used it for work-related goal setting. CS was mainly used for normative purposes, to keep work within legal and ethical boundaries (81%) and identify gaps in skills and knowledge (74%). Less than half (46%) used it to reflect on the impact of work on themselves.

Evaluation of CS is interesting, showing that almost half of the respondents (46%) would like CS to be different. Two respondents indicated that CS had been damaging to them or their work. Their comments reveal that one experienced it as “repressing and pressurised” while the other might have misunderstood (“We had some new temperature/ BP charts and we could not accurately record the observations. We passed this on to the clinical supervisor and these charts were changed”). More than half (52%) report that clinical supervisors do not elicit feedback about how CS works for the supervisee but the majority (88%) would feel comfortable to inform the supervisor, and 29% had done so at some point.

4.8 Conclusion

Of the 49 returned questionnaires, 28 were completed beyond the demographics page and most were from the rehabilitation service that responded highly to the invitation for interview. Of this CS, 90% occurs monthly (32%) or less frequently and usually in work time, in group or individual format with supervisee’s manager. The normative functions of CS appear to be the focus, while approximately a third to half of the 28 respondents reported CS use for formative or restorative functions. Supervisors tend not to elicit feedback about the suitability of CS they provide, and although respondents report they would feel comfortable addressing such issues in CS, less than a third have done. These results are not intended for generalization neither can they serve such a purpose due to response rate. Their purpose is to give a general view of the context of the experiences and meanings arrived at through the interview data.

4.9 QUALITATIVE ANALYSIS

Each interview was analysed individually for themes and subthemes within it. Patterns were then identified across cases to move to a different level of abstraction based on idiosyncratic instances as well as similarities among participants' descriptions, as in guidance provided by Smith et al (2009:107) on "identifying recurrent themes" in larger samples once all interviews have been analyzed. They explain that repetition/ frequency may be used as a criterion, for example, that a theme emerges in more than half the sample. Additionally,

the articulacy and immediacy with which passages exemplify themes (perhaps the eloquence with which one participant summarises the point may best sum up what many others sought to say in more words and less precisely) and the manner in which the theme assists in the explanation of other aspects of the account are also important considerations (Smith et al, 1999). (Brocki & Wearden, 2006:97)

Theme recurrence was considered alongside differences and conceptual salience. Superordinate themes consisted of subthemes from at least half the sample. In the final analysis, the original case based themes and subthemes were disbanded and new ones formed by combining themes across participants. The term 'superordinate' refers to these latest themes.

Concordant with IPA's acknowledgement of context affecting individual meaning construction, interviews have been grouped under each workplace: stroke rehabilitation unit (SRU), stroke unit 1 (SU1), stroke unit 2 (SU2). Although "Tim" is a general nursing manager, not a stroke nurse, he is grouped with his employing organization as SU1. Descriptions of the contexts where interview participants worked have been constructed from field observations and data from the service pro forma. These are in appendix 5. The superordinate themes are presented in a list with their subthemes. After the list, each superordinate theme and subthemes are discussed.

Table 4.9 Demographic Information of Interview Participants

Participant Pseudonym	Site	Gender	Age	Years in Nursing	Grade
Adele	C	F	28	6	6
Alex	C	F	50	27	7
Becky	A	F	27	5	5
Betty	B	F	51	27	7
Caroline	B	F	52	30	6
Catherine	C	F	48	25	7
Di	C	F	56	35	7
Elena	B	F	38	15	6
Jim	C	M	51	27	8
Kate	A	F	51	27	8
Natalie	C	F	23	2	5
Steve	A	M	33	12	7
Sue	C	F	59	38	6
Ted	C	M	52	7	6
Tim	A	M	42	20	Managemt

4.11 Stroke Rehabilitation Service

4.11a Jim

Jim was my contact person for this site. He was in his early 50s, with over 30 years NHS experience, personable, enthusiastic about research, a respected figure in his service and in the region (the high response rate from rehabilitation may be associated with this). The warm rapport established during our first meeting was evident in Jim's willingness to discuss sensitive incidences (off the record at his request) during his interview to enhance my understanding of his narrative. Then, during one of my observation visits he also spontaneously discussed some professional issues (unrelated to the study) that troubled him.

Jim's leadership role demanded high quality of clinical knowledge and skills, and excellent professional communication, negotiation and relational skills, highly professional interactions with patients, their families/carers, and health professionals for the purposes of consultation, research, or facilitation, and support change processes in nursing and patient care. Jim liaised and negotiated with collaborating services, including the acute stroke unit. He participated in professional development activities and provided and received clinical supervision (CS). He spoke in local dialect and occasionally used humour.

Jim viewed CS as a complex, purposeful and boundaried relational process within a complicated web of systems serving several functions for clinicians, the systems wherein they operated, and the patient. He used metaphors to describe CS, and described the professional relationship underpinning CS as *therapeutic* (3:97, 5:169, 6:218, 8:275, 11:396, 26:949). This was a very rich interview, opening up complex factors and themes, subsequently experienced in the difficulty grouping themes together under separate themes.

So really what I mean to summarise is that supervision is not just a quick, you know, cup of coffee, half an hour, there can be lots and lots and lots of things that can…rewarding things, change things […] challenging things, reflection things, barriers, so it's not something that you would take on, if you do it properly, lightly. (23:812-821)

Table 4.11a1 The Relationship in CS

Subtheme	Line/ page	Keyword/s
Trust	13:462 1:9 2:44; 6:195 2:45; 5:174, 176 3:96 26:939	Trust Supportive system Private, Confidential Active listening Openness Impartial
Empowering learning	26:936 1:11 10:336 19:672 21:767 22:777 26:931	Empowered, liberated Conducive environment Peer support Role model Feedback Unobtrusively Enlightening
CS as therapeutic	3:97; 5:169; 6:218; 8:275; 26:949 26:929 26:936	Therapeutic Cathartic Empowered, liberated

Table 4.11a2 Purpose

Subtheme	Page/ line	Keywords
Shaping the professional	6:210 6:215 19:670	Sitting on your hands Encourage that person Sitting by Nelly; role model
Support and restoration	2:48 10:336 20:698	To cathartically say Peer support Guidance, good advice, good listener.
Reflection and adaptation	18:632 22:781 22:799 23:820	To fit in Change practice, improve service development Reflect on that and change Reflection things
Dynamics and ethics	2:70 24:877 24:877-8 25:883 29:1036-7 29:1060 30:1078 30:1067 30:1073 30:1096	Open door policy Open and conducive environment Speak up; challenge; beg to differ; not fall out; stick together We're a team really Staff we've had problems with Going wayward Down the wrong road Doing silly things Understand what right and wrong To be good practitioners

Table 4.11a3 Boundaries

Subtheme	Line/ page	Keyword/s
Internal/ external CS	3:108 3:109 4:110 26:939	External supervision Totally independent Balanced view Impartial
CS and other roles	6:216 7:223 29:1063	As opposed to as a manager I see that more as a manager's role To supervise them or parent them
The agreement	7:251 12:425 12:427 15:543	The agreement between supervisee and supervisor The contractual thing The agreement Stay within that boundary

Table 4.11a4 Time

Subtheme	Page/ line	Keyword/s
Time as quantity	3:76-78	5 minutes, here & now, then & there
		can be a short
	3:84	can be as long as
	3:85	having to wait […] another month or another week
	10:361	
	22:778	over a period of time
Continuity	11:393	Continuity (x2)
	10:346	It's about commitment
	10:356	Nothing worse (than) to have it [CS] cancelled
	10:361	having to wait […] another month or another week
	10:363; 11:377	lose the benefits [of CS]
	11:369, 376	lose your thread (x3)
	11:371	protected time
	11:373	want to discuss over a period of time
	11:383	lose track of
	11:394	feel the benefit
	14:501	many disturbances
	14:504	protected environment
	14:504	a burden to [supervisor]
	14:509; 511	interrupted all the time
	14:512	distracted
Time as quality/ respect	10:342-4	Getting the supervisor to get the time […] efficiently and effectively.
	14:504	Protected environment
	14:509	interrupted all the time

	23:834 23:835 23:836 23:839 24:863 24:864	haven't got time for people not got good interpersonal skills actively don't listen quite respected professionally Like having time. Interested in people

4.11b *Di*

The interview with Di was the last of four interviews that day, and is the longest in this study, lasting just under two hours including some interruptions. We established rapport quickly. After the recorded conversation, Di continued chatting about what she was doing that weekend, her holidays, and how she replenished herself outside work time.

Di was in her early 50s, holding a senior position in stroke rehabilitation, with a long career as an NHS nurse. She assisted stroke patients and their loved ones with discharge arrangements, a role requiring good relating and communication skills. Occasionally I found Di difficult to understand (eg. *I think the practitioner who doesn't practice without clinical supervision is very dangerous*- 1:14-15). She also omitted words in her sentences as she produced the next. Despite her doodling while she spoke, Di's manner was personable, pleasant, light. Listening to the recording during analysis, I could still feel the connection and spontaneity. Occasionally, when difficult topics came up, Di laughed and evaded a question (44:1579-81; 47:1722-5; 48:1734) as in the following excerpt:

Say if it were a drug error and that person's not told anybody that came to me over some supervision and I'd dug a bit deeper, I'd have to take it to the manager then, I would have to do. Yeah, if I couldn't solve it, yeah.

(**Q:** *How would you solve it?*)

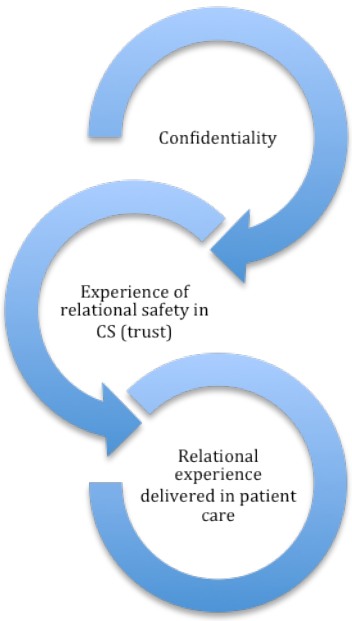
Di: *I think I'm laughing hysterically now. I'm not used to this. It's all gone a bit [laughing] Di's hysteria. What were we talking about?* (24:865-882)

The laughter became an effective distraction from a difficult question. *Di's hysteria* suggested this might have been a way of saying that perhaps she felt pressurized, anxious, and exited the topic through laughter.

Di distinguished CS as formal and informal, explaining the latter was used routinely in the unit. She spoke of CS with enthusiasm, detailing its benefits, experienced or perceived. She described CS as easy to access throughout the hospital, and available inter-departmentally but its availability was decreasing due to service reconfigurations for cost savings and her team's impending relocation further away from established sources of CS. As we completed the interview, Di spontaneously said *this is a bit like clinical supervision* (39:1407) in that it facilitated reflection on various matters (*I've just thought about that.* 40:1454; 41:1472). Di concluded the situation required more reflection than had been afforded.

Major post-interview understandings (noted in my journal) are: the importance of time; how relational safety makes CS an experience like a conversation with an 'older sister', with elements of vicarious learning, support, guidance, validation; but there are occasions when CS takes on a "Big Brother" quality: surveillance and reporting to superiors. The purpose of both is clinical safety (normative function of CS). The following two graphs illustrate some of the insights from Di's interview.

Graph 4.11b1: Relational experience of staff in CS is delivered in patient care



Graph 4.11b2: Time, relationships, and performance

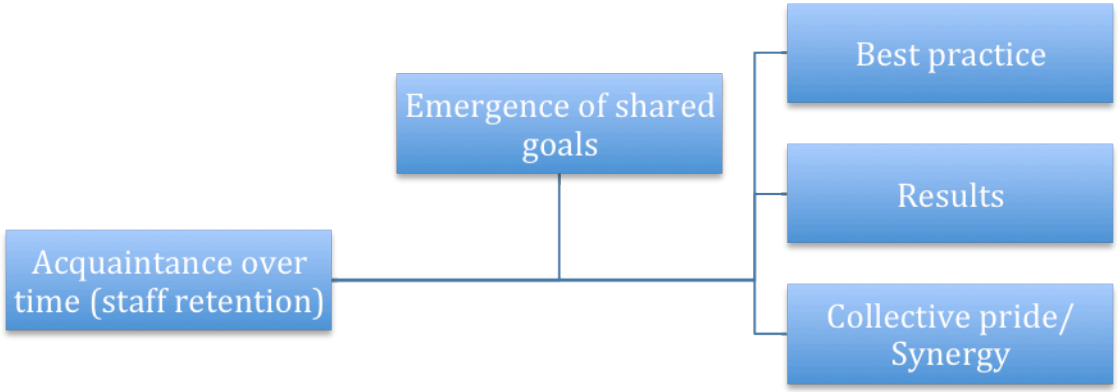


Table 4.11b1 Boundaries

Subtheme	Page/ Line number	Key word/s
Boundaries and limits	22:805 22:806 23:814 27:968 30:1093 45:1631	Knowing your own boundaries What your limits are Deeper than what I can Too familiar. You can know people too well Robust structures Too tired […] too stressed
Formal and Informal CS	1:13 1:14 9:321 36:1302	Formal and informal We do it all the time informally Formalize it Putting it aside for ½ hour
Confidentiality and Safety	13:472 14:478 14:480, 481 14:499 15:515 15:529 23:836	A sense of trust They can trust you You're confidential [confidentiality is] massive safe practitioner safe boundaries confidential issues
Rules or Needs?	25:904 26:923; 925 29:1054 30:1067	Code of conduct Ground rules Duty of care Different ball game
Physical & mental space	17:607; 612 18:645	Park it. Shut the door. Free

Table 4.11b2 Synergy-relationships and leadership

Subtheme	Page/ line number	Keyword/s
Synergy: Contextual productive energy	13:460 15:549 28:1019 31:1137 31:1122 31:1125 31:1129 34:1226; 1228 45:1651 47:1702	Being able to read people How does that other person feel as well Somebody to talk it through with Everybody is a valued member of the team We can't let each other down A lot of staff are proud to work here It's a common pride a good team (x2) we work very closely Delicate handling
Leadership and hierarchy	5:153 30:1101 32:1162 34:1243 45:1637	Influencing somebody for changes Good leadership skills The skills to influence The right sort of leadership qualities Recognize it [stress] in your colleagues
Vicarious learning	1:25 14:477 19:687 40:1450	Listening to other people's professional opinions Good role model Telling anecdotes Understanding of people's roles

Table 4.11b3 Psychological impact

Subthemes	Page/ line number	Keyword/s
Perilous culture	50:1814	Quite cultural around here
Reflection: panacea	5:171 15:533 15:544 17:590	Just to reflect on s/thing It's totally about reflection Helps me reflect on my practice Reflective practice
(Reduced) sense of control	35:1255 36:1306 36:1307 36:1287 36:1308	It comes automatic Somebody could call the buzzer There could be an emergency Daily life is so busy Daily life doesn't allow
Conflict of loyalties	25:903 25:907 25:914 29:1061 30:1067 30:1087	Professional code of conduct For me own conscience Your own personality comes into It's much more, in a sense, simpler Different ball games The NHS
Self-care	22:777 22:794 22:800 43:1565 43:1577 49:1764 49:1768	In your own personal life Too deep emotionally Do you think you need counseling I go to the gym Know when I'm ready for a holiday Do things like yoga Makes the difference between coping

Table 4.11b4 Time

Subthemes	Page/ line number	Keyword/s
CS on the hoof (Time as quantity)	3:103 3:108 9:321 35:1275 35:1279	Staying there for ages A word with you for 5 minutes to one side Block off ½ an hour, ¾ of an hour Be there at all times 24 hours a day 7 days a week
Time to think (quality)	5:170 5:171 49:1775	How would you handle this [future/ planning] You need a bit of CS just to reflect on something [past] keep going and going and going until you burn out.
Time as wealth	31:1120 35:1271 42:1520 42:1521 49:1774	Worked here years and years and years Time poor As you get older you get more experienced You can read people better This is the time, I need to do this more

4.11c Ted

Ted was a Charge Nurse in his early 50s who entered nursing a few years ago. He had completed his Trust's clinical supervisors' training but had never practised it formally. His name was on a list of supervisors somewhere in the system but he did not know where or how someone could find out and contact him about CS. He described supervisors' training as basic and that he lacked the confidence to be a supervisor without feedback about his performance.

The opportunity is there, I mean as far as I'm aware once you've done your clinical supervision training then you go on to a register so… so my name is on a register somewhere and because you can choose anybody, by all accounts, to be a clinical supervisor, you know, somebody…a total stranger could find my name in this list and seek me out for supervision. […] To be honest with you I'm not really clear on it, it would be quite interesting I suppose to find out who could actually access me as a supervisor. But that's as I understand it that there is a register which I will be on and people can access me or any clinical supervisor on this register. (14-15:511-517)

As Ted spoke of his diffidence, and being *very quiet* (6:205), I wondered whether his wish was to be found or not to be found for CS (perhaps expressing ambivalence). His voice was low in volume, steady, audible with easily understood accent. There were silences that I managed with inquiring or empathetic sentences. Where I guessed accurately what Ted was saying, he answered in confirmation. He used the word "problem" frequently. During analysis, I puzzled over what this may have meant to him. Etymology showed Ted was using this rich word to describe the spectrum of matters appropriate for discussion in CS.

Ted tended to say what he was *not saying*, followed by a significant word, for example, *I'm not saying opinionated but* (5:166); *won't say oppressed* (6:186). This may be his lack of confidence (as he described) and a way of stating and denying simultaneously (ambivalence, ambiguity of response). During analysis, questions emerged like "why is this being said if it is not what is being said?", and where in Ted's understanding of the experience did the denied word sit, what did it say about his experience of what he was saying?

The results and Ted's spontaneous feedback that the interview was helpful contradicted my expectations from a 15 minute interview (which he had told me he could give). His was the first interview I conducted in this service. Ted offered spontaneous feedback at the end of the interview (*I've enjoyed it actually* 18:651; *it's*

been a real help 19:661) which disproved my initial concerns about quality of rapport and depth of data from short interviews.

Table 4.11c1Purpose of Clinical Supervision

Subtheme	Page/ Line	Key word/ phrase
CS as clarity and preparation for uncertainty	2:57 2:59 3:95 3:97 3:99 7:234 17:603	Policy and procedure is still not clear Their understanding You're passing on If the same situation happens to them[…] isn't going to be a problem Prepare Problems that might arise Have I done a good job
CS as personalized learning	3:95 3:97 4:140 16:555 16:557	Happened to you If the same situation happens to them Just to discuss problems as they arise More personal to you Specific incident that's happened to you
Safety in CS	6:182; 187 193 205	Relaxed Free; open environment Talk about anything Very quiet personality
Importance of expertise/ Specialism in CS	4:122-3 6:211 6:212	Specialist area; stroke- specific problems It's a specialty Talk to my own colleagues

Table 4.11c2 The meaning of clinical supervision

Subtheme	Page/ Line number	Keywords/s
What is formal CS?	2:67	Sisters' meeting
		Last [day] every month
	2:45	It can be about anything
	2:49	Enhancing professional practice
	2:50	Ask questions
	3:86	A small group of people
	3:87, 92, 97	[it can be about] problem
	15:33	More formal CS
	8:257	Held at weekends
	8:262	Group supervision
CS as any professional communication	1:35	Constantly talking to each other
	4:114	Discussing with colleagues
	4:128	An informal way
	10:338	Consultative communication
	13:469	We do have a lot of conversations which you could argue is CS
	13:473	A bit of a mentor to her
Hierarchy	4:132	Trained nurses
	5:158-160	Clinical work [vs] support
	5:159	Clinical nursing work
		Untrained are really support, aren't they?
	5:173	They just need to see a different view point

Table 4.11c3 CS as feedback

Subtheme	Page/Line	Keyword/ phrase
Facilitating CS in groups	4:128	An informal way
	6:182	Very relaxed
	187	Free open environment
	6:195; 7:235	Discuss anything (x2)
	6:195	Valuable [opportunity]
	6:205	Express feelings views opinions
		My personality […] very quiet
	6:207	Very very opinionated
Training and supervision for supervisors	10:350	done the training [for CS]
	10:359	I need a refresher
	10:366	Solutions to problems
	10:361	[training not] in depth
	11:367	quite daunting
	11:389	how would you know that?
	12:423	uncertain about myself

4.11d Adele

Adele asked to be interviewed in a University venue in her private time. She was in her late 20s and recently appointed to a senior nurse post in stroke rehabilitation. She came across as self-confident, thoughtful, engaging reasoning in her work, able to dialogue with ethical issues, and with a positive attitude towards CS. She had positive experiences as supervisee and valued how CS was organized in her workplace where she could access CS at any point by requesting to see a manager of her choice. She had been attending group CS available to all specialties and a ward-specific meeting she regarded as CS.

Adele's interview highlighted the usefulness of CS in making sense of the emotional impact (helplessness and self-blame) resulting from organisational failures at work. She offered an example of her repeated difficulties in communicating with patients' transport services, which she initially attributed to some error on her part but, through CS, realized that this was a systemic issue that could be resolved through her manager's discussions with patients' transport. This outcome brought substantial change in Adele's attribution of error and resulted in relief from self-doubt and self-blame.

Table 4.11d1 The impact of work

Subtheme	Page/ line	Keyword/s
Impact of system failures on self	25:883	Have I done it right?
		Have I missed something?
	25:890	Done something wrong?
	25:898	System failure definitely
	22:778	Nothing you can do
	23:821	Stressful
	23:825	Frustrating
	23:838	It's not only you
	23:839/ 24:842	It's/ not just me
	26:925	Out of your control
	26:940	Because of the system
	11:2810	You start to doubt yourself
Absorbing others' reaction to system failures	25:913	A patient sat in the middle
	25:914	Trying to explain
	26:918	Duty of care
	22:771	[patient] starts to panic
	22:777	patients nagging
	22:780	[patients] take it out on you

Table 4.11d2 Relief mechanisms of CS

Subtheme	Page/ line	Keyword/ Phrase
Learning 'different', 'other'	7:247 7:248 29:1026 2:63 27:986	Learn from different things Learn from other people's practice. Covers all aspects of your workload […] not just about the patient helping you develop On all levels of nursing
Off your chest	7:248-251 28:1003	Sharing experience […] your ideas and your thoughts Peace of mind
Feedback/ validation/ praise	9:309; 11:397 11:372,387 16:584 17:597 28:997	(Getting) feedback Praised Following guidelines Written feedback You've done it right
CS improves practice	13:450 27:968,979 28:1002/19	Sorted problems Reassurance Clarification

Table 4.11d3 CS and professional relationships

Subtheme	Page/ line	Keyword/ phrase
Team leadership	5:179 4:218-132 4:131	Cos they are in charge […] face more problems Her staff was being a bit awkward [learned] talking to them in a way that they want
Empowerment through CS	22:778 29:925 30:1090-3; 32:1136-1154	Nothing you can do Out of your control Empowerment

Table 4.11d4 Policies and Rules

Subtheme	Page/ line	Keywords/ phrases
Rule or wish?	5:165 5:164 6:214 17:598	They'll not say […] much Part of their NMC requirements They've already got their CS hours My evidence towards my clinical supervision
Red tape	25:914 26:940	Red tape, paper work Because of the system
Empowerment through 360 degree feedback	26:940-2	Taking that to my manager who can […] take it back to […] resolve the problem

4.11e *Alex*

Alex was in her early 50s and a ward manager. Her interview lasted about 20 minutes, as she could not leave her duties for longer. This created dilemmas about what information to seek actively vs letting Alex express her understanding and experience spontaneously, as she was doing. Consequently, various questions emerged during the analysis. Alex expressed positive attitudes towards CS. The interview concluded with her ideas about planning the formalization of availability and uptake of CS for all qualified and untrained nurses she was responsible for.

Around the time of our interview, the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013) had been published. Although Alex did not mention it explicitly, her concern with not only providing CS but "formalizing" it (word appears four times in p.1, three times in p.2 and repeats later) and ensuring it was recorded perhaps reflected the feelings incited by the Inquiry. Consistent with the summary Report's article 1.119 (p. 66) "No tolerance for non-compliance and the rigorous policing of fundamental standards", Alex presented CS as an externally dictated obligation (*have to* 1:35).

Table 4.11e1 Language and concepts about CS

Subtheme	Page/ Line	Key words/ phrase
CS is support	1:24 5:179 5:182 5:151 6:191-201 6:192 194 198 202 10:356-359	It's gaining support from your colleagues It's support, it's about supporting isn't it, it's about supporting them. Support them directly we've got quite a good support network Supported (x2); support (x4) I've always got someone that I can go to. Might want to discuss something If there's anything I'm not sure about Getting other ideas […] from others Supervision […] as a support
CS is the annual appraisal	11:377 11:379	Look at something in the future Development reviews […] that's a form of supervision
CS as debriefing after major events	2:67; 5:181 6:185	Incident Like a debrief.
CS as Feedback	6:184	Feedback
Part = whole	4:120-3 11:379	Regularly come to see me and ask me advice […] and all that is really CS Development reviews […] that's a form of supervision

Table 4.11e2 CS as a formality

Subtheme	Page/ Line	Word/ Phrase
Formalized CS	1:18, 25, 35; 2:58, 59, 68	Formalize/d; formal; formally
Records of CS	1:25; 4:129&130 2:71 7:230-231 7:256 10:365-6	[never] recorded it (x3) evidence get colleagues to sign complete a competency sheet formalizing that and evidence of recording
CS is externally motivated	1:35 2:36 2:36; 3:88&97	We have to (x2) We have had to the NMC guidelines

Table 4.11e3 Developing CS

Subtheme	Page/Line	Word/ Phrase
Specific and publicized time	4:116 4:118 4:19	Going to set time aside during the week It's specific times And let staff know
Familiarity with clinical supervisor	2:55	Tends to be the ward manager that they prefer
Developing reflection, critical/ ethical thinking	9:315 & 318 10:342-3 9:328	Good to question yourself Often a few different right ways and no wrong way sometimes Could have been a combination

4.11f Catherine

Catherine was in her late 40s with work experience as a general nurse and for the past two years in stroke rehabilitation. Due to the service's relocation, it had been difficult to communicate by telephone or email. She approached me during one of my visits and offered to be interviewed that day. We had lunch together and built up good rapport, as she asked about my interests and research prior to the interview. There was warmth in our interaction and laughter to my replies "can you repeat this at interview?".

"Holding" a relationship through time –as she did with me- was also a process she engaged in with patients and their loved ones. Catherine presented as thoughtful, friendly, approachable, cultivating warmth and avoiding conflict. She spoke with a pronounced local accent and grammar, leaving quiet gaps for follow-up questions, as if aware she might not be understood. She conveyed that although still feeling "new" in her post, she was also well-settled, helped by her perception of her job as a manageable challenge, discovering the various stages of competence in a small team (1:20-27), her manager's flexibility about her hours. She appreciated her team as *people who you trust and value* (6:183).

Catherine distinguished between formal *regimented* (1:30) and *very informal* (1:21) CS. Even though formal CS was available, she preferred informal conversations with colleagues onsite that were easily accessible *90% of the time* (1:33). She highlighted the role of nursing and local culture and the preconceptions and prejudices about help-seeking (as weakness or failure) as influential factors in the development of CS in nursing.

Table 4.11f1 Clinical supervision

Subtheme	Page/ Line	Key word/ phrase
CS is about work problems	3:73 21:741 24:855	Problem solving problematic patients Same problems
Opportunities for reflection and containment	10:331 20:732 20:707 21:743-4	Feedback Negative feedback You stand back & have a look at your own practice A negative can be turned into a positive
Learning from mistakes	20:714 20:715	Learn from your mistakes Not make it twice

Table 4.11f2 Professional communications and relationships

Subtheme	Page/ Line	Key word/ phrase
Relational dynamics in the team	7:237 8:276 16:576 16:578	Easy-going, friendly Good rapport with different teams Professional enough to disagree Agreeable
The holding power of relating	23:813 & 831 23:841 23:842 23:818 & 820 23:819 29:1031 30:1068	Draining (x2) Intense Overwhelming Rapport Been several months Lifetime's support It's different [views]
The restorative power of quality team relationships	36:1323 37:1335	Talk to your colleagues Shareable

Table 4.11f3 Nature of the profession and history of CS in it

Subtheme	Page/Line	Key words/ Phrases
Stoic professional culture	33:1184/1203 33:1193	Very stoic I think it's culture
Stoic professional culture inhibits help-seeking	33:1186 33:1187 33:1198 35:1262 34:1223	Not being able to cope [perceived] like a failing you just get on with it you're your own worst enemy [perceived as] always moaning or she's always whinging
History of CS in a stoic professional cuture	2:40 2:41 32:1159 32:1161	Cos it were new Nobody really knew what to expect or what to do Very skeptical [perceived as] just that you weren't coping

Table 4.11f4 Boundaries and permeability

Subtheme	Page/ Line	Key words/ phrase
Psychological work-personal life boundary	11:400 36:1296	Unprofessional I take that home 'cos I see that as me not the work
Practical work-personal life boundary	4:123 4:134 35:1275	Even when we are at home [colleagues] ring each other up on holiday your husband gets all of your moaning
Confidentiality boundary	8:284 11:400 11:403 12:412	It speeds things up Unprofessional even on a social outing lunch or shopping

4.11g Natalie

Natalie was a staff nurse in her mid-20s. At the time of our interview she was leaving this organisation to take up an emergency nursing role elsewhere. Her interview lasted about half an hour. As the interview was ending, her manager interrupted us to ask her to return on the ward.

Natalie came across as a friendly, cheerful individual, and closed several of her comments with laughter. Occasionally, she did not articulate sentences to convey full meaning. At the end, she asked questions about the future of the study and disclosed that she had recently attended a course where the importance of CS and my name had been mentioned. Her narrative indicated good understanding of avenues to support her clinical work, including CS. She spoke of seeking guidance from policies and procedures and from senior colleagues when planning how to respond to a clinical situation, and attended the weekly group CS provided on site to understand, make sense of her actions and consequences better so as to use this learning from experience to the best benefit of patients.

Table 4.11g1 What is Clinical Supervision

Subtheme	Page/ Line	Key word/ phrase
CS is marked with time	1:26 3:87 15:541	Got that time to talk after the event has taken place, you always think back time to reflect with other staff
CS looks at the personal in the professional	3:107 9:315/ 10:349	how things are going to affect you personally [helps you become] a stronger person
CS helps personalize patient care	4:144 11:382 11:389 11:395	patient centred care an understanding patient-wise helps you understand patients more also [understand] the family

Table 4.11g2 Benefits of CS

Subthemes	Page/ Line	Key words/phrases
CS is valuable for its benefits	9:305 9:310 9:312 8:281 9:315 18:643 19:678	it's valuable it's definitely helped develop from being a student to a newly qualified develop professional views and knowledge helps you become a stronger person, be a more professional nurse you do reflect professionally and personally
The Circle of Knowledge, Skill, Wisdom, Praxis (Phronesis)	3:77 4:123 4:125 4:126 19:678 4:130	you've got your head around it and just help you deal with got it in your head a little bit more what you've done what you can carry on doing professionally and personally go back and talk about it
Self confidence, personal and professional	10:363 20:698 20:708	helps you get more confident and getting into professional role praise yourself more more of a self esteem kind of thing

Table 4.11g3 The importance of the quality of team relationships

Subtheme	Page/ Line	Key words/ phrases
A good team has patient-focussed goals	5:149 5:152 7:222 7:223 16:557 16:551/ 572	other professionals looking at the individual patient all working as a team there's that level of trust we're a very good team we're here for the patients
Learning from colleagues is likely when team relationships are good	5:146 15:537 9:324	experience from your other nurses consult with your manager knowledge from other staff nurses

4.11h *Sue*

Sue was in her late 50s and a nurse-in-charge ("sister") with a long career as an NHS nurse (3:108). She was one of the people who came to me offering help when I arrived at the unit for the initial informal visit. Sue came across as a strong personality, efficient, passionate and helpful and with views on the broader political aspects of work, such as the gradual erosion of nursing and its replacement with cheaper labour.

Sue had firm ideas based on her experience as a clinician and as a supervisor. Consistent with her statement that her role required that she did not share much of her private world with colleagues, her interview contained mostly factual information. When I enquired specifically about her feelings regarding the stance of her professional body, she avoided emotional depth with "but hey ho".

Table 4.11h1 Clinical Supervision

Subtheme	Page/ Line	Key words/ phrase
Formal CS	2:49 2:63; 28:1028 1:35; 2:62	Time set aside [for CS] In private; confidential (Very) formalized
Informal CS	2:61 2:39-40 3:92 2:58; 3:67	It's a really broad scope Just reflecting on a point and bouncing it off another colleague We have CS in the MDT Not actually realizing it [was CS]
Confidential nature of formal CS	2:63; 28:1028; 30:1084; 1086 32:1151	In private; confidential In privacy (x2) The confidentiality, yeah
Phronesis	25:891 24:862	Experience is the foresight to see Knowing when to keep rein

Table 4.11h2 Benefits of clinical supervision

Subtheme	Page/ Line	Key word/ phrase
Communicating feedback through CS	6:199	To reinforce
	6:203	In a different way
	9:300	Nothing succeeds like success
	9:327	A building block, a stepping stone
	12:409	Skill of allowing yourself to be criticized
	14: 509	The honesty
	15:528	A bit near to the bone
Function not formality in CS	10:349	More informal setting
	10:350	people are willing to express themselves
	10:358	[not] tick box session
	20:701	[not] lip service
Developing professional nurses and improving practice through CS	10:334	A two-way thing
	10:346	Consolidating good care and improving that care continually
CS supporting leadership	31:1114	No matter what is thrown at us
	32:1157	it's got to be controlled
	32:1172	lead from the front
	30:1081	clinical supervision can help you, it can be a release
	30:1088	and then you come back and you can carry on

Table 4.11h3 CS and Nursing

Subtheme	Page/ Line	Key word/ phrase
Motives for nursing	17:605 17:607 17:612 17:615 17:622	definite need […]to assist other than just being a task basic human connection walk every step of the way with them everything […] in any way
The emotional investment	14:485 14:499 14:486 14:487	Empathetic/sympathetic Support Burden Drags you down
The value/ status of nursing	33:1180; 18:659 19:660 3:104 35:1270-1275	(totally) underestimated Undermined Not taken seriously Time (x4)
Professional alliances	15:514 15:537 15:545 18:629	Honesty Trust making that step alliance

4.12 Stroke Unit 1

4.12a *Steve*

This was the first interview of this study. Steve was a ward manager, in his early 30s, who had always worked in this Trust. He was responsive to the research and keen to facilitate participation of his ward's nurses. This interview was during handover when there were twice as many staff as the rest of the time and he could make himself available. He informed his staff and matron where we would be and why and the matron brought us coffee and mince pies (December).

Steve gave a broad concept of CS:

You can class CS as the fact that I'm on the ward (2:41), overseeing staff on *more and more tasks* (5:157) expected of them but without the opportunities to reflect on their practice or service development:

We don't give them the forum that we have (3:93)

We [managers] have meetings (2:63)

Steve spoke of major changes his service underwent to become a stroke unit, the impact of this on staff, and dynamics and challenges created in his team. At various points during the interview Steve laughed, usually with a dose of sarcasm, describing himself as *deadpan sarcastic* (31:1117) and *I know they [staff] don't know if I'm joking or being serious* (31:1122). I did not reflect on this until I had read the transcript several times and recorded it in my research journal:

Reading Steve's interview for analysis, I identify how issues of boundaries can affect staff across situations. It started with my feeling unclear why Steve was laughing at various points of the interview (funny? Sarcasm? Something else?). Then while re-reading the interview, I realized that his paralinguistic communication was often ambiguous. Thus the ambiguity I experienced might also be his staff's experience. This may be compounded by the lack of clarity between processes like performance review, interviews after sickness absence, professional development, support/ conversation, disciplinary interviews, and this is accentuated when the boundaries are blurred further, eg. work's Xmas do.

<u>Dimensions of ambiguity</u>

Internal consistency of communication
Context's procedural tones vs. support/ personal communication
External 'context' such as a work's social event.

Ambiguity gives persecutory note to communications generally, especially in context so busy that there is no time to stop and think alternative 'scenario' (is feeling rushed similar to feeling anxious/ scared at bodily level?). Is the physical/ bodily state same when we are rushed and when anxious? → The interpretation of ambiguity that predominates is fear-related, persecution, policing side (as proposed by Becky, that if

CS were introduced there now, staff would perceive it as policing and checking mechanism and would not take part!). Add Steve's statement that he floods people with emails about what more/ different they must do. The word "whip" comes to mind.

As this was the first interview of the study, this analysis adhered closely to the process described in the chapter "Analysis" in Smith et al (2009), which I reread several times for reminders and validation. Taking account of the above reflections about this interview, I added "paralinguistic" to the categories of analytic comments, as they were significant communication markers.

Table 4.12a1 Hierarchy, Authority and Power

Subthemes	Page/ Line	Key words/ phrases
CS provision differs depending on seniority (No CS arrangements for lower pay-banded staff).	1/ 16 1/ 30; 3/ 93-94 2/ 63-70 3/ 82 25/887	Massive gap (x2) We don't give them the forum that we have We have meetings Mobile conference CS with any band 6
CS is task oriented, prescriptive ("no errors"), simplified to an instructing manager being present on ward.	2/41-43 4/118 5/ 156-7 5/ 182 20/710 20/ 703 21/ 757	You can class CS as the fact that I'm on the ward. Very dictatorial More and more tasks Task prescriptive Task orientated Very prescriptive Room for […] cock ups
CS boundaries with PDR, training, disciplinary procedures, management, dictating	16/ 585 20/710-11 20/714 25/894 25/903	We've put people on stroke specific study Go and do that, you need to do it now. It's "you will do it". competency issues but starts off as supervision Beyond supervision
The long line of powerlessness	5/ 150 11/ 383 12/435 13/451-453	Higher authority If you can't send them, you can't send them. Authority Some people are just bossy

Quality vs economics (savings)	8/258 16/ 557-8 16/ 559 16/562-3 16/ 570 17/590 17/ 621	Struggling to fill [posts] Can't do redundancy Redeployment It's just a job It really does affect moving things forward Disinterest Spoil the groups

Table 4.12a2 Communication

Subthemes	Page/ Line	Key words/phrases
Ambiguous communication, eg. "unreadable" expression, laughter.	22/795 23/ 833 26/934 31/1117 31/ 1122	Laughter as sarcasm I'm fairly easy going (laughing) Deadpan […] sarcastic Monotone voice I know they don't know if I'm joking or being serious
Email overload becomes overwhelming and leads to frustration & negativity.	4/ 141-144 5/ 160; 6/ 186	A million times Something new (x3) Just frustrates them (Very) frustrating-ed
"*They* [staff] are valued" (also disciplined, dictated to, unsupported, punished)	9/317-8 26/925	They are valued Getting it [competency issue] away from ward
What is CS?	1/22 1/31 14/ 511-2 14/ 512 19/ 670-1 19/690-1 24/ 872	Mentoring Outside of the ward area Go in and moan Change the way they work Never something I've thought about before Pooling of ideas and thinking of things A bit like a student
Organisation's ignorance about CS	2/46 19/ 674 19/ 677	That's how[…] the NHS is happy to class it Nobody told you what that job is [CS] never been ever mentioned

Table 4.12a3 Boundaries vs barriers

Subthemes	Page/ Line	Key words/phrases
Time as a barrier to CS (staffing levels)	20/ 722 21/ 744 22/780; 34/1242 22/ 791	Time's at a premium. But it's time. Rushing If we'd got appropriate staffing levels
Time as protective boundary & healing (sickness absence; example of band 6 nurse).	8/ 285 23/842 24/ 852 27/971-2	Time to complete everything. Needs half an hour […] for discussion […] just to keep her OK. You need to stop and deal with it. CS for them on return [from sickness] is quite intense really
CS boundaries with other activities (PDR, mentoring, disciplinary/ HR procedures)	1/ 12-14 10/ 354-360 26/933 27/ 968-989 28/1002-3 30/1076-1080	Mandatory training […] PDR once a year Progressing [After trying CS], then go to disciplinary level If somebody goes off sick Ought to be […]separate Terrible sickness record […] at risk of being fired

Barriers to CS and trusting a manager	10/ 346 29/1050-2 29/1063 30/1065 31/1102 32/1140	Then they'll put the effort back in To be a manager, a disciplinarian People need to know [what the meeting is for] If they trust you as a manager Oh, he's watching Whether they trust you
Defence (of practice, of oneself)	1/27 2/46	They sort of cover it by saying… That's how […] the NHS is happy to class it

4.12b Becky

Becky was in her late 20s. She had been working in SU1 since completing her nursing qualification, supervised during her preceptorship by Steve (manager). She asked to come to the University for our interview, in her own time, which necessitated her bringing along her toddler. Although this meant interruptions in the conversation, it also highlighted that the factors Becky considered important for clinical supervision, like structure and feedback, were also important in the rest of her life.

For Becky, CS was a process occurring in and for a clinical context where particularities and dynamics between people could and did create chaos. She valued structure and presented feedback as an important element within it, and CS as a supportive mechanism to manage the chaos in the workplace. Becky described how the communication of feedback from hierarchy had been having deleterious effects on team culture, as CS was synonymous with discipline which was synonymous with punishing consequences for errors, not opportunities for learning. The combination of these appeared to affect the emotional atmosphere of SU1, the development of competence, and work culture. There was a sense of persecution from hierarchy, which Becky also seemed to have adopted in her statements about how she established clarity with her supervisees. She disclosed that due to the stress of working conditions, her mental health had suffered and she had had psychological therapy ("CBT").

Table 4.12b1 Clinical Supervision as Structure

Subthemes	Page/ Line	Key words/ phrases
Structure as support, a secure base, and message that supervisee's work matters to supervisor	7/204 5/134 6/188	It's a little bit of a base To go back to someone saying right that's done Having somebody's back
Structure as antidote to chaos, rescue in emergencies (trail), and way to develop accountability	1/24; 2/45&51 2/47 3/78 5/148 6/168; 15/488; 18/585 46/1486	Daunting Terrifying Disorganized chaos When something comes and hits you in the face Nightmare Can't cope with it
Structure as "contract", providing clarity, reciprocity, regulation	7/228; 14/447 8/253	If you give me 100%, I'll give you 100%, if you give me 10%, I'll give you 10% This is what I expect from you
Structure as framework for factual feedback on progress	2/38 5/141 9/280	Build on each section to build the bigger picture Slightly positive reinforcement It shows you progress

Table 4.12b2 Clinical Supervision as Feedback

Subtheme	Page/ Line	Key word/ Phrase
Importance of balanced & accurate/ factual and fair feedback (positive and negative)	12/387 25/802 25/804	Rather than checking full story [not] sugarcoating Sandwich [good & bad]
Feedback as restoration, acknowledgement & validation	11/359; 26/824 22/722; 32/928	Little things (welldone) A thank you
Feedback as teaching/ learning mechanism (mistakes, competences and accountability)	37/1213 37/1215 39/1279 40/1294	It's got to be done right and if it's not […] it's got to be explained as to why […] but there is the [right] way you do it […] a, b, c If you don't tell somebody how it's meant to be done, then they don't know In future […] look at doing this Mistakes are part of learning
Impact of persecutory/ bullying feedback on worker & team/ work culture (morale, trust, motivation, mental health, relationships)	2/61; 2/63 17/528 & 556; 44/1433 20/529 & 530; 21/679 15/473 15/472 10/301 11/345 27/877	Rap; Flack; Never get a welldone [Very, very] bizarre Policing We're not trusted What have we done wrong this time? When she flaps Morale's really low Low morale will never rise

	12/370 23/732 13/413 13/416 38/237 13/425 20/646 32/949 13/427	the standard of care For the rest of the week in that office shouting at Only coming out of the office to shout at them You daren't breathe Terrifying environment Terrified senseless Anxious, stressed all the time backs go up, […] they log off, they switch off yet again, I've been bollocked for this Had to go for CBT
Importance of openness to 360˚ feedback	22/707 22/704 22/721	Troublemaker When you try to put something forward, it's slammed back at you Are you challenging the way we run this ward?

Table 4.12b3 Clinical Supervision as Discipline

Subtheme	Page/ Line	Key words/ phrases
Discipline towards professional autonomy	37/1211 37/1213	Some level of discipline Got to be done right
Discipline & boundaries: Purpose vs actual function	21/679 38/237 38/1248 39/1249	[CS as] another step toward suspension Set boundaries, but not fearful of them Supervising I've disciplined […] But I'll give you a reason why and how it needs to be done
Discipline vs punishment Impact of meaningless "discipline", humiliation	12/391 12/393 17/534 38/1247 42/1374	Assuming us […] at fault People are getting suspended left, right and centre, but for nothing Make a mistake, you're done for There's a massive punishment [role] Being dragged in office
Excessive attention on "targets" disables patient care	11/346 44/1424 46/1484	Can't be bothered Their eyes are shut and their backs are up We've got to hit them targets and not look after patients
Constant defence of self and practice disconnects from internal motivation	15/470 11/348 44/1427, 1433, 1438	Being checked upon again That busy watching their own back all the time It is a very defensive

	45/1453 45/1464	practice, it's personal damage limitation We can never get rid of patients Daren't ask just in case they get in trouble; for looking stupid

4.12c *Kate*

Kate was in her early 50s, with a long career as an NHS nurse, latterly holding a very senior clinical post in stroke care. We met a few times regarding administrational tasks for this study. She informed me of her busy schedule each time, but accommodated my requests for meetings. She arranged for my attendance at a meeting of stroke service managers to introduce the study and elicit willingness for participation.

Kate explained that she chose her position for the autonomy in discharging her duties and responsibilities, including how she chose to be supported through supervision, drawing distinctions between leadership and management, and that she had difficulty finding a suitable clinical supervisor due to her seniority. She considered the quarterly meetings with other lead professionals in stroke as an alternative to CS. Each such meeting was away from their geographical location, lasted 1.5 days, funded by pharmaceutical companies. Kate contrasted this to the experience of lower rank nurses' time for supervision and professional development, whose attendance was unpredictable, dependent on how busy the unit was, and often cancelled CS at short notice.

Kate's role included offering CS and facilitating colleagues' professional development. She spoke of her reluctance to grant time to individual supervision meetings, having cancelled recurring group CS arrangements she had set up, because nurses often did not attend. This was a contrast to her understanding of why nurses were unable to access CS, her experience and concept of the term CS, and what is sought from a professional development process. Kate appeared caught in an attribution conundrum both for herself and for the nurses she was a leader for: How much power and control did clinical nurses have to shape the system in which they worked and meet their professional requirements?

Kate emphasized nurses' self-sacrifice presenting it as both a virtue and a pitfall. She stated that she undertook all her professional development in her own time ("and is that right, is it not?"), and shared her perception of ward nurses as not taking ownership but also as disempowered by the impossibility of being heard by the hierarchy who shaped nursing culture, including CS. She stated that availability of CS depended on her organisation's upper hierarchy and was only ever given lip service. I understood this double blame (lower rank and upper hierarchy) as a polarized, untenable position and that Kate wanted a manageable distance from both sides. I wondered if she experienced guilt for the portrayal of her self- sacrifice to colleagues and its impact. Kate suggested I should also interview people in upper hierarchy to enhance my understanding.

Table 4.12c1 Meaning of clinical supervision

Subthemes	Page/Line	Key words/ Phrases
Holistic focus of CS	4/119 2/44; 19/675 24/848 32/1155 33/1185	To develop your job Tick box Research-clinical gap My own way of doing it It's about yourself
Need for protected boundaries: time, duration, space, contract	1/16 2/39 4/125 5/147 3/93 3/88 4/140 6/193 7/220 10/344 17/615 18/660 34/1224	Lip service Nobody gave nurses time to do it Nurses can't get time off Time constraints of nurses Very closed…confidential Structure(d) had terms of reference & confidentiality Meet in nice venue absolute luxury Mainly in my own time Very stringent way of protected time for CS Valued if you're given time to reflect & develop yourself Being protective
External supervisor preferred	2/62 3/108 17/613 7/247 25/903	Informal supervision from medical colleagues It was outside stroke CS with a psychologist More work outside the conference room Not entrenched in clinical

	25/915	activity Somebody outwith the service

Table 4.12c2 Upper Hierarchy Shapes Clinical Supervision

Subthemes	Page/Line	Key words/ Phrases
Hierarchy as barrier to CS (to be challenged)	1/31 2/47 11/403 27/990 29/1059 30/1071 30/1073 31/1109	[CS] hasn't been given that high support Nurse managers don't put onus on CS It's about planning Perception at that level […] the head of nursing Got to have hierarchy that's supporting otherwise it's not going to happen Break those barriers Challenge Yeah it's about hierarchies
Time & support for CS depends on supervisee's position in hierarchy	3/100 5/177 7/244 7/245 15/542	It's a different level Depends what level you are in the health service Usually a day and a half We're usually overnight Not given opportunities
Leadership vs management	30/1105 8/259 25/891 25/889	Quite blind [managers] It's about leadership Leadership and management's completely different. Management, I absolutely hate it
What it takes for ideas to be heard…	8/274 8/278 31/1112	Ownership Highly unlikely to take it forward Think things through […]

		research it a bit
Dis/Empowerment in nursing (overall policy lacks vision)	5/180 8/280 10/353 10/356; 365 15/544 16/562 27/993 28/1004	A powerful group More like psychologists Empowerment; powerless They are trying to flat line nursing Shortsighted really How much they value CS because if they don't […] that's not gonna be [upper hierarchy] develop the culture of nursing, the philosophy of nursing
Unpredictability of work, control, and planning	9/323 11/369; 379 11/404 12/405 12/417 12/437 28/1018	We don't do enough for nurses Unpredictability (x3) There's a bit of planning that can be done [planning] doesn't always get done [nurses] want to make it happen but it doesn't best thing to do… (plan) autonomous role
Language traps: exaggerations and contradictions	8/283; 9/300; 10/361; 11/383 8/285 9/295 9/315	[Indispensible:] be there 24/7, 7 days/wk; nurses can't leave their patients We can't shut the ward It is "the nature of nursing", but it is "them themselves" who don't prioritize CS & CPD

Table 4.12c3 Clinical supervision and the nature of nursing

Subthemes	Page/Line	Key words/ Phrases
CS: For "tools" and wellbeing.	28/1027 35/1282 35/1288 36/1295	Find my own CS or my own education When you can't function properly There isn't that outlet to talk through things Reflect
Nursing and emotions- Guilt	14/510 14/511 6/216, 218 33/1189 36/1307; 1311 37/1338	A bit soft Softer than medicine A lot of guilt taking time out There's more emotional impact in nursing Absolutely distraught […] I can see it vividly […] stayed with me Frightened of showing their emotions
Showing empathy and staying "intact"	33/1187 33/1199 37/1335	Emotionally intact to carry out your role Arming you emotionally and physically Better to have empathy
Lack of understanding for nurses	3/95 9/295 18/645 23/827	Sometimes people cry The nature of nursing Nurses view things differently Understanding why
Prof boundaries, control,	13/457-	To put more on nurses

relegation, autonomy	13/474 13/475 14/499 14/515	We can't do everything Roles getting blurred Crossed boundaries It's beneath [medics]
Internal (personal) and external barriers: Impact of self-sacrifice culture on prioritizing professional development	9/298-9 9/300 9/315 9/325 16/578	Always nurses can't attend, always miss out But the nurses can't leave their patients [nurses] don't always see [CS] as priority Nurses always struggle to get to those sessions The plodders

4.12d*Tim*

I followed up Kate's suggestion to interview nurses at the top of the hierarchy who, she believed, set the culture of nursing in the organization, including stroke care. The participant information sheet and consent form was sent to Tim two weeks before the interview, but not the questionnaire, as his role is for all nursing, non-clinical, and not specifically for stroke.

Tim was in his mid-forties with an NHS career as a clinical nurse before management. In contrast with the busyness of the wards, Tim's office was in a quiet, architecturally interesting building outside the hospital site, which accommodated upper hierarchy. The interview was my first interaction with him, as prior contact had been with his secretary. We met in his office in work time. We established rapport quickly. He seemed to engage fully and deeply in our conversation, evident in the range of descriptive, clarifying and conceptual comments he made on CS, a topic he maintained was not his expertise.

Tim started the interview with a summary of his career, which my equipment failed to record due to low battery (using a better instrument than usual, I did not have the specific batteries). Tim searched his stationery cupboard for the particular type, apologizing for his poor acquaintance with the cupboard, explaining that his secretary maintained it. It was humbling to receive apologies when he was trying to help. The transcript was of the second part of the interview. Notes made during the first part are summarized in this introduction.

Working in strategic planning, Tim had not practised nursing for over ten years. He explained that his only acquaintance with CS had been in the 1990s, when there was "some move to doing clinical supervision in clinical areas". He spoke of a single meeting where this was announced, but as CS was new to him, expectations of him were and remained unclear. He had participated in "self-directed" CS groups which "did not work well". Team dynamics penetrated CS making it "not safe", resulting in uncomfortable feelings about the very concept, as there had been no discussion about the desirability of implementing CS, which he saw as "remote, staged, forced".

Tim shared his understanding of "a mixed picture" regarding the implementation of CS in his Trust and the need to bring together CS with mentoring, preceptorship, and training, to examine how these work together in "the totality of clinical experience". Tim emphasized consideration of individual supervisee's requirements, the importance of the supervisory relationship. He saw organisational imposition of CS as undesirable.

Table 4.12d1 Snakes and ladders- Clinical Supervision, Preceptorship, and Supervised practice

Subtheme	Page/ Line	Key words/phrases
Theory-practice gap/ incongruence and the role of CS in this (outcomes with and without CS)	5/175 6/185 6/192	Theory practice gap Doesn't chime with their actual experience Don't marry up
Elements of good CS facilitation & Transition Management from preceptorship to CS	4/122-127 3/104-5 3/107	Help people understand Transition from preceptorship into clinical supervision[…] support people through that process
Risks/ threats (assessment, failure, disqualification)	8/275 8/279	Final barrier Potentially career over
"Fully functioning nurse": Role of CS in a "lightly regulated profession"	3/103-104 10/356	Fully functioning nurses Lightly regulated

Table 4.12d2 "One size does not fit all" (page 7, line 252)

Subtheme	Page/ Line	Key words/ phrases
Individualized CS based on supervisee's needs, preferences, personality	2/53 2/55 2/59	Can't force. Willing participant The person […] what their needs are
Importance of quality of relationship in CS (trust and managing perceptions of in/competence)	3/77 3/89 4/129-134	Quite threatening Engage with it Feel comfortable; safe; secure
Developing as mature & competent professional– cyclical reward pattern of feeling competent	7/231-244 6/217	From novice to expert; absolute novice We are very comfortable doing some things
Plus and minus of separating person from practice	16/570 20/714	Effect on the individual […] effect on […]practice Looked after by people nursing […] not by being trained

Table 4.12d3 What is Clinical Supervision?

Subtheme	Page/ Line	Key words/ phrases
Gestalt of practice bolsters and boosters (Preceptorship, training CS, supervised practice)	1/29 13/452-470	Different facets work together Effective; different; CS is a specific term;
CS for totality of practice vs specific skills vs support (disciplinaries)	1/34 2/40	Very narrow spectrum Well-rounded; totality of practice
Reflection vs assessment vs judgment on performance	9/296 10/329 11/391 13/460 14/479	To reflect accurately Judgment to be made Capability; conduct Checking that you are… Satisfactorily demonstrate
Conceptual map: CS and organization's plan (as "not core activity"): purpose, place, budget	20/709 1/10 17/587	not a core activity organizational planning A refresher about what we do in totality
CS requires specialist training	5/145	Specialist training
Transactional approach: Evidence base, economics, politics	8/292 20/723; 728	Transactional approach Evidence base

4.9 Stroke Unit 2

4.13a Betty

Betty was in her early 50s, a distinct presence as a clinical and administrative leader. She had worked as a nurse for thirty years and in this stroke unit since its creation, having developed herself along with the service and with her colleagues. She signed her emails: "Love, xxx". At first this seemed strange, as our acquaintance did not warrant this level of warmth. However, she evidenced this through practical help and advice: she facilitated my visits and interviews and explained that staff would prefer paper rather than online questionnaires.

Betty seemed to know everything about her service, from clinical details to where a key to a particular room would be found on a specific day and time. She used her office only when speaking to patients' relatives or to staff, otherwise it was available to anyone needing a quiet space while she was in ward bays, sleeves rolled up, doing clinical tasks.

I go round saying good morning to patients and having a quick scan who's got drip up or who is looking in pain and it's amazing what you can pick up in a couple of minutes, what's happening to a patient… (14:505-509)

Betty described close and egalitarian relationships within the unit's multi-disciplinary team:

we've sort of all developed together, physios, OTs, and it's helped because we're all on one landing… (5:170-172)

and the evolution of the unit as their "baby":

becoming a ward manager for the first time, in a specialty such as this, which is growing, […] it's been a major challenge but because it's like our baby, we've grown up with it and we've got to know it so thoroughly and with the support of each other, that's how I've sort of gone on and developed the unit as it is. (5-6:183-190)

"Growing up together" had resulted in relationships based on interpersonal knowledge gained through emotional investment in teamwork.

…not only to know the patients as people and their needs, it's about getting to know each other as a team and understanding what each different consultant has, their own ways, so we understand how they…what their needs are and erm I always believe that if you're in a job, although you've signed your contract and you've done your training, you have to be passionate about what you're doing and if you don't like the specialty then move on and find something that you're passionate about, it's no good being in a

specialty if you're not passionate about meeting the needs and I feel that all my staff are passionate about that. (7:244-257)

Professional relationships were based on empathetic, warm communication, described in instances of seeking clinical support from Dr. X:

I found him really helpful and if anything I didn't know about stroke we'd ask him and he was very and still is very supportive and is able to answer any question that you didn't understand the answer to. (3:76-80)

Betty had good readings of the "thermometer" of staff motivation and morale: for example, when the outcomes of national inquiries injured staff's pride, they would threaten to leave for work in a supermarket. She was able to encourage, coax, and restore them back to team functioning, in addition to encouraging a shame-free learning culture on the ward:

Yeah, there is… A lot of communication. Cos if you don't…as we always say, if you don't know, ask, it's not a sign of failing, it's a sign of wanting to know and learn and develop yourself, but it's a sign that you don't want to put the patient to any harm…. (9:321-325)

Betty helped ward nurses *feel proud* (15:524 & 527) by ensuring that messages and acts of gratitude were conveyed to staff, *how wonderful they are, this is what you've done* (15:526), telling them *how brilliant they are* (15:534). This communication facilitated managing staff shortages and overcoming difficulties in meeting targets.

"Table 4.13a1 We" (Relationships are the key)

Subtheme	Page/ Line	Key words/ phrase
Continuity of patient care through relating	8:267 8:278	Better rapport A degree of continuity
Major challenges and developing harmoniously	6:187 6:187 8:263/ 283	Major challenge Our baby Staffing shortages/ levels
Importance of communication (inc. feedback)	9:321 15:524 15:526 15:527 15:534	A lot of communication. Make them feel proud How wonderful they are this is what you've done You should be proud of yourself Tell them how brilliant they are
Egalitarianism	5:172	All on one landing
Reporting vs seeking solutions from manager	14:495 14:497	I think you should know this by now Finding your solutions, then coming to me
Impact of national inquiries on self concept	15:529 15:530	They all start to get down They're all going off to work in a supermarket
Role of colleagues during lengthy transitions	2:54 2:58 2:71	Without a band 6 I were doing sort of it all and sinking A band 6 who was very supportive
Team as family	8:264 15:522	We're like a family to get to know the staff

Table 4.13a2 Boundaries

Subtheme	Page/ Line	Key words/ phrases
Helping/ caring in excess (own compelling need)	10:353 11:395 11:398 12:427	It overstretched me I take it too far I can't let go, I have to help them I can't say no to anybody
Personal responsibility and systemic failures	19:670 19:681 19:685 19:687 19:689	We'd not managed to do things because of others' schedules Massive audit yesterday I'm not the only one It's not me that's failing the system It's not just me
Leadership, niceness and assertiveness	11:383 11:384 11:389	I'm always accused of being too nice. I'm diplomatic Should be more assertive
Targets, protocols, pathways & over-management of risk	5:153 5:154 5:158 5:161-163	Key performance indicators On the pathway for stroke A lot of targets Protocol/s (x3)
Passionate: similarity & contrast of self and other	7:251-255 12:433 16:574-5 16:581-2 16:587	Passionate (x4) I like how I am (x2) Less softer a bit harder I can't, I am what I am You can't be who you're not, can you? Her character is so

	17:600	different to mine
Self care	3:107 18:643 18:645	I've just created […] without really any support from my peers [CS] gives me confidence I'm doing the right thing

Table 4.13a3 Clinical Supervision is…

Subtheme	Page/Line	Key words/ phrases
A way toward managing fear of failure	18:641 18:644	It is valuable at the time I'm not failing/ a failure
Personal & Confrontational	11:377 11:383	I've got to stop being […] Always accused of […]
Different from management	10:366 15:550	Somebody neutral Need somebody to go and talk to
"a moan" (feedback, expression of emotions)	11:371 11:372 11:372 11:374	Meet up to have a moan Not gone quite right How did you handle it? Could have done better
Trans-disciplinary	4:11 4:140 9:311	Dr [X], he was my clinical supervisor Consultant's clinical supervision [physios & OTs] ask for our [nurses'] advice
Supporting, validating, exchanging ideas	9:329 10:339 18:645	The support Not quite sure I'm doing the right thing the right way,
Insufficiently used	15:543 15:547	Any leader needs CS We don't use it as much as we should

Table 4.13a4 Role ambiguity

Subtheme	Page/ Line	Key word/ phrase
Failing alone	2:62 4:110	Fail (x4) I'd failed myself Without causing too much concern
Learning from mistakes	2:59 14:513	I didn't know how to […] perform the role I'm a good role model
Emotional investment into work, pressure, & fatigue	13:457 13:463 10:356 10:357	I'm kinaesthetic […] a huggy sort of person that gets emotional easily I'm a person who likes to help It got me down
Self-motivated professional development	2:39 2:42	I decided to stay in stroke Always looked upon stroke as the forgotten disease
Incentives and mechanisms of personal change	2:39 2:42 12:70 7:600 17:606	I decided to stay in stroke Always looked upon stroke as the forgotten disease I felt like I were being looked at […] as if I were struggling when I wasn't A tall order A bit of me would rub off on her and a bit of her would rub off on me

4.13b Elena

Elena was in her mid-30s and had been a charge nurse in SU2 for two years. She presented as very calm through her movements, facial expression and tone of voice. When I arrived for the interview, Elena was caught in three things: a visit from the Primary Care Trust commissioners; organizing cover to allow a distressed nurse involved in a clinical emergency to manage the personal impact; and managing the clinical scene. We rearranged to meet later that day.

Elena's role included overseeing various professional development activities in which there was an element of CS. She described her understanding of CS narrating her experiences as a clinical supervisor. Many of these were observations and feedback during assessment of specific competences. We discovered that stroke nursing involved sensitive communication between staff, patients and their loved ones. Communication contributed to the team spirit and to feeling 'held together' at critical times, like sharing news of the deterioration and impending death of a patient.

Elena opened the interview by differentiating between CS *on a very informal ad hoc basis* (1:25), which she described at various points in our conversation, and *formal clinical supervision* (1:22), which she stated did not happen on her ward, although later she re-interpreted as CS the monthly meetings the ward manager offered to a vulnerable member of staff. In her account, CS was situated firmly in the domain of competency development and happened mainly through conversations with colleagues when in doubt. It included observation, assessment and feedback (4:110), but not in-depth shared reflection.

Elena discussed CS in relation to competences (2:36 & 46; 3:73) required by healthcare assistants on stroke wards, detailed in a book and, as the assistants already had them, involved very little new learning; a box ticking exercise (18:659), observing them and certifying competences. Her own experience of CS in a previous post was similar:

that was my understanding when I was clinically supervised on [previous place]. I had er the ward sister would say, right, tomorrow I'm going to come and just check that you're putting cannulas in correctly and you're doing this and you're doing that and so she followed me around and as I did practical things she supervised me and then said yes I was OK to carry on, so, that was my update for the year. (3:99-106)

you don't hear about it very often while you're on your little clinical area, you just don't hear about it. You hear about assessing all the time and you hear about competencies and various other things but not about supervision. (34:1229-1233)

Table 4.13b1 Informal ad hoc clinical supervision

Subtheme	Page/ Line	Key word/ phrase
A procedure for checks, observation, assessment and feedback on manualized learning of tasks	2:50 3:102 2-3:72-75 2:49 18:659 18:654 18:655	A booklet we work through Check Supervised and assessed Assess their competency Regular checks Cross all the Ts and dot all the Is. Assessed & watched & supervised
Self-audit: Procedural box- ticking	17:626 18:637 18:640	A self audit tool A tick box […] definitely Yes/ no
No time for reflection except alone at home (no shared reflection)	18:643-4 33:1186 32:1148	Haven't got time to do that The privilege of time Go home & reflect upon it
"Policing" (follow up)	17:610-616	Policing (x4)
Fulfilling the nursing role	21:773; 22:775	Fulfill their whole role
Managing ethical dilemmas	4:127-9 5:163 5:182	An ethics team Our chaplain Nice not having to make a decision and worry
Managing unpredictability	17:594 31:1137	We have a SOP for everything Supervision there & then

Managing the emotional impact of clinical work	12:440; 28:997 20:701 22:782; 806-808 26:933 26:942	["healthy"] detachment The benefits […] outweigh…(rationalizing) (en)courage x5 Go home and talk to family Knock on [Dr's] door

Table 4.13b2 Worker's emotional investment into clinical work

Subtheme	Page/ Line	Key word/ phrase
Emotional response to high dependency needs and to individual patients' characteristics	27:968 25:908-914 26:957	High dependency acute Can always relate to something in the family Certain patients get […] you
Conveying bad news	9:305 9:313; 316 11:383	[family] are misguided Anger, denial; traumatic [Nurse] crying her eyes out
Nursing as traumatic job	10:347 13:449 30:1074 30:1077 30:1081 31:1111	It's huge A lot of sad things and upsetting things The intensity […]something that you take on yourself Feeling the enormity of it It does get too intense To last the day out
Compassion and detachment	10:354 11:373 11:383 11:395 13:477 13:450 25:909 12:441 13:465	…want a lot from you Staff do get worn down [Nurse] crying her eyes out It's something that you never forget Too close to home Healthy detachment Everybody thinks of their own lives Not easy to do [detach] when you've been involved Nurses are compassionate …impinge, yes.

	13:472 13:478	When you do break down
Between reality, empathy and hope	27:983 27:987 28:1026 28:1017	But they won't be alright No, no, no (can't offer hope) A slow long hard process Very realistic and he [Dr] is very thorough with his comments
Rumination in lieu of reflection	11:400 11:404 11:425 13:444 12:430 13:472	I'll never forget And you just go over Questions that you question yourself I'm at home thinking about quite a lot Go over your decisions Impinge
Benefits of "formal" CS	12:409 12:414 36:1297 36:1298 36:1311 36:1312 36:1317	We talked it through Come to terms with it Feel committed and part of the team Back into the swing of things sickness has gone down feels she's being supported and listened to very empowered

Table 4.13b3 Workplace culture

Subtheme	Page/ Line number	Key word/ phrase
Effective communication	7:231	It is finely tuned […] it does run very smoothly
	7:243	We do work very closely together […] we knit together very well
	14:481	you can always bounce off each other
Disagreements and healthy discussions	15:517	We have healthy discussions
	23:815	Healthy discussions about what's best for our patient
	13:479	A lovely team on here
Leadership by example	28:1012	Always a little silver lining
	28:1013	[Dr X] is marvelous with his patients
	28:1014	[Drs] are good at informing relatives […] and patients
	28:1017	Very realistic and [Dr] is very thorough with his comments
Coping is enhanced through empathy & team spirit	6:203	We all value each other's opinions
	14:480	Very supportive of each other
	14:513	A nice family, a caring family [the team is]
	30:1091	Because we all help each other
	30:1092	There's good team spirit

	30:1098 14:481 30:1101 31:1107 31:1210	She hasn't had to be asked Just moved in and helped Been looked after now, so she'll be OK What can I do to help you And work through it The knowledge that there is always somebody that you can turn
Personalized patient care and family involvement	6:205 7:250 23:940	Work so closely with the patient Involve the family as much as possible in all aspects Recognizing when patients aren't the same
Acknowledging the emotions of patients and their loved ones	24:849 24:867 11:383 11:387	You'd be abnormal if you didn't feel like this. I can't recognize me in this bed [Neglect? Denial?] Talk to the wife and explain She's [wife] doubly hurt

4.13c Caroline

Caroline was in her mid-50s and had worked as an NHS nurse for 34 years, mostly in her current Trust. She was a ward sister for 13 years (10:338). Caroline offered to participate in this study via a colleague who mentioned my research. Her interview was arranged during my recruitment activity on site and occurred on that day, necessitating the phasing of the interview into two parts to accommodate Caroline's clinical commitments. We avoided conceptual fragmentation by summarizing the first part at the start of the second section of the interview. Caroline's narrative was rich, containing descriptions of complex concepts, as indicated by the variety of themes represented in what she says.

Caroline was in role-transition, gradually leaving her post as a full-time ward sister elsewhere and engaging in a different kind of work in this stroke unit (undisclosed, to protect her anonymity). She distinguished between clinical and managerial supervision and other support mechanisms, having experienced definitional CS as supervisee within a group-CS arrangement, albeit only for three sessions. In her account, CS provision arrived in her workplace with a champion, and ended with the departure of that person. She spoke of the absence of any CS provision in recent years, the potential benefits of CS on the psychological wellbeing of staff, and her wish that it be reinstated.

[…] personally, I think it would be a very good thing, er stroke's very…it's difficult work, we know that communication with patients is difficult, we know that they're in a very poor condition when they come to us, that the work can be quite heavy, that patients need feeding and lots of…so, it's hard work… (25:898-903)

Table 4.13c1 Pressure and Stress

Subtheme	Line/ Page number	Key word/ phrase
Physical and emotional strain: tears and incidents	2:52; 6:198	traumatic work
	7:228	It's a tough old world on the wards
	10:345	You stay late every day
	10:347	there's so much to do out on the ward
	10:354	very often they're coming in tears
	10:385	the pressure of the job and it culminated in this particular event [pt death]
	13:455	they end up in tears
	25:901	burden
	25:893	quite heavy
	25:890	difficult
	26:927	Very stressful work
	26:937	Exhausted and stressed
The strain and stress of not being heard	10:380	wards being dreadfully short staffed for months.
	6:198	very often the feelings of the nurses are overlooked.
	7:192-232	you take on quite a heavy burden and are expected to deal with it.
	13:447	Frustration starts to build up
	13:449	They're stopping, they're stopping them
	20:725-7	when staff are under so much pressure and you're

		not being listened to in terms of staffing levels
Disempowering cacophony	13-14:474-476 21:737 22:783-4 21:753 21:759 21:767	what the Trust wants from nurses is tasks being completed in the way to the protocol strictly and every dot being… you don't get chance to say you don't make your own decisions now, you follow what you are told you must do. people say my mum needs the toilet now and they need this and they need that and she needs. Running around after everybody and what everybody says You could miss something vital because you're being told what to do by a relative.
Dehumanization of staff	13:440 21:737 21:738 22:775 22:779	Automaton You don't get chance to say You just have to take this sort of insidious… Not given enough time to think Not given the opportunity to make decisions. you're not a person really,

	27:972 27:958-7	you’re just… you’re expected to take all this.

Table 4.13c2 Deteriorating professional status of nursing

Subtheme	Page/ Line number	Key word/ phrase
Proceduralization	13:441 13:442 15:538 22:795 22:799	It's task orientated You've got this to do, 'cos it's task […] you've got that to do […] by that time, and you've got that and you've got that repetitive mundane tasks there's no individualized patient care any more it's all about tasks
Paper power	21:740 12:435 14:482	From being good people and highly respected […] gone to the complete end of the spectrum we have the rounding form, you have to tick this form, there's an audit form If you haven't written it down, you haven't done it.
Defensive practice	14:496 14:482	because in case there's ever a complaint or an inquiry If you haven't written it down, you haven't done it.

Table 4.13c3 Boundaries

Subtheme	Page/ Line number	Key word/ phrase
CS and not CS	2:51	I don't think you would call it clinical supervision
	2:54	It's not quite the same
	3:76	although there's more (with CS)
	6:192	training processes and it is quite clinical, you do this, you don't do that [CS vs training]
	6:197	it's important to support people emotionally
	10:352	not want to go to a ward sister or a manager
	8:270	speak to someone unofficially
	8:272	you only have your line managers
CS is not available	1:17	the problem is she left the Trust and then the clinical supervision stopped
	2:49	The person went and we never had any further clinical supervision
	2:67	we don't get any clinical supervision at the moment
	8:272	you only have your line managers
	8:271	it's knowing who to talk to
	11:371	It's [CS] not there.
CS contract	7:242	a little contract almost

	7:219 7:240	protected environment like a shared agreement
Confidentiality	1:35 3:107	anything that was said was contained within that group a closed environment we could feel free to discuss

Table 4.13c4 Clinical Supervision as Learning

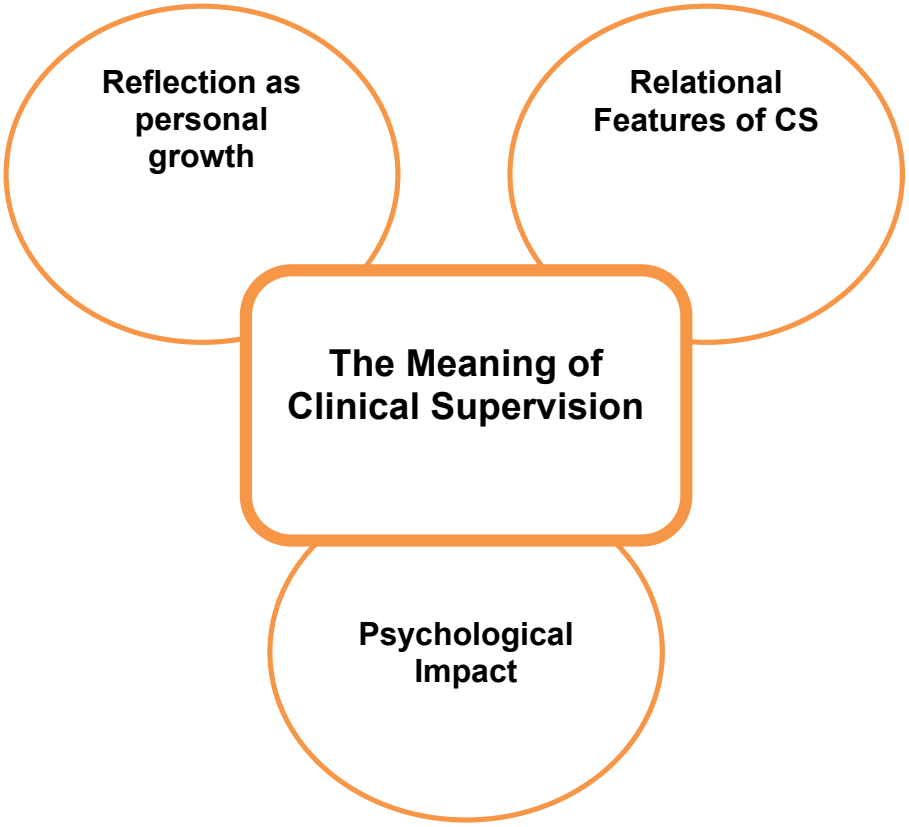
Subtheme	Line/ Page number	Key word/ phrase
Reflection	4:136 9:294 9:295 9:313 19:667	Time to reflect on practice Reflection To participate in reflective practice Anything you could learn from that situation Chance to reflect
Autonomy-automaton	13:440 24:857 24:867	Automaton Quite an autonomous practice Stand alone with yourself responsible for everything
Training for Supervisors	1:11 1:13	you had to have training to do that I've not been trained to do that

4.14 SUPERORDINATE THEMES

In this section, I present four superordinate themes (Table 4.10 and diagrammatically in Diagram 4.10). In attempting to identify a frame through which the data can be presented and understood, I note that whilst all four themes are significant and representative of the experiences of my participants, 'The Meaning of Clinical Supervision' is the most potent relative to others. The aim of this section is to help the reader understand why this might be the case. The superordinate theme 'The Meaning of CS' is central for reflection processes to happen, for the development and quality of the supervisory alliance, and in mediating, protecting, and restoring (or otherwise) the stroke nurse from the potentially damaging experiences of work. 'The Meaning of CS' illuminates aspects of the way in which CS is lived in contexts of organisational, cultural and professional features of stroke nursing which might impede or facilitate its presence.

Whilst it is not possible to claim whether CS does or does not exist, or to identify a full commitment to CS on the part of individuals or organisations, the data presented thus far represent a nuanced version of individuals' realities and indicate the potential for a behavioural outcome on the part of individuals and organisations. Ultimately, it is my conclusion that participants' meanings of CS highlight a circular process between what I have called ambiguity (cognition) and ambivalence (emotion) which result in and are reinforced by avoidance (behaviour/ action) at personal and organizational levels. This framing of the 'Meaning of CS' as the pivotal of all four themes, I hope, will do justice to these claims.

Diagram 4.14 Relationship between superordinate themes



The analytic process produced four superordinate themes with subthemes as in the following table:

Table 4.14 Superordinate Themes and Subthemes

Psychological Impact	**Reflection as personal growth**	**Relational Features of CS**	**Participants' meanings of CS**
Emotional Labour	Transformation	Boundaries, time, confidentiality	CS as essential professional activity
Guilt and blame	Personal awareness	Relational safety and trust	CS as task- and organization-focused
Responsibility and powerlessness	Reflection and the "mirror"	Empowerment	CS as structuring chaos
Maintaining a sense of self			CS as a challenge

4.15 Superordinate theme 1: Psychological Impact

4.15a Introduction

Participants gave various factors associated with the psychological impact of work on the worker (*it's a stressful job,* Di, 45:1619; *when you can't function properly,* Kate, 35:1282), including *unpredictability* (Kate, 11:369-379 x3), personal tendencies to invest too much in caring (*I can't let go, I have to help them,* Betty, 11:398), the range of mechanisms available to nurses -both within themselves and in the workplace- to manage the impact of routine nursing, critical incidents experienced as psychologically demanding, the emotional climate of the work context (eg. team functioning, staff relations) and the culture of nursing as a profession. Participants presented CS as a mechanism that could help nurses to manage the emotional impact of work through opportunities *to cathartically say* (Jim, SRU, 2:48), *reflect* (Kate, 36:1295), seek *clarification*, confirmation/ *reassurance* about clinical decisions and actions, and *peace of mind* (Adele, 28:1002-1013), although *we don't use it as much as we should* (Betty, 15:547).

Participants experienced poor returns for their emotional investment in work mainly due to defensive bureaucratic expectations and inadequate time to accomplish not only the rewarding, relational aspects of work but even mundane tasks. Nursing was experienced as a traumatic job with clinical incidents and their consequences (Elena, 30-31:1074-1111; Kate, 36:1310-1314; Caroline, 11-12:392-424) against a background of job demands, pressures and stress.

It is an intense role being a nurse and it's very underestimated. (Sue, 8:270)

There's more emotional impact in nursing (Kate, 33:1189)

Additionally, role ambiguity had resulted in more volume but less valued work (*beneath* the medical profession. Kate, 14:515) to be completed in less time. They experienced the organization as deaf to their voices in organizational decision-making, especially where there was no CS, which affected their attributions of responsibility and the emotions associated with it. They had to maintain a professional façade in the constant encounter with the shock of sudden disability, grief, loss and death, and maintain a sense of self without thinking space or support. Where supportive supervision was available, nurses experienced it as an opportunity to construe events in ways that softened the impact, reducing their experience of helplessness. Where the supportive supervisor was also the manager, there was opportunity for relief in passing issues onto someone they considered more influential in resolving them.

However, accessing CS was limited by nurses' diffidence, their concern about contextual connotations about competence and (not) coping and help-seeking generally, and by the particular "flavour" CS had acquired in the workplace.

This superordinate theme consists of four subthemes:

- Emotional Labour
- Responsibility and Powerlessness
-Blame and Guilt
- Maintaining a sense of self

Table 4.15a Superordinate theme 1: Psychological Impact

Subtheme	Brief description	Participant numbers	Key quotes
Emotional Labour	Nursing experienced as emotionally intense. Pressurized conditions, few opportunities for restoration, expectations to maintain professional façade, to manage own and others' emotions. CS offered chance for venting and processing emotions.	8	*it might not just be about clinical things, it can go much deeper than that* (Sue) *drags you down* (Sue) *very often they [nurses] are coming in tears […] they end up in tears […] exhausted and stressed* (Caroline) *on automaton* (Caroline)
Responsibility and Powerlessness	Nurses had increasing number of duties, tasks, and responsibilities to perform in less time. They felt they and their professional bodies had no say. CS had ameliorating effect.	11	*Wards being dreadfully short staffed for months […] you stay late every day* (Caroline) *this is your responsibility, code of conduct is this, stroke standards […]* (Sue) *to put more and more on nurses […] roles are getting blurred now, really blurred* (Kate) *it's a bit beneath them [doctors]* (Kate) *like a lion without teeth.* (Sue) *they [nurses] can feel powerless to make things change* (Kate) *you don't get chance to say […] you are expected to take all this* (Caroline)
Blame and Guilt	When incidents occurred, nurses were blamed and expected to make amends (guilt). National Inquiries and the media reinforced these. CS enabled different construing.	8	*If you haven't written it down, you haven't done it […] in case there is ever a complaint or an inquiry* (Caroline) *you're beating yourself up too much* (Sue) *She's just not performing because we are so busy […] work on her and take her down the competency route [to dismissal]* (Steve) *your husband gets all your moaning* (Catherine)

			[guilt] it's grown like topsy and it's eaten away at them (Sue)
Maintaining a Sense of Self	Nursing culture of self-sacrifice, organizational culture, local culture of stiff upper lip & the personal drive/ need to be helpful restricted engagement with CS.	8	*I can't dissociate myself from being a nurse* (Sue) *a definite need with nurses to assist and help […] come from somewhere other than just it being a task, […] from a need to do something that benefits another human being* (Sue) *do that extra, extra mile for a patient* (Natalie) *learn by whatever mistakes you make and not take 'em too personally* (Sue)

4.15b Emotional Labour

We're really dealing with people at their lowest ebb, aren't we, and it can be so draining. It's like I said to you earlier, it's not physical…it is physical, you can do the routine stuff, you can do absolutely everything routinely 'cos it's like inbred in you but when it comes down to, you know, patients dying or even if they're not dying they've had massive life changes from stroke, haven't they, you know, and it's dealing with that sometimes can absolutely drain you, can't it (Di, 43:1547-1555)

In various ways, emotions were the elephant in the room. Encountering the abrupt and severe changes in patients' lives, the ensuing disability and dependence, nurses found their work physically and psychologically disturbing, especially where the goal to save a life was not achieved. Nurses were expected to conceal their psychological reactions routinely, to maintain a professional façade assumed to be useful and helpful to patients and families.

I think after a bad shift, yes, or after a problematic one, I think you can take your work home. I think the more, the longer you do the job the better you get at it 'cos you think you've got to get your work and family life separate, but there's some things that you always take, there's always some things that affect you more than what other things do (Catherine, 35:1280-1287)

Being professional meant *running around everybody and what everybody says* (Caroline, 21:759), completing tasks *to the protocol strictly and every dot being…* (14:475), while tolerating frequent interruptions during tasks where errors entailed disciplinary consequences, for example, dispensing medication. *Frustration starts to build up* because *they [visitors]'re stopping, they're stopping them* (Caroline, 13:447-9), and *you could miss something vital because you're being told what to do by a relative* (21:767). Against this background, the psychological impact of major events, like patients' deaths and their consequences, also had to be held inside, as part of the professional façade.

Staff do get worn down by it, I mean today it's really really sad on the ward at the moment we have a gentleman who came last night who is 48 and he's got a brain stem bleed and erm he's had a re-scan today and he's terminal he is going to die in the next 24 hours probably and his wife is there and she's got two young children, 4 and 7, and her mum's there and his mum is there and they're shocked, it's like yesterday they were a happy family and today this has happened and [name], my staff nurse, is in the office crying her eyes out, she's had to talk to the wife and explain that, you know, should she bring the children in and yes she perhaps should bring them in

to say good bye and they're 4 and 7 so she's doubly hurt, isn't she, she's carrying her children's hurt and her own hurt. (Elena, 11:373-388)

Although the patient and his family were central in this life-and-death story, the nurse involved was carrying, and overwhelmed by, the emotion, the shock and the pain she was witnessing. Later, Elena spoke of the death of a stroke patient she had looked after as *something that you never forget* (11:395), her use of perfect tense (*he's bled and died*, quote below) juxtaposed with past perfect when speaking of when the patient was alive denotes the currency of the incident. She experienced a deep sense of responsibility that became rumination as she continued to *go over it* (11:404) in her mind, holding herself accountable with a self-blame and guilt.

I'd been looking after him and the next morning I came on and he was more unwell and he's bled and died and you just go over should he had ever been thrombolyzed, you know, what would his chances have been if we hadn't have thrombolyzed him, and having talked to the consultant, I spoke to Dr [X] at length about it, I said I feel terrible, I can't get it out of my head and we talked through (Elena, 11-12:400-413)

She had sought to make sense through a detailed discussion with the consultant on the ward, focusing on her responsibility, clinical decisions, and actions. She had understood that the death was inevitable, which *doesn't make you feel any better but I think you can come to terms with it a little better.* (12:413-4)

Kate also spoke of witnessing the death of a patient early in her career as an incident that impinged on her. She had no support to help resolve the impact of that experience *there isn't that outlet to talk through things* (35:1288).

I can see it vividly, so, it's obviously stayed with me and perhaps at that time you should have had somebody that you could talk it through with in a supervision sort of way really, you know (36:1310-1314).

Switching from "I" to "you", Kate's narrative may indicate advice (should this happen to *you*) or Kate's attempt at psychological distancing from this event. She explained the sensitive balance necessary between experiencing and expressing empathy while also staying psychologically intact (33:1187). This was similar to Elena's *healthy detachment* (13:465) which, she clarified, was difficult and often impossible to achieve.

Informing relatives of the death of their loved one was an especially difficult duty. Relaying bad news and absorbing others' reactions in a professional and compassionate manner demanded sensitivity, empathy, and resourcefulness from nurses. These skills and disposition could be hard to access under the pressure of the work circumstances participants described.

I think it's the expectation that don't wear your heart on your sleeve sort of thing, […]…but it's difficult. […] it's been said, hasn't it, over the years […]…you've got to be hard to be a nurse because how could, you know, deal with somebody who is dying and all that and not be affected, so nurses are hard, I think people still think that a little bit but I think there is that sort of, you know, you can't be coming and every time somebody is ill or dying or whatever you've got to be crying (Kate, 35:1269-1279).

Sometimes, situations at work reminded nurses of personal situations, which could complicate the process of emotional labour,

They are too close to home or, you know, I don't know, just little things and […] you do break down (Elena, 13:477), making CS valuable in developing awareness and understanding for supervisees and their supervisor.

a staff nurse perhaps who is finding that extremely difficult and it's only perhaps in the clinical supervisory situation that she might say there's something like well this reminded me, 'cos we all bring our own experiences to what we're doing, of when my mum died or this happened when my father died and, and so, there is a personal, there is that sort of […] a bridge. Because […] it might not just be about clinical things, it can go much deeper than that, it can go a lot deeper than that. (Sue, 17:583-589)

Emotions regarding the inadequacy of the conditions in which this work was happening were also to be processed inside, as employers appeared deaf. Caroline highlighted the impact of the *burden* (7:231; 25:901) of work on nurses' capacity to think, plan, and avoid errors which started formal complaints and litigation. This elucidates the emotional burden carried by the nurses who have to reconcile with their own psychological reactions, blame from outside, but also the background practical conditions in which incidents happened (staffing levels and intensity of work).

Emotions about working conditions included practical issues,

Wards being dreadfully short-staffed for months (Caroline, 10:380)

When staff are under so much pressure and you're not being listened to in terms of staffing levels (Caroline, 20:725-7)

and psychological wellbeing,

very often they're [nurses] coming in tears (10:354), *they end up in tears* (13:455), but

very often the feelings of nurses are overlooked (Caroline, 6:198), they are *not taken seriously* (Sue, 3:104).

Caroline emphasized the strain of the experience of feeling not heard. With a series of "but" (rather than 'and') that perhaps indicates the difficulty she experienced holding all the pieces together, she summarized what was also said by others: how the absence

of CS to support stroke nursing may have led to nurses breaking down. She linked CS to the level of understanding, influence and esteem nurses experienced at work.

and very often they're coming in tears but I'm not their clinical supervisor but we are there to support them, but they do come to you in tears and we've had that in the last few…I've had that in the last few days but there's no time for them and you know if there were…if we were offered clinical supervision, I think, as a ward sister I would want that for staff, I think it's a good thing even if you could just spare an hour once a month or something that helped the staff to feel that their views were important and also the fact that if they had any concerns or they wanted sort of an opportunity to discuss how, how they'd performed or how they felt or they could have that but I'm afraid… […] it's not there. (Caroline, 10-11:353-371)

Perhaps worse than not being listened to was the absence of trust towards ward nurses and the experience of unfair punishing consequences. Becky struggled to process the psychological impact of the persecution of ward nurses by nurses in higher positions (*what have we done wrong this time?* 15:472). She described her unit as a *terrifying environment* (13:416) where *you daren't breathe* (13:413), with *low morale* that *will never rise [sic] the standards of care* (27:877). Feeling *terrified senseless* (38:237) and *anxious, stressed all the time,* she *had to go for CBT* (13:427). There was no provision of CS to support her or her colleagues' work, and as she explained, if CS were introduced, nurses would not use it due to lack of trust for its purpose.

4.15c Responsibility and Powerlessness

Participants described an unbalanced reality at work, with increasing –mostly bureaucratic- responsibilities, less time to complete their work, having no say, and experiencing their work as not valued. Various demands and pressures made stroke nursing *very stressful* (Caroline, 26:937) *traumatic work* (Caroline, 2:52; 6:198) and *the biggest thing, it's out of your control* (Adele, 26:925), often associated with *red tape, paperwork* (25:914).

Having entered nursing believing in a healing relationship, several participants described incongruence, a *theory practice gap* (Tim, 5:175) that *doesn't chime with their actual experience* (Tim, 6:185). They found themselves in a sea of *prescriptive* (Steve, 20:703) *repetitive mundane tasks* (Caroline, 15:538) and little time to complete them all (so *you stay late every day,* Caroline, 10:345; *exhausted and stressed*, 26:937), with limited scope for personalizing patient care (*don't marry up,* Tim, 6:192).

Many such tasks were part of organizational preemptive strategies against litigation, paper power towards proving quality: *We have the rounding form, you have to tick this form, there is an audit form* (Caroline, 12: 435). Paper had the power to annul personal experience, *if you haven't written it down, you haven't done it* (Caroline, 14:482). Participants who worked in acute units were more perturbed by this than in rehabilitation.

[…] but that's how they want us to do it because in case there's ever a complaint or an Inquiry somebody can then go through the notes and say well, look we did do it, it's there, but that's not necessarily saying that you didn't do it because it's not there, you just didn't have the chance to write it down. (Caroline, 14:495-500)

Additionally, Kate and Elena spoke of having encountered situations that training did not prepare for, especially the death of patients, an experience more often reported by participants from acute units. Although such events were intrinsically emotionally taxing, they became stressful when followed by investigations, as happened in a unit Caroline (10:385) worked before, where a patient of very advanced age and frail health died. A formal investigation followed, with little support offered to staff on that shift. This indicated that although clinical events/ incidents were emotionally demanding, they became learning or stressful experiences depending on organizational response.

Role ambiguity was associated with a fractured (and fractious) boundary between nursing and other professions that was *getting blurred now, really blurred* (Kate, 13:475), with increased expectations that nurses take on additional responsibilities that were now considered *beneath* the medical profession (Kate, 5:514). Several nurses experienced sadness and indignation about others' low appreciation for their profession. Sue supported her personal experiences of longstanding undervaluing of nursing (for example, ignoring the importance of time to develop clinical relationships) with historical examples of NHS-wide organizational behaviours degrading to nurses' work. I understood her metaphor of her professional association as *a lion without teeth* (37:1352) as also conveying the metaphor of kick in the teeth.

It's always been seen as tasks that we do. I mean the Hay report in the early 80s, that were down to tasks, nursing, anything we did was down as a task, it was broken down into tasks and because it's a task anybody can do it, you can get anybody who is unqualified to do it, keeps the cost down, etc. It's very political, I think. (Sue: 35: 1251)

Fractured role boundaries resulted in even less available and more fractured time, became a further barrier to nurses' professional development including CS, and added

to the pressures and stresses. Particularly where CS was not available, nurses felt not heard and effectively lacking power to engage with and influence their organization.

[…] it's just about nursing as a profession really, and about the way that nurses work really, that they can feel powerless to make things change […] they're in the life or death situations trying to keep people alive which is what they came into nursing about […] but they sometimes feel powerless because it's…at the end of the day, the priority is always to the patient (Kate, 352-65)

Justifications as given by Kate and others could function as defences reminding of the vital importance of their work, but they were also silencing nurses' voices about such experiences of lack of respect or esteem for their work, leaving associated emotions bottled up. In settings of tight hierarchical boundaries with no CS arrangements, participants experienced barriers to routine 360-degree feedback, to the development/ improvement of their work conditions and their employing organization. There was a dormant awareness that nurses had increasing responsibilities and decreasing or no power to respond to them in ways that maintained their motives, wellbeing, and professional esteem. Nurses felt helpless in resisting these, also experiencing their professional associations as powerless and ready to compromise.

Managers' awareness, understanding and response to the additional responsibilities and lack of time varied. In SU1, where sickness rates were high and recruitment difficult, a rulebook approach applied:

She's [nurse] just not performing because we're so busy in acute, she's come from somewhere that isn't. She's not really doing the job that she needs to be doing so we're having to sort of work on her and take her down the competency route but that goes beyond supervision then, doesn't it, I think…but it starts off as supervision when you try and say look, we need to do this, let's deal with this, let's do that, and the other, and that hasn't happened so it takes a different turn, doesn't it? (Steve 25:899-911)

In contrast, Betty had *gone and done it [task] for them [nurses]* (14:481). Managers experienced a similar reality to ward nurses, with increasing responsibilities, including multiple and incompatible roles as leaders, managers, supervisors and cheerleaders (Sue). Senior staff presented different ways of managing their powerlessness. Kate acknowledged *time constraints for nurses* (5:147) but expected them to take *ownership* (8:274), responsibility for getting what they needed. Steve became directive towards ward nurses (*go and do that, you need to do it now*, 20:510) and resigned to the reality of work conditions: *if you can't send them, you can't send them [for CS]* (11:383). Betty had also used an instructional style (*where I'll say do this, this and this and go and do it*, 14:480-1) as well as positive feedback to restore staff morale.

I were doing sort of it all and sinking a little bit at times because I didn't really know how to, you know, perform in the role except like what I'd watched my other manager do and I didn't want…I wanted to be myself and I wanted to do it and fail if I failed I failed because I'd failed myself (Betty, 2:58-63).

Managers also had limited powers to effect improvements. Helplessness had set in, as some felt they could only act on the edicts of *higher authority* (Steve, 5:150). Such combinations of responsibility and powerlessness made managers susceptible to stress:

It overstretched me and I couldn't cope, I got to the point where I thought I'm not coping very well because I'm a person that likes to help, and it got me down (Betty, 10:352-7)

Although few had training as clinical supervisors, there was awareness that although CS served distinct functions with distinct relational requirements and processes, its poor availability meant that it was mixed with management and administration and this compromised the processes and functions of CS. This watering down worked in SU2 and rehabilitation, but resulted in confusion and a double loss in SU1, where attention to performance rather wellbeing resulted in management appearing persecutory and the potential introduction of CS unwelcome (the experience damaging the meaning construed of CS). There was awareness that these mechanisms should be kept separate.

you end up covering everything, don't you, but I think it ought to be a little separate because I don't think, I mean obviously we do sickness reviews […] but if you're doing clinical supervision you need to put that all aside and just cover…and be their clinical supervisor and support-person separately to being their manager. (Steve: 28:1000-1007)

A systemic understanding entailed a pessimistic outlook, given the fundamentally quantitative and financial priorities of employers (Tim's interview). The term "flat line" conveyed the gravity and graveness of the situation for Kate:

because they're trying to flat line nurses in banding you know and all this sort of thing so what they're trying to say is that we can get more nurses in, we can get cheaper lots more nurses at cheaper, you know, if we don't have to give band 8s or band 7s and all that so there's no incentive then to progress, is there […] that's shortsighted really, isn't it. (Kate, 15-16: 538-563)

Conceptualizing work time exclusively in quantitative/ financial terms missed the qualitative aspect of time, decreased the capital of trust between employer and employees (Steve 30-32: 1065-1102), compromised morale, and resulted in difficulty

recruiting staff (Steve, 8:258). This conceptual omission limited the potential for enthusiasm and passion for the particular type of work and *it can really affect moving things forward* (Steve, 16:570), essentially compromising the quality of performance available to patients and the organization.

[…] it's all about tasks again, instead of sitting with someone and having the time to look at them and see what their problems are and find out what they were doing at home and, you know, have they been eating. You don't have the time to sit and have that personal one-to-one with a patient any more. (Caroline, 164:774-804)

The exclusively quantitative value of time was the basis for favouring proceduralization at the expense of professional decision-making, clinical relationships, and person-centred care. The antithesis between finances and quality of care was lived by several participants at work as diminishing time for collecting and processing detailed patient data of a narrative nature on which to base clinical decisions and actions and was experienced as related to the deteriorating status of the profession.

[…] and what kept coming up was time, the time. Staff nurses- I just wish I had more time to just sit with somebody when they're crying or 'cos they are upset with one thing or another. Somebody else might say, I never get that paperwork done, you know. But what it all boiled down to was this time element and you can't treat nursing like a business, we're not, we're not components, we're people and the job that we do because it's very factor measured, very difficult to measure exactly what we do, it's always seen as something you can cut down on because you can't measure it. (Sue, 35:1270-1281)

4.15d Blame and Guilt

Some participants referred to the impact of adverse publicity nursing had been receiving in the media, especially about outcomes of national inquiries, being internalized as self-criticism, self-blame and guilt. They felt that *from being good people and highly respected [they had] gone to other end of the spectrum* (Caroline, 21:740). They had become sensitive to and internalized negative comments *(you are treating everybody the same, there's no individualized patient care any more, so the nurses aren't seeing that patient as an individual.* Caroline, 22:794-797), which affected their self-evaluation and mood. Some expressed indignation because the focus on malpractice had overshadowed the reality that

There's a heck of a lot of people out there in the environment that we work in, who are really good and they're wanting to do their best. They don't get recognized. (Sue, 33:1195-8)

Sue experienced the status of nursing as *totally underestimated* (18:659, 33:1180), nurses as *not taken seriously* (3:104), being *undermined* (19:660), the public image of nursing as deteriorating due to reportages of misconduct. Additionally, experiencing their professional associations as powerless, some nurses appeared defenceless.

NMC is there purely for patients, to guide what we do, but it's for patient welfare you know, but the RCN yeah but I mean and then myself but I find it sometimes it's it's like a lion without teeth. (Sue, 37:1348-1350)

The diminishing status and esteem of the profession affected nurses' morale, especially after national inquiries that were critical of nursing care. As Betty (14:497) had found, *they all start to get down. They're all going off to work in a supermarket.* Blaming had resulted in anger, frustration, oversensitivity to criticism but also excessive self-criticalness. Revising the viability of one's original vocational plan was the last considered resort, as external *insidious* (Caroline, 21:738) blame became habitual guilt (also discussed under Emotional Labour):

[…] they can come to work and put their brave face on but inside…I know this from speaking to nurses that they are actually torn up about certain situations that they've felt perhaps they've mishandled and when you actually get down to what's happening it's never been usually as bad as what they've thought it is but it's just they've internalized what's happened and it's grown like topsy and it's eaten away at them and this [CS] definitely allows them to speak freely if they so wish and then you tackle whatever problem it is. (Sue, 27:972-82)

In these circumstances, CS could be experienced as an attempt at managing the impact of blame or at learning without guilt.

I think that's why so many newly qualified nurses actually can get distressed because they've been to Uni, they've been told this, that and the other about all different things, and this is your responsibility, code of conduct is this, stroke standards […] and it's actually just a case of standing back and having some sort of time to just nurse and learn by whatever mistakes you make and not take 'em too personally […]. OK, you didn't do quite as well on this occasion but you're beating yourself up too much […] (Sue, 27: 947-959).

However, most participants commented on the lack of time to engage in reflection and CS. Steve felt unable to release staff to participate in group CS because *time's at a premium* (20:722). Di described nurses as *time poor* (35:1271). With no time to

discuss significant clinical issues in a professional confidential context, bottled up work-related issues leaked out of professional boundaries into personal time and space. Catherine described telephone conversations with colleagues, during shopping trips or holidays, pertaining to unfinished business at work (12:403-412), but also pouring out the emotional burden on her partner (*your husband gets all your moaning*, 35:1275). Di gave a vivid metaphor of trying to "park" work issues and shut the door to them when she got home (17:607-612). Jim also discussed work-related issues with his wife, a fellow professional whose opinion he respected. Elena described reflecting on work while alone at home (13:444).

Adele experienced CS as useful in managing not only her own thoughts and emotions but also patient anxiety and dissatisfaction resulting from transport arrangements. CS allowed her to construe more accurate attributions of responsibility for the problems encountered, as she realized this had been an issue for other colleagues, *a system failure, definitely* (25:898) rather than her error. By raising it in CS, she gained relief from self-blame and guilt, while the service benefitted from the formal action to resolve these practical problems and, as a result, patients' and relatives' anxiety and dissatisfaction.

Time pressure, conflicts of requirements and demands in the workplace make CS essential, unavailable or underused. For some stroke nurses (Caroline, Kate, Jim, Adele), CS was a need that transcended the requirements of risk limitation. Its potential to relieve concerns and worries about clinical activity and convey respect for nurses' perspective was part of psychological hygiene. Participants' examples highlighted the relieving reassurance experienced when attribution was changed and system-failures were no longer construed as personal error. By voicing issues to a listening supervisor in CS, nurses experienced a domino effect of empowerment for themselves and patients that transcended rules, and helped nurses understand issues and seek resolutions for themselves, colleagues and patients. Participants' accounts validate the observations reported by managers, that staff were passionate about giving the best care, providing the best relational processes towards positive clinical outcomes, and that this was often achieved in spite rather than because of working conditions.

4.15e Maintaining a sense of self

for myself as a person I can't dissociate myself from being a nurse […] I've spent more time of my life in this job than perhaps I have at home (Sue, 19: 678-83)

For several participants, nursing was a vocation, interweaved with other aspects of their personhood and with their philosophy of life: to engage in helping relationships, to be good and helpful especially to vulnerable others (*nursing is intrinsically linked with vulnerability of people,* Sue, 33:1204). But how did stroke nurses maintain a sense of self, in a job that demanded they bring their personhood, be emotionally present and processing, but treated them like machines? How did they experience their meanings of CS in relation to this untenable position? Finding nursing rewarding through gratification of the need to be helpful and "good" (the relational and altruistic element of nursing), enjoying a sense of community/ belonging, reminding themselves of the nobility of choosing to nurse, using exaggerated language to maintain personal and professional esteem, good team relationships, lack of awareness of how difficult the job was, a "stoic" outlook, and the displacement of negativity into junior colleagues or personal relationships were among the mechanisms I understood as being used by participants, as their words indicated.

Making a positive difference for someone at a time of vulnerability, such as disease, was experienced as rewarding.

[…] being a nurse […] you're the one that the patient sees a lot, the most of, obviously, and you being able to do that extra, extra mile for a patient just to make their stay in hospital a little better than it would be…obviously nobody wants to be in hospital but for 'em to have a nurse that maybe understands the situation a little bit better than they would previously because you've gained that experience I think that helps them a lot more. (Natalie, 12:425-434)

Emotional investment into work and its impact lay between the external reality of the strain and stress of the work environment and nurses' skills to convey empathy, compassion, care, and hope (*pat people on the back and say you'll be alright, but they won't be alright,* Elena, 27:982-3; yet, *we do hold that positivity,* Elena, 28:1011). Nursing was experienced as gratifying their need to be empathic, compassionate, hopeful and helpful. Empathy, hope and compassion sprang from the nurses' personal resources.

There is a definite need with nurses to assist and help and that has to come from somewhere other than just it being a task, it has to come from a need to do something that benefits another human being 'cos that's what we're here for. (Sue, 17:604-9)

Betty made the most of the relational aspect of care for patients and her staff, appreciating the clinical information this provided, and leading by example:

I go round saying good morning to patients and having a quick scan who's got drip up or who is looking in pain and it's amazing what you can pick up in a couple of minutes, what's happening to a patient… (14:505-509)

Sue felt that her wish to help was linked to her sense of community and belonging, bolstering her identity as "good person" and going beyond it:

[…] this is my community, you see. […] I've got a direct link with the people that use our services, you know, it's because I've nursed for a long time, it's surprising how many people come on this ward, I might not know them but their nephew might come or their brother might come and they know me 'cos it's not a massive community that we've got in this area. […] if you nurse, you want to help anybody that you can […] (Sue, 39: 1411-1420)

Several participants described experiences of stroke nursing as distressing and public perceptions as attacking and damaging. CS provided an opportunity to discuss work issues openly and confidentially, and attempt to resolve them (Di, 36; Adele, 26:948; 22-3:778-839). Although some participants felt comfortable discussing with their managers issues that impeded their work and resulted in their experiencing little control over it, such discussions could be difficult: *you can have managers who are quite blind* (Kate, 30:1105). Hierarchical and performance management cultures created distance, increasing nurses' concerns about how their ("quite blind") manager would see them and their performance if they discussed a problematic work situation. The busyness of daily life was experienced as carrying on automatically and in antagonistic ways, leaving little time for making sense or seeking support *(Daily life is so busy*; *daily life doesn't allow*. Di, 36:1287 &1308).

Sometimes, the nobility of nurses' motives in choosing their vocation and their continuing effort to provide their best were the last grains of esteem helping them maintain their sense of self as good people and professionals through and despite the chaotic and draining circumstances that work environments presented. However, this absorbed all their energy and time, deprioritizing themselves and leaving them depleted. Di shared her belief that looking after others but not oneself was endemic to the profession.

[…] this is just a personal thought but nurses on the whole are very good at looking after other people but not good about looking after themselves. Very good at it. 'Cos it's all…well, if I say why didn't you try going for a walk to clear your head – oh I haven't time 'cos I'm doing so and so for my son, my daughter, my mother, my father,

my husband, this that and t'other and it's always that role, isn't it, that sometimes people neglect themselves because they're that busy caring for people at work and everybody else and I think it's quite a downfall of nurses that. (Di, 48:1742-1752)

Use of hyperbole, for example, that nurses were available to patients all the time, aimed at increasing the value of the person and the profession but backfired, resulting in powerlessness, trapping nurses into meanings of almost inevitable self-sacrifice, tolerating poor work conditions, including missing professional development activities unless they used their private time (such language also seemed competitive, attempting to reduce the dedication and importance of other disciplines, for example, [physio- and occupational] *therapists,* Kate, 10:367). Exaggerated language came mainly from staff in leading positions, giving a sense of both defending the profession and purging, cleansing their guilt for perpetuating self-sacrifice by encouraging and modeling it, despite working in more clement conditions, like office hours instead of the sacrificial 24/7.

[therapists] don't have to be there 24/7, 7 days a week, which nurses do, you know, we can't sort of shut the ward and say, you know, you patients get on with things, because the nurses are there responsible for the patients. (Kate: 8:280-7)

The intensity of the need to maintain a sense of self and the absence of opportunities to do so was evident in participants experiencing our interviews as raising awareness of their sense of self from the impact of work, and how little understanding and support had been available. When I checked about Caroline's emotional condition at the end of the interview, she described how everyday work routines disallowed such awareness.

No, not upset me, obviously it makes you think a little bit more about what we're doing with all the things we encounter every day. How that, you know, impacts on us as individuals 'cos you tend not to think about it, you tend to take it as part of your everyday work as though you're expected to take all this. (Caroline, 27:961-7)

Considering the significance of nursing as part of the nurse's self-concept, it seemed that nurses were in danger of damaging or losing part of their sense of self, therefore in need of restoration and maintenance. In the few restorative mechanisms available, what could be used was related to how both the problem and the support were understood and experienced. The restorative power of good quality team relationships was universally appreciated (*peer support*, Jim, 10:336. *We're a very good team*, Natalie, 16:557; *We're like a family,* Betty, 8:264) and often used in lieu of definitional CS.

Accessing CS and other supportive mechanisms depended on nurses' and managers' understanding about supporting staff. For example, within the same unit, Betty (who

provided fortnightly CS to a nurse who was underperforming and had a long period of sickness absence) held different views from Elena (senior nurse). Betty's views might emanate from the benefits she experienced in being a supervisee:

[…] it's valuable at the time and I take onboard things that she says and I put them into practice and then I feel better that it gives me the confidence and it boosts me up to think yeah. I'm not a failure, I'm not failing, I'm doing the right thing, the way, the way I am as a leader (18:641-6).

Elena held a different view about availability of CS:

We couldn't do it with everybody (laughing) […] I mean I don't know whether we would get more out of our staff if we did that and would that investment of time be…I mean at the moment, I know it's perhaps grating on me a little bit that, but the investment of those 2 hours once a month is helping a staff nurse not to go off sick, she's feeling supported, it's good, it's good, so it's a good two-way thing so that investment of time is good, but can we sustain it? (Elena, 34:1334-1343)

Why was this nurse's CS *grating* on Elena? Using the hermeneutic circle within the sample, there may be various reasons: one would be the lack of talk about how CS translates quantitatively in organizational cultures that speak –almost exclusively- of quantitative outcomes. Like Tim, Elena applied a quantitative approach that resulted in dismissing the possibility that time used for CS could be sustainable even if it is efficacious on this occasion. This is evident in Elena's logic: despite acknowledging the obvious benefits, her uncertainty whether CS is sustainable leads not to further consideration about how it may become sustainable but to dismissal. It is possible that Elena's emotions spring from her ideas about the need to be hard to be a nurse (also Kate), therefore, CS would reflect undesirable 'softness', as it is considered unprofessional to bring vulnerability to work.

So, perhaps what is feared as unsustainable is managing personal/ staff vulnerability. I base this on Elena's (and other participants') disclosure that difficult emotions from work belong in the personal time and space. This indicates one-way emotion traffic, an absence of reciprocity: nurses must keep their private issues out of work and appear to care selflessly. They must engage in emotional labour for the benefit of their patients and organisations, but they also have to tackle the emotional 'recycling' from work in their private self/ space/ time. This also indicates a polarity regarding vulnerability: only others can be vulnerable, not the nurse. Sue shares this, when she discusses her role as solitary, so that junior nurses do not witness a vulnerable senior nurse:

Yes, the buck ends with me, yes it does, but in doing that there is a price to pay for that, which is you can be isolated. […] And the isolation is part of the role because you've got to be the one that can sometimes just be aloof from it all. (Sue, 31:1125-1132)

Although there are obvious practical benefits in having a 'strong' manager/ nurse, I believe this is one of the myths in nursing, a belief I base on clinical experience and on research, but also on participants' accounts. Nursing was experienced as entailing risks and perils for the practitioner. Participants pointed to the nature and culture of the profession as predisposing nurses to self-sacrifice and consequently, compromised psychological self-care (Di, 50:1814); *powerless*ness (Kate, 10:356, 365); lack of vision (*shortsighted really*, Kate, 16:562); and encouraging a *very stoic* outlook instead of help-seeking (Catherine, 33:1184 & 1203). Catherine experienced her professional and local culture as misinterpreting the need for help as failure, which prevented discussion about the psychological impact of work and perhaps explained her non-engagement with CS.

I think it's culture. I think it's common in nursing that when you do your shift you like to have everything done in that shift, you don't like to leave any work over. I think it's cultural as well. You've always got a background that you can cope and just with whatever is thrown at you, and you just get on with it. (Catherine, 33:1193-1198)

feeling inadequate and things, so you'll plod on at work but then you might moan when you get home as well. Again, that's the nature of being stoic, isn't it? (laughing) So your husband gets all of your moaning (laughing). (Catherine, 35:1271-1275)

Kate's view corroborated Catherine's experience of help seeking as failure:

but you have got to be able to function as well, haven't you, it's when you can't function properly and that's when you need that, you need to sort of have help really but I think it's almost like nurses see that…I'd be worried to do that because they're seen as a failure or not a good nurse (35:1280-1285)

It was alarming to hear senior nurses hold the view that CS/ help should be sought at the point where functioning is questioned, rather than as routine maintenance of professional fitness. Catherine believed the history of CS in nursing was related to the nursing culture that resulted in the current picture.

I think when it first came out and everybody, I think we did 2 days training if I remember and clinical supervisory, I think a lot of people were very skeptical and saw it as a negative thing. You know, that people felt that it could be just that you weren't coping. (32:1157-1162)

Sue's experience supports Catherine's:

[…] so, say a newly qualified staff nurse and she'll say I want clinical supervision… One of the biggest problems that I think that nursing staff have is when they first start out from and they're starting to discuss that they want clinical supervision, they've tended to think that they're being a little bit silly, a little bit am I making too much fuss over this situation, I've felt it were important but everybody seemed to be managing quite fine. (5:150-158)

Unpacking this, especially the term *newly qualified*, its meanings could be about hesitation due to the novelty of the environment, also revealing underlying assumptions:

My older more responsible nurses I can just pat on the back and say carry on, you know, do what you have to do […] but mainly I cotton more on to my younger newly qualified nurses […] because they need more support, that's the reason. (Sue, 14:492)

This reveals an assumption parallel to Catherine's, that CS is not a mechanism for routine support, development and restoration irrespective of grade and experience, but for the ones who *need* it- those inexperienced, or weak, failing, not coping.

Kate believed that nurses missed out in their professional sphere because of the *nature of nursing*:

I think it's the nature of nursing because […] if I do multi-disciplinary education sessions it's always the nurses that can't attend, they always miss out […] the nurses can't leave their patients, can they, so yeah I think we'd be naïve to think that that's not one of the reasons. (9:294-302)

Contrastingly, she also perceived individual nurses as responsible for arranging CS: *it's them themselves, they don't always see it as a priority and they should* (9:315-6). Therefore, CS was an option for self-care that had fallen out of the priorities list. Perhaps nurses (self-reported) better at self-care were also better at using CS. Di used CS and feedback from her team to enhance her awareness of tiredness, of needing a rest, a holiday, also ensuring her routine maintenance through attending yoga and other physical activities, not because she was good at the activities, but because they offered a different object to occupy and rest her body and mind.

4.15f Summary

Various factors in stroke nursing impacted on nurses' psychological resources. Stressors included constant encounters with shock, suffering and death, in working conditions where role ambiguity led to increased responsibilities but decreasing staff numbers, time, power and respect/ appreciation. Nurses internalized blaming reports in the media and national inquiries on errors and malpractice, becoming oversensitive and prone to feeling guilty. They experienced their increasing responsibilities and decreasing time and power as associated with the nature and culture of the profession, and with hierarchies that considered them individually responsible for their powerlessness. Personal and professional meanings of self-sacrifice led to compromised psychological self-care.

In the one-way emotion traffic, the person of the nurse was a core resource at work but one that received little care and attention even from the individual themselves, highlighting CS as important for restoration and underused due to personal and cultural meanings of help-seeking. Participants suggested that the profession's low esteem was transmitted to its members. The tendency of professional bodies to agree readily to dictates from upper hierarchy, including the government, while workplace conditions remained stressful, demonstrated this. Few opportunities for routine professional development and restoration existed at work, strengthening misconceptions of CS as necessary for those requiring help because they were new/ inexperienced, weak, failing, or not coping.

4.16 Superordinate theme 2: Reflection as Personal Growth

4.16a Introduction

Reflection was mentioned in almost all interviews, not surprisingly, considering its publicized value in academic writing. All participants associated CS with learning that shaped professional decisions and the nurse personally, whether through didactic tools or as a personal process of growth through reflection (*somebody to talk it through*, Di, 28:1019). Didactic-style CS happened generally in work time, as part of the structures that held supervised practice together, or in a momentary consultation with a colleague while making a clinical decision. Learning in CS was often associated with acquisition and assessment of skills and competences of trainees and newly qualified staff. Both didactic learning and reflection involved elements of vicarious learning, whether through observing "how to" or improved awareness and use of one's cognitive and emotional responses.

In acute stroke units, CS was situated in the domain of competency development including the supervisor observing, assessing and feeding back to the supervisee (Elena, 4:110) *to cross all the "t"s and dot all the "i"s* (Elena, 18:654) but not in-depth shared reflection. Elena mentioned an audit tool used in her unit with the potential to facilitate reflection. It transpired that this was a tick box exercise for checking competencies, as time was a *privilege* (33:1186) – making reflection also a privilege. Ethical dilemmas were delegated to a hospital committee external to the ward.

Some participants presented reflection as professional activity synonymous with CS, CS being *totally about reflection* (Di, 15:533), *learning from different things* and *from other people's experience* (Adele, 7:247) so that *if the same situation happens to them […] isn't going to be a problem* (Ted, 3:97) and *enhancing professional practice* (Ted, 2:49). Reflection had the potential to transcend professional roles to become personal transformation.

[…] with clinical supervision, the reflective part of it can let you develop. You might find things out about yourself that you haven't really thought about deeply or you might as a person have thought about certain aspects of your personality or the way you deal with situations but perhaps they might be a little bit too comfortable because you're actually saying well I'm not really as good at this as I thought I was for example… (Sue, 11:377)

This theme consists of three subthemes:

- Reflection as Transformation
- Reflection and Personal Awareness
- Reflection and the “Mirror”

Table 4.16a Superordinate theme 2: Reflection as Personal Growth

Subtheme	Brief description	Participant numbers	Key quotes
Reflection as Transformation	Reflection transformed the experience of practice and of oneself	9	*Helps you become a stronger person* (Natalie) *You don't need to feel bad about something. You learnt your lesson and you know you are not going to do it* (Sue) *peace of mind* (Adele) *park it [issue]* (Di) *change practice, improve service development* (Jim) *to improve the way we think as nursing staff and extend our capability at looking at things a little deeper* (Sue)
Reflection and Personal Awareness	Reflection as facilitating greater power of awareness of oneself as a practitioner and as a person	5	*Developing this skill of allowing yourself to be criticized […] or criticizing yourself* (Sue) *It doesn't desensitize you but it allows you to deal with the sensitivity that comes with the job* (Sue) *Fit in* (Jim) *It's actually made me step back a bit* (Sue) *I know when I'm ready for a holiday* (Di) *The honesty of the situation makes you feel as though you're touching on things that you might not like about yourself* (Sue) *CS, the reflective part of it, can let you develop.* (Sue)
Reflection and the "Mirror"	The supervisor and the work environment acted as mirror reflecting images associated with wellbeing or disturbance	8	an *impartial* and *balanced view* (Jim) *I've noticed what you've just done there and I'd like to talk to you about it* (Sue) *go home and reflect upon it. Alone at home* (Elena) *that's one of the biggest things, you tend to reflect with your peers* (Sue) *you stand back and have a look at your practice* (Catherine) *daren't ask […] for looking stupid* (Becky) *assuming us at fault* (Becky) *[nurses] getting suspended left, right and centre* (Becky)

4.16b Reflection as Transformation

CS was a professional and personal development mechanism using reflection as the process that facilitated transformational learning. Participants experienced transformation through reflection, through permission to think without fear of repercussions within a professional relationship of mutual respect and trust. Thinking facilitated meanings of empowerment, not least by shifting self-perceptions of lacking power, and of helpful learning from experience (it would not be an exaggeration to describe some participants' experience of control over their work as learnt helplessness- as in the experiments by Seligman et al, 1978). Experiencing an improved sense of personal and professional power was then channeled into patient care.

Experienced as *empowerment* (Adele, 30:1090; 32:1136; Elena, 36:1317), reflection empowered learning and enhanced personal and professional self-confidence (*helps you become a stronger person*. Natalie, 9:315; 10:349), enabling the clinician to *understand patients more; also the family* (Natalie, 11:389). Reflection facilitated making sense of clinical experiences and contextualizing them in the specific patient and circumstances, resulting in containment, stress reduction, enabling supervisees to learn, and facilitating problem-solving. Through reflection, CS helped participants change, adapt, and improve clinical practice, *to fit in* (Jim, 18:632); *change practice, improve service development* (Jim, 22:781*).* CS and reflection were also experienced as ways of developing critical ethical thinking in nurses: *good to question yourself* (Alex, 9:315, 318); *often a few different right ways and no wrong way sometimes* (10:342).

Shortness of available work-time was a frequently mentioned obstacle to reflection, making it a solitary activity in participants' private time (*go home and reflect upon it,* Elena, 32:1148*; alone at home*, 13:444). However, this became self-persecutory rumination about performance on a clinical issue (*Park it. Shut the door*. Di, 17:607, 612) that sometimes spilt into family life (*your husband gets all your moaning.* Catherine, 35:1275). Reflecting alone became self-criticism and deprecation, a weapon against oneself rather than a learning tool, highlighting the importance of compassionate feedback.

have I done something wrong, have I missed something? (Adele, 25:883) […] I must have done something wrong (Adele, 25:890)

Talking through clinical experiences confidentially with a trusted person was effective as learning and resulted in relief, de-stress (*peace of mind,* Adele, 28:1003). As a learning tool, because it pertained to the clinician's experience, it personalized learning

(Ted: *happened to you*, 3:95; *more personal to you*, 16:555; Tim: *what their [supervisees'] needs are,* 2:59) in the circle of learning that Natalie described: acquisition of skills and competences, practice, and learning from reflecting on experiencing the practice of the acquired skills and competences. I have given this circle the Aristotelian term "phronesis", loosely translated as practical wisdom gained from applying learning to individual cases and informing future thought and action. However, on acute units, there was no time to reflect on or even *police* (Elena, 4x at 17:610) the application of knowledge, skills and competences.

Participants from SU2 and rehabilitation appreciated the freedom to ask and to learn from mistakes through reflection, learning from and about themselves through another's responses to their narrative. There were qualitative differences between reflection and didactic learning, pertaining to power in/equality, authority and hierarchy, and the subject to be learnt. Intubation was an example (mentioned by Elena) as the kind of competence staff found difficult emotionally and physically. Reflection does not necessarily 'teach' the mechanics of how to intubate, and teaching only the mechanics as a task may risk traumatizing psychologically and perhaps physically the patient, the learner, and/ or the patient's loved ones.

4.16c Reflection and personal awareness

If reflection were a question, it could be "Who am I and who do I become because of my work?". Discovering and revealing one's limitations was more likely where not knowing was explicitly understood as a beginning of learning, as Betty (9:322) encouraged:

if you don't know, ask, it's not a sign of failing, it's a sign of wanting to know and learn and develop yourself, but it's a sign that you don't want to put the patient to any harm….

In SU2 and rehabilitation, it was safe to gain awareness of one's limitations, to admit ignorance, and praiseworthy to want to find out and avoid harmful mistakes. Di acknowledged the importance of knowing *what your limits are* (22:806) and that some psychological issues brought to CS could be *deeper than I can* (23:814). Betty acknowledged that exposing one's ignorance could be interpreted wrongly as failure. This raised the question what conditions facilitated asking, seeking answers, *wanting to develop*, instead of perceptions of not knowing as *failing*?

Several participants (Betty, Jim, Di and others) discussed the importance of professional/ team relationships in facilitating openness and professional and personal

growth. These relationships existed within and had a reciprocal influence with the work context, their character being formed through leadership and management styles. Betty led by example, evident in her rolled up sleeves, plastic gloves and apron on, doing clinical observations and tasks. The manner that upper hierarchy managed their power, authority and control influenced opportunities for reflection on how staff experienced their role. In rehabilitation, relationships were such that participants felt able to *speak up; challenge; beg to differ and not fall out, stick together* (Jim, 24:877), as I witnessed Jim do while discussing a patient's care during the service meeting I attended. There were opportunities for thinking and discussion, for example, about what was legal vs what was ethical in patient care and what the stroke nurses' position and role should/ could be. In settings that allowed the expression of limitations, and where CS was organized and available, staff retention was longer (*there's lots of us have worked here years and years and years,* Di, 31:1120).

Reflection also raised awareness of stress and burnout in participants (*it overstretched me:* Betty, 10:353; *I take it too far*, 11:395) who had various ways of managing stress, including exercise, relaxation, and enjoyment, discussion about stress with their manager/s, or taking leave (*know when I'm ready for a holiday*, Di, 43:1577).

I recognize that and that's why I do things like yoga and practice and that. I'm not reyt good at putting my legs and arms in positions but the whole hour of the music and the breathing can just make a difference between coping and, doesn't it, you just feel right […] I know that I enjoy doing that but for someone else it might be, I don't know, riding a horse, going for a swim, going for a walk. But I think you've got to learn to identify when you're feeling that, so you think, right, this is the time, I need to do this more […] rather than keep on going and going and going until you do burn out. (Di, 49:1763-75)

Among the issues that some participants thought needed addressing was the training available to distinguish CS from other types of supervision, and for clinical supervisors to develop their skills in managing power inequalities in the supervisory relationship, negotiating boundaries within which reflection on clinical practice is to be facilitated and responding to individual supervisees' needs. Some participants stated that clinical supervisors must be trained for the purpose (Caroline, Ted). A few had completed training available through their employing organization (*you had to have training to do that […] I've not been trained to do that.* Caroline, 1:11-13). However, the quality of training programmes was unknown (Ted had found his as lacking depth, 10:361) as was the supervision offered to supervisors.

4.16d Reflection and the 'Mirror'

This subtheme refers to the quality of feedback available to and experienced by participants in their varied meanings of CS and reflection. In close-knit teams, such feedback was an expression of care about colleagues' wellbeing, as Di discovered when her medication was changed (she had not realized that her behaviour had also changed, until a colleague expressed concern to her). The 'mirror' is a metaphor for the supervisor and their responses to the material supervisees brought for discussion. As feedback spread across all aspects of clinical practice, it resembled a hall of mirrors that included organizational and team culture. Various types of reflection were experienced.

At the basic level, reflection was like a quick look in the mirror, *a tick box* and *check* (Elena, 18:637; 3:102), confirmation to a generic enquiry about professional decision making and action, which many participants received from any colleague of their seniority and above, ad hoc, and during team meetings. Participants experienced feedback as professional communication important for good practice, as a learning tool, and for acknowledgement or validation of clinical decisions. Confirmatory feedback provided psychological restoration through relief from uncertainty and anxiety. Some considered CS as mainly work-related feedback confirming their clinical decisions and actions. Tim (6:217-244) described cyclical reward patterns in developing mature and competent professionals, confirmation being a 'reward'.

Bigger or persistent issues, such as drug errors, repeated problems with discharge processes, or other matters experienced as stressful required a closer look in the mirror where *you stand back and have a look at your own practice* (Catherine, 20:707). Participants were selective in choosing this 'mirror', sometimes needing an *impartial* and *balanced view* (Jim, 26:939; 4:110) from *somebody neutral* (Betty, 10:366), and *a sense of trust* (Di, 13:472) that enabled them *to cathartically say what they want or of their experience cos that's what they may want, they may not want you to give an opinion or a view* (Jim, 2:48-51). They looked for someone who understood their role (Catherine; Di) and showed empathy rather than sympathy (Sue). Ted highlighted the importance of *understanding people's roles* (Di, 40:1450) and having CS within his own specialism from supervisors with expertise in stroke.

Reflection could include supervisor's use of power as dispensing positive feedback and praise. Di credited her supervisees with their ideas, praised them if they were appropriate, or encouraged them to think some more. Betty and Adele considered praise important. Betty and Elena discussed the importance of communicating feedback to the relational atmosphere of SU2, relaying gratitude and positive

comments from patients or the achievement of service targets. Communications of praise from manager to staff created a softer background during reflection on performance appraisal: Elena described how, with supportive CS, an underperforming nurse had become a productive member of their team.

Organizational, professional, and team culture affected one's reflection like a hall of mirrors, sometimes beautifying (*a negative can be turned into a positive,* Catherine, 21:743) and sometimes reflecting terrifying distortions. Becky experienced SU1 as a *terrifying environment* (13:416) of *policing* (20:529, 530; 21:679), *being checked upon again* (15:470), where she felt *we're not trusted* (15:473), and *we've got to hit them targets and not look after patients* (46:1484). In SU1, CS was part of disciplinary/ performance management procedures towards dismissal. Its meaning was loaded with conceptual and affective connotations. Obedience was expected, compliance with hierarchy's edicts, while reciprocity in feedback was discouraged (*when you put something forward, it's slammed back at you* 22:704; *are you challenging the way we run this ward?* 22:721).

Learning from mistakes was limited in SU1 because staff *daren't ask just in case they get in trouble* and *for looking stupid* (Becky, 45:1464), *there is a massive punishment role* (38:1247), *being dragged in office* (42:1374) for a *rap; flack* (2:61) but *never get a well done* (2:63). Becky experienced the atmosphere as threatening: *make a mistake, you're done for* (Becky, 38:1247), *another step towards suspension* (Becky, 21:679) and unjust, *assuming us […] at fault* (12:391) while *people getting suspended left, right and centre, but for nothing.* (12:393). Her experience of this *very very bizarre* (17:528, 556; 44:1433) environment affected her psychologically, she felt *anxious, stressed all the time* (13:425) and *had to go for CBT* (Becky,13:427).

Caroline had moved to SU2 from a similar work culture in another Trust. She left because she felt staff were *not given enough time to think* (22:775), *you don't get chance to say* (21:737) and *not given the opportunity to make decisions* (22:779). With sadness in her voice she concluded *you're not a person really, you're just […] the worker* (27:972). The hall of mirrors at work became even more frightening through an insidious process: partial reportages of findings from public inquiries (misconduct) and the absence of positive publicity resulted in the world outside work reproducing images of nursing that were negative, shameful, frightening– to nurses and the public.

you just have to take this sort of insidious sort of… I almost feel it's like nurses from being the good people and highly respected as we were, have gone to the complete end of the spectrum with the public because of the media and that we're some sort of enemy (21:738-744), while *you're expected to take all this* (27:958).

Overlaps emerged between reflection, CS, managerial supervision and leadership featuring the gifts of intelligence and interpersonal skills through which supervisors, managers and leaders appealed to rather than imposed on (and alienated) their colleagues in the process of attempting to reach targets, provide satisfactory patient care, and implement change. Where *the right sort of leadership qualities* (Di, 34:1243) were evident, leaders/ managers demonstrated *the skills to influence* (Di, 32:1162). They facilitated reflection through empathy, attempting to understand *how does that other person feel* (Di, 15:549). Betty considered the relational element of being in SU2 important not just for patients but also for staff, evident in her readiness to share positive feedback, bringing sweets to share, and her general commitment to understanding and supporting them:

…not only to know the patients as people and their needs, it's about getting to know each other as a team and understanding what each different consultant has, their own ways, so we understand how they…what their needs are (7:244-250)

With experience, *you can read people better* (Di, 42:1521). For example, Elena used her own experience as supervisee to understand her supervisees' needs. Supervisors led by example, being a *good role model* (Di, 14:477; Jim, 19:670), their behaviour becoming food for reflection in vicarious learning, as Jim explained the term *sitting by Nelly* (19:670). In supportive contexts, staff were aware of the attempt to manage targets through devising strategic alliances among colleagues:

I think we know each other that well, we all know each other's bad, yeah, more negative traits, I suppose, as to more positive traits so, that helps you build your team better 'cos you think what might not suit one, might be more negative, and I think you can think, well, I'll put that person with x person because I know that person's got the skills to influence that other person and that's the point about knowing everybody so well, isn't it, you can mix people up to influence practice, mix and match to influence your practice and take it forward because you know people that well (Di, 32:1154-1170)

There were consequences to the quality of culture and reflection available at work. While work cultures interpreted as frightening halls of mirrors were associated with high rates of sickness absence and recruiting difficulties (*struggling to fill vacancies,* Steve, 8:258), workplaces with benign hall of mirrors showed better staff retention, enabling colleagues to get acquainted, informed about shared goals, work in synergy and develop team loyalty and collective pride for their outcomes:

Lots of us have worked here years and years and years […] and it's as if we can't let each other down, so, I think that shows in us practice and the way we deliver us

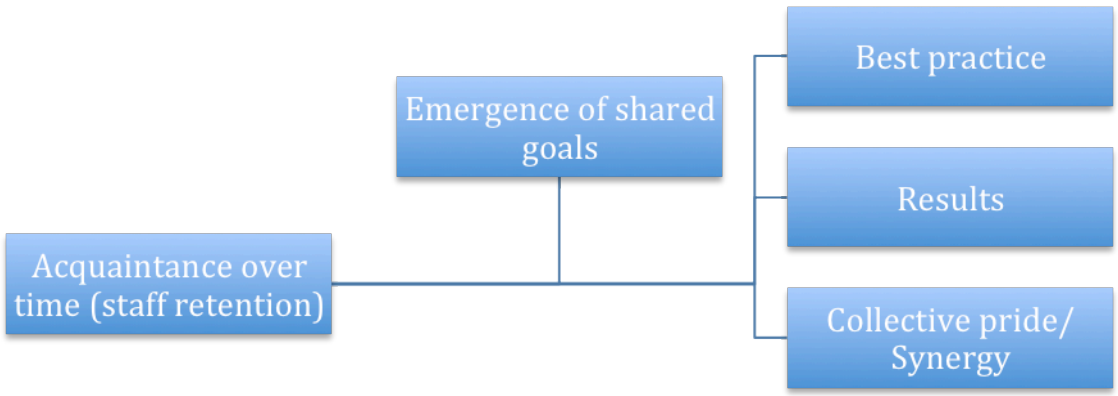
practice as well and we're proud. A lot of staff here are proud to work here and I think that makes a difference. (Di, 31:1120-5)

4.16e Summary

Reflection was the process through which participants experienced CS as development and growth. Reflection was available through interactions other than CS, which afforded incentives for personal transformation and improved personal awareness (for example, of one's limits). The context of the workplace provided the parameters within which reflection occurred, a metaphorical hall of mirrors, transforming stroke nurses into better developed professionals but also occasionally sending terrifying images that matched the negative images of nurses in the media following public inquiries. Workplaces that afforded incentives and positive images from reflection tended to have better staff retention associated with the development of shared goals, synergy, commitment to best practice and pride in their work.

The following diagram summarises this:

Graph 4.11b2: Staff retention, relationships, and performance



4.17 Superordinate theme 3: Relational Features of Clinical Supervision

4.17a Introduction

Most participants considered professional relationships in nursing and the formation of *alliances* (Sue, 18:629) with service users and colleagues as important. Some spoke of collegial relationships being *like a family* (Betty, 8:264). They understood CS as *a two-way process* (Jim, 31:1114) professional relationship featuring confidentiality and time boundaries that engendered trust, and a sense of empowerment. The alliance experienced in CS provided psychological sustenance through supporting, validating, and challenging the supervisee (*different views,* Catherine, 30:1068), reflective processes whereby the supervisee identified their learning needs and evaluated their practice (*I'm doing the right thing the right way,* Betty, 18:645) and their fitness to practice. Becky described this alliance as providing a support structure (*having somebody's back,* 6:188), *a base* (6:188), valuing the supervisee's work, especially *when something comes and hits you in the face* (5:148). Thus within this work-related discussion, the supervisee's needs from CS were the focus and priority.

Relational features distinguished CS from terms such as informal CS, managerial, and disciplinary supervision, and the benefits transferred into patient care. Jim experienced CS as *a platform for active listening* (2:45) and repeatedly referred to the supervisory relationship as therapeutic (3:97; 5:169; 6:218; 8:275; 26:949). CS is not therapy, but it has beneficial effects on supervisee wellbeing similar to those of a therapy relationship.

[…] clinical supervision, its totality, is so important that people feel comfortable with the process irrespective of if that's a group session or a, you know, a one on one, that relationship, those relationships are key to feel safe and secure. (Tim, 4:129-134)

Tim highlighted the importance of relational factors in CS to avoid experiencing it as *quite threatening* (3:89) which it could be in situations that included judgments about supervisees' competence, as in training and preceptorship. These relational features could make the difference between an honest discussion versus understanding CS as another hurdle to overcome before *getting their ticket […] to then go on and have the freedom to practice as a qualified nurse, so, this is the final barrier […] that's going to be put in front of you in terms of becoming a qualified nurse.* (Tim, 8:271-4)

This superordinate theme consists of four subthemes:

- Boundaries, Confidentiality and Time

- Relational Safety and Trust

- Empowerment

Table 4.17 Superordinate theme 3: Relational Features of CS

Subtheme	Brief description	Participant numbers	Key quotes
Boundaries, confidentiality and time	Boundaries, like confidentiality and time, distinguish CS from other support relationships at work. Time meant clock time but also supervisors' respect for the supervisee	9	*a shared agreement, a little contract almost […] anything that was said was contained in that little group* (Caroline) *conducive environment […] private, confidential* (Jim) *[confidentiality] is massive* (Di) *the ones that haven't got time for people, the ones that's not got good interpersonal skills, the ones that actively don't listen* (Jim)
Relational Safety and Trust	Level of trust distinguished CS from other supervisory relationships, enabling supervisees to speak openly and honestly	13	*Honesty Trust* (Sue, Jim, Di, Natalie) *comfortable; safe; secure* (Tim) *Relaxed; free; open environment; you can talk about anything* (Ted) *working as a team I think there's that level of trust there […] I don't think there's really anybody that I wouldn't be able to trust […] We all know we're here for the patients so, we all work together* (Natalie)
Empowerment	Supervisees' trust in themselves was restored through experiencing confidential, respectful, empathic listening about work issues. Also, restored sense of control and power over work and towards solutions	8	*Motivational, and like having time, caring, kindness, that type of thing. Interested in people. Helpful.* (Jim) *there is some sense of empowerment that you do feel that you are going to discuss the issues and someone is listening and taking your views, taking them seriously.* (Adele) *almost empowered and liberated might be the word* (Jim)

4.17b Boundaries, Confidentiality and Time

Those who had received definitional CS described an initial agreement/ contract that included boundaries, like frequency and duration of meetings, purpose, and extents of confidentiality (*like a shared agreement, a little contract almost,* Caroline, 7:240-2; *anything that was said was contained in that little group,* 1:35). Caroline experienced extensive discussion during the first group CS session she attended, negotiating the extents of confidentiality and other issues. Jim described the emotional importance of specifying CS arrangements (date/ time, duration, frequency), the benefit and need to be committed to them and only renegotiate in exceptional circumstances. In informal CS, this boundary was implicit in knowing about organizational policies. Although such policies outlined the duty of confidentiality of patient information, confidentiality in CS was less clear, if mentioned at all. This raised ethical questions, as rules, regulations, policies and procedures could not replace reflection on ethics.

The CS relationship required, was built within, and was defined by relational boundaries. Jim experienced the importance of negotiating boundaries like confidentiality as facilitating a *private, confidential* (2:44; 6:195) *conducive environment* (1:11) for the development of trust necessary for *openness* (3:96) in CS. Speaking of the *massive* importance of confidentiality in developing trust in the CS relationship, Di (14:499) arrived at the realization that although she would explain and agree the limits of confidentiality to supervisees approaching her for "formal" CS, this would be unlikely in the event of a colleague needing immediate, quick, "informal" CS. She justified her realization by reference to organizational policies, adding that although good rapport was facilitative in CS, *You can know people too well* (27:968) which placed an emotional and ethical burden on deciding how to respond to disclosures that contravened policy in major ways, something she had not considered prior to the interview. The importance of managing the boundaries of dual relationships and their limitations on CS emerged clearly. Management responsibilities compromised the professional relationship in CS due to necessary disciplinary, performance or sickness management procedures (*I can't investigate you and support you at the same time,* Tim, 14:516) detailed in organizational policies, the process of which became a barrier to developing the rapport necessary in CS.

Time was an important boundary-marker for CS (Adele, Jim, Steve) that was missing in many nurses' work. Kate experienced the absence of boundaries in frontline nursing as eroding nurses' sense of control over their work and opportunities to develop professionally, including CS. The lack of time boundaries was used in justifications of self-sacrifice (*at the end of the day, the priority is always to the patient.* Kate, 10:365)

given by several participants, which permitted a lowering of priority level for CS (*there is a bit of planning [for CS] that can be done [but] doesn't always get done.* Kate, 11:404) leaving insufficient time for nurses to do anything other than patient care.

For Adele, time marked the purpose of CS as a conversation where she learned from reflecting on clinical decisions and actions she had taken, and used the learning from such experiences in future decisions and actions. For Jim, time was also a marker for CS for which he held emotions, anticipation of relief through substantial conversation, and making sense of work-related material that impacted on him professionally and personally. Time also meant continuity: Jim spoke of the benefit of consistency in the CS relationship over time as maintaining the benefits experienced in CS, and the negative impact of cancellations or interruptions. Jim referred to time in terms of relational continuity (11:393) which he considered important in CS. He spoke of the importance of CS being used *efficiently and effectively* (10:344), where issues were examined as the CS relationship developed and the supervisee built up experience, questions but also trust. By providing space to work on issues that were routinely unexplored in any depth, disruptions to CS arrangements became emotionally laden experiences.

[…] there is nothing worse than having all this wanting to impart, this support and information and things like that and then to be working towards that and looking forward to that probably in some instances, the accessibility and the understanding and that, and then to have it cancelled and having to wait happens whether that be another month or another week or whatever, you can probably lose what is the benefits of having the system in place. (10:355-364)

Time meant clock-time but also had qualitative meanings, like respect. Jim described an unsuitable supervisor as someone who did not display relational features of CS: *the ones that haven't got time for people, the ones that's not got good interpersonal skills, the ones that actively don't listen […]* (23: 835) in contrast to supervisors who could be *motivational and like having time, caring, kindness, that type of thing. Interested in people. Helpful.* (Jim, 24:863-4).

And I have had the experience where, as a supervisee, you know, I have gone and I've thought it's not worth going up 'cos there's that many disturbances and there's that many…and it isn't a protected environment and they doesn't seem to be listening, I seem to be a burden on them, so from my own experience I try to make sure that it is not their experience because again you reflect on that you say well, if I'm going to be a supervisor, I'm not gonna… I wouldn't start to do it if I felt I was going to be interrupted all the time. I have had sessions as a supervisor where I've had to say, I don't really

want to cancel this but I fear that we're going to get interrupted and I'm slightly distracted because we've got a few problems or whatever and I would rather reschedule that to a better time than produce a bad experience. (14-5:499-514)

Di needed the physical and mental space marked by time for CS for reflection to free herself from the material of the working day by analyzing and then 'parking' the issues and shutting her mind's door to them (17:607-645). She used metaphors of wealth to refer to time as quick consultations with colleagues (*a word with you for 5 minutes to one side,* 3:108) instead of longer, planned meetings because work left nurses *time-poor […] because of the needs of the patients on a nurse.* (35:1271).

She also spoke of her wish to impart to junior colleagues learning from her long career that had given her a wealth of clinical experience. Her relational style made her trustworthy and accessible for help, advice and CS. Di experienced the boundary of confidentiality in CS as engendering a sense of safety in supervisees and facilitating actual safety for both patients and staff. She considered staff perceptions of her as trustworthy, especially of the *massive* (14:499) importance she gave to confidentiality (14:480, 481), to be instrumental in their decisions to approach her for CS. She provided a confidential boundary within which she built her trustworthiness and facilitated a sense of relational safety enabling staff to discuss their practice openly and use her professional experience to learn through CS.

4.17c Relational Safety and Trust

The terms *honesty* and *trust* were emphasized as important in the supervisory alliance (Sue, 15: 514-537; Jim, 13:462; Di, 13:472; Natalie, 7:223). Tim highlighted the importance of feeling *comfortable; safe; secure* (4:129-134). Similarly, Ted described the sense of relational safety in CS: *Relaxed; free; open environment; you can talk about anything* (6:182-193). Among the metaphors participants used to describe the relational features of CS in their team was that of a family (Betty, 8:264) within which functions of CS operated (support, challenge, learning and development, ethics). This metaphor captured the complexity, intensity, and impact of the relational context of CS, replete with the variations of dynamic interactions found in close relationships. At a practical level, familiarity with the supervisor and supervisor's understanding of the supervisee's role bred trust: *some people might want to go to one of their work colleagues who they know and trust* (Catherine, 18:638-9); *tends to be the ward manager that they prefer* (Alex, 2:55). Work relationships were not necessarily as emotionally close as personal relationships, but shared elements like respect, listening with interest, caring (even as duty of care rather than as emotion-driven), helping.

Natalie expressed appreciation for her team as a group of people she trusted to work with, a good team with patient-focussed goals (16:551, 572). From her account, a self-perpetuating relationship appeared between the quality of relating among colleagues and having patient focused goals.

I think working in an MDT and all working as a team I think there's that level of trust there […] I don't think there's really anybody that I wouldn't be able to trust (7:222-230)

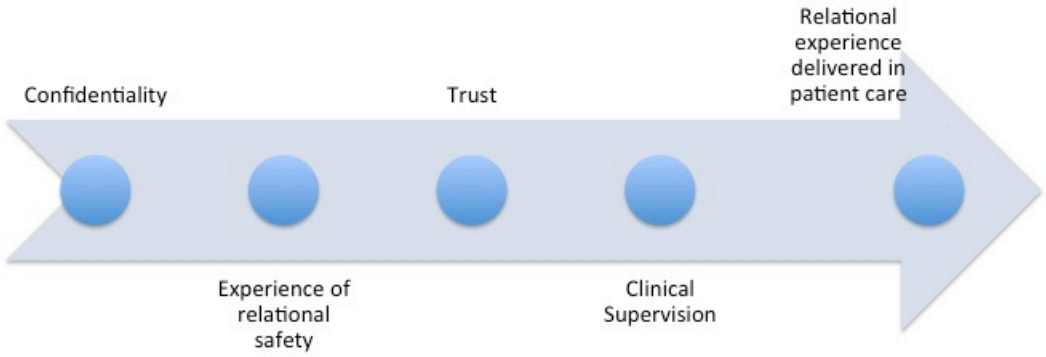
I think we're a very good team here. […] we've all got time erm to help each other when needed. […] *We all know we're here for the patients so, we all work together and we do it to the best of our ability, which is what we're here for. Also the relatives.* (16:557-575)

Natalie suggested that CS helped personalize patient care. While routinely using learning from her training, policies, procedures and professional guidance, Natalie used CS to learn from colleagues' and her own lived experiences with patients and their relatives to treat them according to their individual requirements through the quality of professional relationship she provided. The experience of relational safety in CS was transferred into clinical work.

Natalie believed CS gave her the opportunity to expand her understanding, beyond her training, about patients' individuality, their diverse characteristics and needs. Adele's anecdote about the lack of coordination with patients' transport that had repeatedly led to tensions for and between patients and ward staff was such an example (a situation she discussed in supervision and concluded that, as it was also occurring to other colleagues, it was a systemic rather than a personal failure, and her manager would attempt to resolve it in discussion with the head of that service).

At the practical level, this was about trusting one's clinical supervisor (often also manager) and other colleagues to listen respectfully and be an ally in understanding and resolving work issues. At a psychological level, the relational safety staff experienced as members of a network over time resulted in self-regulation the benefits of which transferred into the safety experienced by patients. The opportunity to gain a more accurate, detailed, or deeper understanding of an issue freed the supervisee from preoccupation with it and from the stress of the preoccupation and its currency, enabling strategic thinking and making its resolution more likely. Supervisees benefitted from the relief and the patient benefitted from better coordination of services. Diagram 4.13c summarises this.

Diagram 4.17c: Relational Safety from CS Delivered into Patient Care



4.17d Empowerment

I don't get clinical supervision formally or there isn't anything sort of set up for us. (Kate, 34:1233-4)

The powerlessness in this statement contrasts the profile of a leader. The form the relationship took in CS usually followed the relational tendencies in the workplace, including how authority and power were exercised. While in both SU1 and SU2 there were no arrangements for definitional CS for ward nurses, there were differences in organizational relational tendencies. Becky, Kate, Steve and Tim (SU1) exhibited the relational style of their organization, which was about edicts from the hierarchy above to be complied with (or risk punishment). Ward nurses were referred to as "they". In contrast, Betty (SU2) described a philosophy of egalitarianism on SU2 (*we've all sort of developed together […] on one landing,* 5:172) as conducive to effective professional alliances and communications between colleagues and with patients. Referring to her team, she used the word "we" ten times in fifteen lines and 14 times in a single page (3:75-90). Natalie spoke of the many benefits she experienced from CS as a newly qualified nurse, the importance of quality in supervisory relationships for gaining knowledge and experience from other nurses, and feeling comfortable to

consult with her manager (5:146; 9:324; 15:537). She considered dedicated time as distinguishing CS from ad hoc consultation with colleagues: she consulted her colleagues prior to taking clinical decisions and actions, while CS was a reflective activity she engaged in usually after such clinical decisions and actions (15:538-544).

[…] sometimes I may ask sometimes it may be just something that I want them to listen to because it almost feels cathartic and you almost for example get it off your chest type of thing and that can be just sort of enlightening in itself really, just being able to say I don't want you to say anything, I just want you to listen because I need someone to listen and understand and just sometimes nod in the most appropriate place and you almost feel that once you have discussed that, almost empowered and erm liberated might be the word if it's a difficult thing. (Jim, 26:927-937)

Experiencing the conditions in Jim's statement leads to a sense of empowerment and liberation, a view also echoed in Adele's interview in terms of what can be achieved when the required conditions Jim states are actually met:

I think there is some sense of empowerment that you do feel that you are going to discuss the issues and someone is listening and taking your views, taking them seriously. (Adele, SRU, 30:1090-3)

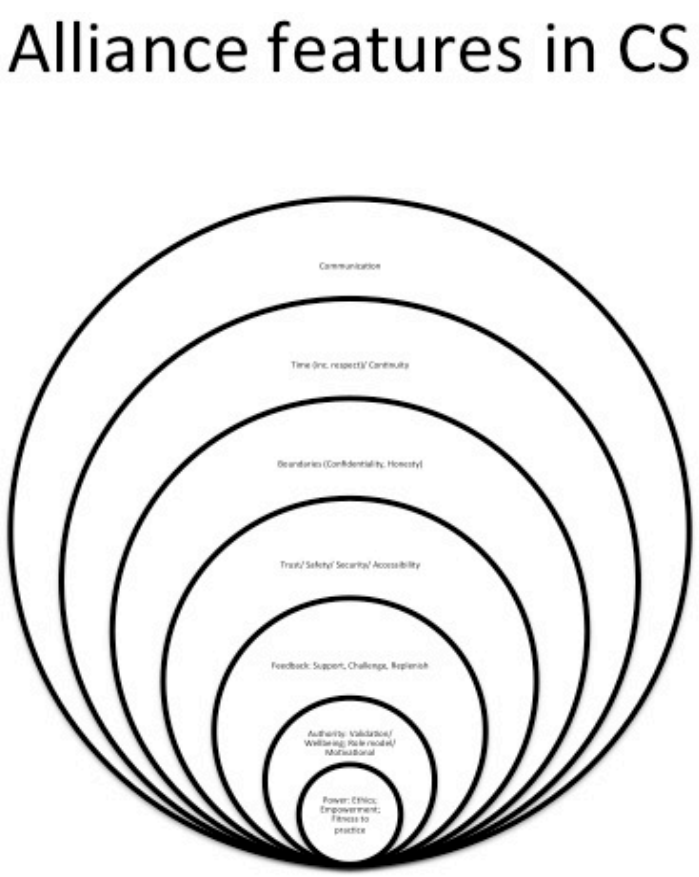
This gives clinical supervision a political dimension where deep understanding within a professional relationship (of often unequal social/ contextual power status) leads to the experience of personal and professional freedom and power.

4.17e Summary

CS was experienced as a professional relationship with features that shaped its meaning as an alliance. It usually existed within certain boundaries, specified by explicit agreement between the parties or implicit in organizational policies. The agreement could refer to dedicated time for CS meetings, confidentiality and purpose. Broadly, the purpose was the availability of an opportunity for supervisees to discuss work related issues openly and honestly in an environment where they felt comfortable, safe and secure, to experience respect and understanding (listened to), make sense of issues, and potentially arrive at re/solutions. Participants reported experiencing the relational features of CS as empowering and liberating.

The following graphic portrays features facilitative of the alliance in CS:

Diagram 4.17e



Key to layers (from outer to inner):

Communication
Time (including respect) / Continuity
Boundaries (confidentiality, honesty)
Trust, safety, security, accessibility
Feedback, support, challenge, replenish
Authority: validation. Wellbeing: role model/ motivational
Power: Ethics, empowerment, fitness to practice

4.18 Superordinate theme 4: Meanings of Clinical Supervision

4.18a Introduction

As may be evident by this point, asking "what is CS to you?" becomes several questions: What is the nature of CS? What is its purpose? What ways and mode/s of delivering CS are preferred? What are the outcome/s of CS? CS for whom? Who can or should be a clinical supervisor? In what circumstances is/ should CS be provided? Participants gave a range of understandings of CS from descriptions as in professional literature to the (at times demanding and threatening) presence of managers in the workplace. These were influenced by cognitive, emotional and behavioural factors pertaining to the stroke nurse, their employing organizations, and their professional association.

Most participants presented conceptual over-inclusiveness, focusing on components of CS and presenting them as the entirety of CS (part=whole). Many experienced CS as synonymous with reflection, conversations with their managers, annual appraisal, training, conversations in multi-disciplinary meetings and brief clinical conversations with colleagues. It was unclear whether over-inclusiveness was a sign of the level of knowledge and experience participants did/not have about CS (cognitive), emotion led (fear, relief), conceptual and practical adaptation in settings where CS was not formally available, or concealing their avoidance of CS (behavioural). Some participants' lived experiences were of *not* having CS, with emotions of sadness, indignation, and some relief (when this was their choice).

All participants shared a meaning of 'CS as dialogue' with another or within themselves, the tone and content of which could be persecutory, directive, commanding, or facilitative of reflection on supervisees' actions, cognitions and emotions. Work-related rumination during participants' private time was also described as reflection and CS, as were unplanned conversations experienced as CS *after* they occurred:

there's a first situation where informally I might be discussing something with somebody and then when I reflect on it afterwards I think oh, that were clinical supervision that I've had and I didn't quite realize and then I've gone back to my colleague and they've said yeah, you know, you are right, it is, so it's a really broad scope and, you know, and unless you actually said oh it's very formalized, a 1:1, it's in private or with your peers in private, actually there's a lot of clinical supervision occurs in a working environment daily, sometimes hourly, that you're not actually realizing

what you're doing unless you actually take the time and say right, clinical supervision, you know. (Sue, 2:55-68)

I consider this superordinate theme the most potent of the superordinate themes and directly related to the research question. It consists of four subthemes:

- CS as essential professional activity
- CS as task based and organizationally focused
- CS as structuring chaos
- CS as personal emotional challenge

Table 4.18 Superordinate theme 4: Participants' Meanings of Clinical Supervision

Subthemes	Brief description	Participant numbers	Key quotes
CS as essential professional activity	CS experienced as essential practice-based learning and professional and personal development	11	*As a professional practitioner, you cannot practice without CS* (Di) *It [CS] is a way of not only consolidating good care but improving that care continually* (Sue) *[CS] can improve my way of practice and I might have been floundering* (Sue) *My staff regularly come to see me and ask me advice about something that's happened and what could we have done* (Alex) *if it is felt that you are not suitable, competent, confident, then that's it, potentially career over* (Tim) *Any leader needs CS* (Betty)
CS as task- and organization-focused	Experiencing CS as prioritizing and accommodating organizational and task-specific requirements (eg. performance reviews)	8	*You can class CS as the fact that I'm on the ward […] the NHS is happy to class it as* (Steve) *Because nursing is task prescriptive and task oriented* (Steve) *They are ticking all the boxes in achieving the competencies* (Elena) *People still think of it as a meeting with their manager and get a bit mixed up with their IPRs, their Independent Performance Reviews* (Kate) *We haven't got a formal CS programme on our unit […] it doesn't mean that it doesn't take place albeit on a very informal ad hoc basis* (Elena)
CS as structuring chaos	How CS can be experienced as a helpful structure that holds together the messiness of work	8	*It's quite daunting […] and he [supervisor] was very good, very structured* (Becky) *This is what we want as an overall but I'm going to put into these sections and we'll build on each section to build the bigger picture* (Becky) *You can use it [CS] as a building block, a stepping stone to better practice* (Sue) *You learn how to do things in a relaxed structured way rather than a chaotic way* (Becky)
CS as challenge	Ways in which CS was experienced as challenging	9	*but nobody really knew what to expect or what to do [even after CS training]* (Catherine) *I can't allocate somebody and say these are your group of people to be your, you're going to be supervising*

			them [because] *time is at a premium* (Steve) *a bit of planning that can be done that doesn't always get done* (Kate) *if the matrons themselves need CS where do they get theirs from?* (Kate) *you've got to have a hierarchy that's supporting things otherwise it's not going to happen […] if Chief Nurse said no, I don't support it, I don't feel it's a priority, then it's not going to happen, is it?* (Kate) *very skeptical [fearing colleagues' perceptions] that you weren't coping* (Catherine)

4.18b CS as essential professional activity

Most participants regarded CS essential professional activity because of the benefits they experienced from it, or because it was a requirement for professional registration, or both. Experiences of definitional CS were conversations mainly about clinical work, mostly within a confidential boundary and viewed as a personalized way of learning (Ted, 3:95; 16:555-7; Tim, 2:59), which addressed the totality of clinical practice (Tim 2:40). Adele, Caroline and Jim included psychological restoration in the meaning of CS (*to cathartically say,* Jim, 2:48; *peace of mind,* Adele, 28:1003). Purpose determined and moderated the overall meaning and the shape of the various components of CS:

[…] we need to be clear about how these different facets work together in terms of mentorship, increasing the numbers of our nurses who going on courses which require them to have clinical supervisors so, in a sense, you know that's clinical supervision but it's often in a very narrow spectrum so, if you do an advance nurse practice you may be working with a clinical supervisor who will be helping you in the assessment and diagnosis, well, assessment in particular of patients' conditions so, that is, if you like, a form of clinical supervision but clearly it's not as well-rounded as looking at that totality of practice of the individual, it focuses on one area (Tim, 1-2:29-41)

In workplaces where CS had been established, like the stroke rehabilitation unit, participants experienced its effects as confirming, energizing, productive, and restorative. Jim experienced CS, his monthly arrangement with a clinical nurse of his seniority, as *therapeutic*, valuing it for the relief and knowledge he gained. Adele and Ted considered the monthly meetings convened by their ward manager as CS and they occasionally attended other formal arrangements for CS open to all clinicians in the hospital at weekends. Comparing participants' accounts, arrangements for CS in rehabilitation were more formally organized than in the acute stroke units.

Participants' understandings of CS were influenced by externally imposed rules and regulations stipulating engagement with CS, like organizational policies and procedures, professional codes of conduct, or duty of care (Di, 25:904; 29:1054; Alex, 3:36; 3:88 & 97). Participants reported that *how* CS was used depended on the meaning it had as support mechanism or obligation and whether use was out of choice or obligation.

I think some of the staff nurses attend because they've got to and it's part of their NMC requirements and they'll not say really much, they'll not want to bring anything up, (Adele, 5:164-7)

Tim added evaluation of supervisees' work to the meaning of the clinical supervisor's role during preceptorship, which influenced CS by importing threat and fear of failure. CS was a condition for continuing employment in these circumstances, and not necessarily involving the supervisee as an entirely *willing participant* (Tim, 2:55).

If you don't get through preceptorship, if it is felt that you are not suitable, competent, confident, then that's it, potentially career over (Tim, 8:270-2).

This resembled the game of snakes and ladders, a range of exciting and threatening consequences and associated emotions related to participants' understanding of the purpose of CS as support, development, weakness/ failure, surveillance, disciplinary measure to ensure mistakes did not recur, or punishment. Meanings and emotions were further influenced by the reality of managers usually acting in dual role as supervisors. Apart from making CS contingent upon managers' meaning of it, their communication and management style and the quality of their relationship with the supervisee informed the meaning and experience of CS. Where such relationships contained respect and trust, this dual role was productive, but this synergy was not always evident.

My staff […] regularly come to see me and ask me advice about things that, you know, something that's happened and what could we have done and various different things and all that is really clinical supervision. (Alex, 4:120-3).

Alex perceived the benefit of CS in its functionality rather than formality. "Formal" CS was widely perceived as impractical due to lack of time, thus substituted by what participants called "informal" and I understood as "CS on the hoof". This type of CS rested on the assumption that CS was for use with immediate problems or decisions rather than as a process of continuous development of professional practice or for improved self-awareness of the nurse. It did not contain explicit agreements about boundaries –other than, implicitly, organizational policies- and its main function was normative, or perhaps defensive, safeguarding the individual and the organization from complaints. Its instantaneous nature meant there was no agenda for development or restoration, although emotional relief could be an outcome.

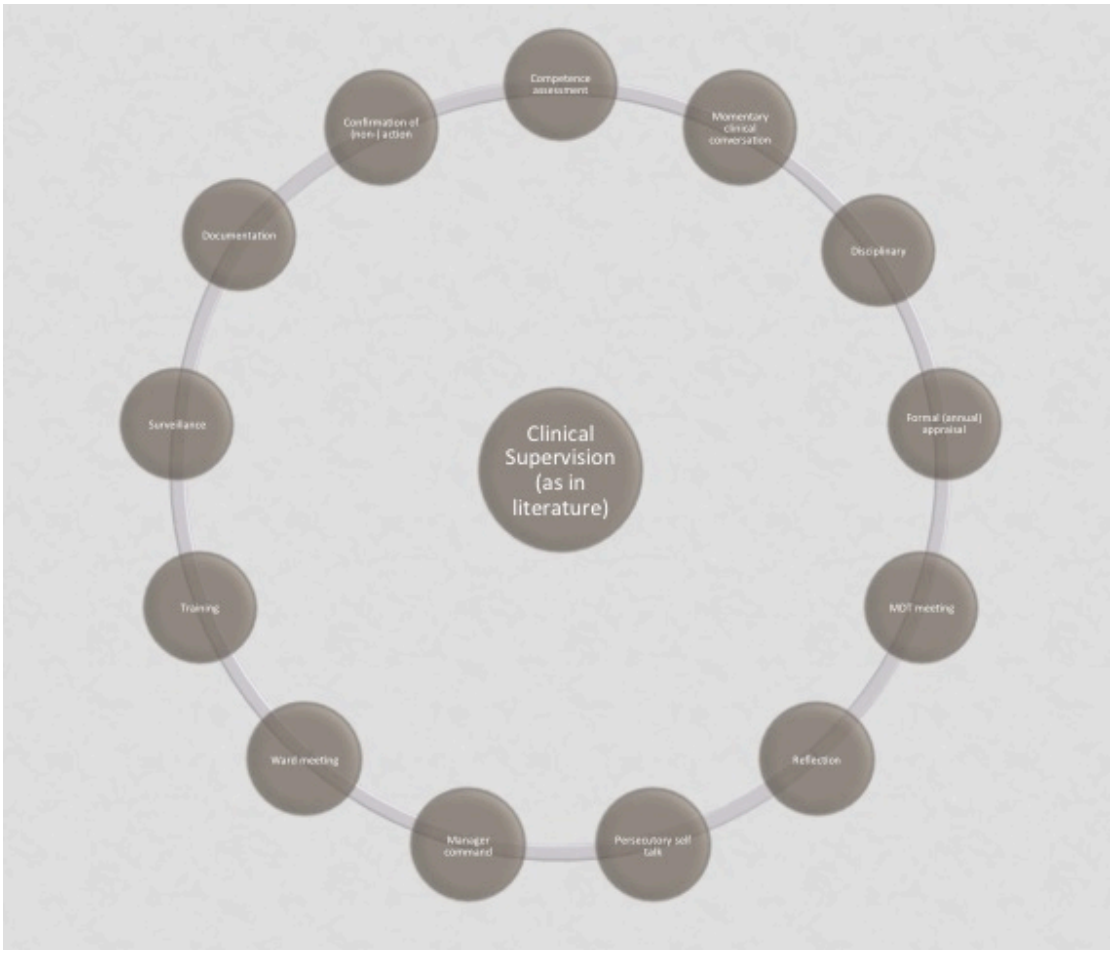
Discrepancies existed in the availability of CS based on patient dependency and one's position in the hierarchy. In the acute units, where patient dependency was high, there was little CS for ward nurses, while the rehabilitation service was better organized with some version of "formal CS" available at least monthly. A pattern emerged whereby very senior nurses had dedicated time for partaking in CS while, down the pay scale, this became "informal" consultation lasting a few minutes with any immediately available colleague about a "here and now" clinical issue, culminating in healthcare

assistants having no CS. This avoidance of CS through active evasion (or failure to undertake it) highlights individual and organizational practices. Steve openly acknowledged this twice as *a massive ga*p (1:16).

Betty's experience of CS was that it was personal and confrontational. In CS she discovered another ward manager's very different interpersonal style in contrast to her own softer approach. It appeared CS had met its purpose of reciprocal influence: Betty said she had realized supervision was about staff reporting their solutions rather than seeking them from her. She encouraged her staff to consider this. Tim stated that CS was *not core activity* (20:709) in his organization's strategy and questioned the evidence of effectiveness of CS in clinical outcomes, whether it made financial sense.

In summary, although CS was presented as essential professional development, this was interpreted variously across cases. CS had been organized differently in participants' workplace contexts and this influenced how it was experienced. Meanings of CS as essential continuing professional development were influenced by variables such as its perceived purpose, contextual variables (especially available time), supervisees' hierarchical position and the amount of choice in participating in it. Although participants in the upper hierarchy had more autonomy regarding work time and as such were better able to arrange CS, at HCA level there was no CS. Definitional CS was rare across the sample. Attendance was different from participation: some stroke nurses attended in order to fulfill the requirements of their professional association, making little contributions to CS group discussions, thus illustrating Tim's assertion that the supervisee must be "a willing participant".

Diagram 4.18b Clinical Supervision and Peripheral Activities



Central Circle: Clinical supervision (as in literature)

Peripheral Circles:

Competence assessment
Momentary clinical conversation
Disciplinary procedure
Formal annual appraisal
Ward meeting
Multidisciplinary meeting
Reflection
Persecutory self-talk
Manager's command
Training
Surveillance
Documentation
Confirmation of (non/) action

4.18c CS as task- and organization- focused

clinical supervision as a specific task or a specific thing has never been ever mentioned before speaking to you. (Steve, 19:675-7)

Despite the meaning of CS as essential professional activity, the meaning, knowledge and availability of CS were often influenced or determined by the management and leadership culture in the team and the wider organization. Availability of CS was often limited because *nobody gave nurses time to do it* (Kate, 2:39). This was because nursing was seen as *task prescriptive* and *task orientated* (Steve, 5:182; 20:710) and CS was not planned among the "tasks". Caroline, Kate and Sue felt that nurses had been treated like machines (*on automaton,* Caroline, 13:440) the efficiency of which had been measured taking no account for relational factors that characterized nursing, or for the fact that nurses were humans, not machines (Sue). Some participants experienced their workplace as focused on externally determined targets and on authority, both in the ways of the hierarchy and in their approach to CS, giving the impression of applying formal policies and procedures obsessively, responding to errors with punishment, and extinguishing sparks of learning from experience. As such CS was represented through a sense of cognitive ambiguity.

Efficiency meant cheaper nursing 'hands'. Parts of the nurses' clinical work were delegated to cheaper labour while nurses were expected to supervise the cheaper labour, do some work previously done by doctors, and *more and more tasks* (Steve, 5:157), *repetitive, mundane tasks* (Caroline, 15:538). Filling forms largely replaced relational aspects of nursing, nurses felt overwhelmed with administrative work and unhappy with what they experienced as erosion of care: *no individualized care any more, so, nurses aren't seeing that patient as an individual* (Caroline, 22:794). This meant that CS was available and experienced as being shown to do tasks and assessment/ confirmation of competence (Elena concluded that assessment was a much more frequently met term than CS).

These denote lack of knowledge, skill, or experience, and as some participants implied, nurses at this level were the ones needing CS. These changes impacted on time available for processes like CS. For example, Caroline's experience of CS was of three occasions in the 34 years of her nursing career. Participants adapted by creating contextual adjustments to the meaning of CS, for example, "informal CS" (discussed previously), a needs led interaction providing quick answers, advice, guidance or reassurance, immediately, about how to perform a task or whether it was performed correctly.

A further adjustment was evident in Steve's meaning of CS as his availability as a manager allocating tasks to staff: *you can class CS as the fact that I'm on the ward* (2:41), which *the NHS is happy to class it as* (Steve, 2:46). As supervisees and now as clinical supervisors, Elena and Becky experienced CS as assessing competence on specific tasks (also detailed by Tim) affecting the quality of CS in circumstances of potential threat when the supervisor was also the manager/ assessor with power to terminate one's career.

Nurses experienced delivering care as doing tasks, and the meaning of CS became about ensuring they were done properly. Adding complexity and complication, various external factors had to be incorporated –but were not properly accounted for- in the delivery of care. For example, all day visiting hours, which increased the number of bodies on the wards and the amount of (requests for) tasks. Such external factors could work in harmony or creative tension, but could also be experienced as disempowering cacophonies when some voices –usually the nurses'- were excluded. Affected participants deplored that the organization's upper hierarchy, rather than ward nurses, usually defined desirable clinical outcomes and authored associated policies, with little attention to the nurses before, during, and after tasks. This task-focused effect was captured in Steve's experience:

I would say, the person who I class as my supervisor…well my supervisor is [name], the matron. […] I pick her up every day so we have like a mobile conference about what's going off on the ward but that's sort of irrelevant really but we have meetings with myself, [name], and [name] meet up usually 2 or 3 times a week, go through what's happening with our work on the ward, anything we need to be doing, any issues, anything that we can sort out for ourselves or any development that we need and we go through it between us and work on that but that doesn't happen for the ward staff, I don't provide that, as I said it's basically the fact that we're working with them on the ward and I'd expect them to bring anything up or we'll bring things up with them, so, we don't give them the forum that we have. (Steve, 3:73-93)

The focus on task and organizational processes at the expense of the other functions of the gestalt of CS created confusion about CS:

People still think of it as a meeting with their manager and get a bit mixed up with their IPRs, you know, their Independent Performance Reviews (Kate, 33:1209)

It limited the meaning of CS and in some of its versions resulted in aversive psychological states (fear, anxiety). Although *clinical supervision is a process you can't force upon someone* (Tim, 2:53), its use as a management/ disciplinary mechanism that could lead to dismissal or disqualification made it *an absolute minefield* (Di,

29:1054). Conducting disciplinary procedures was part of a manager's dual role, starting by offering CS, but containing a conflict of purposes and consequently, a conflict of emotions: *I can't investigate you and support you at the same time* (Tim, 14:516).

In summary, the contextual meaning of efficiency as cheap labour influenced the meaning of CS for several participants. The meaning of CS became narrowed down to the assessment of competences, indicating that CS was important for the less competent, less experienced, or less skilled staff. The drive for this efficiency meant nurses experienced erosion of the relational aspects of their role, also associated with overwhelm by tasks for which work time was insufficient. Lack of time eroded the meaning of CS from a process that develops, supports, and addresses accountability, to a quick encounter with a colleague to confirm suitability of clinical decision-making and action, and to other, less comfortable, (disciplinary) processes, thus preferably avoided. Translating targets in ways that are palatable and digestible to staff was a challenge for first line management, especially where there was limited bidirectional communication between clinicians and hierarchy. Attention to targets made it possible to detract from focusing on relationships and process, with the potential of alienating the very people working to achieve the targets by making targets appear more valued than the people involved. Loss of individualized care to patients (who were treated by nurses on similar principles as their employer treated them) was the price of these adaptations and the sense that:

you're not a person really, you're just… […] the worker. (Caroline, 27:972-976)

4.18d Clinical supervision as structuring chaos

Differentiation in the meaning of CS from generic management, appraisal, performance management (Kate, 33:1210-213), training (Tim), multidisciplinary meetings (Catherine), disciplinary procedures (Tim, Steve), checking/ surveillance/ policing (Elena), or support (Alex) varied across the sample. These data reinforce the sense of ambiguity associated with CS.

Some leadership styles invited the use of managerial supervision as CS through creating professional relationships that enabled and balanced communication of feedback (conveying messages of gratitude from service users or achievement of service targets) to provide support, boost nurses' morale, and facilitate clinical accountability (*to go back to someone and say, right, that's done.* Becky, 5:134). Other leadership styles were associated with distancing staff, especially those already disaffected, by becoming the mouthpiece of upper hierarchy conveying expectations, demands, commands and criticism, which increased negativity, resistance, and a sense of mutiny and chaos. CS could be experienced as a structure that contained this "chaos" (Becky, 3:78) and its personal, psychological impact.

Becky experienced and delivered CS as a useful *structure* (1:27; 3:76, 94) for managing the impact of constant changes at work experienced as *daunting* (1:25; 2:45, 51), *terrifying* (2:47) and *disorganised chaos* (3:78) especially during preceptorship, to facilitate an experience of CS as *a little bit of a base* (7:204) and as *having somebody's back* (6:188) *when something comes and hits you in the face* (5:148). This structure consisted of giving supervisees small, clearly defined tasks to complete and report back for appraisal that included praise, gradually increasing the number and difficulty of tasks towards full competence. This structure enabled supervisees to *build on each section to build the bigger picture* (2:38), through experiencing *slightly positive reinforcement* (5:141) and other feedback that *shows you progress* (9:280). Clear and accurate appraisal feedback was considered important as a corrector and as motivator for improvement.

And in clinical supervision, you can actually say that, say you did that really, that was really fantastic, have you tried so-and-so yet, and you can use it as a building block, a stepping stone to better practice. (Sue, 9:325-7)

Several participants used specification of meeting time and space to initiate a structure for group CS. Time had various meanings, including clock time but also more qualitative elements. For Jim, having time for someone meant having respect, seen as the foundation of the supervisory relationship, evident in his description of unsuitable clinical supervisors as ones who have *not got time for people* (23:834). Making time

also meant the opportunity to examine and understand one's internal processes: the reasoning used in clinical decision making, hurdles experienced in the process, associated emotions, consequences of clinical actions, and a collaborative search for solution/s. Making such shared structured time in CS was experienced as facilitating professional bonds through communication of shared goals, commitment to their achievement, and subsequently, empowerment and pride. Adele's experience was that in CS,

there is some sense of empowerment that you do feel that you are going to discuss the issues and someone is listening and taking your views, taking them seriously (11:281)

In the -usually understaffed- exceedingly busy acute stroke units, initiating structured group CS was unworkable:

there isn't a specific time for people, say…you've got a group of people, you know, I can't allocate somebody and say these are your group of people to be your…you're going to be supervising them (Steve, 2:47-50) because *time is at a premium* (Steve, 20:722). However, there was potential for accommodating 1:1 arrangements in the busyness of the context, as Betty was doing with an underperforming nurse and achieving positive results, but such planning was experienced as lacking (Kate, 11:403). Perhaps the ambiguity of CS at descriptive level had led to its structural dissolution into the urgencies of the ward environment.

4.18e Clinical supervision as personal challenge

There were contextual and personal challenges to accessing suitable CS. There was a sense of deprivation and loss, as participants highlighted the benefits and deplored the absence of CS (Caroline, Kate). Kate discussed the absence of CS in the context of SU1 describing the powerlessness of ward nurses in the matter, because it was for upper hierarchy to agree to CS (and as Tim stated, CS was not core activity in this Trust). Simultaneously, Kate attributed responsibility to ward nurses, arguing that they should research and propose it to their hierarchy. This seemed a major personal challenge for a stroke ward nurse: to find time for such effort in the face of CS not being an organizational/ management priority, and in a context of overworking in pressurised conditions.

Deeper personal challenges also existed due to meanings of CS as for those less competent, as a sign of weakness, failure, and not coping, experiences of CS as a threat or ordeal, and the need for defence. Although experienced as personal, these

challenges went back into the history and culture of nursing. Although working in a context where CS is well organized and available, Catherine chose not to have CS, and she gave an account of how the history of the profession continued to shape CS as a personal challenge.

in early mid 90s, clinical supervision were really quite a big buzz word at that time and the majority of trained staff have had clinical supervisor training but very, very limited to the number of people that used it, I think it were 'cos it were new and everybody had done their training but nobody really knew what to expect or what to do (Catherine, 1:35-40)

Catherine may have been alluding to events following the Clothier et al report (1994), an important contextual and historical influence on the meaning and drive of CS in nursing, after which the Department of Health recommended that, to ensure patient safety, CS should be used as a safeguard in autonomous clinical practice. This was because of the behaviour of a pediatric nurse causing patients' deaths, who went undetected for a considerable time. Although none of the participants mentioned it, this case tainted the image of nursing *from being good people and highly respected […] gone to the complete end of the spectrum* (Caroline, 21:740).

Individual and collective nursing identity was injured and remained under threat from the idea of the 'bad nurse'. CS is associated with this as a weeding tool against 'bad nurses'. With the events culminating in the Clothier et al (1994) report, the bar for 'badness' had been set high. It seemed nurses have had to strive and prove themselves the opposite, to be seen as "good people" through altruism/ self sacrifice, working hard and for longer hours than contracted (*keep going and going and going until you burn out*, Di, 49:1775), attending to everyone's but their own needs (including professional development needs), and declaring their goodness by highlighting their devotion and role as pivotal in patient care, often using hyperbole. More recent inquiries, like the Francis report (2013), reignited the anxiety to be proven good. Catherine described nurses as *very skeptical* (32:1159) about CS, fearing and wanting to avoid colleagues' perceptions *that you weren't coping* (32:1161). The workplace culture in which CS was provided influenced the experiences and meanings of the novice, the failing, and the *fully functioning nurse* (Tim, 3:103).

None of the participants spoke of having experienced CS as a disciplinary procedure. They had found it helpful in their work, psychological wellbeing, professional development, accountability, preparation for solving problems, managing ethical dilemmas, alleviating uncertainty and unpredictability in clinical decision making, (Betty, Caroline, Di, Jim, Ted), and as a bridge in the *theory-practice gap* (Tim, 5:175).

There was awareness that CS could be experienced as a personal challenge because of emotions associated with its meanings including fear of being perceived as underperforming, failing, or weak, therefore in need of CS (Di, Catherine, Sue). These meanings were additionally influenced by factors such as the local tradition of toughness whereby seeking reflection, help and advice carried risks of being judged negatively (*she's always moaning or she's always whinging,* Catherine, 34:1223), so, *you just get on with it* (Catherine, 33:1198). This was combined with experiencing professional nursing associations as leaving nurses undefended and unsupported against external negative perceptions and judgments, accepting increasing impositions of tasks and responsibilities without resistance or recompense, and encouraging toleration, effort to satisfy impositions, maintaining a *very stoic* (Catherine, 33:1184)*, self sacrificing* attitude (Di) that resulted in nurses being their *own worst enemy* (Catherine, 35:1262). Awareness of the inclusion of CS as an element in disciplinary proceedings added more cognitive and emotional complexity to an already loaded concept.

Emotions experienced towards meanings of CS were a shield or a significant challenge for participants. Those with lived experiences of definitional CS appeared least affected by negative contextual meanings (Caroline, Jim) distinguishing CS from other process and associating CS with positive emotions. However, experiencing CS as policing and disciplining even for others, elicited fear of being stigmatized and led to nonparticipation in CS even where CS was easily available (Catherine has already been mentioned as an example). In the acute stroke unit where staff were dissatisfied with and threatened by management, and CS was part of disciplinary procedures, Becky expressed certainty that if CS became available, her colleagues would not use it. This presents the sense of ambivalence in the data regarding stroke nurses' meanings of CS.

4.18f Summary

Participants held various meanings of CS. Although most considered it as essential continuing professional development, one stated complete ignorance of it until taking part in the study and another did not wish to engage in it. Few participants had experienced CS as in its literature definition. Most stroke nurses had adapted their understanding to mean any consultative support they received from colleagues in relation to clinical work. The meaning of CS was influenced by characteristics of the workplace, which included its absence as a support mechanism. It was an aid to managing chaos but also a challenge to access or to approach.

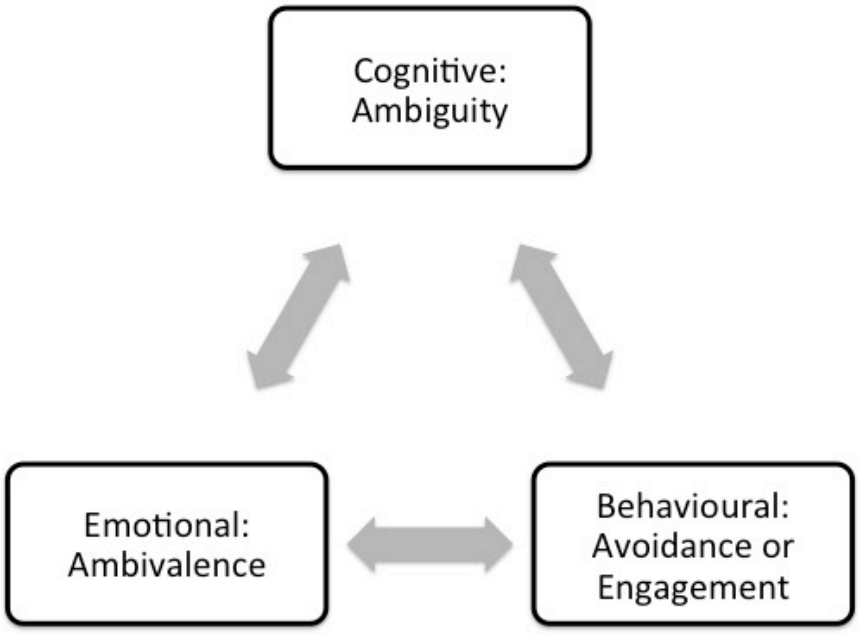
Historical reasons and mechanisms in the local, professional and organisational cultures reinforce the ambiguity of CS (cognitive meaning of the experience) which became associated with ambivalence (contrasting/ conflicting emotions about CS) that led to avoidance. Such avoidance could reinforce the negativity associated with the ambiguity at conceptual level and the ambivalence or anxiety at the emotional level due to lack of opportunity to collect evidence that would challenge one's fears and preconceptions. Those who had experienced definitional CS continued to hold clear ideas and emotions about it and were ready to engage with it.

This is summarized in the following diagram:

Diagram 4.18f AMBIGUITY, AMBIVALENCE, AVOIDANCE

Ambiguity, Ambivalence and Avoidance of or Engagement with CS

(The AAA of CS use)



4.19 OVERALL SUMMARY OF QUALITATIVE ANALYSIS

The qualitative analysis produced four superordinate themes with subthemes:

Psychological Impact	**Reflection as personal growth**	**Relational Features of CS**	**Participants' meanings of CS**
Responsibility and powerlessness	Transformation	Boundaries, time, confidentiality	CS as essential professional activity
Guilt and blame	Personal awareness	Relational safety and trust	CS as task- and organization-focused
Emotional Labour	Reflection and the "mirror"	Empowerment	CS as structuring chaos
Maintaining a sense of self			CS as a challenge

Providing nursing care in stroke services was experienced by participants as being emotionally and physically demanding due to witnessing the effects of the illness, requirements to manage one's emotions and maintain a professional façade, experiencing strenuous working conditions, and organizational and external factors impinging on the job and the person of the worker. Engaging in CS had the potential to ameliorate the psychological impact of work and improve conditions for both staff and service users.

Through reflection, participants reported they had experienced transformational learning, increased self-awareness, and developed professionally and personally. The quality of feedback, the 'mirrors', available for reflection in the workplace influenced the quality of transformation. Some workplaces offered comfortable and useful reflections while others were experienced as "terrifying" (Becky).

Based on the interpretation of the accounts of interview participants, the professional relationship in CS can be experienced as an alliance characterised by at least three relational features: Boundaries, such as agreements about dedicated time, confidentiality, purpose. Boundaries facilitated relational safety and trust, and by using (supportive/ developmental/ restorative) CS, participants reported having experienced a sense of empowerment or liberation. CS appears to have the potential for the

transfer of the experience of relational safety and empowerment into patient care and improved patient experience.

CS in stroke nursing had various meanings mostly built on fragments of definitions of CS in professional literature, adjusted to the pressures of work and for historical and cultural reasons. CS provided a structure to manage workplace chaos and accompanying emotions. Various connotations complicated the meaning of CS, based on historical experiences or beliefs inherited from professional and local culture. Meanings included professional development, support, confirmation, relief, but also threat, ordeal, and defence. The accompanying conflicting emotions resulted in some participants' avoidance of CS.

CS had the potential for positive effects on staff development and wellbeing by addressing learning needs, supporting efficiency and high standards, and ameliorating the psychological impact of work and the conditions of work. The quality of leadership and management was a stressor or a support, manifest in dual roles (manager and clinical supervisor) problematic due to boundary issues and the consequent risk of staff being clinically supervised and investigated by the same individual. With CS training and sufficient reflection on dual roles, managers could offer suitable CS.

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4.20 INTEGRATION OF QUALITATIVE AND QUANTITATIVE DATA

This study used various methods to understand stroke nurses' meanings and experiences of CS. Interviews were the main source of information, supplemented with questionnaires from a greater number of participants, and observation and a service pro forma about participants' workplaces (context). Here, an attempt is made to weave all the sources together to contextualize the meanings and experiences of CS reported in this study. The quantitative data collected with the service pro forma were not sufficiently complete to allow meaningful comparisons, especially between the acute services and rehabilitation. Detailed pro forma information is in appendix 5. The services were geographically and demographically different. However, as discussed later, answers to three questions raised potentially useful understandings: age of service, frequency of team meetings (communication), and management arrangements.

The questionnaire data indicated that 58% had quarterly or less frequent CS (10% never) lasting between 60-90 minutes (57%), while for 43% it was half an hour or less (one indicated none). CS was mostly in one-to-one (44%) or small group format (37%). Nearly all CS took place during work time with a nominated supervisor, usually their manager. Most participants had some choice regarding who their supervisor was, either chosen from a range offered (26%) or one of their own choosing (30%), while 44% had a supervisor assigned to them. Participants indicated that CS helped manage (64%) and develop (68%) their work, observe ethical and legal boundaries (81%), identify knowledge gaps (74%), and learn skills (54%). To a lesser extent, CS helped set work goals (43%), and consider the impact of work on oneself (46%). Evaluating their CS, two (8%) felt there had been a damaging effect from CS on themselves or their work, nearly half (46%) wanted changes to CS, and although 87% felt confortable to discuss if CS worked for them, 48% indicated that their supervisor seeks feedback on CS, and only 29% had ever raised such issues with their supervisor.

In relation to the pro forma and observations made, the most interesting information was the age of the service and the formal arrangements for clinical communication and management. Regarding age, Tuckman's (1965) model of group development (forming, storming, norming, performing) may offer insights. Acute stroke unit 1 had been in existence for three years, while unit 2 for eight years. In relation to group formation, this could account for the differences in the emotional climate of these services: SU1 appeared to be in a "forming-storming" stage complicated by the emotions of staff who had experienced limited choice but to be there following service

reconfiguration (prior to SU1), while SU2 appeared to be in norming, and rehabilitation in performing stages. Staff pride for the performance of the rehabilitation service (13 years in existence) may also be related to more acceptance of sharing clinical practice (most spoke of having some form of CS) and their twice weekly clinical meetings compared to once weekly in acute units. The other important difference was that SU2 and rehabilitation, where a supportive and cooperative atmosphere existed, had split management arrangements: individual professions had their own leader with single management for the unit. In SU1, single management arrangements existed for clinical and managerial issues. These are speculative ideas, but potentially useful for future research.

Separation of management from professional leadership may have outlined helpful boundaries, eliminated dual role conundrums, and expanded the matrix of support options for raising issues from different perspectives and with different sources of power (professional head and operational manager). Supervisees could have opportunities to receive specialist clinical consultative support within their specialism, which a few stated they valued, and consultation on operational issues with a manager, as participants from rehabilitation discussed. This could also improve options for managing chaotic work environments and their associated sense of overwhelm and powerlessness.

In the rehabilitation service, twice weekly team meetings brought staff and management together and increased the chance of acquaintance and dialogue, which facilitated trust and good patient care, evident from the interview data. Acquaintance over time was experienced as facilitating trust, which could increase the range of informal clinical consultation available, and consequently produce confirmation, and reduce uncertainty and associated anxiety. Positive clinical outcomes were the result of shared efforts, therefore shared pride that reinforced the sense of team cohesion and synergy, not least through the shared positive reflections. The latter may have moderated the psychological impact of ambiguous responsibilities and sense of powerlessness, while shared pride could have moderated the impact of blame and guilt.

There was another important ‘ingredient’ in SU2 and rehabilitation, and that was the nature of relating between ward staff and management. Interview data suggest that upper hierarchy shapes not only the meanings and availability of CS, but also the relational style in the organization. The observation data support this. In SU1, there was a diffuse mixture of superficiality, uncertainty, fear and anxiety that permeated my being there. The installation of a video-buzzer at the door, which lets anyone in

(without any questions) but then the absence of a reception space/ person are bewildering in such a big space. During observations, an explanation denoting lack of trust was offered: there was no reception area so that staff would not congregate at the reception desk and not look after patients (also in Becky's interview "we are not trusted").

According to interview participants, SU1 is a busy, target driven unit. The nature of the organizational relational style (limited trust, suspicion) accentuated the distance between targets and the people involved with them (interview data), a distance also experienced in the physical space. From the manager's communication style in commenting that a chair in the room was broken (that I experienced as blaming me), to the absence of both people supposed to be my contacts during the manager's absence when I visited for observations, to an interview participant's divulgence that events on SU1 had caused her to seek psychological therapy, SU1 was an uncomfortable space to be in. The ambiguity in the manager's communication, intended to be neutral, took on the surrounding sense of terror ("terrifying environment" and "terrified senseless" were phrases of an interview participant). Staff blamed each other, ward staff blamed management and management blamed and persecuted ward staff, with "people getting suspended left, right and centre" (SU1 interview participant).

Regarding CS, a service leader attempted to run group CS, but unsuccessfully due to non-attendance. There seemed to be practical but also psychological reasons for this. As the manager explained, it is not feasible to release a group of people to attend. Psychologically, it might have been difficult for a group of people working in conditions of suspicion and poor trust to speak openly about work. Nurses had been asking for one-to-one CS, but the clinical leader was reluctant to commit such an amount of her time to CS in a Trust that did not place importance on CS. In SU1, CS was available to managers, trainees and newly qualified nurses, and as the beginning of a disciplinary route that could result in dismissal. As the ward nurse participant commented, if definitional CS were introduced in the unit, staff would feel suspicious about it and not use it.

SU2 was also target driven, and a similarly busy unit as SU1, but had a different personality or emotional atmosphere, helped by the presence of a staffed reception desk (occasionally with a vase of flowers on it) at the entrance, which moderated early uncertainty and anxiety. The prevalent relational style was egalitarian: inequality in knowledge, skill and experience was acknowledged, accepted and responded to helpfully. There was openness, a welcome for ignorance, its expression being perceived as a first step towards learning, with expressed encouragement to ask.

Communication was clear and included understanding, expectations, instructions (I was informed clearly early on that “staff don’t like survey monkeys”), and gratitude.

CS was available as a competency check for staff who had just completed learning a skill. CS was also available to staff returning from long-term sickness absence and struggling with their return to work. CS for them was provided by the ward manager, in a supportive and restoring way. Anecdotal evidence was reported that the results were good, and staff were able to reintegrate in and make a useful contribution to the service. In SU2, CS is for those who do not know yet or those who cannot cope any more, regardless of grade. All interview participants were of senior grade, and only one questionnaire was received, so, these observations would have been without foundation, were they not similar to the observations of the rehabilitation service.

The rehabilitation service had received an accolade as one of the best in the country, and had the longest history of operation among this study’s interview sites. During the study, the service moved to purpose built accommodation. This was discussed in some of the interviews as staff tried to balance positives and negatives, especially that in the 12 years that the unit had been in the original location, strong relations had been formed with the rest of the hospital, including ones for CS. This team appeared to be very cohesive, evident in the interview material from eight nurses. It was a very open team in terms of communication, evident in clinical discussions during the team meeting I attended, where Jim’s words at interview “speak up, challenge, beg to differ, and not fall out, stick together” could be witnessed in action.

CS has various meanings here, mostly as a process that supports clinical work and alleviates its emotional burden on the clinician. Those available to offer CS, some of whom came forward to be interviewed, have had training as supervisors, have an understanding of the boundaries of the role, especially the importance of confidentiality and trust, and their responsibilities as role models. Participants described experiences as supervisees where they experienced relief, change of attribution that improved self-confidence and gave a sense of empowerment, and instances of CS leading to improved patient care. Where CS was suggested as a corrective measure, the prospective supervisor clarified that the purpose was to keep the staff/ supervisees employed as well as ensure that their conduct was professional.

In conclusion, in this study, participants held various meanings of CS, sometimes contrary to the meanings stated in professional literature (for example, as part of a disciplinary procedure). Those who had experienced definitional CS appreciated its benefits and deplored the low level of availability and use in stroke and physical health nursing more widely. Apart from knowledge and personal experience of CS, the context of work shaped CS meanings, availability and expectations. In settings where

there was a climate of trust and openness between staff and hierarchy, participants shared meanings of CS as a developmental/ learning process or as a mechanism to help manage adverse effects of work. This gave CS an identity as targeted at those lacking knowledge, skills, experience, and those struggling or not coping, leaving open the implication that experienced good nurses may not need CS. A more extreme meaning of CS was as part of a set of disciplinary mechanisms and procedures, with connotations about poor conduct or performance, or not coping with work. This latter meaning was shaped through criticism in major national inquiries and media that gave nursing adverse publicity, disappointment with the response of nursing professional bodies to those publications, but also about an atmosphere of blame, suspicion and lack of trust between ward nurses and hierarchy, part of a general malaise in an employing organisation's relating style where staff were treated in mechanistic and persecutory ways, with serious adverse effects on their psychological wellbeing, understandable by reference to the interview data about the tight intertwining of personal and nursing identities. Table 4.17 summarises this.

Table 4.21: Context, Processes, Outcomes

CONTEXT	PROCESS	PROXIMAL OUTCOMES	DISTAL OUTCOMES
External Factors	**Emotions**	**Protective**	**Clinical Outcomes**
Leadership/ Management Roles	**Reflection& Learning**	**Restorative**	
Barriers& Boundaries	**Feedback**	**Developmental**	
Relationships	**Relational factors**	**Coping**	
Delivery variables (Formal/ informal)	**Other reasons for CS (outcomes)**		

5. DISCUSSION

5.1 Introduction

The aim of this study was to explore stroke nurses' experiences and meanings of CS through a primarily qualitative approach using interviews analyzed through IPA, contextualized through observations and quantitative information. The paucity of scientific literature on CS for stroke nurses informed the questions of this study, pointing to new areas of knowledge. By addressing a topic not explored previously, elucidating stroke nurses' experiences, understanding and meanings of CS, this study makes a unique contribution to knowledge. Insights emerged about understandings and meanings of CS and its place in NHS acute and rehabilitation stroke services, the journey of CS in nursing within NHS organizations, nurses' experiences of the absence of CS, and wider issues vis-à-vis the nursing profession and the wider NHS in the "post Francis" era.

Data collection for this study commenced in 2012, a few months prior to the publication of the Francis report (2013) that shocked the public, NHS staff, and their professional and training organizations. It is impossible to estimate the impact of the report's publication on participants' accounts. By the close of data collection in July 2013, the inquiry had been mentioned in some interviews. Some recommendations of the Francis report are directly connected to functions of definitional CS. These recommendations are similar to the Clothier et al report (1994) which had revived discussions about formalizing CS in nursing. For example:

Make all those who provide care for patients- individuals and organisations- properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service; […]

Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do […] (Francis, 2013: 4-5)

The literature review showed an abundance and variety of documents on CS generically. Accounts contained in Cutcliffe et al (2001) suggest that, in nursing, the goal toward CS implementation in the 1990s was awareness about the regulatory and beneficial effects of CS. In services for older people (who form the largest percentage of stroke patients), the literature review indicated that usually CS was the variable introduced, therefore previously absent (Dinshaw, 2006). Where CS existed or was

introduced, a range of positive effects on staff were reported, some extending to the quality of care given to patients/ clients (Berg et al, 2008; Berggren & Severinsson, 2000; Edberg & Hallberg, 2001; Edberg et al, 1996; Edvarsson et al, 2008; Edwards et al, 2006; Flackman et al, 2007; Hallberg & Norberg, 1993; Hansebo & Kihlgren, 2004; Olsson et al, 1998; Severinsson, 1999).

This chapter starts with an evaluation of the study. The findings of the study are then discussed further in relation to the literature review and sources published subsequently. Discussion is arranged under the titles of the superordinate themes while also opening the issues of time and purpose of CS. Implications and recommendations follow, then some reflections on this study.

5.2 STUDY EVALUATION

This is a qualitative study with quantitative supporting data to describe its context. CS is a complex phenomenon spanning from subjective to inter-subjective and into systemic and organizational processes. Inevitably, aspects of this complexity cannot be captured fully or entirely accurately by a single study. Although I have attempted to keep interpretations close to transcript material, they involve my subjectivity and pre-understandings. Therefore another researcher's interpretation of the transcript material may be different.

IPA typically involves an indepth analysis of a set of case studies (Smith, 2004:43), provides detailed descriptions rather than explanations of the phenomena of the experience under investigation, aiming to understand experiencer's meaning making. Highly contextualized idiographic research is useful in clinical applications. It resembles the knowledge and learning that occurs through CS in phronetic practice (Benner, 2004). Building up a number of detailed case studies becomes an excellent source of detailed and potentially generalizable knowledge on a particular phenomenon in human sciences.

Given the complexity of the topic, the size of the sample, and scarcity of literature on it, it would be inappropriate to speak of generalizing the findings. This was not an aim of this study. Some of the limitations of the study derive from limitations of qualitative research generally. IPA is a qualitative method and as such it does not address cause and effect questions or generalizability (Smith et al, 2009). However, literature from nursing specialties similar to stroke lends support to the findings, making the study a signpost towards understanding the experiences and meanings of this CS, complex mechanism, within stroke settings (also complex contexts).

The evaluation of qualitative research has been examined from various fields in the past twenty years (Malterlud, 2001; Mays and Pope, 2000; Yardley, 2000). Mays and Pope provide seven questions to assess the quality of qualitative studies. These pertain to the study's useful contribution to knowledge (worth/ relevance), clarity of research question, appropriateness of design, adequacy of description of context, sampling strategy (allowing a full range of cases and enabling contradictions to emerge in the analysis), how systematic data collection and analysis were (*did the researcher search for discomforting cases?* p.52), and the reflexivity of the account. Yardley's criteria incorporate these and have been adopted in the criteria used for assessing IPA specifically (Smith et al, 2009), and in a collection of papers published in 2011 regarding quality in IPA studies to critique IPA in the study's context, mindful that *guidelines are not prescriptions* (Smith, 2011b:57)

Smith et al (2009:184) advocate a flexible but meaningful approach to validity criteria, not a checklist mentality (p.113). They focus on Yardley's (2000) four principles for assessing qualitative studies: Sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. The quality of interviews is emphasized as of paramount importance, as the study's findings depend on it. Here is an account of how these criteria appear in this study:

5.2a Sensitivity to context

This includes description that allows the reader to relate the findings to other settings (Mays and Pope, 2000:52), how the existing literature on the topic is used, the sociocultural environment of the study, and how the data are handled. In IPA this sensitivity is important at every stage (Smith et al, 2009:180-5) from research question to reflections on the whole study. It is demonstrated through sensitivity towards others contributing to the research, especially participants and gate-keepers, as these relationships affect the quality of data: in good interviews, researchers put participants at ease establishing rapport through empathy, are aware of power differentials, and behave respectfully.

IPA treats each participant's contribution as a detailed case study with a large amount of data available for analysis. This is particularly useful for minimally understood phenomena (as is CS in stroke care) but does not generally speak of the general population. Literature searches found no items on CS of stroke nurses. Like dementia, the probability of a stroke increases with age but differs in its suddenness and mortality, is amenable to rehabilitation, and therefore has a different prognosis. Its impact on survivors and their carers may also be different. Some dementias are vascular, linked to higher stroke incidence in old age. Stroke patients have been

included in the context studied by some sources in the literature search but not exclusively. I attempted to gain an understanding of issues related to CS in stroke by analogy to CS in services for older adults. I included all such studies in the literature review regardless of quality because, having been conducted by nurses, they represented nurses' understandings. I critiqued them individually and remained aware of their limitations.

IPA uses language-based data. This has informed critical debate about how accurately language can depict experience, participants' articulation capabilities limiting IPA's applicability, and subjectivity (Willig, 2008). This study's participants were educated to degree level in a profession that demands good communication. I appreciate the importance of language. I also believe that the willingness to communicate is as important, and quality of interaction facilitates communication of different depths. I was keen to get in-depth material, but also respected participants' boundaries about disclosing experiences. I am aware of the power inherent in questions and that participants may perceive me as the expert researcher. At the start of interviews, I informed participants that what and how much they said was their prerogative giving them explicit 'permission' to tell me if any question went too far so that I would not pursue it further. These permissions felt liberating for me, a boundary to potential intrusiveness into participants' personal worlds and an attempt at managing inequalities in these relationships.

I enjoyed interviews as interesting conversations with health service colleagues. I had met some participants during field visits and found we developed rapport easily, partly because they knew of CLAHRC's research through my supervisors' other studies. It is possible that participants volunteered because of their interest in the topic and that this facilitated conversation. On reflection, enjoyment was also due to the different nature of responsibility to participants compared to my therapy clients. I became aware of this early in data collection when I experienced worry about a participant who did not keep our appointment.

Having practised as a counselling psychologist for 20 years, my skills in managing professional relationships with empathy and sensitive curiosity contributed to interview quality (Goldstein, no date; Kvale, no date). I gave participants much genuine attention, following their account closely, as confirmed by their agreement and elaboration in response to empathic/ clarification summaries and questions conveying understanding and eliciting more material. In this way, I attempted to work with the *complex power play* inherent in qualitative research (Brinkmann, 2007:140) to *let the object show its nature and [to] object to interpretations and descriptions* (Brinkmann,

2007:142).

I realize that interpretative processes do not start at data analysis but at interviews and possibly before them, with the gradual mutual forming of impressions. Interpretation exists in the nature and focus of questions emerging from and asked of accounts, in the empathic response, and participants' experience of the interview. *All interviews are interpretatively active, implicating meaning-making practices on the part of both interviewers and respondents* (Holstein and Gubrium, 1995:4, in Brinkmann, 2007:135). Kvale (1996) argues interpreting is one of the ten capabilities of good qualitative researchers, reinforced by the capabilities to tune into nuances and be mindful (critical) of the validity of participants' accounts, linking previous with current material in the account for the participant to dis/confirm.

Additional evidence of sensitivity to context is the disciplined and attentive manner in which the researcher immerses themselves into each participant's account during analysis (Smith et al, 2009). I demonstrate this during Steve's interview analysis. I created another category of annotation, *paralinguistic*, to help me understand his incongruent laughter (this can also be seen as the welcomed stretching of IPA boundaries: Smith, 2011a/b), as noted in my research journal:

It started with my feeling unclear why he was laughing at various points of the interview (funny? Sarcasm? Something else?). Then, while re-reading the interview, I realized that his paralinguistic communication can be often ambiguous, so, what I experienced as a question might also be what his staff experience. This may be compounded by the lack of clarity between processes like performance reviews, interviews after sickness absence, prof development support/ conversation, disciplinary procedures/ interviews […].

This was significant due to the distant professional relationships Steve (and later, Becky) reported with nurses he managed, making CS inaccessible.

5.2b Commitment and Rigour

IPA is idiographic in its commitment to analyse each case in a corpus in detail. Sometimes this commitment is made manifest in the writing up of single case-studies which represent in-depth examinations of the lived experience of a single person […] More commonly IPA involves the detailed analytic treatment of each case followed by the search for patterns across the cases. (Smith, 2011a:10)

For some elements of the research process, a demonstration of commitment can be synonymous with a demonstration of sensitivity to context (Smith et al, 2009: 181).

Commitment is demonstrated by attentiveness to data, as discussed regarding sensitivity to context. Rigour pertains to sampling, interview quality, and completeness of analysis (also: Mays and Pope, 2000). As mentioned in methodology, the sample was selected purposefully to include qualified stroke nurses and exclude students, assistants, and other disciplines. Flexibility favoured meaning: I followed up a participant's suggestion to interview people at the level of NHS Trust's Chief Nurse because they were experienced by nurses as shaping the culture and meaning of CS. The participant (Tim) was not a stroke nurse, but was at a level of hierarchy and power that enhanced the study's aim of understanding the experiences and meanings of CS by taking a glimpse at the shaping impact of upper hierarchy's meanings.

Consistent with IPA's idiographic approach, I analyzed each interview individually; analysis of another interview only started upon completion of the previous. I then involved my supervisors in the search for superordinate themes across cases. Focus on individuals' experiences and meanings limits the focus given to personal power and political contextual issues that emerge in this study. Larkin et al (2006) discuss the *complementary commitments* regarding power of participants' voice in IPA studies. Lyons (2007) suggests that speaking for the participant through our research may be both empowering and disempowering. I suggest this remains a matter for consideration not only in IPA but social sciences generally (Flyvbjerg, 2001).

Attentiveness to data was my concern not just during analysis but also at interviews, as discussed above. Quality of interviewing is evidenced strongly in the request of two participants (Jim and Di) to speak off the record, completely confidentially and explicitly, providing real life examples, demonstrating the level of rapport, trust, and skill in managing my interpretations through empathic interactions. A dilemma discussed during research supervision was how to conceal their identity effectively while preserving this level of richness in the study. Apart from the anonymising measures already taken, we decided that correspondence with Trusts' Research and Development departments will not form part of this thesis (letterheads identifying workplace). Similarly, transcripts would not be publically available (page/ line numbers in quotes from transcripts are for audit/ validity purposes).

The interview schedule is another consideration in judging commitment and rigour. Understanding Smith's (2004:43) emphasis on the *inductive stance*, I welcomed the possibility of being surprised by my data. I facilitated the flow of conversation using the interview schedule not as a guide but aide memoir. I asked questions as their relevance arose. At the end of the interview, I checked with participants and the schedule for anything not covered. Several participants thanked me, describing

interviews as a rare opportunity to consider the topic. Rigour is also evidenced in the analysis, prioritizing idiographic engagement in moving beyond description to interpretation. I provide extensive quotes, foundations of the study's themes, enabling transparency and judgment about rigour. The following quotes from my research journal exemplify idiographic engagement during analysis and how seriously I have treated the data. Reference to laundry sorting came from a metaphor colleagues used for qualitative research.

22/7/2013 I could not spare much empathy after first reading. But I could have easily started to "sort" in laundry fashion. My second reading did not improve my empathy either…It was not until I read two articles, Rachel Shaw's on reflexivity (2010) and Jonathan Smith's on "pearls", that I shifted my perspective, ie. I made a conscious decision to understand THIS guy. Not his staff, not me, HIM. This was a really good idea. I started asking questions of his statements rather than "sort" them in laundry fashion. This, I believe, is where the Interpretative comes in. The questions come from 'cognitive' analysis of the material but also from emotional analysis. Something about recognizing that perhaps his ideas and lack of organization re: implementing CS have been shaped to a large extent by his own experience of CS.

IPA is based on phenomenology and hermeneutics, using the double hermeneutic of participants' and researcher's subjectivities to arrive at its findings. During analysis, I found that phenomenology is used first and interpretation follows (therefore, its title would be more accurately Phenomenological Interpretative Analysis):

25/7/2013 As I afford empathy to participants, things happen inside me, the closest term that could summarily describe them would be "good passions". This was the way I attempted to articulate to my "laundry sorting" colleague what IPA is about. And that the 'P' must come before the 'I' in IPA. And a strong 'P' at that → passion. "Openness to being astonished" (Fink, in Finlay, 2008).

Alongside the qualitative engagement with the data, I have demonstrated commitment and rigour through the quantity of time I spent analyzing each interview, evidenced in the time-extensions required to complete the thesis.

5.2c Transparency and Coherence

Transparency refers to clarity in describing each study-phase *so reader can see what was done* (Smith, 2011a:17) and how systematic data collection and analysis procedures were (Mays and Pope, 2000) to judge the study's trustworthiness (rather than definitiveness/ reproducibility of findings) and seems related to Brinkmann's (2007) proposal that *the epistemic and the ethical domains are often inseparable in*

qualitative research (p. 127). I have described details in the methodology and analysis chapters and have provided extensive quotes to enable transparency.

The reader judges coherence by the final write up (Smith et al, 2009:182), seeking evidence that there is logical sequence in the phases of the study; data collection, analysis and reporting are consistent with IPA; and the author manages ambiguities and contradictions sensibly, describing them clearly. The idiographic, phenomenological and interpretative bases of IPA must be evident (Smith, 2011a; Smith et al, 2009). In addition, Smith (2011a:17) specifies that acceptable IPA studies with large samples (N<8) contain *extracts from at least three participants for each theme + measure of prevalence of themes, or extracts from half the sample for each theme*.

To demonstrate these, I provide (more than) the required number of subthemes that constitute summative themes. Additionally, I provide excerpts from my research journal, photographs, and extensive transcript quotes.

5.2d Impact and importance

Additional tests of validity are the importance, usefulness of any knowledge contributed, and power to engage the reader (Smith et al, 2009). Supervisors and examiners judge this (being the earliest readers). Evidence of the study's importance exists in activities where, in various forums, I captured the attention of managers, clinicians and researchers and received positive responses. I find the topic intrinsically interesting and convey this during conversation. My supervisors confirmed the positive feedback afterwards (when they had been present). I presented the literature review at an international conference in Singapore, receiving congratulations from attendees who considered the topic important and under-researched. I spoke at local and national meetings of CLAHRC Stroke theme, receiving enthusiastic responses from medical consultants stating they wished they had CS for their practice. I also presented IPA and some of my findings at a qualitative research seminar in Derby University and have invitations to speak at IPA- and CS-related events in the Universities of Edinburgh and Manchester.

The process of this research has witnessed changes. Between initial informal visits to recruitment sites and data collection, attitudinal changes occurred in service managers and clinicians, from superficial to serious consideration of the importance of CS in nursing practice. In one Trust, a few months after data collection, a review of CS policy took place. During a visit to another Trust, I noted the following in my research journal:

4/5/2012 I had been told […] that he'd probably see me for a few minutes, agree to help with my research and that was it. As it often happens when I hold conversations about my research, it lasted much longer, the full hour. […] And the content was very interesting. […] We gradually came to agreement in our debate, with him having started this conversation with blanket statements about all nurses knowing about and receiving CS in various formats, to an exploration of benefits of CS beyond 'information' and to a question from him: "So, how do we get these nurses to engage in CS?" […] I explained again that there is no literature on CS in stroke nursing, and my research is to find out nurses' experiences about CS in stroke, therefore, on my part, there was no need, never mind hurry, to institute a CS structure in his service. That may be something to be decided post data analysis. I was thinking on the way back how this conversation had started with him giving me several packs of information, for which I expressed gratitude, as they will provide the context; to a very explorative and reflective discussion on CS, which I felt became increasingly open and honest as it progressed.

My impact plans include publicizing parts of the study widely upon completion for academic, health service management and clinical audiences, sharing findings, observations and indications from the data to open dialogues about CS (and other support mechanisms) using my past experience as Head of Staff Counseling Services. Similarly, I intend to develop further the methodological critique and share within the research community through presentations and publications, starting with the Yorkshire IPA group that I convene and my supervisors' departments. I have identified possible article titles about CS in routine stroke nursing care, the Francis report, IPA interviews, epistemology of IPA, and the relationship between case studies and IPA. As the findings may be of interest to nurses, and *IPA is increasingly of interest to people in cognate disciplines* (Smith, 2011a:25), some papers will be sent to journals of nursing and health service management.

5.2e Independent audit

. […] the independent auditor is attempting to ensure that the account produced is a credible one, not that it is the only credible one. This speaks to the particular nature of qualitative inquiry. The aim of an independent audit is not to produce a single report which claims to represent 'the truth', nor necessarily to reach a consensus. Instead the independent audit allows for the possibility of a number of legitimate accounts and the concern therefore is with how systematically and transparently this particular account has been produced. (Smith et al, 2009:183)

Independent auditing is presented as a validity tool. The audit trail consists of items ranging from notes on developing *the research question, an interview schedule, audio tapes, annotated transcripts, tables of themes and other devices, draft reports and the final report.* (ibid) This is a *hypothetical or virtual* audit (ibid). In this thesis, I provide an account of developing the research question and append the interview schedule. My supervisors (albeit not entirely "independent" auditors) have seen draft reports. I have provided excerpts about my thought trails towards findings, including from my research diaries. So, this thesis is the final report, to be audited by the examiners.

5.3 DISCUSSION OF FINDINGS

The superordinate and subthemes found from this study were:

Psychological Impact	**Reflection as personal growth**	**Relational Features of CS**	**Participants' meanings of CS**
Responsibility and powerlessness	Transformation	Boundaries, time, confidentiality	CS as essential professional activity
Guilt and Blame	Personal awareness	Relational safety and trust	CS as task- and organization-focused
Emotional Labour	Reflection and the "mirror"	Empowerment	CS as structuring chaos
Maintaining a sense of self			CS as a challenge

5.3a Psychological Impact

Walsh & Walsh (2001) found that mental health work poses risks to the mental health of the worker. Although stroke manifests in obvious physical ways, patients nevertheless require helping relationships alongside technical skills, emotional labour (Hoschschild, 2012). Even if their mental state is unaffected, feeling vulnerable may incite emotions in a range of quality and intensity, requiring skill to identify and process them and respond in a helpful manner. Patients' psychological reactions to stroke are not unusual: anxiety, depression, posttraumatic stress (Noble et al, 2008), higher

levels of suicidal ideation than the general population (Eriksson et al, 2015), apathy (Caeiro et al, 2013) or pre-existing psychological problems (Goldfinger, 2015).

Additionally, people with mental health problems also have strokes. For example, Goldfinger (2015) found a greater probability of stroke in people with a PTSD diagnosis. Some services had better mental health resources (have a counsellor or a psychiatric nurse in the team). The results of the Sentinel audit (SSNAP, 2014) showed inadequate provision of psychological help to stroke patients and their families. In the present study, one of the interview participants from acute stroke care described an incident involving a patient who accused staff of malpractice. A formal investigation started, increasing the, already high, pressure on staff. It found that the patient had been suffering from delusions and the complaint was part of his symptoms (this does not imply that people with delusions should not be believed but demonstrates the lack of psychological awareness staff had and its consequences).

Obholzer (1995) discusses psychological defences of institutions, while Merodoulaki (1994) and Roberts (1995) propose that occupational choices are related to significant early experiences. These relate to our emotional attachment capabilities which can create vulnerability to difficult dynamics absorbing emotional and physical energy. Therefore, in addition to job-related risk factors to mental health, staff engage –and are increasingly required to engage- in their work as whole persons by involving their capacity for empathy and compassion. This includes their personal histories and psychological development.

Therein lies a contradiction: staff are expected to invest their personal/psychological resources into work, but, as Dixon-Woods (2013) and Collins (2015) found, the managerial and leadership cultures of many NHS organizations treat them not as thinking persons, but as instruments of compliance with external demands be they for data provision, risk management, or guidelines. Although there is evidence of the negative impact of such unquestioned compliance in NHS organizations (Dixon-Woods et al, 2015; Greenhalgh et al, 2014; Levy, 2001; Rolfe, 2005), what emerges from this study is that some participants also see their professional organizations (for example, NMC and RCN) as taking a similar line. This compounds the experience of frustration and powerlessness.

Several interview participants discussed their psychological struggle with their work (one referring explicitly to having sought psychological therapy). This was due to emotional labour, as described above, but also factors listed in HSE's (2007) guidance about stress at work: excessive demands, experiencing little power or control over their workload and over decisions made about work, facing aggression from service

users (and blame from within and outside the organization), adapting to frequent, poorly organized and communicated changes in the organization, having insufficient support, and for some, the increasing number of responsibilities compromised role clarity. Participants viewed CS as helpful in managing this psychological burden. This restorative function of CS is not emphasized enough in statutory definitions of CS, but the Care Quality Commission (2013) describes CS as an aspect of employers' duty of care to staff. Therefore, arguments against CS as not evidence based or financially viable pertain to (abdication of) employer's duty of care.

Clinically supervised staff bring additional benefits to their work including systematic accountability, experiences of compassion, validation, relational energy, and wellbeing, which are transmitted to patient care. However, this study found that nursing in acute stroke units is delivered by rushed, threatened, stressed and distressed staff who have limited or no access to CS and are target-managed with little focus on qualitative aspects of their experience, including their sickness absence which risks disciplinary responses. Questions of outcomes vs processes have been raised but not addressed while metrics preside over process and meaning (Patterson et al, 2011). Requirements to treat all patients the same result from policies and procedures aligned more with bureaucratic than care responsibilities, stemming from misconceptions of evidence-supported practice (Greenhalgh et al, 2014; Rolfe, 2005). Bureaucratic efforts to eliminate risk prioritise 'evidence' over particularity in individual patient/ situation characteristics and needs (Levy, 2001). This defensive approach (Dixon-Woods et al, 2015) has deleterious effects on the meaning and satisfaction derived from clinical work as it results in robotized rushed practice.

Shared aims and goals create opportunities for localized bespoke learning and development (Dixon-Woods et al, 2015). Research indicates that staff experiences as employees influence patient reported satisfaction with service provided (Boorman, 2009; Dixon-Woods et al, 2013; Nolan et al, 2003; Watson & Frampton, 2009; West & Dawson, 2012). In this study, clinicians' relational experiences in CS affected the relational experience delivered in patient care (Olsson & Hallberg, 1998). Where CS occurred regularly, participants expressed appreciation and linked it to their professional development and to improved patient care in various practical and psychological ways: from managing conflicting policies associated with recurrent practical problems to using their personal reactions in developing better understanding of particular patients' needs. The full set of information available to a clinician includes research findings, policies and procedures, particulars of a specific situation, but also

their own emotional response. Engaging clinician's capacity to process and use these prudently facilitates consideration of ethical issues in personalizing care.

Collins (2015) highlights integrity and trust in organizational culture as important for staff engagement and retention. There is an ethical issue in depriving staff of CS due to absence of "research evidence" that it benefits patients. If CS provides the aforementioned functions to staff, would you choose to be nursed by someone who can be present for one more hour a month in a rushed and burnt out state, or someone benefitting from the containment of a mechanism like CS? Additionally, the 'patient benefit' argument ignores the ethical and legal obligations of employer to staff, as CS is encouraged in Codes of Conduct and valued by those partaking in it. It is difficult to design studies for causative or even correlational conclusions about such a complex phenomenon, and perhaps the issue can be seen as what difference one hour of CS per month makes to the quality of working life and qualitative output of staff in the rest of their working hours; and to staff retention.

Participants reported a low level or no training in managerial or clinical supervision. Quality of training is important to outcome: for supervisors to provide efficacious CS (Hyrkäs et al, 2006; Milne, 2009; White and Winstanley, 2011); for supervisees to understand how to make the most of CS; and for managers to understand the importance of incorporating CS time in work planning. CS is not a panacea. Its introduction is unlikely to solve every problem in a service. It can help 'contain' the impact of work events on staff so that there are more psychological resources to manage problems more creatively. As the NMC (2011) recommends, it is important to consider what type of CS is likely to benefit the purposes of particular services ("locally") and prepare the ground for its implementation rather than rush into seeding ambiguity and ambivalence in infertile ground.

5.3b Reflection and Personal Growth

Recent NMC published figures show that 90.48% of registered nurses passed the newly introduced revalidation process, which was interpreted as *patients and the public are receiving safe care at the hands of professionals who regularly reflect on their practice* (NMC, May 2016). Reflection is one of the cornerstones of CS and some participants in this study see it as synonymous with CS. This is consistent with CS literature where reflection, reflexivity and reflective practice hold great importance in supporting and transforming practice, practitioners and their wider contexts (Benbow & Jordan, 2007; Cutcliffe et al, 2001; Johns, 2004; Johns and Freshwater, 1999/2005; Watson, 2005). Reflection exists in all functions of CS, normative, formative and

restorative (Proctor 2001). This is more evident in psychological therapies regardless of clinicians' original discipline (Carroll, 2011; Grinberg, 1997; Milne, 2009; Scaife, 2009 & 2010; Shohet, 2011). Like CS, reflection is a concept within a range of understandings, from *benign introspection* to *radical constitutive reflexivity* (Shaw, 2010:235). It focuses on practice both retrospectively (learning from self-appraisal) and prospectively (planning). It also focuses on the journey of practitioners' developing identities personally and professionally. Without CS, this may become a journey from ideals to burnout (Shohet, 2011).

Reflective practice refers to the positioning of the clinician's self in providing therapy/ care (Freshwater, 2005:99). It is subjective, particular, and described as a fusion of perceptual, cognitive and meaning-making mechanisms (Johns, 2005:2). Nurses in psychological therapies seem better acquainted with reflecting on 'the use of self' than nurses working in physical health. As this study found, this does not mean that there is less use of self or that reflection is less useful in stroke nursing, but that in psychological therapies, it is explicitly acknowledged and intentionally engaged with. Reflection may focus on how well the practitioner applies knowledge and skills in a clinical situation (Begat et al, 1997), termed *informational learning* (Fuchs, 2011:9) or *single loop learning* and problem solving (Carroll, 2011:23). Participants who did not partake in formal CS suggested this reflection was available as confirmation, received through quick conversations with colleagues about "what I did/ not do" or "will/ not do" (normative function of CS: Proctor, 2001), resembling a quick look in the mirror. It resulted from acquaintance with policies and standardized care based on an understanding of equality as 'same for every patient with/ in this condition'. The latter is observable, measurable and therefore can be stated in terms of outcomes important in service metrics.

Although useful and important at least in appearing to provide equity of care, metrics prioritise concrete over abstract 'softer' aspects of being of service (Patterson et al, 2011). The same care may not suit all patients. Deeper reflection extends to considering 'who I become through what I do', involving additional dimensions: the person of the worker and in relation to 'the other' (patient, colleague). This involves psychological processes and surpasses manuals and procedures. It examines the significance of relational qualities, treating oneself as a unique person working with unique individuals (Carroll, 2011; Patterson et al, 2011), and the process of becoming through relating in order to practice not only competently but also conscientiously and ethically, entwining who one is and becomes through organizing their work experiences psychologically.

Johns (2005:10) suggests three questions for use in reflection:

"To what extent did I act for the best and in tune with my values? […]
What knowledge informed or might have informed me? […]
What factors influenced the way I was feeling, thinking or responding?"

This study found that in the absence of an alliance like CS, nurses reflected on such questions in their private time but arrived at persecutory (rather than enquiring) internal dialogues that demanded, rather than facilitated, improved practice. Such self-persecution indicates that fear of naming, blaming and shaming as a method of service improvement has been incorporated in self-appraisal and it is counterproductive. It is beyond the scope of this thesis to critique neoliberal politics and shaming as a mechanism of sociopolitical control (Peacock et al, 2014), but as Carroll concludes, *there is some learning I cannot do on my own* (2011:17).

Chia's (1996) *becoming realism* in contrast to *being realism*, the primacy of process over fact, seems important for the contrast presented through the predominant epistemologies in healthcare, which privilege quantitative types of evidence applied towards quantifiable results rather than examining qualitative processes. As Rolfe (2005) demonstrates, the predominance of positivism and 'evidence-based practice' has distorted reflection, presenting it as not supported by research, therefore of questionable value. Reflection is purposeful (Johns, 2005). Purpose is owned; so, the question arises: reflection for *whose* purpose and to *what* purpose?

Shohet (2011:11; see also Owen & Shohet, 2012) proposes that medical professionals have not embraced CS due to the loaded meaning it carries, *a remedial word, or the idea of being checked upon*. These reactions require understanding and respect; they counter literature that includes formal assessment/ judgment on performance through CS. They also contrast with the language of the Francis report which emphasizes policing and compliance as accountability mechanisms. Assuming a relationship between purpose and need, we can consider that reflection and CS meet potentially different needs dependent on supervisee characteristics (Hyrkäs et al, 2006). These considerations indicate that an approach involving ethical dialogue/ practical philosophy and CS may prove more productive than increasing rules and regulations which has already been found to compound rather than resolve problems (Dixon-Woods et al, 2013). Such reflective approaches require time off task and a sharper focus on quality rather than numbers.

Learning must be adapted to learner variables. Skillful CS is an individualized way of learning (Carroll, 2011). This approach involves challenges to the academic heritage (for example, consequences of conceptual "watering down"), to health services (demands made on time/ monetary costs), and on the psychological resources of

practitioners. However, there are obvious gains in a workforce capable of not only developing skills but also applying learning discreetly and ethically in specific clinical situations through reflection (phronesis, Benner, 2004). Conditions required for reflection and CS to be productive include: clear understanding and purpose, protected time and space, confidentiality, respect, and trust to eliminate the detrimental impact of fear and shame and to allow relational learning from experience (Carroll, 2011). Importantly, it is personal choice to engage in reflective practice and CS, as where nurses were obliged to participate in (group) CS for revalidation purposes, they exercised their choice by being present quietly. This latter finding also raises questions about the suitability and efficacy of group CS, a popular mode of CS in nursing.

Sensitivity in supervisory relationships reflected in nurses' capacity to conceptualize and form alliances with patients. In two stroke units where managers applied soft skills (empathy, appreciation) as mechanisms of clinical support, motivation was reported to be recharged and staff retention and recruitment less problematic. This relational background facilitated the use of CS as a support mechanism towards improved performance, including after long-term sickness absence, with desirable effects. Where targets were prioritized over relating, there was a climate of fear and insecurity that pervaded the experience of CS as disciplinary procedure to manage performance.

Arguably, service managers may read the eloquent literature on reflective practice, presenting philosophical ideas and qualitative/ case study evidence, as poetry rather than a statement of practical value. Using a language markedly different from the predominant discourse in NHS management, reflection risks being perceived by managers and practitioners as an abstract intellectual exercise (Johns, 2005), seeming barely relevant to the tasks on busy wards, and associated with the theory-practice-theory gap and incomprehensibility of CS. This highlights the challenge of how fundamental processes, like reflection, can be communicated in ways that converse with how meaning is conveyed in specific contexts- and whether indeed such attempts should be made.

Reflection is about feedback, ubiquitous in CS, serving various functions, among which:

Normative: Are decisions/ actions taken ethical, safe and correct?

Formative: Have competences been developed, and what further development areas emerge?

Restorative: How does the supervisee feel about their practice? How can we restore enthusiasm for the purpose of their work?

This study found nurses needed and appreciated routine feedback, especially positive, particularly patients' words of gratitude. However, use of feedback from managers ranged from frequent and generous praise to improve morale, inspire and motivate staff, to issuing criticisms and commands impersonally. Reflection was minimal and ultimately responsibility for CS was seen as the concern of hierarchy in command. Ethical consideration was confused with following rules rather than reflecting on their applicability. Known as 360-degree feedback, mutual exchange of feedback facilitates the development of supervisee, supervisor and the service. In some sites, however, staff felt their feedback was unwelcome. Service managers may benefit from greater reflection on these matters.

In definitional CS, routine appraisal is achieved through the supervisor's sensitive exploration of supervisees' accounts facilitating deep reflection producing supervisees' self-appraisal. This informs formal appraisal. Although scarce, this occurred in the stroke rehabilitation service here, where relationships between staff had been forged through a history of synergy and a beneficent circle of trust and openness whereby leaders were experienced as "good", approachable and supportive. Following policies may be a matter of compliance, but feedback and self-appraisal in CS help nurses grasp what is best for specific patients in specific situations (Olssen and Hallberg, 1998), moving away from 'conveyor belt' towards individually tailored, relationship-based care (Patterson et al, 2011). Where, with CS, staff felt secure in their roles, and the style and practices of management acknowledged them as persons, staff reported to have shared clinical goals that reinforced professional relationships and improved the quality of clinical outcomes and nurses' satisfaction with those outcomes. Such findings are rare in CS research due to the remoteness of clinical outcome from CS as intervention.

5.3c Relational Features of CS

Clinical supervision relies on an effective relationship with engagement between the supervisor and supervisee. (Hadfield, 2001:116)

All models of CS address the professional relationship. For example, Proctor (2001:25) names the model she and Francesca Inskipp devised "Supervision Alliance Model", emphasizing its distinction from hierarchical supervision and describing the values, attitudes and tasks that characterize it. Relational aspects of CS also feature in other models, such as the systems approach (Holloway, 1995) and the psychodynamic approach (Scaife, 2009). Consistent with Ashman and Macintosh (1999), this study found that relationship qualities feature as important in choosing a supervisor or a colleague to discuss clinical issues generally. Although specialist

knowledge is valued (preferring colleagues from their specialty), interpersonal qualities like respect ("time") and trustworthiness override specialist expertise. Unlike informational learning, which can happen in solitude, transformational learning occurs within relationships that provide facilitative conditions (Carroll, 2011). Thus although CS is distinct from psychotherapy, its transformational effects may be experienced as "therapeutic" (word used by a participant), providing relief from difficult emotions through deeper understanding, restoring enthusiasm and passion. Flexible CS can be customized to the supervisee's learning needs enhancing CS relationship and quality. Reflecting on their shared experience as a professional and service user, Pauly & James (2005) argue that moral knowledge and ethical practice develop through relationships without which, knowledge becomes powerless.

The relational climate within organizations and teams facilitates arrangements for formal or "informal" CS. Where long-standing working alliances existed, formal and informal systems of consultative support had evolved over time, including the culture of cooperation shaped by and fuelling clinical goals. Commitment to not disappoint colleagues highlights the importance of retaining staff (where things work well), preventing recruitment problems in short-staffed wards. There are advantages and disadvantages of separating managerial and clinical supervision (Scaife, 2009). Some managers developed quality alliances enabling them to manage sickness absence, improve staff performance and exorcise guilt and attribution anxieties. In contrast, where an austere managerial style operated, CS was experienced as threatening and team dynamics resembled mutiny.

Olsson & Hallberg (1998) report that CS enabled workers to gain a deeper understanding of their dementia clients, enhancing workers' capacity to form good relationships with them, their families and other agencies. The Senses Framework of relationships in care (Nolan et al, 2003) may be a useful conceptualisation in providing the working conditions that facilitate a sense of security, belonging, continuity, purpose, achievement, and significance in staff.

This study found that boundaries such as confidentiality, respect, trust, and protected CS time can facilitate CS implementation. Quality of communication in the nursing hierarchy can lead to frustration in attempts of senior nurses to provide CS sessions that are not attended. There was a spiral of misunderstanding involving overestimation of control that staff nurses experienced over their work, leading to assumptions that they do not take ownership of their development. Some senior nurses simultaneously acknowledged and denied barriers to attending CS faced by staff nurses on acute wards.

Establishing relational factors may be a challenge in conditions of target driven league tables, constant criticism, naming, blaming and shaming, which appear in the media about the NHS. Policies and procedures for risk-elimination may shield against prosecution but result in increased bureaucracy and diminished staff morale (Macintosh & Ashman, 1999). At times, the combination of external and internal factors was experienced as a disempowering cacophony that silenced the voices of staff (Dixon-Woods et al, 2013). The result is an ontological challenge of endowing paper and rules with greater power to determine reality, 'truth', and experience than the people involved in them. Commitment to clinical excellence goes beyond compliance with policies, tailored prudently to the specific patient (Benner, 2004) and CS to the specific supervisee.

Supportive management and team synergy facilitated remedial action, like informal peer support with examples such as offers to cover duties to afford distressed nurses time away from the immediate scene. Synergy and CS presented as facilitative of one another, of psychological wellbeing, and service improvement and development through validation and empowerment of nurses' voices. This has similarities with cultures of collective and distributed leadership, *where all staff are supported to play leadership roles* (Collins, 2015:7). As senior clinicians in this study suggested, in some services:

The combination of a rule-based hierarchy and traditional subordination may have had the effect of creating a number of key problems that acted as barriers to change. Importantly the management style that arises from such circumstances is often one that is based on control and discipline. Research has demonstrated that in such a climate change is more likely to be treated with suspicion when suggested from above, and unlikely to emerge from below. (Macintosh and Ashman, 1999:63)

More than a decade later, this study indicates that CS is still 'new' for many stroke nurses. Lower pay-band nurses in acute stroke units are considered indispensible from direct clinical work so there is no time for their CS. This is an ironic appraisal incorporating both that they are important and indispensible, but also poorly supported and vulnerable to the emotional and physical impact of the intensity of their work.

5.3d Stroke nurses' meanings and experiences of clinical supervision

Willig (2008:38) asserts that all research questions contain assumptions. The main assumption at the outset of this study was that, generally, stroke nurses had experienced definitional CS and this would have been mostly beneficial. However, one experience of CS in stroke nursing was its absence, CS as "the (un)known

phenomenon" (Cruz et al, 2012). The literature review and this study's findings suggest this is likely the case for older people's services more generally.

Questionnaire data indicated that 53% had no formal CS arrangements while for 25% of those who did, it was annual (which likely refers to performance appraisal). Interview data indicated that the meaning of CS was not that of definitions (or 'formal'). 'Formal' CS was available to "therapists", as some participants stated, while nurses tended to have quick "informal" checks with colleagues, which they called CS. A discrepancy emerged in availability of CS depending on workplace and nursing grade (CS is more accessible to higher grade nurses). Ward nurses in acute stroke units were least likely to access definitional or other formal CS, although textual comments in a questionnaire received from a rehabilitation service (that did not participate in interviews) stated that CS had never been available. This meant that the experiences and meanings of the absence of CS and of informal CS were also important. What is CS when it is and is not formally available?

5.3d(I) Meanings in the absence of CS

In this study, the absence of CS was attributed to lack of time to incorporate it in routine work, nurses' commitment to patients, external factors (discussed later), and personal choice not to partake in CS (perception). Nurses' experiences of CS were presented as contrasting therapists' CS. Consistent with Haggstrom and Bruhn's (2009) findings, this was due to inadequate planning to protect nurses' time for CS, largely justified on the profession's identity, its philosophy of altruism, and beliefs that nurses' pivotal role in patients' lives meant nurses could not leave patients for an hour of CS a month.

Although these justifications served to support the profession's identity as "good people", expressing value and pride, it also trapped nurses into poor professional development and minimized the image of therapists' altruism/ "goodness" (and perhaps allayed envy towards therapists). Altruism leaked into the personal domain, hindering or prohibiting nurses' self-care and consequently, capacity for sound thinking. Can self-neglecting staff provide good care? Is neglect of professional development also neglect of duty of care? Is this about obedience and exploitation? In this austere climate, such altruistic justifications undermine not only nurses' but also therapists' CS structures.

5.3d (II) Meanings of informal CS

Macintosh and Ashman (1999) discuss the history of ambiguity of CS in nursing generally, with the absence of detailed guidance continuing to trigger questions about

what CS is, while implementation initiatives conflict with underpinning philosophy. Focusing on stroke nurses' experiences and meanings of CS, this study identified ambivalence associated with this ambiguity: Alongside any reasons/ justifications about the uneven state of CS in stroke nursing, there were obvious but unacknowledged emotional factors linked to meanings of CS in specific work contexts.

At best, informal CS was a limited improvisation of (definitional) CS, a partial and temporary substitute for normative and restorative processes. Participants experienced informal CS as needs-led, ad hoc, minutes-long clinical conversations without follow-up or reflective discussion, confirming immediate and specific answers to a clinical matter, pursuing best care and peace of mind. Participants appreciated informal CS. Some experienced it as happening often or "all the time", and even without their awareness (or consent).

These conversations were important therefore they should not be endangered by implementation of formal CS. They allayed the doubts that fed fears, and resulted in temporary relief from uncertainty, from the torture of the possibility of adverse consequences to patients and staff. In contrast with its history and meaning in psychotherapies and mental health services (Macintosh and Ashman, 1999; Milne, 2009; Scaife, 2009) where CS developed as distinct, regular, practice focused, professional development meetings to *challenge me sufficiently and encourage me to explore my assumptions and practice […] and concentrate on the process of work* (Hadfield, 2001), there was a range of meanings in stroke nursing. There were no explicit boundaries or agreements in informal CS except as implied in Trust policies. With the exception of CS as annual appraisal, when performance targets were set and training needs identified (usually limited to service targets rather than career development), there were no aims regarding professional development. This indicates conceptual and practical conflation of managerial with clinical supervision (Ashman & Macintosh, 1999; Soini & Valimaki, 2002) in contrast to literature that presents CS as distinct and separate from managerial supervision (Proctor, 2001; Scaife, 2009). Reflection on managing these dual roles was rare. Given the limited career structures participants reported, this highlighted questions about developing nursing careers, usually part of the formative function of CS.

Participants stated that the majority of staff-grade nurses in acute units had no formal CS arrangements. This may be due to what Hadfield (2001:114) describes as *'fire-fighting' culture, […] where demands create reactivity rather than reflection and proactivity*. Newly qualified nurses engage in preceptorship with clinical supervisors who assess their performed competences in the first six months of employment.

Consistent with the literature review, CS arrangements after preceptorship were rare or non-existent. Some nurses in higher graded posts had formal consultations about their work, their development, and psychological support. A different picture was reported in rehabilitation where various types and frequency of CS operated. Even here, some nurses chose to have no engagement with formal CS despite its availability at work, considering themselves well supported through discussions in meetings. The importance of these meanings lay in the history of CS in nursing as a mechanism for failing, inexperienced or less competent nurses, imposed for surveillance rather than nurses' development and wellbeing (Ashman & Macintosh, 1999).

5.3d (III) The experience of definitional CS

Definitional CS was rare across sites. Those with experience of it had deep appreciation for its boundaries (time, confidentiality) and benefits (honesty, openness, trust, offloading and emotional relief), deplored its absence, and expressed a longing for it, detailing the restorative function even in anticipating the next CS appointment. Consequently, cancellation of CS was reported as upsetting, adding to the experience of the restorative value of CS in practice and anticipation. As Williamson and Harvey (2001) found, where CS had been implemented, it usually disappeared with the departure of CS champions. This was mentioned in interviews and during informal site-visits. There is no forum equivalent to definitional CS for basic grade nurses. It is surprising that this situation has survived more than two decades of enthusiasm for CS in nursing literature.

5.3d (IV) Influences -external to the participant- on meanings and experiences of CS

Questions of what CS is must also address the "what for?" of CS honestly, as this appears to be the central axis from which ambiguity spins off. Such ambiguity fed ambivalence, a mixture of wanting the support but fearing punishment or being perceived as less competent, unable to cope or performing poorly. Perhaps the preference for "informal" CS is based on the person being consulted not having power and authority over the nurse. Ambiguity and ambivalence formed a circle that some participants completed by avoiding CS. This highlights the importance of educating nurses about the value of CS not just for clinical practice, but also for their own wellbeing, and ensuring that CS is routine practice, available to all and independent from performance management. This has started to happen in related professions, for example, the recent initiative by NHS England to address the absence of the

restorative function of CS in midwifery (Ariss et al, 2017). Next, a discussion about the influence of hierarchy and official nursing culture on CS are discussed.

Hierarchy

Obholzer (1994:47) concludes on *the importance of sanction from below* in dialoguing with the workforce, but especially from one's inner sense of authority; and the need for power to initiate change within *a system of accountability* enabling the flow of authority and feedback. Like authority and power, leadership and management –often used interchangeably- are essential to the proper functioning of an organization. Authority refers to the power to make an ultimate decision, including decisions binding on others: participants believed their hierarchies had the power to decide and implement CS. The study's results and literature indicate a conflation and, simultaneously, a conceptual divide between leadership and management with psychological and practical consequences. Unlike leadership, management may be experienced in ways that attract and discharge intense negative emotions, adding to any challenges in communicating unwelcome decisions and actions from the hierarchy above. A trend of *managerialism* (Macintosh and Ashman, 1999:67), defined as preoccupation with *quasi-market* (ibid) principles, costs and quantitative performance, can create resentment between clinicians and managers. Each side experiences the other as not understanding the purpose of the other's work, resulting in mistrust (ibid).

Clinical leadership, managerial and clinical supervision have different functions (CQC, 2013) and require various levels of interpersonal and leadership skills. Views vary in the literature whether CS should be provided outside the immediate management structure of the supervisee to enhance openness and reduce self-censorship due to fear/ threat experienced about managerial performance appraisal (Proctor, 2001; Scaife, 2009), or whether managers are in the best position to know the particulars of a supervisee's situation, and help. There is a good discussion on advantages and disadvantages of separation vs integration of supervisions in Scaife (2009).

In this study, leaders and managers often lacked training in management, leadership, and CS. However, training is not a panacea and will not necessarily address issues like the long line of powerlessness found in some of the interviews and echoed in the King's Fund report on the stressful reality of being an NHS Chief Executive (Timmins, 2016). Managers are under pressure, forming bridges between the staff they manage and dictates from hierarchy and the Department of Health. Thus they are unlikely to prioritize consideration and reflection about dual roles, ethical issues pertaining to them and how to perform them- even though this may have beneficial results.

Managers' lack of understanding of the differences between group CS and service meetings was evident across participating services. Additionally, the extent to which formal or informal within-service arrangements for CS were available depended on the predominant style of leadership and management and generally their relating style that influenced how they exercised their power and authority. Leaders varied in the relational immediacy of their availability and accessibility as clinical experts, but also as advocates of patients' and staff's rights and wellbeing.

Although there was an obvious hierarchy in all three organizations, how power, authority and control were exercised, the experience of staff as employees, and team dynamics varied. Where there was synergy, it was attributed to managers' good leadership skills, particularly communication and ability to retain good staff. The latter engaged in forming professional alliances based on commitment to best practices that reflected and maintained collective pride about work, supporting the synergy, CS, and experienced as transcending physical space. These can be understood in relation to the Senses Framework proposed by Nolan et al (2003).

Leadership and management styles vary in their effect on the nurses' psychological management of work. 'Softer' management styles facilitate an emotional atmosphere where survivors' experiences of stroke can be acknowledged and 'held' by the individual nurse and the team. In power-based management, emotional impact seems linked to the tension and sense of threat in the relationships between nurses and their managers. The effects of management approaches reverberate through professional relationships including with patients. As leadership and management are sensitive and emotion-attracting responsibilities, it is important to understand emotion cascades in stroke nursing hierarchies, including the impact of conveying budget cuts, reorganization, targets, etc. on managers as persons and in dynamics that may reverberate down the hierarchy and into patient care (Obholzer, 1994). There is a need for education about what CS is, and for this education to be aimed at supervisees, supervisors and managers.

Is nursing culture a barrier to CS?

Describing their attempt to implement CS, Williamson and Harvey (2001:142) note:

I also realized that I would have to battle with hearts and minds and that something approaching a cultural revolution would be required for CS to become embedded in the organization.

There is a risk that a meaningful process will become yet another box to tick for nurses to prove their "road worthiness". In the spirit of compliance and obedience, CS can become compulsory and policing: senior staff may patrol less senior staff to ensure

that they continue to perform appropriately. Macintosh and Ashman (1999:63) discuss *the reality of the traditional and reactionary culture that pervaded nursing and was creating a very real barrier to change.*

A shared clearer understanding of what CS can be and entails seems necessary and urgent. Questioning or even challenging the extents of altruistic philosophy in nursing may be essential in order to relay that good patient care implies good self-care. The question is how possible this is in a climate of over-justification of the very existence of nurses, who appear to have capitulated to everything the employer/ government demands, also evident in the readiness to agree with the Francis report that nurses must demonstrate (more) compassion, minimally addressing the deprecation implied in the demand.

Macintosh and Ashman (1999) suggest that appreciation for nursing has never flourished. Issues within the culture of the profession seem to have led to the gradual erosion of the notion that the conduct of a few cannot speak for all. Some participants viewed their local nursing hierarchy –whom they perceived as setting their Trust's nursing culture- as not supporting the development of CS, and their professional organisations as complying too readily with demands on nurses at a time when the profession's public image and esteem were low while time and conditions for formal CS were poor. In a Portuguese study of chief nurses' opinions on CS in nursing, Cruz et al (2012:864) recommend that *chief nurses need to improve their knowledge on CSN* [clinical supervision in nursing].

In summary, the lack of a clear shared understanding of CS has been hindering its implementation in nursing generally. In stroke nursing, current understandings and experiences include notions of part=whole CS, which, at the personal level, stem from and are maintained by fear of shame and humiliation. Reinforced by systemic overvalued ideas of self-sacrifice (which also sacrifice professional development and career progression), ambiguity generates distance from meanings of CS as learning, development and support, leading to ambivalence, disengagement and even avoidance. Disengagement and avoidance maintain or reinforce ambiguity and ambivalence through a lack of opportunity to experience CS and challenge one's own meanings.

Systemically, successful implementation of CS will require safeguarding the profession's esteem from shame and damaging over-generalisations that maim CS meanings and experiences to policing and disciplinary procedures. Implementation is unlikely in organizational cultures that prioritise metrics over meaning (Patterson et al, 2011); where, as participants explained, management and clinical leaders are

reluctant to carry the burden of responsibility for what may seem “revolutionary” changes; where staff time is seen dryly as recurrent cost rather than investment. Such environments are infertile for the development of supported accountability and autonomy, the ideas in A Vision for the Future (Department of Health, 1993).

5.4 IMPLICATIONS

IPA does not produce generalizable findings, theories, or explanations, but detailed understandings that can contribute to these, as it has done in this investigation of CS in stroke care nursing. Understandings from this study are:

- Stroke nursing can be experienced as stressful and traumatic due to distressing clinical material, job demands exceeding fundamental resources such as time, management styles emphasizing power and authority, system failures, prioritization of service targets over people.
- CS appeared to be poorly understood and defined in stroke nursing except by nurses who had experienced definitional CS. This partly reflects issues of definition of CS and nomenclature, although robust definitions are available (eg. Milne, 2009). The substitute, 'informal CS', provided impromptu essential checks for practice safety, and consisted of a range of over-inclusive rationalizations of all clinical conversations as CS.
- Participants experienced little systematic provision of CS. What existed was available to the members of the upper hierarchy. Thus nursing practice is unlikely to be systematically reflected upon and accountable, and appears to leave nurses emotionally and physically depleted. It also leaves nurses vulnerable to accusations of unethical practice and their employers to neglect of duty of care.
- Arguments justifying the absence of CS were based on lack of time (understaffed wards) and lack of evidence for patient benefit. These are weak logistically and ethically (senior nurses in this study explained it is possible to plan for CS). They add to impressions of Trusts neglecting duty of care, especially in the light of evidence that better staffing of stroke units tends to lower patient mortality rates (Cole, 2014; Bray et al, 2014). Thus conditions are stressful due to short-staffing and the nature of the work, but also the means for preventing their impact are not provided (there is evidence that staff benefit from and appreciate CS).
- Consideration of what a desirable state of CS is in what type of stroke unit must precede decisions about whether and how to implement CS. Close attention to 360-degree feedback is likely to be useful in this.
- Meaningful implementation requires preparation and planning: training for supervisors, supervisees, and managers, towards high quality CS, sustained over time, that should be audited and evaluated regularly.

- Professional bodies, professional leadership, and management can be experienced as complying too readily with significant national policies and public inquiries, and disappointing in the poor protection and support to (stroke) nurses. Issues included perceptions of deteriorating status and public image of nursing, also experienced as related to profession's altruistic/ self-sacrifice philosophy.
- Retention of 'good' staff was experienced as contributing to a culture of cooperation, pride in work and the organization, and synergy towards best patient care. (CS is an appreciated support mechanism and an attraction of advertised posts)
- Time is brain: for stroke patients and for stroke care nurses

5.5 RECOMMENDATIONS

With a complex mechanism such as CS, the stakeholders are multiple and there are some competing interests. Nevertheless, it is possible to consider what is likely to be helpful to which or all type/s of stakeholder.

5.5a Nurses/ clinicians:

- CS is the individual's informed choice. Choice includes that of supervisor, format (individual or group), aims, content and frequency
- Awareness of the potential benefits of CS to clinical practice and supervisee has room for improvement
- Supervisees are likely to benefit from training to clarify what their responsibilities are as supervisees (and maximize the benefit of CS)
- Systems recording details of supervisors for prospective supervisees to access need to be transparent, well publicized and user-friendly
- Training in CS is important for prospective supervisors, but also team/ service managers and supervisees (all clinical staff)
- NHS organisations can encourage more participation in CS activities offered within and outwith the organisation

5.5b Research:

In partnership with health colleagues, researchers can contribute:

- existing specialist knowledge (or develop/ create it) towards assessing stroke services' requirements of CS
- exploration of contextual and process variables related to distal (clinical) outcomes: the benefits of CS in stroke contexts for staff (proximal outcomes) and patients (distal outcomes)
- knowledge and skills in identifying preferred CS models for staff nurses in stroke services
- evaluation of the quality of CS training
- This study has focused on acute and rehabilitation services. There is scope to explore the topic in community services
- Further meaningful involvement of NHS staff in all and any stages of research about them remains a matter requiring further thought, reflection and action.

5.5c Management:

- Improve understanding of dual roles (manager and clinical supervisor) and their ethical management

- Improve understanding of what CS is, what it can do for specific services, staff, patients
- Contribution to CS needs assessment of service
- Contribution to implementation

5.5d Professional Bodies:

- Creation of a working party on CS in stroke care with a research and implementation remit
- Review of professional codes
- Consideration of maximising the effect of CS for the public image and esteem of nursing
- Consideration of issues of maximizing invested power for the benefit of members and patients

5.6 Some personal reflections on aspects of this study

The writing in this thesis represents my voice, my power and interpretation in portraying my and others' experiences and meanings. Along with my wish and effort to remain open to other conceptualisations and transcend the boundaries of my understanding about CS, this thesis is an expression of my understanding; I have reviewed, maintained and expanded my ideas about CS through this learning journey. I have come to see myself as privileged for having had regular, good quality "formal" CS throughout my career. I value it and wish to maintain it. At the same time, I can see and have experienced the value of an answer that was needed urgently in my clinical work and was provided on the spot, which for several participants has the meaning "informal supervision", which I consider a looser and partial idea of CS. Some participants also held my view of CS even though few had experienced the same quality or consistency themselves. I have previously referred to my appropriation of Willig's metaphor of research as recipe and I extend this to meanings of CS. ("Formal") CS is a regular nourishing meal. "Informal" CS is a flapjack, a (healthy) snack that fills a gap temporarily.

Literature review

PhD research usually starts with a review of relevant literature. However, the question of timing arises in phenomenological research as the researcher is required to manage their own preconceptions- likely to be formed or multiplied by the literature. Although I had plenty of knowledge and experience of CS, stroke was a field of which I had limited knowledge. I have wondered for future IPA studies if it would be better to start

with as little as possible, and find out more after data collection. However, unless two researchers carry out the literature review and the rest of the research independently of one another, how would the research questions develop without adequate idea of what already exists to manage interference from one's own presuppositions?

I answered this by expanding my understanding of 'interference' to my pre-understandings beyond the topic; how I approach knowledge, how I experience the world and myself; and that this is part of the knowledge produced, so, it cannot be excluded but acknowledged and managed. This meant that even if I had no prior knowledge of the topic, I still had pre-established ways of interpretation relating to my existence, the world, knowledge, and so on. As a psychological therapist, I have a grasp of how I operate; this study stretched that intimate knowledge, revealing more. Sometimes I thought I could feel my cranium expand!

As much learning takes place 'between people' as within people' (Carroll, 2011:17). I am referring to my research supervisors, who produced extremely intelligent questions for me through their lack of knowledge about both CS and IPA. Initially I found these unanswerable, partly because I did not have the knowledge and partly because I interpreted them (wrongly) as silencing. As I got to know their own relating, I felt safe, went to the edge and opened my wings (as in the poem by Christopher Logue). The viva assessed my ability to "fly".

Meaning and meaninglessness in authorization reviews

This study underwent several authorization reviews prior to data collection. The time these devoured (1.5 year) became a disincentive after the PhD upgrade viva (July 2011) until the final NHS R&D permission was granted (March 2013). 'One size fits all' forms demanded answers to irrelevant questions on electronic forms of R&D departments. I reflected on the purpose of life and whether this authorization process should constitute part of my life's purpose. An impromptu conversation with my main supervisor sustained me through this, as I kept recalling my promise to complete the PhD. Later, when recruitment stalled for two months, just 4 months prior to the studentship running out, with only two participants interviewed, the time spent on NHS authorizations seemed totally wasted. Fortunately, things changed considerably after the final authorization.

Time to think, absorb and produce

IPA is a deep, time-consuming method of data analysis requiring empathy not only at interview but also during analysis. The PhD process demands completion of a number of tasks/ stages prior to analysis. In this study, they proved time-devouring, adding much pressure on my remaining enrolled time. This had parallels with my topic. My

participants talked about not having enough time to complete their work tasks and de-role. I felt I just did not have enough time, for anything, and needed time for deep thinking. Gemignani's (2011) ideas about countertransference between researcher and the researched were an interesting way to view this. The loss of four close friends (from old age) during this study added to the time-experience while waiting for authorisations and hearing and re-reading emotive interview material.

Existing professional skills proved invaluable in my personal restoration. I also found it easy to conduct the interviews, due to the difference in responsibility from my clinical roles. My curiosity and clinical skills transferred to the interview context and made field visits interesting and enjoyable. Having the privilege to consider someone's account in the detail required by IPA was an experience that I compared to clinical practice and reflected on parallels between the two lines that run next to each other to meet in infinity.

It was impossible to speed up the analysis. I am a slow, careful reader anyway, and enjoy thinking, so in a way I was the perfect person to handle IPA, but it was a very time consuming method for someone like me. With 15 interviews in my hands, I took all the available enrollment time. Like Boethius, reading around IPA's philosophical underpinnings was a consolation at a time when my country of origin was in such a distressed (and distressing) state. I am considering using the reading to write an addendum to the philosophical basis of IPA to incorporate the classical philosophy that informed phenomenology and hermeneutics.

This learning process has positioned me in a paradox. I feel I know more and perhaps am a little more 'intelligent' than when I started, and in a better position to support my views, not least because I had the opportunity to become better acquainted with published literature and to reinforce my ability how to make a strong case beyond "in my clinical experience", including a closer acquaintance with sacred cows in research and clinical practice guidelines (see Greenhalgh et al, 2016; Lenzer, 2013; Mendelson et al, 2011). However, I also feel more 'stupid'. Perhaps -as with Flyvbjerg's/ Dreyfus's experts- in trying to make all my research moves explicit, I have become aware of my unconscious competence but also more conscious of my incompetence (compared to the enormity of knowledge and wisdom). At the end of this PhD, I have revised but also reinforced my personal epistemological position, owing to the flexibility and creativity encouraged in using IPA.

I see obsession with procedure in modern science tripping creativity and innovation, just as external demands on healthcare work can affect individualized clinical flair and expert competence. Research must be proven 'right', someone must be able to

replicate/ confirm what has been found, or audit the steps to it. The researcher can become imprisoned in language and categories, as I felt when I was reading about conducting mixed methods research. I do not challenge the functionality of procedure; just add my view that there is always ‘space’ for interpretation however precise we attempt to make our meanings. It is in that space that the evolution in knowledge occurs. I view science as ‘temporarily established opinion’ on humanity’s timeline into wisdom (or doom, depending on one’s political/ critical awareness).

Finally, my paradox may be because the more we learn the more aware we become of all the things we do not even know that we do not know- and that a PhD gives a flavor of. As Socrates said with the humility of wisdom, I know one thing that I know nothing.

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APPENDICES

Appendix 1: Sheffield University Ethics Permission

The University Of Sheffield.

The School Of Nursing And Midwifery.

Ms.G Merodoulaki
School of Nursing and Midwifery

Dean of School
Professor Anne M Peat

School of Nursing and Midwifery
Barber House
387 Glossop Road
Sheffield S10 2HQ

Telephone: +44 (0) 114 2222042
Email: j.flint@sheffield.ac.uk

17 September 2012

Dear Manya

Re: ERP 123 – Clinical supervision in stroke care

I am pleased to inform you that on 17th September 2012 the School's Ethics Reviewers **approved** the ab named project on ethics grounds, on the basis that you will adhere to and use the following documents submitted for ethics review:

- Research ethics application form v2, 13/09/12
- 'Resubmission to ethics' v3, 08/2012
- Demographic information sheet
- Invitation letter 09/2012
- Participant information sheet for questionnaire 07/2012
- Participant information sheet for interview 09/2012
- Consent form v2
- Questionnaire v4
- Interview schedule

If during the course of the project you need to deviate from the above-approved documents please inf The written approval of the School's Ethics Review Panel will be required for significant deviations from significant changes to the above-approved documents. If you decide to terminate the project prematur inform me.

Yours sincerely

Jane Flint

Jane Flint
Ethics Administrator

cc Dr S Hinchliff, ERP Chair
Dr T Ryan, supervisor
Dr S Ariss, supervisor

Appendix 2: Focused Literature Review

Authors, Year, Aim	Meth	Sample	Setting	Design	Outcome	Change mechanism	Appraisal
Begat, Severinsson, Berggren 1997 Aim: not stated	Quant	Trained nurses	Sweden, Hospital wards, Some stroke patients on ward	Questionnaire administered at start and 9 months after CS implementation	Greater self-awareness and self-value; Improved communicn and info; Nurses felt "confirmed"	"Emotional responses" from CS & Professional validation	No stated aim Unknown validity of measure Unwarranted inference in data interpretatn re: staff satisfaction with work & patient satisfaction
Berg, Hanssson, Hallberg 1994 Aim: to study creativity & innovative climate, tedium & burnout among nurses with intro of individualsd care and CS	Quant	Nurses & aides	Sweden Nursing home wards Dementia	Experimental interventions Training, CS, Patient centred care	Tedium, burnout and conflict decreased in Experimental Ward. No change in Control Ward	CS; Individualisd care	Varied level of staff competence at start Unknown validation of translated questionnaires No definition or measure for tedium Why use 2 burnout measures? Unaccounted impact of high unemployment or of major organizational change.
Berg & Welander Hansson 2000 Aim: "reveal 13 nurses' experiences of systematic clinical group supervision and supervised individually planned nursing care"	Mix	Female and male registered or enrolled nurses, and aides	Sweden Dementia ward	Interventions: Group CS; individualised client care; Interviews Latent content analysis Questionnaire: Wilcoxon	"Confirming the nurse as a person and a professional" "Confirming the patient as a unique human being" (from task-oriented to person-oriented)	Professional competence Enhanced knowledge of dementia & understanding of patients; Closer rel'ps between colleagues; Cathartic effect of talking about work	Social desirability (pleasing the researcher)
Berggren & Severinsson 2000 Aim: How CS influences nurses' moral decision making	Qual	N=15 Reg nurses in group CS	Sweden; hospital wards; Dementia, inc stroke patients	Interviews "Hermeneutic Transformative Process"	4 themes 1. Increased self-assurance/ autonomous decisions for care quality. 2. Improved support to patients (inc.	Reflection/ time to think. Job clarification and affirmation. Containment of staff emotions	

					involvement) 3. Increased ability to be in relationship w' patients [better empathy]. 4. Better capacity for responsibility for pts who can't self- care.		
Dinshaw, 2006	Mix	Staff of in-patient gerontology wards	England, hospital wards for elderly in-patients	Various methods, inc questionnaire, audit, review of patient records, interviews	CS was " not fully implemented" Ward managers had monthly CS	Lack of time, resources, & Trust policy guidelines Importance of manager's support	CS was one aspect of a wider survey of in-patient services for elderly. Links to training
Edberg & Halberg 2001 Aim: investigate occurrence of patient actions viewed by nurses as demanding	Mix	Small N, unspecified staff and patient variables	Sweden, nursing home wards for severe dementia where individuald care and CS were introduced	Experimental 'Demanding beh asst scale' 2 sub-scales of MIDDAS Interviews T=0, T=6m and T=12m	Exp ward: Fewer challenging behaviours & less seclusion. Better job satisfaction & view of patients, tedium, creativity & burnout. Control ward: increased incidence of challenging behaviours		Threats to internal validity. Reliability & validity of measures? Which 'intervention' reduced perceived demanding actions?Exp ward had 1 more nurse than control ward. Control ward had 3 untrained staff (1 in exp ward)
Edberg, Hallberg & Gustafson 1996 Aim: to evaluate effect of systematic CS and supervised implementation of individualisd care on nurse-patient cooperation	Quant	Male and predominantly female staff Registered nurses, licensed mental nurses, licensed practical nurses, aides, and staff with no vocational training	Sweden Dementia wards	Experimental: 2-day training to staff in both conditions (Exp&Control) to equalize knowledge about the work. Experimental ward staff had systematic regular CS (guided narrative and reflection). Systematic observations of staff-patient interactions in mornings	Before: Similar cooperation After: more mutual cooperation in exp ward, while in control ward staff-patient cooperation deteriorated Greater understanding of pt led to "primary nursing" and organisational change, more focus on person compared to task previously	CS supports implementation of new way of caring. CS enhances staff understanding [empathy] of patients, communicated in staff-patient encounter. Empathy is related to affective regulation in staff (less anger and frustration) Patients appear to feel less fear and to reciprocate	Observer / researcher not blind to intervention: bias? Observer effects? Lost info in observation processes. Some mechanisms to limit bias Qualitative data used in quantitative analysis
Edvardsson et al	Quant	Nurse, aides,	Sweden, residential	Extracted data from earlier	(Self-reports) job	Staff state of mind/	Extracting data from

2008 Explored co-variation of residents' "behavioural symptoms" [BS] in relation to: staff job strain; care climate; and staff knowledge		licensed practical nurses, reg nurses	care for people with dementia	study to examine this study's hypotheses	strain positively correlated with behavioural symptoms [BS]; "positive" caring climate inversely correlated with BS. Staff level of knowledge not related to level of BS.	emotional regulation? Or reverse, where levels of BS were high, job strain and caring climate were negatively affected?	previous study= less respondent fatigue; but validity? Accuracy of self-reports
Flackman, Fagerberg, Haggstrom, Kihlgren 2007 Aim: to describe nursing home caregivers' work experiences while receiving education & CS over 2 yrs	Qual	Licensed nurses, aides and "care givers"	Sweden Nursing home for elderly Organisatn l change CS as pedagogic al process	Interviews (3x) T=0; T=12m; T=24m "Qualitative Content Analysis"	Themes Value of caring milieu (relationshi p experience s) Value of knowledge from rel'ps with residents Personalise d care. Trust, help	'Despite shattered expectations , willingness to care for elders remains with education and CS'	Carers' excessive use of self? (breaks spent with residents) Unaddresse d issue of unemploymt or worse work-conditions elsewhere as factor for commitment
Gallinagh, Campbell, Getty & McKenna 2000 Aim: CS course to explore and examine the concept of CS and the main issues associated with it	'Audit'	16 Nurses (post-qualif)	N. Ireland Rehabilitati on ward for older people	1-day CS course, then 'audit' of staff's knowledge & understanding of CS. Audit repeated after 3 months	At baseline, most staff unable to say what CS was or its purpose. At repeat audit, better knowledge but not complete retention	Student-centred training improved understandi ng of CS and maintained knowledge over 3 month period	Though phase 1 was an audit, the rest of the study has a more experiment al approach not acknowledg ed by authors
Haggstrom & Bruhn 2009 Aim: to find out caregivers' attitudes to education, support & supervision; and why they would not participate in them	Qual	Convenien ce sample Enrolled nurses; aides. All female	Sweden, residential care for elderly	Education and supervision during work hours. 14 of 51 staff volunteered for interviews Manifest content analysis	Staff valued education and CS if their choice and in work time. Demotivato rs: Lack of time, Low staffing, Work on computer, Financial concerns, Training "not followed through", Feeling too old for it	Training and CS must be: encouraged by managers; in work time; & worker's choice	
Haggstrom, Mamhidir, Kihlgren 2010	Qual	Enrolled nurses; aides. All female	Sweden, Nursing homes	Intervention: Group CS 5 Focus groups Latent content	Theme: Strong commitmen t to	Subthemes Increased theoretical & practical	

Aim: to describe care- givers "good" and "bad" experiences working with elderly				analysis	relationship; importance of CS for personal developme nt, identity, self-esteem	knowledge; Fear of wrong-doing; Guilt because time constraints resulted in decline of patients' autonomy & independen ce	
Hallberg & Norberg 1993 Aim: to explore nurses' views and emotional reactions towards dementia patients, and any changes to these during a year of interventions , including CS	Quant (also interview s, but no findings reported from these)	'Nurses'	Sweden Severe dementia wards	Experimental interventions: training course, CS, inividualised care (as in Edberg, Hallberg, Gustafson)	Improved nurse-patient relationship s, more understandi ng (tolerance) of patient behaviour Change in attribution re: patient behaviour Reduced experience of burden in nurses	CS Individualize d care program	"Various sources of error"; difficult to attribute findings to intervention rather than "researcher s as persons" Participants' departure from post, thus small N
Hansebo & Kihlgren 2004 Aim: to illuminate changes in carers' approach after [CS] intervention	Mix	Registered nurses; enrolled nurses; aides	Sweden Nursing home wards for elderly with cognitive and physical disabilities	Data collected before, during & after CS introduced. Nursing documents; patient life stories; videos; stimulated recalls; questionnaire (RAI/MDS)	Complete assessmen t to care plan Fuller but incomplete care-records Improved knowledge of patient aimed at comfort. Improved competenc e, patience, respect, cooperation Improved staff self-esteem & confidence. Some staff resistant to change	Importance of feedback from video records Reflection on work in CS increases staff self-awareness Can improve practice	Includes mechanism s to reduce researcher bias
Hyrkas, Appelqvist-Schmidlchn er, Haataja 2006 Aim: How supervisees' background and surrounding infrastructur e predict efficacy of CS, Job satisfaction, burnout and care quality	Quant	Nurses, aides, physio, midwives	Finland 2000-1; Hospital; Previous experience of CS	Questionnaire packs delivered by supervisor. Cronbach's a Student's t-test ANOVA Fwd step-wise linear regression analysis	Highest CS scores given by female respondent s		Mixed 1:1 and group CS. Translated measures. Potential Supervisor bias in package delivery

James , Allen & Collerton 2004 Aim: to explore CS process in CBT	Qual	N=1 trainee clinical psychologist	England Stroke service	Video rec:4 CS sessions T=1 and T=2 Thematised commentary (supervisee and supervisor) Independent rater for CS	Supervisor behaviour alleviated performance anxiety in short-term	Address emotions Use ZPD & 'scaffolding' as per supervisee needs. Supervisor supports and controls	Non-verbal data missing. Limitations of CBT model of CS & task-focused CS (even when competently performed)
Olsson, Bjorkhem & Hallberg 1998 Aim: to illuminate the content and reasoning about caring for demented people and the reflections of home care staff about it during CS	Qual	Mostly female (1 male) Home-help staff, Home care managers, Licensed mental practical nurses, District nurses, and Staff with no vocational training	Sweden Home care	Tape- recorded CS sessions & interviews with supervisors Content analysis: Phenomenological Hermeneutic Method	Supervisees created meaning of clients' unusual thinking and behaving (attributions to disease, personal history), staff own context (organisation, colleagues) and feelings about clients and work	Narration, reflection and supervisors' intervention sharing own ideas made carers' philosophy of care more explicit. This understanding was taken to relationships with clients and others. Effect: better cooperation	Information on supervisors' professional background
Soini & Valimaki 2002 Aim: to discover nursing problems of homecare staff and nursing interventions they considered helpful	Quant	Registered nurses, nursing assistants, home help staff	Finland Home care of older people	Questionnaire Descriptive statistics and ANOVA	CS and managerial supervision and other consultations with colleagues were most useful		Well researched, conducted and reported.

Appendix 3: RESEARCH PACK

QUESTIONNAIRE

NHS
National Institute for Health Research

CLINICAL SUPERVISION IN STROKE CARE

What is this research about?

This research is about clinical supervision in stroke care. There is hardly any research in this area, so I invite you to share your experiences and views about it to improve our knowledge and understanding. The study consists of two phases, a questionnaire and interviews. You are invited to take part in either or both phases.

Who should complete the questionnaire?

This questionnaire has been sent to you because the study is about the views and experiences of qualified nurses who work in stroke care. Before completing it, please read the Information Sheet.

Completing the questionnaire

Completion takes 15-20 minutes. For some questions there is choice of answers to be ticked, while others require you to write. Space is left between all questions for additional comments.

Returning the questionnaire

Please return the completed questionnaire in the next two weeks in the enclosed reply envelope.

Thank you,

Manya Merodoulaki

CLAHRC-SY, Innovation Centre (Room 107)

Portobello, Sheffield S1 4DP
Email: G.Merodoulaki@sheffield.ac.uk Telephone: 07900654229

The University Of Sheffield.

NIHR CLAHRC for South Yorkshire

ABOUT YOU

1.What is your professional title?

- ☐ Staff Nurse
- ☐ Senior Nurse
- ☐ Ward Manager
- ☐ Nurse Consultant
- ☐ Other (please specify)…….

2. What is your agenda for change pay band?

- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8a-d

3. How many years of experience have you had:

a) since you qualified as a nurse……

b) in stroke services…….

4. What was your year of birth?

(Please write in) | 1 | 9 | 5 | 8 | e.g.

1	9		

5. Do you have a formal arrangement for clinical supervision of your work?

❒ Yes ❒ No

6. Do you *offer* clinical supervision in an NHS context?

❒ Yes ❒ No

If yes, have you had any training in clinical supervision? ❒ Yes

❒ No

If you have answered 'no' to question 5 above, the rest of the questionnaire may appear not relevant. However, please feel free to read the rest of the questionnaire and to comment on or answer any other questions you consider relevant to your own work circumstances.

ARRANGEMENTS

In the following questions, please tick the box that best describes your clinical supervision arrangements

7. I have clinical supervision approximately (please tick one only):

- ☐ Once a week or more often
- ☐ Once a fortnight or three weeks
- ☐ Once a month
- ☐ At quarterly intervals (every three months)
- ☐ Once every three to six months
- ☐ Once a year

8. Usually, my clinical supervision sessions last approximately (please tick one only):

- ☐ Less than an hour
- ☐ About an hour
- ☐ About an hour and a half
- ☐ Two to three hours

9. I have clinical supervision

- ☐ With one person (the supervisor)
- ☐ In a small group (3-4 supervisees) with a supervisor
- ☐ In a large group (4 or more supervisees) with a supervisor
- ☐ As peer group supervision (no designated supervisor)

10. Mainly, the time for clinical supervision is from (please tick one only):

- ☐ Work time, including time-in-lieu arrangements
- ☐ My own personal time

11. Do you have a nominated clinical supervisor? (please tick one only)

☐ No

☐ Yes, a qualified professional from nursing

☐ Yes, qualified in another health profession

(Please specify which profession:) ……

12. Is your clinical supervisor (please tick one only)

☐ Also your manager

☐ A member of staff within your team

☐ Someone external to your immediate work context

13. How was your clinical supervisor chosen? (please tick one only)

☐ A clinical supervisor was assigned to you

☐ You had a choice from a number of clinical supervisors

☐ Neither of the above. Your clinical supervisor is someone you suggested

RELATIONSHIP AND CONTENT OF SUPERVISION

Please tick 'Yes' or 'No' options here, and *use the blank spaces for any comments*, for example, how clinical supervision does or does not provide what is important to you in your work:

14. Does your clinical supervision help you manage your work?

❒ Yes ❒ No

If yes, please say how:

Anything else, apart from clinical supervision, that helps you manage your work (eg. appraisal)?

15. Does your working relationship with your clinical supervisor support and develop your work?

❒ Yes ❒ No

If yes, please say how:

What else supports and develops your work?

16. Does your working relationship with your clinical supervisor help you learn skills related to your role?

❒ Yes ❒ No

If yes, please say how this happens:

Any other ways whereby you learn skills related to your role?

17. Does your clinical supervision help you set goals in clinical work?

❒ Yes ❒ No

If yes, please say how:

Anything else that helps you set goals in clinical work?

18. Does clinical supervision help you keep your work within ethical and legal boundaries (this refers to guidance from your employer, your professional association/s, Department of Health, etc.)?

❒ Yes ❒ No

If yes, please say how:

Anything else that helps you work within ethical and legal boundaries?

19. Does clinical supervision help you identify gaps in your knowledge and skills?

❒ Yes ❒ No

If yes, please say how:

Any other ways in which you identify gaps in your knowledge and skills?

20. Does clinical supervision help you to think about the good and not-so-good effects of work on yourself?

❒ Yes ❒ No

If yes, please say how this happens:

Any other ways you have available for considering the effects of work on yourself?

EVALUATING CLINICAL SUPERVISION

21. Are there things about clinical supervision that you would like to be different?

❒ Yes ❒ No

If yes, please say what these 'things' are and what you would like instead:

22. Have you ever felt or thought that something about or during clinical supervision was damaging to yourself or to your clinical work/ to patients?

❒ Yes ❒ No

If yes, please give more information:

23. Does your clinical supervisor ask ***you*** for feedback on whether and how supervision is working for you? (this may include conversation, a questionnaire or some other way)

❒ Yes ❒ No

If yes, please give details:

24. Do you feel comfortable enough to discuss with your supervisor whether you feel supervision works for you?

❒ Yes ❒ No (please say why not:)

25. Have you ever raised such issues with your supervisor?

❒ Yes ❒ No (please say why not:)

OTHER COMMENTS

If there is anything else you would like to say about clinical supervision, please write it here.

Thank you. There are no more questions. Please check that you answered all the questions that apply to you.

Please post this questionnaire to me in the **envelope** provided.

INTERVIEW PHASE

Please also consider taking part in the interview phase of this study. If you would like to participate in the interview, or have any questions, please contact me.

With sincere thanks,
Manya Merodoulaki
CLAHRC-SY
Innovation Centre (Room 107)
Portobello, Sheffield S1 4DP
Email: G.Merodoulaki@sheffield.ac.uk

CLINICAL SUPERVISION IN STROKE CARE

PARTICIPANT INFORMATION SHEET FOR QUESTIONNAIRE

Thank you for your interest in this study. This sheet contains information about the research questionnaire. Please read it before deciding whether to take part. After reading it, if you have any questions, please contact me for clarification. You will find my contact details at the end.

"What is clinical supervision?"

The Department of Health (1993) defined clinical supervision as *a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex clinical situations.*

"What is the purpose of this study?"

I recently reviewed the literature on clinical supervision specifically in stroke care and found no references. So, this study aims to increase our knowledge in these areas by employing questionnaires and interviews. The study's purpose is to increase understanding of clinical supervision currently in place, and nurses' meanings and views about clinical supervision. It is part of my PhD, funded by the National Institute for Health Research CLAHRC for South Yorkshire.

"Why have I been chosen?"

This study aims to find out about clinical supervision of qualified nurses working in stroke care. The questionnaire will be distributed to qualified nurses working in various stroke services to help us get a picture of clinical supervision in stroke care services in South Yorkshire.

"Do I have to take part?"

It is up to you to decide whether to take part. If you fill in and return the questionnaire to me, this will be interpreted as your consent to participate in the questionnaire part of the study. You can withdraw by not sending the questionnaire. As the questionnaires are anonymous, it will not be possible to withdraw or change your data after I have received your questionnaire.

"What are the advantages of taking part?"

There is no financial or other material incentive for participating. However, you

will be contributing to the development of professional support structures and new knowledge about clinical supervision in stroke care. If you wish, I will send you a summary of findings upon completion of the study.

What are the possible disadvantages of taking part?"

There are no foreseeable disadvantages from completing this questionnaire.

"Who will see my replies?"

No identifying data you provide will be made public. In the final report, multiple choice replies will be presented in aggregate form. The data will be accessed by the study's research team and may also be used in future studies.

Although every effort will be made to maintain confidentiality, for the protection of vulnerable persons or the public, certain types of information you may provide cannot be kept confidential and may need to be disclosed to the authorities, including within your service. Confidentiality will only be broken in extreme circumstances, eg in the unlikely event that patient safety is at risk.

"What do I have to do?"

To participate in the questionnaire part of this study, you fill in the questionnaire, put it in the reply envelope and post it to me in the enclosed envelope. The questionnaire takes 15-20 minutes to complete. If you prefer to fill it in during work time, then you should obtain your manager's agreement for this. It should be recognised that your time will contribute towards your Trust's matched funding agreement for collaboration with the National Institute for Health Research CLAHRC for South Yorkshire.

Thank you again for your willingness to consider participating.

Best wishes,

G. Manya Merodoulaki
PhD Candidate
CLAHRC, Room 1.07
Innovation Centre
Portobello
Sheffield S1 4DP
Telephone: 07900654229
Email: G.Merodoulaki@sheffield.ac.uk

CLINICAL SUPERVISION IN STROKE CARE

PARTICIPANT INFORMATION SHEET FOR INTERVIEW

Thank you for your interest in this study. This sheet contains information about the research interviews. Please read it before deciding whether to take part. After reading it, if you have any questions, please contact me for clarification. You will find my contact details at the end.

"What is clinical supervision?"

The Department of Health (1993) defined clinical supervision as *a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety of care in complex clinical situations.*

"What is the purpose of this study?"

I recently reviewed the literature on clinical supervision specifically in stroke care services and found no references. So, this study aims to increase our knowledge and understanding in these areas. Interviews help to achieve a deep understanding of the issues.

The study is part of my PhD, funded by NIHR CLAHRC for South Yorkshire.

"Why is my participation important?"

The interviews for this study are to help understand qualified nurses' views and experiences of clinical supervision in stroke care.

"Do I have to take part?"

It is up to you to decide whether to take part. If you decide to take part, you will be asked to sign a consent form. You can withdraw at any time without it affecting any benefits that you are entitled to in any way. You do not have to give a reason if you withdraw.

"What are the advantages of taking part?"

There is no financial or other material incentive for participating. However, you will be contributing to new knowledge about clinical supervision in stroke care and the development of professional support structures for staff. If you wish, I will send you a summary of findings upon completion of the study. Depending on individual circumstances, your participation could count towards your Continuing

Professional Development.

"What are the possible disadvantages of taking part?"

There are no foreseeable disadvantages from taking part in this study. No identifying data you provide will be made public. However, there is a small chance that others might still guess your identity, for example from interview quotations used to illustrate the findings of the research.

"Who will see my interview details?"

Interviews will be sound-recorded, then transcribed for analysis. Identity data will be kept separately from recordings and transcripts and in locked cabinets, or password protected computers, audio storage and electronic storage devices. The recordings will be used only for analysis and will be destroyed at the end of the study. No one outside the project will be allowed access to original recordings. Transcripts will not contain identifying data. Anonymised quotations from transcripts may be used for illustration in lectures, publications, and conference presentations resulting from this study and in future research.

Although every effort will be made to maintain confidentiality, for the protection of vulnerable persons or the public, certain types of information cannot be kept confidential and may need to be disclosed to the authorities, including within your service. Confidentiality will only be broken in extreme circumstances, for example, in the unlikely event that patient safety is at risk.

"What do I have to do?

There are no special requirements in order to participate. Interviews will take place at a mutually convenient place and time and are envisaged to last up to an hour. You are free to stop at any time, whether for a break or to end the interview. If your preference is to participate during work time, then you should obtain your manager's agreement for this. It should be recognised that your time will contribute towards your Trust's matched funding agreement for collaboration with the National Institute for Health Research CLAHRC.

Thank you for your time to read this information. If you would like to ask any other questions or to be interviewed, my contact details are:

Mobile: 07900654229 Email: G.Merodoulaki@sheffield.ac.uk

Alternatively, please complete the next page and return it to me:

To:

Manya Merodoulaki

CLAHRC

Innovation Centre (Room 107)

University of Sheffield

Portobello

Sheffield S1 4DP

I would like to be interviewed for the study on **clinical supervision in stroke care**. Please contact me to arrange a suitable time.

Please print your name:

Telephone number:

Email address:

The University Of Sheffield.

Centre Number:

Study Number:

Participant Identification Number:

CONSENT FORM

Title of Project: **Clinical Supervision in Stroke Care**

Name of Researcher: **G. Manya Merodoulaki**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **07/2012** (version….) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐

3. I understand that relevant sections of my data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant for research governance purposes only. I give permission for these individuals to have access to my records. ☐

4. I understand that this interview will be recorded and agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

INTERVIEW SCHEDULE

Introduction to the interview: "Thank you for offering to be interviewed for this research. Just to remind you that the theme of our conversation today is about clinical supervision, *your* experience of supervision, or the lack of it, as a clinician in stroke services. I envisage our conversation to last up to an hour. You can stop it at any point for a break or to end it.

Although I will be asking you some questions that I hope will be interesting and comfortable enough for you to give me your views, I would like you to take the lead in this conversation. Obviously, you choose how much to say in your answers, and, if anything I'm asking at any point is too sensitive for you to discuss, please tell me, so that you can continue to feel comfortable enough throughout the conversation.

As you may know, this conversation will be sound-recorded.

[Point:] this is the recording device.

The live recording will be kept secure in a password-protected computer or electronic storage device, to maintain confidentiality, and the recording will be destroyed at the end of the study.

Is this OK? If you agree, I would like you to read this consent form and sign it.

Introductory question: So, maybe a starting point would be to hear if you have completed the questionnaire part of this study. (If yes: were there any topics you would like to highlight?)

Please tell me briefly about the nature of your work in stroke care and anything about clinical supervision in relation to it. [Then allow interviewee to steer the conversation].

Potential probes: How often does CS happen? Does it happen?

If NO:

What alternative clinical support? What's the arrangement called?

Where?

With whom?

Supporting person's position in organization or in interviewee's service?

How arranged? Who chose and how/ on what criteria?
How well does the arrangement work?

[Supervisory] relationship:

What is the relationship with your [clinical supervisor/] support person like?

How do you use the time [during 'supervision']?

[Supervisory] Process:

What expectations do you have from the process/meetings? Are they met?

What functions does it have for you? [How do you use it, for what purposes?]

What's your [supervisor's /] support person's style in this process? What does s/he tend to do or say? (Structured/ agenda-setting, unstructured, etc.)

What themes tend to come up most frequently or most strongly? [new vs on-going clients; clinical or service planning; supervisee development, stress, etc]

How open would you say you are in your conversations with…?

What value do you attach to your conversation with…?

Is there any element of evaluation in the support you receive? [any links to appraisal?]

Outcomes

What could be /are the benefits of this arrangement for you? (professional and personal)

Positive and negative effects/ outcomes associated with these conversations. Anything that stands out?

How do you know if it has/ had a positive effect on

your clinical work?

you as a professional?

Any unwanted outcomes, ever?

Conclusion and debriefing

We have been talking for [however long…]. We have covered a few themes about clinical supervision and I thank you for your contribution. Just before we close, I wonder, is there anything you have been wishing to say but feel you have not had the chance to?

How was this conversation for you? Was there anything about which you felt upset?

NO: -> Thank you. If it's OK with you, we can close this conversation here.

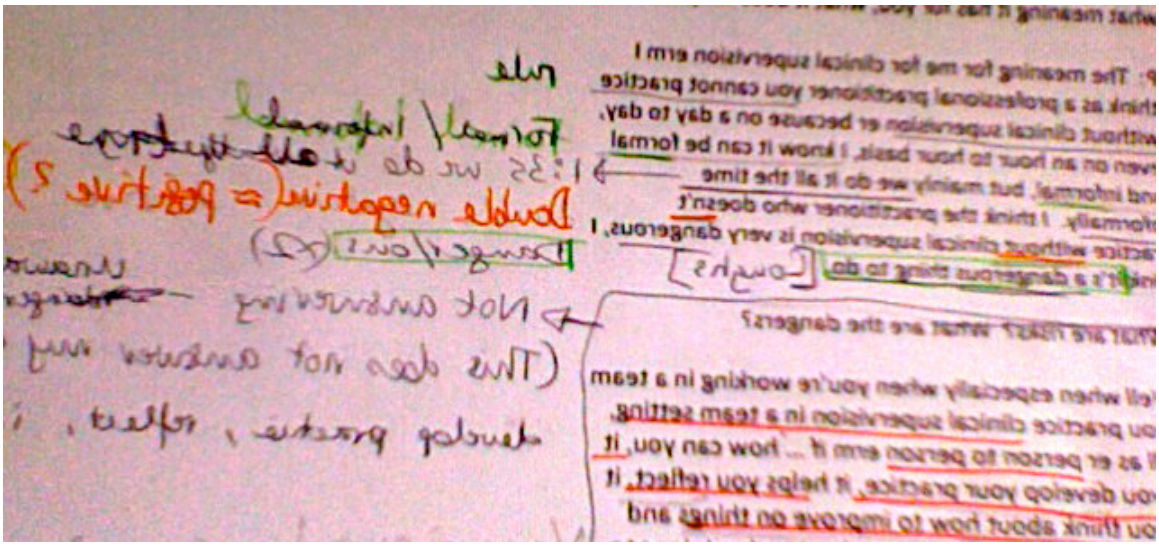
YES: -> [Acknowledge] What do you feel would help you feel less upset?

[Discuss resources for help, including staff counselling service].

In case I need more information from you after this interview, would you be happy for me to contact you about this and possibly to arrange another interview? [If yes, recheck contact details]

Appendix 4: PICTORIAL PROGRESS OF IPA

Working with the transcript (mirror image)

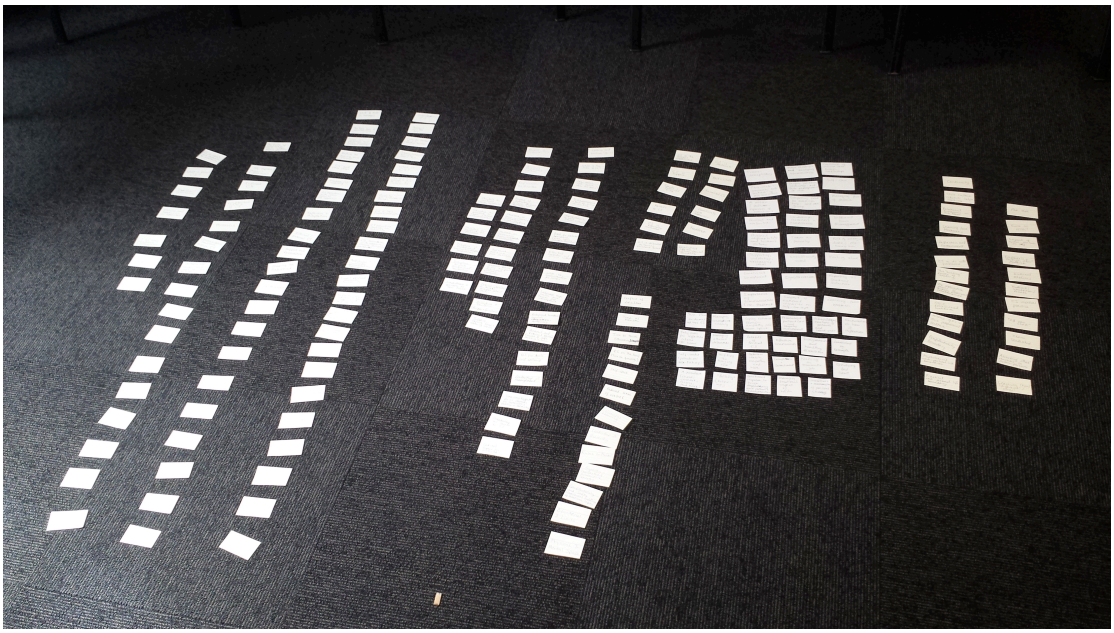


Themes

Theme board (superordinate and sub-themes)

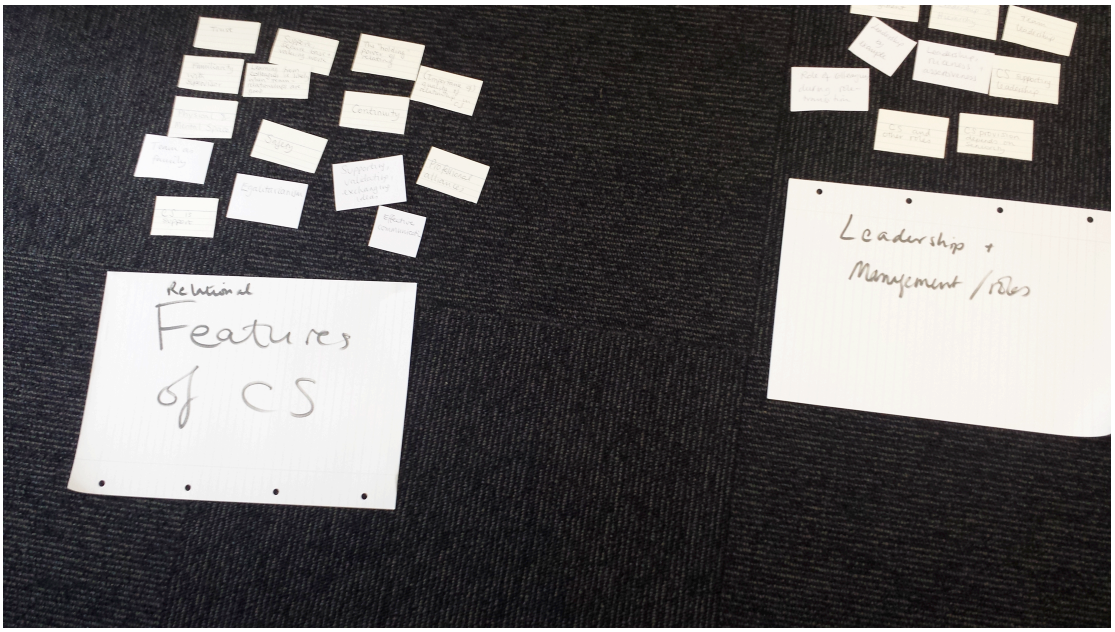
Integration of themes across cases

Themes arranged on large surface

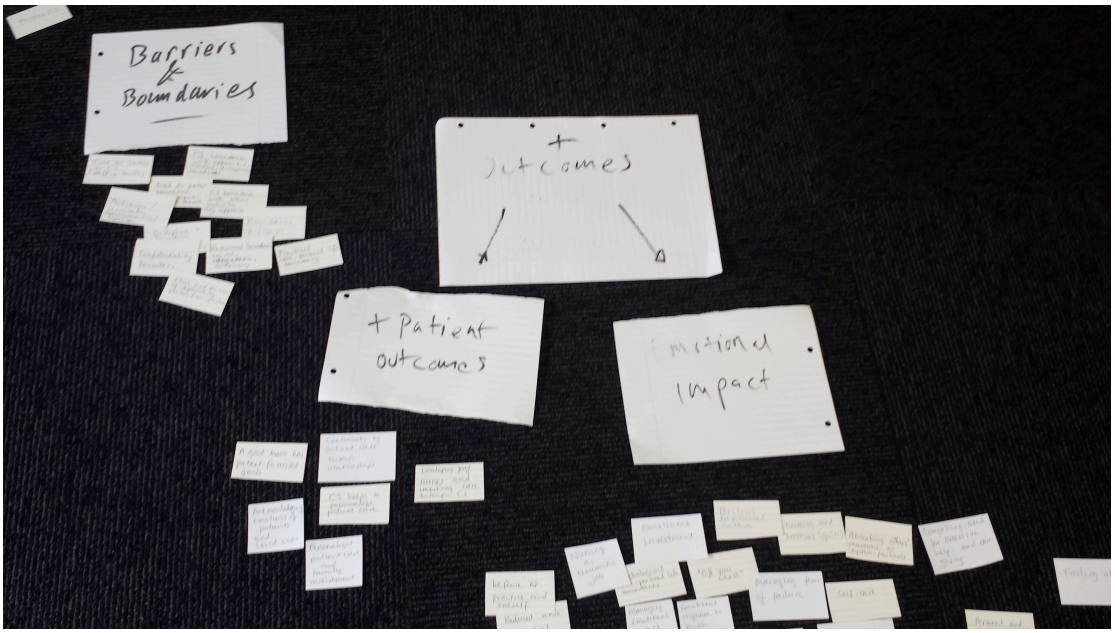


Grouping themes towards integrative themes

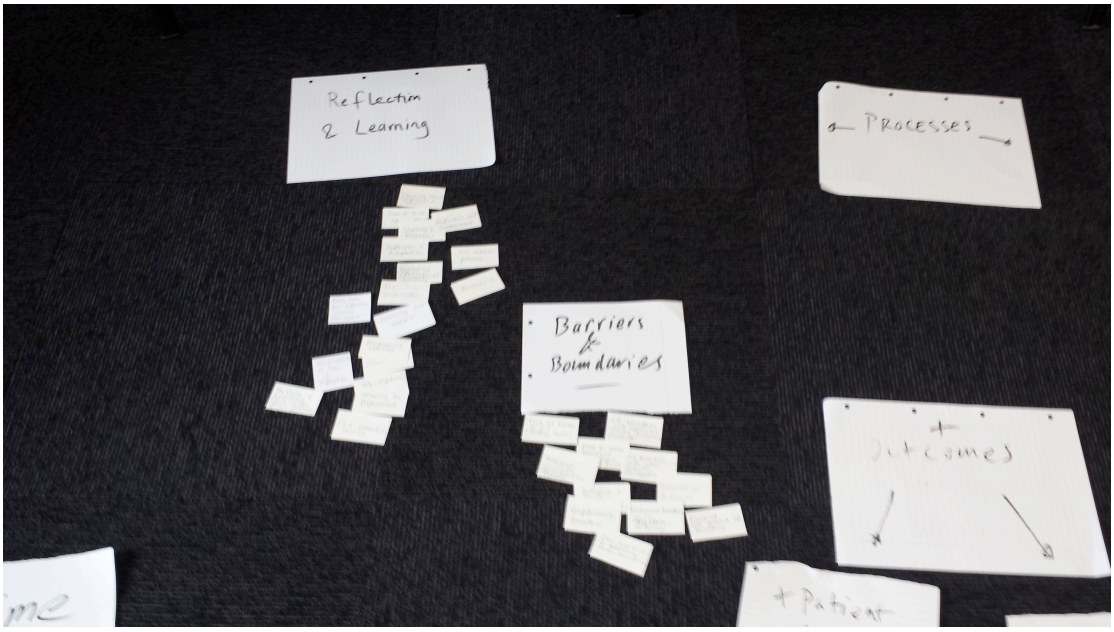
Integrating themes



Relationships between themes



Relationships between themes



Appendix 5: WORKPLACE CONTEXTS OF INTERVIEW PARTICIPANTS

This appendix contains information about the contexts where interview participants worked. It starts with observations recorded in the research journals, and site-specific information from the questionnaires.

A table follows summaring the information from the pro forma that site contacts completed (some categories have been removed because that were not completed).

OBSERVATION NOTES

Stroke Rehabilitation

Of the two rehabilitation services approached to participate in this study, staff from this one came forward for interviews. The service underwent some major changes during the study: it became part of a different Trust from the one that hosted the service at the start of the study. This organizational change is not mentioned in any interviews, perhaps because another major and practical change a year later, in accommodation, became more prominent. The service was set up 13 years ago, in a town of about 230,000 predominantly white, British, working class people in northern England, about 45,000 of whom over 65 years old. The service was set up as per national strategy, to provide free of charge inpatient and community-based rehabilitation following a stroke. Most patients of the service are aged over 65. The service aims to prevent loss of independence and physical and psychological deterioration while promoting wellbeing, positive attitude to independence, and healthy living. It provides observation, assessment, measurable rehabilitation, adaptation aids, aiming to alleviate or reduce impairment, speed up recovery, and maximize level of functioning after stroke.

The service operates 24/7 and receives approximately 140 referrals per year. Input duration varies from six to sixteen weeks. There are close links with patients' GPs, social services, voluntary sector services, as well as mental health and domiciliary services. The multi-disciplinary team consists of physiotherapists, occupational therapists, nurses, social workers, speech and language therapists, trained and untrained nurses, dieticians, a psychologist, a pharmacist, medical staff, and other assistant-level and administrative staff. Twice weekly clinical meetings and monthly operational meetings are convened.

During the study, this service moved to a purpose built space in a different hospital, thus some interviews took place in the previous, some in the new site, and one in University space. Apart from the visits to introduce myself, the study, and to carry out

interviews, I spent two days here, one in each location. On all occasions, as soon as I entered the unit, a member of staff was available to help. The new reception area is a well kept, light, clean and tidy area flanking the offices of senior clinicians. It is the centre of a space from which start corridors leading to patients' lounge, bedrooms, and to the corridor for team office and physiotherapy gym. One cannot get lost here, as all the corridors meet in reception. At quieter moments, the reception desk became a gathering point for staff exchanging follow-up details from decisions made during the team meeting and chatting. Patients' rooms are spacious and comfortable, with large windows, disabled-accessible bathrooms, technology assisted hoists, and entertainment sets. There is a comfortable patients' lounge with an adjacent large kitchen and separate women's lounge.

There is a modern physiotherapy gym, small meeting rooms for care planning meetings with patients and families, and a large staff office where team meetings are held. The multi-disciplinary meeting takes place in this staff office arranged so that to participate in the meeting, staff just turn their chairs thereby forming an open circle. Team meetings are interruptible to accommodate urgent communication with other services and facilitate patients' care plans. Attending the team meeting allowed a close understanding of the complexity and potential clinical and ethical dilemmas facing clinicians in this service, including conceptual differences between "responsibility" and "care". For example, discharge planning for a patient who was the carer for her partner who cannot care for her due to chronic illness; deciding on the extent of patient's family involvement in clinical decisions, patient's capacity for self-determination, and care plans; ensuring patients get the full service necessary when other services' bureaucratic procedures become exclusionary, bringing questions of the range of resources available and entry requirements; and the sequence of actions needed to minimize/ eliminate patient displeasure and discomfort. Clinical discussion was lively. Strong personalities became apparent, respectful of each other, maintaining a view of the ultimate goal: the patient's best interests. Heated debate on how to work around exclusionary procedures of external services that patients needed to access ranged from acknowledging the limited influence this service had, to a tone of indignation about the limits of the patient's entitlement and the service's ethical and legal responsibility in ensuring patient access to care.

The level of responsiveness to the study was high: of the 19 questionnaires delivered, 17 were returned (89%) from: nine staff nurses, three senior nurses, one ward manager, four higher graded nurses. Due to the high response level, the site's questionnaire data are separated from the set and presented here to illuminate the

context further. Eight nurses volunteered to be interviewed. This can be attributed to the active involvement of “Jim”, clinical leader and contact person for the study, who distributed the research packs, reminded staff to return the questionnaires and encouraged them to consider participating in interviews, leading by example.

Jim facilitated my observation of a team meeting where I met staff of all job descriptions. He provided a detailed, guided viewing of the new unit, then I spent the afternoon observing life in the unit from the reception and the patients’ lounge. He exemplified the importance of an immediately accessible, personable, knowledgeable and strategic clinical leader, evident during the team meeting and our subsequent conversations. Interview participants speak about clinical supervision arrangements at weekends provided by a duty-manager to any of the staff in the previous site. The extent this supervision is used is unclear. At ward level, participants mention regular clinical meetings facilitated by senior nurses or ward managers that any nurse can attend.

Questionnaire data show a wide range of respondents’ age and nursing experience and indicate that this service employs several older nurses with many years of experience. Ages ranged from 23 to 71 (two were 23-30; two were 31-40; six were 41-50; and seven were aged 51-71). Their nursing experience varied from newly qualified (two) to over 20 years (11 participants). Four had between one and four years nursing experience and one had seven years of nursing experience. Their stroke-specific experience was also extensive, with nine participants reporting 10-15 years experience, three had 4-8 years, and five had less than four years experience in stroke nursing.

Fifteen of 17 participants indicated that they had formal CS arrangements, while eight offered CS and eight had received some training to be clinical supervisors. CS arrangements happened during work time. Three participants received CS on a weekly basis, eight on a monthly basis, two quarterly and two every 3-6 months. CS usually lasted less than an hour for four participants, one hour for ten participants. One participant reported 90 minutes long CS. Eight participants received CS in small groups and one participant in large group, while six participants engaged in one-to-one CS.

Thirteen participants had a nominated clinical supervisor; two did not. Participants’ managers were usually also their clinical supervisors (12); three had CS with a peer/ colleague. Five reported that their clinical supervisors were assigned to them, six had selected from a range of supervisors, and four had made other choices.

Participants experienced CS as helping them to manage their work (13 of 15), supporting and developing their work (14 of 15), learning skills related to their role (11 of 15), keeping work within ethical and legal boundaries, (12 of 13), identifying gaps in their knowledge and skills (11 of 15), and considering the impact of work on themselves (9 of 15). There were several comments about how the CS relationship helped:

"*Able to discuss anything in a group each contributing their opinion in confidence",*

"By clarifying problems",

"By having to discuss concerns and any way forward about our workplace and patients",

"Decision making/ organizational skills/ people management improving my clinical and leadership skills",

"Feedback and ideas from other members of the group",

"Give you the opportunity to discuss any issues, problem or thing that you feel didn't go well and see how other would have dealt with same problems",

"helping to sort out different situations",

"We discuss anything that is topical or important to work issues at the time",

"Helps me reflect and see different points of view",

"Helps sort out any problems that might happen and if they don't know the answer they find it out for you",

"Managing complex problems with patients and discussing ethical and legal problems, reflective practice",

"By active listening giving/ offering different models perspective- reflection",

"Regular clinical supervision enhances working relationships",

"Supervisor in same job role and very supportive towards me",

"All evidence based information is shared during clinical supervision",

"Yes, a working relationship helps my supervisor relate and understand my issues, also helps to work them out"

"Helps me clarify problems",

"Learn from their experience"

"in the ways of helping me think of the skills I need to continue to be the nurse I want to be".

Participants also commented on mechanisms that complemented CS, such as MDT discussions and training:

"Experience from other members of the MDT. Current relevant government/ RCP guidelines",

"Internet. Working alongside others. Listening to others",

"mandatory training and courses that are identified to enhance your role as link nurses",

"Relevant training",

"team meetings, development reviews, 1:1 meetings. Appraisal".

To a lesser extent, CS was also reported to help set work-related goals (7 of 15). However, there were comments such as:

"ensuring all staff are up to date with information relevant to role allowing goal setting within the team",

"Weekly goal setting for patients",

"I set my own goals in line with other service, strategic goals/ targets metrics etc".

Thirteen of 14 participants indicated they had not experienced damage to themselves or patients from CS. Commenting under this question, a participant wrote "*We had some temperature/ BP charts and we could not accurately record the observations we passed this onto the clinical supervisor and these charts were changed".*

Eleven of 13 participants did not wish anything different from CS. Comments under this question are *"different days- normally on Sundays when wards quieter"* and *"More accessible at short notice".*

Eight of 14 participants indicated that their clinical supervisors sought feedback about CS. Their comments indicate that such feedback is given at the end of each session, including previous sessions of group CS. All 13 participants who answered the question whether they would feel comfortable to discuss with their supervisor whether CS works indicated they would be and their comments emphasised such openness in the supervisory relationship. Three of 12 responded that they had raised such questions. Comments indicated that there had not been any need to raise such issues.

Stroke Unit 1

Stroke Unit 1 (SU1) is an acute hospital ward that operates 24-hours-a-day since 2010, aiming to provide high quality stroke care free at the point of delivery from this single location. It cares for people over 18 years of age who suffered a stroke. Prior to the stroke unit being set up, the service catered for older people. According to the unit's manager, the change was variously welcomed or resented by staff and has presented management challenges.

Part of a large NHS Trust in a northern English city with an industrial past, the unit has close links to various research organizations and University departments. There is also access to rehabilitation and other post-discharge services through care planning referral. The unit takes referrals from A&E and acute hospital wards. Most patients usually arrive in an emergency ambulance. There is no maximum duration of patient stay. Average stay is 21 days.

The team comprises of six physiotherapy and six occupational therapy full-time posts, one full-time podiatrist, three full-time speech and language therapists, 40 nurses, one full-time dietician, one full-time psychologist, five full-time medical doctors, four geriatricians, a pharmacist, 25 clinical support posts, two full-time managers, two cleaning staff, and two admin/ secretarial full-time posts. A full-time consultant stroke nurse guides the service. Clinicians collaborate with a range of services, including social services, voluntary organizations, family doctors, and home-delivered services. Communication in the team occurs through keeping a single patient record for all disciplines, a daily ward round, and a weekly multi-disciplinary meeting. There is also a bimonthly clinical governance meeting.

As with other data-collection sites, I visited SU1 a few times. The first visit was to meet one of the ward managers, "Steve", my contact person for this site, who received the research packs to distribute to qualified nurses and agreed to be interviewed for the study. The following excerpt is from my journal entry about that visit.

I prepared 42 packs for SU1 and delivered them to the ward manager. When I arrived I noticed there were lots of renovation works in progress. There is no reception as such, no identifiable "nurses station", although there is an office with a computer for the ward manager. It is made of glass allowing view of the bays (beds) opposite. I was shown to a room (quiet? room) where I waited. There was at least one chair there which needed serious repair. When the ward manager arrived, he commented that some furniture needed repair ("that chair is broken"). For some unknown reason, I felt very defensive and semi-jokingly said "I didn't break it!".

I reminded him of the purpose of the research question and gave the questionnaires for distribution to qualified nurses. He was conveying his willingness to help, promised to distribute them and agreed to send email reminder, if necessary, at my request in future. I asked for a tour of the ward and he obliged. He asked if I had been in contact with [name] and gave me her contact details.

During interviews with "Becky" and "Kate" later, this scene and the memory of guilt and defensiveness returned, indicating I may have tuned into and experienced emotions prevalent in this work context. At the end of that visit, I was shown around the already refurbished part, which had bays and single rooms with modern equipment and large windows allowing plenty of light in with views of the city and the meteorological phenomena.

I visited the unit subsequently to attend service meetings and carry out interviews and observations. On all visits, the absence of a reception desk was noticeable, as there was no specific point where visitors could seek information and advice. On one occasion, during a casual conversation with a staff member, I was informed that the reason there was no reception was to avoid clustering of staff in one place instead of spending their time on patient care. This distrust and austere spirit of "economy-cum-motivation" is also evident in the interview with Tim, one of the Trust's senior nursing managers.

Later, Steve gave me the names of two nurses, my contacts if I needed anything during my observation visit, as he was not available. When I arrived, another person (a member of the public) pressed the entry buzzer and we both entered unquestioned, which raised the question of the purpose of the buzzer. Several members of staff were gathered in an open space of the ward, discussing patient care (from the few words I caught). They did not notice me. Not wishing to interrupt, I felt lost as to whom to ask regarding my visit. I walked around until I found someone uniformed. This staff member walked with me to the other end of the ward, where we discovered that both of my contact persons were on training that day.

Another group of nurses stood outside an office, and I explained the purpose of my visit. They cheerfully said that was "OK", and left me to my own devices. I found a plastic chair, pulled it to one side and asked for permission to just sit and observe from there. Someone else informed me that visiting hours were starting in a few minutes and I might be in the way.

The refurbishment was complete by the time of this observation visit. The side I observed had been completed most recently. The unit is organized as a long corridor, with men's bays at one end and women's at the other, presumably complying with

government requirements for single-sex wards. There is scope for staff to serve both sides. The middle part consists of offices, bathing rooms and auxiliary spaces.

The ward became quite busy with visitors who took patients out of their bays on (slow) walks around the ward or out on wheelchairs. Further down the corridor, two therapy staff were discussing how to use equipment with patients. At some point, the matron emerged and asked some visitors how to help them, took them somewhere, then disappeared in the direction she had come from. Junior staff who had not seen me earlier, asked me about the purpose of my visit and left satisfied with my explanation. Colour of uniform marks different disciplines and seniority here. Interestingly, the uniforms of nursing assistants and cleaners are of same colour.

This unit's response rate was about 21% (nine questionnaires returned from the 42 delivered). Having received very few responses, I arranged to attend a team meeting to discuss the study and improve participation rates. Staff proposed to contact them by email, but even this did not have significant effects. Four staff of this Trust participated in the interviews, Steve, ward manager and study's contact; Kate, clinical lead nurse; Becky, staff nurse; and Tim, a senior nursing manager of the Trust.

Eight of the nine respondents answered the age question. There were two in each decade, 20s, 30s, 40s, 50s. Seven staff answered the job-title question: six were staff nurses one was a ward manager. There was great variation in the length of nursing experience: One had three years experience, one had four, three had between ten and eighteen years nursing experience, and three had more than 23 years. Two participants had 2-3 years stroke-specific experience, three had three years stroke experience, one had nine and one ten years stroke experience.

Four of eight participants had formal CS arrangements, one monthly, five annually, one commented that they had no CS after the first six months, and one wrote *"NEVER"* (in capitals), as 'never' was not a response option. Seven offered CS, of whom six had received training. Three indicated that CS lasted less than an hour, three indicated one hour. One wished "it happened". CS took place during work time: one-to-one for two participants, in small groups for two, in large group for one, and for as peer CS. Three (of six) had a nominated clinical supervisor five were supervised by their manager and one by a colleague. A clinical supervisor had been assigned to five participants while one chose their own.

Two (of seven) participants indicated that CS helps them manage their work (five ticked 'no'). One participant commented *"understanding of clinical need"*. Another commented *"Annual appraisal (not received in 18 month)"*. Three participants indicated that their CS relationship helped them learn new skills related to their role (three ticked

'no'), with comment *"pushes for new learning"*. Other ways that they learned this was through the *"clinical educator", "attending clinical courses"*, and *"personal study and searches of my own".*

Three participants indicated that CS helped them set goals in clinical work, and three ticked 'no'. One commented *"Targets in IPR"* (annual appraisal). Five (of seven) participants indicated that CS helps keep their work within ethical and legal boundaries, by *"Following procedures that outline jobs that I am legally allowed to complete", "Knowing the policies and changes to them", "professional duty"*, while one commented *"this is carried out regardless"* (professional duty?).

Five of six participants indicated that CS helped them to identify gaps in their knowledge and skills. *"Highlights areas of improvement", "through verbal indication that a training need is apparent*", and *"Discussion with others at a similar level which helps spot gaps in knowledge"*. One participant commented that *"personal awareness and reassessment"* also contributed to this.

Five (of six) participants ticked 'no' to the question "Does CS help you to think about the good and not-so-good effects of work on yourself?". One commented that speaking to colleagues did this.

Four (of six) participants indicated that they would like things in CS to be different. Comments included:

"Clinical supervision should be regular and related courses arranged for staff. Must make time for all staff to attend",

"I would like to receive it [CS]", and

"More frequent smaller supervision".

One participant indicated that there had been a damaging effect through CS, commenting *"Feels very repressing and pressurized",* while five ticked 'no'. Two indicated that their clinical supervisor asks for feedback on how CS works for the supervisee, while four ticked 'no'. Four (of six) indicated that they would be comfortable giving feedback. One commented "no issues".

In the section for any other comments, one participant wrote *"Morale is not enhanced when someone you know that is less experienced than you asked to be your clinical supervisor. When your observation/ comments are not taken into consideration for whatever reason".*

Stroke Unit 2

Stroke Unit 2 (SU2) serves a large northern English town of low socio-economic indices with a mixed urban, rural and suburban population of 410,000. This acute unit is part of a large general hospital, the architecture and tiredness of which indicate it was built in the 1960s. The unit has been operational for about ten years as a new specialized facility providing full, timely, evidence based stroke care (acute and hyper-acute), within a single unit. SU2 nurses liaised closely with A&E and social services to inform care and facilitate relational continuity across services for stroke patients and their loved ones. Reception services were professional and helpful both at the hospital entrance and at the unit entrance. There were boards on the entrance wall of SU2 with useful information, including the availability of the charge nurses and ward manager for consultation in private. Facilities at the unit include therapy room, kitchen, MDT room and more recently, telemedicine.

The unit received approximately 600 referrals a year for acute or suspected stroke from A&E, other hospital wards, family doctors and paramedics. The average stay was ten days and the maximum is six months. The service operated 24 hours a day, seven days a week. There were approximately 20 nurses, three consultant grade doctors and three junior doctors, a half-time pharmacist, and a sessional counselor. Administrative support was by the ward clerk. There was a common physical base for the team. Each professional group kept their own patient files, as care was managed within the profession.

Led by Dr X, consultant physician in stroke, service expansion had resulted in the recruitment of two additional consultants recently. Dr. X was the initial point of contact for the study, keen to facilitate research into the service. Our communications indicated interpersonal sensitivity and ease of understanding and relating. His questions and comments showed interest in this study. This is the entry in my research journal after my first visit:

Yesterday I visited SU2 after email exchanges between my supervisor, me, and Dr. X. I phoned Dr. X as I was leaving the house, as I had not been there before. He was very reassuring about his flexibility with time, "I'll be on the stroke unit all afternoon, so if you're late, don't panic". His instructions to get to the unit were so crystal clear, I just got there, no problem. Dr. X was talking to a junior Dr. and other staff about a particular patient. I was welcomed to the office and offered a seat. The computer screen was showing a patient's brain scan, and the discussion was about further investigations. When their discussion finished, Dr. X welcomed me again and asked questions about my study. We talked about the concept of CS, the possibility that

some of CS functions/ purposes are met in different interactions, eg. ad hoc chats, and how formal and informal supervision-type of arrangements may and may not meet the clinicians' needs. I told him a little about IPA […].

Dr. X took me on a tour of the unit at my request, and I met some more staff […]. Everyone had a smile and a welcoming word. Dr. X showed me the telemedicine equipment, explained its use during on-call times and its benefits to improve patient care. He told me [...] [about] his dedication of time and availability, describing himself as someone who likes to be available immediately, so staff can just knock on his door with a question. We talked about the function of this as relief from uncertainty staff may have and as an element of what CS would provide. I was there for about 45 minutes, aware that it is a busy unit serving a very important function. He said I was welcome to attend the unit's MDT meeting on a [day]. […]

I left with a smile on my face and in my heart, reflecting on what I had just experienced. If the same helpful and informative attitude is also towards patients and their loved ones, going through the stroke unit here may be quite a "holding" experience that systemically and culturally manages the physical but also some of the psychological elements of the shock of stroke. In my brief conversation/ introduction to [ward manager], it was made clear that staff would prefer paper questionnaires to "survey monkeys".

Subsequently, in various opportunities for observations while waiting to interview staff, there was a tangible sense of synergy in the unit, seen in the readiness of staff at the unit's reception to help, in the smiles and manner of staff around the ward, and the presence of senior staff in routine care, as the ward manager mentioned in her interview. Although managers' presence may be experienced as intrusive or policing, here it seems a reassuring part of the team spirit, the sense of "we". Support is more prevalent than hierarchical authority.

During research recruitment visits, the ward manager organized meetings with interested prospective participants in groups of 2-3 at a time, so that we could discuss the study and hand out the research packs. A few staff showed interest in the study and offered their experience and understanding of CS and their email addresses to be contacted for the interviews. However, only one of the 20 questionnaires was returned (5% response rate) and attempts to contact those who gave their email addresses yielded no further participation.

Reciprocal flexibility of time and space has been key in interviewing here. This meant that on occasion, I left the unit not having conducted interviews due to clinical demands; or "broke" the interview in parts to accommodate clinical work; cancelled

private space booked in the Education Centre to conduct the interview in ward offices and in shorter time than originally arranged.

Four qualified nurses were interviewed: The ward manager, who volunteered during our conversations; one of the charge nurses, who was invited by the manager and agreed; and two research nurses, who contacted me via a third party, as I had not met them during recruitment visits. Unfortunately, due to equipment failure, the interview recording with one of the research nurses has been accidentally deleted.

INFORMATION FROM SERVICE PRO FORMA

The service pro forma was partially filled in different questions. In this table, there is a summary of the most important and fully filled questions.

Question	Stroke Unit 1	Stroke Unit 2	Rehabilitation
Name of service	Acute stroke unit	Stroke unit	Stroke Rehab Unit
Years of operation	3	8	13
Why was the service set up?	To care for people in [location] who have had a stroke	Specialist facility to treat people with stroke instead of general ward	Unmet service in the community. To meet National Strategy
What is the primary goal of the service?	To give high quality stroke care for patients	Early, aggressive evidence based management of hyper acute and acute stroke	Provide inpatient community rehabilitation
Who refers to the service?	Accident and Emergency Ward in acute hospital	GP Accident & Emergency Acute hospital wards Paramedics	Outside providers
How do clients access the service	999 Ambulance	Through hotline telephone number on stroke unit	In-reach assessment team
What are the eligibility criteria for the service?	We take all stroke patients who need our service	Acute or suspected stroke	
Any explicit exclusion criteria?	No	No	
What is the main location of the	Hospital inpatient	Hospital inpatient	Other

service provision?			
Any services provided in more than one location- where?	N/A	Client's home Hospital inpatient	Other
How would you describe your service?	Inpatient hospital ward	Acute and hyper acute	Inpatient community rehab
What facilities are available?	Physio gym, OT kitchen, SALT therapists, Medics, specialist nurses	Ward, therapy room, kitchen, MDT room	Single sex accommodation, En-suite, Gym, dining room, sitting room
Annual number of referrals	Not known	Approx 600	Approx 140
Average duration of a care episode	21 days	10 days	6 weeks average
Maximum duration of a care episode	Open-ended- depending on condition	180 days	16 weeks
Hours of operation of the service	24/7	24/7	24/7
What agencies do you work with?	CICS + RAs Rehab centre	Social Services	Social services Voluntary sector (age concern etc) Community mental health Domiciliary therapy/ nursing services GP Early supported discharge

What is the professional background of the team leader?	Nursing	Medical Consultant Physician Ward manager (nurse)	Nursing
Is a single file/ client record used by all providers?	Yes	No	Yes
Do social services have a separate file/ client record to health?	Yes	Yes	Yes
Do different professions have different files/ client records?	No	Yes	No
Is there a common physical base for the team?	Yes	Yes	
How often does the whole team meet for operational meetings?	Daily board round Weekly MDT Bimonthly clinical governance meeting	Formal and informal meetings on the stroke unit	Monthly
How often does the whole team meet for case conferencing?	Weekly	Weekly	Twice weekly
What is the management structure in your service?	Specific team manager (single person responsible for both clinical and management issues)	Individual profession management (each individual is managed by their service/	Split management (team leader is responsible for team management; service/ professional heads

		professional head	for clinical teams
STAFF			
Physiotherapist	6 WTE		2.5 WTE
Occupational Therapist	6 WTE		2.8WTE
Social worker	0		0.5WTE
Podiatrist	1 WTE		Casual/ Sessional
Speech & Language Therapist	3 WTE		2.6 WTE
Trained Nurse	40		
Untrained Nurse			
Dietician	1		
Psychologist	1		
Other – Assistant			
Doctor	5	3 junior doctors	1.5 WTE
Geriatrician	4	3 consultants	0.5 WTE
Counsellor	0	Sessions as req	None
CPN	0	None	Casual/Sessional
Mental Health Nurse	0	None	Casual/ Sessional
Pharmacist	1	0.5 WTE	Casual/ Sessional
Other	Clinical support staff: 25		Nurse consultant 1.0 WTE
Manager	2		1.0 WTE
Team Leader	0		1.0WTE
Stroke Coordinator	0		1.6 WTE
Context			

Size of population served		410,000	Approx 231,000
What type of population?	Urban	Mixed	Rural
What proportion of population is over 65 years old?	Not known		Approx 44,800
What is the nature of your funding?	NHS- PCT funded	Recurrent	Recurrent
Who funds your service?	PCT	Clinical Commissioning Group	Clinical Commissioning Group
Who makes decisions about the direction of the service?	Clinical Lead	Commissioners	Hospital Manager
Do you have an operational plan?	Yes	Yes	Yes
What is the organisation's setting or host institution?	Acute Trust	Acute Trust	Primary Care Trust Mental Health
What are the case-mix/ diagnostic groupings of service users?	Stroke	Stroke, TIA	Strokes
What is the demographic profile of your service?	Not known		Male/ Female White/ British
What is your service's target	Over 18 years old	Suspected strokes and TIA	Age 18 and above Mostly 85% are over 65 years of

population?			age
What is the most common level of care your clients/ patients need?		All levels	Patient needs medical care and rehabilitation