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Doctoral Thesis:

Burnout and Compassion in Acute Mental Health Wards

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Thesis Abstract	282	-	282
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Abstract

Section one of this doctoral thesis presents a literature review examining the prevalence of burnout in mental health inpatient staff, whilst synthesising relevant factors linked to the development of burnout. Across the 17 papers examined, emotional exhaustion was high whilst depersonalisation and personal accomplishment were average when compared with mental health worker norms. Factors consistently related to burnout were divided into two groups: staff factors and organisational factors. Within staff factors, negative attitudes and poor mental and physical health were related to higher levels of burnout, whilst within organisational factors, a poor ward climate, lack of social support and team working, and exposure to violence were related to higher burnout. The clinical implications and methodological and theoretical limitations were considered.

Section two reports the findings of the empirical paper, that qualitatively explored staffs' conceptualisation of the development, loss and restoration of compassion within acute mental health wards. A total of 11 participants were interviewed, and using grounded theory informed methodology, five theoretical categories were identified: a compassionate stance, the challenges of acute mental health wards, feeling under threat and the negative appraisal system, restoring compassion and the compassionate organisation. This informed a sequential model of the processes underpinning the development, loss and restoration of staff compassion within this environment. The findings highlight the importance of colleague support, knowing and understanding patients and their history, accessing a reflective space and a compassionate organisation in the maintenance and restoration of compassion. The clinical implications arising from the findings are considered.

Finally, a critical appraisal of the work is presented, which offers reflections on the process, the influence of epistemology and terminology, adopting a compassionate stance towards the project and directions for future research.

Declaration

This thesis represents work undertaken for the Doctorate in Clinical Psychology at Lancaster University's Division of Health Research from June 2018 to June 2019. The work presented here is the author's own, except for where due reference is made. This work has not been submitted for the award of a higher degree elsewhere.

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Section One: Literature Review

Burnout in mental health inpatient staff: Prevalence and determinants.

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Abstract

Background: Staff working in mental health inpatient wards experience unique stressors. Previous research has suggested that levels of burnout in this staff group are high. However, to date, no review has assessed the factors related to the development of burnout in this population.

Aims: To examine the prevalence of burnout in mental health inpatient staff internationally, whilst synthesising relevant individual and organisational factors linked to the development of burnout.

Method: Eight databases were systemically searched, which yielded 18 relevant papers. The prevalence of burnout, and significant factors related to high burnout, were synthesised.

Results: Levels of emotional exhaustion were high, whilst depersonalisation and personal accomplishment were average, when compared to mental health worker norms. Factors within two domains: staff factors (attitudes, physical and mental health) and organisational factors (ward climate, social support, team working, exposure to violence) were significantly related to burnout levels.

Conclusion: The significant factors are discussed in relation to models of burnout. Suggested areas for intervention and future research are also discussed.

Key words: staff; burnout; acute mental health; inpatient.

Introduction

Stress and psychological ill-health are a widespread problem amongst healthcare professionals. A survey completed by 497,000 National Health Service (NHS) staff in 2018 highlighted that 40% of them had felt unwell due to work-related stress in the past 12 months (NHS England, 2018). This is also of international concern: a study surveying twelve countries found high levels of stress, dissatisfaction and intention to leave amongst healthcare professionals (Aiken et al., 2012). Research has shown that staff experiencing high levels of stress are less engaged, less productive and have lower job satisfaction than those who are less stressed (Moustaka & Constantinidis, 2010). Prolonged exposure to work-stress can also lead to burnout, a psychological condition characterised by emotional fatigue, reduced productivity and engagement, cynicism and psychological detachment (Cherniss, 1980; Maslach & Jackson, 1981).

Burnout

The concept of burnout was first introduced by Freudenberger in 1974, initially defined as "to fail, wear out or become exhausted by making excessive demands on energy, strength or resources" (Freudenberger, 1974, p. 159). In this original paper, Freudenberger speculated that the condition predominantly affected frontline human service workers (people who work intensely with others), and manifested itself in a range of physical, emotional and behavioural symptoms such as exhaustion, fatigue, lack of accomplishment and low-mood.

Since its introduction, the concept of burnout has been further explored. In 1981, Maslach and Jackson proposed their multi-dimensional model of burnout, which consists of three separate, but related, domains: emotional exhaustion, depersonalisation, and reduced personal accomplishment. They initially suggested that burnout occurred only in those who worked in human service organisations, although they have since revised this view (Maslach, Schaufeli, & Leiter, 2001). And whilst they hold firm to the idea that burnout consists of

these three domains, they have continued to debate on the mechanisms that lead to the development of burnout, and the exact relationships between the domains (Maslach & Leiter, 2016; Maslach et al., 2001).

Other authors have proposed models in an attempt to explain how burnout develops. Demerouti, Bakker, Nachreiner, and Schaufeli (2001) argued that burnout is not limited to human service workers but can afflict workers in any organisation. To explain this, they proposed The Job Demands-Resource model (JD-R), whereby an overload of job demands, such as workload, time pressures and poor environmental conditions, can lead to emotional exhaustion. Secondly, a lack of job resources, such as performance feedback, rewards, job security, participation in decision making and job control, can lead to disengagement from work. They suggest that when job demands are high, staff will experience exhaustion (but not disengagement), and when job resources are lacking, the experience will be that of disengagement (but not exhaustion). It is only when both job demands are high and job resources are low that staff will experience both exhaustion and disengagement. Although posited as an alternative model of burnout, The JD-R model is not dissimilar to that of Maslach and Jackson (1981), with the main difference being the lack of depersonalisation in the former. However, Demerouti et al. (2001) acknowledge that when human service staff are disengaged, depersonalisation is likely to occur; it is absent from the model solely so that it remains applicable to staff from all professions.

Researchers have since proposed a revised JD-R model, to include the mediating effect of personal resources on exhaustion and disengagement (Schaufeli & Taris, 2014; Xanthopoulou, Bakker, Demerouti, & Schaufeli, 2007). Within these models, personal resources (a sub-set of job resources) offset the effect of demanding conditions by buffering against the negative impact of job demands, and exacerbating the positive effects of job resources, thus reducing burnout. The addition of this supplementary element is helpful in

explaining individual differences between staff, i.e. why, when staff are faced with the same demands and have access to the same resources, burnout may develop for some staff but not others. An outline of the original, and revised, JD-R model can be seen in Figure 1.

A second model, proposed by Kristensen, Borritz, Villadsen, and Christensen (2005), generally agrees with the core concepts proposed by Maslach and Jackson (1981). However, it suggests that the core features of burnout are fatigue and exhaustion, with depersonalisation being a coping strategy (rather than a defining feature of the syndrome), and reduced accomplishment a consequence of experiencing burnout. They also separate burnout into three core domains: personal burnout, work-related burnout and client-related burnout. Questionnaires for each domain are administered separately, dependant on the relevance to the individual completing the measure, i.e. those who are unemployed complete only the personal burnout questionnaire, those employed in non-human services jobs complete questionnaires for the first two domains, and those employed in human services (and work with clients) complete all three questionnaires. The development of this new measure was an attempt to acknowledge that burnout can afflict people with or without employment, and from any professional background. Maslach and colleagues took a similar approach, with the development of the Maslach Burnout Inventory – General Survey (Maslach, Jackson, & Leiter, 1996), which is designed to measure burnout in staff not working in human service settings. A description of all aspects of burnout, by model, can be seen in Table 1.

Whilst there might be differing opinions on the precise mechanisms of burnout, there is general agreement on the detrimental impact that burnout has on both individuals and organisations. Research has shown burnout to increase the risk of serious physical health conditions such as diabetes, raised cholesterol, cardiovascular disease and even death (Ahola, Väänänen, Koskinen, Kouvonen, & Shirom, 2010; Melamed, Shirom, Toker, Berliner, & Shapira, 2006; Salvagioni et al., 2017). It has also been associated with mental health

difficulties such as insomnia, anxiety and depression (Peterson et al., 2008; Salvagioni et al., 2017).

On an organisational level, burnout is associated with reduced job satisfaction, productivity, commitment to the job, and an increase in absenteeism, turnover and intention to leave (Maslach & Leiter, 2016; Salvagioni et al., 2017). It can also impact staff's ability to provide effective care, form and maintain therapeutic relationships, and feel empathy for their clients (Hunt, Denieffe, & Gooney, 2017; Maslach & Jackson, 1981; Wilkinson, Whittington, Perry, & Eames, 2017). Multiple reviews have highlighted the concerning links between staff well-being, burnout and patient safety and outcomes (Dewa, Loong, Bonato, & Trojanowski, 2017; Hall, Johnson, Watt, Tsipa, & O'Connor, 2016; Panagioti et al., 2018). It is understandable, therefore, why burnout in healthcare staff would be of concern, both in terms of employee well-being and the care received by service users.

Burnout in Mental Health Staff

In epidemiology, prevalence is generally defined as the proportion of a population afflicted with a condition at a point in time (Munn, Moola, Lisy, & Riitano, 2014). Research examining burnout in the general population has reported the prevalence to be between 13% and 28% (Lindblom, Linton, Fedeli, & Bryngelsson, 2006; Norlund et al., 2010; Shanafelt et al., 2012). However, two recent reviews examining burnout amongst mental health staff have estimated the prevalence to be as high as 40% - 67% (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012; O'Connor, Muller Neff, & Pitman, 2018). Mental health staff also have higher levels of stress, burnout, turnover and sickness absence when compared to their physical health colleagues, both in the UK and internationally (Aarons & Sawitzky, 2006; Eriksen, Bruusgaard, & Knardahl, 2003; NHS Digital, 2017; Sahraian, Fazelzadeh, Mehdizadeh, & Toobaee, 2008; Yousefy & Ghassemi, 2006). This is thought to be due to unique stressors in mental health settings, such as daily contact with intense distress,

challenging therapeutic relationships, threats of violence and exposure to suicide (Rössler, 2012).

Organisational factors also play a role in the high prevalence of burnout in mental health services. The NHS, and particularly mental health services, have seen significant changes over the past few years. Reduced funding and budget cuts have been detrimental to staffing levels, pay, and the work environment, all of which have been shown to impact levels of burnout amongst mental health staff (Johnson et al., 2018). These challenges are not unique to the UK; two recent reviews by Vigo, Kestel, Pendakur, Thornicroft, and Atun (2019) and The Lancet Commission (Patel et al., 2018) reported global under-funding of mental health services, including across the USA, Canada, China, Africa and South-East Asia.

Acute Inpatient Wards

Acute inpatient wards exist to safely care for service users who, due to risk to self or others, cannot be supported in a community setting (Bowers, Chaplin, Quirk, & Lelliott, 2009; Royal College of Psychiatrists, 2016). Staff working on acute wards experience daily exposure to the most distressed service users who are experiencing mental health crises (Bowers, Chaplin, et al., 2009). Staff face a high risk of exposure to violence, self-harm, suicide and other serious untoward incidents, which have a detrimental impact on morale (Bowers et al., 2006). The short nature of admissions, the complexity of service users' difficulties, and the need to provide safety for staff and patients have all been reported as challenges of working in this environment (Wyder et al., 2017).

Rationale for the Current Review

It is perhaps unsurprising, therefore, that research has shown high levels of emotional exhaustion and overall burnout in mental health inpatient staff (Johnson et al., 2012; Madathil, Heck, & Schuldberg, 2014; Sahraian et al., 2008). A previous review by Richards

et al. (2006) aimed to assess the prevalence of poor staff morale on acute inpatient mental health wards, with morale encompassing occupational stress, job satisfaction, burnout, psychological well-being and sickness rates. They included studies published between 1990 and 2003 (inclusive) that examined staff working in adult acute or non-specified inpatient mental health settings. They excluded articles that examined other specialities (e.g. learning disability, child and adolescent) or that failed to specify the setting.

The review reported mixed findings, with some included studies reporting alarmingly high levels of burnout amongst staff (over 50% of staff rating themselves as high on emotional exhaustion and depersonalisation), with others reporting low to average burnout levels. However, when summarising the data, Richards et al. (2006) chose to use conservative cut-off values,[1] and based on the graphs provided, only 8% of included studies indicated high emotional exhaustion, 15% reported high depersonalisation, and 62% of studies indicated reduced personal accomplishment. The authors concluded that whilst emotional exhaustion across studies appeared average, there were high levels of depersonalisation and low levels of personal accomplishment, although staff also reported neutral to high job satisfaction. The authors acknowledged that the studies reviewed were generally of low quality and utilised small sample sizes.

However, Richards et al.'s (2006) choice to utilise a wide definition of morale (stress, satisfaction, sickness etc.) meant that there were relatively small numbers of studies to synthesise in each domain. The authors also separated their results by type of ward; they summarised results for studies that specified the environment as "acute inpatient", a term generally used in the UK, but not internationally. They then separately summarised the results of studies with "non-specified ward-based settings", which limited their ability to provide an overall synthesis of the data. The authors also did not examine individual or

[1] The difficulties associated with the use of cut-off values will be considered further in the discussion.

organisational factors related to burnout. To date, no review has examined factors related to the development of burnout in mental health inpatient staff, considering theoretical approaches and models of burnout.

Aims of Current Review

The current review aims to examine the prevalence of burnout in mental health inpatient staff, whilst synthesising relevant individual and organisational factors linked to the development of burnout.

Method

Search strategy

The review question was initially defined using CoCoPop; an adaptation of PICO designed for use when assessing the prevalence of a phenomenon (Munn et al., 2014). This requires the author to outline the condition (Co: burnout), context (Co: mental health inpatient wards) and population (Pop: staff) to guide the question, search terms and inclusion/exclusion criteria. The PRISMA guidelines for reporting of systematic reviews were consulted and followed throughout (Moher, Liberati, Tetzlaff, & Altman, 2009).

Initial scoping searches were undertaken to define the appropriate search terms. Burnout terms were defined as “burn-out” (hyphenated terms are searched for in both hyphenated and non-hyphenated forms) and “burnout”, to capture all relevant results. Stress related terms were limited to “occupation stress” and “organi?ation* stress”; using “stress” as a stand-alone term included an additional 18,000 results, the majority of which were irrelevant. “Asylum” was included in terms related to setting, as it is widely used in the European literature to describe mental health inpatient wards/hospitals.

A subject specialist librarian was consulted to confirm the appropriate search strategy. The following search terms were agreed upon: “compassion fatigue” OR burn-out OR burnout OR “occupational stress” OR “organi?ation* stress” AND “acute mental health” OR

psychiatric OR inpatient OR asylum. Terms related to inpatient wards were deliberately kept broad, due to a large variety in wording throughout the literature. A full list of search terms, by database, can be seen in Appendix 1-A.

Thesaurus and MeSH terms were used where available and appropriate. Search terms were used to search title and abstract only, due to the large numbers of relevant results. On 22nd November 2018, eight databases were searched using the search strategy: PsycINFO, MEDLINE, EMBASE, CINAHL, Academic Search Ultimate, PubMed, ProQuest and the Cochrane Library. Results from PubMed were limited to the last 12 months, due to older results being indexed in MEDLINE.

Inclusion/Exclusion criteria

A full outline of the inclusion and exclusion criteria utilised can be seen in Table 2. Of note, given that Richards et al.'s (2006) review included studies published up to, and including 2003, the current review only included studies published from 1st January 2004 onwards.

Study Selection

After removing duplicates, all titles and abstracts were reviewed for eligibility. The full-texts were then reviewed of the remaining potentially relevant studies. Eligibility was decided based on the inclusion/exclusion criteria outlined in Table 2.

Quality Assessment

The quality of included studies was assessed using the Appraisal Tool for Cross-Sectional Studies (AXIS). This tool was developed by Downes, Brennan, Williams, and Dean (2016) following two systematic reviews highlighting the lack of an appropriate tool for assessing the quality of cross-sectional studies (Katrak, Bialocerkowski, Massy-Westropp, Kumar, & Grimmer, 2004; Sanderson, Tatt, & Higgins, 2007). As all studies included in this

review were cross-sectional in nature, this tool appeared both the most relevant and comprehensive, given it assesses risk of bias, study design and reporting quality.

There is no numerical scale included in the AXIS; each question is scored as 'yes', 'no' or 'don't know'. The authors encourage users to apply the tool as they see fit; for the purposes of this review, each question that is recorded as 'yes' was allocated a score of 1 point, with a maximum score of 20 points per study. Questions 13 and 19 were reverse scored; i.e. responses recorded as 'no' were allocated one point.

As per the method outlined by Downes et al. (2016), individual questions were clustered to provide overall scores for different aspects of quality: a risk of bias score, a study design score, and a reporting quality score.

Data Synthesis

Demographic information from each study was extracted, alongside prevalence data. Factors related to burnout were then synthesised, and effect sizes reported. Statistical meta-analysis of the data was considered; however, included studies were too heterogenous in terms of their design, population, sample sizes and outcome measures for it to be viable or meaningful. Instead, a narrative synthesis of the data is presented, in line with recommendations for systematic reviews of observational studies and prevalence data (Munn et al., 2014; Stroup et al., 2000).

Results

Search Results

A flow-chart of the selection and exclusion process can be seen in in Figure 2. Initial searches yielded 6,960 results, of which over half were removed when date, English language and academic journal limiters were applied. Of the remaining 3,325 articles, 1,343 were duplicates.

Title and abstracts were reviewed based on the inclusion/exclusion criteria, and 136 articles were identified to be potentially relevant. Following full-text review, 18 articles met the inclusion criteria and were therefore considered in this review. A manual search of the reference lists of all included studies was conducted, as well as of previous reviews on a similar topic (e.g. O'Connor et al., 2018). However, no new articles were identified.

One study (Ashtari, Farhady, & Khodaee, 2009) appeared to make a number of errors when scoring the MBI. Firstly, they specified measuring intensity as opposed to frequency of experiences. The original version of the MBI (Maslach & Jackson, 1981) included scales for both frequency and intensity; however, the intensity scale was dropped in subsequent versions. Ashtari et al. (2009) did not use the frequency measure and failed to justify this decision. Secondly, they describe the reversal of scores for DP, when in fact the correct scoring of the measure means scores are reversed for PA. Given the issues with the reliable utilisation of the measure, this study was excluded from further analysis, leaving 17 studies to be considered. A full list of the included studies, as well as information on the studies' designs, samples and results can be seen in Table 3.

Quality of the Included Studies

Table 4 provides a summary of the quality scores given for each research paper, with a total possible score of 20 (a full list of questions, and scores for each question, can be seen in Appendix 1-B and 1-C). The maximum score for risk of bias, study design and reporting quality were 6, 7 and 7 respectively. No papers were excluded based on their quality score; however, more weight was placed on the results of studies with superior quality scores, particularly their risk of bias scores, as recommended by The Cochrane Collaboration (Higgins & Green, 2011).

Scores varied considerably between papers and aspects of quality. Total quality score ranged from a lowest score of 7 to a highest of 17. The two studies with the lowest

overall quality scores (Ogińska-Bulik, 2006; Yousefy & Ghassemi, 2006) also scored poorly on risk of bias, with scores of 2 and 0 respectively. Risk of bias scores for all studies ranged from 1 to 4, study design quality from 3 to 6 and reporting quality from 2 to 7.

Participant Characteristics

A total of 4,095 staff were surveyed across all 17 studies, with samples ranging from 30 to 1,525. The mean ages of participants ranged from 30.9 to 48.6 years, with an average age across all studies of 38.9 years. Sixteen studies included both male and female staff, although the majority of the total sample were female (69%). One study's sample (Mathew, Ram, Bhattacharjee, & Sharma, 2013) was entirely female. The percentage of female participants for the remaining 16 studies ranged from 44.2% to 92.3%. The number and percentage of participants by professional backgrounds can be seen in Table 5.

Measurement of Burnout

All 17 studies used self-report questionnaires to measure burnout, and the specific measures utilised in each study can be seen in Table 3. Of note, two different versions of the Maslach Burnout Inventory (MBI; Maslach et al., 1996) were utilised. Nine studies used the MBI-HSS (Human Services Survey), designed for use with human services personnel, and three studies chose the MBI-GS (General Survey), designed for use with employees working outside of human services or education. Both versions measure burnout across three domains: emotional exhaustion (EE), depersonalisation (DP) and personal accomplishment (PA) for the MBI-HSS, and emotional exhaustion (EE), cynicism (Cy) and professional efficacy (PE) for the MBI-GS. The former is comprised of 22 questions, whilst the latter uses 16. None of the authors provided justification for their choice of the MBI-GS as opposed to the MBI-HSS. High scores on EE and DP/Cy, and low scores on PA/PE indicate high levels of burnout.

Two studies utilised the Copenhagen Burnout Inventory (CBI), developed by

Kristensen et al. (2005) in response to concerns about the wide-spread use of the MBI in burnout research. The CBI measures burnout across three domains: personal burnout, work-related burnout, and client-related burnout, consisting of six, seven and six items respectively. Scores can range from 0 – 100, and the authors suggest that scores of 50 – 74 suggest moderate burnout, and scores of 75 – 100 indicate high/severe burnout.

Two studies utilised the Professional Quality of Life Scale (ProQOL; Stamm, 2005), which measures professionals' quality of life across three domains: compassion satisfaction, burnout and compassion fatigue/secondary trauma. For the purposes of this review, scores on, and factors related to, the burnout domain were considered. Burnout is assessed on the ProQOL with 10 questions; the manual suggests that scores of over 22 indicate the presence of burnout (Stamm, 2005).

The final study utilised the Burnout Clinical Subtypes Questionnaire (BCSQ-12; Montero-Marín, Skapinakis, Araya, Gili, & García-Campayo, 2011), a measure created to differentiate between different manifestations of burnout, that develop dependent on how dedicated a person is to their job. It proposes three sub-types of burnout: 'frenetic', characterised by individuals who are highly involved, ambitious and over-worked; 'underchallenged', in which individuals are indifferent, bored and do not find personal development in their work; and 'worn-out', where the rigidity of the organisational structure means that individuals feel a lack of control and recognition for their efforts, therefore neglecting their responsibilities.

Prevalence of Burnout

Of the 12 studies that utilised the MBI, 10 reported mean scores and standard deviations for EE, DP/Cy and PA/PE. Two studies (Ohnishi et al., 2010; Yang, Stone, Petrini, & Morris, 2018) divided the means by the number of questions in each domain. To make scores comparable to the remaining studies, the means were multiplied by the number

of questions to achieve a domain score.

Figures 3 – 5 outline the mean scores on EE, DP/Cy and PA/PE across the 10 studies that reported these figures. As the MBI-GS includes fewer questions, scores on the MBI-GS are lower and are therefore not directly comparable to the MBI-HSS. The three studies (Norio et al., 2017; Ohnishi et al., 2010; Yang et al., 2018) that used the MBI-GS are included at the beginning of the graphs.

Across the seven studies that utilised the MBI-HSS and reported mean scores, the average scores per domain were as follows: EE = 22.7, DP = 5.9 and PA = 31.1. Using the cut-offs for mental health workers outlined in the MBI manual, EE would be classified as high, and DP and PA as average. Similarly, the average scores of the three studies that used the MBI-GS were 13.9 for EE, 9.1 for Cy and 11.4 for PE, which equate to average levels of EE and Cy, and low levels of PA, which due to its inverse scoring indicates high burnout.

Of the five studies that did not use the MBI, only three reported mean burnout scores on the measures utilised. Mangoulia, Koukia, Alevizopoulos, Fildissis, and Katostaras (2015) utilised the ProQOL, and reported an average score on the burnout dimension of 25.2, with scores over 22 indicating burnout. Mathew et al. (2013), using the CBI, reported a total burnout score of 31.9 (client burnout = 28.2, personal burnout = 40.3, work burnout = 28.2), however they did not provide cut-off scores to determine if these findings were high, moderate or low. The final study (Velimirović, Vranko, Ferić, & Jendričko, 2017) utilised the BCSQ-12 and reported an average of 3.3 for frenetic, 2.6 for under-challenged and 2.7 for worn-out; they suggest that these scores indicate moderate levels of burnout, but it is unclear how this conclusion has been reached.

Measurement of Factors Related to Burnout

All 17 studies used self-report questionnaires to measure a range of demographic, staff and organisational factors related to burnout levels. A full outline of the factors

measured, and statistical analyses undertaken in each study can be seen in Appendix 1-D. None of the studies reported conducting a power analysis to justify the sample size. Summary tables of consistently significant staff and organisational factors can be seen in Tables 6 and 7.

Summary of Burnout Determinants

Initially, factors relevant to the development of burnout that are consistent amongst studies will be outlined, separated into two broad categories: staff factors and organisational factors (Tables 6 and 7). Secondly, inconsistent results will be reported, and the possible reasons for these inconsistencies explored. Size of the correlations and significance values will be considered throughout the synthesis.

Consistent Results: Staff Factors

Two studies (Bowers, Allan, Simpson, Jones, & Whittington, 2009; Verhaeghe et al., 2016) found positive staff attitudes to be significantly correlated to lower levels of burnout. In the case of Verhaeghe et al. (2016), this finding was in relation to overall burnout as measured on the ProQOL, and Bowers, Allan, et al. (2009) found positive attitudes to be highly correlated with EE, DP and PA. Within the revised JD-R model of burnout, attitudes can be considered a personal resource, with personal resources offsetting the effects of demanding conditions, reducing the chance of burnout developing (Schaufeli & Taris, 2014; Xanthopoulou et al., 2007). The findings related to attitudes appear to be in keeping with this revised model; that is, that positive attitudes (personal resource) are related to lower levels of burnout.

Again in keeping with this revised model, the studies in this review consistently found high levels of burnout to be correlated with poorer physical and mental health. Chakraborty, Chatterjee, and Chaudhury (2012) found that staff experiencing high levels of burnout scored more poorly on measures of physical well-being and global adjustment, and similarly, Norio

et al. (2017) found that staff who were experiencing high EE, DP and low PA were also experiencing higher levels of depression than their less burnt-out colleagues.

There were a number of staff factors that were only examined by singular studies, although the strength of the correlations provide justification for their inclusion here. Chakraborty et al. (2012) found emotional maturity to be highly correlated with lower levels of overall burnout, and locus of control was moderately correlated, factors which could be considered as personal resources. Similarly, Norio et al. (2017) found work-life conflict to be associated with higher levels of EE and DP, and although personal in nature, it is defined as an additional job demand by Schaufeli and Taris (2014).

Several studies also examined factors related to self-efficacy and organisational self-esteem, with the latter being defined as "the degree to which organizational members believe that they can satisfy their needs by participating in roles within the context of an organization" (Pierce, Gardner, Cummings, & Dunham, 1989, p. 625). Professional self-doubt, role ambiguity and role conflict were all found to be related to higher levels of EE and DP, and in the case of the latter two, also reduced PA (Jenkins & Elliott, 2004; Konstantinou, Bonotis, Sokratous, Siokas, & Dardiotis, 2018). All these findings appear to support the role of personal resources in the development of burnout, as conceptualised in the revised JD-R model (Schaufeli & Taris, 2014; Xanthopoulou et al., 2007).

Consistent Results: Organisational Factors

All four studies (Hamaideh, 2011; Jenkins & Elliott, 2004; Konstantinou et al., 2018; Mangoulia et al., 2015) that examined social support found it to be significantly correlated with burnout. Konstantinou et al. (2018) reported some of their largest correlations to be between satisfaction with professional support and EE ($r = -.602$) and PA ($r = -.679$); Hamaideh (2011) also found higher levels of social support to be related to lower DP and higher PA. When examining specific types of support, Jenkins and Elliott (2004) found a

relationship between support from co-workers and lower EE, but interestingly no relationship between support from supervisors, partners/spouse or friends and relatives and any aspect of burnout. They also found conflict with other professionals to be highly correlated with EE and DP, perhaps suggesting that relationships with co-workers and within teams is a significant influencing factor of the development of burnout. Mangoulia et al. (2015) supports this view, reporting the frequency of team work and relationships with colleagues to be significant predictors of burnout amongst their sample. Given the consistency of results, and moderate to high quality scores across studies, it can be concluded that social support, and particularly relationships with colleagues, have particular relevance when considering factors related to the development of burnout.

Three studies found the ward climate to be significantly associated with levels of burnout. Bowers, Allan, et al. (2009) found that a positive ward atmosphere, specifically the order and organisation of the ward, and programme clarity (including clarity of routines and rules) were associated with lower EE and DP and higher PA. The same relationship was found with team vision (team members sharing clear values and objectives), whilst support for innovation was associated with lower DP. Task orientation (the team's concern for high-quality work) was related to lower EE and DP, but had no relationship with PA. In support of these findings, Jenkins and Elliott (2004) found organisational structures and processes to be significantly correlated with EE, and Hanrahan, Aiken, McClaine, and Hanlon (2010) reported that a positively rated nursing environment was associated with lower levels of EE and DP, although none of the elements were associated with PA. More specifically, nurses' ability to participate in hospital affairs, high quality of care and leadership skill were all associated with lower EE and DP. Taken as a whole, it appears the ward climate/nursing environment shares a significant relationship with burnout levels, with a more positively rated environment being associated with lower EE and DP, and in some cases higher PA.

All three studies that examined the impact of workplace violence found the prevalence of workplace violence to be related to higher levels of EE and DP (Bowers, Allan, et al., 2009; Hamaideh, 2011; Yang et al., 2018). Interestingly, none of the studies found a relationship between violence and reduced PA, suggesting that staff still gained satisfaction from their work even when experiencing violence. All studies found similar correlations for verbal aggression, physical aggression and sexual harassment, with no one type of violence being noticeably more related to burnout. Given the agreement amongst the results, and the high quality scores across all studies, it is safe to conclude that staff that experience work-place violence (of any type) are likely to experience higher levels of EE and DP.

The impact of caseload on burnout levels was examined by five studies (Hamaideh, 2011; Jenkins & Elliott, 2004; Konstantinou et al., 2018; Norio et al., 2017; Ogińska-Bulik, 2006), with all but one finding higher caseloads to be significantly related to higher EE. Perhaps surprisingly, Hamaideh (2011) reported that nurses with a lower caseload experienced higher levels of EE but also reduced PA. However, this correlation was relatively weak, and on further examination, caseload was measured based on the ward participants worked on (acute vs chronic), where acute wards had fewer patients than chronic wards. It may be, therefore, that nurses on acute wards experienced higher EE due to factors unrelated to caseload, such as high turnover or short length of admissions. Two studies also found a relationship between larger caseloads and higher DP (Konstantinou et al., 2018; Norio et al., 2017), and in one study reduced PA (Konstantinou et al., 2018). Given the consistency in findings across the remaining studies, and when considering models of burnout, it appears safe to conclude that higher caseloads (job demands) are associated with an increase in levels of EE, and in some cases DP and reduced PA, corresponding with the JD-R model of burnout (Demerouti et al., 2001).

Inconsistent Results: Staff Factors

There was inconsistency in the reported results when examining staff demographics such as age, gender, qualification level, length of working experience and ethnicity. Significant correlations were found in some studies but then were insignificant in others, or correlations were reported in opposing directions (e.g. some studies report younger staff to be more burnt-out, whilst others report the opposite finding). These inconsistencies may be explained by the differing way these variables were measured, with some studies using continuous variables, whilst others broke participants into categories or bands (e.g. under 30 or over 30). The inconsistencies related to gender were compounded by poor reporting; Laker et al. (2012) reported a significant difference in burnout levels between men and women but failed to specify which gender was experiencing higher burnout. Similarly, Hamaideh (2011) reported their results inconsistently, once referring to females experiencing higher EE, and later reporting this finding as relating to males. Both of the authors were contacted for clarification of these results; however, no reply was received. Given the lack of consistent findings across these domains, it is difficult to draw firm conclusions on the influence of demographic factors on levels of burnout.

Inconsistent Results: Organisational Factors

There was contradictory evidence for the relationship between job satisfaction and burnout levels, with one study (Mathew et al., 2013) finding no relationship. However, the remaining two studies (Hamaideh, 2011; Konstantinou et al., 2018) found that staff who reported being more satisfied with their job were experiencing lower EE, DP and higher PA. The JD-R suggests that job satisfaction is impacted when job demands are high and job resources are low (Demerouti et al., 2001; Schaufeli & Taris, 2014), and the staff sampled in Mathew et al.'s (2013) study were generally experiencing low levels of burnout, perhaps suggesting low levels of job demands and/or high levels of job resources. This is in contrast

to the remaining two studies, whose samples were experiencing high levels of emotional exhaustion, and therefore likely high job demands and/or low job resources, perhaps explaining why job satisfaction was significantly correlated in these circumstances.

There was also a lack of agreement when comparing burnout levels between psychiatric staff and physical health staff, with Mathew et al. (2013) reporting higher levels of burnout in physical health staff. However, they acknowledge that the psychiatric staff in their sample experience higher pay and other benefits when compared to physical health nurses, due to the set-up of services in India, which may impact their experience of burnout. In contrast, both Sahraian et al. (2008) and Yousefy and Ghassemi (2006) concluded the psychiatric staff were more burnt-out than their physical health colleagues. Due to the moderate to poor quality scores across studies, and the relatively few studies that compared staff groups, it is difficult to draw conclusions on the differences in levels of burnout in physical and mental health staff.

Discussion

Summary of Findings

This review sought to examine the prevalence of burnout amongst staff in mental health inpatient wards across international settings, whilst considering the factors related to the development of burnout. Of the ten studies that utilised the MBI, 70% reported overall levels of EE that would be classed as high. Only 20% of studies reported high DP, whilst 40% of studies reported reduced PA amongst their sample. The average scores on EE (22.7), DP (5.9) and PA (31.1) across studies are strikingly similar to those found by O'Connor et al. (2018); their review of burnout prevalence in mental health staff across a variety of settings reported average scores of 21.5, 6.82, and 34.1 on EE, DP and PA respectively (with DP and PA being slightly lower in the current research). When compared to the general population

these levels appear to be high; Shanafelt et al. (2012) reported that within the general population, 23.4% were experiencing high EE, and 14.8% high DP.

These findings also differ from those of the previous review by Richards et al. (2006); using their chosen cut-offs, only 8% of included studies indicated high EE, 15% reported high DP, and 62% of studies indicated reduced PA, and they concluded that burnout was generally low amongst their sample. However, Richards et al. (2006) utilised the general cut-offs in the MBI manual, rather than those specific to mental health staff. The general cut-offs have a higher threshold for 'high' burnout; when their findings are adjusted to reflect the cut-offs used in the current research, 46% of studies reported high EE, 38% reported high DP, and only 8% reported reduced PA. The current review found higher levels of EE, slightly lower levels of DP, and higher levels of reduced PA. The impact of the choice of cut-offs on the interpretation of results is stark and will be discussed further in the theoretical limitations. Of note, Richards et al. (2006) failed to report which version of the MBI was used in each included study. As highlighted previously, the MBI-GS has fewer questions and therefore lower overall scores and is not directly comparable to the MBI-HSS. It is unclear whether this issue was taken into consideration in the previous review.

These findings, however, perhaps support the notion that PA is a separate construct not directly related to EE and DP, and that it can remain relatively high even in the face of high EE and/or DP. This supports the findings of Paris and Hoge (2010), who argued that staff who are emotionally exhausted are still able to emotionally connect with clients, and gain a sense of achievement from their work. This current review would support that opinion, as although 70% of studies reported high EE, the reported levels of DP and reduced PA were significantly lower. Comparing the findings with Richard et al.'s (2006) review perhaps suggests that mental health inpatient staff are suffering from higher levels of burnout, particularly EE and reduced PA, than was reported in 2006.

The factors related to burnout were considered across two broad domains: staff factors and organisational factors. There were a number of factors that were found to be consistently and significantly related to burnout. Within staff factors, positive attitudes, better physical and mental health, emotional maturity and locus of control were all found to be correlated with lower levels of burnout. As for organisational factors, better social support, and particularly relationships with colleagues, a more positive ward climate, and less frequent work-place violence and lower caseload were all consistently related to lower levels of burnout. These significant factors align with the original and revised JD-R model of burnout (Demerouti et al., 2001; Schaufeli & Taris, 2014; Xanthopoulou et al., 2007), i.e. high job demands (e.g. caseload, violence), low job resources (social support, ward climate) and low personal resources (attitudes, emotional maturity, locus of control) lead to the development of burnout.

Methodological Limitations

The quality of the papers included in this review widely varied, with three studies achieving a score of less than 10 (out of 20) on the quality assessment. Of particular concern were the poor risk of bias scores, of which only three studies scored 4 or above (out of a possible 6). One paper had to be removed from the analysis due to obvious errors in its application and scoring of the MBI (Ashtari et al., 2009).

None of the papers reported power analyses, meaning that it is hard to determine whether studies were sufficiently powered to detect meaningful results. Similarly, some studies did not report the results of all correlations, choosing to report only the results of certain factors and domains. Whilst this may suggest that these missing correlations are non-significant, without the reasons being documented, it is hard to conclude which factors are most relevant to the development of burnout.

The heterogeneity of the factors related to burnout that were examined across the included studies may have hindered the drawing of conclusions. Some factors were only measured and examined by single studies, and although the evidence from the individual studies seems strong, it is hard to conclude the relevance of these factors when the results are not reported in other investigations. Where this has occurred, the quality and sample size of the study was considered, to decide if weight can be placed on the findings of one study alone. For example, family-work conflict was only examined by Norio et al. (2017), but the strength of the correlations (r = .501 - .708), and the high quality score of 17, justified the inclusion in the results.

Theoretical Limitations

Whilst there is evidence in this review to support prior models of burnout, there are also some limitations. Thirteen studies used some form of the MBI, which conceptualises burnout to be constructed of three separate, but linked domains (EE, DP and PA). The widespread utilisation of the MBI in burnout research has been criticised, with an estimated 93% of journal articles using the MBI to measure burnout (Doulougeri, Georganta, & Montgomery, 2016). Critics have highlighted the circular nature of the definition and measurement of burnout; that is, that the model outlined by Maslach and colleagues informed the development of the MBI, and the MBI measures that model (Kristensen et al., 2005). And whilst their confirmatory factor analysis appears to support the theory that three distinct dimensions together form burnout (Cordes & Dougherty, 1993; Poghosyan, Aiken, & Sloane, 2009; Worley, Vassar, Wheeler, & Barnes, 2008), a number of authors have found high levels of EE without associated increases in DP or decreases in PA (See Paris & Hoge, 2010, for a review). Most commonly, evidence points towards PA being a separate, independent construct, not automatically impacted by high EE and/or DP (Paris & Hoge, 2010; Worley et al., 2008). The results from this review may support that notion, with the majority of studies

reporting EE to be high whilst DP and PA remaining average. This suggests that even when staff feel emotionally exhausted and fatigued, they are still able to emotionally connect to clients and gain a sense of achievement from their work.

Relating to this, researchers have raised concerns about the validity of using the cut-off values in the MBI manual to determine the presence of burnout (Doulougeri et al., 2016). The authors of the MBI have argued that the tool was developed for use in research, and not as a diagnostic instrument, and have gone so far as to remove the cut-off values from the most recent, 4th edition, of the manual (Maslach, Jackson, & Leiter, 2017). However, this has not prevented researchers from widely using cut-off values to determine the prevalence of burnout. In fact, five studies in the current review referred to the specific cut-off values they utilised to determine whether participants were experiencing high, moderate or low degrees of burnout. Perhaps confusingly, Version 3 of the MBI manual (Maslach et al., 1996) outlines two sets of cut-off scores: general cut-off points included in the questionnaire and cut-off scores based on normative data from a sample of mental health staff. The studies included in this review varied in their choice of cut-offs, with some using the general data and others using the mental health specific data. The choice of cut-off values can have an impact on the interpretation of results and estimations of burnout prevalence, as highlighted in the comparison between this review and that of Richards et al. (2006). And whilst this review acknowledges the concerns about diagnostic validity, it has chosen to use the normative data from the mental health sample as it is most relevant to the population being studied, in order to provide an estimate of prevalence. Caution must be applied in the interpretation of this data, however, given that cut-offs are by nature, arbitrary, and lack diagnostic validity.

An automatic limitation of examining correlations is the inability to establish causality. This is particularly relevant when examining internal staff factors, such as the

impact of staff holding negative attitudes, or having poor physical and/or mental health. It is unclear whether these factors are a contributor to burnout, or a consequence of being burnt-out, or both. It is difficult, therefore, to establish where interventions should be targeted, i.e. whether reducing burnout would improve attitudes/well-being, or whether improving attitudes/well-being would reduce burnout.

Clinical Implications

The significant findings in this review have implications for the prevention and/or reduction of burnout. The relatively high prevalence of burnout amongst the included studies highlights the importance of service commissioners and managers considering ways in which they can support their staff to reduce burnout amongst their workforce. Given that the findings of this review can be conceptualised as fitting within both the original and revised JD-R model of burnout (Demerouti et al., 2001; Schaufeli & Taris, 2014; Xanthopoulou et al., 2007), this may be a helpful model for services to adopt to understand how burnout develops. Within this model, both reducing job demands, and/or increasing job/personal resources have a positive impact on burnout, providing services with multiple areas for targeted intervention to improve staff well-being.

Staff's experience of the environment they work in is clearly important, with ward climate, organisation of the ward and programme clarity having a positive impact on burnout. Similarly, nurses' ability to participate in hospital affairs (e.g. involvement in policy making, visible leadership, development opportunities etc.) were also associated with lower levels of EE and DP. It could be argued that many of these factors are determined by the type and quality of the management/leadership, which was also associated with lower burnout levels. Visible, supportive and accessible management appears to be an important factor in preventing staff burnout.

Similarly, the consistent findings on social support being associated with lower burnout, and particularly relationships with colleagues, suggest this may be a helpful area for intervention. Peer support groups, reflective practice and team formulation may all help to provide staff with a sense of support and team working, all of which have been shown to be beneficial in this environment (Cleary, Horsfall, & Happell, 2010; Heneghan, Wright, & Watson, 2014; Johnstone, 2014; Mankiewicz, 2014). The adoption of one or more of these groups may help foster a sense of social support and encourage collaborative working, increasing job resources and reducing burnout.

Another consistently significant factor was the impact of work-place violence on burnout levels. Perhaps surprisingly, there appeared to be no discernible difference in the impact between types of violence, with verbal aggression, physical aggression and sexual harassment all having the same detrimental effect on burnout. Whilst it is more common for violence to occur in this environment than in community settings (O'Rourke, Wrigley, & Hammond, 2018), models and approaches have been specifically designed to attempt to reduce violent behaviour. Approaches such as Positive Behavioural Support (PBS; Repp & Singh, 1990), Reinforce Appropriate, Implode Disruptive (RAID; Davies, 2001) and Safewards (Bowers, 2014) all aim to alter staff's response to challenging behaviour to allow patients to feel heard and understood, reducing the need for them to act violently to communicate their needs. Whilst directly attempting to reduce violence (a job demand), these approaches may also provide staff with structure, programme clarity and a sense of team working (job resources) and were shown to be beneficial to burnout in this review.

Conclusion

This review aimed to assess the prevalence of burnout in inpatient mental health wards, whilst also determining the factors related to the development of burnout. Eight databases were systematically searched, eliciting 18 relevant studies; one was excluded due

to its misuse and scoring of the MBI. The findings of these studies were synthesised, and relevant findings reported.

Results from included studies suggested that the levels of emotional exhaustion amongst staff in this environment were high, whilst depersonalisation and personal accomplishment were average. The prevalence of burnout in the current review was higher than that of the general population (Lindblom et al., 2006; Norlund et al., 2010; Shanafelt et al., 2012), but similar to that found in mental health staff working across a variety of settings (O'Connor et al., 2018).

A number of staff and organisational factors were found to be important in the development of burnout, particularly personal resources such as attitudes, emotional maturity and locus of control, job resources such as social support, ward climate, leadership and programme clarity, and job demands such as caseload and violence. These findings were discussed in the context of models of burnout, and areas for intervention were suggested. However, the nature of correlational research means it is difficult to determine causality; longitudinal research examining the impact of staff and organisational factors over time is required. Similarly, research examining the effectiveness of the outlined interventions on reducing burnout levels would be of benefit.

References

Aarons, G. A., & Sawitzky, A. C. (2006). Organizational climate partially mediates the effect of culture on work attitudes and staff turnover in mental health services. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(3), 289-301. doi:10.1007/s10488-006-0039-1

Ahola, K., Väänänen, A., Koskinen, A., Kouvonen, A., & Shirom, A. (2010). Burnout as a predictor of all-cause mortality among industrial employees: A 10-year prospective

register-linkage study. *Journal of Psychosomatic Research, 69*(1), 51-57. doi:10.1016/j.jpsychores.2010.01.002

Aiken, L. H., Sermeus, W., Van den Heede, K., Sloane, D. M., Busse, R., McKee, M., . . . Kutney-Lee, A. (2012). Patient safety, satisfaction, and quality of hospital care: Cross sectional surveys of nurses and patients in 12 countries in europe and the united states. *BMJ, 344*, e1717. doi:10.1136/bmj.e1717

Ashtari, Z., Farhady, Y., & Khodaee, M. R. (2009). Relationship between job burnout and work performance in a sample of iranian mental health staff. *African Journal of Psychiatry, 12*(1), 71-74. doi:10.4314/ajpsy.v12i1.30282

Bowers, L. (2014). Safewards: A new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing, 21*(6), 499-508. doi:10.1111/jpm.12129

Bowers, L., Allan, T., Simpson, A., Jones, J., & Whittington, R. (2009). Morale is high in acute inpatient psychiatry. *Social Psychiatry and Psychiatric Epidemiology, 44*(1), 39-46. doi:10.1007/s00127-008-0396-z

Bowers, L., Chaplin, R., Quirk, A., & Lelliott, P. (2009). A conceptual model of the aims and functions of acute inpatient psychiatry. *Journal of Mental Health, 18*(4), 316-325. doi:10.1080/09638230802053359

Bowers, L., Simpson, A., Eyres, S., Nijman, H., Hall, C., Grange, A., & Phillips, L. (2006). Serious untoward incidents and their aftermath in acute inpatient psychiatry: The Tompkins Acute Ward Study. *International Journal of Mental Health Nursing, 15*(4), 226-234. doi:10.1111/j.1447-0349.2006.00428.x

Chakraborty, R., Chatterjee, A., & Chaudhury, S. (2012). Internal predictors of burnout in psychiatric nurses: An indian study. *Industrial Psychiatry Journal, 21*(2), 119-124. doi:10.4103/0972-6748.119604

Cherniss, C. (1980). *Staff burnout: Job stress in the human services*. London: Sage Publications.

Cleary, M., Horsfall, J., & Happell, B. (2010). Establishing clinical supervision in acute mental health inpatient units: Acknowledging the challenges. *Issues in Mental Health Nursing, 31*(8), 525-531. doi:10.3109/01612841003650546

Cordes, C. L., & Dougherty, T. W. (1993). A review and an integration of research on job burnout. *The Academy of Management Review, 18*(4), 621-656. doi:10.2307/258593

Davies, W. (2001). *The RAID manual: A relentlessly positive approach to working with extreme behaviour*. Leicester: APT Press.

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The Job Demands-Resources model of burnout. *Journal of Applied Psychology, 86*(3), 499-512. doi:10.1037/0021-9010.86.3.499

Dewa, C. S., Loong, D., Bonato, S., & Trojanowski, L. (2017). The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: A systematic review. *BMJ open, 7*(6), e015141. doi:10.1136/bmjopen-2016-015141

Doulougeri, K., Georganta, K., & Montgomery, A. (2016). "Diagnosing" burnout among healthcare professionals: Can we find consensus? *Cogent Medicine, 3*(1), 1. doi:10.1080/2331205X.2016.1237605

Downes, M. J., Brennan, M. L., Williams, H. C., & Dean, R. S. (2016). Development of a critical appraisal tool to assess the quality of cross-sectional studies (AXIS). *BMJ open, 6*(12), e011458. doi:10.1136/bmjopen-2016-011458

Eriksen, W., Bruusgaard, D., & Knardahl, S. (2003). Work factors as predictors of sickness absence: A three month prospective study of nurses' aides. *Occupational and Environmental Medicine, 60*(4), 271. doi:10.1136/oem.60.4.271

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues, 30*(1), 159-165. doi:doi:10.1111/j.1540-4560.1974.tb00706.x

Hall, L. H., Johnson, J., Watt, I., Tsipa, A., & O'Connor, D. B. (2016). Healthcare staff wellbeing, burnout, and patient safety: A systematic review. *PLoS ONE, 11*(7), e0159015. doi:10.1371/journal.pone.0159015

Hamaideh, S. H. (2011). Burnout, social support, and job satisfaction among jordanian mental health nurses. *Issues in Mental Health Nursing, 32*(4), 234-242. doi:10.3109/01612840.2010.546494

Hanrahan, N. P., Aiken, L. H., McClaine, L., & Hanlon, A. L. (2010). Relationship between psychiatric nurse work environments and nurse burnout in acute care general hospitals. *Issues in Mental Health Nursing, 31*(3), 198-207. doi:10.3109/01612840903200068

Heneghan, C., Wright, J., & Watson, G. (2014). Clinical psychologists' experiences of reflective staff groups in inpatient psychiatric settings: A mixed methods study. *Clinical Psychology & Psychotherapy, 21*(4), 324-340. doi:10.1002/cpp.1834

Higgins, J., & Green, S. (Eds.). (2011). *Cochrane handbook for systematic reviews of interventions* (5.1.0 ed.): The Cochrane Collaboration.

Hunt, P. A., Denieffe, S., & Gooney, M. (2017). Burnout and its relationship to empathy in nursing: A review of the literature. *Journal of Research in Nursing, 22*(1-2), 7-22. doi:10.1177/1744987116678902

Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: Nurses in acute mental health settings. *Journal of Advanced Nursing, 48*(6), 622-631. doi:10.1111/j.1365-2648.2004.03240.x

Johnson, J., Hall, L. H., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes,

implications, and recommendations for future interventions. *International Journal of Mental Health Nursing, 27*(1), 20-32. doi:10.1111/inm.12416

Johnson, S., Osborn, D. P. J., Araya, R., Wearn, E., Paul, M., Stafford, M., . . . Wood, S. J. (2012). Morale in the english mental health workforce: Questionnaire survey. *The British Journal of Psychiatry, 201*(3), 239-246. doi:10.1192/bjp.bp.111.098970

Johnstone, L. (2014). Using formulation in teams. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy: Making sense of people's problems* (2nd ed., pp. 216-242). London: Routledge.

Katrak, P., Bialocerkowski, A. E., Massy-Westropp, N., Kumar, S., & Grimmer, K. A. (2004). A systematic review of the content of critical appraisal tools. *BMC medical research methodology, 4*, 22.

Konstantinou, A.-K., Bonotis, K., Sokratous, M., Siokas, V., & Dardiotis, E. (2018). Burnout evaluation and potential predictors in a greek cohort of mental health nurses. *Archives of Psychiatric Nursing*. doi:10.1016/j.apnu.2018.01.002

Kristensen, T. S., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work & Stress, 19*(3), 192-207. doi:10.1080/02678370500297720

Laker, C., Rose, D., Flach, C., Csipke, E., McCrone, P., Craig, T., . . . Wykes, T. (2012). Views of the therapeutic environment (vote): Stakeholder involvement in measuring staff perceptions of acute in-patient care. *International Journal of Nursing Studies, 49*(11), 1403-1410. doi:10.1016/j.ijnurstu.2012.06.001

Lindblom, K., Linton, S., Fedeli, C., & Bryngelsson, I.-L. (2006). Burnout in the working population: Relations to psychosocial work factors. *International Journal of Behavioral Medicine, 13*(1), 51-59. doi:10.1207/s15327558ijbm1301_7

Madathil, R., Heck, N. C., & Schuldberg, D. (2014). Burnout in psychiatric nursing: Examining the interplay of autonomy, leadership style, and depressive symptoms. *Archives of psychiatric nursing, 28*(3), 160-166.

Mangoulia, P., Koukia, E., Alevizopoulos, G., Fildissis, G., & Katostaras, T. (2015). Prevalence of secondary traumatic stress among psychiatric nurses in Greece. *Archives of Psychiatric Nursing, 29*(5), 333-338. doi:10.1016/j.apnu.2015.06.001

Mankiewicz, P. D. (2014). Reflective practice on inpatient mental health wards (2/2): Evaluation of CBT-integrated reflective learning process. *British Journal of Healthcare Assistants, 8*(7), 346-351. doi:10.12968/bjha.2014.8.7.346

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior, 2*, 99-113.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *The Maslach Burnout Inventory manual* (3 ed.). Palo Alto: CA: Consulting Psychologists Press.

Maslach, C., Jackson, S. E., & Leiter, M. P. (2017). *The Maslach Burnout Inventory manual* (4 ed.). Palo Alto: CA: Consulting Psychologists Press.

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry, 15*(2), 103-111. doi:10.1002/wps.20311

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annu Rev Psychol, 52*, 397-422. doi:10.1146/annurev.psych.52.1.397

Mathew, J., Ram, D., Bhattacharjee, D., & Sharma, A. (2013). Self-esteem, job satisfaction and burnout between general and psychiatric nursing staff: A comparative study. *Journal of Health Management, 15*(4), 595-612. doi:10.1177/0972063413516232

Melamed, S., Shirom, A., Toker, S., Berliner, S., & Shapira, I. (2006). Burnout and risk of cardiovascular disease: Evidence, possible causal paths, and promising research

directions. *Psychological Bulletin, 132*(3), 327-353. doi:10.1037/0033-2909.132.3.327

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The prisma statement. *PLoS Med, 6*(7), e1000097. doi:10.1371/journal.pmed.1000097

Montero-Marín, J., Skapinakis, P., Araya, R., Gili, M., & García-Campayo, J. (2011). Towards a brief definition of burnout syndrome by subtypes: Development of the "Burnout Clinical Subtypes Questionnaire" (BCSQ-12). *Health and quality of life outcomes, 9*, 74-74. doi:10.1186/1477-7525-9-74

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(5), 341-352. doi:10.1007/s10488-011-0352-1

Moustaka, E., & Constantinidis, T. C. (2010). Sources and effects of work-related stress in nursing. *Health Science Journal, 4*(4), 210.

Munn, Z., Moola, S., Lisy, K., & Riitano, D. (2014). *The systematic review of prevalence and incidence data*. Retrieved from http://joannabriggs.org/assets/docs/sumari/ReviewersManual_The-Systematic-Review-of-Prevalence-and-Incidence-Data.pdf

NHS Digital. (2017). Sickness absence by staff group and organisation type, October 2016 to September 2017 supplementary information. https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/staff-absence/sickness-absence-by-staff-group-and-organisation-type-october-2016-to-september-2017-supplementary-information

NHS England. (2018). *NHS staff survey 2018*. Retrieved from http://www.nhsstaffsurveyresults.com/

Norio, S., Kazuma, D., Hanako, F., Yasushi, S., Tetsu, T., Akira, F., . . . Norio, Y.-F. (2017). Work-family conflict as a mediator between occupational stress and psychological health among mental health nurses in Japan. *Neuropsychiatric Disease & Treatment, 13*, 779-784. doi:10.2147/NDT.S127053

Norlund, S., Reuterwall, C., Höög, J., Lindahl, B., Janlert, U., & Birgander, L. S. (2010). Burnout, working conditions and gender - results from the northern Sweden MONICA study. *BMC Public Health, 10*(1), 326. doi:10.1186/1471-2458-10-326

O'Rourke, M., Wrigley, C., & Hammond, S. (2018). Violence within mental health services: How to enhance risk management. *Risk management and healthcare policy, 11*, 159-167. doi:10.2147/RMHP.S131834

O'Connor, K., Muller Neff, D., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry, 53*, 74-99. doi:https://doi.org/10.1016/j.eurpsy.2018.06.003

Ogińska-Bulik, N. (2006). Occupational stress and its consequences in healthcare professionals: The role of Type D personality. *International Journal of Occupational Medicine & Environmental Health, 19*(2), 113-122. doi:10.2478/v10001-006-0016-7

Ohnishi, K., Ohgushi, Y., Nakano, M., Fujii, H., Tanaka, H., Kitaoka, K., . . . Narita, Y. (2010). Moral distress experienced by psychiatric nurses in Japan. *Nurs Ethics, 17*(6), 726-740. doi:10.1177/0969733010379178

Panagioti, M., Geraghty, K., Johnson, J., Zhou, A., Panagopoulou, E., Chew-Graham, C., . . . Esmail, A. (2018). Association between physician burnout and patient safety, professionalism, and patient satisfaction: A systematic review and meta-analysis. *JAMA Internal Medicine, 178*(10), 1317-1330. doi:10.1001/jamainternmed.2018.3713

Paris, M., & Hoge, M. A. (2010). Burnout in the mental health workforce: A review. *The Journal of Behavioral Health Services & Research, 37*(4), 519-528. doi:10.1007/s11414-009-9202-2

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., . . . UnüTzer, J. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet, 392*(10157), 1553-1598. doi:10.1016/S0140-6736(18)31612-X

Peterson, U., Demerouti, E., Bergström, G., Samuelsson, M., Åsberg, M., & Nygren, Å. (2008). Burnout and physical and mental health among Swedish healthcare workers. *Journal of Advanced Nursing, 62*(1), 84-95. doi:10.1111/j.1365-2648.2007.04580.x

Pierce, J. L., Gardner, D. G., Cummings, L. L., & Dunham, R. B. (1989). Organization-based self-esteem: Construct definition, measurement, and validation. *The Academy of Management Journal, 32*(3), 622-648. doi:10.2307/256437

Poghosyan, L., Aiken, L. H., & Sloane, D. M. (2009). Factor structure of the Maslach Burnout Inventory: An analysis of data from large scale cross-sectional surveys of nurses from eight countries. *International Journal of Nursing Studies, 46*(7), 894-902. doi:10.1016/j.ijnurstu.2009.03.004

Repp, A. C., & Singh, N. N. (1990). *Perspectives on the use of nonaversive and aversive interventions for persons with developmental disabilities*. Sycamore, IL, US: Sycamore Publishing Company.

Richards, D. A., Bee, P., Barkham, M., Gilbody, S. M., Cahill, J., & Glanville, J. (2006). The prevalence of nursing staff stress on adult acute psychiatric in-patient wards: A systematic review. *Social Psychiatry and Psychiatric Epidemiology, 41*(1), 34-43. doi:10.1007/s00127-005-0998-7

Rössler, W. (2012). Stress, burnout, and job dissatisfaction in mental health workers. *European Archives of Psychiatry & Clinical Neuroscience, 262*(2), 65-69. doi:10.1007/s00406-012-0353-4

Royal College of Psychiatrists. (2016). *Old problems, new solutions: Improving acute psychiatric care for adults in England*. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/old_problems_new_solutions_caapc_report_england.pdf?sfvrsn=610ebd71_2

Sahraian, A., Fazelzadeh, A., Mehdizadeh, A. R., & Toobaee, S. H. (2008). Burnout in hospital nurses: A comparison of internal, surgery, psychiatry and burns wards. *International Nursing Review, 55*(1), 62-67. doi:10.1111/j.1466-7657.2007.00582.x

Salvagioni, D. A. J., Melanda, F. N., Mesas, A. E., González, A. D., Gabani, F. L., & Andrade, S. M. d. (2017). Physical, psychological and occupational consequences of job burnout: A systematic review of prospective studies. *PLoS ONE, 12*(10), e0185781. doi:10.1371/journal.pone.0185781

Sanderson, S., Tatt, I. D., & Higgins, J. P. T. (2007). Tools for assessing quality and susceptibility to bias in observational studies in epidemiology: A systematic review and annotated bibliography. *International Journal of Epidemiology, 36*(3), 666-676. doi:10.1093/ije/dym018

Schaufeli, W. B., & Taris, T. W. (2014). A critical review of the Job Demands-Resources model: Implications for improving work and health. In *Bridging occupational, organizational and public health: A transdisciplinary approach* (pp. 43-68). Dordrecht: Springer Netherlands.

Shanafelt, T. D., Boone, S., Tan, L., Dyrbye, L. N., Sotile, W., Satele, D., . . . Oreskovich, M. R. (2012). Burnout and satisfaction with work-life balance among US physicians

relative to the general US population. *Archives Of Internal Medicine, 172*(18), 1377-1385.

Stamm, B. H. (2005). *The ProQOL manual. The professional quality of life scale: Compassion satisfaction, burnout & compassion fatigue/secondary trauma scales*. Retrieved from http://compassionfatigue.org/pages/ProQOLManualOct05.pdf

Stroup, D. F., Berlin, J. A., Morton, S. C., Olkin, I., Williamson, G. D., Rennie, D., . . . Thacker, S. B. (2000). Meta-analysis of observational studies in epidemiology: A proposal for reporting. Meta-analysis of observational studies in epidemiology (MOOSE) group. *The Journal of the American Medical Association, 283*(15), 2008-2012.

Velimirović, I., Vranko, M., Ferić, M., & Jendričko, T. (2017). Burnout syndrome in mental health professionals: Psychiatric hospital setting. *Alcoholism and Psychiatry Research, Journal on Psychiatric Research and Addictions, 53*(2), 123-138. doi:10.20471/dec.2017.53.02.03

Verhaeghe, S., Duprez, V., Beeckman, D., Leys, J., Van Meijel, B., & Van Hecke, A. (2016). Mental health nurses' attitudes and perceived self-efficacy toward inpatient aggression: A cross-sectional study of associations with nurse-related characteristics. *Perspectives in Psychiatric Care, 52*(1), 12-24. doi:10.1111/ppc.12097

Vigo, D. V., Kestel, D., Pendakur, K., Thornicroft, G., & Atun, R. (2019). Disease burden and government spending on mental, neurological, and substance use disorders, and self-harm: Cross-sectional, ecological study of health system response in the americas. *The Lancet Public Health, 4*(2), e89-e96. doi:https://doi.org/10.1016/S2468-2667(18)30203-2

Wilkinson, H., Whittington, R., Perry, L., & Eames, C. (2017). Examining the relationship between burnout and empathy in healthcare professionals: A systematic review. *Burnout Research, 6*, 18-29. doi:10.1016/j.burn.2017.06.003

Worley, J. A., Vassar, M., Wheeler, D. L., & Barnes, L. L. B. (2008). Factor structure of scores from the Maslach Burnout Inventory:A review and meta-analysis of 45 exploratory and confirmatory factor-analytic studies. *Educational and Psychological Measurement, 68*(5), 797-823. doi:10.1177/0013164408315268

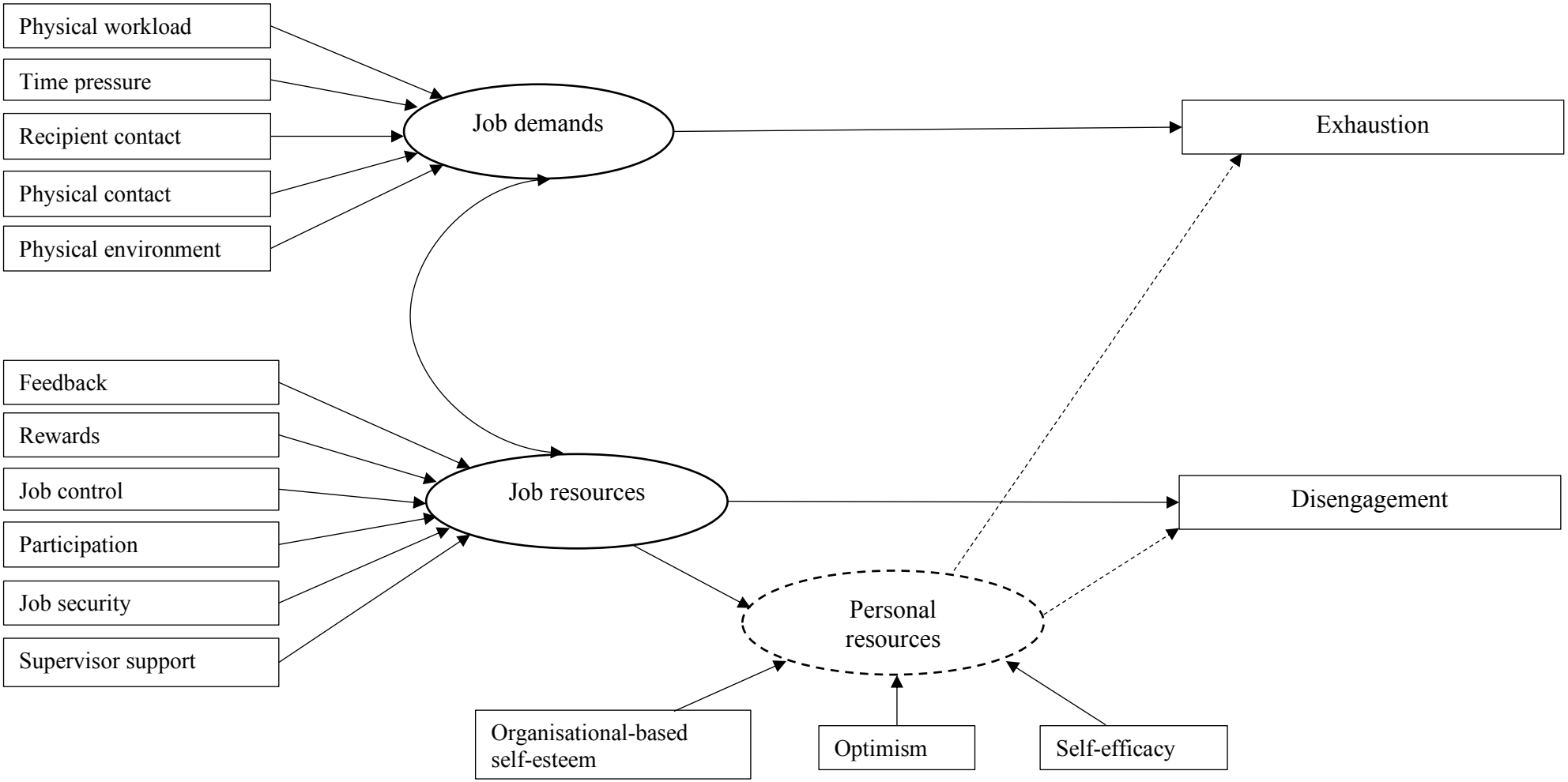
Wyder, M., Ehrlich, C., Crompton, D., McArthur, L., Delaforce, C., Dziopa, F., . . . Powell, E. (2017). Nurses experiences of delivering care in acute inpatient mental health settings: A narrative synthesis of the literature. In (Vol. 26, pp. 527-540).

Xanthopoulou, D., Bakker, A. B., Demerouti, E., & Schaufeli, W. B. (2007). The role of personal resources in the Job Demands-Resources model. *International Journal of Stress Management, 14*(2), 121-141. doi:10.1037/1072-5245.14.2.121

Yang, B. X., Stone, T. E., Petrini, M. A., & Morris, D. L. (2018). Incidence, type, related factors, and effect of workplace violence on mental health nurses: A cross-sectional survey. *Archives of Psychiatric Nursing, 32*(1), 31-38. doi:10.1016/j.apnu.2017.09.013

Yousefy, A. R., & Ghassemi, G. R. (2006). Job burnout in psychiatric and medical nurses in isfahan, islamic republic of iran. *Eastern Mediterranean Health Journal, 12*(5), 662-669.

Figure 1. Diagram of the Job Demands-Resources Model (Demerouti et al., 2001), with the addition of personal resources as outlined in the revised Job Demands-Resources Model (Schaufeli & Taris, 2014; Xanthopoulou et al., 2007).



Note. Discontinuous line indicates mediating effect of personal resources.

Table 1. Descriptions of the aspects of burnout, by model.

Aspect of burnout	Description
Maslach and Jackson (1981)	
Emotional exhaustion	As emotional resources are depleted, the worker feels they are no longer able to give of themselves at a psychological level.
Depersonalisation	The development of negative, cynical attitudes and feelings about one's clients.
Reduced personal accomplishment	The tendency to evaluate one's self negatively, particularly with regard to one's work with clients.
Demerouti et al. (2001)	
Exhaustion	Extreme job demands lead to constant overtaxing, and in the end, to exhaustion.
Disengagement	A lack of resources, unable to meet job demands, leads to withdrawal and disengagement from work.
Kristensen et al. (2005)	
Personal burnout	The degree of physical and psychological fatigue and exhaustion experienced by a person.
Work-related burnout	The degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his or her work.
Client-related burnout	The degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his or her work with clients.

Table 2. Inclusion and exclusion criteria utilised for all search results.

Inclusion criteria	Exclusion criteria
English language.	No English translation available.
Peer reviewed journal.	Unpublished theses, dissertations, opinion pieces.
Published between 1st January 2004 and 22nd November 2018.	Published prior to 2004.
Quantitative analysis.	Qualitative analysis.
Staff on inpatient mental health wards, or mixed settings (community and inpatient) if inpatient data is extractable.	Community staff, staff working on wards with other client groups e.g. learning disability, dementia, drug and alcohol etc. Setting or the nature of the ward ambiguous. Inpatient data not extractable.
Staff from any professional background, if they have clinical contact with service users.	Staff who do not have a clinical aspect to their role (e.g. administrative staff).
Utilised a standardised, validated measure of burnout e.g. MBI, CBI, ProQOL.	Does not utilise a measure of burnout or uses an unvalidated measure.
Examines factors related to burnout.	Does not examine factors related to burnout.

Figure 2. Flowchart of the inclusion/exclusion process for all studies.

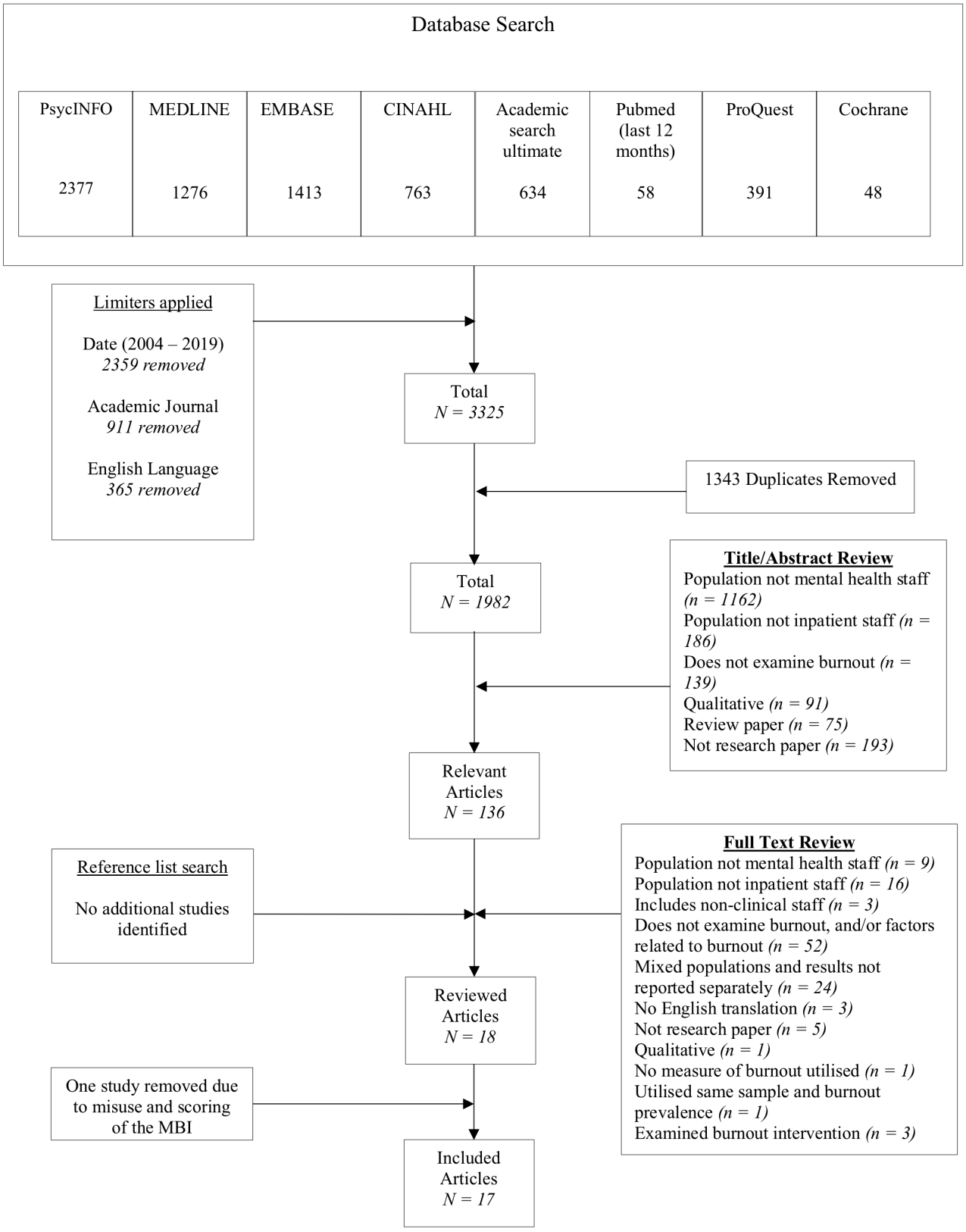


Table 3. Description of the 17 included studies

Study	Design	City and country	Study population	Response rate (%)	Sample size and characteristics	Burnout measure	EE mean (SD)	DP mean (SD)	PA mean (SD)	Comments
Bowers et al. (2009a)	CS	UK wide	MHPs on 136 wards at 67 hospitals	56%	N = 1525 Male: 34% Female: 66% Mean age: NR White: 68%	MBI	17.78 (11.39)	5.49 (5.09)	35.46 (8.16)	Significantly lower EE, DP and higher PA than US human service norms. Lower EE and DP than 1993 acute ward study.
Chakraborty et al. (2012)	CS	India	Nurses in 2 psychiatric hospitals	NR	N = 101 Male: 15.8% Female: 84.2% Mean age: 44 years	CBI	NR	NR	NR	Total burnout not reported
Hamaideh (2011)	CS	Jordan	Nurses on inpatient mental health wards	82.2%	N = 181 Male: 55.8% Female: 44.2% Mean age: 30.9 years	MBI	23.96 (13.91)	6.98 (7.07)	31.58 (11.52)	
Hanrahan et al. (2010)	CS	Penns, USA	Nurses from psychiatric wards in general hospitals	52%	N = 353 Male: 7.7% Female: 92.3% Mean age: 45 years	MBI	20.8 (12.1)	4.81 (4.8)	37.4 (7.5)	
Jenkins and Elliott (2004)	CS	London & SE, UK	Nurses on acute mental health wards	39%	N = 93 Male: 33.3% Female: 66.7% Mean age: 37.1 years	MBI	NR	NR	NR	EE, DP and PA means not reported

Study	Design	City and country	Study population	Response rate (%)	Sample size and characteristics	Burnout measure	EE mean (SD)	DP mean (SD)	PA mean (SD)	Comments
Konstantinou et al. (2018)	CS	Greece	Nurses from 4 psychiatric hospitals	33.6%	N = 93 Male: 28.2% Female: 71.5% Mean age: NR	MBI	26.9 (13.9)	8.04 (6.9)	10.68 (8.9)*	* score reversed for PA, therefore high PA = high burnout
Laker et al. (2012)	CS	London, UK	Nursing staff from acute wards	NR	N = 245 Male: 45% Female: 47% Mean age: 39 (9.6)	MBI	NR	NR	NR	
Mangoulia et al. (2015)	CS	Athens, Greece	Nurses working at 3 hospitals	59.0%	N = 174 Male: 29.9% Female: 70.1% Mean age: 36.87 (7.37)	ProQOL	Overall burnout score: 25.15 (.94)			Scores above 22 = burnout
Mathew et al. (2013)	CS	Ranchi, India	Psychiatric nurses vs physical health nurses	Selected (NR)	N = 30 (psych) Male: 0% Female: 100% Mean age: 37.1 years Nurse: 100%	CBI	Client burnout 28.19 (17.3)	Personal burnout 40.27 (14.1)	Work burnout 28.19 (16.6)	Psychiatric nurses had lower burnout than general nurses.
Norio et al. (2017)	CS	Japan	Nursing staff, 3 psychiatric hospitals and 4 general hospitals	74.8%	N = 180 Male: 22.8% Female: 77.2% Mean age: 48.6 (11.5)	MBI-GS	**Ex** 14.0 (8.0)	**Cy** 10.1 (7.3)	**PE** 11.6 (6.1)	
Ogińska-Bulik (2006)	CS	Lodz, Poland	Healthcare workers in mental hospital		N = 79 Male: 31.6% Female: 68.4% Mean age: 39.71 (8.02)	MBI	21.67 (12.84)	4.54 (5.21)	29.77 (9.01)	

Study	Design	City and country	Study population	Response rate (%)	Sample size and characteristics	Burnout measure	EE mean (SD)	DP mean (SD)	PA mean (SD)	Comments
Ohnishi et al. (2010)	CS	Japan	Nurses in 6 hospitals	73.9%	N = 264 Male: 25.8 Female: 73.1 Mean age: 39.1	MBI-GS	**Ex** 3.52 (1.53)	**Cy** 2.57 (1.62)	**PE** 1.60 (1.11)	
Sahraian et al. (2008)	CS	Shiraz, Iran	Nurses on psychiatric ward compared to burn, surgery, internal medicine wards	100%	N = 45 (psychiatric) Male: 48.9% Female: 51.1% Mean age: NR	MBI	26.93 (4.75)	6.87 (0.66)	30.36 (1.18)	Nurses on psychiatric ward had significantly higher BO then all other wards.
Velimirović et al. (2017)	CS	Zagreb, Croatia	Mixed staff from psychiatric hospital		N = 141 Male: 31.9% Female: 68.1% Mean age: 38.98	BCSQ-12	Frenet. 3.31	Under chall. 2.57	Worn out 2.72	Reports low-moderate stress at work, but unclear how this assumption has been reached.
Verhaeghe et al. (2016)	CS	Belgium	Nurses at psychiatric hospital	Sampled	N=291 Male: 23.7% Female: 72.6% Mean age: 41.23 (11.43)	ProQOL	NR	NR	NR	
Yang et al. (2018)	CS	China	Nurses at psychiatric hospital	Sampled – 81.7% of pop	N = 245 Male: 33.2% Female: 66.8% Mean age: 31.4 (7.43) NR: 15.7%	MBI-GS	**Ex** 1.99 (1.25)	**Cy** 1.24 (1.24)	**PE** 2.18 (1.21)	

Study	Design	City and country	Study population	Response rate (%)	Sample size and characteristics	Burnout measure	EE mean (SD)	DP mean (SD)	PA mean (SD)	Comments
Yousefy and Ghassemi (2006)	CS	Isfahan, Iran	Nurses from psychiatric hospital compared to general nurses	Sampled - NR	N = 55 (psychiatric) Male: 43.6% Female: 56.4% Mean age: 35 (4.6)	MBI	21.07 (8.87)	4.38 (5.10)	15.87 (11.63)	Psychiatric nurses had significantly higher EE. No difference in DP or PA.

Note. CS = cross-sectional, EE = emotional exhaustion, DP = depersonalisation, PA = personal accomplishment, Ex = exhaustion, Cy = cynicism, PE = professional efficacy, Frenet. = frenetic, under chall. = under-challenged.

Table 4. Summary of quality assessment scores for each study.

Study	Design	Risk of bias score (Max = 6)	Study design score (Max = 7)	Reporting quality score (Max = 7)	Total quality score (Max = 20)
Bowers et al. (2009a)	CS	4	6	7	17
Chakraborty et al. (2012)	CS	2	4	6	12
Hamaideh (2011)	CS	3	6	7	16
Hanrahan et al. (2010)	CS	4	5	7	16
Jenkins and Elliott (2004)	CS	2	6	7	15
Konstantinou et al. (2018)	CS	2	5	4	11
Laker et al. (2012)	CS	2	5	6	13
Mangoulia et al. (2015)	CS	2	6	6	14
Mathew et al. (2013)	CS	2	3	6	11
Norio et al. (2017)	CS	4	6	7	17
Ogińska-Bulik (2006)	CS	2	3	2	7
Ohnishi et al. (2010)	CS	3	6	6	15
Sahraian et al. (2008)	CS	2	4	5	11
Velimirović et al. (2017)	CS	1	5	2	8
Verhaeghe et al. (2016)	CS	3	6	6	15
Yang et al. (2018)	CS	3	6	7	16
Yousefy and Ghassemi (2006)	CS	0	3	4	7

Note. Quality was assessed using AXIS (Downes et al., 2016). Full scores for each question can be seen in Appendix 1-B. CS = cross-sectional.

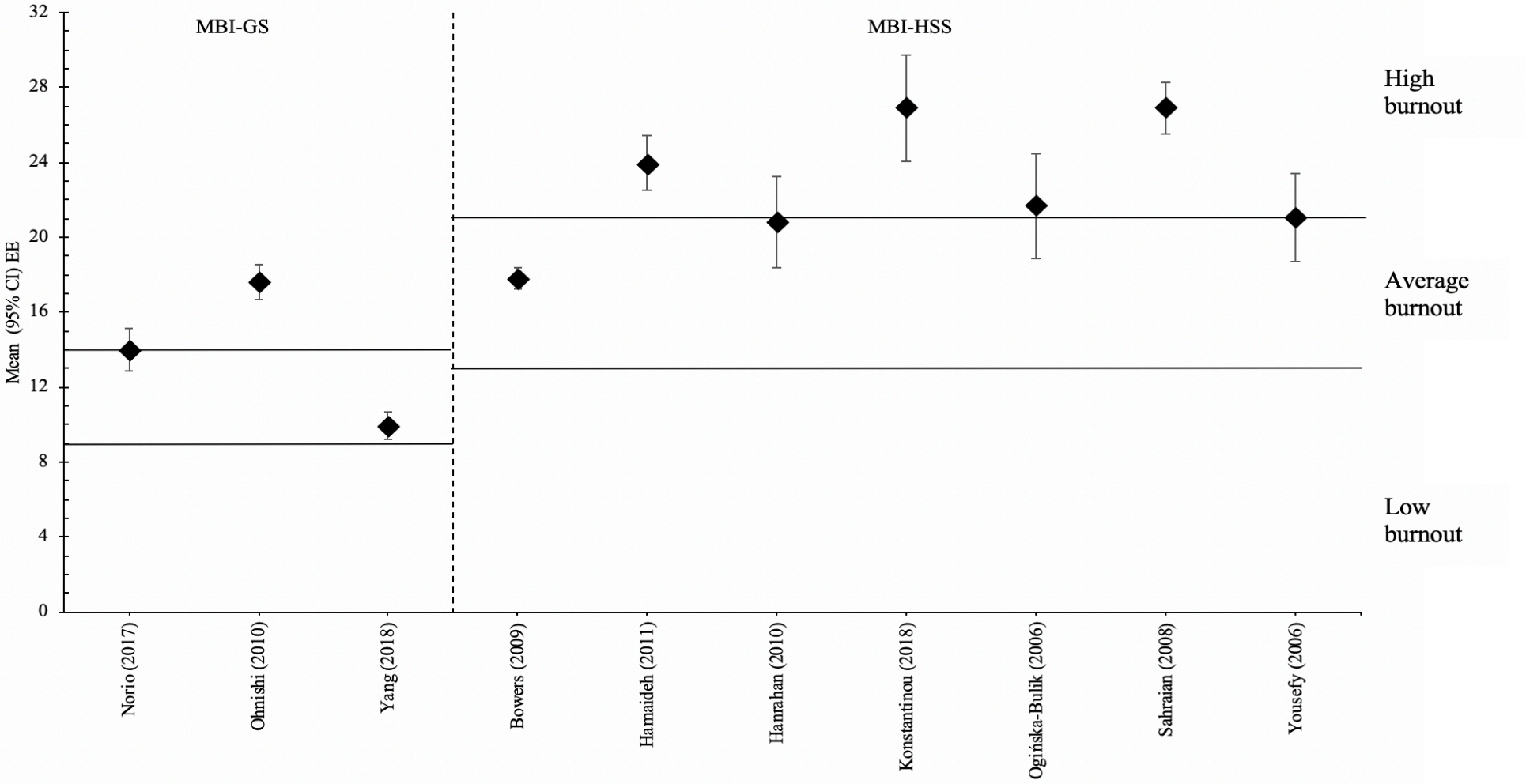
Table 5. Number and percentage of participants by profession.

Study	Sample size	Nurse (unspecified)	Qualified nurse	Charge nurse	Team leader	Health care assistant	Psychiatrist	Occupational therapist	Other/ unspecified
Bowers et al. (2009a)	1525	0	1022 (67%)	0	0	442 (67%)	0	0	61 (4%)
Chakraborty et al. (2012)	101	101 (100%)	0	0	0	0	0	0	0
Hamaideh (2011)	181	181 (100%)	0	0	0	0	0	0	0
Hanrahan et al. (2010)	353	353 (100%)	0	0	0	0	0	0	0
Jenkins and Elliott (2004)	93	0	57 (61.3%)	0	0	36 (38.7%)	0	0	0
Konstantinou et al. (2018)	93	0	43 (46.2%)	0	0	50 (53.8%)	0	0	0
Laker et al. (2012)	245	0	100 (41%)	44 (18%)	17 (7%)	72 (29%)	0	0	0
Mangoulia et al. (2015)	174	0	89 (51.2%)	0	0	85 (48.8%)	0	0	0
Mathew et al. (2013)	30	30 (100%)	0	0	0	0	0	0	0
Norio et al. (2017)	180	180 (100%)	0	0	0	0	0	0	0
Ogińska-Bulik (2006)	79	28 (35.4%)	0	0	0	0	51 (64.6%)	0	0
Ohnishi et al. (2010)	264	0	181 (68.6%)	0	0	80 (30.3%)	0	0	3 (1.1%)
Sahraian et al. (2008)	45	45 (100%)	0	0	0	0	0	0	0

Study	Sample size	Nurse (unspecified)	Qualified nurse	Charge nurse	Team leader	Health care assistant	Psychiatrist	Occupational therapist	Other/ unspecified
Velimirović et al. (2017)	141	0	76 (53.0%)	0	0	35 (24.8%)	10 (7.1%)	5 (3.5%)	15 (10.6%)
Verhaeghe et al. (2016)	291	291 (100%)	0	0	0	0	0	0	0
Yang et al. (2018)	290	0	113 (46.7%)	91 (37.6%)	38 (15.7%)	0	0	0	0
Yousefy and Ghassemi (2006)	55	55 (100%)	0	0	0	0	0	0	0
Total	4095	1265 (30.9%)	1681 (41.1%)	135 (3.3%)	55 (1.3%)	800 (19.5%)	61 (1.5%)	5 (0.1%)	94 (2.3%)

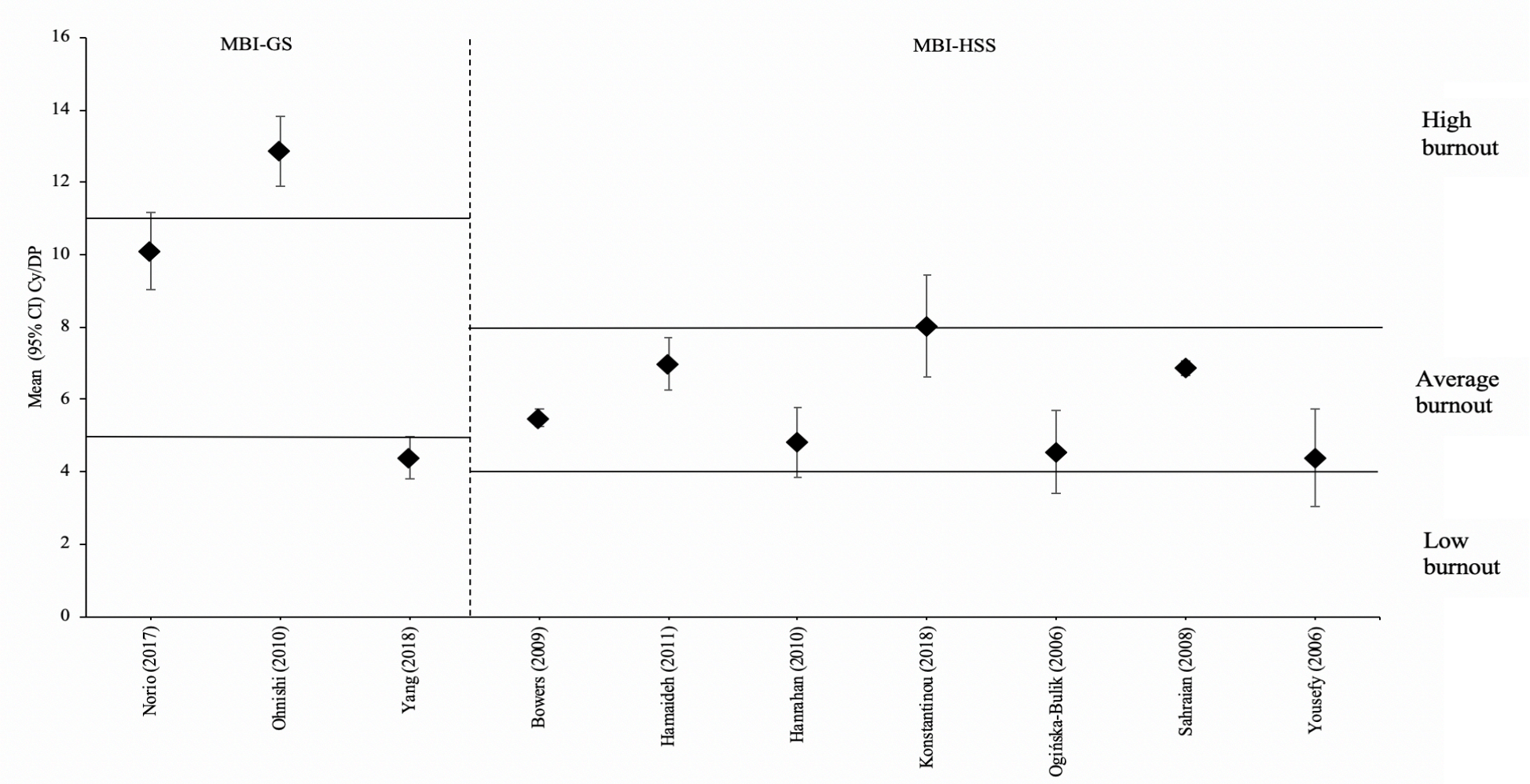
Note. 'Nurse (unspecified)' includes nursing staff but whose specific role/qualification level was not reported. 'Other/unspecified' includes participants for whom their profession was not specified, as well as professions that were specified but the exact breakdown of numbers/percentages was not provided, e.g. psychologists, social workers etc.

Figure 3. Emotional exhaustion means and confidence intervals across studies



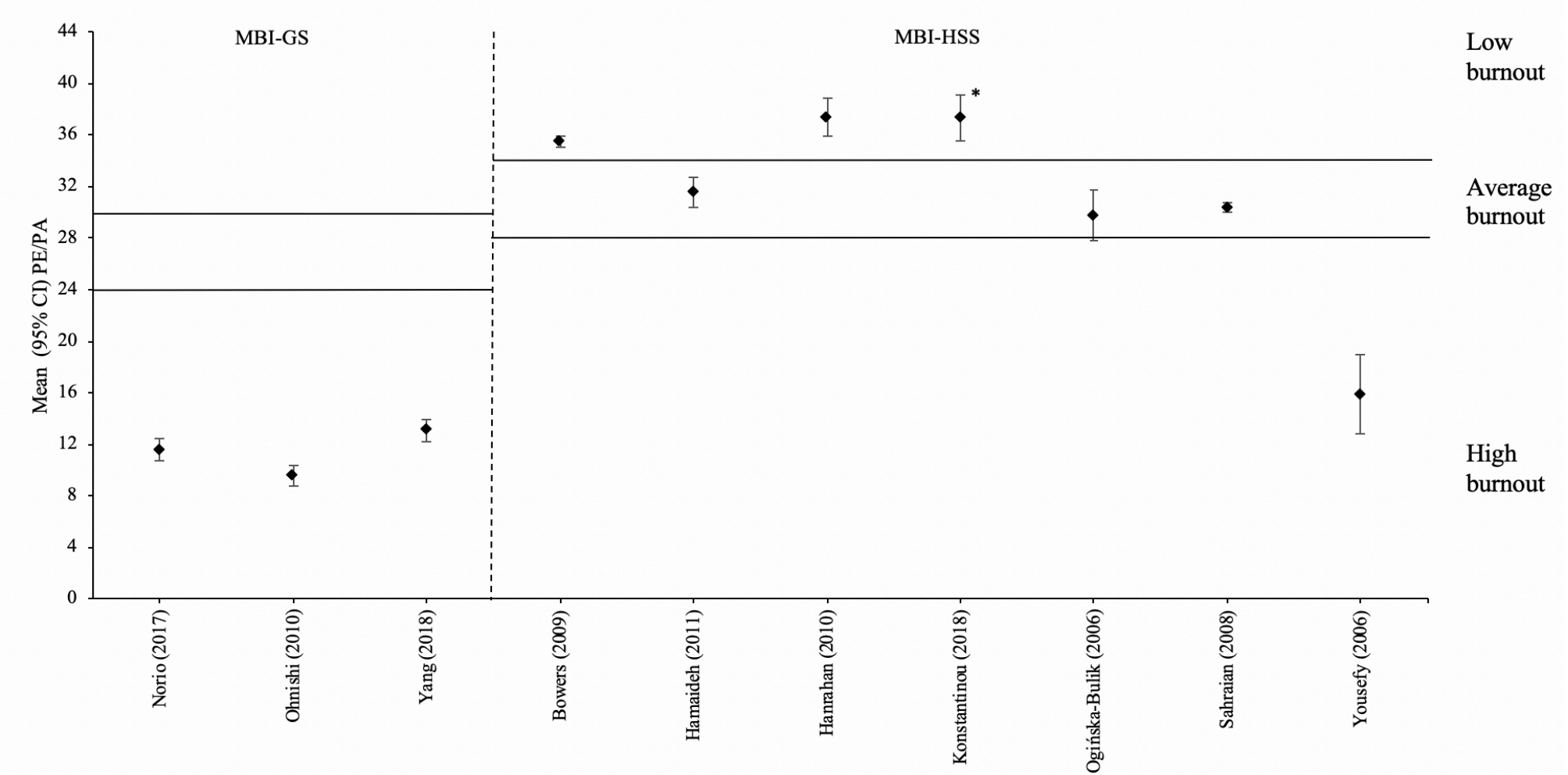
Note. The cut off values used are those based on the normative scores for mental health workers included in the MBI manual (Maslach et al., 1996).

Figure 4. Depersonalisation/Cynicism means and confidence intervals across studies



Note. The cut off values used are those based on the normative scores for mental health workers included in the MBI manual (Maslach et al., 1996).

Figure 5. Personal accomplishment/Professional efficacy means and confidence intervals across studies



Note: * = scores had been reversed for PA in this study, so high PA = high burnout. The scores were re-reversed in this review to ensure they were comparable to the remaining studies. The cut off values used are those based on the normative scores for mental health workers included in the MBI manual (Maslach et al., 1996).

Table 6. Staff factors consistently reported as significant across studies.

Staff factor	Study	Measure (if used) and specific items/domains	EE	DP	PA	Total burnout
Attitudes	Bowers et al. (2009)	**Attitudes to Personality Disorder Questionnaire (APDQ)**				
		APDQ enjoyment	r = -.198*	r = -.227**	r = .302***	
		APDQ security	r = -.327***	r = -.273**	r = .234**	
		APDQ acceptance	r = -.311***	r = -.346***	r = .357***	
		APDQ purpose	r = NS	r = -.176*	r = .335***	
		APDQ enthusiasm	r = -.363***	r = -.344***	r = .371***	
	Verhaeghe et al. (2016)	**Attitude Towards Aggressive Behaviour Questionnaire (ATABQ)**				
		Total score				r = -.149*
		Patient attribution and responsibility for aggression				r = -.148*
Physical and mental health	Chakraborty et al. (2012)	**Global adjustment scale**				
		Total adjustment score				r = .511***
		PGI general well-being scale				
		Well-being score				r = -.403***
	Norio et al. (2017)	**Centre for Epidemiological Studies for Depression Scale**				
		Total CES-D score	r = .586***	r = .548***	r = -.212**	
Self-efficacy & organisational self-esteem	Jenkins and Elliott (2004)	**Mental Health Professional Stress Scale**				
		Professionals self-doubt	r = .38***	r = .40***		
	Konstantinou et al. (2018)	**Role Conflict Scale**				
		Role conflict	r = .605	r = .409	r = .412	

Staff factor	Study	Measure (if used) and specific items/domains	EE	DP	PA	Total burnout
		Role Ambiguity Scale				
		Role ambiguity	r = .411	r = .275	r = .497	
Emotional maturity	Chakraborty et al. (2012)	**Emotional maturity scale**				
		Total emotional maturity score				r = -.554***
Locus of control	Chakraborty et al. (2012)	**Locus of control scale**				
		Total LoC score				r = -.280**
Work-family conflict	Norio et al. (2017)	**Family Conflict Scale**				
		Work interference with family	r = .708***	r = .585***		
		Family interference with work	r = .503***	r = .501***		

Note. Only significant correlations have been included in this table. For a full list of significant and non-significant correlations, see Appendix 1-D. EE = emotional exhaustion, DP = depersonalisation, PA = personal accomplishment. * $p < .05$, ** $p < .01$, *** $p < .001$

Table 7. Organisational factors consistently reported as significant across studies.

Organisational Factor	Study	Measure (if used) and specific items/domains	EE	DP	PA	Total burnout
Social support	Hamaideh (2011)	**Social support scale**	r = -.280**	r = -.301**	r = .172*	
		Social support score				
	Jenkins and Elliott (2004)	**Social support subscale**				
		Support from co-workers	r = -.32**			
		Total social support score	r = -.28**			
	Konstantinou et al. (2018)	**Measure of Job Satisfaction**				
		Satisfaction with professional support	r = -.602	r = -.313	r = -.679	
	Mangoulia et al. (2015)	Staff work as a team most time (vs all the time)				β = 2.362*
		Staff work as a team sometimes (vs all the time)				β = 3.299 *
		Very good relationships with colleagues (yes vs no)				F = 7.40***
Ward climate	Bowers et al. (2009)	**Ward Atmosphere Scale**				
		WAS order and organisation	r = -.212*	r = -.295**	r = .290**	
		WAS program clarity	r = -.227**	r = -.245**	r = .251**	
		Team Climate Inventory				
		TCI support for innovation		r = -.266**		
		TCI vision	r = -.201*	r = -.251**	r = .190*	
		TCI task orientation	r = -.172*	r = -.225**		
	Hanrahan et al. (2010)	**Practice Environment Scale – Nurse Work Index**				
		Participation in hospital affairs	r = -.15**	r = -.12*		
		Foundations for quality of care	r = -.11***	r = -.19*		
		Manager skill at leadership	r = -.20***	r = -.13*		
		Nurse-physician relationship	r = -.21***	r = -.12*		
		Composite score of PES-NWI	r = -.26***	r = -.16***		

Organisational Factor	Study	Measure (if used) and specific items/domains	EE	DP	PA	Total burnout
	Jenkins and Elliott (2004)	**Mental Health Professional Stress Scale**				
		Organisational structure and processes	r = .42***			
Work place violence	Bowers et al. (2009)	**Conflict (rate per 24h)**				
		Verbal aggression	r = .219*	r = .253**		
		Physical aggression against objects	r = .211*	r = .218*		
		Physical aggression against others	r = .221*	r = .187*		
	Hamaideh (2011)	Experience of physical assault	r = -.353**	r = -.261**		
		Experience of verbal assault	r = -.272**	r = -.220**		
	Yang et al. (2018)	**Workplace Violence Questionnaire**				
		Annual frequency of work-place violence	r = .365***	r = .290***		
		Annual frequency of verbal aggression	r = .368***	r = .265**		
		Annual frequency of sexual harassment	r = .253***	r = .179***		
		Annual frequency of physical attack	r = .294***	r = .244***		

Note. Only significant correlations have been included in this table. For a full list of significant and non-significant correlations, see Appendix 1-D. EE = emotional exhaustion, DP = depersonalisation, PA = personal accomplishment. * $p < .05$, ** $p < .01$, *** $p < .001$

Appendix 1-A

Table A1. Search terms used for each database

Database		Search terms
PsychINFO MEDLINE CINAHL Cochrane Library	#1	MeSH burnout, professional OR MeSH occupational stress OR MeSH morale OR MeSH compassion fatigue
		OR
	#2	AB: "compassion fatigue" OR burnout OR burn-out OR "occupational stress" OR organi?ation* stress
		OR
	#3	TI: "compassion fatigue" OR 'burnout' OR 'burn-out' OR "occupational stress" OR organi?ation* stress
	#4	#1 OR #2 OR #3
	#5	MeSH 'hospitals, psychiatric' OR MeSH 'psychiatric nursing'
		OR
	#6	AB: 'acute mental health' OR 'psychiatric' OR 'inpatient' OR 'asylum'
		OR
	#7	TI: 'acute mental health' OR 'psychiatric' OR 'inpatient' OR 'asylum'
	#8	#5 OR #6 OR #7
	#9	#4 AND #8
Academic Search Ultimate	#1	DE 'job stress' OR DE 'morale OR DE 'secondary traumatic stress'
		OR
	#2	AB "compassion fatigue" OR burn-out OR burnout OR morale OR "occupational stress" OR "organi?ation* stress"
		OR
	#3	TI "compassion fatigue" OR burn-out OR burnout OR morale OR "occupational stress" OR "organi?ation* stress"
	#4	#1 OR #2 OR #3
	#5	

		DE psychiatric nurses OR DE psychiatric hospital care OR DE psychiatric hospitals
	#6	OR
		AB "acute mental health" OR psychiatric OR inpatient OR asylum
		OR
	#7	TI "acute mental health" OR psychiatric OR inpatient OR asylum
	#8	#5 OR #6 OR #7
	#9	#4 AND #8
Pubmed	#1	MeSH burnout, professional OR MeSH professional burnout OR MeSH morale
		OR
	#2	AB "compassion fatigue" OR burn-out OR burnout OR morale OR "occupational stress" OR "organi?ation* stress"
		OR
	#3	TI "compassion fatigue" OR burn-out OR burnout OR morale OR "occupational stress" OR "organi?ation* stress"
	#4	#1 OR #2 OR #3
	#5	MeSH department, hospital psychiatric OR MeSH psychiatric hospital OR MeSH psychiatric nursing
		OR
	#6	AB "acute mental health" OR psychiatric OR inpatient OR asylum
		OR
	#7	TI "acute mental health" OR psychiatric OR inpatient OR asylum
	#8	#5 OR #6 OR #7
	#9	#4 AND #8
EMBASE	#1	SH burnout OR SH compassion fatigue OR SH job stress
		OR
	#2	AB "compassion fatigue" OR burn-out OR burnout OR morale OR "occupational stress" OR "organi?ation* stress"
		OR
	#3	TI "compassion fatigue" OR burn-out OR burnout OR morale OR "occupational stress" OR "organi?ation* stress"

	#4	#1 OR #2 OR #3
	#5	SH psychiatric nursing OR SH psychiatric hospital OR SH mental hospital
		OR
	#6	AB "acute mental health" OR psychiatric OR inpatient OR asylum
		OR
	#7	TI "acute mental health" OR psychiatric OR inpatient OR asylum
	#8	#5 OR #6 OR #7
	#9	#4 AND #8
PROQUEST	#1	SH occupational stress OR SH burnout
	#2	AB "compassion fatigue" OR burn-out OR burnout OR morale OR "occupational stress" OR "organi?ation* stress"
		OR
	#3	TI "compassion fatigue" OR burn-out OR burnout OR morale OR "occupational stress" OR "organi?ation* stress"
	#4	#1 OR #2 OR #3
	#5	SH psychiatric mental health nursing
		OR
	#6	AB "acute mental health" OR psychiatric OR inpatient OR asylum
		OR
	#7	TI "acute mental health" OR psychiatric OR inpatient OR asylum
	#8	#5 OR #6 OR #7
	#9	#4 AND #8

Appendix 1-B
AXIS quality assessment (Downes et al., 2016)

	Question	Yes	No	Don't know/ Comment
Introduction				
1	Were the aims/objectives of the study clear?			
Methods				
2	Was the study design appropriate for the stated aim(s)?			
3	Was the sample size justified?			
4	Was the target/reference population clearly defined? (Is it clear who the research was about?)			
5	Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?			
6	Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?			
7	Were measures undertaken to address and categorise non-responders?			
8	Were the risk factor and outcome variables measured appropriate to the aims of the study?			
9	Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?			
10	Is it clear what was used to determined statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)			
11	Were the methods (including statistical methods) sufficiently described to enable them to be repeated?			
Results				
12	Were the basic data adequately described?			
13	Does the response rate raise concerns about non-response bias?			
14	If appropriate, was information about non-responders described?			
15	Were the results internally consistent?			
16	Were the results presented for all the analyses described in the methods?			
Discussion				
17	Were the authors' discussions and conclusions justified by the results?			
18	Were the limitations of the study discussed?			
Other				
19	Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?			
20	Was ethical approval or consent of participants attained?			

Appendix 1-C

Table C1. Scores on each item of the quality assessment, per study.

		Question number																				
Study	Des	1	2	3	4	5	6	7	8	9	10	11	12	13 *	14	15	16	17	18	19 *	20	Total quality score
Bowers et al. (2009a)	CS	1	1	0	1	1	1	0	1	1	1	1	1	1	0	1	1	1	1	1	1	17
Chakraborty et al. (2012)	CS	1	1	0	1	0	0	0	1	1	1	1	1	0	0	1	1	1	0	1	0	12
Hamaideh (2011)	CS	1	1	0	1	1	1	0	1	1	1	1	1	1	0	0	1	1	1	1	1	16
Hanrahan et al. (2010)	CS	1	1	0	1	1	1	0	1	1	1	1	1	1	0	1	1	1	1	1	0	16
Jenkins and Elliott (2004)	CS	1	1	0	1	1	0	0	1	1	1	1	1	0	0	1	1	1	1	1	1	15
Konstantinou et al. (2018)	CS	1	1	0	1	1	0	0	1	1	0	0	1	0	0	1	0	0	1	1	1	11
Laker et al. (2012)	CS	1	1	0	1	0	0	0	1	1	1	1	0	0	0	1	1	1	1	1	1	13
Mangoulia et al. (2015)	CS	1	1	0	1	1	0	0	1	1	1	1	1	0	0	1	0	1	1	1	1	14
Mathew et al. (2013)	CS	1	1	0	1	0	0	0	1	1	1	1	1	0	0	1	1	0	0	1	0	11

		Question number																				
Study	Des	1	2	3	4	5	6	7	8	9	10	11	12	13 *	14	15	16	17	18	19 *	20	Total quality score
Norio et al. (2017)	CS	1	1	0	1	1	1	0	1	1	1	1	1	1	0	1	1	1	1	1	1	17
Ogińska-Bulik (2006)	CS	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	1	0	0	1	0	7
Ohnishi et al. (2010)	CS	1	1	0	1	1	1	0	1	0	1	1	1	1	0	1	1	1	0	1	1	15
Sahraian et al. (2008)	CS	1	1	0	1	1	0	0	1	0	1	0	1	1	0	1	1	0	0	0	1	11
Velimirović et al. (2017)	CS	1	1	0	1	1	0	0	1	1	0	0	0	0	0	0	0	1	0	1	0	8
Verhaeghe et al. (2016)	CS	1	1	0	1	1	0	1	1	1	1	1	0	0	0	1	1	1	1	1	1	15
Yang et al. (2018)	CS	1	1	0	1	1	0	0	1	1	1	1	1	1	0	1	1	1	1	1	1	16
Yousefy and Ghassemi (2006)	CS	1	1	0	1	1	0	0	1	0	1	0	0	0	0	0	1	0	0	0	0	7

Note. * donates that item is reversed scored.

Appendix 1-D

Table D1. Analyses of factors related to burnout across all studies

Study	Sample size	Measure of burnout	Analysis	Determinants	EE	DP	PA	Total burnout
Bowers et al. (2009a)	1525	MBI	Spearman's correlation	**Conflict (rate per 24h)**				
				Verbal aggression	r = .219*	r = .253**	r = NS	
				Physical aggression against objects	r = .211*	r = .218*	r = NS	
			Stepwise regression	Physical aggression against others	r = .221*	r = .187*	r = NS	
				Smoking in non-smoking area	r = NS	r = .213*	r = NS	
				Refusing to attend to personal hygiene	r = NS	r = .228**	r = NS	
				Refusing to get out of bed	r = NS	r = .217*	r = NS	
				Refusing to go to bed	r = NS	r = .200*	r = NS	
				Refused regular medication	r = NS	r = .255**	r = NS	
				Refused PRN medication	r = NS	r = .246**	r = NS	
				Staff demographics				
				Number of consultant psychiatrist locums	r = NS	r = NS	r = -.198*	
				Proportion of staff over 30 years of age	r = NS	r = -.233**	r = .201*	
				Proportion of staff white	r = NS	r = NS	r = -.193*	
				Proportion of staff African	r = NS	r = NS	r = .237**	
				Attitudes to Personality Disorder Questionnaire				
				APDQ enjoyment	r = -.198*	r = -.227**	r = .302***	
				APDQ security	r = -.327***	r = -.273**	r = .234**	
				APDQ acceptance	r = -.311***	r = -.346***	r = .357***	
				APDQ purpose	r = NS	r = -.176*	r = .335***	
				APDQ enthusiasm	r = -.363***	r = -.344***	r = .371***	
				Ward Atmosphere Scale				
				WAS order and organisation	r = -.212*	r = -.295**	r = .290**	
				Was program clarity	r = -.227**	r = -.245**	r = .251**	
				Team Climate Inventory				
				TCI support for innovation	r = NS	r = -.266**	r = NS	
				TCI vision	r = -.201*	r = -.251**	r = .190*	
				TCI task orientation	r = -.172*	r = -.225**	r = NS	
Chakraborty et al. (2012)	101	CBI	Pearson's and	**Staff demographics**				
				Age				r = -.236*

Study	Sample size	Measure of burnout	Analysis	Determinants	EE	DP	PA	Total burnout
			Spearman's correlation	Duration of total period of nursing				r = -.252*
				Duration of total period of psychiatric nursing				r = NS
				Education				r = NS
			Multiple linear (stepwise) regression	Duration of army service				r = -.332**
				Qualification level				r = NS
				Marital status				r = NS
				Family status				r = NS
				Emotional maturity scale				
				Total emotional maturity score				r = -.554***
				PGI general well-being scale				
				Well-being score				r = -.403***
				Locus of control scale				
				Total LoC score				r = -.280**
				Global adjustment scale				
				Total adjustment score				r = .511***
Hamaideh (2011)	181	MBI	Pearson's and Spearman's correlation	**Job satisfaction scale**				
				Job satisfaction score	r = -.313**	r = -.349**	r = .187*	
				Social support scale				
				Social support score	r = -.280**	r = -.301**	r = .172*	
				Staff demographics				
			Multiple linear (simultan.) regression	Age	r = NS	r = NS	r = .200**	
				Gender	r = -.186*	r = NS	r = -.167*	
				Participation in workshops	r = NS	r = NS	r = .202**	
				Marital status (single vs married)	β = .260**	NR	NR	
				Distance between home and work	β = .291**			
				Experience of physical assault	r = -.353**	r = -.261**	r = NS	
				Experience of verbal assault	r = -.272**	r = -.220**	r = NS	
				Intent to leave	r = -.282**	r = -.194**	r = .170*	
				Caseload	r = -.171*	r = NS	r = -.186*	
				Psychiatric experience	r = NS	r = NS	r = .195**	
				Stress level	r = .353**	r = .429**	r = -.265**	
Hanrahan et al. (2010)	353	MBI	Pearson's correlation	**Practice Environment Scale – Nurse Work Index**				
				Participation in hospital affairs	r = -.15**	r = -.12*	r = NS	
				Foundations for quality of care	r = -.11***	r = -.19*	r = NS	

Study	Sample size	Measure of burnout	Analysis	Determinants	EE	DP	PA	Total burnout
			General linear regression	Manager skill at leadership	r = -.20***	r = -.13*	r = NS	
				Nurse-physician relationship	r = -.21***	r = -.12*	r = NS	
				Patient to nurse staffing ratio	r = NS	r = NS	r = NS	
				Composite score of PES-NWI	r = -.26***	r = -.16***	r = NS	
Jenkins and Elliott (2004)	93	MBI	MANOVA, Mann-Whitney U & Chi-Squared (for differences between qualified & unqualified staff) Pearson's and Spearman's correlation Multiple linear (hierarchical) regression	**Mental Health Professional Stress Scale**				Note: Correlations significant at .05 level not highlighted.
				Workload	r = .51***	r = NS	r = NS	
				Client-related difficulties	r = .42***	r = .39***	r = NS	
				Organisational structure and processes	r = .42***	r = NS	r = NS	
				Relationships/conflicts with other professionals	r = .46***	r = .39***	r = NS	
				Lack of resources	r = NS	r = . NS	r = NS	
				Professionals self-doubt	r = .38***	r = .40***	r = NS	
				Home-work conflict	r = .46***	r = .33**	r = NS	
				Total MHPSS score	r = .60***	r = .43***	r = NS	
				Social support subscale				
				Support from supervisor	r = NS	r = NS	r = NS	
				Support from co-workers	r = -.32**	r = NS	r = NS	
				Support from spouse/partner	r = NS	r = NS	r = NS	
				Support from friends & relatives	r = NS	r = NS	r = NS	
				Total social support score	r = -.28**	r = NS	r = NS	
Konstantinou et al. (2018)	93	MBI	t-tests & ANOVA (for comparison between groups) Multiple regression (type unspecified)	**Role Conflict Scale**	(sig NR)	(sig NR)	(sig NR)	Note: No significance levels reported.
				Role conflict	r = .605	r = .409	r = .412	
				Role Ambiguity Scale				
				Role ambiguity	r = .411	r = .275	r = .497	
				Organisational Commitment Revised Scale				
				Affective commitment	r = -.389	r = -.249	r = -.439	
				Continuance commitment	r = -.209	r = -.137	r = -.225	
				Normative commitment	r = -.220	r = -.118	r = -.220	
				Measure of Job Satisfaction				
				Personal satisfaction	r = -.569	r = -.302	r = -.553	

Study	Sample size	Measure of burnout	Analysis	Determinants	EE	DP	PA	Total burnout
				Satisfaction with professional support	r = -.602	r = -.313	r = -.679	
				Satisfaction with workload	r = -.601	r = -.302	r = -.658	
				Satisfaction with pay	r = -.368	r = -.154	r = -.312	
				Satisfaction with training	r = -.567	r = -.289	r = -.502	
				Satisfaction with standard of care	r = -.357	r = -.184	r = -.305	
				Satisfaction with prospects	r = -.546	r = -.268	r = -.594	
Laker et al. (2012)	245	MBI	t-test (examining whether high/low VOTE scores indicated burnout)	**Staff Demographics**				
				Length of employment				r = NS
				Occupational status				r = .25**
				Education				r = NS
				Ethnicity				r = NS
				Country of birth				r = NS
				Gender				r = -.15*
				Age				r = -.18*
			Pearson's correlation	**VOTE scores (stressors in acute settings)**				
				VOTE total score				β = 0.44**
			Random effects regression analysis					
Mangoulia et al. (2015)	174	ProQOL	ANOVA, t-tests and non-parametric equivalent (Mann-Whitney U & Kruskal-Wallis)	**Staff demographics**				
				Working hours				β = -3.431*
				Years in the current position				β = -.181*
				Patient per nurse on night shift				β = -.250**
				Economic stress				β = 3.210**
				Would choose nursing profession again				β = -2.329**
				Experienced death of a loved one				β = -1.885*
				Married				β = 3.118**
				Master's degree				β = 5.560*
				Staff work as a team most time (vs all the time)				β = 2.362*
			Pearson's and	Staff work as a team sometimes (vs all the time)				β = 3.299 *
				Very good relationships with colleagues (yes vs no)				F = 7.40***

Study	Sample size	Measure of burnout	Analysis	Determinants	EE	DP	PA	Total burnout
			Spearman's correlation	Physical health good (vs excellent)				β = 4.057***
				Physical health average (vs excellent)				β = 5.069***
				Mental health average (vs excellent)				β = 4.416***
			Logistic and linear regression	**ProQOL**				
				Compassion Fatigue				r = .64***
				Compassion Satisfaction				r = -.60***
Mathew et al. (2013)	30	CBI	t-test & chi-squared (to compare psychiatric & general nurses)		Personal burnout	Work-burnout	Client-burnout	
				Staff Demographics				
				Age	r = NS	r = NS	r = NS	r = NS
				Monthly income	r = NS	r = NS	r = NS	r = NS
				Total years of employment at hospital	r = NS	r = NS	r = NS	r = NS
				Years of working experience	r = NS	r = NS	r = NS	r = NS
				Travelling time to office	r = NS	r = NS	r = NS	r = NS
			Pearson's correlation	**Job Satisfaction Scale**				
				Pay	r = NS	r = NS	r = NS	r = NS
				Promotion	r = NS	r = NS	r = NS	r = NS
				Supervision	r = NS	r = NS	r = NS	r = NS
				Fringe benefits	r = NS	r = NS	r = NS	r = NS
				Contingent rewards	r = NS	r = NS	r = NS	r = NS
				Operating conditions	r = NS	r = NS	r = NS	r = NS
				Co-workers	r = NS	r = NS	r = NS	r = NS
				Nature of work	r = NS	r = NS	r = NS	r = NS
				Communication	r = NS	r = NS	r = NS	r = -.461*
				JSS total	r = NS	r = NS	r = NS	r = NS
Norio et al. (2017)	180	MBI-GS	t-test & chi-squared (to compare genders)	**Family Conflict Scale**				
				Work interference with family	r = .708***	r = .585***	r = NS	
				Family interference with work	r = .503***	r = .501***	r = NS	
				Generic Job Stress Questionnaire				
				Qualitative workload	r = .524***	r = .307***	r = NS	
			Pearson's correlation	Variance in workload	r = .517***	r = .359***	r = NS	
				Mental demands	r = .372***	r = .159*	r = NS	
				Centre for Epidemiological Studies for Depression Scale				
				Total CES-D score	r = .586***	r = .548***	r = -.212**	

Study	Sample size	Measure of burnout	Analysis	Determinants	EE	DP	PA	Total burnout
			Linear (hierarchical) regression					
Ogińska-Bulik (2006)	79	MBI-GS	t-test (to compare personality types) Linear regression (dummy variables)	**Staff Demographics** Work overload Negative affectivity Lack of rewards Physical burden Unpleasant working conditions Profession*gender*work experience	 β = 1.22*** β = 0.61***	 β = 0.54** β = 0.56***	 β = -0.70*** β = 0.79*** β = -1.99*	
Ohnishi et al. (2010)	264	MBI-GS	t-tests (to compare gender and qualification level)	**Moral Distress Scale for Psychiatric Nurses** Total MDS-P intensity score Total MDS-P frequency score **Staff Demographics** Age Sex Years of nursing experience Years of psychiatric nursing experience Licence type Hospital worked at **Moral Distress Scale for Psychiatric Nurses** Total MDS-P intensity score Total MDS-P frequency score Unethical conduct by caregivers (intensity) Unethical conduct by caregivers (frequency) Low staffing (intensity) Low staffing (frequency) Acquiescence to patients' right violations (intensity) Acquiescence to patients' right violations (frequency)	 r = .23 r = .31 β = NS β = NS β = NS β = NS β = NS β = NS β = NS β = 0.29*** β = NS β = NS β = NS β = 0.36*** β = NS β = NS	 r = NR r = NR β = NS β = NS β = NS β = NS β = -0.13* β = -0.13* β = NS β = 0.38*** β = NS β = NS β = NS β = 0.44*** β = NS β = NS	 r = .30 r = .42 β = NS β = NS β = NS β = NS β = NS β = NS β = NS β = 0.15* β = NS β = .021*** β = NS β = NS β = NS β = NS	Correlation significance not reported

Study	Sample size	Measure of burnout	Analysis	Determinants	EE	DP	PA	Total burnout
Sahraian et al. (2008)	45	MBI	t-tests (for staff sec, age, marital state, work shift, second job, education, disease, drug use and work environment)	**Staff Demographics** Age (older = higher) Sex (male = higher) Night shift (more = higher) Psychiatric morbidity (more = higher) Martial state (married = higher)	 p = .000*** p = .001** p = .029*	 p = .001** p = .003**	p = .041* p = .041*	
Velimirović et al. (2017)			t-test & one-way ANOVA	**Staff Demographics** Level of education Relationship status Overtime	**Under chall.** Indifference F = 7.707*** Lack of dev. F = 3.855* Boredom F = 12.364*** Indifference F = 4.240** Lack of dev. F = 3.161* Boredom	**Worn out** Neglect F = 6.311*** Lack of ackn. F = 4.269** Lack of cont. F = 6.788***	**Frenetic** Involvemen. F = 2.360* Ambition F = 3.531** Overload F = 2.418* Involvemen. F = NS Ambition F = NS Overload	

Study	Sample size	Measure of burnout	Analysis	Determinants	EE	DP	PA	Total burnout
					F = 4.608**		F = 5.394***	
				Length of Service		Neglect F = NS Lack of ackn. F = 2.320* Lack of cont. F = 3.673**		
Verhaeghe et al. (2016)	291	ProQOL	t-test & one-way ANOVA Pearson's correlation Forward step-wise regression	**Attitude Towards Aggressive Behaviour Questionnaire (ATABQ)** Total score Prediction subscale Patient attribution and responsibility for aggression Staff anxiety and fear of assault Need or skilled intervention to prevent and manage aggression Staff confidence **Coping with Patient Aggression Instrument (CCPAI)** Total score				r = -.149* r = NS r = -.148* r = NS r = NS r = NS r = NS
Yang et al. (2018)	290	MBI-GS	Spearman's correlation	**Staff Demographics** Age Years of employment in mental health units **Workplace Violence Questionnaire** Annual frequency of work-place violence Annual frequency of verbal aggression Annual frequency of sexual harassment Annual frequency of physical attack	 r = .365*** r = .368*** r = .253*** r = .294***	 r = .141* r = .152* r = .290*** r = .265** r = .179*** r = .244***	 NR NR NR NR NR NR	

Study	Sample size	Measure of burnout	Analysis	Determinants	EE	DP	PA	Total burnout
Yousefy and Ghassemi (2006)	55	MBI	t-test Pearson's correlation	**Staff Demographics** Age Years of experience Frequency of being on-call	r = .3*** r = .3*** r = .6***	r = .5***	r = .5***	

Note. EE = emotional exhaustion, DP = depersonalisation, PA = personal accomplishment. Under chall. = under challenged, lack of dev. = lack of development, lack of ackn. = lack of acknowledgement, lack of cont. = lack of control, involvmen. = involvement * $p < .05$, ** $p < .01$, *** $p < .001$

Appendix 1-E
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Section Two: Research Paper

Staff compassion in acute mental health wards: a grounded theory investigation

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Abstract

Background: Staff working on acute inpatient mental health wards face unique challenges in terms of short length of stays, acuity, complexity and exposure to violence, suicide and self-harm. Research has shown that staff working in this environment experience high levels of stress and burnout, which can impact staff's ability to maintain compassion.

Aim: To qualitatively explore staff's understanding and conceptualisation of the development, loss and restoration of compassion within acute inpatient environments.

Method: Eleven participants from a variety of professional backgrounds currently working on acute wards were interviewed. Using constructivist grounded theory informed methodology, data were analysed and synthesised into theoretical categories and sub-categories.

Results: A sequential model was developed based on the five conceptual categories that emerged from the data: A compassionate stance, the challenges of acute wards, feeling under threat and the negative appraisal system, restoring compassion and a compassionate organisation.

Conclusions: The findings highlight the importance of colleague support, knowing and understanding patients and their history, and accessing a reflective space in the restoration of compassion. Similarly, a compassionate organisation reduced the impact of the environment on staff compassion at every stage. Clinical implications and interventions to support the maintenance of compassion are discussed, and directions for future research considered.

Key words: staff compassion; compassionate healthcare; acute mental health; inpatient.

Introduction

Over the past 10 years, there has been an increased focus in research, policy and practice on the importance of compassion in healthcare. Compassion has been described as being fundamental to patient care (NHS England, 2013), and is incorporated into nearly all qualified healthcare professionals' code of ethics and conduct (British Psychological Society, 2009; General Medical Council, 2017; Nursing and Midwifery Council, 2015). It became one of the National Health Service's (NHS) core values in 2008, and multiple initiatives have been implemented in an attempt to increase and encourage staff compassion within the NHS (Darzi, 2008; Health Education England, 2017; NHS England, 2012; NHS Improvement, 2016). Despite this, a number of high profile investigations have identified a lack of compassion as a contributing factor in poor care received by service users (Berwick, 2013; Francis, 2013). And whilst compassion is regularly mentioned throughout the NHS, many researchers have highlighted the lack of an agreed definition of what constitutes compassion and compassionate care (Barron, Deery, & Sloan, 2017; Brown, Crawford, Gilbert, Gilbert, & Gale, 2014; Chadwick, 2015).

What is compassion?

The concept of compassion has been discussed and explored in the research base for a number of decades (e.g. Lazarus, 1991; Shaver, Schwartz, Kirson, & O'Connor, 1987). Compassion has been considered as evolutionarily advantageous, described as "an affective state that is oriented toward enhancing the welfare of those who suffer" (Goetz, Keltner, & Simon-Thomas, 2010, p. 354). Definitions of compassion have focused on a two-stage process: the recognition of another's suffering, and the subsequent desire to alleviate that suffering (Goetz et al., 2010; Lazarus, 1991; Strauss et al., 2016). This definition separates compassion from empathy, with the latter referring to the vicarious experiencing of another's emotion (Goetz et al., 2010).

There has been debate around the exact nature of compassion: that is, whether it is an attitude (Sprecher & Fehr, 2005), a variant of love and/or sadness (Shaver, Wu, & Schwartz, 1992), or a distinct affective state. Goetz et al.'s (2010) review of the taxonomy of compassion concluded that "compassion arises out of distinct appraisal processes and has distinct display behaviours, distinct experiences, and an approach-related physiological response" (p. 368). The authors developed an appraisal model of compassion (Figure 1), which attempts to explain both the conditions and decision-making required to feel and display compassion. Firstly, the person assesses whether the other person is deserving of help, and secondly whether they themselves have the available resources to provide support. Only if the other is appraised as deserving, and the person has adequate resources, will a feeling of compassion occur.

Compassionate Healthcare

Perhaps surprisingly, there has been relatively little research examining what constitutes compassion within healthcare. There have been attempts to define how compassion applies to practice, incorporating staff and service user perspectives (Dewar, Pullin, & Tocheris, 2011; Lloyd & Carson, 2011; Sinclair et al., 2018; Sinclair, McClement, et al., 2016; Sinclair, Norris, et al., 2016; van Der Cingel, 2011). Common factors across research include empathic, trusting relationships, open and honest communication, a genuine understanding, and acting to help. Service users who receive compassionate care have been shown to experience more positive outcomes, in terms of feeling in control (Lloyd & Carson, 2011; van Der Cingel, 2011), feeling heard and understood (Vivino, Thompson, Hill, & Ladany, 2009), an increased sense of hope (Lown, Rosen, & Marttila, 2011) and decreased suffering and improved well-being (Sinclair, McClement, et al., 2016) . Similarly, compassion has also been associated with positive outcomes for clinicians, such as increased

job satisfaction and accomplishment, and lower levels of burnout (Graber & Mitcham, 2004; Sinclair, Norris, et al., 2016; Way & Tracy, 2012; Zhang, Zhang, Han, Li, & Wang, 2018).

Compassion focused therapy (CFT; Gilbert, 2005, 2009) was developed as an intervention that focuses on compassion, incorporating evolutionary and neuropsychological understandings of affect regulation. It outlines a three-affect regulation system, including threat, drive and soothing, all of which need to be equally balanced to achieve well-being (Figure 2). When a person's threat system is activated, they are likely to feel emotions such as anxiety, anger and disgust. The activation of the soothing system is helpful in counteracting this, eliciting feelings of safety, connection and well-being.

Challenges to Compassion

A larger body of research exists on the absence of compassion, or compassion fatigue (Coetzee & Klopper, 2010; Coetzee & Laschinger, 2018; Ledoux, 2015). Compassion fatigue has been defined as "the disengagement of caregivers from their patients, which culminates in a reduction or inability to feel empathy and compassion toward patients and an inability to provide the patient care that is deemed appropriate" (Coetzee & Laschinger, 2018, p. 4). There has been ongoing debate about the exact mechanisms of compassion fatigue, and its link to empathy and burnout (Coetzee & Laschinger, 2018; Ledoux, 2015).

Early models conceptualised compassion fatigue as a secondary traumatic stress disorder, suggesting that caregivers who feel empathy for clients exert personal resources and emotional energy, leading to compassion fatigue (Figley, 1995, 2002). However, critics have noted that the model fails to explain why some caregivers develop compassion fatigue whilst others do not, when they likely all feel empathy for clients (Sabo, 2011). More recent research has suggested the relationship is more complex, with personal, organisational and client-related factors being involved in its development (Coetzee & Klopper, 2010; Coetzee & Laschinger, 2018; Fernando & Consedine, 2014; Sinclair, Raffin-Bouchal, Venturato,

Mijovic-Kondejewski, & Smith-Macdonald, 2017). It has been suggested that compassion fatigue develops when staff with low personal (skills, attitudes, appraisal) and organisational (staffing, infrastructure) resources, are in constant contact with intense distress (Sinclair et al., 2017). This model mirrors that of the Job Demands-Resources (JD-R) model of burnout (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Xanthopoulou, Bakker, Demerouti, & Schaufeli, 2007), so it is unsurprising that staff who are burnt-out are more likely to experience compassion fatigue (Keidel, 2002; Rossi et al., 2012; Yoder, 2010; Zhang et al., 2018). Given the lack of clarity on its aetiology, experts have called for further research into the understanding of compassion, as a prerequisite to understanding compassion fatigue (Fernando & Consedine, 2014; Ledoux, 2015; Sinclair et al., 2017).

Acute Inpatient Wards

Given that compassion fatigue is more likely to occur in those who have constant contact with intense distress, compassion in acute mental health wards is of particular interest. Acute mental health inpatient wards admit service users who, due to risk to self or others, cannot be cared for safely in a community setting (Bowers, Chaplin, Quirk, & Lelliott, 2009; Royal College of Psychiatrists, 2016). The number of weekly admissions on such wards is high, and staff experience high levels of stress and burnout (Currid, 2008; Deacon, Warne, & McAndrew, 2006; see Paper 1 for a review). Staff have highlighted unique stressors in this environment, such as balancing therapeutic needs and risk management, ensuring safety for staff and service users, tolerating challenging behaviour, high workload and limited resources, and the acuity of service user difficulties (Wyder et al., 2017). Such units have also been the focus of national improvement, following several reports that noted poor standards of care (Crisp, Smith, & Nicholson, 2016; Department of Health, 2002; Griffiths, 2002). Crisp et al. (2016) make specific mention of the need for a culture of

compassion on acute wards, modelled by leadership and supported with appropriate structures and processes.

Rationale for the Current Research

Given the complexities of acute inpatient wards, there is surprisingly little research on staff compassion within this environment. Two papers by Brown et al. (2014) and Crawford, Gilbert, Gilbert, Gale, and Harvey (2013), who accessed the same participants, interviewed nursing staff and psychiatrists working on acute wards about their understanding of compassion, and barriers and facilitators of compassionate care. Using discourse analysis, Crawford et al. (2013) reported an absence of compassionate language used by staff, and noted that participants often mentioned organisational barriers (staffing levels, time, complexity and organisational targets) that interfered with their ability to deliver compassionate care. They concluded that the language chosen by the participants suggested emotional distancing between participants and patients.

Also using discourse analysis on the same interview data, Brown et al. (2014) noted that participants drew upon two distinct repertoires in their discourse: the 'practical compassion' repertoire, which focused on the practical support provided to patients, and the 'organisational' repertoire, where participants discussed the organisational challenges that restricted their ability to provide compassionate care.

Whilst these papers are helpful in beginning to explore staff compassion within this environment, their choice of discourse analysis has some limitations. Discourse analysis is primarily interested in what is happening outside the person, in terms of social context and social interaction (Braun & Clarke, 2013). Whilst this approach has its merits, it could be argued that investigation of the internal processes relating to the maintenance and loss of compassion is also required. Similarly, only nurses and psychiatrists were interviewed; they did not include the views of staff from other professional backgrounds, who may have

different conceptualisations of compassion. Crawford et al. (2013) concluded that additional research is required to achieve a rich understanding of staff compassion within this environment.

Aims of the Current Research

The aim of the current research is to qualitatively explore staff's conceptualisation of compassion within acute mental health wards. Eliciting the views of staff from multiple professional backgrounds, it will explore fluctuations in compassion, processes underpinning the loss and restoration of compassion, as well as barriers and facilitators to compassionate care.

Method

Design

A qualitative approach was taken to data collection and analysis, allowing exploration of phenomena for which there has been little prior research, and providing rich data from which meaningful conclusions can be drawn (Braun & Clarke, 2013; Marshall & Rossman, 2016). A grounded theory informed methodology was deemed most appropriate, as its primary aim is to offer an explanatory theory or model that is 'grounded' in the data (Charmaz, 2006; Starks & Brown Trinidad, 2007).

By providing "a flexible set of inductive strategies for collecting and analysing qualitative data" (Charmaz, 2008), grounded theory allows the researcher to generate theoretical concepts and categories through a simultaneous process of data collection and analysis. Charmaz's (2006) social constructivist grounded theory acknowledges that concepts and theory are a co-creation of the participant's data and the researcher's interpretation of those data. To increase awareness of the influence the researcher is having on the data, reflexive processes are employed throughout data collection and analysis.

Reflexivity

The research was undertaken by a 31-year-old female trainee clinical psychologist. Her interest in staff compassion arose after completing a placement across two acute wards and being struck by the complexity of this environment. She became interested in fluctuations in staff compassion, which appeared a more complex process than either being compassionate or having compassion fatigue. It is likely, therefore, that the research was influenced by the researcher's views on both compassion and the challenges of the environment. For example, the researcher believes compassion to be fundamentally important to patient care, however acknowledges that this view may not be held by all. And similarly, the researcher's use of supervision to discuss the challenges of maintaining compassion led her to ask particular questions around facilitators of compassion and the role of social support.

Participants

Staff working on acute inpatient wards and/or psychiatric intensive care units (PICU: a sub-set of acute wards designed for service users whose level of risk requires a higher staff-to-patient ratio for a short period of time) for a minimum of three months were eligible to participate in this study. Staff from multiple professional backgrounds (e.g. nurses, psychologists, psychiatrists, occupational therapists etc.) were specifically recruited, to ensure a wide range of views were incorporated. Staff had to hold a substantive contract on the ward (to exclude bank/agency staff who also work elsewhere) and have clinical contact with service users as part of their role.

Ethics and Recruitment

Ethical approval to conduct this research was granted by the Lancaster University ethics committee. As the research required interviewing NHS staff, approval was also gained from the Health Research Authority (HRA; see ethics section). Two local NHS Trusts

provided approval for their staff to be recruited. Eligible participants were recruited from a total of 19 acute wards and PICUs spanning the two Trusts. Ward managers, psychologists and previously established contacts were approached to distribute the information packs to their staff teams. A total of 17 staff expressed an interest in participating in the study, of which 2 did not meet the inclusion criteria. Four subsequently withdrew their interest due to time constraints; the remaining 11 staff completed interviews. The demographic information of the 11 participants can be seen in Table 1.

Procedure

An initial semi-structured interview schedule (Appendix 2-A) was developed to guide the discussion. Questions focused on staff's understanding of compassion, times that they have witnessed both compassion and a lack of compassion, and when their compassion had been challenged. Questions were asked about the specific challenges of working in the acute inpatient environment (e.g. ward atmosphere, high turnover, team dynamics, managerial support etc.), and the impact that this had on compassion. Lastly, barriers and facilitators to compassion were explored, and the link between negative emotions/distress at work and compassion. In keeping with the iterative process of grounded theory, both the interview schedule and the emphasis of follow-up questions were adapted throughout, guided by the emerging concepts and theory (Charmaz, 2006). Adaptations in this study included additional emphasis on emotions before, during and after fluctuations of compassion, and the mechanisms of facilitators of compassion.

Ten interviews were conducted at participants' place of work, and one over the phone. All interviews were audio recorded and ranged from 15 minutes to 100 minutes in length, with an average interview length of 49 minutes.

Data Analysis

All 11 interviews were transcribed verbatim by the lead researcher, and identifying information redacted. Pseudonyms were allocated to maintain participants' confidentiality. Data analysis was informed by Charmaz's (2006) constructivist grounded theory, which includes two levels of coding. Initially, data were coded line-by-line, using gerunds where appropriate, as they ensure the researcher focuses on the meaning, process and action behind a participant's words, as opposed to providing a description (Charmaz, 2006).

The second phase of analysis involves focused coding, to "synthesise and explain larger segments of data" (Charmaz, 2006). These focused codes were then synthesised to create theoretical categories and sub-categories, to develop an emerging theory. An excerpt of an interview transcript demonstrating line-by-line and focused coding can be seen in Appendix 2-B (published with consent from the participant).

In keeping with the constant comparative method (Charmaz, 2006; Glaser & Strauss, 1967), emerging theoretical categories and sub-categories were continually compared with earlier emergent codes/categories, and adjusted accordingly. Memos, described as "analytic notes to explicate and fill out categories" (Charmaz, 2006, p. 72) were written throughout, to document and inform the development of the emerging theory (Appendix 2-C). Data were gathered until data sufficiency (Dey, 1999) was reached, i.e. when theoretical categories have sufficient data and do not require adjustment in light of new data. Finally, the theoretical categories and sub-categories were synthesised and amalgamated into a conceptual model. This model was constructed with input from both the researcher's supervisors; similarly, the model was reviewed by one of the participants, and changes made accordingly.

Credibility Evaluation

Whilst there are no set criteria for ensuring the credibility of qualitative research, measures can be taken to improve integrity. The credibility criteria outlined by Charmaz (2006) and Elliott, Fischer, and Rennie (1999) guided the design and analytic process of this project. Both highlight the importance of transparency around the researcher's position, and likely influence on the data and emerging theory (see reflexivity). Credibility was also enhanced through the keeping of a reflective journal and memo writing, to document the decision-making process. Similarly, a sample of transcripts were coded by the researcher's field supervisor, and codes chosen by the researcher and supervisor were compared to ensure reliability and fit with the data.

Results

A sequential model was developed outlining the processes underpinning the development, loss and restoration of compassion in acute inpatient staff (Figure 3). The following narrative outlines the theoretical categories and sub-categories identified within the data and should be considered alongside the model.

Five conceptual categories emerged from the data (Table 2). The first explains the adoption of a compassionate stance, and the feelings and behaviours associated with compassion. The second considers the stressors of the acute inpatient environment, including a lack of time and resources, multiple competing demands, and the limited capacity for compassion. The third conceptualises the process that occurs when staff feel under emotional, organisational or physical threat, which can lead to an activation of a negative appraisal process and a lack of compassion. The fourth category outlines the processes that support the restoration of compassion, and the final category explains the positive impact of a

compassionate organisation. Additional quotes to support each sub-category can be seen in Table 3.

A Compassionate Stance: "To understand with empathy and genuine human feeling"

The qualities of compassion

All participants acknowledged the importance of compassion in supporting patients, and all aimed to achieve a compassionate stance from the outset. Multiple steps were involved in the adoption of a compassionate stance, the first of which encompasses the underlying qualities, values, feelings and attributes of compassion. These most often included patience, kindness, equality, being non-judgmental, and a genuine feeling of empathy for the patient's distress: "some kind of attempt to understand with some empathy and genuine human feeling" (Elaine, line 290). Participants often spoke of these qualities coming from underlying values and personality traits within themselves: "it's from within. It's got to be. You either are a person who is empathic or you're not" (Emma, line 1048). This compassionate connection and feeling led to participants wanting to know, understand and do their best for their patients.

Knowing and understanding

The majority of participants spoke about the importance of knowing and understanding a client in order to feel and demonstrate compassion. This often took the form of knowing and understanding a client's history, experiences and trauma, which triggered feelings of empathy: "and I think that, those experiences and the vulnerability, was what made me feel very very strongly" (Maria, line 304).

This understanding was also helpful in maintaining compassion, even in the face of violent or distressing incidents, as participants were able to rationalise these behaviours and put them in context, "without being judgemental, understanding where certain behaviours have come from, and then just displaying the appropriate care and affection in relation to that"

(Robert, line 83). Some participants spoke about personal resonance in the feeling of compassion; if hearing someone's experience resonated with their own experiences, they often felt more deeply compassionate: "they trigger something in you, and that's when you feel the most moved I think, they remind you of something or someone that's close to you" (Elaine, line 490). When participants felt this deep empathy and connection, they were motivated to display compassion, and alleviate the patient's distress.

Demonstrating compassion

Participants spoke of a genuine desire to alleviate distress and do their best for the patient: "a genuine kind of desire to help somebody to make their situation better" (David, line 192). This was often described as giving sufficient time, being patient, communicating openly and honestly through conversation and body language, sitting alongside a patient's distress, and doing what they could to help: "coming from your body language and just throughout your interaction, and demonstrating care and saying, how can I help?" (Robert, line 94).

Striking a balance

Some participants discussed the need to strike a balance between feeling compassion, and protecting their own emotions: "something I have learnt …. [is] around having adequate levels of compassion to be able to do my job, and knowing [when] I'm starting to be depleted" (David, line 807). Alongside this, some participants felt that having too much compassion was in itself unhelpful, due to staff becoming overly-involved and invested: "you have to be careful… sometimes to use the word compassion may involve high levels of emotion, and that in itself is to be watched for" (Michael, line 310). There was a sense of a fine balance between being overly and insufficiently compassionate, and the need to notice when this shift occurs: "it's better to be somewhere in that central zone of we're not overly

kind of caring, we're not doing too much, but holding a central, stable, caring position that we know isn't over-stepping any mark" (David, line 828).

The Challenges of Acute Wards: "You sometimes feel like going and lying down in a cupboard"

Lack of time and resources, and competing demands

Short admissions, and the constant stream of admissions and discharges, led to difficulties in delivering compassionate care: "One of our wards has five admissions and five discharges a day… So if you're working in a system like that, how can you possibly, even if you were compassionate, demonstrate it?" (David, line 520). Participants felt that this lack of time impeded their ability to get to know patients, which they acknowledged is important in the maintenance of compassion: "I'm their named nurse. I couldn't tell you much about them, really, and it saddens you. It makes you feel like you're a shit nurse." (Meg, line 249). Similarly, participants spoke about the lack of physical resources, such as adequate staffing, impacting staff's ability to reflect and unwind, depleting their compassion: "they're not getting time to wind down… they go non-stop and they're working extra hours, so I think sometimes compassion can take a hit." (Daniel, line 660).

Related to this was the role of competing demands that prevented staff from delivering compassionate care. This was often in relation to risk and complexity, and the need to keep the ward safe: "you find yourself feeling like you're fobbing people off… Because you've got more immediate things that you need to manage just to keep the ward more settled" (Meg, line 252). Organisational targets and bed pressures were also a source of stress for staff, and there was a sense of staff feeling drained from the speed at which they were required to work: "And I think sometimes just the amount of stuff coming at you on these wards is really hard. You sometimes feel like going and lying down in a cupboard." (Elaine, line 877).

Limited capacity

Participants spoke of a limited capacity for compassion, that was drained by the day-to-day pressures of the ward, particularly when having to deal with multiple risk-related incidents in quick succession: "because compassion isn't always easy, especially if you're a bit fatigued on the ward, and if things are happening quite incessantly" (Meg, line 80). There was also a sense that this capacity could be consumed by personal stressors: "I think it's also important to have the brain capacity, so obviously, if I've had a bad week… then capacity is a bit limited for compassion" (Maria, line 587). Participants reflected on times that their compassion had become entirely depleted: "I've got nothing in me left. There is not one ounce of the ability to show care to anybody else at the moment… I need a break." (David, line 398).

Feeling Under Threat: "If you feel afraid… it's very difficult to feel compassion"

Feeling overwhelmed by complexity and risk

The subsequent stage in the loss of compassion began when participants felt under physical, emotional or organisational threat. This most often occurred when staff felt overwhelmed by complexity and risk:

> If you feel afraid or blamed or scared that somebody is going to end their lives, and it's your responsibility… if things don't feel safe, if you feel alone in it, then that will make it very difficult to feel compassion. (Maria, line 540).

Participants described incidents of violence or self-harm evoking strong emotions for staff, impacting their ability to maintain compassion: "you get people who are really really challenging, and engaging in very severe self-harm, or risk or violence…which brings up a whole lot of different things for people" (David, line 527).

Feeling inadequate

When feeling overwhelmed by complexity and risk, staff often felt inadequate in being able to meet the person's needs and keep them safe: "what will it take to make them happy? I've given my whole day and then I've still not managed to prevent this person self-harming." (Elaine, line 660). Feelings of inadequacy were exacerbated when participants felt unable to understand the function of a risky behaviour: "and I just didn't understand that behaviour at all… She was making a real mess of herself… I felt like I was failing in some way." (James, line 825). Other staff spoke about their role in reducing feelings of inadequacy and responsibility in others: "the ones who are experienced look after the ones that are inexperienced. They are the ones that are crying, and we're the ones who are saying, it's not your fault, it's nobody's fault." (Emma, line 1218).

Protecting own emotions

In an attempt to protect their own emotions, staff felt the need to distance themselves from suffering, so as not to be consumed by it: "to a certain extent you do have to distance yourself from it as well, otherwise it will affect you too much." (Maria, line 558). Two participants discussed mechanisms they have developed to protect themselves, described as a "wall" (Michael, line 444) and a professional veneer: "my own emotions feel very under that harsh veneer. I can still feel it, but I don't let it affect me anymore". (Emma, line 1092).

Professional scrutiny

In the face of risk events, participants described a fear of being blamed by the organisation and being under increased professional scrutiny: "But I think in mental health care there is a balance… between positive risk taking, and then it being a blame culture." (Meg, line 410). This scrutiny made them feel vulnerable, even when they felt confident in their decision making and care:

> I've got experience of it. Two suicides. [I felt] just vulnerable…. very preoccupied around what did I do wrong?... Strangely switching between very confident that we did everything we could, and more, to "oh my gosh, somebody is going to find fault in what we've done, or what I've suggested we do as a team". (David, line 595).

One participant described the way in which the Trust had changed investigations after a serious incident, to reduce feelings of blame: "rather than interviewing people individually, they'll interview all the people concerned together… So people don't feel so victimised and worried." (Emma, line 1320).

Negative appraisal system

When participants felt under threat, it activated negative pre-conceptions of the patient based on diagnosis and/or presentation. Although none of the interview questions enquired about diagnosis, several participants mentioned challenges in relation to compassionately caring for people with a diagnosis of personality disorder:

> They [people with personality disorders] can be quite demanding, and they demand a lot of staff time, you might be like fire-fighting… And you might be a bit abrupt with them, without actually knowing it. And I think that's probably a lack of compassion on our front. (Robert, line 131)

Incongruence in presentation was a particular challenge for participants, predominantly when they found it difficult to understand or interpret a behaviour: "people will say "oh no she's just self-harmed, but half an hour earlier she was laughing and joking" (Elaine, line 658). This activation of pre-conceptions led to an appraisal of whether someone was deserving of compassionate care, and could lead to the rejection of a 'difficult' patient:

> there is this wanting to reject a difficult person, like get rid of the problem, and that is when people are really at the end of their compassion I think, when they just want that

person out, so it's not our problem anymore, because it's too difficult. (Elaine, line 924).

Restoring Compassion: "When we were reminded what she'd gone through, compassion was restored"

Offering and receiving support

All participants discussed the support they received from colleagues, and the support that they offered in return: "I mean we've got quite a good staff on the ward, we sort of talk to each other, offer each other support, I think we do it quite well." (Robert, line 162). This was always an informal process, occurring in the absence of formal support: "but formally, we don't have the capacity to sit down… and to explore what had preceded the incident… but we do it more informally." (Meg, line 436).

This process was most apparent in the aftermath of an incident on the ward, where the staff provided emotional support and reassurance to each other: "I think each time we've had an incident…we all pull together." (Robert, line 294).

A reflective space

All participants described a process of reflection that helped support their emotional well-being and restore compassion. Some used an internal process: "I think I am very much a self-reflector. Why didn't I see that, or I should have done this differently?" (Stacey, line 573). Others spoke of the benefit of supervision: "[supervision] helped me understand, understand myself and my reactions, understand the situation better, you know consider different ways of approaching it" (Maria, line 531).

Several participants also highlighted the benefit of debriefs after an incident, providing a space to share and reflect on strong emotions: "It's important to get it off your chest. It stops you like bitching and moaning in the office. I think it's really detrimental to the ward" (James, line 364).

Re-engaging with knowing and understanding

Participants spoke of the power of hearing or being reminded of a patient's history, particularly after risk events when compassion may have been challenged. This reflected the category 'knowing and understanding' in the compassionate stance; however, a lack of time and resources meant that this did not always occur at the outset of someone's admission. This also appeared to reduce the activation of the negative appraisal process: "when we were having conversations about her and we were reminded what she'd gone through… then compassion was kind of restored in a way" (Meg, line 160).

The Compassionate Organisation: "If the staff are looked after and supported, they can do a better job at providing compassionate care"

Compassion across the system

Participants spoke about the importance of feeling compassion from the organisation, in order to feel valued and supported. This sometimes took the form of team members noticing and praising acts of compassion in others: "[I] reward them when I see them do it. Give them lots of praise… [reward the] willingness to show care and compassion, alive in the system" (David, line 290). However, participants also described the importance of feeling compassion from supervisors and senior managers, and the positive impact that this has on their ability to deliver compassionate care: "if the staff are looked after and supported, they can do a better job at providing compassionate care" (Emma, line 260).

Participants also described the detrimental effect that feeling unvalued by the organisation had on their capacity for compassion: "if people don't feel that they're considered, if they feel they're distressed and overworked or put upon or put in dangerous situations then that is even more of a challenge on their compassion" (Elaine, line 786). There was also an acknowledgement of the importance of compassion being demonstrated and felt at every level of the organisation: "it's got to be at every level. It can't be owned by

the top, it can't be owned by the bottom, because unless they're both on board, it's not going to work" (Emma, line 1034).

Psychological safety of the team

Participants consistently spoke of a sense of security that was felt in knowing that they had the support of the team around them. This didn't appear to be an active process, unlike offering and receiving support, but a felt sense of safety that supported staff's ability to maintain compassion: "Having a team that you feel is there for you, that helps with compassion" (Maria, line 723).

This also encompassed shared decision-making in relation to risk, and the security that comes with making decisions as a multi-disciplinary team: "you know you're there for them and they're there for you. You share responsibilities, you hold the risk together." (Maria, line 723). Equally, when staff felt psychologically secure within their team, they were able to challenge each other's attitudes and pre-conceptions: "if somebody is having negative views, we can challenge them… help them reshape their thoughts" (Daniel, line 883).

The model as a safety net

Three participants described a process whereby an overarching model of care provided a sense of safety and security, particularly after a serious incident: "It [the model] helps me to sort of like stay focused. Because you want to be supportive to that patient, so if I deviate away from that I am not being supportive" (Stacey, line 659). It also provided a framework for consistent care, which in turn fostered a greater sense of team-working and psychological safety: "the staff are dealing with it a lot better than they used to in the olden days, before we had [model]… now it's more consistent." (Daniel, line 1074). Similarly, it also reduced the impact of disagreements in professional opinion, as the team would defer to the model for the answer, supporting team relationships:

> what are the principles [of the model]? What would it say? If we make a decision based on the model, it's very easy. Things are negotiated very quickly. And people start to make similar decisions. (David, line 763).

There was also a sense that the model provided a framework in which to praise and support colleagues, restoring and renewing compassion and improving patient care:

> [the model] enables us to go out of our way to look for things that people are doing right that ordinarily wouldn't get noticed… the language changes when you implement a model like that, to being more positively focused. Which lends itself more easily to people feeling that they want to give care. (David, line 295).

Discussion

This study aimed to explore staff's conceptualisation of compassion within acute inpatient environments, and barriers and facilitators to compassionate care. Using grounded theory informed methodology, a sequential model was developed that includes five theoretical categories: A compassionate stance, the challenges of acute wards, feeling under threat and the negative appraisal system, the restoration of compassion and a compassionate organisation.

A Compassionate Stance

The descriptions of a compassionate stance are in keeping with the definition of compassion as a two-step process of feeling and acting (Gilbert, 2009; Goetz et al., 2010; Sinclair et al., 2018). The role of the underlying values and personality traits supports the findings of Sinclair et al. (2018), and research on the characteristics of those who choose, and are chosen, to work in healthcare (Patterson et al., 2016; Sand, 2003). Perhaps more novel is the finding related to the role of knowing and understanding. The longer-term work in community settings assumes that this process will occur over time; however, short

admissions on acute wards meant that staff did not always have the time to get to know and understand their patients. This appeared to have a dramatic impact on their ability to feel compassion.

The Challenges of Acute Wards

A lack of time and resources, and competing demands, also appeared to deplete participants' capacity for compassion. This finding supports research that has examined the specific challenges of working in this environment (Currid, 2008; Deacon et al., 2006; Wyder et al., 2017). It is also mirrors the JD-R model of burnout (Demerouti et al., 2001; Xanthopoulou et al., 2007), in that overwhelming job demands, and a lack of job and/or personal resources, can lead to exhaustion and disengagement from work. This finding perhaps supports the notion that burnout and a lack of compassion are intrinsically linked, which has been acknowledged in the research base (Keidel, 2002; Rossi et al., 2012; Yoder, 2010; Zhang et al., 2018). The importance of having adequate resources is also outlined in Goetz et al.'s (2010) model of compassion (Figure 1), and suggests that if staff feel a person is deserving of help, but do not have adequate resources to provide that help, it will evoke feelings of distress, anxiety and fear.

Feeling under Threat, and Negative Appraisal

Perhaps most striking was the process that occurred when staff felt under emotional, physical or organisational threat. This often began when participants felt overwhelmed by complexity and risk, a common occurrence on wards that admit service users whose level of risk precludes them from being cared for safely in the community (Bowers et al., 2009; Royal College of Psychiatrists, 2016). During and after risk incidents, feelings of inadequacy often arose, and staff then felt the need to protect their own emotions, triggering an appraisal process strikingly similar to that outlined by Goetz et al. (2010). Staff began to appraise whether someone was deserving of compassion, based on negative pre-conceptions of the

patient's diagnosis and presentation. If deemed undeserving, staff often depersonalised, and even rejected, the patient. Goetz et al. (2010) conceptualise this appraisal as being based on an assessment of the other person's altruism; if the other person appears selfish, or of poor character, they will likely be viewed as undeserving of help. The findings in the current research support that notion, and additionally identify the role of negative pre-conceptions based on diagnosis, that appear to be activated when staff feel under threat, and/or were unable to understand the function of a risky behaviour.

Within the burnout literature, depersonalisation is described as the development of negative, cynical attitudes and feelings about one's clients, and occurs in conjunction with emotional exhaustion, where emotional resources are depleted and staff are no longer able to give on a psychological level (Maslach & Jackson, 1981). However, Kristensen, Borritz, Villadsen, and Christensen (2005) have conceptualised depersonalisation as a coping strategy, utilised to prevent emotional exhaustion from occurring. The findings appear to support that notion; depersonalisation occurred when participants felt overwhelmed, perhaps in an attempt to avoid the onset of emotional exhaustion. Similarly, this process appears in keeping with the literature on empathic distress, described as "a strong aversive and self-oriented response to the suffering of others, accompanied by the desire to withdraw from a situation in order to protect oneself from excessive negative feelings." (Singer & Klimecki, 2014, p. 75). This withdrawal process again overlaps with both Maslach and Jackson's (1981) and the JD-R models of burnout (Demerouti et al., 2001).

Surprisingly, there is little research on the process underpinning the development of emotional exhaustion and depersonalisation, despite its prevalence. The original (Demerouti et al., 2001) and revised (Xanthopoulou et al., 2007) JD-R model explain this process as occurring when staff feel overwhelmed by job demands, and have a lack of job and personal resources to cope with those demands. Theoretical categories from the current research

appear to fit within that model, suggesting that a lack of resources and overwhelming demand may lead to not only burnout but also a lack of compassion.

The Restoration of Compassion

Participants identified processes that support the maintenance and restoration of compassion, the first of which was knowing and understanding patients' histories. As time was not always available for participants to do this individually, this sharing of information often came in reflective practice meetings, where the team would collaboratively develop a psychological formulation that incorporated background history and made links to current presentation. Psychological formulations have been shown to increase staff's understanding and knowledge of service users, reduce negative attributions and blame, and increase hope for change (Berry, Barrowclough, & Wearden, 2009; Mohtashemi, Stevens, Jackson, & Weatherhead, 2016; Summers, 2006). Team formulation meetings are also helpful in providing a space for reflection, and fostering a sense of team-working and colleague support (Bensa & Aitchison, 2016; Summers, 2006).

Similarly, participants highlighted the utility of accessing a reflective space, either internally or with colleague support. In the absence of formal processes, staff often undertook this process informally, by checking in with each other and holding informal debriefs. This enhanced their feelings of psychological safety, defined as "a belief that the work environment is safe for interpersonal risk taking", where staff feel able to ask questions, propose ideas, and raise concerns (Edmondson, 2018, p. 8). Psychological safety has been highlighted as an important factor in promoting staff confidence, decision-making, positive risk-taking, and innovation (West, Eckert, Collins, & Chowla, 2017).

Those who had access to formal procedures (clinical supervision, debriefs, reflective practice), described them as helpful in allowing them to feel contained, cared for and valued. Staff working in these environments are often exposed to traumatic incidents of self-harm,

suicide and violence, and some participants in this study described being traumatised by what they had witnessed. Research has argued that clinical supervision is critical in mitigating the impact of such trauma (Berger & Quiros, 2014); however, some participants did not receive regular clinical supervision. And whilst the use of debriefs is perhaps controversial (Kenardy, 2000; Rose, Bisson, Churchill, & Wessely, 1998), they were generally viewed favourably by the participants, particularly when staff were interviewed jointly to avoid fears of blame. It would seem imperative, therefore, that organisations implement appropriate procedures to allow staff space to reflect, and to keep themselves well.

The Compassionate Organisation

Feeling compassion from the organisation reduced the challenges of the environment at every level; when staff felt cared for, they felt more able to adopt a compassionate stance, cope with the demands of the acute inpatient environment, and felt less under threat. Whilst the need for compassionate leadership has been identified by the NHS (NHS England, 2012; NHS Improvement, 2016; West et al., 2017), some participants expressed frustration at the lack of compassion felt from the organisation. This is perhaps exacerbated by the lack of supervision, inadequate staffing, vacancies in the staffing team, and a sense of scrutiny. Participants acknowledged the importance of compassion at every level of the organisation; organisations must do more to ensure that their staff feel supported and valued, in order for them to be able to deliver the compassionate care the NHS desires.

Clinical Implications

Given the lack of previous research on staff compassion within this environment, the model has implications for staff, service users and organisations. Staff consistently described feeling under emotional, organisational or physical threat, and this appeared to be where compassion became entirely depleted, activating the negative appraisal process. It appears

important, therefore, that interventions are targeted to mitigate this process, to ensure staff are able to remain compassionate, even in challenging circumstances.

From a CFT perspective, the activation of the threat response occurs when people feel the need to protect themselves, and evokes feelings of anger, anxiety and disgust, which mirrors the process described by participants in this study (Gilbert, 2005). The activation of the soothing system counteracts this, creating feelings of safety, connectedness and well-being (Figure 2). Participants in this study appear to be using colleagues to activate their soothing system, by seeking reassurance and offering support. However, there is scope for this to be developed further, perhaps through offering CFT groups to staff on the ward. CFT focuses on the engagement of self-compassion to balance the activation of the threat response. Self-compassion has been associated with increased well-being, connectedness, life satisfaction, optimism and positive-affect (Neff, 2011). Research has also suggested that supporting self-compassion in healthcare providers increases the compassion they feel towards service users (Beaumont, Durkin, Hollins Martin, & Carson, 2016).

Staff also highlighted the importance of understanding a patient's context and accessing a reflective space in the maintenance and restoration of compassion. They acknowledged the lack of formal processes in which this occurs, due to challenges of the acute environment. In actuality, having formal processes that allow staff to reflect is a requirement outlined by The Department of Health (2002). This protected time should be provided in addition to individual, clinical supervision.

Team formulation sessions have been shown to be beneficial in terms of collaborative working, challenging pre-conceptions and supporting staff to manage risk through a greater understanding of the behaviour (Johnstone, 2013, 2014; Kennedy, 2009). They also provide a reflective space, and time out from the day-to-day stressors of the environment (Bensa & Aitchison, 2016; Summers, 2006). Similarly, reflective practice meetings, which have less

emphasis on, but still include, elements of formulation, have been shown to be beneficial within this environment in allowing space to reflect on strong feelings, and generate new ideas for care (Mankiewicz, 2014). Given clinical psychologists' specialist training on the use of formulation and reflection (Division of Clinical Psychology, 2011), their skill set may be best placed to facilitate these meetings.

Similarly, organisations should consider implementing an overarching model of care across the ward, as it reduces professional conflict, provides staff with a shared vision, and acts as a safety net in the wake of a serious incident. Models of care have been designed specifically for this environment, such as Trauma Informed Care (Sweeney, Clement, Filson, & Kennedy, 2016), Reinforce Appropriate, Implode Disruptive (RAID; Davies, 2001) and Safewards (Bowers, 2014). The adoption of a model would be beneficial for the psychological safety of staff, reducing threat, and renewing and restoring their capacity for compassion.

And finally, organisations need to ensure that their staff feel compassion from above, as this nurtured staff's compassion at every stage of the model. Prioritising regular supervision, visible and approachable managers, and support after incidents will allow staff to feel supported, valued and cared for, which is important in the delivery of compassionate care.

Limitations and Directions for Future Research

Although the current research has made useful contributions to a currently modest research base, the limitations must also be highlighted. Firstly, only four of the eleven participants were nursing staff or healthcare assistants. An aim of this research was to gather a range of views from staff from different professional backgrounds, due to research in this area often being focused on nursing/medical staff only (e.g. Brown et al., 2014; Crawford et al., 2013). Although participants described similar processes in the loss and restoration of

compassion, it is acknowledged that staff with differing roles may have varying experiences, particularly in relation to time, resources and ability to access a reflective space. Future research examining whether the developed model is equally applicable to different staff groups could address this.

Similarly, participants in this study volunteered to take part based on the information provided, which outlined the study's focus as being on compassion. Self-selection bias may have meant that participants generally regarded compassion as important, and the views of staff who regarded compassion as less important, or were less compassionate, were not included. Likewise, whilst every step was taken to encourage open and honest answers and reflections from staff, they also may have felt the need to answer in a 'socially desirable' way. Although this didn't appear evident in the interview transcripts, it needs to be considered when assessing the credibility of the results, and future research considering alternative views should be considered.

Conclusion

This research aimed to explore staff's conceptualisation of compassion within acute mental health wards and understand the processes that underpin the development, loss and restoration of compassion. Data were gathered from semi-structured interviews with 11 participants from a variety of professional backgrounds. Using grounded theory informed analysis, five theoretical categories emerged from the data, and a sequential model was developed. Staff acknowledged the importance of compassion and attempted to adopt a compassionate stance from the outset. However, the challenges of acute wards began to deplete their capacity for compassion. When staff felt under emotional, physical or organisational threat, a negative appraisal system was activated, which could lead to depersonalisation and/or rejection of the patient. Staff's compassion was restored through re-engaging with the patient's history, offering and receiving support from colleagues, and

accessing a reflective space. The role of a compassionate organisation was also important in maintaining and renewing staff's capacity for compassion. The findings of this study have important implications for organisations, staff and patient care; if the NHS want staff to deliver the compassionate care they desire, interventions need to be implemented to support staff's ability to maintain compassion in this challenging environment.

References

Barron, K., Deery, R., & Sloan, G. (2017). Community mental health nurses' and compassion: An interpretative approach. *Journal of Psychiatric and Mental Health Nursing, 24*(4), 211-220. doi:10.1111/jpm.12379

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016). Compassion for others, self-compassion, quality of life and mental well-being measures and their association with compassion fatigue and burnout in student midwives: A quantitative survey. *Midwifery, 34*, 239-244. doi:10.1016/j.midw.2015.11.002

Bensa, S., & Aitchison, R. (2016). An evaluation of inpatient staff perceptions of psychological formulation meetings. *Clinical Psychology Forum, 278*, 33-38.

Berger, R., & Quiros, L. (2014). Supervision for trauma-informed practice. *Traumatology, 20*(4), 296-301. doi:10.1037/h0099835

Berry, K., Barrowclough, C., & Wearden, A. (2009). A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural and Cognitive Psychotherapy, 37*(1), 39-48. doi:10.1017/S1352465808005018

Berwick, D. (2013). *A promise to learn – a commitment to act: Improving the safety of patients in England.* Retrieved from

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

Bowers, L. (2014). Safewards: A new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing, 21*(6), 499-508. doi:10.1111/jpm.12129

Bowers, L., Chaplin, R., Quirk, A., & Lelliott, P. (2009). A conceptual model of the aims and functions of acute inpatient psychiatry. *Journal of Mental Health, 18*(4), 316-325. doi:10.1080/09638230802053359

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: SAGE Publications.

British Psychological Society. (2009). *Code of ethics and conduct.* Retrieved from http://www.bps.org.uk/system/files/Public%20files/bps_code_of_ethics_2009.pdf

Brown, B., Crawford, P., Gilbert, P., Gilbert, J., & Gale, C. (2014). Practical compassions: Repertoires of practice and compassion talk in acute mental healthcare. *Sociology of Health & Illness, 36*(3), 383-399. doi:10.1111/1467-9566.12065

Chadwick, R. (2015). Compassion: Hard to define, impossible to mandate. *BMJ, 351*, h3991. doi:10.1136/bmj.h3991

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: SAGE Publications.

Charmaz, K. (2008). Grounded theory. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed.): SAGE Publications.

Coetzee, S. K., & Klopper, H. C. (2010). Compassion fatigue within nursing practice: A concept analysis. *Nursing & Health Sciences, 12*, 235-243. doi:10.1111/j.1442-2018.2010.00526.x

Coetzee, S. K., & Laschinger, H. K. S. (2018). Toward a comprehensive, theoretical model of compassion fatigue: An integrative literature review. *Nursing & Health Sciences, 20*, 4-15. doi:10.1111/nhs.12387

Crawford, P., Gilbert, P., Gilbert, J., Gale, C., & Harvey, K. (2013). The language of compassion in acute mental health care. *Qualitative Health Research, 23*(6), 719-727. doi:10.1177/1049732313482190

Crisp, N., Smith, G., & Nicholson, K. (2016). *Old problems, new solutions: Improving acute psychiatric care for adults in England*. Retrieved from https://www.basw.co.uk/system/files/resources/basw_92050-3_0.pdf

Currid, T. J. (2008). The lived experience and meaning of stress in acute mental health nurses. *British Journal of Nursing, 17*(14), 880-884. doi:10.12968/bjon.2008.17.14.30652

Darzi, A. (2008). *High quality care for all: NHS next stage review final report.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf

Davies, W. (2001). *The RAID manual: A relentlessly positive approach to working with extreme behaviour*. Leicester: APT Press.

Deacon, M., Warne, T., & McAndrew, S. (2006). Closeness, chaos and crisis: The attractions of working in acute mental health care. *Journal of Psychiatric and Mental Health Nursing, 13*(6), 750-757. doi:10.1111/j.1365-2850.2006.01030.x

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The Job Demands-Resources model of burnout. *Journal of Applied Psychology, 86*(3), 499-512. doi:10.1037/0021-9010.86.3.499

Department of Health. (2002). *Mental health policy implementation guide: Adult acute inpatient care provision.* Retrieved from http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009156

Dewar, B., Pullin, S., & Tocheris, R. (2011). Valuing compassion through definition and measurement. *Nursing Management - UK, 17*(9), 32-37.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. San Diego, CA: Academic Press.

Division of Clinical Psychology. (2011). *Good practice guidelines on the use of psychological formulation.* Retrieved from http://www.bps.org.uk/system/files/Public%20files/DCP/cat-842.pdf

Edmondson, A. C. (2018). *The fearless organization: Creating psychological safety in the workplace for learning, innovation, and growth*. Hoboken, NJ: John Wiley & Sons.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *The British journal of clinical psychology, 38*, 215.

Fernando, A. T., & Consedine, N. S. (2014). Beyond compassion fatigue: The transactional model of physician compassion. *Journal of Pain and Symptom Management, 48*(2), 289-298. doi:10.1016/j.jpainsymman.2013.09.014

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. London: Brunner-Routledge.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58*(11), 1433-1441. doi:10.1002/jclp.10090

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: Executive summary.* Retrieved from

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

General Medical Council. (2017). Generic professional capabilities framework. https://www.gmc-uk.org/-/media/documents/Generic_professional_capabilities_framework__0817.pdf_70417127.pdf

Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy*. London: Routledge.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment, 15*(3), 199. doi:10.1192/apt.bp.107.005264

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. London: Weidenfeld and Nicolson.

Goetz, J. L., Keltner, D., & Simon-Thomas, E. (2010). Compassion: An evolutionary analysis and empirical review. *Psychological Bulletin, 136*(3), 351-374. doi:10.1037/a0018807

Graber, D. R., & Mitcham, M. D. (2004). Compassionate clinicians: Take patient care beyond the ordinary. *Holistic Nursing Practice, 18*(2), 87-94.

Griffiths, H. (2002). Acute wards: Problems and solutions. *Psychiatric Bulletin, 26*(11), 428.

Health Education England. (2017). Framework 15: Strategic framework 2014-29. https://www.hee.nhs.uk/sites/default/files/documents/HEE%20strategic%20framework%202017_1.pdf

Johnstone, L. (2013). Using formulation to change team cultures. *Mad in America: Science, Psychiatry and Community*. https://www.madinamerica.com/2013/04/using-formulation-to-change-team-cultures/

Johnstone, L. (2014). Using formulation in teams. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy: Making sense of people's problems* (2nd ed., pp. 216-242). London: Routledge.

Keidel, G. C. (2002). Burnout and compassion fatigue among hospice caregivers. *American Journal of Hospice and Palliative Medicine, 19*(3), 200-205. doi:10.1177/104990910201900312

Kenardy, J. (2000). The current status of psychological debriefing. *BMJ (Clinical research ed.), 321*(7268), 1032-1033. doi:10.1136/bmj.321.7268.1032

Kennedy, F. (2009). The use of formulation in inpatient settings. In I. Clarke & H. Wilson (Eds.), *Cognitive behaviour therapy for acute inpatient mental health units: Working with clients, staff and the milieu*. London: Routledge.

Kristensen, T. S., Borritz, M., Villadsen, E., & Christensen, K. B. (2005). The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work & Stress, 19*(3), 192-207. doi:10.1080/02678370500297720

Lazarus, R. S. (1991). *Emotion and adaptation*. Oxford, England: Oxford University Press.

Ledoux, K. (2015). Understanding compassion fatigue: Understanding compassion. *Journal of Advanced Nursing, 71*(9), 2041-2050. doi:10.1111/jan.12686

Lloyd, M., & Carson, A. (2011). Making compassion count: Equal recognition and authentic involvement in mental health care. *International Journal of Consumer Studies, 35*(6), 616-621. doi:10.1111/j.1470-6431.2011.01018.x

Lown, B. A., Rosen, J., & Marttila, J. (2011). An agenda for improving compassionate care: A survey shows about half of patients say such care is missing. *Health affairs (Project Hope), 30*(9), 1772. doi:10.1377/hlthaff.2011.0539

Mankiewicz, P. D. (2014). Reflective practice on inpatient mental health wards (2/2): Evaluation of CBT-integrated reflective learning process. *British Journal of Healthcare Assistants, 8*(7), 346-351. doi:10.12968/bjha.2014.8.7.346

Marshall, C., & Rossman, G. B. (2016). *Designing qualitative research*. London: SAGE Publications.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior, 2*, 99-113.

Mohtashemi, R., Stevens, J., Jackson, P. G., & Weatherhead, S. (2016). Psychiatrists' understanding and use of psychological formulation: A qualitative exploration †. *BJPsych Bulletin, 40*(4), 212-216. doi:10.1192/pb.bp.115.051342

Neff, K. D. (2011). Self-compassion, self-esteem, and well-being. *Social and Personality Psychology Compass, 5*(1), 1-12. doi:10.1111/j.1751-9004.2010.00330.x

NHS England. (2012). *Compassion in practice*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

NHS England. (2013). *Compassion in practice – one year on*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/05/cip-one-year-on.pdf

NHS Improvement. (2016). *Developing people improving care: Compassionate, inclusive and effective leaders at all levels*. Retrieved from https://improvement.nhs.uk/documents/3756/01-NHS114-04_Improving_Care_Mini_Guide-Condition_2_041018_I.PDF

Nursing and Midwifery Council. (2015). *The code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. Retrieved from https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Patterson, F., Prescott-Clements, L., Zibarras, L., Edwards, H., Kerrin, M., & Cousans, F. (2016). Recruiting for values in healthcare: A preliminary review of the evidence.

Advances in Health Sciences Education, 21(4), 859-881. doi:10.1007/s10459-014-9579-4

Rose, S. C., Bisson, J., Churchill, R., & Wessely, S. (1998). Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Depression, Anxiety and Neurosis Group, 2008*(2). doi:10.1002/14651858.CD000560

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., . . . Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research, 200*(2), 933-938. doi:https://doi.org/10.1016/j.psychres.2012.07.029

Royal College of Psychiatrists. (2016). *Old problems, new solutions: Improving acute psychiatric care for adults in England*. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/old_problems_new_solutions_caapc_report_england.pdf?sfvrsn=610ebd71_2

Sabo, B. (2011). Reflecting on the concept of compassion fatigue. *Online journal of issues in nursing, 16*(1), 1. doi:10.3912/OJIN.Vol16No01Man01

Sand, Å. (2003). Nurses' personalities, nursing-related qualities and work satisfaction: A 10-year perspective. *Journal of Clinical Nursing, 12*(2), 177-187. doi:10.1046/j.1365-2702.2003.00729.x

Shaver, P. R., Schwartz, J., Kirson, D., & O'Connor, C. (1987). Emotion knowledge: Further exploration of a prototype approach. *Journal of Personality and Social Psychology, 52*(6), 1061-1086. doi:10.1037/0022-3514.52.6.1061

Shaver, P. R., Wu, S., & Schwartz, J. C. (1992). Cross-cultural similarities and differences in emotion and its representation. In M. S. Clark (Ed.), *Review of personality and social*

psychology: Vol. 13. Emotion (pp. 175-212). Thousand Oaks, CA, US: Sage Publications, Inc.

Sinclair, S., Hack, T. F., Raffin-Bouchal, S., McClement, S., Stajduhar, K., Singh, P., . . . Chochinov, H. M. (2018). What are healthcare providers' understandings and experiences of compassion? The healthcare compassion model: A grounded theory study of healthcare providers in canada. *BMJ open, 8*(3). doi:10.1136/bmjopen-2017-019701

Sinclair, S., McClement, S., Raffin-Bouchal, S., Hack, T. F., Hagen, N. A., McConnell, S., & Chochinov, H. M. (2016). Compassion in health care: An empirical model. *Journal of Pain and Symptom Management, 51*(2), 193-203. doi:10.1016/j.jpainsymman.2015.10.009

Sinclair, S., Norris, J. M., McConnell, S. J., Chochinov, H. M., Hack, T. F., Hagen, N. A., . . . Bouchal, S. R. (2016). Compassion: A scoping review of the healthcare literature. *BMC Palliative Care, 15:6*. doi:10.1186/s12904-016-0080-0

Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-Macdonald, L. (2017). Compassion fatigue: A meta-narrative review of the healthcare literature. *International Journal of Nursing Studies, 69*, 9-24. doi:10.1016/j.ijnurstu.2017.01.003

Singer, T., & Klimecki, O. M. (2014). Empathy and compassion. *Current Biology, 24*(18), R875-R878. doi:10.1016/j.cub.2014.06.054

Sprecher, S., & Fehr, B. (2005). Compassionate love for close others and humanity. *Journal of Social and Personal Relationships, 22*(5), 629-651. doi:10.1177/0265407505056439

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380. doi:10.1177/1049732307307031

Strauss, C., Lever Taylor, B., Gu, J., Kuyken, W., Baer, R., Jones, F., & Cavanagh, K. (2016). What is compassion and how can we measure it? A review of definitions and measures. *Clinical Psychology Review, 47*, 15-27. doi:https://doi.org/10.1016/j.cpr.2016.05.004

Summers, A. (2006). Psychological formulations in psychiatric care: Staff views on their impact. *Psychiatric Bulletin, 30*(9), 341-343. doi:10.1192/pb.30.9.341

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review Journal, 21*(3), 174-192. doi:10.1108/MHRJ-01-2015-0006

van Der Cingel, M. (2011). Compassion in care: A qualitative study of older people with a chronic disease and nurses. *Nursing Ethics, 18*(5), 672-685. doi:10.1177/0969733011403556

Vivino, B. L., Thompson, B. J., Hill, C. E., & Ladany, N. (2009). Compassion in psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research, 19*(2), 157-171. doi:10.1080/10503300802430681

Way, D., & Tracy, S. J. (2012). Conceptualizing compassion as recognizing, relating and (re)acting: A qualitative study of compassionate communication at hospice. *Communication Monographs, 79*(3), 292-315. doi:10.1080/03637751.2012.697630

West, M., Eckert, R., Collins, B., & Chowla, R. (2017). *Caring to change: How compassionate leadership can stimulate innovation in health care*. Retrieved from https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf

Wyder, M., Ehrlich, C., Crompton, D., McArthur, L., Delaforce, C., Dziopa, F., . . . Powell, E. (2017). Nurses experiences of delivering care in acute inpatient mental health settings: A narrative synthesis of the literature. In (Vol. 26, pp. 527-540).

Xanthopoulou, D., Bakker, A. B., Demerouti, E., & Schaufeli, W. B. (2007). The role of personal resources in the Job Demands-Resources model. *International Journal of Stress Management, 14*(2), 121-141. doi:10.1037/1072-5245.14.2.121

Yoder, E. A. (2010). Compassion fatigue in nurses. *Applied Nursing Research, 23*(4), 191-197. doi:10.1016/j.apnr.2008.09.003

Zhang, Y.-Y., Zhang, C., Han, X.-R., Li, W., & Wang, Y.-L. (2018). Determinants of compassion satisfaction, compassion fatigue and burn out in nursing: A correlative meta-analysis. *Medicine, 97*(26), e11086. doi:10.1097/MD.0000000000011086

Figure 1. Appraisal model of compassion outlined by Goetz et al. (2010)

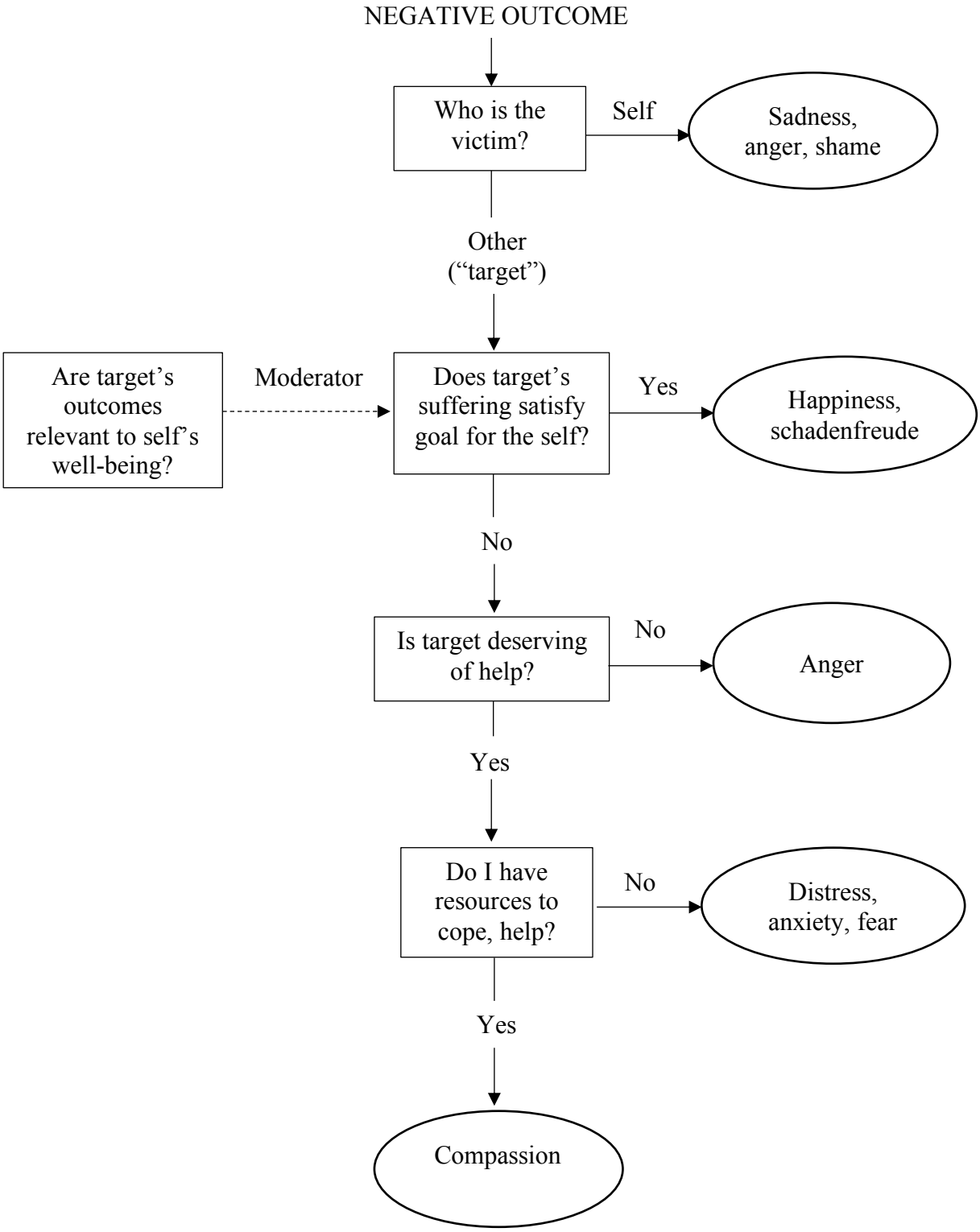


Figure 2. The three affect-regulation system (adapted from Gilbert, 2010)

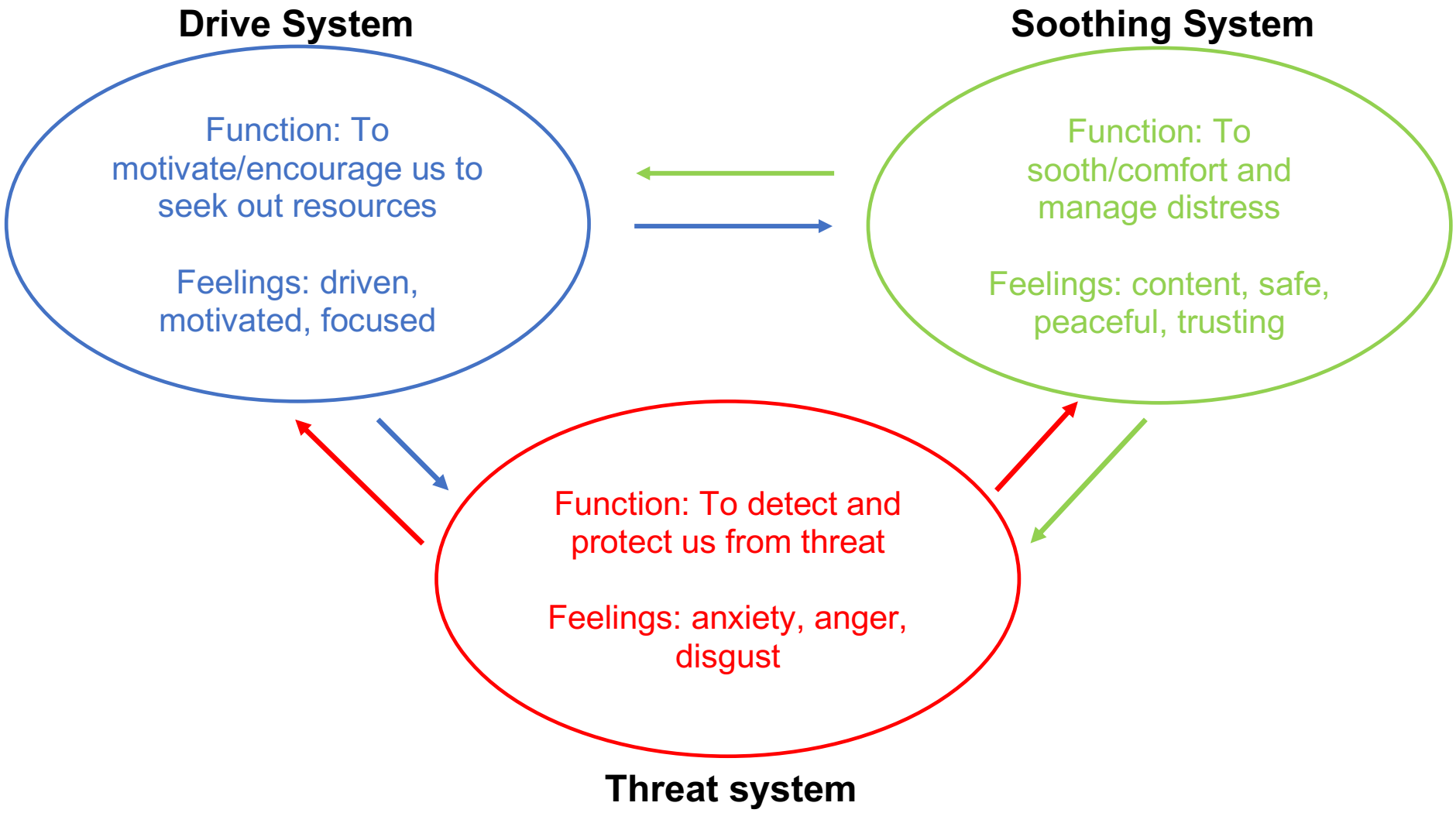


Table 1. Participant demographics

Participant number	Pseudonym	Gender	Age	Profession	Time since qualification (if applicable)	Time in current role	Wards worked on
1	Meg	F	25	Staff nurse	3 years	3 years	Female acute
2	Robert	M	31	Staff nurse	1.5 years	10 months	Female acute
3	Hannah	F	30	Health care assistant		4 months	Female acute
4	Maria	F	39	Clinical Psychologist	1.5 years	1.5 years	Female and male acute
5	David	M	39	Clinical Psychologist	10 years	7 years	Mixed gender PICU, female and male acute
6	Michael	M	57	Lead Occupational therapist	32 years	1.5 years	Mixed gender PICU, female and male acute
7	Stacey	F	46	Occupational therapist	5 years	2 years	Female and male acute
8	Daniel	M	45	Consultant Psychiatrist	10 years	5 years	Mixed gender PICU
9	James	M	51	Health care assistant		6 years	Mixed gender PICU
10	Emma	F	56	Lead Occupational therapist	19 years	19 years	Female and male acute, mixed gender PICU
11	Elaine	F	51	Art therapist	25 years	10 years	Mixed gender acute

Figure 3. Model of staff compassion (displayed on next page)

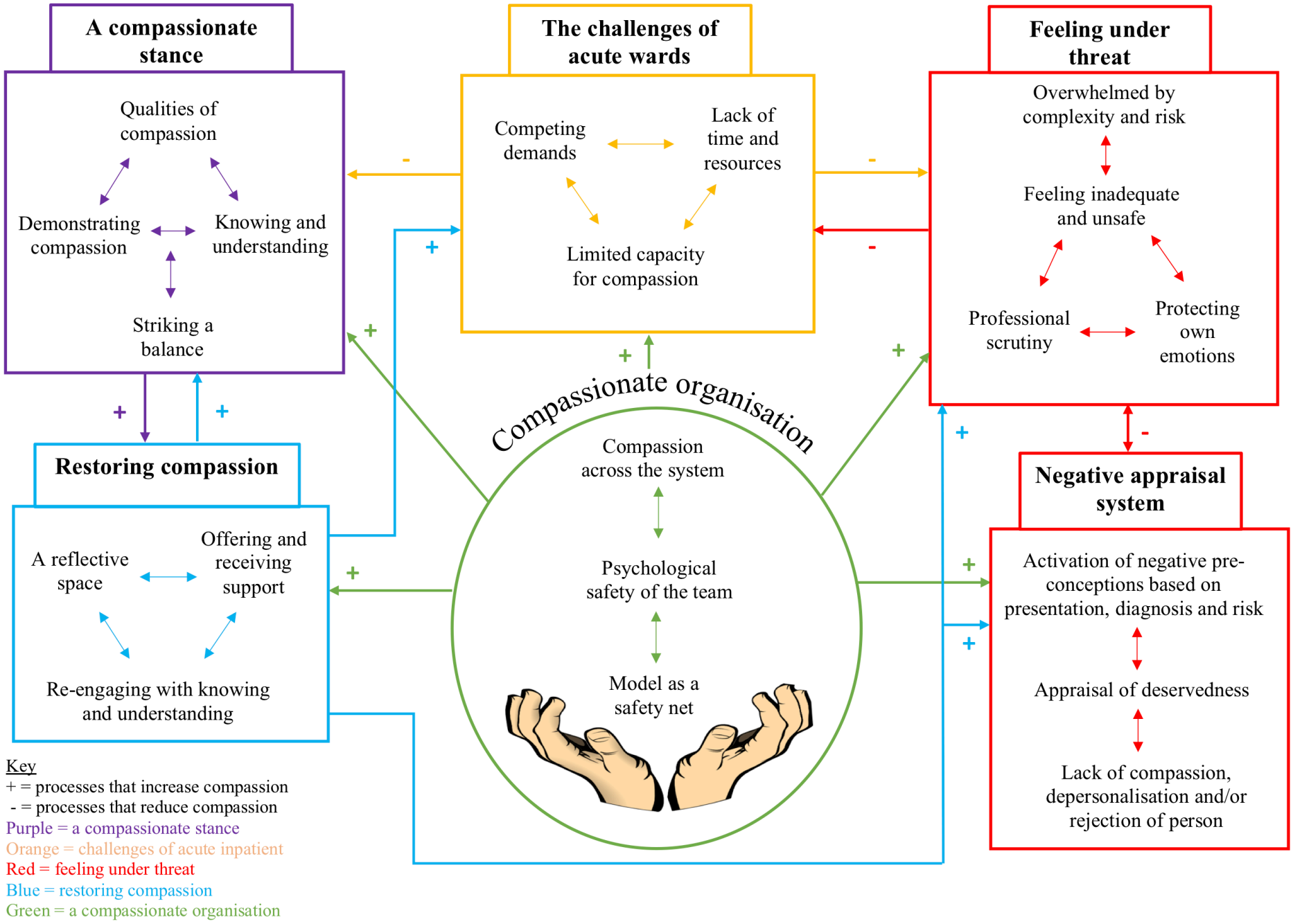

A compassionate stance
Qualities of compassion
Demonstrating compassion
Knowing and understanding
Striking a balance
The challenges of acute wards
Competing demands
Lack of time and resources
Limited capacity for compassion
Feeling under threat
Overwhelmed by complexity and risk
Feeling inadequate and unsafe
Professional scrutiny
Protecting own emotions
Restoring compassion
A reflective space
Offering and receiving support
Re-engaging with knowing and understanding
Compassionate organisation
Compassion across the system
Psychological safety of the team
Model as a safety net
Negative appraisal system
Activation of negative pre-conceptions based on presentation, diagnosis and risk
Appraisal of deservedness
Lack of compassion, depersonalisation and/or rejection of person
Key
+ = processes that increase compassion
- = processes that reduce compassion
Purple = a compassionate stance
Orange = challenges of acute inpatient
Red = feeling under threat
Blue = restoring compassion
Green = a compassionate organisation

Table 2. Theoretical categories and sub-categories

Theoretical category	Sub-category
A compassionate stance	Qualities of compassion
	Knowing and understanding
	Demonstrating compassion
	Striking a balance
The challenges of acute wards	Lack of time and resources
	Competing demands
	Limited capacity
Feeling under threat	Feeling overwhelmed by complexity and risk
	Feeling inadequate
	Protecting own emotions
	Professional scrutiny
	Negative appraisal system
Restoring compassion	Offering and receiving support
	A reflective space
	Re-engaging with knowing and understanding
Compassionate organisation	Compassion across the system
	Psychological safety of the team
	Model as a safety net

Table 3. Additional quotes for each sub-category

Theoretical category	Sub-category	Participant and line number	Additional quotes
A compassionate stance	Qualities of compassion	Daniel, line 168	"showing them they are treated equally no matter their race, religion, culture, background, sexual orientation, not pre-judging the diagnosis"
		David, line 556	"I'm going to attribute it to my general values in life… reminding myself that I'm hopefully somebody who is able to try and see the good in people, staff or patients."
		Daniel, line 874	"my religion teaches me compassion to animals, trees, humans, everything, it's that compassion"
	Knowing and understanding	Maria, line 336	"And also what helps people is also if they have got a similar experience like that, that they can tap into. Loss for example, is something that most people relate to, and that helps people feel the compassion, when they can tap into their own loss, and how they've dealt with it."
		David, line 248	"there is a real sense of knowing that this poor lad hasn't had a chance. You know. And everything around him in his world has been forced, what we are seeing now is a result of lived experiences, and treatment from the environment, rather than being inherently bad."
	Demonstrating compassion	Robert, line 90	"Someone that's, you know, actively listens, you know is not judgemental, allows the person to express themselves without any interruptions, so maybe get your perspective on things and maybe asks questions following on from what they've disclosed. Coming from your body language and just throughout your interaction, and demonstrating care and saying "how can I help?"
		Hannah, line 83	"compassion is giving the service users that you are looking after the time for them to speak with you, not to rush them, all the time making sure they feel comfortable

			in coming to you when they need to approach you, and when they need to confide with you over something…. as a professional you always need to give them their respect and their dignity, and just help them as much as you can, but also encourage them to do things for themselves as well."
	Striking a balance	David, line 816	"So I think I've learnt from this to think about where am I at, and is my gauge saying it's here, past the heart, metaphorically speaking.
		Michael, line 297	"So it's a very fine balance, compassion, and what it defines. Because it can actually be disruptive in itself."
The challenges of acute wards	Lack of time and resources and competing demands	Emma, line 927	"I think there is a capacity for people not to get to know people very well, and to have to make quick decisions, based on judgement rather than fact maybe"
		David, line 520	"One of our wards has five admissions and five discharges a day, working on four staff, one nurse might be in review, what's the other nurse got to do? Five care plans, five admission plans, the volume of admin means that they never feel like they've got a moment. So if you're working in a system like that, how can you possibly, even if you were compassionate, demonstrate it?"
		Emma, line 927	"I think there is a capacity for people not to get to know people very well, and to have to make quick decisions, based on judgement rather than fact maybe"
	Limited capacity	Emma, line 1146	"It's taken something from me. To give, to get strong, to give that at this end, it's had to come off the other end"
		Emma, line 1417	"if you're going to get strong that side, you've got to lose something this side. You've only got that much capacity moving along the line, you know."
		Emma, line 537	"if you expect them to give compassionate care… you can't come to work with a serious problem, or a health problem that's weighing on your mind."

		David, line 398	"And I was like "I just can't do it". Literally, this is it. I don't want to hear a thing about anybody else right now… I've got nothing in me left. There is not one ounce of the ability to show care to anybody else at the moment left in me. I need a break."
Feeling under threat	Feeling overwhelmed by complexity and risk	Daniel, line 668	"if they've been attacked by the same patient previously, they might be less compassionate towards them on this admission, because they've got a history."
		Meg, line 210	"you're only human aren't you, you can only put up with so much abuse, and your team can as well, and it's… you do, you forget that that person in poorly"
		Robert, line 148	"I mean over a four-month period not so long ago we had quite a lot of people with personality disorder, quite a lot of self-harm, quite demanding of staff, tended to split the team, and this was relentless for about four months. And I don't think I wasn't demonstrating compassion, but it wouldn't surprise me if sometimes, without knowing, I might have been a bit abrupt, or not really demonstrating care that I should have been demonstrating, not like unsafe, but might have been a bit abrupt on some interactions, sort of due to the fact of this relentless thing that had been going for a long period."
	Feeling inadequate	Meg, line 383	"I had quite open conversations with her about the adverse implications of repeated ligaturing… and she went "I'm fully aware of it, I know it could go wrong and I'm going to do it", and then that kind of felt like that's quite selfish. Only because I've been in an incident with another young lady and we had to give her life support, and I found that quite traumatising to be honest."
		David, line 604	"I certainly felt angry, and felt like you know when somebody betrays you?"
	Protecting own emotions	Michael, line 444	"well the wall is referring to how I protect my emotions"

	Emma, line 1092	"And that's what I have to do here, and I've been doing for so long, to the point where my own emotions feel very under that harsh veneer. I can still feel it, but I don't let it affect me anymore"
Professional scrutiny	Meg, line 410	"But I think in mental health care there is a balance isn't there, between positive risk taking, and then it being a blame culture. So I think that anxiety is always there in terms of managing self-harm"
	Meg, line 494	"I think maybe what it may have highlighted is me being more thorough with my documentation, and rationale for decision making more than anything"
Negative appraisal system	Meg, line 141	"I think it can happen quite routinely, with.. particularly with people who have personality disorders, when they are self-harming a lot. We had a young lady on here… and on my night shifts within about half an hour, she'd done about 6 ligatures. Now, on a night shift, when you don't have staff in, and to repeatedly going in to cut something off someone's neck, it really grates on you doesn't it? It really does. And it's quite difficult, you become quite burnout, quite pessimistic really, on your outlook of that person's care and how they're going to move forwards. We were drained."
	Robert, line 193	"With a male ward, you probably wouldn't get a lot of self-harmers or the EUPD's that might sort of take a lot of staff time, you know, be fire fighting for most of the time. So even though we demonstrate compassion, it might be a bit more difficult in certain situations like on a female acute ward, due to the complexity of what we nurse, and the treatment we deliver."
	Maria, line 427	"I think they feel manipulated. And maybe they are being manipulated, and it's difficult to deal with that. So then they get defensive."
	Daniel, line 414	"Well, years ago, I maybe had less compassion for people with addiction problems, so if somebody was taking drugs, I used to go "it's their own problem"… So

			anybody with substance misuse problem was self-inflicted, shouldn't be taking drugs, and it wouldn't be a problem."
		Daniel, line 450	"I used to dread people with emotionally unstable personality disorder, and what am I going to do? How am I going to fix them? I can't, I can't fix them"
		Emma, line 958	"but then there might be other people who come in and they're bouncing round, and they're taken a load of drugs or they're drying out or whatever, and they don't normally elicit empathy, so readily"
Restoring compassion	Offering and receiving support	Meg, line 446	"We try and understand what happened, what was the incident about? How is everyone feeling and how can we support the patient and the team "it helps to talk about [an incident]… [if] something has happened that could have been avoided, or we felt as if something could have been done different, that helps us …. as it's a bit more reassuring that that may not happen again in the future."
		Maria, line 678	"The most important thing for me is having my team. My immediate team, the psychologists, it's so massive. There is always somebody around, so I will go straight and talk to them, and there is always somebody available who will drop what they're doing and sit down and listen. That's the most important thing. And then the broader team who I can talk to."
		Stacey, line 673	"But if I need support or anything like that we have… I think we've got really really good relationships with all the professionals here"
	A reflective space	David, line 698	"I was like "I need to make sense of what happened here". Like this isn't good, I don't like feeling this way, it's not normal, not me, I definitely don't want this to happen again"
		Michael, line 623	"I don't have a regular supervisor, because within the structure, there isn't anyone who is higher than me, who gives regular supervision. There are people that I'd go to, and it would be a choice. There are two people that I speak to that are part of

			my peers. And there is probably one person externally who I speak to, in sort of an anonymised way, and again it's somebody that I tend to trust, who I have used before, but our supervision structures here are awful, to say the least. That's why I've sort of relied on internal reflection a lot."
	Re-engaging with knowing and understanding	Meg, line 297	"her formulations were really helpful, it was quite nice to look back at someone's history… like I don't have time to always sit… and think "oh where was this person brought up, what experiences did they have, are they traumatised? Have they had anything for that? What therapy have they received if they've had any or not? What do they think helps? What doesn't help them? We don't have time to have those conversations, and when [psychologist] was doing the formulation, I think it was quite nice for us all to be together and to have conversations about why things were happening on the ward, in light of what they'd been through. It just adds a bit more context doesn't it, to people's stories really. Think it focuses on them being more of a person, than just "bring them in, get them out""
		Maria, line 320	"I tried to put it across… so that maybe the compassion could be passed on to everyone in the room. To see it from that side as well, from his perspective, that we can see this person as very vulnerable based on what they have been through, and these behaviours could be explained. So I shared a formulation basically, it was based on that."
		Maria, line 374	"People usually don't have the time to go through all the history. And that's why things like reflective practice are useful, because we've got the space and the time to think about what we know about somebody."
Compassionate organisation	Compassion across the system	Elaine, line 1303	"I had some colleagues saying to me the other week how anxious and unhappy she was about that not knowing [about the certainty of her job], and saying "this trust talks to me about being compassionate and caring and good communication, where does that fit in terms of me?" … So yeh, it has to be a holistic thing doesn't it, and apply to the staff as well as the patients."

	David, line 543	"generally what I've witnessed is staff being uncared for or unsupported, and they start to be more concerned about themselves than what they're doing for patients."
	Emma, line 1034	"If it's going to work, it's got to be at every level. It can't be owned by the top, it can't be owned by the bottom, because unless they're both on board, it's not going to work. So I think there's the culture, and the team culture, which directly affects you. And the people who, your managers, but also the Trust in general, so I think organisationally, it's got to come from that to maintain it, because people can come in full of empathy, and I'd imagine end up having it just beaten out of them, by being in the wrong place with the wrong people."
Psychological safety of the team	Hannah, line 235	"just knowing that you've got your team there to support you, and you've got each other's back with things"
	Meg, line 510	"I prefer to work in a ward environment, I think, not that I've ever done community properly, but I think I quite like, it feels like we look after each other. It just feels quite comforting sometimes."
Model as a safety net	Stacey, line 652	"I just say "get on with it". I just have to, and especially if it's in the care plan, you know, or on the self-injury pathway, so it's having that training and that understanding, to actually adhere to that."
	Daniel, line 127	"it gives the staff a new skill set to manage patients with challenging behaviour, and we didn't have that before, so our philosophy of care was completely different a couple of years ago to where we are now, so I think the patients have benefited from that. Massively."

Appendix 2-A
Semi-structured interview schedule

1. Opening

    A. **(Establish Rapport)** Introductions.

    B. (**Purpose)** Explanation of research project

        i. Research is about people's thoughts, views and experiences of compassion.

        ii. I've worked in this environment, so I know it can be a challenge.

        iii. Going to cover a range of topics including your understanding on compassion, what it looks like in your job role, challenges to maintaining compassion and emotions at work.

        iv. No right or wrong answers – please contribute whatever occurs to you that you feel is relevant.

    C. **(Motivation)** Explanation of why they have been asked to undertake interview. Explain recording process.

    D. **(Timeline)** Explain how long the interview should take.

    E. **(Consent)** Confirm consent, remind participants of breaking confidentiality protocol and distress protocol. Remind them of right to stop interview at any time. Check they are happy to continue.

2. **General demographic information**

    A. Age

    B. Profession

    C. Time since qualification

    D. How long have you been in current role

    E. What does your role generally consist of?

    F. How many hours do you work?

G. On what types of ward? E.g. male, female, acute PICU

H. What drew you to inpatient work?

I. What do you like most about your role?

3. Overview of compassion (example questions)

A. **Over the last 5-10 years there has been lots of talk of compassion in the workforce, particularly in the NHS– have you seen any policy documents or heard anybody talk about it within the trust?**

i. If yes, what do you think of them?

ii. In what context?

B. **Part of the difficulty with compassion is that there isn't an agreed definition - In your words, can you describe what 'compassion' means to you?** (provide definition if struggling to answer – see if they are in agreement).

i. "the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help"

ii. "a deep sensitivity to the suffering of self and others, with a deep commitment to try and relieve it"

C. **What qualities would you expect to see in a compassionate person?**

D. **What do you think compassionate care looks like in your role or on the ward?**

E. **Can you think of a time, perhaps when you first started in your role, when you witnessed another staff member being particularly compassionate or kind to a service user?**

i. What did they do?

ii. How did you feel, witnessing it?

F. **Can you think of an example of a time that you felt deeply compassionate towards a service user? Someone you really felt for or wanted to help?**

i. How did it feel?

ii. What did you do?

G. **Can you give an example of a time that you witnessed a lack compassion towards a service user?**

i. How did it make you feel?

ii. How did you act?

H. **Can you give an example of a time that you yourself struggled to feel compassionate towards a service user?**

i. What was happening?

ii. How did it make you feel?

iii. What did you do?

4. Compassion in their role (example questions)

A. **How easy/difficult it is to maintain compassion towards service users in this role?**

B. **When is it most difficult?**

i. Effect of the ward atmosphere

ii. Impact of management support

iii. Impact of team dynamics

iv. Effect of supervision

C. **What impact, if any, do you think the high turnover has?**

D. **What helps you to maintain compassion? Both personally and organisationally.**

E. **Do you think compassion is different in this role** (if they've worked in other roles/settings)?

5. Negative emotions or distress (example questions)

   A. **How do you feel when there is a serious incident on the ward? (violence, self-harm, suicide attempt).**

      i. What emotions do you experience?

      ii. What impact does it have on your work?

   B. **What helps you manage your distress?**

   C. **Do you notice an impact on the team as a whole after an incident?**

      i. What changes?

   D. **When you feel distressed, what impact does it have on your work with clients?**

      i. What impact does it have on your relationships with the team?

   E. **Does your distress impact your home life? Does it influence your behaviour with friends and family?**

   F. **What is it like working within a team? Benefits and challenges?**

      i. What is it like when there is an issue or disagreement?

      ii. How does it make you feel?

   G. **What processes are there if you feel you need to raise an issue?**

      i. E.g. management, whistleblowing

      ii. Do you think people feel safe to raise issues?

   H. **Is there anything you feel we haven't talked about today that you would like to add?**

Appendix 2-B

Excerpt of an interview transcript (published with the participant's consent), which outlines line-by-line and focused coding, and the development of sub-categories.

LINE NO.	Time	TEXT	Line-by-line coding	Focused coding/ sub-category
834	50:39	R: And do you think that helps, or doesn't help? As a process that you just go through?		
835				
836			Relying on colleagues in the absence of formal clinical supervision	Relying on colleagues in the absence of formal clinical supervision – ***Offering and receiving support***
837		P: I don't really get clinical supervision. I would say that I get good management supervision, off two managers now, across two sites, and they are both very good, both very different, both listen, but most of the things I talk about in my supervision are about getting what we need for the team and things like that. In terms of supervision with managing emotions and compassion and all that, I've got good networks, with [lead OT], the other lead who manages with me, we've worked together for quite a long time now, and as much as we are chalk and cheese, our values and what we want, you know, we're both really hard working, we both trust each other completely, we both want the same things for the staff, and we have different approaches, different ways, different strengths, our basics are right and we absolutely have got each other's back, so that's really good. And also the other lead OT at [location], I was actually, she used to manage me years ago, and we've got a really close peer friendship, and we meet every few months outside worktime just to debrief.		
838				
839				
840			Trusting colleagues	
841			Having each other's backs, creating safety	Having each other's backs, creating safety – ***Psychological safety of the team***
842				
843				
844				
845			Using colleagues for informal debrief	
846				
847				
848				
849				
850				
851				
852				
853				
854		R: So it sounds like you get your supervision….		
855				
856		P: From my peers.		
857				
858		R: Yeh from peers.		
859				
860	51:24	P: Yeh.		

861				
862		R: And do you supervise, clinically supervise, your staff.		
863				
864		P: Yes. I clinically supervise half the staff here and all the staff in		
865		[location].		
866				
867		R: That must be a lot. Is that a large number of people?		
868				
869		P: I'd say it's about 16 and 20 people.		
870				
871		R: That's a lot. And how often do they have clinical supervision?		
872		Is there guidance within their roles for how often it should be?		
873				Impact of organisational
874		P: Every 6 weeks. And I'm starting to devolve some of it down, but	Staff requiring a lot of	uncertainty –
875		I'm in a bit of a transient phase at the moment, and the people in	support due to	***Psychological safety of***
876		[location] are going through this redesign so some of them are moving on,	organisational uncertainty	***the team***
877		so they need a lot of support at the moment.		
878				
879		R: And what impact do you think regular supervision has for staff?		
880				
881		P: Massive. And some staff, even though you could hand them to		
882		someone else, they need to be seen by the manager, otherwise they don't		
883		feel validated.		
884				
885		R: And how important do you think it is?		
886				
887		P: I think it's really important.		
888				
889		R: What impact do you think it has? Like what does it help with?		Staff feeling valued and
890				trusting managers –
891		P: It helps with people feeling valued, and it helps with training,	Feeling valued	***Compassion across the***
892		because you can give them individual coaching and training and that, it	Providing training	***system***

893 894 895 896 897 898		helps with really getting to know people, it helps with them getting to know you, and trusting that you've got their back, it provides a forum for serious conversations, it provides a forum for people talking about their personal issues if they want to, that might be affecting their work, it's just a really good thing, supervision, I think.	Getting to know people – feeling compassion Trusting you've got their back Exploring personal issues and impact on work	Exploring own emotions– ***A reflective space*** Trusting you've got their back – ***Psychological safety of the team***
899 900 901 902	52:32	R: I guess as a manager, what are your thoughts on, I guess I'm thinking about HCAs who often, I don't know about in this trust, but go for a long time without supervision.		
903 904 905 906 907 908		P: Yeh, I don't think anyone should. I've got quite a lot of unqualified staff here and you know they all get supervision. And I think it's really important. If you're going to let people go without supervision, don't be surprised when it all goes Pete Tong really. When they're doing something they shouldn't be doing, well why is that then?	Lack of supervision detrimental	
909 910 911		R: What happens when, I don't know if you ever had had a staff member who think I don't need supervision, or I don't want supervision?		
912 913 914 915 916 917 918 919 920 921 922	53:16	P: You have staff members who are scared of supervision. But not so much nowadays, but back in the day I have. Worked with people who would sit there, and we've got one at the moment who has just come into the NHS, she's never working in the NHS before, and I had to say "please don't be scared of me". Because I was talking to her and she was doing the whole "yeh yeh yeh", and I'm thinking she's like a rabbit in the headlights, she doesn't understand that supervision is not an opportunity for the boss to try and tell her off. She doesn't know what it is yet, but she'll be fine. But I had to say "please don't be scared of me", and she was like "ooh".	Fear of supervision Not understanding clinical role of supervision	
923 924		R: It's a strange concept if you've never come across it before isn't it, in terms of what it's about.		

		P: Yeh.		
	54:06	R: What else? Do you think the high turnover on acute has any kind of impact on anything we've been talking about in terms of compassion or attitudes?		
		P: Yeh because I think there is a capacity for people not to get to know people very well, and to have to make quick decisions, based on judgement rather than fact maybe. I'm not saying it happens, but I could see how it would happen, because it's like "bam bam bam". But also just being tired, and people are, in acute care now, more…. We don't get the worried well in, let's put it that way. Whereas when I started 20 years ago we got the worried well in, and they stayed for a long time.	Short admissions mean staff don't get to know patients Making quick decisions based on judgment/preconceptions Complexity of acute Competing demands in short time frame	*Not getting to know patients* – ***Lack of time and resources***
		R: And have you noticed a shift in that criteria? In terms of the type of people who are being admitted.		
		P: Oh definitely.		
		R: In terms of risk is it?		
		P: Yes, yeh risk. And challenging behaviour, and acuity, and they're kept out of hospital longer, but they're extremely poorly now when they get here. And you do think "phfff", if they'd have come into hospital earlier, would they have ever got this ill? But they have to get that ill to get into hospital.	Level of complexity admitted into ward	Complexity and level of demand – ***Competing demands***
		R: It's a catch 22 isn't it?		
		P: Yeh.		

		R: And you just mentioned something about, they might not always be able to get to know patients really well. What kind of impact do you think that has in terms of when people don't get to know patients well?		
	55:23	P: Well I think obviously, in terms of empathy, you have to get to know the people to be able to form an empathic relationship. I think you're probably not going to develop empathy in some ways. Particularly for people who, you know there are some people who come in and they're in a sorry state, and of course you're empathic, but then there might be other people who come in and they're bouncing round, and they're taken a load of drugs or they're drying out or whatever, and they don't normally elicit empathy, so readily, as the person who comes in from severe self-neglect, or in extreme distress because of the voices they're hearing or whatever. So it's easier to form empathic relationships with some people than it is with others, because of the circumstances I guess.	Knowing people forms empathy Incongruence in presentation activates appraisal or worthiness	Knowing people forms empathy – ***Knowing and understanding*** Incongruence in presentation activates appraisal or worthiness – ***Appraisal of deservedness***
		R: And do you think that hearing about people's histories helps that?		
	56:16	P: Oh definitely. Definitely. Being able to go through, you know. The whole thing with people with personality disorders, the people that we see who are extremely traumatised, or have been extremely traumatised, and I only have to say "this is the person's back story" and nobody starts saying "they're a pain, they're doing this". There is that whole idea that there but for the grace of god go I.	Sharing backstory restores compassion Knowing history stops negative appraisal	Sharing/knowing backstory restores compassion, prevents negative appraisal – ***Re-engaging with knowing and understanding***
		R: And is there a place where histories can get shared? So I guess I've done interviews with nurses who have said, we just don't have time to read through the notes.		
	56:58	P: Well you know, that just part of your job as far as I'm concerned. I know people can say that, but it doesn't take that much time to read just through documents and find a good clinical history or a psychologist's	Should be part of job	

989 990 991 992 993 994 995 996		report or a CARSO [risk assessment], or whatever. Or we might not have a person's history, to start with. I think that's an excuse really. Because you can… You know you go to ward rounds, we have handovers to feedback, all those sorts of things. You know, there are times in the day when people could choose to just go and have a look and see "what can we find out about this person". If I find a good psychology report I'll print it off and share it.		
997 998 999	57:42	R: And am I right in thinking that you don't have psychology on the wards?		
1000 1001		P: No we don't.		
1002 1003		R: And do you think there is a role for psychology?		
1004 1005 1006 1007 1008 1009 1010 1011 1012		P: Massive role. Massive. You know, I think that psychology on the ward would be excellent for the service users obviously, but also to give opportunity for reflective reviews and to work with staff. Because staff, they get traumatised, some people get traumatised, but what's going on and what they're seeing. The sheer volume. There is a lot of work, there is a lot of work, but everybody has access to care notes. To have a look and see. And I don't expect any of my staff starting to work with people until they've read about them.	Role of psychology in providing space to reflect Becoming traumatised by witnessing events Volume of work	Exposure to incidents traumatising – ***Being overwhelmed by complexity/risk***
1013 1014		R: So that's like the first step before you even…?		
1015 1016 1017 1018		P: Yeh. Yeh. Otherwise you're going in blind. What are you going to interview them about? What are you going to ask them? What shouldn't you be asking them?	Going in blind without history	
1019 1020	58:42	R: And do you know, is there a reason there isn't psychology on the wards? Is it a historic thing?		

1021				
1022		P: Historic finance, I would imagine. Don't quote me on that.		
1023		Because there has never been psychology on the ward, and there will be a		
1024		financial. You know they need to pay someone and they won't.		
1025				
1026		R: What do you think helps makes you be able to maintain		
1027		compassion both personally and organisationally? Are there structures in		
1028		place or things that you do that you think keep you happy and healthy and		
1029		well and able to do your job well?		
1030				
1031		P: I don't know if… I mean there has got to be a culture, and an	Culture of compassion support individual compassion	
1032		attitude, that helps to maintain that and support that.		
1033				
1034		R: What level do you think that's at? Like trust wide or your direct		Culture supports individual compassion – ***Compassion across the system***
1035		superiors, or your team?		
1036				
1037		P: It's got to be at every level. If it's going to work it's got to be at	Compassion across every level	
1038		every level. It can't be owned by the top, it can't be owned by the		
1039		bottom, because unless they're both on board, it's not going to work. So I		
1040		think there's the culture, and the team culture, which directly affects you.	Impact of team culture	
1041		And the people who, you managers, but also the Trust in general, so I	Feeling effect of organisational compassion	
1042		think organisationally it's got to come from that to maintain it, because		
1043		people can come in full of empathy, and I'd imagine end up having it just		
1044		beaten out of them, by being in the wrong place with the wrong people.		
1045		It's becoming less and less though, you'll go on the ward and there will be		
1046		a few people who just rule the roost, you know, it's not happening… it		
1047		doesn't happen like that anymore, it doesn't feel like it happens like that		
1048		anymore. It really genuinely doesn't. And I'm not going back that far, 20		
1049		years is nothing, god what was it like 40 years ago. God knows. So I		
1050		think that's important, but I think from a personal point of view, and I	Underlying values help maintain compassion and empathy	
1051		think that applies to the individuals, it's about…. It's from within. It's got		
1052		to be. You either are a person who is empathic or you're not. And for		

1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067	 61:59	me, empathy doesn't…. I would never describe myself as empathetic, it's not a word I associate with myself, but I am a person who thinks it's really important to do the right thing, and the right thing means treating people properly. And I don't always get it right, I'm not a saint, I don't say that in my personal life I don't have a bitch about friends sometimes, you know, I have got a bad sense of humour, but I just think ultimately… I will never be in a position where somebody is saying to me "you did that because you didn't care or you didn't do the right thing". It isn't in me. I know it isn't. R: And it sounds like even before the empathy there is an underlying value there? P: Yes it's values. Ultimately it's values and attitude. I think.	Doing the right thing Always caring – personal value Values and attitude	Underlying values help maintain compassion and empathy – ***Qualities of compassion***

Appendix 2-C
Example of a memo

Memos were written for each emerging sub-category and took the form of written and diagrammatic notes. They documented the thought processes and ideas of the researcher and began to make links between sub-categories, and the processes underpinning the movement between categories, whilst considering how sub-categories fell into overarching theoretical categories. They also included a collection of relevant quotes from the transcripts to shape thoughts and ideas, and to ensure closeness with the source material. The following memo example is for the category knowing and understanding.

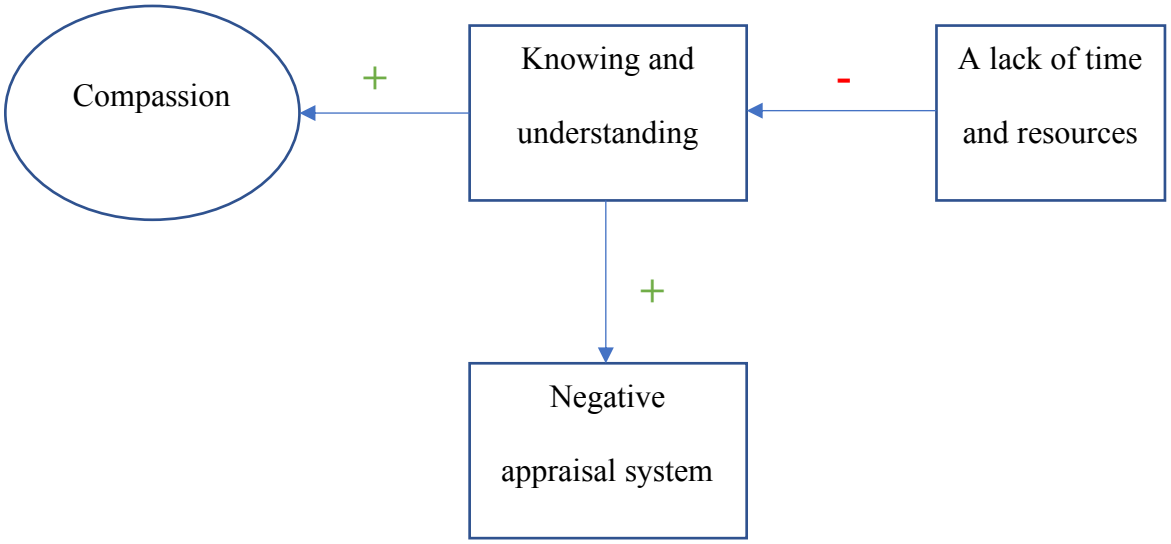
Knowing and understanding

Participants consistently spoke about the importance of knowing and understanding a client in order to feel and demonstrate compassion. This often took the form of knowing and understanding a client's history, experiences and trauma, which triggered feelings of empathy. Some participants mentioned the role of personal resonance in the feeling of compassion, and they felt more connected and moved if a patient reminded them of someone they knew, or of their own personal experience. When participants felt empathy, compassion and connection, they were motivated to display compassion to the patient, and act to alleviate their suffering.

This understanding was also helpful in the context of risk, as participants were able to understand the function of a risky behaviour based on the patient's history. This reduced the negative appraisal system and fostered feelings of empathy and connection.

Interestingly, although acknowledged as important in the adaption of a compassionate stance, participants consistently spoke about having a lack of time to read a patient's history, which not only reduced compassion, but also left them making judgements about care,

without knowing the person. This left them feeling inadequate and frustrated that they were unable to provide the level of care that they aspired to.



Quotes

"I think it's being understanding of what someone has been through, and how you display that towards the person. I think that's in its simplest terms. You know, without being judgemental, understanding where certain behaviours have come from, and then just displaying the appropriate care and affection in relation to that" (Robert)

"And I think that, those experiences and the vulnerability, was what made me feel very very strongly" (Maria)

"And also what helps people is also if they have got a similar experience like that, that they can tap into. Loss for example, is something that most people relate to, and that helps people feel the compassion, when they can tap into their own loss, and how they've dealt with it." (Maria)

“there is a real sense of knowing that this poor lad hasn’t had a chance. You know. And everything around him in his world has been forced, what we are seeing now is a result of lived experiences, and treatment from the environment, rather than being inherently bad.” (David)

“without being judgemental, understanding where certain behaviours have come from, and then just displaying the appropriate care and affection in relation to that” (Robert).

Section Three: Critical Appraisal

Word count: 3,242

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Introduction

This critical appraisal will explore the origins of this project, the underlying personal and professional values that underpin the research, the research process and challenges encountered, and areas for future research. Firstly, I will offer a summary of the findings of the research paper. Secondly, my epistemological position, and the terminology used throughout the paper will be considered. Thirdly, I will discuss my relationship with compassion, and the compassionate stance I attempted to take throughout the interviews, analyses and reporting. Fourthly, I will consider challenges when conducting this research, particularly in relation to recruitment, and the lasting impact this research has had on my views and clinical practice. Finally, I will offer my opinions on areas for future research.

Summary of findings

This project aimed to explore staff's conceptualisations of the development, loss and restoration of compassion within acute inpatient wards. Using grounded theory informed methodology, a sequential model was developed that included five theoretical categories: A compassionate stance, the challenges of acute, feeling under threat and the negative appraisal system, restoring compassion and the compassionate organisation. Participants began their work from a compassionate stance, but the lack of time and resources, and competing demands, began to deplete their capacity for compassion. When participants felt overwhelmed by complexity and risk, this elicited feelings of inadequacy, concern about professional scrutiny, and participants felt the need to protect their own emotions. This activated the negative appraisal system, whereby participants made judgements about patients based on negative pre-conceptions surrounding diagnosis and presentation, which could lead to a lack of compassion, depersonalisation, and the rejection of the 'difficult' patient. However, participants' compassion began to be restored by offering and receiving support from colleagues, re-engaging with knowing and understanding a patient, and accessing a

reflective space. Finally, if staff felt compassion from the organisation, this reduced the impact of the challenges of acute wards and feelings of threat, restoring and renewing staff's capacity for compassion.

My Epistemological Position

Epistemology is concerned with "how we know what we know" (Crotty, 1998, p. 8)**;** that is the philosophical underpinning on which we decide what kind of knowledge exists, which shapes our choice of methodology in research. Over the course of doctoral training, my epistemological position has changed, shifted and evolved. I came onto the course having worked in a setting where the medical model was still very prominent, namely secure services. At this point, I hadn't really considered the construction of reality, and probably would have broadly identified as a positivist. However, throughout the course of teaching, I began to become more interested in people's experiences: their experience of diagnosis and of mental health services, and how these shape their view of themselves, their 'illness' and their prognosis for the future. I became acutely aware of the power of language, and once I'd engaged with the literature around 'evidence based practice', and the assumptions on which NICE guidance is formed (Marzillier, 2004; Mollon, 2009), I realised my position had shifted to one of a social constructionist. That is, that there is no objective reality, but that reality is a social construct, contingent on interactions between people and their world (Crotty, 1998; Mills, Bonner, & Francis, 2006). This fitted with my developing beliefs that people are inherently shaped and influenced by their experiences of their world, which led to a desire to conduct research from a qualitative standpoint, to hear and understand people's experiences of a phenomenon.

Qualitative research provides a 'richness' of data that is sometimes missed in quantitative research (Braun & Clarke, 2013; Charmaz, 2006). Once the research question had been developed, consideration was given to the most appropriate methodology.

Holloway and Todres (2003) argue that the correct methodology is the one that best answers the research question. Given the lack of previous research in the topic area, and its emphasis on understanding processes, grounded theory felt like the most appropriate methodology to answer the research question. Given my social constructionist position, the epistemological position of Charmaz's (2006) constructivist grounded theory aligned with my own views on the nature of knowledge. Its embracing of the influence of the researcher was also freeing in a way that Glazer and Strauss's (1967) original methodology is not; Glazer and Strauss (1967) advocate that the researcher avoids reading the literature base, to prevent tainting the data, a recommendation that is difficult to adhere to when conducting a DClinPsy thesis. As such, given the research question's emphasis on exploring process, and my own epistemological position, Charmaz's (2006) grounded theory was chosen as the most appropriate methodology for this particular project.

A Consideration of Language and Terminology

Throughout the results and discussion of the empirical paper, I have often referred to people admitted to and residing on the wards as 'patients'. I gave this terminology much consideration, as I generally try to avoid the use of medicalised language and labels in my clinical practice. The debate around appropriate terminology has been well documented, particularly in relation to the diagnosis of personality disorder (Coles, 2011; Kinderman, 2017; Recovery In The Bin, 2016). Critics have argued that diagnostic labels increase stigma, shame, and disempower and medicalise the experience of psychological distress (Coles, 2011; Kinderman, Read, Moncrieff, & Bentall, 2013). Interestingly, although none of the interview questions in this project enquired as to specific client groups or diagnosis, the majority of participants made mention to service users with a diagnosis of personality disorder being the most challenging to care for compassionately. This perhaps supports the argument that certain diagnoses elicit negative pre-conceptions, stereotypes and judgements.

However, the argument becomes less clear when considering the more general terminology of 'patient', 'service user' or 'client'. Whilst staff in community settings would most often refer to people using their service as 'service users' or 'clients', the term 'patient' is still widely, and almost exclusively, used in inpatient settings. This is most likely due to the dominance of the medical model, which remains prominent in inpatient mental health settings (Bentley, 2014; Clarke & Wilson, 2009). The term carries certain connotations around mental health being an 'illness', creating an inherent power imbalance between care givers and care receivers (Barnett, 2018; Kinderman, 2017; Kinderman et al., 2013). These views fit with my own; that the labelling of psychological distress as illness is often unhelpful, as it can disempower, marginalise and stigmatise those most in need of support.

Conversely, however, research examining service user perspectives has shown a consistent and overwhelming preference to be referred to as 'patient' (McGuire-Snieckus, McCabe, & Priebe, 2003; Ritchie, Hayes, & Ames, 2000; Simmons, Hawley, Gale, & Sivakumaran, 2010). When considering my choice of terminology, I wanted to ensure that the voice of the participants was heard and reflected throughout the report, and the term most often used by staff in interviews was that of 'patient'. I considered using the term 'service user' in my own narrative, whilst keeping the term 'patient' when quoting participants; however, this felt disingenuous, and created separation between myself and participants, whose views I was trying to reflect. Having considered all the available evidence, I have generally chosen to use the term 'patient' to ensure I have adequately captured the views of participants. However, I acknowledge the controversy, and agree with the sentiments of critics.

My Relationship with Compassion

I have always been interested in compassion within healthcare, having worked in a number of environments where maintaining compassion has been a challenge for staff, for a

myriad of reasons. In 2017, as part of my doctoral training, I undertook a placement across two acute wards, and again witnessed many fluctuations in compassion, attitudes and warmth towards patients. I was also struck by the complexity of the environment, the speed at which the staff were required to work, and the overwhelming level of distress and risk that patients admitted to the wards were presenting with. It was during this time that I met my then supervisor, and field supervisor of this project, Dr Sian Bensa. Within supervision, Sian and I had many discussions about the almost daily trauma experienced by staff and the impact that this must have on their feelings of compassion, particularly towards patients presenting with high levels of risk. It was then that I was introduced CFT and was able to conceptualise the role of the threat response in limiting feelings of safety and security. And through this model, I was able to really engage with feeling compassion for the staff, by understanding how complex and threatening this environment is to work in.

A Compassionate Stance

My curiosity from my clinical work in this environment eventually informed the development of this project. I knew that the NHS had placed great emphasis on the need for compassion from their staff, particularly following the Francis report (Francis, 2013; NHS England, 2012, 2013; NHS Improvement, 2016; West, Eckert, Collins, & Chowla, 2017). However, on beginning to engage with the research base, I was surprised to find a lack of agreement on what constitutes compassion and compassionate care (Fernando & Consedine, 2014; Ledoux, 2015; Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-Macdonald, 2017). Equally, there appeared to be a lack of acknowledgment from the NHS that maintaining compassion is a complex process, particularly in challenging environments such as acute wards. This idea was further confirmed with how compassion is described and discussed in the research base; there is a wealth of literature on compassion fatigue, but comparatively little on compassion. Anecdotally from working within these environments, I

also felt that staff were not either compassionate or compassion fatigued, but that compassion fluctuates at different times and with different people, and I wanted to further understand the processes underpinning the development, loss and restoration of compassion.

Clinically, I had seen the effect that a lack of compassion can have on patient care, and the detrimental impact it can have on patients' views of mental health services. These concerns have been noted elsewhere, with multiple reports highlighting poor standards of care in acute inpatient wards (Crisp, Smith, & Nicholson, 2016; Department of Health, 2002; Griffiths, 2002; Norton, 2004). However, it was imperative to me throughout the project that I explored this process from a stance of compassion; to understand, conceptualise and compassionately convey the challenges and complexities that staff face in attempting to maintain compassion in an incredibly complex environment. I made a conscious decision to use the term compassion, as opposed to compassion fatigue, on all the study documentation sent to ethics boards and participants; this helped ensure that the project adopted a compassionate stance from the outset. It also normalised fluctuations in compassion, which I believe allowed participants to be open and honest about their experiences, without feeling scrutinised or judged.

Indeed, my compassion was sometimes challenged, particularly when hearing some participants' views on the challenges of working with patients with a diagnosis of personality disorder, for example this quote from Robert:

> but sometimes like, with your personality disorders when people are just, they've reached sort of the levels, the ward has been a bit unsettled, you can see people might be a bit abrupt, not intentionally, but you might consider that, you know, a compassion. I mean they don't do that intentionally, obviously, more often than not, if not always, some trauma that has taken place, but I think you know…. they can be quite demanding, and then demand a lot of staff time, you might be like fire-fighting

> if you've got more than one personality disorder, you're sort of just dealing with that, and sometimes through no fault of your own some other service users might be neglected because of that.

Reflecting on this after the fact, I think that my emotional reaction to this statement, and statements such as this, were due to my conceptualisation of 'personality disorder' being vastly different to the sentiment being expressed. I strongly believe that difficulties that are labelled personality disorder are a result of experienced trauma, a position that has long been expressed in the research base (Herman, Perry, & van der Kolk, 1989; van der Kolk, Hostetler, Herron, & Fisler, 1994). Whilst Robert acknowledges the role of trauma, he also appears to be making a number of judgements based on diagnosis alone, which was difficult to reconcile with my own views.

To regain a compassionate stance, I reminded myself of the challenges and complexities that staff on wards such as this face. And in fact, that was the exact point that Robert was trying to convey: that staff are sometimes overwhelmed by complexity, risk, and the need to keep the ward and patients safe. I was also able to discuss these feelings in supervision with my field supervisor, whose vast experience in the area was helpful in normalising both mine and Robert's feelings. And whilst my compassion may have been temporarily challenged, it was restored by understanding the participant's context, receiving support from my supervisor, and accessing a reflective space, mirroring the restorative processes outlined by participants in this research.

The Challenges of Recruitment

Given that paper 1 and 2 both outlined the challenges of working in the acute inpatient environment, it is perhaps unsurprising that recruitment was a challenge. Staff working on these wards are often overwhelmed with demand, and as highlighted in the empirical paper, lack the time to engage in activities other than what is necessary for the day-

to-day running of the ward. The recruitment of nursing staff was perhaps the most challenging; there were many times that I had agreed appointments, only to receive an email to say they could no longer make it due to the demands of the ward. Although, at times, frustrating, it was really a reflection of the topic of interest, and the challenges of working within this fast-paced, often chaotic environment. This quote from David sums up the issue:

> One of our wards has five admissions and five discharges a day, working on four staff, one nurse might be in review, what's the other nurse got to do? Five care plans, five admission plans, the volume of admin means that they never feel like they've got a moment. So if you're working in a system like that, how can you possibly, even if you were compassionate, demonstrate it?

Given these challenges, it was remarkable that four nursing staff were able to find time out of their busy days to meet with me, and their voices and views were so necessary in this research. It is the nursing staff who, day in, day out, have to cope with the demands of the ward, with very little time for breaks or space to reflect. Their contribution to understanding the topic was invaluable.

The Lasting Impact

There have been times in the past where I have felt frustrated and disappointed at the apparent lack of compassion demonstrated by staff towards service users, and concerned about the lasting impact that this may have on their experiences and understanding of their distress. Whilst I still believe that compassion is fundamentally important to care provided by NHS services (NHS England, 2012, 2013; NHS Improvement, 2016; West et al., 2017), I now feel I have a better understanding of the challenges faced by staff, the daily demands and expectations, and the trauma staff are exposed to in trying to care for those with high levels of risk.

I knew from my clinical experience within these environments that resources were painfully limited; that there were often inadequate levels of staffing to allow staff and patients to feel safe, contained and supported. However, when I began to look at the data, I was surprised to find just how overwhelming this disparity truly is. Due the NHS's drive to reduce inpatient admissions, the number of mental health inpatient beds has been reduced by 72% since 1987 (Ewbank, Thompson, & McKenna, 2017). And whilst I agree with the rationale for avoiding hospital admissions (Imison, Sonola, Honeyman, & Ross, 2014), the demand for inpatient care has not fallen in-line with bed decreases, exacerbated by a shortfall in funding to provide alternatives to inpatient care (Gilburt, 2015; Royal College of Psychiatrists, 2016). A report in 2016 found that 93% of wards were operating above the Royal College of Psychiatrists' recommended occupancy rate of 85%, with some wards at 147% capacity (Royal College of Psychiatrists, 2016).

For participants working in this context, it is perhaps unsurprising that themes emerged around having a lack of time and resources, a limited capacity for compassion and feeling under threat. My feelings of frustration and disappointment have diminished, at least towards the individual staff who are tirelessly attempting to provide adequate care in these under-resourced, challenging and sometimes frightening environments. Instead, these feelings have been replaced with compassion: recognising the staff's distress and being motivated to alleviate it. I hope that my writing of this report has done just that; that it will support organisations to understand the complexity of maintaining compassion in these challenging environments, and to recognise their responsibility and role in supporting staff to deliver the compassionate care they desire. As Elaine so eloquently put it: "Compassion definitely needs investment".

Directions for Future Research

Although the empirical paper has made helpful contributions to the understanding of the processes underpinning staff compassion, I am aware that I only elicited the views of staff and did not consider the views of service users. I considered including service users' views when initially developing the project; however, I knew I had to be realistic about time, and what would be achievable in the 9 months available in which I had to complete this thesis. Future research incorporating service user perspectives on their experiences of compassion and compassionate care in acute inpatient wards would be of benefit.

There appeared to be some overlap between the model of compassion developed in the empirical paper, and models of burnout previously proposed (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Xanthopoulou, Bakker, Demerouti, & Schaufeli, 2007). This was particularly evident in the theoretical categories of the challenges of acute wards and feeling under threat, which appeared to mirror both the JD-R model of burnout, (Demerouti et al., 2001; Xanthopoulou et al., 2007), as well as the original domains of burnout outlined by Maslach and Jackson (1981). Specifically, there appeared to be processes that were akin to emotional exhaustion (a depleted emotional capacity) and depersonalisation (the holding of negative, cynical views about clients). It was unclear whether participants were experiencing elements of burnout.

Whilst there is research that outlines the relationship between burnout and compassion fatigue (Keidel, 2002; Rossi et al., 2012; Zhang, Zhang, Han, Li, & Wang, 2018), there is little research examining the impact of burnout on the maintenance of compassion. Conducting a measure of burnout prior to interview would be of use, in an attempt to notice differences in participants' accounts dependent on their level of experienced burnout. Further qualitative and quantitative research exploring the relationship between the

two would be also be beneficial in further conceptualising the association between these two distinct, but apparently related, constructs.

Conclusion

This critical appraisal has explored the values, stances and processes underpinning the completion of this project on the development, loss and restoration of compassion in acute inpatient staff. It has considered epistemology, terminology, my relationship with compassion and challenges that arose in the recruitment process. It commented on my own experiences of the loss and restoration of compassion, mirroring the processes outlined by the participants in this study. Finally, it has made suggestions for future research, to develop and extend the study's findings.

References

Barnett, N. (2018). Person-centred over patient-centred care: Not just semantics. *Clinical Pharmacist, 10*(4). https://www.pharmaceutical-journal.com/opinion/insight/person-centred-over-patient-centred-care-not-just-semantics/20204578.article?firstPass=false

Bentley, M., C. (2014). *How clinical psychologists experience working in an acute mental health inpatient setting*. (Unpublished doctoral thesis). University of Hertfordshire. Herfordshire, UK. Retrieved from https://uhra.herts.ac.uk/bitstream/handle/2299/14328/12019289%20-%20Bentley%20Mary%20-%20Amended%20submission.pdf?sequence=1&isAllowed=y

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: SAGE Publications.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: SAGE Publications.

Clarke, I., & Wilson, H. (Eds.). (2009). *Cognitive behaviour therapy for acute inpatient mental health units: Working with clients, staff and the milieu*. London: Routledge.

Coles, S. (2011). Borderline personality disorder: This house believes. *Clinical Psychology Forum, 225*, 15-18.

Crisp, N., Smith, G., & Nicholson, K. (2016). *Old problems, new solutions: Improving acute psychiatric care for adults in England*. Retrieved from https://www.basw.co.uk/system/files/resources/basw_92050-3_0.pdf

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: SAGE Publications.

Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The Job Demands-Resources model of burnout. *Journal of Applied Psychology, 86*(3), 499-512. doi:10.1037/0021-9010.86.3.499

Department of Health. (2002). *Mental health policy implementation guide: Adult acute inpatient care provision.* Retrieved from http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009156

Ewbank, L., Thompson, J., & McKenna, H. (2017). *NHS hospital beds: Past, present and future*. Retrieved from https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers#reducing-reliance

Fernando, A. T., & Consedine, N. S. (2014). Beyond compassion fatigue: The transactional model of physician compassion. *Journal of Pain and Symptom Management, 48*(2), 289-298. doi:10.1016/j.jpainsymman.2013.09.014

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: Executive summary.* Retrieved from

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

Gilburt, H. (2015). *Mental health under pressure*. Retrieved from https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/mental-health-under-pressure-nov15_0.pdf

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. London: Weidenfeld and Nicolson.

Griffiths, H. (2002). Acute wards: Problems and solutions. *Psychiatric Bulletin, 26*(11), 428.

Herman, J. L., Perry, J. C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry, 146*(4), 490-495.

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research, 3*(3), 345-357. doi:10.1177/1468794103033004

Imison, C., Sonola, L., Honeyman, M., & Ross, S. (2014). *The reconfiguration of clinical services: What is the evidence?* Retrieved from https://www.kingsfund.org.uk/sites/default/files/field/field_publication_summary/Reconfiguration-of-clinical-services-kings-fund-nov-2014.pdf

Keidel, G. C. (2002). Burnout and compassion fatigue among hospice caregivers. *American Journal of Hospice and Palliative Medicine, 19*(3), 200-205. doi:10.1177/104990910201900312

Kinderman, P. (2017, 26 April). Our turbulent minds. *The Psychologist.* Retrieved from https://thepsychologist.bps.org.uk/our-turbulent-minds

Kinderman, P., Read, J., Moncrieff, J., & Bentall, R. P. (2013). Drop the language of disorder. *Evidence Based Mental Health, 16*(1), 2-3. doi:10.1136/eb-2012-100987

Ledoux, K. (2015). Understanding compassion fatigue: Understanding compassion. *Journal of Advanced Nursing, 71*(9), 2041-2050. doi:10.1111/jan.12686

Marzillier, J. (2004). The myth of evidence-based psychotherapy. *The Psychologist, 17*(7), 392-395. https://thepsychologist.bps.org.uk/volume-17/edition-7/myth-evidence-based-psychotherapy

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior, 2*, 99-113.

McGuire-Snieckus, R., McCabe, R., & Priebe, S. (2003). Patient, client or service user? A survey of patient preferences of dress and address of six mental health professions. *Psychiatric Bulletin, 27*(08), 305-308. doi:10.1017/S0955603600002798

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative methods, 5*(1), 25-35.

Mollon, P. (2009). The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help. *Psychodynamic Practice, 15*(1), 9-24. doi:10.1080/14753630802614457

NHS England. (2012). *Compassion in practice*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

NHS England. (2013). *Compassion in practice – one year on*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/05/cip-one-year-on.pdf

NHS Improvement. (2016). *Developing people improving care: Compassionate, inclusive and effective leaders at all levels*. Retrieved from https://improvement.nhs.uk/documents/3756/01-NHS114-04_Improving_Care_Mini_Guide-Condition_2_041018_I.PDF

Norton, K. (2004). Re-thinking acute psychiatric inpatient care. *International Journal of Social Psychiatry, 50*(3), 274-284. doi:10.1177/0020764004043146

Recovery In The Bin. (2016). A simple guide on how to avoid receiving a diagnosis of 'personality disorder'. *Clinical Psychology Forum, 279*, 13-16.

Ritchie, C. W., Hayes, D., & Ames, D. J. (2000). Patient or client? The opinions of people attending a psychiatric clinic. *Psychiatric Bulletin, 24*(12), 447-450. doi:10.1192/pb.24.12.447

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., . . . Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research, 200*(2), 933-938. doi:https://doi.org/10.1016/j.psychres.2012.07.029

Royal College of Psychiatrists. (2016). *Old problems, new solutions: Improving acute psychiatric care for adults in England*. Retrieved from https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/policy/old_problems_new_solutions_caapc_report_england.pdf?sfvrsn=610ebd71_2

Simmons, P., Hawley, C. J., Gale, T. M., & Sivakumaran, T. (2010). Service user, patient, client, user or survivor: Describing recipients of mental health services. *The Psychiatrist, 34*(1), 20-23. doi:10.1192/pb.bp.109.025247

Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-Macdonald, L. (2017). Compassion fatigue: A meta-narrative review of the healthcare literature. *International Journal of Nursing Studies, 69*, 9-24. doi:10.1016/j.ijnurstu.2017.01.003

van der Kolk, B. A., Hostetler, A., Herron, N., & Fisler, R. E. (1994). Trauma and the development of borderline personality disorder. *Psychiatr Clin North Am, 17*(4), 715-730.

West, M., Eckert, R., Collins, B., & Chowla, R. (2017). *Caring to change: How compassionate leadership can stimulate innovation in health care*. Retrieved from

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf

Xanthopoulou, D., Bakker, A. B., Demerouti, E., & Schaufeli, W. B. (2007). The role of personal resources in the Job Demands-Resources model. *International Journal of Stress Management, 14*(2), 121-141. doi:10.1037/1072-5245.14.2.121

Zhang, Y.-Y., Zhang, C., Han, X.-R., Li, W., & Wang, Y.-L. (2018). Determinants of compassion satisfaction, compassion fatigue and burn out in nursing: A correlative meta-analysis. *Medicine, 97*(26), e11086. doi:10.1097/MD.0000000000011086

Section Four: Ethics Section

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Research Protocol

Title: Staff compassion in acute mental health care: A grounded theory investigation.

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Research Supervisor: Dr Ian Fletcher (Senior Lecturer, Lancaster University)

Field Supervisor: Dr Sian Bensa (Clinical Psychologist)

Introduction

There has been an increasing focus in research, policy and practice on the importance of compassion in health care. Following consultation with the public, service users and staff, compassion became one of the NHS's core values in 2008 (Darzi, 2008). However, a number of high profile investigations into failings in NHS care have identified a lack of compassion as a contributing factor in the poor care received by service users (Berwick, 2013; Francis, 2013).

Whilst investigations have highlighted the need for improved compassion in services, there is surprisingly little research on this topic area, particularly relating to mental health services. This is perhaps due to a lack of collective understanding of compassion, and what constitutes compassionate care (Brown, Crawford, Gilbert, Gilbert, & Gale, 2014; Dewar, Pullin, & Tocheris, 2011; Goetz, Keltner, & Simon-Thomas, 2010; Sinclair et al., 2016; Spandler & Stickley, 2011).

Multiple definitions of compassion have been proposed, such as "a deep sensitivity to the suffering of self and others, with a deep commitment to try and relieve it" (Gilbert, 2010, p. 3) and, alternatively, "the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help" (Goetz et al., 2010, p. 351). However, previous research has highlighted the difficulty in transferring these definitions

into practice, due to lack of agreement amongst professionals of what constitutes compassionate care (Barron, Deery, & Sloan, 2017; Dewar et al., 2011). And whilst policy makers emphasise the importance of compassion in health services, they fail to make suggestions as to how to transfer this into service delivery (Lee, Laurenson, & Whitfield, 2012). Research agrees that compassion is fundamentally interpersonal in nature; the relationship between staff and service users is critical to service users feeling compassionately cared for (Brown et al., 2014; Dewar et al., 2011). Service users and their families consistently rank compassion as one of their highest requirements when receiving care (Sinclair et al., 2016).

There has been debate in the literature about the taxonomy of compassion; that is, whether it is an emotional state (Goetz et al., 2010; Nussbaum, 1996) or an attitude (Blum, 1980; Sprecher & Fehr, 2016). Similarly, researchers have debated compassion's similarities and differences to empathy, sympathy and pity (Wispé, 1986), which Goetz et al. (2010) propose belong to the same emotional family as compassion. However, they suggest that while these states share common features with compassion, they differ in terms of peripheral appraisal (e.g. appraised inferiority of other in the case of pity) and display behaviour (Goetz et al., 2010).

Evolutionary theories have proposed that compassion is distinct from other, similar emotions (e.g. love, distress) in that it is "orientated towards reducing the suffering of others" (Goetz et al., 2010, p. 356). Researchers have theorised that it has developed through the need to recognise and alleviate suffering in young offspring (Sober & Wilson, 1998), selection of a mate with desirable, altruistic characteristics (Kenrick, Ackerman, & Ledlow, 2003) and/or the need to form and maintain reciprocal community relationships (Trivers, 1971).

Goetz et al. (2010) combined evolutionary theories with current understanding to propose a model of compassion. The model outlines the appraisal process that occurs prior to compassion being felt. Individuals initially identify the target (the person who is suffering), evaluate whether the target is deserving of help, and whether they themselves have the resources necessary to provide that help.

This model acknowledges that even if the individual appraises the target to be deserving, that their own resource limitations may prevent them from feeling compassionate towards the other. This appears particularly relevant to staff currently working within the NHS; increases in work-load and external pressures have likely had an impact on individuals own resources (Health and Safety Executive, 2016; NHS England, 2016).

Goetz et al. (2010) also discuss the cost of providing compassion: individuals with low coping ability are more likely to feel overwhelming distress than compassion when confronted with another's suffering (Hoffman, 1981; Lazarus & Folkman, 1984). This has often been labelled compassion fatigue, defined as "losing the ability to care compassionately for patients", and can occur when staff feel overwhelmed by their constant contact with intense distress (Lee et al., 2012, p. 123). Staff experiencing burnout are also more likely to simultaneously suffer from compassion fatigue (Rossi et al., 2012). It would make sense, therefore, that in environments where staff are expected to care for many acutely distressed service users, maintaining compassion may prove difficult, and come at a greater personal cost.

Acute inpatient units admit service users who cannot be cared for safely in a less restrictive environment, due to the risk to themselves or others (Bowers, Chaplin, Quirk, & Lelliott, 2009). Their distress can be exacerbated by admittance to an unfamiliar environment, or the process of having been sectioned under the Mental Health Act (Deacon, Warne, & McAndrew, 2006; Hughes, Hayward, & Finlay, 2009; Joint Commissioning Panel

for Mental Health, 2013). The numbers of weekly admissions to such a ward can be high, and research has shown that staff working on these wards suffer from high levels of stress and burnout (Currid, 2008; Deacon et al., 2006; Jenkins & Elliott, 2004). Staff suffering from burnout are more likely to also experience compassion fatigue (Rossi et al., 2012), suggesting that maintaining compassion in this pressured environment may be challenging.

Although reports have noted poor standards of care in acute inpatient wards (Crisp, Smith, & Nicholson, 2016; Department of Health, 2002; Norton, 2004), to date, only one article has examined compassion specifically in this environment. Crawford, Gilbert, Gilbert, Gale, and Harvey (2013) found an absence of compassionate language when interviewing staff specifically about compassion. Whilst staff felt that compassion was an important part of their role, they attributed difficulties with providing compassionate care to limited time and emotional distancing. The authors suggest that further research is required to gain a richer understanding of compassion and compassionate care in these settings.

The aim of the proposed research would be to explore staff member's understanding of compassion, and the role it plays in the care provided in acute inpatient settings. Given the currently limited research base, a grounded theory approach would be taken to allow development of a theory/model of staff compassion in acute inpatient settings.

Method

Participants

Professionals working on acute inpatient wards will be recruited. It is hoped that participants will be from a variety of professional backgrounds/training (e.g. psychologists, psychiatrists, nursing staff, health care assistants, occupational therapists etc.). This will allow exploration of similarities and differences in professionals' understanding of compassion and compassionate care.

Inclusion criteria:

- Minimum age of 18 years, maximum age of 65 years.
- Staff who currently work in on an acute mental health ward.
- Staff from any professional background with a clinical element to their role (e.g. psychiatrists, psychologists, nurses, health care assistants, occupational therapists etc.)
- Staff who are substantively employed on the ward
- Staff who have worked within an acute mental health ward for a minimum of 3 months.

Exclusion criteria:

- Less than 18 years of age or over 65 years of age.
- Staff who do not work on an acute mental health ward.
- Staff who work on an acute mental health ward, but do not have a clinical element to their role (e.g. house keeping, chefs, estates etc.)
- Staff who are not substantively employed on the ward (e.g. agency staff).
- Staff who have previously, but do not currently, work on an acute mental health ward.
- Staff who have worked on an acute mental health ward for less that 3 months.

Recruitment

Ethical approval will be sought from the Faculty of Health and Medicine Research Ethics Committee (FHMREC) at Lancaster University. Once ethically approved, the study will be reviewed and approved by the Health and Research Authority (HRA) to gain access to participants from multiple NHS Trusts, including [redacted]. Within these two trusts, it is

estimated that there will be 6-10 acute wards available from which to recruit staff. Each ward employs around 20-30 staff, which should provide a sufficient participant pool.

Information about the proposed research will be sent to ward managers, ward matrons, service managers and lead professionals (psychiatrists, psychologists etc.), to be disseminated through staff meetings. An information pack, including participant information sheet (Appendix A) and consent form (Appendix B) will be included in the dissemination. The lead researcher may also attend staff meetings to advertise the research. With consent, posters will also be displayed in staff areas with relevant details of the research. Potential participants will be able to contact the lead researcher via phone or email to register their interest in participating.

As grounded theory methodology will be utilised, the aim would be to recruit enough participants to reach theoretical saturation (Charmaz, 2006). A review of multiple grounded theory studies concluded that a set sample size cannot be recommended, due to the impact of the research scope and sensitivity of the phenomena being examined (Thomson, 2011). However, it is estimated that to reach theoretical sufficiency, a sample of between 15 and 20 participants is required. However, due to time and resource restraints, a pragmatic approach of reaching theoretical sufficiency, as opposed to saturation, may be required.

Consent

Participants will have had access to the information sheet for a minimum of 24 hours prior to the interview taking place. Once participants have shown an interest in participating either via phone, email or in person, a meeting will be arranged with the lead researcher at a suitable time and location, either at the staff member's workplace, or another suitable location (e.g. participant's home). During this initial meeting, potential participants will again be shown the information sheet (Appendix A) and will be given an opportunity to

ask any questions. If happy to proceed, the participant will be provided with the consent form (Appendix B) to read and initial.

In the case of an interview being conducted over electronic means, e.g. phone or web-based communication, the phone/video interview will be recorded, and all forms (consent, demographic etc.) will be read out to the participant during the interview. In this instance, verbal consent provided by the participant will be recorded and documented, therefore written consent for these participants will not be required.

Participants will be reminded during the consent process that confidentiality may be broken if a disclosure leads the main researcher to believe that a service user has been harmed, or is at risk of harm. If a disclosure is made, the immediacy of risk will be assessed. If the lead researcher believes a service user is at immediate risk of harm, the interview will be terminated, and the Research and/or Field supervisors will be contacted for advice on how to proceed. If the disclosure is historic, or the service user is not at immediate risk, the interview will be completed. At the completion of the interview, the Research and/or Field supervisors will be contacted for advice on how to proceed. This may result in the need to inform another relevant professional within the Trust of the disclosure.

Participants will also be reminded of their right to withdraw their consent at any time before, or during, the interview. Whilst every effort will be made to withdraw a participant's data after the interview, due to the nature of the write-up and submission of this project, this may not always be possible. As such, the participants will be informed that they can withdraw their data up to one week after the interview has taken place.

Once participants have signed the consent form, and any questions have been answered, the interview will begin and audio recording will commence using a Dictaphone.

Design

The research design will be qualitative in nature, and will take a grounded theory approach.

Service user involvement and opinion will be sought for the materials used, including the interview schedule. Feedback from relevant service users will be incorporated into the design. As this research is utilising staff as participants, opinions from staff currently employed in the NHS will also be sought and will inform the design of materials and the interview schedule.

Materials

The participant information sheet, consent form, interview schedule, distress protocol, breaking confidentiality protocol and participant debrief sheet can be seen in Appendices A-G.

Procedure

Information on the study will be sent to ward managers/ward matrons/service managers to disseminate in staff meetings, handover meetings and specialist inpatient meetings. Any staff who are interested in participating can contact the lead researcher via email or phone for more information or to arrange a suitable time/place to meet. This will primarily be at the staff member's place of work on NHS premises, but may also be at the participant's house if preferred by the participant. In this instance, the Lancashire Care NHS Foundation Trust lone worker policy, and Lancaster University safety in fieldwork guidance will be followed if visiting participants in their home environment. A 'check in' system will be in place so the researcher is able to inform someone of their safety both before and after a home visit. Whilst face-to-face interviews are preferable, interviews can also be conducted via the telephone or web-based electronic communication (e.g. zoom, skype) if preferred by the participant.

On meeting the participant, the consent procedure outlined above will be followed. General demographic information will be included on the consent form (e.g. age, profession, length of time since qualification, length of time in job role etc.). Once consent has been obtained, the researcher will ask the participant to complete a demographic information questionnaire (Appendix C). Following this, the researcher will begin audio recording using a Dictaphone, and the participant will be asked the questions contained in the interview schedule (Appendix D). It is estimated that the interview will last up to 60 minutes.
In the case of an interview being conducted over electronic means, e.g. phone or web-based communication, the phone/video interview will be recorded, and all forms (consent, demographic etc.) will be read out to the participant as part of the interview. Their answers will be recorded and documented by the researcher.

At the end of the interview, participants will be provided with a copy of the debrief sheet (Appendix G), and given the opportunity to ask any questions. The debrief sheet provides support information, contact information for the research team, and the complaints procedure. They will be reminded of their right to withdraw their consent/data, including the length of time after the interview in which they can withdraw (up to 1 week after the interview). They will then be thanked for their participation.

Data storage

All participant identifiable information (consent forms) will be scanned in a stored in a separate folder on the lead researcher's password protected personal file store on the Lancaster University network.

On completion of the interview, the audio recording will be uploaded to the lead researcher's password protected personal file store in Lancaster University's network (H-drive), which can be accessed remotely. If unavailable, the audio file will be transferred to an encrypted, password protected memory stick, until such a time where it can be transferred to

the lead researcher's personal file store on Lancaster University's network. As audio recordings may need to be referred to throughout the analysis process, they will be stored in the lead researcher's personal file store on Lancaster University's network until the project has been submitted, at which point they will be destroyed. Once transcribed, anonymous interview transcripts will also be stored on the lead researcher's personal file store on Lancaster University's network, and/or password protected, encrypted memory stick.

All research data will be encrypted, password protected and transferred to Lancaster University's Data Depository (via PURE) on completion of the study, and kept for a period of 10 years, in line with Lancaster University's data policy. Consent forms and anonymised data will be kept in separately in the Data Depository to maintain confidentiality. Data will be available via restricted access: data can be made available on request, but only to bona fide researchers who provide information regarding proposed use. The research co-ordinator in the Division of Clinical Psychology at Lancaster University will be responsible for deletion of the data at the end of the 10-year period.

Participant distress

If the participant becomes distressed during the interview, the distress protocol (Appendix E) will be followed. The interview will be paused, and the participant will be asked if they wish to terminate the interview. If requested, the interview will be terminated at this point. If the participant wishes to continue, and their distress has decreased, the interview will be recommenced. If the participant continues to be highly distressed, advice will be sought from the Research Supervisor and/or Field supervisor. The participant will also be asked if they would like anyone to be contacted (e.g. manager, colleague).

Breaking confidentiality

If a participant discloses information that leads the researcher to believe a service user has been harmed, or is at risk of harm, the breaking confidentiality protocol (Appendix

F) will be followed. Following the disclosure, the immediacy of risk will be assessed by the lead researcher. If the lead researcher believes a service user is at immediate risk of harm, the interview will be terminated. The participant will be informed of the need to contact Research and/or Field supervisors for advice on how to proceed. If the disclosure is historic, or the service user is not at immediate risk, the interview will be completed. At the completion of the interview, the lead researcher will inform the participant of the need to contact the Research and/or Field supervisors for advice on how to proceed. This may result in the need to inform another relevant professional within the Trust of the disclosure.

Ethics Processes

Ethical approval for the project will be sought from both the Faculty of Health and Medicine Ethics board at Lancaster University. Once ethical review has been granted, the study will also be reviewed and approved by the Health Research Authority.

Proposed Analysis

The proposed study would build upon the findings of Crawford et al. (2013), utilising qualitative techniques to further explore staff compassion within acute inpatient settings. Qualitative techniques are of particular use here, as they allow exploration of phenomena on which there is little prior research. These approaches also provide rich data, from which meaningful conclusions and recommendations can be drawn (Marshall & Rossman, 2016). As the current, small body of research on staff compassion has focused on nursing staff, the current research would expand upon this to include staff from a variety of professional backgrounds (e.g. psychiatrists, psychologists, nurses, occupational therapists etc.). Whilst Crawford et al. (2013) focused on compassion within language, their scope did not extend to outlining a substantive model as to staff's understanding and maintenance of compassion within this environment.

A grounded theory approach to qualitative data analysis is particularly suited to this type of investigation, as its primary aim is to offer an explanatory theory or model that is 'grounded' in the data (Charmaz, 2006; Starks & Brown Trinidad, 2007). It differs from other qualitative techniques in that it is predominantly concerned with understanding processes. This is in comparison to phenomenological analysis, which is more concerned with participant's experiences, and discourse analysis, which places a greater emphasis on language. It is therefore argued that grounded theory will enable the most meaningful analysis of the processes surrounding staff compassion, and allow suggestions for interventions/support to facilitate increased compassion in this environment.

Within the grounded theory approach, there are multiple methods available through which to analyse data. The researcher will be taking a constructionist epistemological stance, which acknowledges 'truth' to be socially constructed through language and social interactions. It also assumes that data gathered from interviews is collaboratively developed by researcher and participant; that is that the researcher unable to remove their influence from the interpretation of the data. However, utilising reflective memo writing, the researcher is transparent in their own influences and personal assumptions, providing a clear description of how theoretical models are constructed and their grounding in the data (Charmaz, 2006).

Initial interviews will be relatively broad and open-ended. Data collection and analysis will be iterative, allowing for adaption of the interview schedule as data emerges. Field notes and memos will be taken throughout to allow to provide analytic/reflective data required for grounded theory.

Analysis of the data will follow the method outlined by Charmaz (2006). Initially data will be analysed using inductive line-by-line coding. The 'constant comparative' method (Glaser & Strauss, 1967) will be employed throughout, making comparison to

previously collected and coded data. Memos and field notes will be incorporated into the analysis. This will lead to focused coding of the data: condensing and synthesising line-by-line coding to make sense of larger segments of the transcript.

Finally, focused codes will be analysed and combined to form (initially tentative) conceptual categories, informing an emerging theory/model. The aim would be to reach theoretical saturation, but due to time constraints, a pragmatic approach (reaching theoretical sufficiency) may be required.

Practical Issues

The main issue envisaged for this research will be recruiting sufficient numbers of participants. As stated above, although the aim would be theoretical saturation, theoretical sufficiency may be sufficient if recruitment proves difficult.

It is anticipated that interviews will be conducted at the participants' place of work. Finding a suitable space to conduct the interview and room bookings may cause difficulty. Liaising with the Field Supervisor and ward managers may help with this issue. Although face-to-face interviews would be preferred, interviews may be conducted via the telephone or web-based electronic communication (e.g. zoom, skype) if preferred by the participant.

Alternatively, interviews may be conducted at the participant's home, at the participant's request. In this instance, the Lancashire Care NHS Foundation Trust lone worker policy, and Lancaster University safety in fieldwork guidance will be followed if visiting participants in their home environment. A 'check in' system will be in place so the researcher is able to inform someone of their safety both before and after a home visit.

Equally, finding available time to conduct interviews with NHS staff members might be an issue. Negotiation with service and ward managers may be required, to ascertain

whether participants will be released from their duties to conduct interviews during working hours.

It is anticipated that all interviews will be transcribed by the lead researcher. However, due to time constraints, an external transcription service may be utilised if required. In this case, a confidentiality agreement will be in place, and a confidentiality agreement document will be signed by the transcriber (Appendix H). All recorded interviews will be fully anonymised before being sent over to the transcriber. Completed transcriptions will be sent to the lead researcher for storage in the lead researcher's personal file store on the Lancaster University network (or password protected, encrypted memory stick if the network is unavailable. The transcriber will then return the recorded interviews to the lead researcher.

Ethical Concerns

The main ethical concerns for this proposed research are the potential for staff to become distressed during interview, or disclosing information that may qualify as a safeguarding concern. Protocols for both these scenarios have been developed, and can be seen in Appendices F and G.

Timescale:

June – August 2018:

- Development of research protocol, materials, interview schedule.
- Complete IRAS form for HRA ethics.

September 2018 (deadline for FHMREC: 05/09/2018)

- Submit materials to FHMREC for letter of sponsorship.
- On receiving feedback, submit IRAS form for HRA review.

October – December 2018

- Send information to service managers/ward managers/ward matrons for dissemination.

- Begin data collection.
- Transcribe first interview.
- Code initial interview.
- Develop interview schedule based on emerging data.
- Develop tentative conceptual categories.

January – February 2019

- Complete data collection.
- Transcribe remaining interviews.
- Initially code interviews line by line.
- Develop focused coding and conceptual categories.

March – April 2019

- Finalise construction of model.
- Finalise research paper for submission for thesis.

References

Barron, K., Deery, R., & Sloan, G. (2017). Community mental health nurses' and compassion: An interpretative approach. *Journal of Psychiatric and Mental Health Nursing, 24*(4), 211-220. doi:10.1111/jpm.12379

Berwick, D. (2013). *A promise to learn – a commitment to act: Improving the safety of patients in England.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

Blum, L. (1980). Compassion. In A. O. Rorty (Ed.), *Explaining emotions* (pp. 507-517). Berkeley: University of California Press.

Bowers, L., Chaplin, R., Quirk, A., & Lelliott, P. (2009). A conceptual model of the aims and functions of acute inpatient psychiatry. *Journal of Mental Health, 18*(4), 316-325. doi:10.1080/09638230802053359

Brown, B., Crawford, P., Gilbert, P., Gilbert, J., & Gale, C. (2014). Practical compassions: Repertoires of practice and compassion talk in acute mental healthcare. *Sociology of Health & Illness, 36*(3), 383-399. doi:10.1111/1467-9566.12065

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: SAGE Publications.

Crawford, P., Gilbert, P., Gilbert, J., Gale, C., & Harvey, K. (2013). The language of compassion in acute mental health care. *Qualitative Health Research, 23*(6), 719-727. doi:10.1177/1049732313482190

Crisp, N., Smith, G., & Nicholson, K. (2016). *Old problems, new solutions: Improving acute psychiatric care for adults in England*. Retrieved from https://www.basw.co.uk/system/files/resources/basw_92050-3_0.pdf

Currid, T. J. (2008). The lived experience and meaning of stress in acute mental health nurses. *British Journal of Nursing, 17*(14), 880-884. doi:10.12968/bjon.2008.17.14.30652

Darzi, A. (2008). *High quality care for all: NHS next stage review final report.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf

Deacon, M., Warne, T., & McAndrew, S. (2006). Closeness, chaos and crisis: The attractions of working in acute mental health care. *Journal of Psychiatric and Mental Health Nursing, 13*(6), 750-757. doi:10.1111/j.1365-2850.2006.01030.x

Department of Health. (2002). *Mental health policy implementation guide: Adult acute inpatient care provision.* Retrieved from http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009156

Dewar, B., Pullin, S., & Tocheris, R. (2011). Valuing compassion through definition and measurement. *Nursing Management - UK, 17*(9), 32-37.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: Executive summary.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. Hove: Routledge.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. London: Weidenfeld and Nicolson.

Goetz, J. L., Keltner, D., & Simon-Thomas, E. (2010). Compassion: An evolutionary analysis and empirical review. *Psychological Bulletin, 136*(3), 351-374. doi:10.1037/a0018807

Health and Safety Executive. (2016). Work related stress, anxiety and depression statistics in Great Britain 2016. http://www.hse.gov.uk/statistics/causdis/stress/stress.pdf?pdf=stress

Hoffman, M. L. (1981). Is altruism part of human nature? *Journal of Personality and Social Psychology, 40*(1), 121-137. doi:10.1037/0022-3514.40.1.121

Hughes, R., Hayward, M., & Finlay, W. M. L. (2009). Patients' perceptions of the impact of involuntary inpatient care on self, relationships and recovery. *Journal of Mental Health, 18*(2), 152-160. doi:10.1080/09638230802053326

Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: Nurses in acute mental health settings. *Journal of Advanced Nursing, 48*(6), 622-631. doi:10.1111/j.1365-2648.2004.03240.x

Joint Commissioning Panel for Mental Health. (2013). *Guidance for commissioners of acute care – inpatient and crisis home treatment*. Retrieved from http://www.jcpmh.info/wp-content/uploads/jcpmh-acutecare-guide.pdf

Kenrick, D., Ackerman, J., & Ledlow, S. (2003). Evolutionary social psychology. In J. Delamater (Ed.), *Handbook of social psychology*. New York: Kluwer Academic.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*: Springer Publishing Company.

Lee, M., Laurenson, M., & Whitfield, C. (2012). Can compassion be taught to lessen the effects of compassion fatigue? *Journal of Care Services Management, 6*(3), 121-130. doi:10.1179/1750168713Y.0000000016

Marshall, C., & Rossman, G. B. (2016). *Designing qualitative research*. London: SAGE Publications.

NHS England. (2016). NHS staff survey 2016. http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2015-Results/

Norton, K. (2004). Re-thinking acute psychiatric inpatient care. *International Journal of Social Psychiatry, 50*(3), 274-284. doi:10.1177/0020764004043146

Nussbaum, M. (1996). Compassion: The basic social emotion. *Social Philosophy and Policy, 13*(1), 27-58. doi:10.1017/S0265052500001515

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., . . . Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research, 200*(2), 933-938. doi:https://doi.org/10.1016/j.psychres.2012.07.029

Sinclair, S., Norris, J. M., McConnell, S. J., Chochinov, H. M., Hack, T. F., Hagen, N. A., . . . Bouchal, S. R. (2016). Compassion: A scoping review of the healthcare literature. *BMC Palliative Care, 15:6*. doi:10.1186/s12904-016-0080-0

Sober, E., & Wilson, D. S. (1998). *Unto others: The evolution and psychology of unselfish behaviour*. Cambridge, MA: Harvard University Press.

Spandler, H., & Stickley, T. (2011). No hope without compassion: The importance of compassion in recovery-focused mental health services. *Journal of Mental Health, 20*(6), 555-566. doi:10.3109/09638237.2011.583949

Sprecher, S., & Fehr, B. (2016). Compassionate love for close others and humanity. *Journal of Social and Personal Relationships, 22*(5), 629-651. doi:10.1177/0265407505056439

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380. doi:10.1177/1049732307307031

Thomson, S. B. (2011). Sample size and grounded theory. *Journal of Administration and Governance, 5*(1), 45-52.

Trivers, R. L. (1971). The evolution of reciprocal altruism. *The Quarterly Review of Biology, 46*(1), 35-57.

Wispé, L. (1986). The distinction between sympathy and empathy: To call forth a concept, a word is needed. *Journal of Personality and Social Psychology, 50*(2), 314-321. doi:10.1037/0022-3514.50.2.314

NHS Integrated Research Application Form (IRAS)

IRAS Form | Reference: 19-HRA-0451 | IRAS Version 5.9.1

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Staff compassion in acute mental health care: v.0.1

1. Is your project research?

◉ Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product
○ Clinical investigation or other study of a medical device
○ Combined trial of an investigational medicinal product and an investigational medical device
○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
○ Basic science study involving procedures with human participants
○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
◉ Study involving qualitative methods only
○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
○ Study limited to working with data (specific project only)
○ Research tissue bank
○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	◉ No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	◉ No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	◉ No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☐ Scotland

☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

◉ England
○ Scotland
○ Wales
○ Northern Ireland
○ This study does not involve the NHS

4. Which applications do you require?

IMPORTANT: If your project is taking place in the NHS and is led from England select 'IRAS Form'. If your project is led from Northern Ireland, Scotland or Wales select 'NHS/HSC Research and Development Offices' and/or relevant Research Ethics Committee applications, as appropriate.

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

For NHS/HSC R&D Offices in Northern Ireland, Scotland and Wales the CI must create NHS/HSC Site Specific Information forms, for each site, in addition to the study wide forms, and transfer them to the PIs or local collaborators.

For participating NHS organisations in England different arrangements apply for the provision of site specific information. Refer to IRAS Help for more information.

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

◉ Yes ○ No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

☐ Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
☐ Research limited to use of previously collected, non-identifiable information
☐ Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
☐ Research limited to use of acellular material
☐ Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
☑ Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

◉ Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or a Diagnostic Evidence Co-operative in all study sites?

Please see information button for further details.

○ Yes ◉ No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ◉ No

The NIHR Clinical Research Network provides researchers with the practical support they need to make clinical studies happen in the NHS e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.

6. Do you plan to include any participants who are children?

○ Yes ◉ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ◉ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ◉ No

9. Is the study or any part of it being undertaken as an educational project?

◉ Yes ○ No

Please describe briefly the involvement of the student(s):
The student will act as Chief Investigator of the project, and their duties will encompass: design, recruitment, data collection, analysis and reporting of results. The student is a Trainee Clinical Psychologist in their final year of the Doctorate in Clinical Psychology. This project will form part of their thesis submission. They will be supervised throughout by Dr Ian Fletcher, Senior Lecturer and Research Supervisor, Lancaster University, and Dr Sian Bensa, Clinical Psychologist and Field Supervisor.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

(●) Yes ( ) No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

( ) Yes (●) No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

( ) Yes (●) No

Integrated Research Application System
Application Form for Research involving qualitative methods only

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Staff compassion in acute mental health care: v.0.1

Please complete these details after you have booked the REC application for review.

REC Name:
Non-rec study: England

REC Reference Number:
19-HRA-0451

Submission date:
17/10/2018

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Staff compassion in acute mental health care: A grounded theory investigation

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss	Elizabeth	Tane
Address	Clinical Psychology		
	C-Floor, Furness College		
	Lancaster University		
Post Code	LA1 4YG		
E-mail	e.tane@lancaster.ac.uk		
Telephone	07590682274		
Fax			

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Address	Clinical Psychology C-Floor, Furness College Lancaster University		
Post Code	LA1 4YG		
E-mail	i.j.fletcher@lancaster.ac.uk		
Telephone	01524593301		
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
Student 1 Miss Elizabeth Tane	☑ Dr Ian Fletcher

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- ◉ Student
- ○ Academic supervisor
- ○ Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Miss	Elizabeth	Tane
Post	Trainee Clinical Psychologist		
Qualifications	BSc (hons) MSc		
ORCID ID			
Employer	Lancashire Care NHS Foundation Trust		
Work Address	C-Floor, Furness College Lancaster University Lancaster		
Post Code	LA1 4YG		
Work E-mail	e.tane@lancaster.ac.uk		
* Personal E-mail	liz.tane@gmail.com		

Work Telephone	07590682274
* Personal Telephone/Mobile	07590682274
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

	Title	Forename/Initials	Surname
	Ms	Becky	Gordon
Address	Research Services		
	B-Floor, Bowland Main		
	Lancaster University		
Post Code	LA1 4YT		
E-mail	ethics@lancaster.ac.uk		
Telephone	01524592981		
Fax			

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	N/A
Sponsor's/protocol number:	N/A
Protocol Version:	N/A
Protocol Date:	
Funder's reference number (enter the reference number or state not applicable):	N/A
Project website:	N/A

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ◉ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

Compassion, "the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help" is an important part of the care provided within mental health services. Recent investigations into poor standards of care in the NHS have highlighted a lack of staff compassion as a contributing factor. Service users and their families consistently rank compassion as one of their highest requirements when receiving care. Although recommendations have been made to improve compassionate care in the NHS, there is little research examining the application of this in mental health services.

Service users are often admitted to acute inpatient units when they are most vulnerable and distressed. Staff members working in these units have been shown to suffer from high levels of stress and burnout, which can negatively impact their ability to be compassionate towards service users. Given that compassionate care is a high priority for the NHS and for service users and their families, more research is required to examine compassion within acute inpatient settings.

The aim of the research is to qualitatively explore staff member's conceptualisation of compassion and compassionate care in acute inpatient settings. It will enquire about staff's ability/inability to consistently maintain compassion, given the high turnover of service users and levels of distress encountered daily. Furthermore, it will seek to explore staff's perception of facilitators and barriers to maintaining compassion within this environment.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Study purpose
The overall aim of this study is to explore, qualitatively, staff member's understanding of compassion and compassionate care on acute inpatient wards. This will allow the researcher to gain a deeper understanding of the role of compassion in this setting, and potential facilitators and barriers to staff maintaining compassion towards service users.

Study design
This study will use qualitative methods to analyse rich data captured from interviews with staff from multiple professional backgrounds. Participants will be asked to participate in at least one semi-structured interview. They will be asked about their understanding of compassion, how it applies to their role, and barriers/facilitators to compassion. This data will be analysed using grounded theory techniques (Charmaz, 2006). This method has been chosen as it allows exploration of topic areas in which little previous research has been conducted, and will enable construction of a theoretic framework 'grounded' in participant data.

Recruitment
Participants will be recruited through advertisement of the study in acute inpatient wards in [redacted] NHS Trusts: [redacted] Within these two trusts, it is estimated that there will be 6-10 acute wards available from which to recruit staff. Each ward employs around 20-30 staff, which should provide a sufficient participant pool. It is hoped that staff from multiple professions will participate (e.g. nurses, health care assistants, psychologists, psychiatrists, occupational therapists etc.).

Information on the study will be sent to ward managers, ward matrons, service managers and senior professionals (psychologists, psychiatrists etc.) for dissemination to staff members via email. With consent from relevant managers, posters will be placed in staff areas of the wards. The lead researcher may also visit the wards to attend staff meetings, handover meetings etc. to advertise the research. Potential participants will be able to contact the lead researcher via email or phone, for further information or to arrange a time to be interviewed. Interviews will be conducted at the employee's workplace, or an appropriate alternative location (e.g. participant's home) if requested by the participant. In this instance, the Lancashire Care NHS Foundation Trust lone worker policy, and Lancaster University safety in fieldwork guidance will be followed if visiting participants in their home environment. A 'check in' system will be in place so the researcher is able to inform someone of their safety both before and after a home visit. Whilst face-to-face interviews are preferable, interviews can also be conducted via the telephone or web-based

electronic communication (e.g. zoom, skype) if preferred by the participant. In this case, the interview will be recorded and the consent form will be read out to the participant over video/phone. Verbal consent provided by the participant will be recorded and documented, therefore written consent for these participants will not be required.

Initially, a limited number of interviews would be conducted (2-3), and data from these interviews would be coded and analysed to develop tentative emerging categories. Theoretical sampling (Charmaz, 2006) would then be utilised, informing amendments to the interview schedule. Further interviews would then be conducted to explicate and saturate emerging categories. The same approach would be taken with participant demographics: if initial interviews over-represent one professional (e.g. nurses), the researcher will aim for subsequent interviews to be with staff from other professions.

Although it is difficult to predict the number of participants required to reach theoretical saturation, it is anticipated that around 15 participants will be necessary. However, due to time and resource restraints, a pragmatic approach (reaching theoretical sufficiency) may have to be taken.

Inclusion criteria
• Minimum age of 18 years, maximum age of 65 years.
• Staff who currently work in on an acute mental health ward
• Staff from any professional background with a clinical element to their role (e.g. psychiatrists, psychologists, nurses, health care assistants, occupational therapists etc.)
• Staff who are substantively employed on the ward
• Staff who have worked within an acute mental health ward for a minimum of 3 months.

Exclusion criteria
• Less than 18 years of age or over 65 years of age.
• Staff who do not work on an acute mental health ward.
• Staff who work on an acute mental health ward, but do not have a clinical element to their role (e.g. house keeping, chefs, estates etc.)
• Staff who are not substantively employed on the ward (e.g. agency staff)
• Staff who have previously, but do not currently, work on an acute mental health ward.
• Staff who have worked on an acute mental health ward for less that 3 months.

Ethical issues
Distress of participants
Whilst it is not anticipated that the content of the interviews is likely to cause distress, a distress protocol has been developed to outline the procedure if distress occurs. This would initially involve stopping the interview, and enquiring about the participant's distress. If the participant's distress has reduced and they wish to continue, the interview will be recommenced. If they participant's distress does not reduce and/or they do not wish to continue, the interview will be terminated. The participant will be informed that the lead researcher needs to contact the Research and/or Field supervisor for advice. They also be asked if they wish someone to be contacted to provide support e.g. manager/colleague. They will also be provided with information on sources of support, e.g. line manager, staff support.

Breaking confidentialty
Participants will be informed during the consent process that confidentiality may be broken if a disclosure leads the main researcher to believe that a participant, staff member or service user has been harmed, or is at risk of harm. If a disclosure is made, the immediacy of risk will be assessed. If the lead researcher believes a participant, staff member or service user is at immediate risk of harm, the interview will be terminated, and the Research and/or Field supervisors will be contacted for advice on how to proceed. If the disclosure is historic, or the participant, staff member or service user is not at immediate risk, the interview will be completed. At the completion of the interview, the lead researcher will inform the participants of the need to contact the Research and/or Field supervisors for advice on how to proceed. This may result in the need to inform another relevant professional within the Trust of the disclosure.

Confidentiality
Participants will be informed that their data will be kept confidential and not shared, unless in the instances outlined above. The project will adhere to The Data Protection Act (2018). Participants will be informed that project supervisors will also examine anonymised transcript data, to ensure consistency of analysis. However, this will only happen after transcript data has been anonymised, and all participant identifying information (names, places, etc.) has been removed.
Participants will also be informed that direct quotes from interviews may be used in the project write up, and in any academic/professional journal publications. No participant identifying information will be included in the final report, and all quotes used will be anonymised.

Consent and right to withdraw

Participants will be provided with a detailed information sheet, at least 24 hours in advance of the interview taking place. On initially meeting with the lead researcher, the participant will be given the opportunity to ask any questions before they consent to be interviewed. They will be asked to read and initial statements about the research and what is expected of them as participants. They will then be asked to sign and date the consent form, which will be kept separate from anonymised interview transcripts.
Participants will be informed of their right to withdraw their consent at any time before, or during, the interview. Whilst every effort will be made to withdraw a participant's data after the interview, due to the nature of the write-up and submission of this project, this may not always be possible. As such, the participants will be informed that they can withdraw their data up to one week after the interview has taken place.

Data retention and storage
Lancaster University is a registered data controller, and the project will adhere to The Data Protection Act (2018).
All participants will be given a random identification number. This will be used on both the consent form and interview transcripts, to link participant identities to anonymised transcripts. Signed consent forms with participant identifying information will be scanned and stored in a separate folder on the lead researcher's personal file store on the university network. No participant indefinable information will be kept with anonymised data (i.e. anonymised transcripts and consent forms will be kept in separate folders in the lead researcher's personal file store on the Lancaster network).

Interviews will be recorded on a Dictaphone. As soon as possible after the interview has taken place, and within 24 hours, the audio file will be transferred to the lead researcher's password protected personal file store on Lancaster University's network, and deleted off the Dictaphone. If unavailable, the audio file will be transferred to an encrypted, password protected memory stick and deleted off the Dictaphone, until such a time where it can be transferred to the lead researcher's personal file store on Lancaster University's network. These files can then be accessed via a secure VPN connection.

Once transcribed, anonymised transcripts will be also be kept in the lead researcher's password protected personal file store on Lancaster University's network or a password protected encrypted memory stick. As it may be necessary to refer to audio recordings throughout the analysis process, the audio files will be deleted on submission of the research project.

All research data will be encrypted, password protected and transferred to Lancaster University's Data Depository (via PURE) on completion of the study, and kept for a period of 10 years, in line with Lancaster University's data policy. Consent forms will be scanned, encrypted and password protected and transferred to Lancaster University's Data Depository, at which point the hard copies will be destroyed. Data will be available via restricted access: data can be made available on request, but only to bona fide researchers who provide information regarding proposed use. The research co-ordinator in the Division of Clinical Psychology at Lancaster University will be responsible for deletion of the data at the end of the 10-year period.

Timescale:
June – August 2018:
• Development of research protocol, materials, interview schedule.
• Complete IRAS form for HRA ethics.

September 2018 (deadline for FHMREC: 05/09/2018)
• Submit materials to Faculty of Health and Medicine (FHMREC), Lancaster University ethics board for ethical approval and letter of sponsorship.
• On receiving feedback, submit IRAS form for HRA review.

October – December 2018
• Receive HRA approval
• Begin data collection.
• Transcribe first interview.
• Code initial interview.
• Develop interview schedule based on emerging data.
• Develop tentative conceptual categories.

January – February 2018
• Complete data collection.
• Transcribe remaining interviews.
• Initially code interviews line by line.
• Develop focused coding and conceptual categories.

March – April 2018
• Finalise construction of model.

• Finalise research paper for submission for thesis.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply:*

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☑ Qualitative research
- ☐ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

The overall aim of this research is to qualitatively explore staff's understanding of compassion and compassionate care within acute inpatient units.

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

Secondary research questions include: exploring staff's perceptions of facilitators and barriers to maintaining compassion within this environment, and understanding staff's perceptions on the personal costs and benefits of maintaining compassion within this environment.

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

There has been an increasing focus in research, policy and practice on the importance of compassion in health care. Following consultation with the public, service users and staff, compassion became one of the NHS's core values in 2008 (Darzi, 2008). However, a number of high profile investigations into failings in NHS care have identified a lack of compassion as a contributing factor in the poor care received by service users (Berwick, 2013; Francis, 2013).

However, there is still little agreement about the definition of compassion, and how it translates to patient care (Barron, Deery, & Sloan, 2017; Dewar, Pullin, & Tocheris, 2011). Definitions generally suggest that in order to feel compassion, an individual needs to be able to recognise distress in another, and have the desire to alleviate that distress (Gilbert, 2010; Goetz, Keltner, & Simon-Thomas, 2010). There has been ongoing debate about the nature of compassion, and whether it is an emotional state (Goetz, Keltner, & Simon-Thomas, 2010; Nussbaum, 1996) or an attitude (Blum, 1980; Sprecher & Fehr, 2016). Equally, it is still unclear as to how and why, when presented with a similar situation, some individuals may respond compassionately, whilst others may not.

The Department of Health's (2012) 'Compassion in Practice' document, again aimed at nursing staff, outlines a set of values that they suggest lead to compassionate care. Criticisms of this vision highlight a lack of consideration of organisational factors, with the onus being placed on the individual as opposed to the system (Dewar & Christley, 2013). A small body of research which qualitatively examined nursing staff's perceptions of compassion highlighted similar difficulties, with organisational factors impacting staff's ability to provide compassion to patients (Barron et al., 2017; Horsburgh & Ross, 2013).

A model of compassion, proposed by Goetz et al. (2010), has attempted to explain the impact of individual differences and personal resources on feeling and acting on compassion. It outlines individuals' appraisal processes, suggesting that if the individual appraises the person in distress to be underving of help, or that they themsleves have insifficient resources, they will feel an alternative, negative emotion such as anger, distress or fear.

This model is in keeping with research in the area of compassion fatigue, defined as "losing the ability to care compassionately for patients", and can occur when staff feel overwhelmed by their constant contact with intense distress (Lee, Laurenson, & Whitfield, 2012, p. 123). Prior research has shown that individuals with low coping ability are more likely to feel distress than compassion when confronted with another's suffering (Hoffman, 1981; Lazarus & Folkman, 1984). Staff experiencing burnout are also more likely to simultaneously suffer from compassion fatigue (Rossi et al., 2012). It would make sense, therefore, that staff with the least resources, who are confronted with the highest levels of distress, would find it most difficult to consistently maintain compassion.

Acute inpatient units admit service users who cannot be cared for safely in a less restrictive environment, due to the risk to themselves or others (Bowers, Chaplin, Quirk, & Lelliott, 2009). Their distress can be exacerbated by admittance to an unfamiliar environment, or the process of having been sectioned under the Mental Health Act (Deacon, Warne, & McAndrew, 2006; Hughes, Hayward, & Finlay, 2009; Joint Commissioning Panel for Mental Health, 2013). The numbers of weekly admissions to such a ward can be high, and research has shown that staff working on these wards suffer from high levels of stress and burnout (Currid, 2008; Deacon et al., 2006; Jenkins & Elliott, 2004). Such units have also been a focus for improvement, following several reports that noted poor standards of care (Crisp, 2016; Department of Health, 2002; Griffiths, 2002; Norton, 2004).

Research has suggested that staff working within complex, demanding and fast-paced environments have greater difficulty adapting and coping, particularly when organisational resources are limited (Burns, 2001; Dewar & Christley, 2013; Pendleton & King, 2002). Despite this, to date, only one article has examined staff compassion specifically in acute inpatient environments. Using discourse analysis, Crawford, Gilbert, Gilbert, Gale, and Harvey (2013), examined interviews with staff about compassion, and noted an absence of compassionate language within interview transcripts. Whilst staff felt that compassion was an important part of their role, they attributed difficulties with providing compassionate care to limited time and emotional distancing. The authors suggest that further research is required to gain a richer understanding of compassion and compassionate care in these settings.

The proposed study would build upon the findings of Crawford et al. (2013), utilising qualitative techniques to further explore staff compassion within acute inpatient settings. Qualitative techniques are of particular use here, as they allow exploration of phenomena on which there is little prior research. These approaches also provide rich data, from which meaningful conclusions and recommendations can be drawn (Marshall & Rossman, 2016) As the current, small body of research on staff compassion has focused on nursing staff, the current research would expand upon this to include staff from a variety of professional backgrounds (e.g. psychiatrists, psychologists, nurses, occupational therapists etc.). Whilst Crawford et al. (2013) focused on compassion within language, their scope did not extend to outlining a substantive model as to staff's understanding and maintenance of compassion within this environment.

A grounded theory approach to qualitative data analysis is particularly suited to this type of investigation, as its primary aim is to offer an explanatory theory or model that is 'grounded' in the data (Charmaz, 2006; Starks & Brown Trinidad, 2007). It differs from other qualitative techniques in that it is predominantly concerned with understanding processes. This is in comparison to phenomenological analysis, which is more concerned with participant's experiences, and discourse analysis which places a greater emphasis on language. It is therefore argued that grounded theory will enable the most meaningful analysis of the processes surrounding staff compassion, and will allow development of a model and suggestions for interventions/support to facilitate increased compassion in this environment.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

Design and methodology
This study will use qualitative methods to analyse rich data captured from interviews with staff from multiple professional backgrounds. It will aim to explore and construct a theoretical model of staff compassion in acute inpatient units, grounded in the data gained from interviews with staff.

Participants will be asked to participate in at least one semi-structured interview. They will be asked question related to their understanding of compassion and compassionate care, how it applies to their role, and barriers/facilitators to compassion. This data will be analysed using grounded theory techniques (Charmaz, 2006). This method has been chosen as it allows exploration of topic areas in which little previous research has been conducted, and will enable construction of a theoretic framework 'grounded' in participant data.

Within the grounded theory approach, there are multiple methods available through which to analyse data. The researcher will be taking a constructionist epistemological stance, which acknowledges 'truth' to be socially constructed through language and social interactions. It also assumes that data gathered from interviews is collaboratively developed by researcher and participant; that is that the researcher unable to remove their influence from the interpretation of the data. However, utilising reflective memo writing, the researcher is transparent in their own influences and personal assumptions, providing a clear description of how theoretical models are constructed and their grounding in the data (Charmaz, 2006).

Participants
Participants will be recruited through advertisement of the study in acute inpatient wards in two [redacted] NHS Trusts: [redacted]. Within these two trusts, it is estimated that there will be 6-10 acute wards available from which to recruit staff. Each ward employs around 20-30 staff, which should provide a sufficient participant pool. It is hoped that staff from multiple professions will participate (e.g. nurses, health care assistants, psychologists, psychiatrists, occupational therapists etc.).

Information on the study will be sent to ward managers, ward matrons, service managers and senior professionals (psychologists, psychiatrists etc.) for dissemination to staff members via email. With consent from relevant managers, posters will be placed in staff areas of the wards. Potential participants will be able to contact the lead researcher, via email or phone, for further information or to arrange a time to be interviewed. Interviews will be conducted at the employee's workplace, an appropriate alternative location, or via Skype.

Participants will have had access to the information sheet for a minimum of 24 hours prior to the interview taking place. Once participants have shown an interest in participating, a meeting will be arranged with the lead researcher at a suitable time and location, either at the staff member's workplace, or another suitable location (e.g. participant's home). During this initial meeting, potential participants will again be shown the information sheet, and will be given an opportunity to ask any questions. If happy to proceed, the participant will be provided with the consent form to read and initial. They will then be asked to complete a short demographic information questionnaire (e.g. age, profession, length of time since qualification, length of time in job role etc.). Following this, the Dictaphone will be switched on and the interview commenced. It is anticipated that the interview will last around 60 minutes. On completion of the interview, the participant will be provided with the debrief sheet, which outlines contact details of relevant people they can contact either for support, or if they have any concerns/wish to make a complaint about the research. Their right to withdraw their consent/data will also be explained, including the length of time after the interview in which they can withdraw (up to 1 week after the interview). They will then be thanked for their participation.

In the case of an interview being conducted over electronic means, e.g. phone or web-based communication, the phone/video interview will be recorded, and all forms (consent, demographic etc.) will be read out to the participant during the interview (participants will have had access to the information sheet at least 24 hours prior to conducting the phone/video interview). In this instance, verbal consent provided by the participant will be recorded and documented, therefore written consent for these participants will not be required.

Initially, a limited number of interviews would be conducted (2-3), and data from these interviews would be coded and analysed to develop tentative emerging categories. Theoretical sampling (Charmaz, 2006) would then be utilised, informing amendments to the interview schedule. Further interviews would then be conducted to explicate and saturate emerging categories. The same approach would be taken with participant demographics: if initial interviews over-represent one professional (e.g. nurses), the researcher will aim for subsequent interviews to be with staff from other professions.

Although it is difficult to predict the number of participants required to reach theoretical saturation, it is anticipated that between 15 and 20 participants will be necessary. However, due to time and resource restraints, a pragmatic approach (reaching theoretical sufficiency) may be required.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- [x] Design of the research
- [ ] Management of the research
- [ ] Undertaking the research
- [ ] Analysis of results
- [x] Dissemination of findings
- [ ] None of the above

Give details of involvement, or if none please justify the absence of involvement.
Members of Lancaster University Public Involvement Network (LUPIN), who work closely with Lancaster University, have been consulted during the proposal and design stages this study. One such expert, who was asked to comment on the chosen thesis topic, provided the following feedback (and consented for it to be shared here):

"I think compassion is vital in healthcare but we don't see enough of it. I'm also interested in the comparative importance of compassion in the effective discharge of their duties by different professional groups. I am fairly convinced that compassion is essential among clinical psychologists and I believe that the profession (at least in the UK) is a repository of knowledge and understanding of compassion. I also appreciate that many factors may cause someone who is naturally, or through training, compassionate, to become less so over time. Because the expression of compassion is so important it is essential to identify these factors and how they might be ameliorated and to develop ways of helping individuals to preserve their compassionate feelings and behaviour. Hence the need for research in this area and - and the validity of your thesis theme."

The results of the research will be presented at a conference held at Lancaster University, with members of LUPIN being invited to attend.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- ☐ Blood
- ☐ Cancer
- ☐ Cardiovascular
- ☐ Congenital Disorders
- ☐ Dementias and Neurodegenerative Diseases
- ☐ Diabetes
- ☐ Ear
- ☐ Eye
- ☑ Generic Health Relevance
- ☐ Infection
- ☐ Inflammatory and Immune System
- ☐ Injuries and Accidents
- ☐ Mental Health
- ☐ Metabolic and Endocrine
- ☐ Musculoskeletal
- ☐ Neurological
- ☐ Oral and Gastrointestinal
- ☐ Paediatrics
- ☐ Renal and Urogenital
- ☐ Reproductive Health and Childbirth
- ☐ Respiratory
- ☐ Skin
- ☐ Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit: 65	Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Inclusion criteria:
• Minimum age of 18 years, maximum age of 65 years.
• NHS staff who currently work in on an acute mental health ward
• NHS staff from any professional background with a clinical element to their role (e.g. psychiatrists, psychologists, nurses, health care assistants, occupational therapists etc.)
• NHS staff who are substantively employed on the ward
• NHS staff who have worked within an acute mental health ward for a minimum of 3 months.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Exclusion criteria:
• Less than 18 years of age or over 65 years of age.
• NHS staff who do not work on an acute mental health ward.
• NHS staff who work on an acute mental health ward, but do not have a clinical element to their role (e.g. house keeping, chefs, estates etc.)
• NHS staff who are not substantively employed on the ward (e.g. agency staff)
• NHS staff who have previously, but do not currently, work on an acute mental health ward.
• NHS staff who have worked on an acute mental health ward for less that 3 months.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Obtain informed consent	1	0	10 minutes	Liz Tane will gain informed consent in private room at staff member's work place (or other suitable location e.g. staff member's house, other NHS premises)
Demographic questionnaire	1	0	5 minutes	Liz Tane will administer demographic questionnaire in private room at staff member's work place (or other suitable location e.g. staff member's house, other NHS premises)
Semi-structured interview	1-2	0	60 minutes	Liz Tane will conduct interview in private room at staff member's work place (or other suitable location e.g. staff member's house, other NHS premises)
Debrief	1-2	0	5 minutes	Liz Tane will provide and discuss participant debrief sheet in private room at staff member's work place (or other suitable location e.g. staff member's house, other NHS premises)

A21. How long do you expect each participant to be in the study in total?

9 months

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

It is possible that sharing thoughts related to compassion or compassionate care may cause distress for some participants, particularly if staff express concerns about the level of care in their workplace. Participants will be reassured that they are under no obligation to share any information that they do not feel comfortable with. A distress protocol has been developed for use in the instance that a participant becomes distressed. This includes temporarily pausing or terminating the interview dependent on the participant's wishes. Participants will also be provided with a debrief sheet outlining sources of support should they experience distress during the research process.

Participants will be informed of confidentiality, but also the limits of confidentiality, particularly in relation to information that may indicate risk or safeguarding concerns. Participants will be informed that in this instance, information will be shared with academic and/or field supervisors, and may have to be shared with other relevant professionals.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

(●) Yes ( ) No

If Yes, please give details of procedures in place to deal with these issues:

A 'breaking confidentiality' protocol has been developed for instances in which staff member's disclose information that leads the researcher to believe that a participant, staff member or service user has been harmed, or is at risk of harm. In the event of a disclosure, the researcher would first assess the immediacy of the risk. If the information suggests that a participant, staff member or service user may be at risk of imminent harm, the researcher would immediately terminate the interview, and inform the participants of their need to seek advice from their Research and/or Field supervisors. If the information provided is historic, and there is no immediate risk of harm, the researcher would conclude the interview, and inform the participant of the need to contact the Research and/or Field supervisors for advice. In both cases, the researcher would contact their Research and/or Field supervisors for advice, and agree on a course of action which may involve handing over the information to another relevant NHS professional.

A24. What is the potential for benefit to research participants?

There is not direct benefit to taking part in this research. However, data gathered from this research may inform future training and/or support structures for staff, potentially improving staff well-being in the workplace, as well as improving the quality of the support we provide to service users within acute inpatient environments.

A26. What are the potential risks for the researchers themselves? *(if any)*

The Lancashire Care NHS Foundation Trust lone worker policy, and Lancaster University safety in fieldwork guidance will be followed if visiting participants in their home environment. A 'check in' system will be in place so the researcher is able to inform someone of their safety both before and after a home visit.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Information about the proposed research will be sent to ward managers, ward matrons, service managers and lead professionals (psychiatrists, psychologists etc.) to be disseminated through email to their staff team. An information

pack, including participant information sheet and consent form will be included in the dissemination, so potential participants can review the materials before deciding on their participation. The lead researcher may also attend staff meetings (e.g. team meetings, handover meeting, specialist inpatient network meetings) to advertise the research. With consent, posters will also be displayed in staff areas with relevant details of the research. Potential participants will be able to contact the lead researcher via phone or email to register their interest in participating, or ask any questions about the research.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ◉ No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◉ Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

It is anticipated that an email containing study information will be sent to potential participants by ward managers, ward matrons, service managers and lead professionals (psychiatrists, psychologists etc.). This will include the participant information sheet, consent form and contact details of the lead researcher.

With relevant consent, posters advertising the research will also be placed in staff areas of the ward (e.g. staff office, staff break room), with contact details of the lead researcher.

The lead researcher may also attend relevant staff meetings to advertise the research.

A29. How and by whom will potential participants first be approached?

Potential participants will initially be approached by managers or lead professionals on the wards, or provided with information in staff meetings (which the lead researcher may attend).

A30-1. Will you obtain informed consent from or on behalf of research participants?

◉ Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Information on the study will be sent to ward managers/ward matrons/service managers to disseminate via email, in staff meetings, handover meetings and specialist inpatient meetings. The dissemination email will include copies of the participants information sheet and consent form for potential participants to view. Any staff who are interested in participating can contact the lead researcher via email or phone for more information or to arrange a suitable time/place to meet. Participants will have had access to the information sheet for a minimum of 24 hours before the interview takes place.

On meeting the participant, the lead researcher will review the information sheet with the participant, and provide an opportunity for the participant to ask any questions. If happy to continue, they will be asked to read the participant consent form. Their right to withdraw and time limits associated with this will be explained (i.e. they can withdraw their consent anytime before or during the interview, and up to one week after the interview has taken place). Confidentiality and the limits of confidentiality will also be explained. If participants consent to undertake the interview, they will be asked to initial and sign the consent form, which the lead researcher will also sign.

If any participants request the interview to be conducted over the phone or a web-based communication device (e.g. zoom, Skype), the consent for will be read out to them as part of the interview. In this instance, verbal consent

provided by the participant will be recorded and documented, therefore written consent for these participants will not be required.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

◉ Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

At least 24 hours.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

Those who are unable to understand or speak English are unlikely to be employed within the roles from which the research is recruiting. However, within this instance, all information and consent forms will be adapted/translated to ensure that they are accessible. Whilst translators could be used for interviews, as this is an educational project it is unlikely that funds would be available to recruit a translator.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

○ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

◉ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

☐ Access to medical records by those outside the direct healthcare team

☐ Access to social care records by those outside the direct social care team

☐ Electronic transfer by magnetic or optical media, email or computer networks

- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices
- ☑ Storage of personal data on any of the following:
  - ☑ Manual files (includes paper or film)
  - ☐ NHS computers
  - ☐ Social Care Service computers
  - ☐ Home or other personal computers
  - ☑ University computers
  - ☐ Private company computers
  - ☐ Laptop computers

Further details:
Participants will provide informed consent to audio-record interviews.

Electronic data will be stored on password protected, encrypted memory sticks, and/or password protected computers and laptops (home and university). Audio recordings will be stored on the lead researchers personal drive on Lancaster University's network, which is password protected.

The researcher will seek informed consent to report and publish direct quotations from participants. All quotes will be anonymised, so that participants will not be identifiable from the quotations used.

A37. Please describe the physical security arrangements for storage of personal data during the study?

All participant identifiable information (consent forms) will scanned and stored in a separate folder in the lead researcher's password protected personal file store on the Lancaster University network.

Interviews will be recorded on a Dictaphone. As soon as possible after the interview has taken place, and within 24 hours, the audio file will be transferred to the lead researcher's password protected personal file store on Lancaster University's network, and deleted off the Dictaphone. If unavailable, the audio file will be transferred to an encrypted, password protected memory stick, until such a time where it can be transferred to the lead researcher's personal file store on Lancaster University's network.

Once transcribed, anonymised transcripts will be also be kept in the lead researcher's password protected personal file store on Lancaster University's network or a password protected encrypted memory stick. As it may be necessary to refer to audio recordings throughout the analysis process, the audio files will be retained and deleted on submission of the research project.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Participants will be informed that the information they provide within interviews will be confidential, and will not be shared with their staff team or anybody else. Participants will also be informed about the limits of confidentiality; that is if they provide information that suggests they are a risk to themselves or others, or related to safe-guarding of service users, confidentiality will be broken. In the first instance, advice will be sought from academic and/or field supervisors, who will advise on the best course of action. After this, other relevant professionals may be informed dependant on the nature of the concern. Participants will also be informed that their anonymised interview transcripts may be shared with academic and/or field supervisors, as part of the research process.

Participant identification numbers will be used to link personal data to anonymised data, and participant names will not appear on interview transcripts. Interview transcripts may be shared with academic and/or field supervisors to

monitor data analysis. However, this will only include anonymised data.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Only the lead researcher will have access to participants' personal data. In the instance of risk or safeguarding concerns, the lead researcher may be required to share personal data with the academic and/or field supervisor, to seek further advice. This may also result in the need to inform another relevant NHS professional. However, participants will be informed of this possibility prior to consenting to participate.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Audio recordings will be stored on the lead researcher's personal file store on the Lancaster University network (or password protected, encrypted memory stick if the network is unavailable). It is anticipated that all interviews will be transcribed by the lead researcher. However, due to time constraints, an external transcription service may be utilised if required. In this case, a confidentiality agreement will be in place, and a confidentiality agreement document will be signed by the transcriber. All recorded interviews will be fully anonymised before being sent over to the transcriber. Completed transcriptions will be sent to the lead researcher for storage in the lead researcher's personal file store on the Lancaster University network (or password protected, encrypted memory stick if the network is unavailable. The transcriber will then return the recorded interviews to the lead researcher.

Analysis of the data will follow the method outlined by Charmaz (2006). Transcripts will be analysed using inductive line-by-line coding, conducted by the lead researcher. The 'constant comparative' method (Glaser & Strauss, 1967) will be employed throughout, making comparison to previously collected and coded data. Memos and field notes will be incorporated into the analysis. This will lead to focused coding of the data: condensing and synthesising line-by-line coding to make sense of larger segments of the transcript. Anonymised transcripts and coding may be shared with the Research and Field supervisors to monitor the consistency of the analysis process.

Finally, focused codes will be developed and combined by the lead researcher to form (initially tentative) conceptual categories, informing an emerging theory/model. The aim would be to reach theoretical saturation, but due to time constraints, a pragmatic approach (reaching theoretical sufficiency) may be required.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Post	Research Supervisor and Senior Lecturer		
Qualifications	PhD		
Work Address	Clinical Psychology		
	C-Floor, Furness College		
	Lancaster University		
Post Code	LA14YG		
Work Email	i.j.fletcher@lancaster.ac.uk		
Work Telephone	01524593301		
Fax			

A43. How long will personal data be stored or accessed after the study has ended?

- ◯ Less than 3 months
- ◯ 3 – 6 months
- ◯ 6 – 12 months

○ 12 months – 3 years

◉ Over 3 years

If longer than 12 months, please justify:
Participant identifying information (signed consent forms) will be scanned, encrypted and password protected, and stored in Lancaster University's Data Depository (via PURE), for a period of 10 years after the study completion, in line with Lancaster University's Data Policy. Anonymised data (interview transcripts) will also be transferred stored in Lancaster University's Data Depository (via PURE) for the same period of time. Electronic consent forms and anonymised data will be kept separately to maintain confidentiality. All files will be encrypted and password protected prior to transferring to Lancaster University's Data Depository.

Hard copies of the consent forms will be destroyed once they have been electronically stored in Lancaster University's Data Depository (via PURE).

As it may be necessary to refer to audio recordings throughout the analysis process, the audio files will be deleted on submission of the research project.

A44. For how long will you store research data generated by the study?

Years: 10
Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. *Say where data will be stored, who will have access and the arrangements to ensure security.*

Research data will be stored in Lancaster University's Institutional data repository (via PURE). The data will be available on a restricted-access basis: data can be made available on request, but only to to bona fide researchers who provide information regarding proposed use.

All data will be destroyed 10 years after completion of the project. The researcher co-ordinator in the Division of Clinical Psychology at Lancaster University will be responsible for destroying the data once the lead researcher has finished their doctoral training.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

○ Yes ◉ No

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ◉ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ◉ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

○ Yes ◉ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

○ Yes ◉ No

Please give details, or justify if not registering the research.
As this project is for educational purposes, it will not be registered on a public database.

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? *Tick as appropriate:*

- ☑ Peer reviewed scientific journals
- ☑ Internal report
- ☑ Conference presentation
- ☐ Publication on website
- ☑ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- ☐ No plans to report or disseminate the results
- ☐ Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Direct quotations from interviews will be used in the report. These quotes will be fully anonymised, and pseudonyms assigned to prevent participants being identified. Participants will be informed of this as part of the consent process.

A53. Will you inform participants of the results?

◉ Yes ○ No

Please give details of how you will inform participants or justify if not doing so.
Participants will be able to request a short summary report of the findings. Although they may be able to identify themselves from the quotations used, they will not be able to identify any other participants.

Summary of the findings will be provided to relevant stake-holders within the NHS. The findings will also be presented and a conference held at Lancaster University, where relevant professionals and experts by experience will be in attendance.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? *Tick as appropriate:*

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi−centre research group
- ☑ Review within the Chief Investigator's institution or host organisation
- ☐ Review within the research team
- ☑ Review by educational supervisor
- ☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The research proposal was peer-reviewed within Lancaster University by members of the research team and experts by experience within the Lancaster University Public Involvement Network. Feedback from the committee was then incorporated into the research design.

The researcher's academic supervisor has also reviewed the research protocol and associated documents, and alterations have been made in line with their recommendations.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	15
Total international sample size (including UK):	15
Total in European Economic Area:	15

Further details:

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

It is anticipated that a sample of 15 participants will be sufficient to generate meaningful qualitative analysis within the interview data. Bertaux (1981) suggests that 15 participants is sufficient for small qualitative projects.

Whilst the aim in grounded theory is to reach theoretical saturation, the nature of this educational project means that a pragmatic stance may be required. As such, theoretical sufficiency as opposed to saturation may be required.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

This study will use qualitative methods to analyse rich data captured from interviews with staff from multiple professional backgrounds. It will aim to explore and construct a theoretical model of staff compassion in acute inpatient units, grounded in the data gained from interviews with staff.

Participants will be asked to participate in at least one semi-structured interview. They will be asked question related to their conceptualisation of compassion and compassionate care, how it applies to their role, and barriers/facilitators to compassion. This data will be analysed using grounded theory techniques (Charmaz, 2006). This method has been chosen as it allows exploration of topic areas in which little previous research has been conducted, and will enable construction of a theoretic framework 'grounded' in participant data.

Within the grounded theory approach, there are multiple methods available through which to analyse data. The

researcher will be taking a constructionist epistemological stance, which acknowledges 'truth' to be socially constructed through language and social interactions. It also assumes that data gathered from interviews is collaboratively developed by researcher and participant; that is that the researcher unable to remove their influence from the interpretation of the data. However, utilising reflective memo writing, the researcher is transparent in their own influences and personal assumptions, providing a clear description of how theoretical models are constructed and their grounding in the data (Charmaz, 2006).

Initially, a small number of interviews will be undertaken (2-3) before being transcribed. The researcher will then code the data line-by-line, before creating 'focused codes', which will begin to synthesise and explain larger segments of the transcript. Focused codes will be combined to form tentative emerging categories and themes from all available data.

As the process is iterative, adaptions will be made to the interview schedule, so that future interviews help to 'thicken out' emerging categories. Further interviews will then be conducted, and the same analysis undertaken. Throughout this process, the researcher will write memos that capture their thoughts and ideas relating the themes and categories, and how they might be linked. This reflective process allows the researchers assumptions and pre-defined ideas to be explicitly stated, so as to minimise the impact on the interpretation of the data.

This process continues until theoretical categories are well defined and theoretical saturation has been reached.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Post	Research Supervisor and Senior Lecturer		
Qualifications	PhD		
Employer	Faculty of Health and Medicine, Lancaster University		
Work Address	Lancaster University Bailrigg Lancaster		
Post Code	LA1 4YW		
Telephone	01524593301		
Fax			
Mobile			
Work Email	i.j.fletcher@lancaster.ac.uk		

	Title	Forename/Initials	Surname
	Dr	Sian	Bensa
Post	Clinical Psychologist		
Qualifications	BSc, DClinPsy		
Employer	[redacted]		
Work Address			
Post Code			
Telephone			
Fax			
Mobile			
Work Email			

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
- ○ NHS or HSC care organisation
- ◉ Academic
- ○ Pharmaceutical industry
- ○ Medical device industry
- ○ Local Authority
- ○ Other social care provider (including voluntary sector or private organisation)
- ○ Other

Commercial status: Non-Commercial

If Other, please specify:

Contact person

Name of organisation	Lancaster University
Given name	Becky
Family name	Gordon
Address	Research Services, Lancaster University
Town/city	Lancaster
Post code	LA14YT
Country	UNITED KINGDOM
Telephone	01524592981
Fax	
E-mail	ethics@lancaster.ac.uk

A65. Has external funding for the research been secured?

Please tick at least one check box.

- ☐ Funding secured from one or more funders
- ☐ External funding application to one or more funders in progress
- ☑ No application for external funding will be made

What type of research project is this?

- ○ Standalone project
- ○ Project that is part of a programme grant
- ○ Project that is part of a Centre grant
- ◉ Project that is part of a fellowship/ personal award/ research training award
- ○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ◉ No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

○ Yes ◉ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

Title Forename/Initials Surname

[redacted]

Organisation
Address

Post Code
Work Email
Telephone
Fax
Mobile

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/08/2018
Planned end date: 01/08/2019
Total duration:
Years: 1 Months: 0 Days: 1

A71-1. Is this study?

○ Single centre
◉ Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England
☐ Scotland
☐ Wales

☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 2

Does this trial involve countries outside the EU?
○ Yes ◉ No

A72. Which organisations in the UK will host the research? *Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England	2
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	
☐ GP practices in Wales	
☐ GP practices in Scotland	
☐ GP practices in Northern Ireland	
☐ Joint health and social care agencies (eg community mental health teams)	
☐ Local authorities	
☐ Phase 1 trial units	
☐ Prison establishments	
☐ Probation areas	
☐ Independent (private or voluntary sector) organisations	
☐ Educational establishments	
☐ Independent research units	
☐ Other (give details)	
Total UK sites in study:	2

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ◉ No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

The lead researcher will work under supervision of the Research supervisor and Field supervisor. The principles outlined in the Policy Framework for Heath and Social Care Research will be adhered to at all times, and monitored by the Research and Field supervisors.

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:* in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland**

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☐ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

◉ Yes ○ No ○ Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site	Investigator Name
IN2	◉ NHS/HSC Site ○ Non-NHS/HSC Site Organisation name Address Post Code Country	Forename Middle name Family name Email Qualification (MD...) Country
IN3	◉ NHS/HSC Site ○ Non-NHS/HSC Site Organisation name Address Post Code Country	Forename Middle name Family name Email Qualification (MD...) Country
IN5	◉ NHS/HSC Site ○ Non-NHS/HSC Site	Forename Middle name

Organisation name [redacted]

Address

Post Code

Country

Family name [redacted]

Email

Qualification (MD...)

Country

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.
3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.
11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

NRES would like to include a contact point with the published summary of the study for those wishing to seek further

information. We would be grateful if you would indicate one of the contact points below.

- (•) Chief Investigator
- ( ) Sponsor
- ( ) Study co-ordinator
- ( ) Student
- ( ) Other – please give details
- ( ) None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☑ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Miss Elizabeth Tane on 16/10/2018 10:56.

Job Title/Post:	Trainee Clinical Psychologist
Organisation:	Lancashire Care NHS Foundation Trust
Email:	e.tane@lancaster.ac.uk

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co−sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*
7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at ethics@lancaster.ac.uk on 17/10/2018 08:32.

Job Title/Post:	Deputy Head of Research Services
Organisation:	Lancaster University
Email:	b.gordon@lancaster.ac.uk

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr Ian Fletcher on 16/10/2018 10:54.

Job Title/Post:	senior lecturer
Organisation:	lancaster university
Email:	i.j.fletcher@lancs.ac.uk

Governance Checklist

Introduction

Please complete all sections (1 to 4) below. If none of the self-assessment items apply to the project then you do not need to complete any additional LU ethics forms.

Further information is available from the FHMREC webpage

Note: The appropriate ethics forms must be submitted and authorised to ensure that the project is

covered by the university insurance policy and complies with the terms of the funding bodies.

Name: Liz Tane **Department**: Doctorate in Clinical Psychology

Title of Project: Staff compassion in acute mental health care: a grounded theory investigation

Supervisor (if applicable): Dr Ian Fletcher

Section 1A: Self-assessment

1.1 Does your research project involve any of the following?

a. Human participants (including all types of interviews, questionnaires, focus groups, records relating to humans, use of internet or other secondary data, observation etc)

b. Animals - the term animals shall be taken to include any non-human vertebrates, or cephalopods.

c. Risk to members of the research team e.g. lone working, travel to areas where researchers may be at risk, risk of emotional distress

d. Human cells or tissues other than those established in laboratory cultures

e. Risk to the environment

f. Conflict of interest

g. Research or a funding source that could be considered controversial

h. Any other ethical considerations

☑ Yes - complete Section 1B

☐ No - proceed to Section 2

Section 1B: Ethical review

If your research involves any of the items listed in section 1A further ethical review will be required. Please use this section to provide further information on the ethical considerations involved and the ethics committee that will review the research.

Please remember to allow sufficient time for the review process if it is awarded. The ethical review process can accommodate phased applications, multiple applications and generic applications (e.g. for a suite of projects), where appropriate; the Research Ethics Officer will advise on the most suitable method according to the specific circumstances.

1.2 Please indicate which item(s) listed in section 1A apply to this project. Provide information below if ticking 'h'

a ☑ b ☐ c ☐ d ☐ e ☐ f ☐ g ☐ h ☐

Click here to enter text.

1.3 Please indicate which committee you anticipate submitting the application to:

☐ NHS ethics committee

☐ Other external committee

☑ LU FHM Research Ethics committee

☐ LU FASS/LUMS Research Ethics committee

☐ LU FST Research Ethics committee

☐ LU AWERB (animals)

Section 2: Project Information

This information in this section is required by the Research Support Office (RSO) to expedite your proposal.

2.1 If the establishment of a research ethics committee is required as part of your collaboration, please indicate below. (This is a requirement for some large-scale European Commission funded projects, for example.)

☐ Establishment of a research ethics committee required

2.2 If the research involves either the nuclear industry or an aircraft or the aircraft industry (other than for transport), please provide details below. This information is required by the university insurers.

Section 3: Guidance

The following information is intended as a prompt and to provide guidance on where to find further information. Where appropriate consider addressing these points in the proposal.

- If relevant, guidance on data protection issues can be obtained from the Data Protection Officer - see Data Protection website
- If relevant, guidance on the Freedom of Information Act can be obtained from the FOI Officer - see FOI website
- The University's Research Data Policy can be downloaded here
- The health and safety requirements of each research project must be considered, further information is available from the Safety Office website
- If any of the research team will be working with an NHS Trust, consider who will be named as the Sponsor (if applicable) and seek agreement in principle. Contact the Research Ethics Officer for further information
- If you are involved in any other activities that may result in a conflict of interest with this research, please contact the Head of Research Services (ext. 94905)
- If any of the intellectual property to be used in the research belongs to a third party (e.g. the funder of previous work you have conducted in this field), please contact the Intellectual Property Development Manager (ext. 93298)
- If you intend to make a prototype or file a patent application on an invention that relates in some way to the area of research in this proposal, please contact the Intellectual Property Development Manager (ext. 93298)
- If your work involves animals you will need authorisation from the University Secretary and may need to submit an application to AWERB, please contact the University Secretary for further details
- Online Research Integrity training is available for staff and students here along with a Research Integrity self-assessment exercise.

3.1 I confirm that I have noted the information provided in section 3 above and will act on those items which are relevant to my project.

☑ Confirmed

Section 4: Statement

4.1 I understand that as researcher I have overall responsibility for the ethical management of the project and confirm the following:

- I have read the Code of Practice, Research Ethics at Lancaster: a code of practice and I am willing to abide by it in relation to the current proposal
- I have completed the ISS Information Security training and passed the assessment
- I will manage the project in an ethically appropriate manner according to: (a) the subject matter involved; (b) the code of practice of any relevant funding body; and (c) the Code of Practice and Procedures of the university.
- On behalf of the institution I accept responsibility for the project in relation to promoting good research practice and the prevention of misconduct (including plagiarism and fabrication or misrepresentation of results).
- On behalf of the institution I accept responsibility for the project in relation to the observance of the rules for the exploitation of intellectual property.
- If applicable, I will give all staff and students involved in the project guidance on the good practice and ethical standards expected in the project in accordance with the university Code of Practice. (Online Research Integrity training is available for staff and students here.)
- If applicable, I will take steps to ensure that no students or staff involved in the project will be exposed to inappropriate situations.

☑ Confirmed

Please note: If you are not able to confirm the statement above please contact Research Governance and Integrity Officer and provide an explanation

Applicant: Name: Liz Tane Date: 03.09.2018

Supervisor (if applicable)*: Name: Dr Ian Feltcher

Head of Division* Name: Prof Bill Sellwood

(or delegated representative)

Submission Guidance

1. You should submit the checklist as an **individual** word document (you do ***not*** need to combine this form with your FHMREC application documents)
2. Submit the checklist from your **Lancaster University** email address
3. ***Copy your supervisor and Head of Division in to the email in which you submit this document

Please return this form to Diane Hopkins

Lancaster University Faculty of Health and Medicine Ethical Approval Letter

Lancaster University

Applicant: Elizabeth Tane
Supervisor: Ian Fletcher
Department: Health Research
FHMREC Reference: FHMREC18003

09 October 2018

Dear Elizabeth

Re: Staff compassion in acute mental health care: A grounded theory investigation

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

R.E. Case

Becky Case
Research Ethics Officer, Secretary to FHMREC.

Lancaster University Faculty of Health and Medicine Sponsorship Letter

Lancaster University

Applicant name: Elizabeth Tane
Supervisor: Ian Fletcher
Department: Health Research

10 October 2018

Dear Elizabeth

Re: Staff compassion in acute mental health care: A grounded theory investigation

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

Yours sincerely,

R·E·Case

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

Health Research Authority Approval Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Elizabeth Tane
Trainee Clinical Psychologist
Lancashire Care NHS Foundation Trust
C-Floor, Furness College
Lancaster University
Lancaster
LA1 4YG

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

22 November 2018

Dear Miss Tane

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Staff compassion in acute mental health care: A grounded theory investigation**
IRAS project ID:	**251508**
Protocol number:	**N/A**
Sponsor	**Lancaster University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Participating NHS organisations in England and Wales **will not** be required to formally confirm capacity and capability before you may commence research activity at site. As such, you may commence the research at each organisation 35 days following sponsor provision to the site of the local information pack, so long as:

- You have contacted participating NHS organisations (see below for details)
- The NHS organisation has not provided a reason as to why they cannot participate
- The NHS organisation has not requested additional time to confirm.

You may start the research prior to the above deadline if the site positively confirms that the research may proceed.

IRAS project ID	251508

If not already done so, you should now provide the local information pack for your study to your participating NHS organisations. A current list of R&D contacts is accessible at the NHS RD Forum website and these contacts MUST be used for this purpose. After entering your IRAS ID you will be able to access a password protected document (password: [redacted]. The password is updated on a monthly basis so please obtain the relevant contact information as soon as possible; please do not hesitate to contact me should you encounter any issues.

Commencing research activities at any NHS organisation before providing them with the full local information pack and allowing them the agreed duration to opt-out, or to request additional time (unless you have received from their R&D department notification that you may commence), is a breach of the terms of HRA and HCRW Approval. Further information is provided in the "*summary of assessment*" section towards the end of this document.

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

IRAS project ID	251508

The sponsor contact for this application is as follows:

Name: Ms Becky Gordon
Tel: 01524592981
Email: ethics@lancaster.ac.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **251508**. Please quote this on all correspondence.

Yours sincerely

[redacted]

Email: hra.approval@nhs.net

Copy to: [redacted]

IRAS project ID	251508

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Lancaster University Ethics Approval]	v0.1	09 October 2018
Copies of advertisement materials for research participants [Recruitment poster]	v0.2	26 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance]	v0.1	10 October 2018
HRA Schedule of Events	2	21 November 2018
HRA Statement of Activities	2	21 November 2018
Interview schedules or topic guides for participants [Interview topic guide]	v0.3	07 October 2018
IRAS Application Form [IRAS_Form_17102018]		17 October 2018
IRAS Application Form XML file [IRAS_Form_17102018]		17 October 2018
IRAS Checklist XML [Checklist_17102018]		17 October 2018
Letter from sponsor [Letter from sponsor]	v0.1	10 October 2018
Letters of invitation to participant [Recruitment email]	v0.1	06 July 2018
Non-validated questionnaire [Demographic questionnaire]	v0.1	05 August 2018
Participant consent form	3	22 November 2018
Participant information sheet (PIS)	3	06 November 2018
Research protocol or project proposal [Research proposal]	v0.3	07 October 2018
Summary CV for Chief Investigator (CI) [Chief Investigator CV]	v0.1	02 August 2018
Summary CV for student [Student CV]	v0.1	05 August 2018
Summary CV for supervisor (student research) [Supervisor CV]	v0.1	12 October 2018
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [Exclusions]	v0.1	10 October 2018
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Distress protocol]	v0.2	26 July 2018
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Breaking confidentiality protocol]	v0.3	07 October 2018

IRAS project ID	251508

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	As per the Statement of Activities, no additional funding will be provided from sponsor to site.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments

IRAS project ID	251508

Section	Assessment Criteria	Compliant with Standards	Comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
Activities at all participating sites will be the same; there will be one site type. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
Neither a Principal Investigator nor a Local Collaborator is expected to be in place at participating sites, however the site is requesting a Local Collaborator. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

IRAS project ID	251508

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
DBS checks and occupational health clearance are not required for interviews with members of staff as no clinical area should be accessed for the purpose of the research.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

NHS Trusts' Approval letters

[redacted]

[redacted]

Standardised Process for Electronic Approval of Research

10th December, 2018

Liz Tane

[redacted]

Dear Liz,

Re: NHS Permission for Research

Project Title: Staff compassion in acute mental health care
Sponsor: Lancaster University
SPEAR: 1540

Further to your request for permission to conduct the above research study at this Trust, we are pleased to inform you that this Trust has given NHS permission for the research to proceed.

Your NHS permission to conduct research at this site is only valid upon receipt of a signed 'Conditions for NHS Permission Reply Slip' which is enclosed.

Please take the time to read the attached conditions for NHS permission. Please contact the Research Office should you require any further information. You will need this letter as proof of NHS permission.

NHS permission for the above research has been granted on the basis described in your university application form and supporting documentation.

The documents reviewed were:

- Protocol, v0.3, 07/10/2018
- Participant information sheet, v0.4, 30/11/2018
- Consent form; staff v0.4, 30/11/2018
- IRAS form, ref: 251508

[redacted]

- Health Research Authority approval, 22/11/2018
- University ethics approval, ref FHMREC18003, 09/10/2018

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP (if applicable), and NHS Trust policies and procedures. Permission is only granted for the activities for which a favourable opinion has been given by the Ethics Committee (where appropriate).

May I wish you every success with your research.

Yours sincerely,

[redacted]

PP

Enc: Approval Conditions Leaflet

[redacted]

Study Title: Staff compassion in acute mental health care

Conditions for NHS Permission Reply Slip: for reference.

In order for your NHS permission to be valid, please return this form to the address below to confirm that you have read and understood the conditions of NHS permission to conduct research.

1. I confirm that I have read and understand my duties and responsibilities as part of the conditions for permission to conduct research at this site.
2. I understand that I must submit the following information to the Trust's R&D department:
    - Recruitment figures on a monthly basis
    - New researcher details prior to them commencing on the research project
    - Any amendments submitted to the Ethics Committee
    - Changes to the status of the research project
    - Any urgent safety measure incorporated
    - Untoward Incidents and Unexpected Events within 24 hours of their occurrence
    - A final summary report
    - A copy of the Ethics letter confirming receipt of the End of Study Declaration
3. I understand I must complete and return in a timely manner any audit forms sent to me by the Trust.
4. I understand that I must gain permission from the Trust in order to publish or place information of the current research into the public domain.

[redacted]

Study Title: ***Staff compassion in acute mental health care***

SPEAR number: 1540

Conditions for NHS Permission Reply Slip

In order for your NHS permission to be valid, please return this form to the address below to confirm that you have read and understood the conditions of NHS permission to conduct research.

1. I confirm that I have read and understand my duties and responsibilities as part of the conditions for permission to conduct research at this site.
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    - New researcher details prior to them commencing on the research project
    - Any amendments submitted to the Ethics Committee
    - Changes to the status of the research project
    - Any urgent safety measure incorporated
    - Untoward Incidents and Unexpected Events within 24 hours of their occurrence
    - A final summary report
    - A copy of the Ethics letter confirming receipt of the End of Study Declaration
3. I understand I must complete and return in a timely manner any audit forms sent to me by the Trust.
4. I understand that I must gain permission from the Trust in order to publish or place information of the current research into the public domain.

Signed.....

PRINT NAME..... Elizabeth Tane.....

Date..... 13.12.18.....

Estimated Start date to commence research at this Trust ..... 02.01.19.....

At which site will you approach first? ..... [redacted] .....

Expected recruitment target at this Trust? ..... 5-7.....

Please email to [redacted]

[redacted]

Dear Liz,

Full Study Title: Staff compassion in acute mental health care: A grounded theory investigation.

[redacted] Trust has received a HRA Approval Letter regarding the above study which confirms the HRA has determined that no formal assessment of capacity and capability is required by sites.

Please accept this email as acknowledgement of capacity and capability/no objection at [redacted] Trust for the above referenced study.

Recruitment
The Trust is required to report on research activity and recruitment. Please note that you are required to confirm the date of your first recruit by email, to provide regular updates on recruitment progress and to notify us when study recruitment ends.

Safety Reporting
We would like to remind you that all serious adverse events or incidents must be reported to the research department on [redacted] quoting the IRAS number for the study. This is in addition to any reporting requirements to the relevant Research Ethics Committee.

Progress reporting
You are also expected to report to the research department, any substantial or non-substantial amendments to the study or any changes to study personnel. Please also provide copies of any progress reports to the REC or HRA and a final report on completion of the study.

Access to NHS Premises
All study personnel not employed by [redacted] must be issued with a Letter of Access or Honorary Research Contract from the research department before commencing research activity at this site if the project involves patients or will be conducted in clinical areas.

If you wish to discuss this further, please do not hesitate to contact the research department.

Kind Regards,

[redacted]t

[redacted]

Our Ref: 251508

Date: 30th November 2018

Elizabeth Tane
Trainee Clinical Psychologist
C-Floor, Furness College
Lancaster University
LA1 4YG

Dear Elizabeth,

Letter of access to undertake research on the following study: Staff compassion in acute mental health care

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. The organisation is satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer.

Your employer is fully responsible for ensuring such checks as are necessary have been carried out.

Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. Evidence of checks should be available on request to [redacted]

This letter should be presented to each participating organisation before you commence your research at that site.

In accepting this letter, [redacted] confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on **30th November 2018** and ends on **31st April 2019** unless terminated earlier in accordance with the clauses below.

[redacted]

[redacted]

Please note that you cannot start the research until the Principal Investigator for the research project has received an email from us confirming capacity and capability for the project.

- You have a right of access to conduct such research as confirmed in writing in the Statement of Activities for this NHS organisation
- You are considered to be a legal visitor to [redacted]
- You are not entitled to any form of payment or access to other benefits provided by [redacted] to employees and this letter does not give rise to any other relationship between you and to [redacted] Healthcare NHS Foundation Trust, in particular that of an employee
- While undertaking research through [redacted] will remain accountable to your employer Lancashire Care NHS Foundation Trust
- You are required to follow the reasonable instructions of your nominated manager or Head of relevant NHS Department/research supervisor in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access
- Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings
- You must act in accordance with [redacted] Trust policies and procedures, which are available to you upon request, and the Research Governance Framework
- You are required to co-operate with [redacted] in discharging its duties under the Health and Safety at Work etc. Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [redacted] premises
- Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times
- If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust prior to commencing your research role at each site
- You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times
- You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution
- [redacted] will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998
- Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer

[redacted]

[redacted]

- You should ensure that, where you are issued with an identity or security card, a bleep number, e-mail or library account, keys or protective clothing, these are returned upon termination of this arrangement
- Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property
- This letter may be revoked and your right to attend the Trust terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence
- You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated
- Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately
- Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you
- If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures
- You must also inform your nominated manager in this NHS organisation

Yours sincerely

[redacted]

cc: HR department of the substantive employer

[redacted]

Appendix 4-A
Participant Information Sheet

Participant Information Sheet

Staff compassion in acute mental health care

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage:

www.lancaster.ac.uk/research/data-protection

My name is Liz Tane and I am Trainee Clinical Psychologist at Lancaster University. As part of my Doctorate in Clinical Psychology I am conducting research into staff's understanding of compassion on acute mental health wards.

What is the study about?

The purpose of this study is to gain a better understanding of staff member's understanding of compassion and compassionate care in acute inpatient environments, and barriers/facilitators to delivering compassionate care.

Why have I been approached?

You have been approached because the study requires information from staff who currently work on an acute mental health ward, and have done for a minimum of 3 months.

Do I have to take part?

No. It's completely up to you to decide whether you would like to take part.

What will I be asked to do if I take part?

If you decide you would like to take part, I will arrange a time to come an interview you, usually at your work place but it may be at another suitable location (another NHS premises, or your home). I will ask you some questions related to compassion and compassionate care within your role. The interview will be recorded and then transcribed. Your name will not be on the transcription, so it will be anonymous.

Will my data be Identifiable?

The information you provide will be fully anonymised, so you will not be identifiable from the answers you give.

The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data:

- Audio recordings will be deleted once the project has been submitted for publication/examined.
- The files will be stored on the Lead Researcher's password-protected personal file store on the Lancaster University network.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, but your name will not be attached to them.
- All your personal data will be confidential and will be kept separately from your interview responses.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and speak to a member of staff about this. If possible, I will tell you if I have to do this.

Personal data generated by this research (signed consent forms) will only be seen by the lead researcher, and will be scanned and stored on the lead researcher's password protected file store on the Lancaster University network. On completion of the study, signed consent forms will be encrypted, password protected and stored in Lancaster University's Data Depository (via PURE), for a period of 10 years after the study completion, in line with Lancaster University's Data Policy. Anonymised data (interview transcripts) will also be transferred stored in Lancaster University's Data Depository (via PURE) for the same period of time. Electronic consent forms and anonymised data will be kept separately to maintain confidentiality. Audio recordings of interviews will only be available to the lead researcher, and/or an external transcriber who will have signed an appropriate confidentiality agreement. Audio recordings will be kept until the project has been submitted and examined, after which they will be deleted.

Lancaster University will be the data controller for any personal information collected as part of this study.

Under the GDPR you have certain rights when personal data is collected about you. You have the right to access any personal data held about you, to object to the processing of your personal information, to rectify personal data if it is inaccurate, the right to have data about you erased and, depending on the circumstances, the right to data portability. Please be aware that many of these rights are not absolute and only apply in certain circumstances. If you would like to know more about your rights in relation to your personal data, please speak to the researcher on your particular study.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

What will happen to the results?

The results will be summarised and reported in my doctoral thesis, and may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet. You can also stop the interview at any time.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

Ethical approval for this research was sought and obtained from the Faculty of Health and Medicine Research Ethics Committee at Lancaster University. The study has also been reviewed and approved by the Health Research Authority.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:

Liz Tane (Trainee Clinical Psychologist)
Email: e.tane@lancaster.ac.uk

Or alternatively

Dr Ian Fletcher (Research Supervisor)
Email: i.j.fletcher@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Bill Sellwood (Research Director)
Tel: 01524 593998
Email: b.sellwood@lancaster.ac.uk
Department of Health Research
Lancaster University
Lancaster
LA1 4XY

If you wish to speak to someone outside of the Doctorate in Clinical Psychology Programme, you may also contact:

Professor Roger Pickup (Associate Dean for Research)
Tel: +44 (0)1524 593746
Email: r.pickup@lancaster.ac.uk

Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance:

- Speaking to your line manager.
- Asking your line manager to make a referral to your Trust's Staff Support Service.

Appendix 4-B
Consent Form

Health & Medicine | Lancaster University

Consent Form

Study Title: Staff compassion in acute mental health care

We are asking if you would like to take part in a research project that looks at staff's understanding of compassion and compassionate care on acute mental health wards.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Liz Tane.

		Please initial each statement
1.	I confirm that I have read the information sheet and fully understand what is expected of me within this study	☐
2.	I confirm that I have had the opportunity to ask any questions and to have them answered.	☐
3.	I understand that my interview will be audio recorded and then made into an anonymised written transcript.	☐
4.	I understand that audio recordings will be kept until the submission of the research project.	☐
5.	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.	☐
6.	I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn. I understand that I can withdraw my data up to one week after the interview.	☐
7.	I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published.	☐
8.	I consent to information and quotations from my interview being used in reports, conferences and training events.	☐
9.	I understand that the researcher will discuss anonymised data with their supervisors as needed.	☐
10.	I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with their research supervisors.	☐
11.	I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished.	☐
12.	I consent to take part in the above study.	☐

Name of Participant_____ **Signature**_____ **Date** _____

Name of Researcher _____**Signature** _____**Date** _____

By proceeding to the interview, you confirm that:

- You have read the information sheet and understand what is expected of you within this study.
- You confirm that you understand that any responses/information you give will remain anonymous.
- Your participation is voluntary.
- You consent for the anonymised transcripts of your interview to be shared and discussed with the research team.
- You consent to Lancaster University keeping the anonymised data for a period of 10 years after the study has finished.

You will be provided with a copy of the signed consent form for your records, and another copy will be kept by the lead researcher. The researcher's copy will then be scanned, uploaded and stored in the lead researcher's password protected file store on the Lancaster University network, separately from any anonymised data (e.g. audio files or interview transcripts).

Participant identifier: .....

Appendix 4-C
Study Poster

Staff compassion in acute mental health care

My name is Liz Tane and I am Trainee Clinical Psychologist at Lancaster University. As part of my Doctorate in Clinical Psychology I am conducting research into staff's understanding of compassion on acute mental health wards.

Who can participate?

We are looking to recruit staff members who currently work on an acute inpatient ward, and have done for a minimum of 3 months.

What is involved?

We are asking staff to undertake an interview, which will last up to 1 hour. During this time, you will be asked some questions about your views on compassion and compassionate care in your current job role.

Interested?

If you are interested in participating, you can contact the lead researcher (Liz Tane) at:

Email: e.tane@lancaster.ac.uk

Appendix 4-D
Example Recruitment Email

Dear (name of professional),

My name is Liz Tane, and I am a Trainee Clinical Psychologist at Lancaster University. As part of my doctoral thesis, I am conducting research into staff's conceptualisation of compassion on acute mental health wards.

I am looking to recruit staff who currently work on an acute inpatient ward, and have done for a minimum of 3 months. I am asking staff to undertake an interview with myself, about their views on compassion and compassionate care within their job role. The interview should take no more than an hour, and I will visit them at their workplace to conduct the interview.

I would be grateful if you would be able to share the above information with your staff, and have attached an information sheet with further details. If you could disseminate this information in the next staff meeting/handover/team meeting (delete as appropriate), I would be most grateful.

If any staff would like to participate, or have any questions, they can contact me at:

Email: e.tane@lancaster.ac.uk
Phone: (work mobile number)

I understand that, in the current NHS climate, it may be difficult to spare staff members for the hour required to undertake the interview. However, I can be flexible in arranging an interview time, and if there is any opportunity to release staff to participate, I would be very grateful.

If you have any further questions or require any further information, please do not hesitate to contact me. I would also be happy to attend a team meeting to share more information on this research, if you think that would be of use.

I attach the participant information sheet with further details. Please feel free to circulate this amongst your team.

Yours sincerely,
Liz Tane
Trainee Clinical Psychologist
Lancaster University.

Appendix 4-E
Interview Schedule

1. Opening

   A. **(Establish Rapport)** Introductions.

   B. (**Purpose)** Explanation of research project

      i. Research is about people's thoughts, views and experiences of compassion.

      ii. I've worked in this environment, so I know it can be a challenge.

      iii. Going to cover a range of topics including your understanding on compassion, what it looks like in your job role, challenges to maintaining compassion and emotions at work.

      iv. No right or wrong answers – please contribute whatever occurs to you that you feel is relevant.

   C. **(Motivation)** Explanation of why they have been asked to undertake interview. Explain recording process.

   D. **(Timeline)** Explain how long the interview should take.

   E. **(Consent)** Confirm consent, remind participants of breaking confidentiality protocol and distress protocol. Remind them of right to stop interview at any time. Check they are happy to continue.

2. **General demographic information**

   A. Age

   B. Profession

   C. Time since qualification

   D. How long have you been in current role

   E. What does your role generally consist of?

   F. How many hours do you work?

G. On what types of ward? E.g male, female, acute PICU

H. What drew you to inpatient work?

I. What do you like most about your role?

3. Overview of compassion (example questions)

A. **Over the last 5-10 years there has been lots of talk of compassion in the workforce, particularly in the NHS– have you seen any policy documents or heard anybody talk about it within the trust?**

i. If yes, what do you think of them?

ii. In what context?

B. **Part of the difficulty with compassion is that there isn't an agreed definition - In your words, can you describe what 'compassion' means to you?** (provide definition if struggling to answer – see if they are in agreement).

i. "the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help"

ii. "a deep sensitivity to the suffering of self and others, with a deep commitment to try and relieve it"

C. **What qualities would you expect to see in a compassionate person?**

D. **What do you think compassionate care looks like in your role or on the ward?**

E. **Can you think of a time, perhaps when you first started in your role, when you witnessed another staff member being particularly compassionate or kind to a service user?**

i. What did they do?

ii. How did you feel, witnessing it?

F. **Can you think of an example of a time that you felt deeply compassionate towards a service user? Someone you really felt for or wanted to help?**

i. How did it feel?

ii. What did you do?

G. **Can you give an example of a time that you witnessed a lack compassion towards a service user?**

i. How did it make you feel?

ii. How did you act?

H. **Can you give an example of a time that you yourself struggled to feel compassionate towards a service user?**

i. What was happening?

ii. How did it make you feel?

iii. What did you do?

4. Compassion in their role (example questions)

A. **How easy/difficult it is to maintain compassion towards service users in this role?**

B. **When is it most difficult?**

i. Effect of the ward atmosphere

ii. Impact of management support

iii. Impact of team dynamics

iv. Effect of supervision

C. **What impact, if any, do you think the high turnover has?**

D. **What helps you to maintain compassion? Both personally and organisationally.**

E. **Do you think compassion is different in this role** (if they've worked in other roles/settings)?

5. Negative emotions or distress (example questions)

   A. **How do you feel when there is a serious incident on the ward? (violence, self-harm, suicide attempt).**

      i. What emotions do you experience?

      ii. What impact does it have on your work?

   B. **What helps you manage your distress?**

   C. **Do you notice an impact on the team as a whole after an incident?**

      i. What changes?

   D. **When you feel distressed, what impact does it have on your work with clients?**

      i. What impact does it have on your relationships with the team?

   E. **Does your distress impact your home life? Does it influence your behaviour with friends and family?**

   F. **What is it like working within a team? Benefits and challenges?**

      i. What is it like when there is an issue or disagreement?

      ii. How does it make you feel?

   G. **What processes are there if you feel you need to raise an issue?**

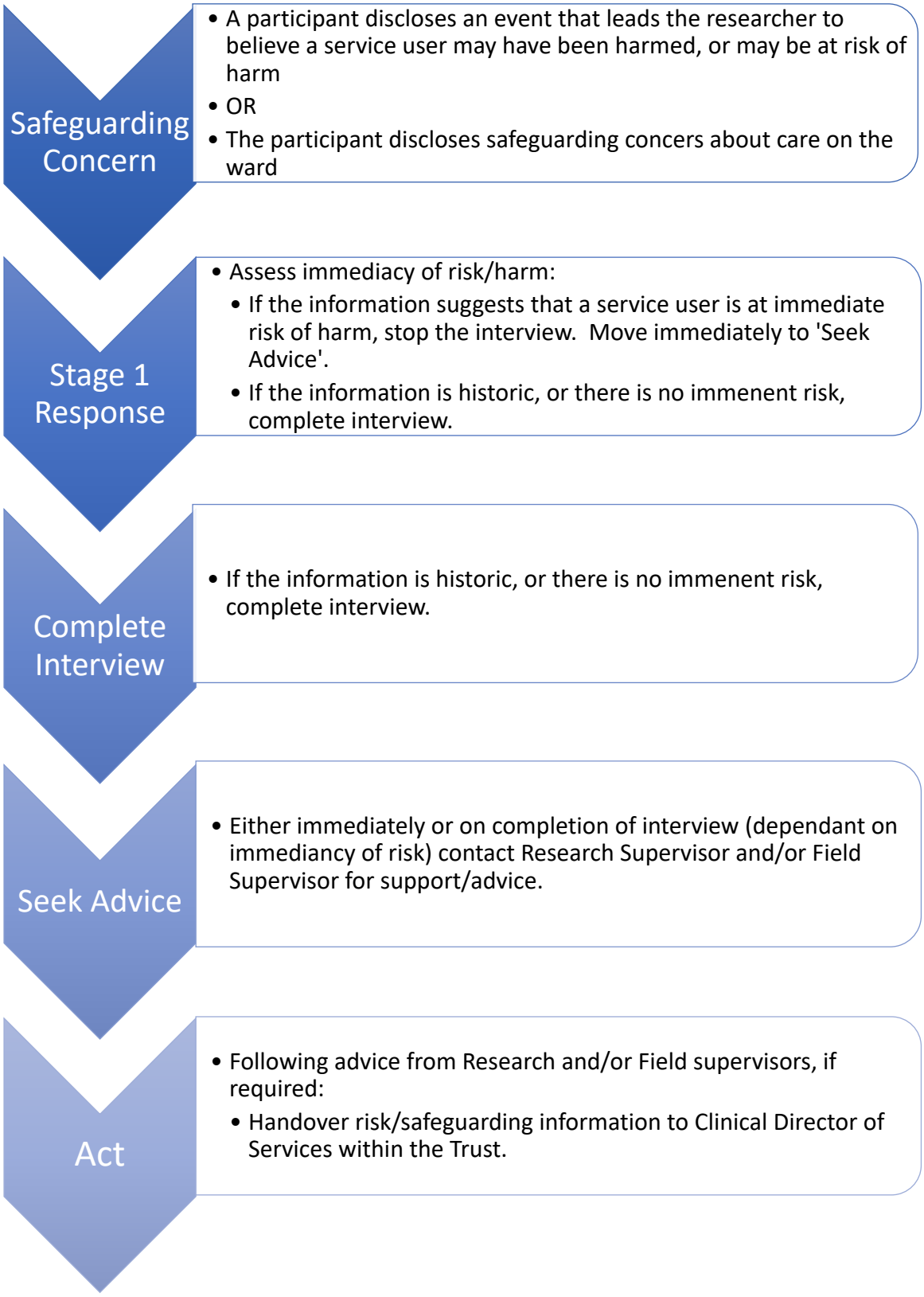
      i. E.g. management, whistleblowing

      ii. Do you think people feel safe to raise issues?

   H. **Is there anything you feel we haven't talked about today that you would like to add?**

Appendix 4-F
Distress Protocol

Appendix 4-G
Breaking Confidentiality Protocol



Appendix 4-H
Participant Debrief Sheet

Thank you for taking part in this research project. This study is examining staff's conceptualisation of compassion and compassionate care on acute inpatient wards.

How the data will be used

The recording of the interview will now be transcribed, and collated with data from other interviews I have conducted. Your data will be anonymised, so you will not be identifiable from the information you provided.

The audio recording and transcription will be encrypted and stored on a password protected computer. Any personal data you provided will be kept separate from your interview.

Once all interviews have been conducted, the data will be collated into themes to look for similarities/differences in participants' responses. The research project will be submitted as part of my Doctoral studies, and may also be submitted for publication in an academic/professional journal. Specific quotes from interviews may be used, but these will all be anonymised.

Sources of support

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance:

- Speaking to your line manager.
- Asking your line manager to make a referral to your Trust's Staff Support Service.

Further information

If you would like to discuss any aspect of your participation in this research, or have any concerns, please contact:
Liz Tane (Lead Researcher)
Email: e.tane@lancaster.ac.uk

Or alternatively

Ian Fletcher (Research Supervisor)
Email: i.j.fletcher@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Bill Sellwood (Research Director)
Tel: 01524 593998
Email: b.sellwood@lancaster.ac.uk
Department of Health Research
Lancaster University

Lancaster
LA1 4XY

If you wish to speak to someone outside of the Doctorate in Clinical Psychology Programme, you may also contact:

Professor Roger Pickup (Associate Dean for Research)
Tel: +44 (0)1524 593746
Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
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