A work-based learning approach for clinical support workers on mental health inpatient wards


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Conflict of interest
None declared

Review
All articles are subject to external double-blind peer review and checked for plagiarism using automated software

Abstract

Background With a rise in the number of unqualified staff providing health and social care, and reports raising concerns about the quality of care provided, there is a need to address the learning needs of clinical support workers. This article describes a qualitative evaluation of a service improvement project that involved a work-based learning approach for clinical support workers on mental health inpatient wards.

Aim To investigate and identify insights in relation to the content and process of learning using a work-based learning approach for clinical support workers.

Method This was a qualitative evaluation of a service improvement project involving 25 clinical support workers at the seven mental health inpatient units in South London and Maudsley NHS Foundation Trust. Three clinical skills tutors were appointed to develop, implement and evaluate the work-based learning approach. Four sources of data were used to evaluate this approach, including reflective journals, qualitative responses to questionnaires, three focus groups involving the clinical support workers and a group interview involving the clinical skills tutors. Data were analysed using thematic analysis.

Findings The work-based learning approach was highly valued by the clinical support workers and enhanced learning in practice. Face-to-face learning in practice helped the clinical support workers to develop practice skills and reflective learning skills. Insights relating to the role of clinical support workers were also identified, including the benefits of face-to-face supervision in practice, particularly in relation to the interpersonal aspects of care.

Conclusion A work-based learning approach has the potential to enhance care delivery by meeting the learning needs of clinical support workers and enabling them to apply learning to practice. Care providers should consider how the work-based learning approach can be used on a systematic, organisation-wide basis in the context of budgetary restrictions.

Keywords
clinical skills tutors, clinical support workers, mental health training, professional development, service evaluation, work-based learning

THE QUALITY OF CARE and patient experience continues to be an area of concern for healthcare policymakers, providers and service users. This concern was exemplified by the findings of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis 2013). The role and training of non-professionally qualified staff – clinical support workers and healthcare assistants – is an area of particular focus (Kelly et al 2013). Non-professionally qualified staff constitute approximately one-third of the healthcare workforce in the UK (Cavendish 2013), and they have an important role in supporting qualified nurses. The report recommended the regulation of clinical support workers (Francis 2013), which is also supported by the Royal College of Nursing (2014). However, the UK
government has not made the regulation of clinical support workers a statutory requirement.

The variation in learning pathways for non-professionally qualified staff has caused some confusion among healthcare providers employing clinical support workers. There have been various efforts to provide a structure for the training of clinical support workers, but approaches remain inconsistent (The Scottish Government 2010).

The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings (Cavendish 2013) proposed what became the Care Certificate – an initiative aimed at delivering common training standards across health and social care. Following trials of the initiative (Allan et al 2014), the Care Certificate was introduced across NHS England from April 2015. However, the certificate only provides basic training (a minimum requirement) for new non-professionally qualified staff and thus raises the question of how training for clinical support workers can be developed as they gain experience, particularly in complex care settings such as acute mental health.

In 2013, South London and Maudsley NHS Foundation Trust implemented a clinical skills training initiative for clinical support workers. In addition to the wider issues previously outlined, the organisation was concerned about the limitations of classroom-based learning, and wanted to explore the advantages of developing practice associated with work-based learning. This article reports on a qualitative evaluation of the service improvement project.

**Background**

This study was part of a wider service improvement project undertaken in South London and Maudsley NHS Foundation Trust, a mental health services provider. The aim of the project was to improve care delivery through the development and implementation of a training programme designed to meet identified skills needs for clinical support workers. The project focused on four categories of competence: clinical communication skills, engagement skills, promoting meaningful activity and meeting physical health needs.

Three clinical skills tutors were appointed to develop, implement and evaluate a work-based learning approach on selected inpatient wards. The clinical skills tutors were qualified nurses who worked in the organisation. The work-based learning approach involved teaching identified skills individually and in small groups to the clinical support workers in each of the wards. The approach involved the clinical skills tutors working alongside the clinical support workers in real situations. They provided feedback on the performance of the clinical support workers’ in relation to the four categories of competence to help them develop and model effective practice. The clinical skills tutors worked with the clinical support workers for around 2 hours at a time, and the skills were related to the clinical skill workers’ engagement with service users on the ward.

**Aim**

The aim of this qualitative evaluation was to investigate and identify insights in relation to the content and process of learning using a work-based learning approach for clinical support workers.

**Method**

The study was undertaken in the seven inpatient mental health wards in South London and Maudsley NHS Foundation Trust. The project lasted 9 months, and data were collected in 2013-2014. The participants were clinical support workers from seven mental health inpatient wards. All clinical support workers on these wards were invited to participate. Complete data were collected from a total of 25 clinical support workers. Additional qualitative data were obtained from the inpatient ward managers, supervisors of the clinical support workers and other members of the clinical team, using an evaluation questionnaire requesting written feedback. The age of the clinical support workers ranged from 26-64 years, with more than
half of the participants aged over 40 years (13/25). Their experience in these roles ranged from 1 year to more than 25 years.

**Ethical approval**

Since this was a service evaluation project, ethical approval from the NHS National Research Ethics Service was not required. However, formal scrutiny and approval for the service evaluation was given by South London and Maudsley NHS Foundation Trust following their nursing and education governance procedures. Participants were given an information sheet about the project, and further explanation and clarification was provided verbally by the clinical skills tutors. Written consent forms were completed by each participant, which also ensured anonymity.

**Data collection**

The sources of data used for the qualitative evaluation of the project were:

- Reflective journals maintained by the three clinical skills tutors for the duration of the project. They comprised notes of events, relevant quotes, observations and reflections of their engagement with the clinical support workers, as well as examples illustrating learning points. These reflective journals were handwritten.

- Qualitative responses to open-ended questions in the evaluation questionnaires. These were used to collect data for the wider project evaluation. Ward managers and the supervisors of the clinical support workers completed the questionnaires. Responses were extracted from them and tabulated verbatim.

- Focus group discussions with the clinical support workers at the end of the project. The 25 clinical support workers who participated in the project were invited to attend the focus group discussions, and 12 agreed to do so. Three focus groups were held involving four, three and five participants respectively, lasting between 30 and 60 minutes. The groups were facilitated by an independent senior nurse clinician. Discussions were digitally recorded and transcribed.

- A group interview lasting one hour with the three clinical skills tutors, facilitated by a member of staff from a partner university acting in a research supervisor role (PK). The interview was digitally recorded and transcribed.

**Data analysis**

Analysis of qualitative data used the phased approach to thematic analysis described by Braun and Clarke (2006):

- Phase 1: familiarising oneself with the data.
- Phase 2: generating initial codes.
- Phase 3: searching for themes.
- Phase 4: reviewing themes.
- Phase 5: defining and naming themes.
- Phase 6: producing the report.

Data were analysed manually. This was, in part, for methodological reasons, because it was considered an effective means of ensuring familiarity with the data. There were also practical reasons in that an important source of data, the reflective journals, were handwritten and would have been difficult to enter into an electronic software package. Data analysis used the following seven steps:

1. The clinical skills tutors read through their reflective journals and undertook initial coding following training. Codes were recorded on index cards. The information recorded on each card included the code, a brief explanatory note, and exact details of the source to enable retrieval later.

2. The clinical skills tutors and PK met twice to collate, clarify and review initial codes and to identify provisional themes emerging from the coding.

3. The provisional themes were used to inform and develop a topic guide for the group interview with the clinical skills tutors and for the clinical support worker focus groups.

4. Analysis of the group interview transcript and further review of the themes were used to develop and refine provisional themes.

5. The refining process was repeated for the focus group transcripts, to revise and develop the initial themes that were identified.
6. The refining process was repeated for the qualitative responses to the open-ended questions included in the standardised questionnaires.

7. The three clinical skills tutors and the university facilitator reached a consensus on final thematic interpretations.

Findings

Six major themes were identified from the data analysis. The themes fell broadly into two categories: individualised impacts and systemic influences (Box 1). The individualised impacts were themes that related directly to the clinical support workers’ personal experience of learning and skills development. The systemic influences were themes that provided insights into the broader role and functioning of the clinical support workers in practice.

Individualised impacts

Real-time facilitation

An important aspect of the training involved the clinical skills tutors facilitating face-to-face learning on the ward. Their role was highly valued by the clinical support workers, although not at the outset of the project. Initially, the clinical skills tutors were sometimes viewed with suspicion by the clinical support workers, as ‘someone checking up on them’. Crucially, the relationship between the clinical support workers and clinical skills tutors developed over time. The credibility and appreciation of the clinical skills tutors among the clinical support workers increased after they saw the tutors working in practice situations:

‘At the beginning [we] didn’t think it was a good idea. But after a couple of sessions, you changed your mind’ (Clinical support worker 1, focus group 1).

‘I’ve been able to find out that it was quite necessary; this kind of developed me’ (Clinical support worker 2, focus group 1).

‘Having someone shadowing us was a bit strange at first but I got used to it’ (Clinical support worker 6, focus group 2).

The clinical skills tutors sensed the reservations of the clinical support workers at the outset of the project and felt:

‘We were checking up on them’ (Clinical skills tutor 1, group interview).

‘[Clinical support workers] were under surveillance’ (Clinical support worker 7, focus group 2).

The clinical support workers valued working alongside the clinical skills tutors as well as face-to-face learning in actual practice situations on the ward:

‘[The clinical skills tutor] divides every single thing into segments and says this is what I have been teaching you; this is how it is in practice’ (Clinical support worker 4, focus group 1).

‘She can spot our weaknesses… make us reflect on one thing’ (Clinical support worker 7, focus group 2).

‘We will do something but [the clinical skills tutor] will be able to put that in the jigsaw she has been teaching us and why’ (Clinical support worker 6, focus group 2).

The presence of the clinical skills tutors appeared to create opportunities for reflection and learning that would not otherwise have arisen, particularly opportunities for learning that appeared to be difficult for nurses on the ward to reproduce.

BOX 1. Main themes of the data analysis

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<th>Individualised impacts</th>
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<tr>
<td>» Real-time facilitation</td>
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<td>» Reflective capacity</td>
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<td>» Peripheral engagement</td>
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<td>» Clinical integration</td>
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<td>» Being ‘called out’: challenges of work-based learning</td>
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Reflective capacity

The learning potential of individual clinical support workers appeared to increase during the project, in part because of the development of their relationship with the clinical skills tutors. In particular, it appeared that the ability of the clinical support workers to reflect on practice improved over time. The clinical support tutors used a structured approach to prompt the clinical support workers to reflect on a practice event, and this was useful in developing their reflective skills. The clinical support workers valued the benefits of receiving micro-feedback from the clinical skills tutors, and it helped them to refine the skill in question.

The clinical support workers also reported a sense of satisfaction from ’doing things right’ (Clinical support worker 9, focus group 3), which may have helped to reinforce practice learning:

’It’s always nice to be able to reflect a bit more about our practice’ (Clinical support worker 6, focus group 2).

One clinical support worker provided a realistic assessment of the benefits of feedback. They were:

’... on the lookout and it joggs your memory [in how they interact with patients]. It is not a drastic change but it is a slight change which benefits patients’ (Clinical support worker 6, focus group 2).

User-focused interactions

Communication and engagement with service users is an essential requirement for professional development (Cavendish 2013). An important theme arising from the qualitative evaluation was indications of effective interactions with service users. Much of the clinical skills tutors’ work alongside clinical support workers related to real interactions with service users on the ward. The clinical skills tutors provided feedback and were able to suggest alternative approaches to communication in various situations, which could then be trialled under supervision. One technique was to ask the clinical support workers how they thought the service user felt after an interaction with them. There was some evidence that this approach helped the clinical support workers to reconsider their attitudes to service users:

’The way we approached the patient as well was looked at. [It helped] how we talked to them’ (Clinical support worker 4, focus group 1).

’And you know, on one-to-one [training] we see the difference is when [clinical skills tutors] are explaining to the person you have more insight about what they actually mean... For example, our body language’ (Clinical support worker 12, focus group 3).

’I’ve learned a lot about how effective communication could be between you and the patient... I’m really trying to encourage myself to communicate [more] effectively’ (Clinical support worker 4, focus group 1).

Systemic influences

Several wider themes were identified that revealed insights into the role of clinical support workers and the broader effects of the project on learning and development.

Peripheral engagement

The clinical skills tutors often found that the clinical support workers were not fully aware of the content or rationale informing service users’ care plans, or did not fully understand why certain treatment decisions had been made. There was also a concern that the clinical support workers might experience the most challenging situations but were the least qualified and least trained members of the team:

’Support workers seemed to be on the periphery. I felt that some support workers felt excluded from what was going on with a patient’ (Clinical skills tutor 1, group interview).

’They don’t always understand why a decision has been made but they are the ones who have to implement this. There is an absence of an holistic perspective’ (Clinical skills tutor 3, group interview).
Nevertheless, the clinical support workers felt that as a result of their training they had learned new skills, improved their existing skills and performed their roles with increased confidence:

‘It made our picture clearer and more to the point of “ah yes, this is what it is all about”’ (Clinical support worker 7, focus group 2).

Clinical integration

Often, the clinical support workers did not routinely take part in formal clinical discussions such as ward rounds and care review meetings. This also included handovers, in which treatment plans and their rationale are often discussed and agreed. Although clinical support workers often spend more time with service users compared with qualified nurses, it appears their particular knowledge of service users is not used. For example, clinical support workers might not be debriefed after escorting a service user on a home visit. This may be considered a missed opportunity in terms of care delivery, and results in clinical support workers feeling that their role is undervalued. Several of the clinical support workers were of the view that:

‘We can contribute!’ (Clinical support worker 5, focus group 2).

‘We don’t do this, don’t do tribunals, don’t do the medicine, but we are expected to do everything else, which we do’ (Clinical support worker 6, focus group 2).

The clinical support workers were aware of the potential limitations of the work-based learning approach in terms of their relationship with the wider clinical team. Some realised that effective mental health care is predicated on all members of the team being consistent in their practice, whether they are professionally qualified or not. The implication was that:

‘Qualified staff can benefit from this [training] as well’ (Clinical support worker 6, focus group 2).

There was also implied criticism of some qualified staff. The clinical support workers felt the training they received from the clinical skills tutors was the ‘proper way’, particularly in relation to physical health clinical skills, and that they were often shown shortcuts by qualified staff.

Several of the clinical support workers observed that improvement in quality of care comes from changes in ward culture, not only by changing individual care practices:

‘[Despite the benefits] you know doing this course with support workers doesn’t change the culture of the ward’ (Clinical support worker 7, focus group 2).

‘I think paperwork has overtaken a lot. [Qualified staff are] not even looking up at the patients; you know patients talk about this all the time’ (Clinical support worker 6, focus group 2).

Despite this, as a result of the training the clinical support workers often felt ‘more part of the team’ (Clinical support worker 12, focus group 3). When their improved skills were acknowledged by qualified colleagues they valued this positive reinforcement.

Being ‘called out’: challenges of work-based learning

A potentially problematic area of the work-based learning approach was the context of its delivery. Commitment to the project varied among the ward managers, who act as gatekeepers to the training and determine the extent it is prioritised on their wards. A ‘lack of prioritisation’ (Clinical skills tutor 1, group interview; Clinical support worker 6, focus group 2) on some wards was a frequently cited complaint of the clinical support workers, and was also noted by the clinical skills tutors. The attitudes of the ward managers appeared to reflect those of the wider clinical team on the ward.

A logistical issue that was consistently expressed was the frequency of the clinical support workers being ‘called out [called away]’ (Clinical support worker 7, focus group 2) from the training because of
events taking place on the ward, or for specific activities such as escorting service users. Even if the clinical support workers were not overtly called away in this way, many experienced ‘distractions on the ward’ (Clinical support worker 7, focus group 2), as well as a general awareness of other things happening while on-site training was taking place, and feeling compelled to assist. One consequence of these distractions was that often:

‘The learning is incomplete’ (Clinical support worker 5, focus group 2).

‘[This was] the only thing that got in the way with us, it was to [necessary to] be released from duties’ (Clinical support worker 7, focus group 2).

‘At times we felt pressurised; there were times when the tutor was there but we couldn’t come because we were needed on the ward… I felt a bit upset because I was looking forward to doing it [a training session] but the ward needed us’ (Clinical support worker 6, focus group 2).

Discussion
The qualitative evaluation of this service improvement project focused on using a work-based learning approach to meet the learning needs of clinical support workers. It is important to undertake a qualitative evaluation to supplement the main quantitative evaluation of competency development, because it might provide insights into the process of learning. A qualitative evaluation also emphasises aspects of care delivery that are less directly measurable, rather than instrumental role performance alone.

There were features of the work-based learning approach that were highly valued by the clinical support workers. In particular, these included individual face-to-face learning in real practice, micro-feedback, opportunities for reflection, and the supervisory relationship with the clinical skills tutors who were external to the clinical team. This approach appears to be an effective way of engaging participants in learning.

Literature supports the benefits of work-based learning approaches (Flanagan et al 2000) as well as the use of clinical tutors in pre-registration nurse education (Ioannides 1999). However, the transfer of learning to practice using conventional classroom-based learning and the theory-practice gap is a long-standing issue. It is interesting to note, for example, that participants in this evaluation eschewed the use of online learning for the improvement in role performance that this project focused on. However, it should be recognised that this mode of delivery is labour-intensive and relatively costly – important considerations for service providers in the current economic climate.

A particularly interesting finding was that the clinical support workers not only developed their clinical skills but also their capacity for practice learning during the project. Reflection is an essential skill for practice learning in care work. The project provided a structured approach for participants to practise learning throughreflection. This type of personal development is difficult to acquire in short training courses.

The project focused on the clinical support workers’ competence in relation to communication and engagement with service users. An important feature of the work-based learning approach was supervised practice and feedback in trialling skills in real practice situations, alongside the teaching of techniques. The clinical skills tutors were able to focus on attitudes in interactions and prompted reflection on service-user perspectives of the clinical support workers’ engagement. Learning does not take place independently of the practice setting. However, the practice setting can present barriers to, as well as facilitate, practice learning. The qualitative evaluation identified several themes that focused on wider systemic considerations. There appeared to be tension between developing new skills, knowledge and confidence in practice, and ward cultures that did not fully include the clinical support workers in clinical discussions and decision-making. This resulted in a disconnect between the
clinical support workers and engagement with the wider context of care. While the work-based learning approach emphasised person-centred approaches to learning and care provision, on some wards there was a tendency to view the role of clinical support workers as providing essentially task-orientated contributions to practice.

The relationship between the clinical support workers and the wider clinical team was related to this tension in role expectations. Clinical support workers spend much time in direct contact with service users, and as a result they might get to know them well. This day-to-day knowledge of service users can be considered an area of expertise of the clinical support workers (Kemp 2000). Findings of the qualitative evaluation suggest that this knowledge was underused, particularly if the clinical support workers did not routinely contribute to formal clinical discussions or debriefings. As the confidence and competence of clinical support workers increases through work-based learning, so too will their ability to contribute to the wider clinical team.

There are practical and financial challenges in delivering the work-based learning approach used in this project. Organisational and team cultures can act as potential barriers to learning, and for some clinical support workers the process was fraught with ‘distractions’ despite perceived benefits. A further concern was that qualified staff are not always effective role models – they may not competently perform some of the skills that the clinical support workers were expected to develop through their training.

Qualified staff acting as practice supervisors to clinical support workers have an important role in developing and embedding the therapeutic practices and skills that clinical support workers undertake as part of their role.

**Conclusion**

A full analysis of the effect of the work-based learning approach on the competence of the clinical support workers has yet to be completed. However, the qualitative evaluation described in this article provides useful insights that warrant consideration. The role of the clinical skills tutor as a learning facilitator was highly valued by the clinical support workers. Since the relationship between the clinical skills tutors and clinical support workers develops over time, so too may the potential for learning.

Practice that is supervised by a clinician with appropriate supervision skills has the potential to enhance the quality of care provided as well as skill performance. This is important in the context of concerns about the quality of care and the interpersonal aspects of care delivery, especially in mental healthcare settings. However, there are logistical challenges to delivering the work-based learning approach, and it is relatively labour-intensive and costly compared with classroom-based teaching and online learning.

It is important that qualified staff recognise their potential influence in facilitating and shaping the practice of clinical support workers and how this can be affected at an individual and team level.

**References**


