Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

Doctoral Thesis:

A qualitative exploration of the impact of stress and workplace adversity on healthcare staff experiences, well-being and resilience

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Words Counts

	Main Text	**Appendices (including tables, figures and references)**	**Total**
Thesis abstract	292	N/A	292
Literature Review	7896	4847	12743
Research paper	7958	5193	13151
Critical Appraisal	3998	678	4676
Ethics Section	4020	4997	9017
Total	**24164**	**15715**	**39879**

Abstract

This thesis is comprised of a systematic literature review, empirical paper and critical appraisal. Firstly, a systematic literature review of qualitative studies exploring staff experiences of violence and aggression in the emergency department was conducted. A meta-ethnographic approach was used to review 12 papers. The results showed that staff working in the emergency department appeared to resign themselves to the inevitable experience of violence and aggression. Staff made attributions about the cause of violence and aggression which affected their emotional responses. They also often felt isolated when managing violent incidents and the experience of violence and aggression had significant consequences on their psychological and physical well-being. A consistent organisational response to violence and aggression was recommended through both frontline and management staff training.

Secondly, the empirical paper explores staff perceptions of well-being and resilience using a constructivist grounded theory framework. 11 staff were interviewed from a range of professional backgrounds across two forensic services. A model of staff perceptions of the factors which contribute to well-being and resilience when working in secure forensic services was developed. Staff resources were depleted through: working with clients who have complex difficulties, experiencing constant change and through the indirect impact of pressure from external organisations. This had a subsequent negative impact on their well-being. Factors including breaks and reflection in and out of work, support from colleagues and witnessing client progress allowed staff to feel ‘re-charged’ and motivated staff to continue working. Clinical implications included: organisations providing opportunities for time and reflection in work for staff, self-care training for new starters and advice for managers.

The final section outlined a critical reflection of the journey conducting research with staff in the current climate of healthcare and considering the findings within the existing resilience literature base.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at the Division of Health Research at Lancaster University from January 2016 to June 2017.

The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

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I would like to thank the eleven members of staff who kindly took time out of their busy days to share their views on well-being and resilience with me. It was a privilege to hear your experiences and to be able to play my part in sharing them within this thesis.

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Word count: 7896 words

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ABSTRACT

Introduction Patient and visitor violence or aggression against healthcare workers is a significant issue in hospitals across the world, and staff working in the Emergency Department (ED) are at even greater risk. Existing reviews simply describe the phenomenon of violence and aggression in the ED. The aim of this review was to synthesise existing qualitative papers exploring the first-hand experiences of staff working in the ED to provide greater understanding around preventing this issue.

Method A meta-ethnographic approach was used to review 12 papers.

Results Four main concepts were identified: 'The inevitability of violence and aggression'; 'Staff judgments about why they face violence and aggression'; 'Managing in isolation'; and 'Wounded heroes'.

Discussion Staff resigned themselves to the inevitable experience of violence and aggression due to a perceived lack of support from the organisation and the high frequency of violent incidents. Whilst frequently feeling unsafe at work, staff appeared to make judgements about the reasons for aggressive or violent behaviour which impacted on how staff coped and subsequently tolerated the aggressor. Staff often felt isolated when managing violence and aggression. One novel finding was whereby staff felt "wounded" when occupying the role of 'victim'. Key recommendations included: consistent organisational response to incidents, improved incident reporting infrastructure and staff training in understanding violence and aggression. Training for managers promoting a tranformational leadership style and clinical supervision was also recommended.

Conclusions Violence and aggression in the ED is an overwhelming yet inevitable experience for staff. A strong organisational commitment to reducing violence and aggression is imperative.

Keywords: Workplace Violence; Aggression; Emergency Services; Health Personnel; Qualitative Studies

INTRODUCTION

Violence against healthcare workers is a significant problem in the United Kingdom (UK) and worldwide [1,2]. The latest UK statistics demonstrated that there were 1,343,464 total reported assaults on National Health Service (NHS) staff in the last year [3]. A systematic literature review of patient and visitor violence in general hospitals from multiple countries showed that on average 50 per cent of healthcare staff reported experiencing verbal abuse and 25 per cent had experienced physical abuse [4]. A survey completed across three general hospitals in the UK showed that, in the previous four weeks, 83 per cent of staff working in acute medical wards had experienced verbal aggression, 50 per cent had been threatened and 63 per cent had been physically assaulted [5]. Similarly, one study reporting data from a Swiss general hospital showed that 50 per cent of staff reported violence in the last 12 months, and 11 per cent in the previous week [6].

Violence and aggression against staff has been documented as a significant problem in EDs specifically [7]. In one study conducted in Australia, 70 per cent of nurses working in two EDs reported that they had experienced violence in the previous five months [8]. A literature review found that, in half the studies, between 53-90 per cent of staff in the ED had experienced violence or aggression [9].

Current literature has also highlighted the types of violence and aggression that occur in EDs. One literature review found that verbal abuse was reportedly three times more likely to occur than physical aggression in EDs [10]. Common types of verbal assaults included insults, humiliation, being yelled at and swearing; common physical violent acts included spitting, hitting, pushing, scratching, kicking, slapping and biting [9,10]. ED nurses perceived that healthcare support workers and nurses were more likely to experience violence and aggression compared to other staff, and the main reasons for violence included people being either under the influence of alcohol or drugs, or having mental health issues [8].

Rates of verbal and physical aggression have been shown to vary greatly between different countries. One literature review of studies across 18 countries showed significant discrepancy between staff reports of the incidence of verbal aggression (21-82 per cent), and physical aggression (13-79 per cent) across studies [9]. This disparity in experience is likely to be, at least in part, a product of the different funding and service structures across the world. Typically healthcare services in the European Union are funded through the state either directly or indirectly [11], whereas the United States (US) does not have a universal health system and 89.6 per cent of the population own private healthcare insurance [12]. Moreover, there are also differences in health delivery in low to middle income countries across Africa and South-East Asia [13]. Therefore, it is likely that the experience of violence and aggression in EDs is not the same universally.

Research has also highlighted the significant and far-reaching consequences of patient and visitor violence against staff. These experiences can negatively affect the psychological and physical well-being of staff, with reported responses including anger,

fear or anxiety, post-traumatic stress ‘symptoms’, guilt, self-blame and shame [14]. Another consequence of violence and aggression for staff is physical injury; studies have shown that 56 percent of staff reported being physically injured following an assault [4]. Moreover, violence and aggression against ED nurses has been shown to reduce work productivity and quality of patient care [15]. This in turn increases the costs to the organisation and impacts on the service provided to patients [16]. Another potential long-term consequence of violence and aggression could be difficulties in recruitment and retention of nurses. Jackson, Clare and Mannix [17] have argued that nursing in Australia has faced a serious recruitment problem which is even more pronounced in EDs, suggesting that violence and aggression in the workplace is one of the potential reasons for such difficulties.

Nurses are subjected to verbal and physical abuse so frequently in some EDs that it has now arguably become an accepted part of the job [18]. The normalisation of violence in the workplace has significant implications for incident reporting. Chronic under-reporting of violent incidents in EDs has been well-documented both in Australia and worldwide [19]. This qualitative study conducted in Australia highlighted staff perceptions of the reasons for under-reporting including: a lack of policy and procedure, feeling discouraged to report by management and a lack of follow-up [19]. Other reasons, such as a fear of being negatively judged, fear of vendetta or lack of necessary reporting systems were also stated reasons for staff not reporting incidents [9]. Pich et al. [18] have argued that the normalisation and under-reporting of patient and visitor violence can become embedded within the organisational culture which inhibits the implementation of effective preventative strategies and a safe working environment.

It also worth noting that in over 1.3 million cases of assault against NHS staff in the UK, only 1,740 cases led to criminal sanctions [3], and it has been suggested that NHS staff who are victims of assault are “often treated as little more than statistics” [20]. McKoy [21] argues that, by law in the US, staff are entitled to a safe workplace that is free from violence and nurses should be aware of their legal rights to take action against employers who fail to provide safety measures against violence. Therefore, it is imperative that healthcare organisations take more proactive measures in preventing patient and visitor violence and aggression against staff.

In the UK, NHS personal safety training and zero tolerance policies have been implemented, however, it has been argued that this is not sufficient [20]. Existing preventative strategies have been environmentally focussed, such as alarms, security presence or metal detectors. Other strategies include zero tolerance policies, which stipulate that specific actions or behaviours will not be accepted. This approach was initially implemented across the UK, US, Australia and New Zealand, but is not always considered the most effective approach to reducing violence and aggression [22]. Few studies exist which assess the effectiveness of interventions aimed at reducing violence in EDs [23], and reviews in this area have been inconclusive due to design issues, difficulty defining violence and a paucity of papers [24]. Moreover, Anderson, FitzGerald and Luck [24] suggested that training is commonly seen as a panacea to reducing violent incidents, however, one study showed that violence management and de-escalation training did not reduce violent incidents [5].

In the existing literature, there are limited studies examining first-hand experiences of nurses and frontline staff dealing with violence and aggression. Such accounts can provide valuable insight into how staff experience violence and aggression

to offer novel ways of preventing this issue and supporting staff. Exploring staff experiences can also provide insight into the impact and consequences of experiencing violence and aggression within the context of the ED. Qualitative methodologies can be useful in exploring perspectives, and the value of qualitative systematic reviews has been increasingly recognised [25]. Existing quantitative reviews have focused on simply describing the phenomenon [7], and there are no known qualitative reviews exploring the experience of violence and aggression in staff working in the ED. Moreover, synthesising studies across countries and contexts can offer greater understanding about the factors which influence the experience of violence and aggression in the ED. Therefore, the aim of this review was to synthesise existing qualitative studies exploring staff experiences of violence and aggression in EDs. The main research question of this meta-synthesis was: What are staff's experiences of violence and aggression in EDs?

METHOD

Search strategy

A 'Context-How-Issues-Population' (CHIP) mind map [26] was utilised to identify search terms. Four electronic databases were identified to provide a comprehensive search relevant to the research question (CINAHL, PsycINFO, Pubmed and Web of Science). Four concepts were identified: 'staff'; 'violence and aggression'; 'accident and emergency'; and 'qualitative'. For each database, a free text search and a search using subject terms or Medical Subject Headings (MeSH) for all four concepts was completed separately and the results were combined to identify relevant papers, except for Web of Science where only free text searching is available. See Appendix 1-A for a

detailed breakdown of the final search strategy, which was verified by the academic librarian at the University.

Papers were identified using the following inclusion criteria, studies that: were written or available in English; used qualitative approaches with an inductive phenomenological standpoint, as analysis can be problematic when different epistemological perspectives are included [27]; reported on ED or triage; explored experiences of any staff member working in the ED; used mixed-methods due to the paucity of papers in this area; reported patient or visitor violence or aggression. In this review, violence or aggression was taken to refer to "a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is behaviourally or verbally expressed, physical harm is sustained or the intention is clear." [2]. The review focussed on the ED to increase the application of the findings to this setting; the definition of ED used was "a health care setting in which patients may receive accident and emergency services and initial, stabilising treatment for medical, surgical and/or mental health care" [7].

Papers were excluded if the study: was not written or available in English; was based in any other department or pre-hospital emergency service; used qualitative approaches that were not phenomenological; used exclusively quantitative methodology; explored any experiences that were not related to violence and aggression; explored views of anyone who did not work in the department unless the paper reported data for department staff separately; reported on aggression that was sexual, stalking or not related to physical or verbal assault.

A total of 3603 papers were identified (CINAHL: 730, PsycINFO: 682, Pubmed: 717, Web of Science 1474); 1339 duplicates were removed both manually and using

Endnote software. The titles and abstracts of all the papers were reviewed and a further 2212 papers were excluded. The remaining 52 papers were reviewed in full against the inclusion criteria. After this stage, 40 papers were excluded including one paper by Luck, Jackson and Usher [28] due to reporting the same data as Luck, Jackson and Usher [29]. A hand search of reference sections of the full papers was also completed, however, this resulted in no additional papers being identified for inclusion. A total of 12 papers met the inclusion criteria and were included in the meta-synthesis, see Figure 1 for a PRISMA flow diagram of the process [30].

Insert Figure 1 here

Characteristics of included studies

The 12 papers included in the meta-synthesis reflected staff experiences of violence and aggression in EDs (See Table 1). All the papers reported data from hospital EDs, except for one paper which was an ED in a trauma centre. All of the papers interviewed registered nurses, with three papers also interviewing other staff members working in the department.

Critical appraisal of papers

The value of quality appraisal in meta-synthesis remains disputed [31], and there are a lack of tools developed to use for qualitative research in comparison with quantitative reviews [25]. It has been argued that study quality can impact on the overall meta-synthesis, with better quality papers contributing more to the results [32]. In this paper,

quality appraisal was used to understand the strengths and weaknesses of the studies to minimise potential bias rather than a tool for exclusion. Papers were included in the meta-synthesis regardless of quality appraisal as it has been suggested that a low score may be more indicative of reporting quality, which may have been influenced by word limits in journals, rather than the actual research procedure [32]. This approach to quality appraisal was in keeping with the researcher's social constructionist epistemological stance. A researcher with this standpoint perceives that people create meaning through interactions with people, thus it was important to include as many experiences as possible to provide a rich picture of the experience of violence and aggression in the ED.

The Critical Appraisal Skills Programme (CASP) [33] is one tool used to measure quality of papers across ten domains that are considered vital in qualitative research. All 12 papers were assessed using the CASP [33] alongside a three-point rating system developed by Duggleby et al. [34]. Each paper was given a score between one to three depending on whether the study provided a weak (1), moderate (2), or strong (3) explanation in its report of a particular area. These scores were kept in mind during analysis; for instance, Ramacciati et al. [35] scored highly on the CASP and one of the themes "long lasting effects" described the notion of 'wounds' which significantly contributed towards the development of the final theme within this meta-synthesis. See Table 2 for a summary of scores for each paper.

Insert Table 1 and 2 here

Analysis and synthesis

Meta-synthesis is a method of systematically integrating the findings of qualitative research to create new meaning [36]. The meta-synthesis conducted for this review is meta-ethnography which was developed by Noblit and Hare [37]. This method was chosen as it aims to retain the interpretative nature of qualitative studies rather than simply summarising the findings.

Noblit and Hare's guidance for synthesizing qualitative literature [37] was followed to complete the meta-synthesis, alongside a worked example adapted for health research [38]. After the papers were read, key themes and subthemes from each paper were recorded using the original authors' language. Both the participants' accounts and original authors' interpretations were used in the synthesis. Themes and subthemes from each study were compared to highlight similarities and differences between the studies. Similar themes and ideas were collected into groups through reciprocal translation, which formed second-order constructs and iterations. Each results and discussion section was read again to confirm that each iteration was representative of the second-order constructs, as it is considered necessary to preserve the integrity of each study [39]. The same approach was then used to develop the analysis, whereby second-order construct groups were then repeatedly compared to ascertain similarities and differences to devise final third-order constructs. Third-order interpretations offer conceptual development beyond that of each paper, as shown in the approach by Reid et al. [40]. See Appendix 1-B for details of the analysis process.

Reflexivity

The researcher was a trainee clinical psychologist who had no experience working in an ED previously. It is necessary to acknowledge that the findings represent the author's

own interpretation of the studies and for this reason, an audit trail was kept to ensure transparency of synthesis and interpretation. The analysis was also conducted under the supervision of a researcher who had experience in conducting meta-syntheses.

RESULTS

Four core concepts emerged from this meta-synthesis: 'The inevitability of violence and aggression', 'Staff judgments about why they face violence and aggression', 'Managing in isolation' and 'Wounded heroes'.

The inevitability of violence and aggression

Narratives conveyed a sense that staff had resigned themselves to the inevitability of violence and aggression in the ED. The frequency of incidents and the lack of perceived preventative measures and consequences from management or the organisation further exacerbated the notion that violence and aggression should be expected.

Violence and aggression was experienced as a regular occurrence in the ED "I couldn't count how many times I have been yelled at by patients and their families" [41], which was remarked on by one author 'The idea of violence … was recurrent and consistent in most interviews' [42]. Unsurprisingly, nurses frequently felt vulnerable, unsafe and fearful for their own and others' safety "…I just feel so unsafe…" [43]. Due to the frequency of exposure, violence and aggression became an inevitable part of the job "…in the triage area it really seems to be the norm, it seems like an inevitable part of the situation…" [35]. One author discussed staff's 'resignation to violence' as it was 'beyond their control' [43]. These accounts portray how staff had given up trying to prevent violence and aggression, and felt they had no alternative but to passively accept these incidents.

Preventative measures which were inconsistently implemented by the organisation also appeared to exacerbate the feeling that violence and aggression in the ED should be an accepted part of the job. Ease of access to the department and lack of methods to spot weapons contributed to staff concerns regarding their safety: “the department is not secure – people continue to come and go freely” [44]. When employers’ reactive strategies, such as security presence, panic alarms and zero tolerance policies were perceived as being poorly enforced then staff felt unsafe:

> [The signs stated] ‘we won’t tolerate violence, acting out, threats or cursing.’ The sign also stated that if you acted in any of these ways, you were going to be escorted out by security and police. I have yet to see this happen. I finally asked if we were ever going to act on these signs and I was told that basically they were just put up for show [45]

This meant that ‘the responsibility of surveillance placed a burden on the already busy nursing staff’ [46], which could offer an explanation for why some staff felt ‘that there was a need for increasing security presence’ [44].

Experiences of staff training as a preventative measure varied greatly between countries, with staff from one study within Singaporean EDs highlighting the importance of training ‘Workplace education, preparation and training were deemed important to prepare nurses in ED for their role in managing aggressive behaviours’ [47]. Conversely, staff working in Australian EDs reportedly received no formal training “We do not actually have like formal training in regards to that - no” [41]. Furthermore, in relation to training, one staff member from the UK discussed perceiving

assault as an initiation into the job “everyone has been telling me for two years that I’d have to expect violence in a&e and then I was hit and felt well now I’m initiated” [48].

A perceived lack of consequences and response from the organisation and police during incidents and towards the perpetrators of abuse also appeared to demonstrate that violence and aggression was tolerated in the ED. Staff from one of the UK studies perceived that the organisation neglected to defend staff when they were managing violence and aggression “Most irritating point, that riles me, is that the Trust states that they won’t tolerate aggressive behaviour but don’t back up the individual” [49]. One US study highlighted that staff felt that they were actively discouraged from pressing charges, and that management were concerned, not for the safety of staff, but with the reputation of the hospital “[the Chief Nursing Officer] seemed to be more concerned that I was filing a police report than over the fact that I was assaulted” [45]. Staff from the Italian study found that, on the rare occasion that staff did feel supported, this helped with dealing with the incident “in my case, my coordinator openly defended me, in front of me, and I felt really supported by that, it had a healing effect at the time” [35]. These narratives show that there were cultural differences in what staff constituted as an organisational response to incidents, with staff from the US study placing emphasis on legal action whereas staff from the Italian study wanted verbal support in the moment. In spite of these differences, the uniting theme across the accounts was that staff felt unsupported when the organisation was perceived as not defending them when they were faced with violence or aggression.

In line with this, inadequate incident reporting procedures contributed to staff perceptions that preventing violence and aggression was not an organisational priority. The severity of incidents seemed to determine whether incident reports were completed,

with staff from one of the Australian studies describing "people can swear at us, spit at us, bite at us…try and hurt us and nobody puts an incident report in" [43], whereas one author noted that only 'inconsequential incidents' were not reported as minor incidents appeared to be 'justified and normalized by the high frequency of aggressive incidents' [47]. When incident reporting procedures were difficult-to-use or adequate time was not allocated to complete incident reports during staff shifts, then staff felt that dealing with violence and aggression was a lesser priority for the organisation. The lack of perceived action or feedback from management also meant that staff considered the process to be pointless:

> Why fill a form in when nothing happens… I spent 2 hours working over last night, why would I want to spend another 30 min filling in report forms when you're late home when no-one (in the Trust) does anything about it? [49]

One motivating factor for completing incident reports was to avoid legal liabilities "…if ever the patient sues us or writes a complaint letter, we have this written report of what really happened that time, that day" [47]. This suggests a lack of protection on an organisational level whereby staff felt that they needed to justify their actions; one author discussed how this defensive practice could have 'implications for [staff's] ability to effectively engage with their patients' [43]. Thus, narratives regarding the incident reporting process further demonstrates the overarching feeling for staff that the organisation was not committed to reducing violent incidents and providing a safe place for staff to work.

<u>Staff judgments about why they face violence and aggression</u>

Staff had their own perceptions regarding the antecedents to violence and aggression in the ED. A significant proportion of the perceived reasons were related to the individual or the department. Very few accounts discussed the role of staff in the escalation of violence and aggression. Staff appeared to make judgements about whether violence was justified which helped them to cope with it; however, on the occasions where staff negatively appraised the reason for violence, this sometimes led to anger about the injustice of being assaulted.

Some nurses used formal assessment to assess aggressive behaviours, although the majority of staff appeared to informally assess individuals as part of their work "You can observe their behavior is a bit abnormal when a patient starts to shout ... Potentially, they will be difficult to manage." [47]. Environmental factors, such as long waiting times appeared to be an issue across most of the studies. However, it is unlikely that there were similar waiting times across the different services and multiple countries, thus perhaps the issue was more reflective of patient expectations of how long they should wait rather than actual waiting times. For instance, it is possible that patients whose waiting time was longer than they expected were more likely to become aggressive, as this staff member alludes to: "Nobody wants to wait…nobody thinks they should wait…and it doesn't matter whether two or 22 people arrive at once because expectations of those who become aggressive is that they shouldn't have to wait" [49]. Similarly, staff working in the paediatric ED highlighted a 'generational issue' whereby younger patients expected to be seen immediately. Other staff cited drugs and alcohol or mental health issues as the main precipitator to violence and aggression.

Staff appeared to make judgements about whether violence or aggression was justified which was dependent on certain factors. If violence was seen as unintentional,

for example, due to a physical health problem or a psychosocial issue which reduced a person's capacity to act in a rational manner, staff viewed this less negatively and appeared to absolve patients of blame "If the patient has dementia that's a bit different than a drunk patient or just a patient angry about waiting time. So it depends on what sort of patient it is I suppose" [29]. Moreover, staff reported being empathic towards people who were perceived to be violent or aggressive due to anxiety. Thus, it appeared that justifying or excusing violence and aggression made it easier for staff to deal with the emotional consequences of their experiences.

The 'legitimacy' of patients' presentation at EDs was also appraised by staff. For instance, if someone was deemed able to use alternative services, then staff were less tolerant towards violence or aggression "… take a look at yourself, you know you're not really that sick. You're here with a sore toe, there's people dying next door" [29]. This implies that staff felt that some patients were less deserving of care than others, which appeared to be heightened when the person was violent or aggressive.

On some occasions, violence was seen as an injustice which brought about strong feelings of anger and rage "I want to scream and say how dare you" [48]. Particularly, it was harder for staff to understand why they had been subjected to violence and aggression when they were trying to help "…how could you do that? Tell me why. I did everything I could, even more than I was supposed to, and you turned violent. Why?" [35]. Assaults which were directed towards staff's personal characteristics were harder to cope with emotionally "when somebody attacks you personally – your appearance, your manner whatever even though you know that it shouldn't affect you, it does at some level. Sort of, you know, feel awful" [29]. It

seemed that staff were trying to find logical explanations for the incidents and when they were unable to make sense of it, this led to anger and frustration.

A few staff acknowledged their part in precipitating violence and aggression "this thing (violence) can be triggered by our behaviour too" [35]. One author proposed that many staff accounts were unaware of signs of increasing aggression 'Cues or precursors to violence were often missed or ignored in nurses' narrative accounts…Nurses detailed clear cues of threats yet appeared completely taken by surprise at the violent attack' [45]. It appeared that it was difficult for staff to see their role in the incidents, and there was limited discussion in the papers as to why this may be the case. However, this could provide some insight into why some staff felt that sometimes violence and aggression was unjustified.

Managing in isolation

From the descriptions that staff gave, there was a portrayal of staff managing very challenging circumstances in isolation and in whatever way they could. Despite attempting to take a stoic stance to violence and aggression, there were many times when staff were less able to cope with the incidents.

Underlying narratives was a sense of abandonment. In two of the UK studies specifically, accounts gave a sense of a physical absence of support staff and managers on the wards which meant that staff 'often felt totally alone in a difficult and dangerous situation' [48]. One author interpreted that 'there was also an overriding sense of "us versus them"' between staff and patients in addition to staff and management [41]. Staff also described feeling uncared for by management "nobody cared at all, not even the head nurse. You feel abandoned" [35]. It appeared that when staff managed violent

incidents on their own, this made them feel that the organisation was unconcerned regarding their well-being.

There was limited discussion about formal strategies to deal with violence and aggression in the accounts, with one author noting ‘Few collective strategies to cope with violence were mentioned’ [50]. Without the support of management, staff appeared to attempt any possible method of reducing violence and aggression “you need to … be nice to them, but not too nice (to the extent) you do everything for them…just be nice to them, do whatever you need to do” [47]. However, when staff felt they were unable to manage the situation on their own, then they sought support from police or security.

Within the accounts, staff alluded to how they coped with violence and aggression, which also varied across studies. Cultural narratives of how staff should cope with violence and aggression possibly influenced the coping strategies of some staff. For instance, staff in the Singapore study and one UK study, appeared to take a ‘stoic’ stance to aggression whereby staff gave an appearance of strength regardless of the difficult nature of the experiences: ‘every member of staff spoke of their commitment to working in the ED despite the aggressive incidents’ [49]. However, on occasion, staff appeared to struggle to cope with violence and aggression. Some staff from the study conducted in France spoke about times when they were unable to maintain their professionalism “So I was like ‘no, it’s unacceptable!’ I said ‘no, I can’t. It’s not possible’ I..I was wound up, angry” [50]. Other staff also appeared to oscillate between different coping strategies, such as minimising or attempting to forget episodes “You have to forget or you won’t cope” [50], to then recognising their own limits and the fact that they were only ‘human’ when they were unable to effectively deal with violence and aggression. Other staff from the UK valued informal debriefing with

colleagues which also appeared to bring a sense of belonging “Outside the department no one seems to understand what it’s really like but your colleagues do” [48]. This variety in staff strategies provides insight into the overwhelming experience of violence and aggression in the ED, and potentially mirrors the chaotic and inconsistent response from the organisation.

Wounded heroes

The experience of violence and aggression appeared to have significant consequences for staff including reduced well-being, physical injury and willingness to do their job. Some staff were left with significant “wounds” as a result of being hurt whilst caring for someone and being unable to prevent violence and aggression.

Staff appeared to differ in terms of acknowledging the impact of violence and aggression. Some staff were reportedly in ‘denial’ about the effect of violence and aggression [45], whilst other staff described feeling upset, powerless and frustrated. Only one study described some staff as being ‘burned out’ [47]. Many staff discussed feeling scared and fearful of violent patients returning to the ED ‘Workers feared retaliation after managing conflicts with patients and caregivers… “I’m afraid, yes, because nowadays we cannot trust anybody…I’m always worried whether the person will come back or not”’ [42].

Additionally, the experience of violence and aggression appeared to have a consequential effect on the ability or willingness of staff to do their job. One author remarked about the impact of violent incidents on the quality of the work completed by staff ‘Almost all the healthcare workers interviewed considered that acts of violence and antisocial behaviour had an impact on the quality of their work, motivation, or

relationship with patients' [50]. Physical injury from incidents was also discussed, which sometimes meant staff were less able to do their job or they had to take early retirement "I ended up tearing cartilage in my left knee, ended up having surgery" [45]. Furthermore, the incidents made staff reluctant to work in the ED "being kicked in the teeth…leaving you a little hesitant to work in triage" [41].

Other staff reported deep, psychological 'pain' described as "wounds" or 'wounded professionalism' related to particularly difficult incidents [50]. One staff member eloquently shared the significant and long-term impact of violence and aggression on them:

> A female patient…came in to be treated. For some reason this triggered a post traumatic reaction for me. I instantly became very shaky, nauseated, and started crying…I then went to counseling for a couple of months, I think. My biggest hurdle…was [that I felt], and still do, feel like a victim, rather than getting to be in the 'superman' role [45]

This portrays an image of staff taking on the role of hero when caring for patients in the ED. It also gives a sense of how difficult staff found being a 'victim' of violence and aggression whilst occupying a caring role. In spite of staff being victimised, when some staff were not able to prevent violence and aggression, this led to feelings of 'inadequacy and guilt' [35]. These accounts imply that staff's sense of self-worth was dependent on their ability to care and rescue patients; thus, when they were unable to prevent violence and aggression, this perhaps led to a feeling of failure. These narratives reflect how many staff were left with significant psychological and physical wounds through experiencing violence and aggression.

DISCUSSION

The aim of this review was to synthesise studies exploring ED staff experiences of violence and aggression. Existing quantitative reviews have focused on simply describing violence and aggression in the ED [7], and there were no known qualitative reviews exploring first-hand experiences of violence and aggression against staff working in the ED. By carrying out a meta-synthesis, the current review addressed this gap in the literature.

The first concept 'The inevitability of violence and aggression' illustrated how staff often resigned themselves to the experience of violence and aggression due to the high frequency of violent incidents and perceived a lack of preventative and reactive measures implemented by the organisation. The findings are consistent with previous research regarding the perpetual normalisation of violence and aggression against staff in the ED [18]. In one US study, ED nurses identified that being assaulted "goes with the job" which was shown to negatively impact on staff feelings of safety [51]. The finding that staff resigned themselves to the experience of violence and aggression is in line with 'learned helplessness', a theory developed by Seligman [52] which explains that when people have no perceived control over a negative situation, they learn to become helpless and give up trying to change the situation. According to this theory, learned helplessness can lead to depression [52], which has negative implications for staff well-being in the long-term. It appeared that this feeling of powerlessness was mainly perceived as being caused by a lack of consistently enforced preventative and reactive strategies such as zero tolerance policies, security measures and ease of access to the department. Moreover, incident reporting procedures which were difficult to use, or where there was a lack of transparency regarding how the incident information was

utilised, also appeared to contribute to staff feeling that the organisation tolerated violence and aggression. Previous research findings are consistent with the notion that a lack of robust reporting procedures are seen as resulting from a lack of organisational priority [53]. This has implications for organisations to ensure that preventative and reactive measures aimed at reducing violence and aggression are consistently implemented to prevent staff becoming helpless towards violent incidents.

The findings showed that staff appeared to make judgments about the causes of violence and aggression, which were based on the person's perceived capacity and intention. These judgments seemed to affect how staff coped with violence and aggression and subsequently the extent to which they tolerated the perpetrator. The idea that nurses rationalise violence and aggression to cope with it has been documented elsewhere [18,54]. Weiner [55] postulated that peoples' causal attributions about whether behaviour is under the personal control of an individual affects their emotional responses to the behaviour. Much of the existing research relating to staff attributions of aggressive behaviour can be found within the challenging behaviour literature: Hill and Dagnan [56] conducted a study examining the role of coping style, attributions and emotions in response to challenging behaviour in predicting the helping behaviour of support staff working with people with learning disabilities. They found that staff attributions of challenging behaviour being due to internal, stable factors was correlated with sympathy and likelihood of helping [56]. Within other literature, Markham and Trower [57] examined how service users' diagnostic label 'borderline personality disorder' (BPD) affected staff's perceptions and causal attributions about their behaviour. They found that clients with a diagnosis of BPD were perceived by staff as being more in control of their behaviour compared to clients with depression or

schizophrenia, which subsequently meant staff were less sympathetic and rated their experience more negatively when working with clients with BPD [57]. This suggests that when challenging behaviour is perceived as within a person's control, this has a negative impact on staff's perceptions and sympathy towards that person. Within this study, staff appeared to become less tolerant towards clients' aggressive behaviour when they perceived that the person was able to use alternative services or the behaviour was within the person's control. Ballatt [58] suggested that staff find it easier to dislike patients who undermine their efforts or are seen as undeserving, such as those who have harmed themselves or fallen over in a drunken state. Currently, it is unclear precisely how staff responded differently based on their appraisals of violence and aggression which could be explored further in future research.

Very few staff acknowledged any role that they may have played in the occurrence of violence and aggression. This is consistent with the research finding that staff tended to perceive violence and aggression to be due to internal patient factors whereas patients saw their violence as response to issues related to staff [59], although this finding was related to inpatient mental health wards. Research has also found that triage nurses considered that ED staff's verbal and non-verbal communication could contribute to violence [60]. Additionally, emotionally depleted staff have been shown to be less tolerant of aggressive behaviour [61]. Stressful events can also negatively impact on staff sensitivity, warmth and tolerance towards patients [62]. This means that staff may inadvertently trigger violence and aggression due to being unaware of their own behaviour towards clients. Thus, providing staff with greater understanding and awareness of their role in difficult interactions with patients may reduce violence and aggression.

The ‘managing in isolation’ concept suggested that staff often felt isolated when managing violence and aggression in the ED, and the perceived lack of support from management appeared to impact on the consistency of staff’s use of management and coping strategies. This concept could be understood from an attachment theory perspective; this theory suggests that children’s experiences with primary attachment figures form an internal working model for future relationships [63]. Ainsworth, Blehar, Waters and Wall [64] proposed that attachment styles depend on whether the child learnt that the caregiver was available, responsive or helpful when called upon. It has been posited that organisational leader-follower relationships may be influenced by attachment styles [65]. Within this review, it appeared that staff wanted support from management during violent incidents however they perceived that help was not available, which fits with an ambivalent attachment style [64]. When faced with conflict, children use strategies such as crying to elicit containment from the attachment figure, thus attachment quality impacts on emotional regulation [66]. This suggests that the absence of management may have been less containing for staff and could explain why staff often oscillated between various coping and management strategies. Research has shown that attachment styles can have an impact on how staff cope in response to work-related stress [67]. Therefore, management style can have an impact on how staff manage and cope with violence and aggression.

The findings suggested that there were potential cultural differences in how staff coped with violence and aggression across the various EDs. Remaining strong in spite of their own personal feelings was one strategy discussed by staff from studies conducted in the UK and Singapore. Conversely, staff from the study conducted in France appeared to move between being unable to maintain their professionalism and

'trying to forget' episodes of aggression. Staff from another UK study suggested that informal debriefs were helpful. This highlights the variety in coping strategies across different services in multiple countries, although it was unclear whether this was related to the individual services or whether culture impacted on coping strategies used by ED staff. The area of research regarding cultural differences in coping strategies is relatively unexplored thus further research is warranted.

The final concept 'wounded heroes' demonstrated the significant impact of violence and aggression on staff's emotional and physical well-being and on their willingness to do their job. Previous research has shown that staff have experienced a range of emotional responses to violence and aggression including anger, fear, guilt, self-blame and shame [10,14]. This concept gave a portrayal of staff being in conflict between being a 'hero' and 'victim', with some narratives describing the long-term impact of violence and aggression as psychological "wounds".

The findings suggested that staff's sense of self-worth was based on rescuing patients but when they were unable to prevent violent incidents this led to feelings of failure. This notion is consistent with Bowlby's [68] 'compulsive care-giving' attachment style whereby the person has learnt that the attachment bond is dependent on them giving care rather than receiving it. Some healthcare professionals have been considered to be vulnerable to being 'compulsive caregivers', and this pattern of relating to clients has been considered to contribute to burnout [69]. This style of attachment may also offer an explanation as to why staff may have found it difficult to be in the 'victim' role as this may have placed them in the position of needing care. This is a novel finding which may expand our conceptual understanding about staff's experiences of violence and aggression.

Recommendations for clinical practice

The findings showed that staff appeared to passively accept violence and aggression when preventative and reactive strategies were inconsistently enforced. One literature review suggested that zero tolerance policies are "largely impractical for clinicians in the ED" [22]. This has implications for whether zero tolerance policies should be implemented at all given that it may not be possible to enforce this strategy and this lack of enforcement negatively impacted on staff experiences. Thus, it is necessary to suggest that organisations should only advertise strategies which can be realistically and consistently implemented. Moreover, organisations could provide staff with regular feedback on the outcome of incident reports; this transparency would highlight the organisation's response to violent incidents.

A practical alternative to zero tolerance policies could be staff training [22]. Given that staff appraisals of violent behaviour affected how they responded to patients and the fact that staff did not acknowledge their own role in the escalation of violent incidents, it is necessary to suggest that all ED staff receive training in communication and negotiation strategies to reduce violence and aggression [60]. Although it is widely used and widely regarding as being helpful, currently there is a lack of empirical evidence demonstrating the efficacy of de-escalation training [70]. Conversely, research has shown that Positive Behavioural Support (BPS) training can positively impact on staff attributions of causality and control which can lead to staff being more helpful and more confident in managing challenging behaviour [71]. PBS training is traditionally aimed at staff working with people with learning disabilities to provide greater understanding about the internal and external factors that contribute to challenging behaviour. This type of training within the ED may be beneficial as it would enable

staff to consider all the factors which contribute to violence and aggression, including their own role; this would likely influence how staff respond to clients which in turn may reduce challenging incidents. Clinical psychologists could be involved in developing the materials and facilitating this type of training. Psychological models of violence and aggression could be incorporated within the training to emphasise the interaction between staff and patients in exacerbating violent incidents. By highlighting such interactions as neither the fault of staff nor patients, this could provide a non-blaming way of describing the causes of violence and aggression.

The findings suggested that staff felt abandoned by management which impacted on how they managed and coped with violence and aggression. Managers with a 'transformational' leadership style, aimed at inspiring positive change and rewarding effort, has been positively correlated with secure attachment [65]. Management training focused on this style of leadership would be helpful in providing leaders with the tools to potentially contain the emotional responses of staff and help them to effectively manage violence and aggression.

The results showed that staff may be drawn into patterns of 'compulsive caregiving' and rescuing service users, which in psychological therapy is referred to as countertransference. Supervision can be an effective way of understanding and exploring countertransference [72]. Moreover, a literature review of 22 studies concluded that clinical supervision has been shown to be beneficial for nurses through providing peer support and stress relief, promoting professional accountability and knowledge development [73]. However, caution must be taken with the findings of this review as the majority of studies was related to the experiences of mental health nurses and the professions of the supervisors was unclear. Clinical supervision is a key feature

of clinical psychologists' professional practice. This has implications for their role in providing supervision to staff within the forensic setting. Group supervision is currently provided by clinical psychologists in many forensic services, however individual clinical supervision would be more effective in light of the findings of the above study.

Limitations and future research

The results and themes of this review are reflective of the author's own preconceptions and experiences, which may have differed had more authors been involved in the meta-synthesis. One particular strength of this review was the inclusion of papers from several different countries which potentially offers an international viewpoint of violence and aggression in the ED.

The precise mechanisms by which staff responded when they negatively appraised violence and aggression remain unclear. Future research could explore staff perceptions of their responses and behaviour following violent incidents. This could be achieved by conducting a mixed-methods study, through the use of questionnaires asking staff about their attributions, emotional response and helping behaviours alongside observation of ED staff after incidents.

As there was significant discrepancy in staff's reported coping strategies across different studies, future research could explore cultural influences on coping strategies. A quantitative study comparing coping styles, well-being and culture would begin to address this gap. This would provide greater understanding of coping strategies used by staff across different contexts.

CONCLUSIONS

This review provides an international perspective on staff experiences of violence and aggression in the ED. This meta-synthesis contributes to the existing literature base by providing valuable insight into the first-hand experiences of staff on the hospital frontline. The findings suggest that the experience of violence and aggression in the ED is a complex picture. A significant finding was that staff appraisals of the causes of violence and aggression affected how they coped and responded to patients which has implications for further escalation of violent incidents in the ED. Staff also struggled to be in the ‘victim’ role when caring for violent patients, which could negatively impact on them seeking care from staff and the wider organisation. A strong organisational commitment to reducing violence and aggression is needed through a focus on staff training and management adopting a transformational leadership style.

REFERENCES

[1] Lau JB, Magarey J, McCutcheon H. Violence in the emergency department: A literature review. Aust Emerg Nurs J 2004;7:27–37. doi:10.1016/S1328-2743(05)80028-8.

[2] British Psychological Society, The Royal College of Psychiatrists. Violence and aggression short-term management in mental health, health and community settings, https://www.nice.org.uk/guidance/ng10/resources/violence-and-aggression-shortterm-management-in-mental-health-health-and-community-settings-pdf-1837264712389 2015 [accessed 01.12.16].

[3] NHS Protect. Reported physical assaults on NHS staff figures. Physical assaults against NHS staff 2015/16, http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Reported_Physical_Assaults_2015-16_Final.pdf 2015 [accessed 01.12.16].

[4] Hahn S, Zeller A, Needham I, Kok G, Dassen T, Halfens RJG. Patient and visitor violence in general hospitals: A systematic review of the literature. Aggress Violent Behav 2008;13:431–41. doi:10.1016/j.avb.2008.07.001.

[5] Lepping P, Lanka SV, Turner J, Stanaway SE, Krishna M. Percentage prevalence of patient and visitor violence against staff in high-risk UK medical wards. Clin Med Lond Engl 2013;13:543. doi:10.7861/clinmedicine.13-6-543.

[6] Hahn S, Hantikainen V, Needham I, Kok G, Dassen T, Halfens RJG. Patient and visitor violence in the general hospital, occurrence, staff interventions and consequences: a cross-sectional survey. J Adv Nurs 2012;68:2685–99. doi:10.1111/j.1365-2648.2012.05967.x.

[7] Taylor JL, Rew L. A systematic review of the literature: workplace violence in the emergency department. J Clin Nurs 2011;20:1072. doi:10.1111/j.1365-2702.2010.03342.x.

[8] Crilly J, Chaboyer W, Creedy D. Violence towards emergency department nurses by patients. Accid Emerg Nurs 2004;12:67–73. doi:10.1016/j.aaen.2003.11.003.

[9] Pourshaikhian M, Gorji HA, Aryankhesal A, Khorasani-Zavareh D, Barati A. A systematic literature review: Workplace violence against emergency medical services personnel. Arch Trauma Res 2016;5:213-224. doi:10.5812/atr.28734.

[10] Edward K, Ousey K, Warelow P, Lui S. Nursing and aggression in the workplace: a systematic review. Br J Nurs 2014;23:653–9. doi:10.12968/bjon.2014.23.12.653.

[11] Jakubowski E, Busse R. Health care systems in the EU: A comparative study, http://www.europarl.europa.eu/workingpapers/saco/pdf/101_en.pdf 1998 [accessed 28.04.17].

[12] Dorning J. The U.S healthcare system: An international perspective, http://dpeaflcio.org/programs-publications/issue-fact-sheets/the-u-s-health-care-system-an-international-perspective/ 2016 [accessed 28.04.17]

[13] Basu S, Andrews J, Kishore S, Panjabi R, Stuckler D. Comparative performance of private and public healthcare systems in low- and middle-income countries: A systematic review. PLoS Med 2012;9:e1001244. doi:10.1371/journal.pmed.1001244.

[14] Needham I, Abderhalden C, Halfens RJG, Fischer JE, Dassen T. Non-somatic effects of patient aggression on nurses: a systematic review. J Adv Nurs 2005;49:283–96. doi:10.1111/j.1365-2648.2004.03286.x.

[15] Gates DM, Gillespie GL, Succop P. Violence against nurses and its impact on stress and productivity. Nurs Econ 2011;29:59-66.
[16] Mechem CC, Dickinson ET, Shofer FS, Jaslow D. Injuries from assaults on paramedics and firefighters in an urban emergency medical services system. Prehosp Emerg Care 2002;6:396–401.
[17] Jackson D, Clare J, Mannix J. Who would want to be a nurse? Violence in the workplace – a factor in recruitment and retention. J Nurs Manag 2002;10:13–20. doi:10.1046/j.0966-0429.2001.00262.x.
[18] Pich J, Hazelton M, Sundin D, Kable A. Patient-related violence against emergency department nurses. Nurs Health Sci 2010;12:268–74. doi:10.1111/j.1442-2018.2010.00525.x.
[19] Hogarth KM, Beattie J, Morphet J. Nurses' attitudes towards the reporting of violence in the emergency department. Australas Emerg Nurs J 2016;19:75–81. doi:10.1016/j.aenj.2015.03.006.
[20] Madine K, Smith B. WorkForce and your workforce. Emerg Nurse 2005;13:10-11.
[21] McKoy Y, Smith MH. Legal considerations of workplace violence in healthcare environments. Nurs Forum (Auckl) 2001;36:5–14. doi:10.1111/j.1744-6198.2001.tb00235.x.
[22] Wand TC, Coulson K. Zero tolerance: A policy in conflict with current opinion on aggression and violence management in health care. Australas Emerg Nurs J 2006;9:163–70. doi:10.1016/j.aenj.2006.07.002.
[23] Stirling G, Higgins JE, Cooke MW. Violence in A&E departments: a systematic review of the literature. Accid Emerg Nurs 2001;9:77–85. doi:10.1054/aaen.2000.0204.
[24] Anderson L, Fitzgerald M, Luck L. An integrative literature review of interventions to reduce violence against emergency department nurses. J Clin Nurs 2010;19:2520–30. doi:10.1111/j.1365-2702.2009.03144.x.
[25] Dixon-Woods M, Fitzpatrick R. Qualitative research in systematic reviews. BMJ 2001;323:765. doi:10.1136/bmj.323.7316.765.
[26] Shaw R. Identifying and synthesizing qualitative literature. In: Harper D, Thompson AR, editors. Qualitative research methods in mental health and psychotherapy, West Sussex, United Kingdom: John Wiley & Sons, Ltd.; 2012, p. 9–22.
[27] Estabrooks C, Field P, Morse J. Aggregating qualitative findings: An approach to theory development. Qual Health Res 1994;4:503–11.
[28] Luck L, Jackson D, Usher K. Conveying caring: Nurse attributes to avert violence in the ED. Int J Nurs Pract 2009;15:205–12. doi:10.1111/j.1440-172X.2009.01749.x.
[29] Luck L, Jackson D, Usher K. Innocent or culpable? Meanings that emergency department nurses ascribe to individual acts of violence. J Clin Nurs 2008;17:1071–8. doi:10.1111/j.1365-2702.2006.01870.x.
[30] Moher D, Liberati A, Tetzlaff J, Altman DG. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. BMJ 2009;339: e1000097. doi:10.1136/bmj.b2535.
[31] Spencer L, Richie J. In pursuit of quality. In: Harper D, Thompson AR, editors. Qualitative research methods in mental health and psychotherapy, West Sussex, United Kingdom: John Wiley & Sons, Ltd.; 2012, p. 227–42.

[32] Lewin S, Atkins S, Smith H, Engel M, Fretheim A, Volmink J. Conducting a meta-ethnography of qualitative literature: Lessons learnt. BMC Med Res Methodol 2008;8:21. doi:10.1186/1471-2288-8-21.
[33] Public Health Resource Unit. Critical Appraisal Skills Programme: Making sense of evidence, http://docs.wixstatic.com/ugd/dded87_25658615020e427da194a325e7773d42.pdf 2013 [accessed 01.10.16].
[34] Duggleby W, Holtslander L, Kylma J, Duncan V, Hammond C, Williams A. Metasynthesis of the hope experience of family caregivers of persons with chronic illness. Qual Health Res 2010;20:148–58. doi:10.1177/1049732309358329.
[35] Ramacciati N, Ceccagnoli A, Addey B. Violence against nurses in the triage area: An Italian qualitative study. Int Emerg Nurs 2015;23:274–80. doi:10.1016/j.ienj.2015.02.004.
[36] Harden A, Thomas J. Methodological issues in combining diverse study types in systematic reviews. Int J Soc Res Methodol 2005;8:257–71. doi:10.1080/13645570500155078.
[37] Noblit G, Hare R. Meta-ethnography: Synthesizing qualitative studies. 1st ed. United States of America: Sage Publications Inc.; 1988.
[38] Britten N, Campbell R, Pope C, Donovan J, Morgan M, Pill R. Using meta ethnography to synthesise qualitative research: a worked example. J Health Serv Res Policy 2002;7:209–15. doi:10.1258/135581902320432732.
[39] Sandelowski M, Docherty S, Emden C. Focus on qualitative methods. Qualitative metasynthesis: issues and techniques. Res Nurs Health 1997;20:365-371.
[40] Reid B, Sinclair M, Barr O, Dobbs F, Crealey G. A meta-synthesis of pregnant women's decision-making processes with regard to antenatal screening for Down syndrome. Soc Sci Med 2009;69:1561–73. doi:10.1016/j.socscimed.2009.09.006.
[41] Pich J, Hazelton M, Sundin D, Kable A. Patient-related violence at triage: A qualitative descriptive study. Int Emerg Nurs 2011;19:12–9. doi:10.1016/j.ienj.2009.11.007.
[42] Lancman S, Mângia E, Muramoto M. Impact of conflict and violence on workers in a hospital emergency room. Work 2013;45:519-527. doi: 10.3233/WOR-131638
[43] Pich J, Hazelton M, Kable A. Violent behaviour from young adults and the parents of paediatric patients in the emergency department. Int Emerg Nurs 2013;21:157–62. doi:10.1016/j.ienj.2012.08.007.
[44] Hyland S, Watts J, Fry M. Rates of workplace aggression in the emergency department and nurses' perceptions of this challenging behaviour: A multimethod study. Australas Emerg Nurs J 2016;19:143–8. doi:10.1016/j.aenj.2016.05.002.
[45] Wolf LA, Delao AM, Perhats C. Nothing changes, nobody cares: Understanding the experience of emergency nurses physically or verbally assaulted while providing care. J Emerg Nurs 2014;40:305–10. doi:10.1016/j.jen.2013.11.006.
[46] Catlette M. A descriptive study of the perceptions of workplace violence and safety strategies of nurses working in level I trauma centers. J Emerg Nurs 2005;31:519–25. doi:10.1016/j.jen.2005.07.008.
[47] Tan MF, Lopez V, Cleary M. Nursing management of aggression in a Singapore emergency department: A qualitative study. Nurs Health Sci 2015;17:307–12. doi:10.1111/nhs.12188.
[48] Hislop E, Melby V. The lived experience of violence in accident and emergency. Accid Emerg Nurs 2003;11:5–11. doi:10.1016/S0965-2302(02)00124-8.

[49] Knowles E, Mason SM, Moriarty F. “I”m going to learn how to run quick’: exploring violence directed towards staff in the Emergency Department. Emerg Med J 2013;30:926-931. doi:10.1136/emermed-2012-201329.
[50] D’Aubarede C, Sarnin P, Cornut PL, Touzet S, Duclos A, Burillon C, et al. Impacts of users’ antisocial behaviors in an ophthalmologic emergency department--a qualitative study. J Occup Health 2016;58:96–106. doi:10.1539/joh.15-0184-FS.
[51] Erickson L, Williams-Evans SA. Attitudes of emergency nurses regarding patient assaults. J Emerg Nurs 2000;26:210–5. doi:10.1016/S0099-1767(00)90092-8.
[52] Seligman ME. Learned helplessness. Annu Rev Med 1972;23:407-412. doi: 10.1146/annurev.me.23.020172.002203
[53] Ferns T. Recording violent incidents in the emergency department. Nurs Stand 2012;26:40–8. doi: 10.7748/ns.26.28.40.s51
[54] Ray MM. The dark side of the job: Violence in the emergency department. J Emerg Nurs 2007;33:257–61. doi:10.1016/j.jen.2007.01.015.
[55] Weiner B. An attributional theory of motivation and emotion. 1st ed. New York: Springer-Verlag; 1986.
[56] Hill C, Dagnan D. Helping, attributions, emotions and coping style in response to people with learning disabilities and challenging behaviour. J Learn Disabil UK 2002;6:363–72. doi:10.1177/146900470200600403.
[57] Markham D, Trower P. The effects of the psychiatric label “borderline personality disorder” on nursing staff’s perceptions and causal attributions for challenging behaviours. Br J Clin Psychol 2003;42:243–56. doi:10.1348/01446650360703366.
[58] Ballatt J. Intelligent kindness: Reforming the culture of healthcare. 1st ed. London: The Royal College of Psychiatrists; 2011.
[59] Duxbury J, Whittington R. Causes and management of patient aggression and violence: staff and patient perspectives. J Adv Nurs 2005;50:469–78. doi:10.1111/j.1365-2648.2005.03426.x.
[60] Morphet J, Griffiths D, Plummer V, Innes K, Fairhall R, Beattie J. At the crossroads of violence and aggression in the emergency department: perspectives of Australian emergency nurses. Aust Health Rev 2014;38:194–201. doi:10.1071/AH13189.
[61] Whittington R. Attitudes toward patient aggression amongst mental health nurses in the “zero tolerance” era: associations with burnout and length of experience. J Clin Nurs 2002;11:819–25. doi:10.1046/j.1365-2702.2002.00659.x.
[62] Motowidlo SJ, Packard JS, Manning MR. Occupational stress: Its causes and consequences for job performance. J Appl Psychol 1986;71:618–29. doi:10.1037/0021-9010.71.4.618.
[63] Bowlby J. The making & breaking of affectional bonds. 1st ed. London: Tavistock Publications; 1979.
[64] Ainsworth MS, Blehar MC, Waters E, Wall, S. Patterns of attachment: a psychological study of the strange situation. Hillsdale, NJ: Lawrence Erlbaum Associates; 1978.
[65] Popper M, Mayseless O, Castelnovo O. Transformational leadership and attachment. Leadersh Q 2000;11:267–89. doi:10.1016/S1048-9843(00)00038-2.
[66] Cassidy J. Emotion regulation: Influences of attachment relationships. Monogr Soc Res Child Dev 1994;59:228–49. doi: 10.1111/j.1540-5834.1994.tb01287.x

[67] Johnstone M, Feeney JA. Individual differences in responses to workplace stress: the contribution of attachment theory. J Appl Soc Psychol 2015;45:412–24. doi:10.1111/jasp.12308.
[68] Bowlby J. The making and breaking of affectional bonds. I. Aetiology and psychopathology in the light of attachment theory. An expanded version of the Fiftieth Maudsley Lecture, delivered before the Royal College of Psychiatrists, 19 November 1976. Br J Psychiatry J Ment Sci 1977;130:201-210.
[69] Berry K, Drake R. Attachment theory in psychiatric rehabilitation: informing clinical practice. Advances in psychiatric treatment 2010;16:308–15. doi: 10.1192/apt.bp.109.006809.
[70] Inglis P, Clifton A. De-escalation: the evidence, policy and practice. J Intellect Disabil Offending Behav 2013;4:100–8. doi:10.1108/JIDOB-01-2013-0001.
[71] Davies B, Griffiths J, Liddiard K, Lowe K, Stead L. Changes in staff confidence and attributions for challenging behaviour after training in positive behavioural support within a forensic medium secure service. J Forensic Psychiatry Psychol 2015;10:1–15. doi:10.1080/14789949.2015.1072574.
[72] Stewart L. Relational needs of the therapist: Countertransference, clinical work and supervision. Benefits and disruptions in psychotherapy. Int J Integr Psychother 2010;1:41–50.
[73] Brunero S, Stein-Parbury J. The effectiveness of clinical supervision in nursing: an evidenced based literature review. Aust J Adv Nurs 2008;25:86-94.

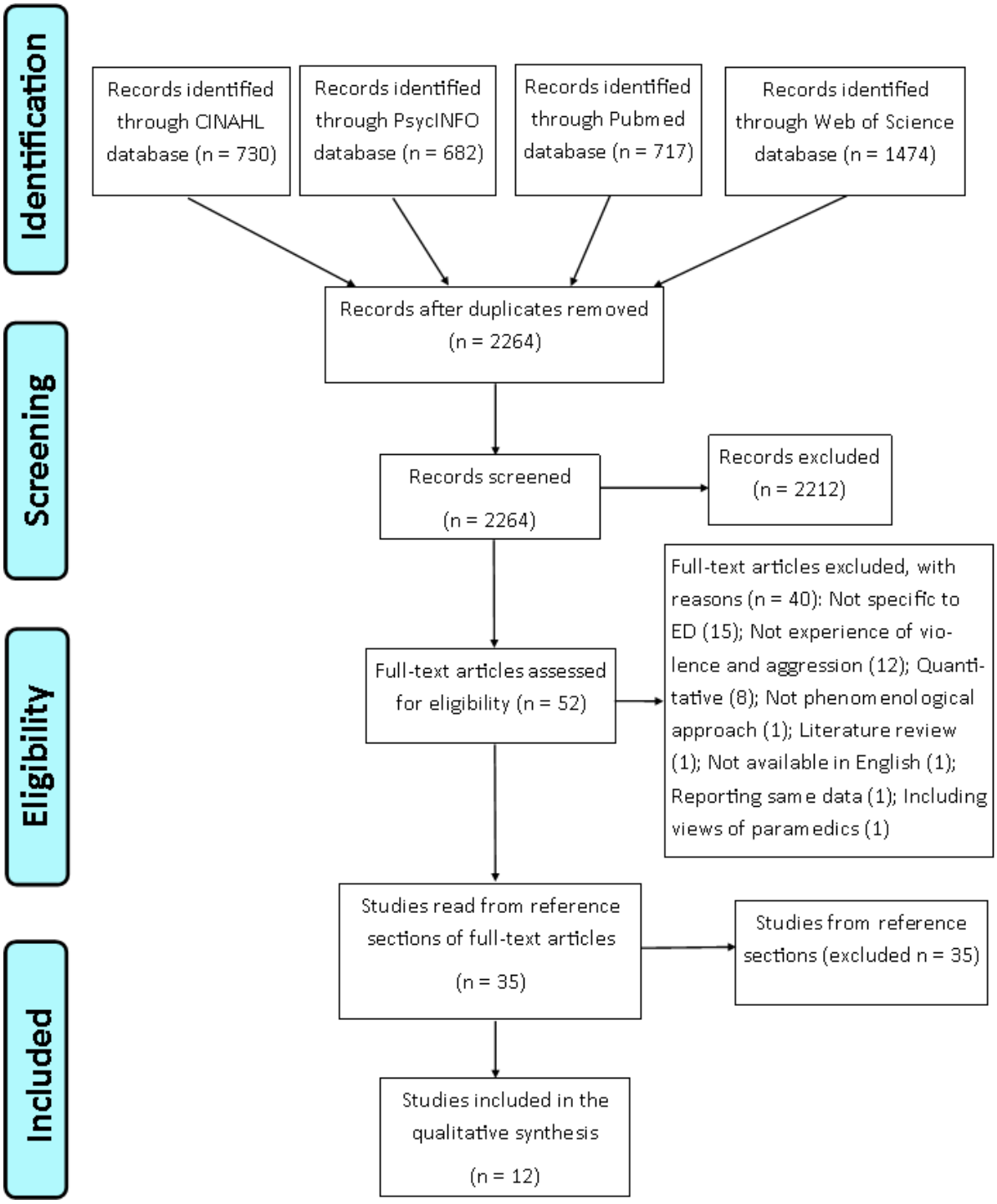

Figure 1. PRISMA diagram of search strategy.

Table 1. Characteristics of included studies.

	Country	Aims of study	Stated Methodology	Data collection methods	Participants
Catlette [2005]	USA	To study the phenomenon of workplace violence by interviewing emergency nurses who had experienced violence while on duty	Phenomenology	One-to-one interviews	8 nurses
d'Aubarede et al. [2016]	France	To explore and describe the opthalmology emergency department personnel's experience of acts of violence and anti-social behaviour	Grounded theory, thematic content analysis	Field observations and semi-structured one-to-one interviews	30 staff; 15 nurses, 5 nursing auxilaries, 7 interns, 2 receptionists and 1 senior physician
Hislop & Melby [2003]	UK	To describe and explore accident and emergency nurses' lived experience of violence in the workplace in one major acute hospital	Phenomenology (Giorgi, 1985)	One-to-one interviews	5 nurses
Hyland, Watts & Fry [2016]	Australia	To explore emergency nurses' perceptions of caring for patients displaying challenging behaviour	Thematic analysis	Open-ended survey questions	53 nurses
Knowles, Mason & Moriarty [2013]	UK	To examine staff perceptions and experiences of violent behaviour directed towards them within the emergency department	Thematic framework	Incident reporting, ethnographic observation and staff interviews	16 nurses, healthcare assistants, receptionist or hospital attendant
Lancman, Mângia & Muramoto [2013]	Brazil	To learn about situations of violence at work and their impact on workers in an emergency room	Tranversal, exploratory, descriptive and observational study	Semi structured one-to-one interviews	11 staff from different professional categories including nursing, psychology, security

Luck, Jackson & Usher [2008]	Australia	To explore meanings that emergency department nurses ascribe to acts of violence from patients, their family and friends and what impact these meanings have on how they respond to such acts	Thematic analysis	Participant observation, one-to-one interviews, informal field interviews and researcher journaling	20 nurses
Pich et al. [2011]	Australia	To describe the experiences of a group of triage nurses with patient-related workplace violence during the previous month	Content analysis	Semi structured one-to-one interviews	6 nurses
Pich, Hazelton & Kable [2013]	Australia	To describe the experiences of australian emergency department nurses with episodes of patient-related violence from young adults	Content analysis	Semi structured one-to-one interviews	11 nurses
Ramacciati, Ceccagnoli & Addey [2015]	Italy	To investigate the feelings experienced by nurses following episodes of violence in the workplace	Phenomenology (Colaizzi method)	Focus groups	9 nurses
Tan, Lopez & Cleary [2015]	Singapore	To explore nurses perceptions of managing aggressive patients in an emergency department	Thematic analysis	One-to-one interviews	10 nurses
Wolf, Delao & Perhats [2014]	USA	To better understand the experience of emergency nurses who have been physically assaulted while providing patient care in US emergency departments	Narrative	Narrative accounts	46 nurses

Table 2. Quality appraisal scores.

	Research design	Recruitment strategy	Data collection	Relationship between researcher and participants	Ethical issues	Data analysis	Findings	Value of research	Total
Catlette [2005]	2	3	3	2	3	3	3	2	21
d'Aubarede et al. [2016]	3	2	2	2	2	2	3	1	17
Hislop & Melby [2003]	3	3	2	3	2	2	3	1	19
Hyland, Watts & Fry [2016]	2	2	2	1	2	2	2	2	15
Knowles, Mason & Moriarty [2013]	2	1	2	1	1	2	3	2	14
Lancman, Mângia & Muramoto [2013]	2	1	3	2	2	1	2	1	14
Luck, Jackson & Usher [2008]	3	1	3	2	2	2	3	2	18
Pich et al. [2011]	3	2	1	1	2	2	3	2	16

Pich, Hazelton & Kable [2013]	2	2	2	1	2	2	2	2	15
Ramacciati, Ceccagnoli & Addey [2015]	3	2	2	2	3	3	3	2	20
Tan, Lopez & Cleary [2015]	2	1	2	1	2	2	2	2	14
Wolf, Delao & Perhats [2014]	2	2	2	1	1	2	2	2	14

APPENDICES

Appendix 1-A. Detailed search strategy.

Pubmed	
Free text search terms (applied to Title/Abstract)	Qualitative OR perception* OR experienc* OR thematic analysis OR grounded theory OR semi structured OR focus group OR narrative OR interview* OR perspective* OR view* AND [Accident AND emergency] OR a&e OR emergency department OR emergency medical services OR triage OR paramedic OR hospital AND violen* OR aggressi* OR workplace violence OR [violence AND aggression] OR patient violence OR aggressive behavi* OR restraint OR physical intervention AND Staff OR nurs* OR medical staff OR healthcare staff OR medical personnel OR professionals OR health personnel OR healthcare workers
MeSH terms	violence OR aggression OR physical restraint AND "nursing" OR allied health personnel OR hospital medical staff AND emergency care OR emergency health service OR emergency hospital service OR emergency medical service OR emergency care AND qualitative research

Web of Science	
Topic terms	Qualitative OR perception* OR experienc* OR thematic analysis OR grounded theory OR semi structured OR focus group OR narrative OR interview* OR perspective* OR view* AND [Accident AND emergency] OR a&e OR emergency department OR emergency medical services OR triage OR paramedic OR hospital AND violen* OR aggressi* OR workplace violence OR [violence AND aggression] OR patient violence OR aggressive behavi* OR restraint OR physical intervention AND Staff OR nurs* OR medical staff OR healthcare staff OR medical personnel OR professionals OR health personnel OR healthcare workers

CINAHL	
Free text search terms (applied to Abstract)	Qualitative OR qualitative research OR experienc* OR perception* OR thematic analysis OR grounded theory OR "semi structured" OR interview* OR focus group OR narrative OR perspective* OR view* AND [Accident AND emergency] OR a&e OR "emergency department" OR "emergency medical services" OR triage OR paramedic OR hospital AND violen* OR aggressi* OR "workplace violence" OR [violence AND aggression] OR "patient violence" OR aggressive behavi* OR restraint OR physical intervention AND Staff OR nurs* OR medical staff OR medical personnel OR professionals OR healthcare workers OR health personnel OR healthcare staff
Subject terms	"Nursing Staff, Hospital" OR "Medical Staff, Hospital" OR "Attitude of Health Personnel" OR "Staff Nurses" OR "Health Personnel" OR "Medical Staff" AND "Restraint, Physical" OR "Aggression" OR "Violence" OR "Workplace Violence" AND "Qualitative Studies" AND "Emergency Service" OR "Emergency Medical Services"
PsycINFO	
Free text search terms (applied to Abstract)	Qualitative OR qualitative research OR experienc* OR perception* OR thematic analysis OR grounded theory OR "semi structured" OR interview* OR focus group OR narrative OR perspective* OR view* AND [Accident AND emergency] OR a&e OR "emergency department" OR "emergency medical services" OR triage OR paramedic OR hospital AND violen* OR aggressi* OR "workplace violence" OR [violence AND aggression] OR "patient violence" OR aggressive behavi* OR restraint OR physical intervention AND Staff OR nurs* OR medical staff OR medical personnel OR professionals OR healthcare workers OR health personnel OR healthcare staff
Subject terms	"Medical Personnel" AND "Emergency Services" AND "Violence" OR "Patient Violence" OR "Workpalce Violence" OR "Aggressive Behavior" "Aggressiveness" OR "Physical Restraint" AND "Qualitative Research" OR "Action Research" OR "Grounded Theory"

Appendix 1-B. Themes and concepts.

Key themes, first iterations	Key themes, final iterations (second order constructs)	Core concept, first iteration	Core concept, final iteration (third-order constructs)
Acts of violence and antisocial behaviour (D'Aubarede et al, 2016) Physical abuse (Pich et al, 2011) Verbal abuse (Pich et al, 2011) Behaviours (Pich, Hazelton & Kable, 2013)	Experience of violence and aggression	Inevitable experience of violence and aggression	The inevitability of violence and aggression
Comprehension of violence, aggression and conflict (Lancman, Mangia & Muramoto, 2013) The incidence of violence (Knowles, Mason & Moriarty, 2013) Inevitability (Ramacciati, Ceccagnoli & Addey, 2015) Feeling unsafe at work (Pich, Hazelton & Kable, 2013)	Inevitability of violence and aggression		
Feeling unsafe at work (Pich, Hazelton & Kable, 2013) Inadequate safety measures (Catlette, 2005) Vulnerability (Catlette, 2005) Feeling vulnerable (Ramacciati, Ceccagnoli & Addey, 2015) Increasing security (Hyland, Watts & Fry, 2016) Open access (Hyland, Watts & Fry, 2016) Rostering imbalance Hyland, Watts & Fry, 2016 Cue recognition (Wolf, Delao & Perhats, 2014)	Feeling vulnerable and unsafe	Feeling unsafe and unsupported	

Feeling alone and unsupported by management (Ramacciati, Ceccagnoli & Addey, 2015) Organizational support and responsiveness (Tan, Lopez & Cleary, 2015) Environmental (Wolf, Delao & Perhats, 2014) The impact of violence (Knowles, Mason & Moriarty, 2013) Risk management strategies (Pich et al, 2011)	Feeling unsupported by management		
Reporting antisocial behaviors and acts of violence (D'Aubarede et al, 2016) Issues with the reporting process (Knowles, Mason & Moriarty, 2013) Organizational support and responsiveness (Tan, Lopez & Cleary, 2015)	Issues with reporting		
Nursing assessment of aggressive behaviours (Tan, Lopez & Cleary, 2015) Cue recognition (Wolf, Delao & Perhats, 2014)	Formal assessment of violence and aggression	Making sense of the reasons for violence and aggression	Staff judgments about why they face violence and aggression
Environmental (Wolf, Delao & Perhats, 2014) Vulnerability (Catlette, 2005) Local context factors inducing violence (D'Aubarede et al, 2016) Antecedents and risk factors (Pich et al, 2011) Antecedents (Pich, Hazelton & Kable, 2013) Staff perceptions about why they face violence (Knowles, Mason & Moriarty, 2013) Gender difference (Ramacciati, Ceccagnoli & Addey, 2015) Self awareness (Ramacciati, Ceccagnoli & Addey, 2015)	Perceptions about antecedents to violence		
Why me? (Hislop & Melby, 2003) Injustice (Ramacciati, Ceccagnoli & Addey, 2015)	Injustice		

Antecedents and risk factors (Pich et al, 2011) Degree of personalization of the violence (Luck, Jackson & Usher, 2008) Presence of mitigating factors (Luck, Jackson & Usher, 2008) Reason for ED presentation (Luck, Jackson & Usher, 2008)	Mitigating factors		
Sense of isolation (Hislop & Melby, 2003) Feeling alone and unsupported by management (Ramacciati, Ceccagnoli & Addey, 2015) The impact of violent behaviour, personal and professional (Pich et al, 2011) Individual strategies for dealing with the public (D'Aubarede et al, 2016) Collective strategies (D'Aubarede et al, 2016) Nursing management of aggressive behaviors (Tan, Lopez & Cleary, 2015)	Strategies to manage violence and aggression	Dealing with violence and aggression	Managing in isolation
Sense of belonging (Hislop & Melby, 2003) The impact of violence (Knowles, Mason & Moriarty, 2013) Collective strategies (D'Aubarede et al, 2016)	Coping with violence and aggression		
Health impact (D'Aubarede et al, 2016) Impact on work (D'Aubarede et al, 2016) The impact of violence (Knowles, Mason & Moriarty, 2013) The emotional impact of violence and conflict in the workplace and its interference in other spheres of life (Lancman, Mangia & Muramoto, 2013) The impact of violent behaviour, personal and professional (Pich et al, 2011) Feeling of inadequacy and guilt (Ramacciati, Ceccagnoli & Addey, 2015) Long lasting effects (Ramacciati, Ceccagnoli & Addey, 2015) Fear (Ramacciati, Ceccagnoli & Addey, 2015) Impact of patients' aggressive behaviours on nurses (Tan, Lopez & Cleary, 2015) Personal (Wolf, Delao & Perhats, 2014)	Impact of violence and aggression	Impact of violence and aggression	Wounded heroes

Appendix 1-C. Summary of guide for authors for International Emergency Nursing Journal.

International Emergency Nursing is a peer-reviewed journal devoted to nurses and other professionals involved in emergency care. It aims to promote excellence through dissemination of high quality research findings, specialist knowledge and discussion of professional issues that reflect the diversity of this field. With an international readership and authorship, it provides a platform for practitioners worldwide to communicate and enhance the evidence-base of emergency care. The journal publishes a broad range of papers, from personal reflection to primary research findings, created by first-time through to reputable authors from a number of disciples. It brings together research from practice, education, theory, and operational management, relevant to all levels of staff working in emergency care settings worldwide. Page charges This journal has no page charges.
Ethics in publishing

Declaration of interest

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential conflicts of interest include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding.
Authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work on their Title page. If there is no Conflict of Interest a statement stating None declared must be uploaded.

All original contributions and reports will be submitted to double-blind peer review. As an editorial team, we are committed to providing objective, rigorous and fair feedback. Comments made by referees will be provided to all authors.

Your article (written in English) should be typed on A4 format, double-spaced with margins of at least 3cm. To facilitate the review process line numbering is required in the left margin of the manuscript. (Line numbering can be added from the Page Setup or Format menu of word processing programs.) The line numbering should be continuous throughout the entire manuscript.

Types of contributions
International Emergency Nursing publishes Original Research articles, Reviews, Case Studies and Contemporary Issues. In addition we publish Editorials and Letters.

Research Papers - 2,500-5,000 words The word count includes abstract and references.
Reviews - 2,500-5,000 words
Reviews, including:

- systematic reviews, which address focussed practice questions;

- literature reviews (scoping reviews, narrative reviews), which provide a thorough analysis of the literature on a broad topic;
- policy reviews, i.e. reviews of published literature and policy documents which inform nursing practice, the organisation of nursing services, or the education and preparation of nurses and/or midwives).

The word count includes abstract and references.

Preparation of the Manuscript
A structured abstract, of your manuscript, by means of appropriate headings, should provide the context or background for the research and should state its purpose, basic procedures (selection of study subjects or laboratory animals, observational and analytical methods), main findings (giving specific effect sizes and their statistical significance, if possible), and principal conclusions. It should emphasize new and important aspects of the study or observations.

The sub-headings used in the Abstract should align to sub-headings used within the article.

The abstract should be a maximum of 200 words and should be provided on a separate sheet following the title page.

Highlights

Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). You can view example Highlights on our information site.

Keywords

Include six or ten keywords. These are to increase the likely accessibility of your paper to potential readers searching the literature. Use the Medical Subject Headings (MeSH(r)) thesaurus or Cumulative Indexto Nursing and Allied Health (CINAHL) headings where possible (see External link http://www.nlm.nih.gov/mesh/meshhome.html).

Guidance on the submission of Systematic Review and Meta-Analysis Guidelines

All reviews submitted MUST include a PRISMA flow chart and have followed the PRISMA guidelines. These can be accessed via: External link http://www.prisma-statement.org

PRISMA stands for Preferred Reporting Items for Systematic Reviews and Meta-Analyses. It is an evidence-based minimum set of items for reporting in systematic reviews and meta-analyses. The aim of the PRISMA Statement is to help authors improve the reporting of systematic reviews and meta-analyses. We have focused on

randomized trials, but PRISMA can also be used as a basis for reporting systematic reviews of other types of research, particularly evaluations of interventions. PRISMA may also be useful for critical appraisal of published systematic reviews, although it is not a quality assessment instrument to gauge the quality of a systematic review.

Headings: The content of your paper should determine the headings which you use. If yours is a research paper the headings should follow the usual layout; such as: Introduction, Background/Literature, Methods, Data/Results, Discussion, Conclusions. If your paper takes another form you should use the appropriate headings, but do bear in mind that headings should facilitate reading and understanding. You should use only two kinds of headings: major headings should be indicated by underlined capital letters in the centre of the page, whereas minor headings should be underlined, have lower case letters (beginning with a capital) and begin at the left hand margin.

Acknowledgements
A separate title page file is required which contains all author details. For Review and Research papers the title page should also include the following declarations: (1) Conflict of Interest, (2) Ethical Statement, (3) Funding Source in the order given here. Clinical Trials Registry and Registration number and any Acknowledgments can be stated under 4th and 5th headings if applicable. Where no information is available, the headings (1)-(3) should still be used with "None", or "Not applicable" used.For revised manuscripts these headings should be transferred to the manuscript file in order that they will be published, should the article be accepted for publication.

References

Responsibility for the accuracy of bibliographic citations lies entirely with the authors.

The Editors of International Emergency Nursing would like to alert authors to the new reference style below - "Vancouver non-superscript numbered".

Reference style

Text: Indicate references by number(s) in square brackets in line with the text. The actual authors can be referred to, but the reference number(s) must always be given.
List: Number the references (numbers in square brackets) in the list in the order in which they appear in the text.
Examples:
Reference to a journal publication:
[1] Van der Geer J, Hanraads JAJ, Lupton RA. The art of writing a scientific article. J Sci Commun 2010;163:51–9.
Reference to a book:
[2] Strunk Jr W, White EB. The elements of style. 4th ed. New York: Longman; 2000.
Reference to a chapter in an edited book:

[3] Mettam GR, Adams LB. How to prepare an electronic version of your article. In: Jones BS, Smith RZ, editors. Introduction to the electronic age, New York: E-Publishing Inc; 2009, p. 281–304.
Reference to a website:
[4] Cancer Research UK. Cancer statistics reports for the UK, http://www.cancerresearchuk.org/aboutcancer/statistics/cancerstatsreport/; 2003 [accessed 13.03.03].
Note shortened form for last page number. e.g., 51–9, and that for more than 6 authors the first 6 should be listed followed by 'et al.' For further details you are referred to 'Uniform Requirements for Manuscripts submitted to Biomedical Journals' (J Am Med Assoc 1997;277:927–34) (see also Samples of Formatted References).

Web References

As a minimum, the page name, full URL and date of access should be given. Any further information, if known (author names, dates, etc.), should also be given. Where there is no named author, authorship may be attributed to the organisation producing the site, (if appropriate). Where journal articles have been accessed online a full bibliographic reference to the publication should be given in the style illustrated above although a doi or web address may be added.

Royal College of Nursing (2012) New RCN initiative to shape nursing's future. http://www.rcn.org.uk/newsevents/news/article/uk/new_rcn_initiative_to_shape_nursings_future accessed 5/12/2012

Section Two: Research Paper

Staff Perceptions of the Contributing Factors related to Psychological Well-being and Resilience when Working in Secure Services

Word Count: 7958

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Abstract

Aim. To explore staff perceptions of the factors that contribute to resilience and well-being when working in secure forensic services.

Background. There is a growing body of research into the factors which promote resilience and positive well-being of healthcare staff in general, however limited research has been conducted exploring such factors within the forensic setting.

Design. A qualitative study informed by constructivist grounded theory.

Method. A total of 11 staff from a range of professional backgrounds across two forensic services participated in a semi-structured interview.

Findings. Six conceptual categories emerged from the data: challenging nature of working with clients; being part of a changing organisation; the impact of pressure from above; experiencing the impact of work on staff well-being; coping with difficulties at work; and factors which enabled staff to manage stress at work. The findings revealed that staff resources were depleted through working with clients with complex needs, experiencing constant change and experiencing the indirect impact of an increase in accountability from external organisations. Staff reported trying to cope with the difficulties but this did not always appear to help in the long-term. Consequently, staff experienced a decline in their well-being. However, there were numerous factors which helped staff to manage stress within the workplace, such as having space for reflection in and out of work, receiving support from colleagues, feeling valued by managers and experiencing client progress. Clinical recommendations highlighted the need for breaks and reflection within the working day and training for new starters regarding effective self-care strategies. Also, recommendations for ward managers included: being present, praising staff and involving them in decisions, in

addition to maintaining consistent staffing and ensuring that staff are not moved across wards without prior warning.

Keywords: Well-being; Resilience; Staff; Qualitative; Forensic

INTRODUCTION

Within the current climate of healthcare services, there has been growing interest in the well-being and stress levels of staff. According to the World Health Organisation (Leka *et al.* 2004), work stress is a major cause of absenteeism, poor productivity and unsafe working practices in organisations worldwide. A large-scale study of National Health Service (NHS) staff in the United Kingdom (UK) found that 26.8 per cent of workers reported significant levels of anxiety and depression compared with l7.8 per cent of people in the general population (Wall *et al*. 1997). More recently, the Boorman Review published by the Department of Health (DoH 2009) reported that a quarter of the absence from work in UK NHS employees was due to stress, anxiety or depression.

Background

Work-related stress has significant consequences for staff. Occupational stress has been shown to be associated with higher levels of anxiety and depression compared with those with low levels of job stress (Mark & Smith 2012). Job stress was consistently found to negatively impact quality of life in Greek nurses (Sarafis *et al*. 2016). Work stress can also lead to burnout, which was a construct first introduced by Freudenberger (1975) as a conceptualisation of the impact of work stresses on the individual. Burnout is considered to be a response to chronic emotional and interpersonal stressors of the job, and is traditionally defined by the three dimensions of exhaustion, cynicism and inefficacy (Maslach *et al*. 2001). Work-related stress also has implications for the physical health of employees; exposure to

stress is known to affect endocrine, immune and metabolic functions (Koelsch *et al*. 2016). Nurses who reported high work-related stress were found to have the poorest health and highest health risk behaviours compared to nurses with perceived low job-stress, with 70 per cent reportedly consuming junk food during times of stress as a way of coping in one study conducted in the US (Jordan *et al*. 2016). Studies have also shown that job stress can contribute to the presence of chronic fatigue and irritable bowel syndrome, although this was also affected by personality traits including neuroticism (De Gucht *et al*. 2003).

Work-related stress is pervasive and can have far-reaching effects on patients, the organisation and society (Hill *et al*. 2003). The European Agency for safety and health at work suggested that, in Europe, the organisational and societal cost of stress at work is considerable (Hassard *et al*. 2014), with the calculated costs of work-related stress in the European Union (EU) at €20 billion a year (European Commission 2002). When employee well-being is not prioritised, this is likely to increase organisation costs associated with replacing staff in addition to 'presenteeism' (being at work but not fully functioning due to illness) and critical incidents resulting from poor staff performance (Royal College of Physicians 2015). Moreover, reducing staff absence by a third could save the NHS approximately £555 million annually (DoH 2009).

Work-related stress can also lead to poor patient care, with up to 80 percent of NHS staff reporting that their health and well-being impacts on the care they provide to patients (DoH 2009), which also has implications for organisational costs (Royal College of Nursing 2009). Research has demonstrated that nurses' levels of burnout and psychological distress can impact on their caring behaviours (Aiken *et al*. 2002, Laschinger & Leiter 2006, Sarafis *et al*. 2016). Specifically, job stress, anxiety and depression in staff was shown to be negatively correlated with self-reported ratings of interpersonal aspects of job performance,

such as warmth and tolerance, in addition to cognitive functions including concentration and adaptability (Motowidlo *et al*. 1986). Moreover, staff who are 'burnt out' are likely to be much less tolerant towards client's challenging behaviour (Whittington & Higgins 2002). Burnout in staff is also considered to increase the likelihood of aggressive encounters with service users (Winstanley & Whittington 2002). This is thought to be due to the behavioural changes in staff whereby they are more emotionally and physically distant from clients (Winstanley & Whittington 2002). In inpatient mental health services, therapeutic relationships are key determinants of patient experiences (Johnson *et al*. 2010). Therefore, it is in the best interests of staff, patients and organisations for the health and well-being of the workforce to be prioritised (Royal College of Physicians 2015).

Staff working in secure mental health hospitals have been found to experience higher levels of work-related stress and burnout compared to those who work in general hospitals or community settings (Fagin *et al*. 1995, Qi *et al*. 2014). This was seen as being due to dissatisfaction with clients' therapeutic change and lesser degree of responsibility over their work compared to their community colleagues (Fagin *et al*. 1995), in addition to working with aggressive clients in a closed environment (Qi *et al*. 2014). Johnson *et al.* (2011) conducted a national study in the UK exploring the morale of NHS inpatient mental health staff and found that although most staff were fairly satisfied with their work, approximately half of staff working on acute wards met the threshold for emotional exhaustion on the Maslach Burnout Inventory (Maslach *et al*. 1996). One study exploring the well-being of forensic health care professionals working in medium-secure units in the UK found high reported levels of occupational and psychological distress in addition to moderate levels of burnout in staff (Elliott & Daley 2013). A third of staff working in medium secure provision for people with learning disabilities scored highly on ratings of emotional exhaustion (Dennis & Leach 2007), and a third stated that they were likely to actively seek new employment in

the next year (Robertson *et al*. 2005). Therefore, further understanding of the factors which impact on well-being in staff working in secure services is needed.

Much of the existing research has focused on exploring what factors lead to burnout and a deterioration of well-being at work. However, simple removal of such factors does not necessarily lead to positive well-being and resilience. Attempts to understand the latter have more recently led to a shift in the focus of research from a 'pathogenic paradigm' focusing on psychological morbidity and burnout to a 'salutogenic paradigm' focusing on health and well-being when faced with stressful situations. A historical review of the concept of resilience suggested that the construct stems from physiological and psychological research from the 1800s and continues to the present time (Tusaie & Dyer 2004). Currently there is not a universally accepted definition of resilience (Aburn *et al*. 2016). Rutter (1999) conceptualised resilience as the "phenomenon of overcoming stress or adversity". A review has suggested that nurses can develop personal resilience strategies to overcome workplace adversity (Jackson *et al*. 2007). Moreover, resilience has been shown to act as a protective factor against emotional exhaustion in at least one study conducted with general nurses in Spain (García & Calvo 2011). Furthermore, resilience training has been shown to improve personal resilience and was a useful method of improving well-being in employees in a systematic review (Robertson *et al*. 2015).

There is also a growing body of research into the factors which promote resilience and positive well-being in general healthcare staff. Some of the useful findings from such studies to date conclude that being able to access a quiet place for a short time was helpful in managing stress as reported by general nurses (Wright *et al*. 2016). Also, having a supportive professional network, being positive, developing emotional insight, achieving life balance and becoming more reflective have also shown to increase personal resilience in a review of

nurses (Jackson *et al.* 2007). A qualitative study of note was conducted by Ablett and Jones (2007) exploring palliative nurses' experiences of working with patients with cancer who had lower levels of burnout compared to other specialties. Themes showed that staff felt a strong sense of commitment and purpose to the work, and it was concluded that interpersonal factors, such as hardiness and coherence were important in moderating the effects of stress (Ablett & Jones 2007).

The concept of resilience is pertinent to staff working in forensic secure services, as this setting is often singled out as being particularly stressful due to the complexity of the client group (Happell *et al*. 2003). Interestingly, one quantitative study in Norway found that staff working in the community scored higher for resilience than staff working in a secure forensic service, whereas there were no differences on scores of quality of life across both services (Søndenaa *et al*. 2013). Community staff specifically scored higher on the control subscale of the resilience measure, thus, Søndenaa *et al.* (2013) offered one suggestion whereby staff working in secure forensic services were less resilient due to having less control over their work, as institutions place greater emphasis on routines and hierarchical systems. This demonstrates that further understanding around resilience in staff in secure forensic settings is needed, however, currently there is limited research exploring resilience and well-being in professionals working in such services.

Qualitative studies have a major role in providing an understanding of how staff make sense of their experiences at work, their views about how to improve their experiences and the mechanisms that might underlie their responses to certain sources of stress and satisfaction (Totman *et al*. 2011). Currently, there are no known qualitative studies that explore resilience in staff working in secure forensic settings specifically. The current study addresses this gap in the literature by exploring first-hand perspectives of staff working in

forensic services. The main research question was: What do staff consider to be the influencing factors regarding their psychological well-being and resilience when working in secure services?

THE STUDY

Aim

The aim was to explore staff perceptions of the factors that contribute to resilience and well-being when working in secure forensic services.

Design

A qualitative study informed by constructivist grounded theory. This methodology was chosen as it is a flexible, systematic way of gathering, analysing and conceptualising qualitative data to construct theory (Charmaz 2014). The systematic nature of the approach enables the ideas to be verified through quantitative methods (Charmaz 2008).

A social constructionist epistemological position was adopted whereby the researcher acknowledged their influence on the construction and interpretation of the data (Charmaz 2014). A researcher with this standpoint perceives that people create meaning through interactions with others and intends to seek understanding for how participants make sense of their subjective experiences.

Participants

A purposive sampling method was used to recruit direct clinical staff, which was defined as any member of staff that works directly with service users. Any staff who worked within the service for at least six months and worked directly with service users were included in the

study. Non-clinical staff or any staff who have worked in the organisation for less than six months were excluded from the study. The study took place in two forensic services for adults in Northern England. One service was a forensic learning disability service consisting of medium-secure, low-secure and step-down services; the second service was a forensic hospital with both medium-secure and low-secure wards.

A global email (Appendix 4-A) was circulated to all clinical staff by local collaborators at each site. Participants were provided with information about the study through the participant information sheet (Appendix 4-B) and were invited to opt in via the expression of interest form (Appendix 4-C). Demographic information was collected using the expression of interest form to facilitate theoretical sampling (Charmaz 2014). A total of 17 staff opted into the study, all of whom met inclusion criteria and were contacted to arrange interviews. Recruitment took place in three phases which was concurrent with data analysis (Charmaz 2014).

A total of 11 staff (five males and six females) participated in the study, ranging from 22 – 55 years of age, with an average age of 41 years. Participants were from a range of professional backgrounds, with experience of working in the service ranging from 9 months to 33 years. See Table 1 for participant job role information, which is reported separately from demographic data to maintain confidentiality of participants.

Insert table 1 here

Data collection

Staff took part in a semi-structured interview about their perceptions of the factors that contribute to well-being and resilience at work. Interviews took place in a quiet room on working premises where staff worked, at a time most convenient for them. Participants were given the opportunity to re-read the participant information sheet and were provided with an explanation of confidentiality. Participants were then asked to sign two consent forms (Appendix 4-D), one of which participants kept for their own record. Interviews were based on a broad interview guide (Appendix 4-E) which was adapted after each group of interviews. Interviews lasted between 42 and 106 minutes and were taped on a digital recorder. After the interview, participants were given a debrief sheet (Appendix 4-F).

Ethical considerations

Ethical approval was obtained from Lancaster University Research Ethics Committee and the Health Research Authority (see ethics section for ethical adherence of this study).

Data Analysis

Data collection and analysis occurred concurrently in line with grounded theory methodology (Charmaz 2014). Data collection and analysis took place in three separate phases to give time for preliminary data analysis to guide the following interviews; initially four participants were interviewed and preliminary analysis took place up to the point of conceptual codes. This same process was followed with three participants and then a further four participants. In ‘pure’ grounded theory research, data collection continues until subsequent data would not change existing categories. However, pragmatic grounded theory researchers often collect data until data are sufficient to construct a model rather than saturated (Dey 1999, Kahlke 2017), which is how data were collected within this study.

All interviews were transcribed by the researcher. Each interview was initially coded incident-by-incident (Charmaz 2014). Following this, focused codes were developed to synthesise larger segments of significant or frequent initial codes (Appendix 2-A). Tentative conceptual categories were then built from focused codes to go beyond describing the data using a constant comparative method. Throughout the process, memos were recorded to capture the researcher's reflections of interviews and coding; between each group of interviews, clustering was also used which is a non-linear, visual and flexible technique to understand and organise the material (Charmaz 2014, see Appendix 2-B for an example memo and clustering). Freewriting was also utilised as a pre-writing exercise after the second group of interviews. Finally, a theory of staff's perceptions of well-being and resilience when working in secure settings was developed and finalised.

Rigour

Quality in qualitative research is concerned with contribution, credibility and rigour (Spencer & Ritchie 2012). Relating to credibility, conceptual codes and model iterations were shared at regular intervals with the researcher's academic and field supervisors. An example of a coded transcript was also sent to the researcher's University supervisor to check and validate analysis. Dependability was another aspect of this study: a detailed audit trail was created for the generation of initial, focussed and conceptual codes to enable transparency in decision-making and analysis. Memo-writing also formed part of the audit trail.

Reporting on reflexivity is considered important in good quality qualitative research (Meyrick 2006). Declaration of the researcher's own role, interests and assumptions can also enable the reader to keep this in mind when considering the findings (Elliot *et al*. 1999). The researcher was a 28-year-old trainee clinical psychologist working in the UK undertaking doctoral training in clinical psychology. Having worked in medium-secure provision as a

support worker prior to training, the researcher had experience and an interest in the well-being and resilience of staff working in secure services.

Supervision with an academic supervisor and a reflective diary was kept throughout the research to minimise the imposition of the researcher's own preconceptions onto the data. A pragmatic approach to reading prior literature was taken in line with constructivist grounded theory (Charmaz 2014), whereby minimal reading was conducted to develop a protocol but further reading was postponed until after analysis was completed.

FINDINGS

Through the process of analysis, a model of staff perceptions of the factors contributing to resilience and well-being when working in secure forensic services was developed. Six conceptual categories emerged from the data: challenging nature of working with clients; being part of a changing organisation; the impact of pressure from above; experiencing the impact of work on staff well-being; coping with difficulties at work; and factors which enabled staff to manage stress at work. This model is explored narratively and presented diagrammatically (See Figure 1). Pseudonyms were used throughout to maintain the confidentiality of participants.

Insert Figure 1 here

Challenging nature of working with clients

The core of participants' narratives highlighted the complex and challenging nature of working with the client group which appeared to deplete staff of their emotional and physical resources. Participants perceived that clients with mental health issues required a significant amount of support: "someone who is so mentally unwell they need like a lot of support … so you're using all your own resources … so them days are very stressful" (Eliza). For ward-based staff, it appeared that the incessant nature of client demands "lots and lots of demands, that repetition" (Jerome), and "dealing with things constantly" (Billie) was particularly draining. The complexity of clients' needs appeared to be consuming for staff, which left limited opportunity for considering their own needs: "you're always thinking about someone else" (Eliza).

Working with this client group also meant that an awareness of risk was a constant feature of the work, with participants highlighting the need to be "aware of your own safety" (Eliza). Exposure to aggressive and challenging behaviour, especially if it was directed towards participants, made staff feel unsafe "the majority of people that are here… present a risk to themselves or to other people so that's something that … can make you feel unsafe" (Jessica). Thus, constantly managing challenging behaviour, thinking about clients' needs and constant vigilance regarding risk caused participant's resources to be depleted which negatively impacted on their well-being.

Being part of a changing organisation

Working with clients' changeable moods and perceiving that the NHS was a constantly changing organisation meant staff often passively accepted change as part of their work.

NHS and service changes

Passive acceptance of change was apparent within the accounts, with staff perceiving that "there are constant changes in the NHS" (Daniel). In one site, the NHS Trust was being merged with another NHS Trust, which was considered to be a cause of staff sickness and resignation by participants: "low staffing numbers and the fact that because the place is closing a lot of the younger, experienced staff are moving on" (Michael).

Experiencing constant change

Predicting and managing clients' fluctuating moods appeared to be stressful for some staff, whereas other staff enjoyed the variety that such changes brought. Staff from one service were often moved between wards "without any kind of warning" (Michael) which led to feelings of sadness and anger. It was easier for participants to deal with change when they had been "communicated that information … in advance" (Daniel), in addition to being involved in decisions regarding any changes. To cope with constant changeability in clients' moods, participants appeared to prefer to work with familiar service users "I'm happy, I'm content here … if you put me perhaps working with women over on [another ward area] I wouldn't be happy" (Agatha); it appeared that working with the same clients meant staff became familiar with their behaviour, thus making it less unpredictable, which helped staff to feel safe. However, this was not always possible due to the inevitability of change which had a subsequent negative impact on staff well-being.

The impact of pressure from above

Increasing demands regarding accountability from external organisations meant managers perceived that they had to prioritise administration over client care. These significant administration and job demands depleted the time and resources of managers, which led to

front-line staff feeling increasingly distant from and neglected by management. *Greater demands for accountability from external organisations*

Participants described an increase in “ticking a box” (Daniel) whereby there were greater expectations placed on the organisation and staff regarding accountability from external organisations including “NHS England” (Jerome), and the Care Quality Commission (CQC). Consequentially, managers felt that they spent less time with service users to complete paperwork “you can spend hours in the office recording stuff means that you're not actually out there doing the stuff that needs to be done” (Michael). On the occasions when staff neglected administrative demands to prioritise working with service users, this was perceived to lead to criticism from senior management, which led to conflict: “you're getting told different messages” (Jessica). However, other staff had positive perceptions of the changes regarding accountability “it feels better anyway because there's more accountability” (Paul).

Playing ‘catch up’ with administration and job demands

Due to the complexity of the client group and demands from external organisations, participants’ workload was reportedly increasing “there's probably double the amount of meetings for each person” (Jessica). Some staff were unable to take breaks or had to work longer to complete administration demands, which left them feeling stressed as they felt that they had to constantly “play catch up” (Eric).

Creating distance: A top-down management approach

Greater demands for accountability and a top-down management approach meant that managers were perceived to be less ‘present’ on ward areas, which created a feeling of distance between clinical staff and management for the majority of participants. This distance was also perceived to lead to poorer communication “it's top-down feed-down so it's

management via email" (Jerome). Underlying narratives was a sense of a "loss of humanity" (Jessica) from management, which was also intrinsically linked to emotional distance, with staff feeling "like a number" (Billie). This physical and emotional distance appeared to divide front-line staff and management which gave rise to resentment and dissatisfaction "It's probably made me a very bitter person towards management" (Agatha). This implied blame towards management for being distant, however managers had no choice but to meet the expectations of external organisations. The term 'management' also appeared to describe any individual that was senior to the staff member, and implicit within the narratives was the negative perception of management even if staff were unclear as to who was responsible for decisions made within or outside the organisation.

Feeling neglected

Implicit within staff narratives was a perceived disregard for the needs of staff, which appeared to be caused by feeling distant from management. Perceived criticism from management led to staff feeling "attacked" (Billie), "blamed" (Agatha), and "defensive" (Jessica). This approach to rectifying errors appeared to be mirrored by staff, as some participants felt criticised by colleagues. A sense of powerlessness was also present in staff accounts, with participants describing a lack of control over their workload "you don't have that control over your diary" (Jessica) and feeling that they had limited input over decisions related to their work: "the nurse on charge allocates, that's it, it's out of our control really" (Eliza). Underlying these accounts was a portrayal that the needs and voices of participants were unheard within the workplace.

Narratives implied mistreatment from managers and service users "I'm not here to be abused … I am a person too" (Billie). Participants often perceived that their work was unappreciated which resulted in one staff member asking "why bloody bother?" (Agatha) as a

sign of decreasing motivation. Within these accounts was a sense that staff “didn't really get …that feeling of value” (Melissa) by people at work. It was apparent that participants, including those in managerial positions, did not feel that their fundamental needs of being valued and heard were being met which caused a significantly decline in their well-being.

Coping with difficulties at work

Numerous coping strategies to deal with stress from working with clients, experiencing change and pressure from above, were highlighted within participants accounts. Participants seemed to distance themselves from negative experiences and feelings; this was present through staff “not personalising it” (Jerome) and “keeping my … private and work life separate” (Paul). Participants also appeared to need to ignore their own feelings about situations at work in order to cope. For instance, staff felt they had no choice but to “just get on with it” (Agatha) despite their feelings. Participants’ also varied in their coping strategies, with participants in managerial positions attempting to take greater control over their workload, which was more difficult for support staff. Many staff described managing difficult situations by asserting and expressing their opinion “I ranted and raved cause I was not happy” (Michael). These strategies appeared to help participants to manage in the short-term but made limited difference in the long-term, which further impacted on their well-being.

Experiencing the impact of work on staff well-being

Dealing with clients who had complex needs, experiencing constant change and feeling pressure from above was perceived to cause a decline in staff’s well-being. Poor staff well-being was perceived to reduce staffing levels which meant that a greater number of inexperienced staff were employed. Staff perceived that there was a causal link between inexperienced staff and an increase in challenging behaviour shown by service users. Staff

who had previously experienced the negative impact of work-stress on their well-being, appeared to learn from such experiences by implementing greater self-care strategies outside of work.

Work-related stress reportedly had significant consequences for the emotional and physical well-being of staff. Staff appeared to notice changes in themselves as a first sign of stress after particularly difficult days, such as staff would “lose [their] appetite” (Agatha), were “not sleeping” (Daniel), or they struggled to “switch off” (Melissa). This was evident when staff had been unable to take time to process the events at work which meant that they were “stuck with it” (Jessica). At other times, staff were anxious in anticipation of a challenging day. In some cases, staff spoke about being “traumatised” (Daniel) due to stress at work, with some staff being told by doctors that they were “experiencing anxiety and low mood” (Melissa) due to work. The impact of stress also had a negative impact on participants’ physical health which resulted in some staff taking sickness leave.

Reduced staff well-being was perceived to lead to lower staffing levels. Staff being absent due to sickness or leaving the organisation appeared to lead to greater strain on the resources of existing staff. Newer or temporary staff were employed to cover staffing numbers “we're on a really bad day there's not enough staff, people have turned in sick there's a lot of agency on or unfamiliar agency” (Eliza). Multi-disciplinary professionals also perceived the impact of less experienced staff on the consistency of the implementation of therapeutic programmes, which was considered to cause an escalation in client’s challenging behaviour:

> Wards require consistency, structure, routine, and they need the consistent staff… I think because they've been short staffed there's been bank and agency

> coming in that don't know the model, they don't know the service users that well and consequently that increases people's violence and aggression (Daniel)

Staff who had experienced poor well-being due to work stress in the past appeared to learn from such experiences which lead to an increase in their focus on their own well-being outside of work. Greater compassion towards themselves and their colleagues was apparent: "just trying to be a bit more you know compassionate [towards staff]… I think it makes me kinder on myself aswell" (Agatha). Moreover, effort to implement more "self-care" (Melissa) activities and hobbies than before "if I feel stressed… I try and do more [hobbies]" (Eric).

Factors which enabled staff to manage stress at work

Within the narratives emerged an analogy of a battery whereby participants had a finite amount of resources to cope with the demands at work. Negative experiences drained this battery, whereas having breaks and reflection in and out of work, having support from colleagues, being valued at work and having positive experiences with clients all led to participants feeling "recharged" and motivated to work again.

Needing space and reflection

Due to the challenging nature of interactions with clients, staff appeared to need breaks and reflection in and out of work to replenish their resources.

Valuing breaks and reflection in work.

Due to the intensity of the interactions with service users, particularly difficult days with clients led to staff appearing to withdraw from social interaction at home: "when you've had a bad day you want to shut down especially cause you feel like you've been in contact with people the whole day and it's been negative experiences the whole time you don't really want

to chat" (Billie). Staff also appeared to need a break from interacting with their colleagues "we never tended to speak to each other" (Jerome), which suggests that negative interactions with clients appeared to negatively influence the amount of interaction that participants wanted to have with other people. Narratives gave a portrayal of breaks allowing staff to be "re-charged" (Eric), whereby they were able to process and reflect on issues. Participants associated having breaks with reduced risk to service users through improving effectiveness and reducing tiredness "you were effective when you went back cause you'd had time away" (Jerome).

Participants also valued reflection on difficult incidents to improve future practice. Some staff identified debriefs and sharing professional opinions as opportunities for reflection "it's really important to have debriefs after major incidents" (Eliza). Other staff valued supervision which was perceived to enable participants to share and process difficult experiences "[supervision] is processing… it's very much like a sounding board I talk and then it's having somebody else listen" (Jerome). Supervision which was work-focused (discussing job responsibilities), shorter and arranged dependent on ward factors appeared to be less helpful and containing "when you've had really chaotic, busy, eventful times supervision doesn't happen as much… [staff are] just getting fuller and fuller with all what they've not processed" (Melissa).

Experiencing positive well-being outside of work.

All participants identified the importance of having positive well-being outside of work to cope with stress in work. When home life was stressful, this had catastrophic consequences for staff's resilience in work "it's a lot harder to manage things at work when you're having a horrible home life" (Billie). All the participants described feeling supported by either friends, family or partners. Some participants felt supported when they were listened to "I offloaded

to my partner" (Daniel). One participant spoke about how it was helpful when their partner was able to identify when their well-being was deteriorating "my wife's noticing that I'm coming home there's a bit of pressured speech" (Paul).

Having positive well-being at home reminded participants that "there's a life outside of work" (Jessica). Many accounts described the importance of hobbies to reduce stress and replenish staff resources "I get recharged when I do these things that enthuse me" (Eric). Calming hobbies were pursued by staff which perhaps mitigated the impact of the anxiety-provoking work environment. As a result, participants felt that they came into work "not holding onto anything" (Melissa). Thus, it appeared that having a positive life outside of work led to increased staff resources to manage stress in work.

Support from colleagues

Having support from colleagues appeared to be an essential factor in leading to an increase in participants' ability to manage stress. Narratives gave a portrayal of staff being 'in it together' which helped them to feel understood "it's a shared experience… it's a shared weird place to be" (Jessica). Reciprocal support between staff was evident within the accounts "you rely on each other to look after each other" (Michael). Support was evident in numerous ways; emotional support was important for some participants "she kind of said 'are you okay?'" (Jessica). For ward-based participants, having staff support during incidents helped them to feel safer "I knew I was in for a rough night …but I knew that the staff team that I had around me were supportive" (Eliza). Feeling supported by colleagues also helped newer staff to learn "it's nice to have more experienced staff that I can learn from" (Billie). Teamwork between colleagues and other professionals was also valued which brought a sense of belonging and cohesion "the nursing team … it's like knuckling through …like when things get really tough the team are really resilient with it and like everyone kind of supports

each other" (Cynthia). The social interaction between colleagues and humour also helped to mitigate the seriousness of the job "there's good teamwork in the office, good sense of humour going on, plenty of banter and I think that really helps because that gives you a release" (Paul). The accounts gave a sense that the work was not possible without the support of colleagues.

Valued aspects of organisational and leadership approach

Being provided with opportunities to learn and bring their own skills to the job helped staff to feel valued. Staff also valued working with managers who were 'present' and 'led from the front'. This appeared to improve communication and caused an increase in staff's motivation to work.

Feeling valued.

Being provided with opportunities through work, such as training, further education and in one instance, being able to take a sabbatical, appeared to make staff feel valued. Other staff appeared to enjoy being able to bring their strengths to the job, which was seen as a positive part of the work "I've got quite a lot of strengths… I'm a do-er" (Daniel). Participants felt appreciated and valued when their work was praised, which motivated them to work harder and had a positive impact on their self-esteem "she gives me really good feedback …so yeah definitely feel like my opinion is still valued" (Cynthia).

Preferring managers who "lead from the front".

'Present' managers who took the lead in managing difficulties offered staff a sense of protection "part of leading a team is to be with them and lead from the front" (Michael). Managers who followed through with their promises also helped staff to feel reassured and

contained “he addressed it” (Jerome). Such qualities also improved communication, which helped staff to feel supported “if there was stuff you were concerned about, you could ring and leave a message direct for [the Chief Executive]” (Jerome). Staff also appeared to be motivated to work harder for managers who were perceived as supportive: “you really feel that support … really having each other's back kind of thing and in turn you're more prepared to do more than the team leaders that would be less kind of fostering of that” (Melissa).

Enjoyable aspects of job and working with clients

Many participants described feeling happy in their job and felt that being part of clients’ progress was the most rewarding aspect of the work which appeared to lead to an increase in staff’s motivation to keep working. Forming positive relationships with service users boosted staff’s well-being “I've quite a good relationship with him” (Cynthia). Being part of positive changes and witnessing clients’ progress first-hand was rewarding, especially if participants’ actions had influenced that positive change “when you go home and you feel like you've actually made a difference that day it definitely makes you feel a lot better that you go home and you can just relax” (Billie). Many staff also emphasised the importance of “small things” (Melissa) related to client progress which were equally rewarding.

DISCUSSION

The above findings offer an initial conceptualisation of direct clinical staff perceptions of the influencing factors regarding their psychological well-being and resilience when working in secure forensic services.

The findings illustrated how supporting clients with complex difficulties appeared to deplete staff of their emotional and physiological resources. Previous research has shown that violence towards mental health nurses was correlated with job stress (Itzhaki *et al*. 2015, Qi

et al. 2014). Unqualified staff found dealing with ‘demanding’ patients to be the most stressful aspect to the job due to spending the most face-to-face time with clients (Jenkins & Elliott 2004), and support workers have been reported to experience the highest rates of emotional exhaustion compared to other staff (Dennis & Leach 2007). This could be understood in terms of relational security, which is a key feature of secure mental health work whereby safe and effective staff-patient relationships require clear boundaries (Appleby 2010). Research has shown that higher frequency of boundary violations from clients was associated with burnout in staff (Johnson *et al*. 2016). This suggests that the constant nature of having to maintain boundaries with clients was the mechanism which depleted staff resources.

The findings also illustrated that the constant nature of client interactions could be ameliorated by breaks and reflection both in and out of work. Previous research is consistent with this: being able to access a quiet place for a short time (Wright *et al*. 2016), using clinical supervision as a vehicle for reflection (Bégat & Severinsson 2006, Reid *et al*. 1999, Stewart & Terry 2014), and having family and social support outside of work (Lim *et al*. 2010) has been found to be helpful in mitigating the impact of stress at work.

Another finding highlighted that staff had to passively accept both the changeable nature of clients’ moods and working within a constantly changing organisation. The uncontrollable nature of change was particularly difficult for staff to manage, in line with Seligman’s (1972, see literature review for a description of theory) theory of learned helplessness which can lead to low mood. This may provide an explanation as to why some participants felt that uncontrollable organisational changes were responsible for staff sickness and resignation.

The results also illustrated that an increase in demands for accountability from external organisations meant that managers perceived that they spent more time doing paperwork and less time with clients, which caused front-line staff to feel more distant and neglected. Research has demonstrated that austerity measures and scandals related to quality of care have increased the pressure on NHS executive nurse directors, with one stressor being repetitive demands for data from external organisations (Kelly *et al*. 2016). Previous qualitative studies have shown that clinical staff have described feeling isolated and 'alienated' from senior management above ward level in NHS inpatient units (Johnson *et al*. 2011, Kurtz & Jeffcote 2011). UK government ministers have been considered to "display an unforgiving top down control and command style of management" (Smith *et al*. 2001, p. 1262) towards NHS managers. Such an approach is in line with a 'transactional' leadership style aimed at monitoring and correcting errors, which has been linked to poorer job satisfaction in nurses (Morsiani *et al*. 2017). Within the present study, managers appeared to mirror the leadership style which they experienced from people from external organisations. This demonstrates that leadership style can filter down the organisational structure which ultimately impacts on the well-being of staff. It was found that staff preferred working alongside managers who were 'present', praised their work and valued their contribution to decisions. Therefore, greater consideration of the causal link between organisational structures and leadership style on staff's well-being is needed.

The findings also identified the ways in which staff attempted to cope with difficulties at work but which appeared to be ineffective in the long-term. Coping strategies whereby staff 'got on with it' or distanced themselves from negative experiences were consistent with emotion-focused coping according to Lazarus and Folkman's (1984) theory of stress, appraisal and coping. However, this style of coping has been implicated in burnout (Chana *et al*. 2015, Chang *et al*. 2006), and has been shown to be unhelpful long-term due to failing to

overcome the issue (Chang *et al.* 2006, Lazarus & Folkman 1984). Conversely, the strategies whereby participants took control over their workload or expressed their dissatisfaction are in line with problem-focused coping, which has been linked to personal accomplishment (Shin *et al*. 2014). This demonstrates how the coping mechanisms used by staff had consequences for their well-being at work.

The culmination of difficulties at work meant that staff experienced depleted resources and poor well-being which caused a reduction in staffing levels. Depleted emotional resources are a sign of emotional exhaustion according to traditional models of burnout (Maslach *et al*. 2001). Work-stress has been linked to anxiety and depression in UK nurses (Mark & Smith 2012), in addition to causing physical health issues in staff (De Gucht *et al*. 2003, Jordan *et al*. 2016). One novel finding was where staff learnt from negative experiences of poor well-being to implement better self-care strategies outside of work. Self-care strategies, such as sleep hygiene, social support and mindfulness have been shown to mitigate the impact of stress (Myers *et al*. 2012). This has implications for organisational responsibility for encouraging all staff to pursue self-care strategies.

Another finding in this study was the perceived impact of unfamiliar or new staff on clients' challenging behaviour, which was perceived as leading to a decline in staff's well-being. Attachment theory describes how individuals develop relational attachment patterns through repeated 'caregiving' interactions with significant others (Ainsworth *et al*. 1978), and has been proposed as a way of understanding staff–patient relationships (Berry & Drake 2010). Service users in forensic services have often experienced inconsistent, neglectful or abusive behaviour from primary attachment figures leading to insecure attachment styles (Kurtz 2005, Ma 2006). Organisations may act as an inconsistent attachment figure for clients through inconsistent staffing which increases anxiety and challenging behaviour (Adshead

1998). The need for consistent staff to build meaningful relationships with service users to support recovery has been emphasised (Berry & Drake 2010). The findings of the current study also showed that being part of client progress was the most rewarding and motivating aspect of the work for staff (Johnson *et al*. 2011, Kurtz & Jeffcote 2011). Thus, consistent staffing can provide a secure base for clients to progress, which in turn may be rewarding for staff and improve their well-being. Therefore, it is important that forensic organisations commit to employing an experienced and sustainable workforce to both improve client outcomes and staff well-being.

The final concept highlighted factors which helped staff to manage stress at work. Such factors have been highlighted in previous qualitative research, namely having supportive professional relationships, having a life balance and looking after oneself (Edward 2005, Jackson *et al*. 2007). One significant factor within this concept was fundamental support from colleagues. Firstly, staff felt supported through a process whereby they felt 'understood' through sharing difficult experiences with colleagues, which is consistent with Johnson and Johnson's (1987) definition of social groups. Through their shared experience, staff appeared to form a group where the objective was to help each other manage difficulties at work which brought a sense of cohesion. The findings identified certain helpful aspects of support from colleagues such as emotional support which led to an increase in staff's emotional resources and well-being. Existing studies have shown that close relationships with colleagues was perceived as a significant source of support (Kurtz & Jeffcote 2011), and peer support, such as being able to discuss problems with colleagues was highlighted a helpful coping strategy in forensic nurses (Coffey & Coleman 2001). Humour has also been shown to be a mechanism which mitigates the seriousness of the job (Sandhu *et al*. 2012). This has implications for staff and the organisation to promote opportunities for support between colleagues to improve staff resilience.

Clinical implications

Given that breaks and reflection enabled staff to cope with the demands of working with clients in addition to benefitting from support from colleagues, it is recommended that staff are provided with informal time away from clients as an essential aspect of their working day independent of their personal breaks. Staff could choose how to use this time, such as peer support, self-care or individual reflection. Existing evidence is poor regarding current service provisions for staff reflection: research has shown that formal supervision groups have significant barriers, such as poor engagement, group dynamics and lack of management support as reported by clinical psychologists (Heneghan *et al*. 2014). Moreover, the evidence regarding the efficacy of debriefs have been questioned due to the negative implications of re-exposing staff to difficult events (Kamphuis & Emmelkamp 2005). This has significant implications for the role of clinical psychologists in empowering staff to shape how they access psychological support and reflection. Depending on how staff chose to spend their self-care time, clinical psychologists in the service could facilitate these sessions either directly, such as mindfulness groups or indirectly through helping staff to access helpful resources for individual sessions.

As staff identified specific helpful and unhelpful coping strategies, education about the role of stress in the forensic environment and effective self-care strategies for new starters is recommended (Jackson *et al.* 2007). Induction training could incorporate aspects of resilience training which has been shown to have a positive impact on staff well-being (Robertson *et al*. 2015). Current resilience training is based on different psychological principles including mindfulness, compassionate mind exercises and cognitive behavioural therapy concepts (Robertson *et al*. 2015). Current NHS and DoH initiatives to promote staff well-being are based within occupational health departments during working hours (DoH

2009), however the findings from the current study showed that self-care strategies implemented outside of work were helpful in reducing stress, thus educating staff about self-care as part of their overall well-being is necessary. Self-care strategies are often actively encouraged as part of the clinical psychology profession and form part of training on clinical psychology doctorate programmes; research has shown trainee clinical psychologists rated their quality of life higher when training courses placed greater emphasis on self-care (Goncher *et al*. 2013). Therefore, clinical psychologists can play a vital role in using their training and experiences of personal development and reflection to develop and deliver self-care training for staff.

The findings also highlighted ways in which managers can support the well-being of staff. Managers who were more 'present' on wards, praised staff efforts and involved staff in decisions positively influenced staff well-being (Duffield *et al*. 2011). Given that inconsistent staffing had a negative impact on staff and clients' well-being, it is recommended that ward managers maintain consistent staff working with clients; the use of key workers for promoting secure attachments has been recommended (Berry & Drake 2010). As uncontrollable and unexpected change was also difficult for staff, ward changes should be kept to a minimum and staff should be given significant warning if such changes are unavoidable.

Limitations and future research

Due to time restrictions on the project, only two sites were used to optimise data collection within these sites, however a larger sample across a greater number of sites may have provided greater transferability of the findings.

The present study highlighted the need for informal breaks and reflection. Future research could evaluate the use of this time within the forensic setting. This could be achieved by using a questionnaire aimed at gathering qualitative and quantitative data regarding staff well-being before and after a six-month period. The present study also found that staff learnt from experiences of poor well-being, however the exact strategies and mechanisms of such remain unclear. Future research could explore the precise ineffective strategies to incorporate within the self-care training for new starters. A qualitative study using grounded theory interviewing staff who had experienced poor well-being due to work stress and exploring their personal coping strategies could address this gap. Future quantitative research could also explore the causal links highlighted within the current grounded theory study. For instance, testing whether breaks in and out of work, support from colleagues, feeling valued by management and positive changes in clients leads to increased staff's emotional resources, well-being and motivation to keep working.

REFERENCES

Ablett, J. R., & Jones, R. S. P. (2007). Resilience and well-being in palliative care staff: A qualitative study of hospice nurses' experience of work. Psycho-Oncology, 16, 733–740. doi: 10.1002/pon.1130

Aburn, G., Gott, M., & Hoare, K. (2016). What is resilience? An integrative review of the empirical literature. Journal of Advanced Nursing, 72, 980–1000. doi: 10.1111/jan.12888

Adshead, G. (1998). Psychiatric staff as attachment figures: Understanding management problems in psychiatric services in the light of attachment theory. British Journal of Psychiatry, 172, 64-69.

Aiken, L. H., Clarke, S. P., & Sloane, D. M. (2002). Hospital staffing, organization, and quality of care: cross-national findings. Nursing Outlook, 50, 187-94. doi:10.1067/mno.2002.126696

Ainsworth, M. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment: A psychological study of the strange situation (1st ed.). Oxford, UK: Lawrence Erlbaum Associates, Inc.

Appleby, L. (2010). Your guide to relational security: See, think, act. Retrieved from: https://www.rcpsych.ac.uk/pdf/STA_hndbk_2ndEd_Web_2.pdf

Bégat, I., & Severinsson, E. (2006). Reflection on how clinical nursing supervision enhances nurses' experiences of well-being related to their psychosocial work environment. Journal of Nursing Management, 14, 610-616. doi: 10.1111/j.1365-2934.2006.00718.x

Berry, K., & Drake, R. (2010). Attachment theory in psychiatric rehabilitation: informing clinical practice. Advances in psychiatric treatment, 16, 308–315. doi: 10.1192/apt.bp.109.006809

Chana, N., Kennedy, P., & Chessell, Z. J. (2015). Nursing staffs' emotional well-being and caring behaviours. Journal of Clinical Nursing, 24, 2835–2848. doi: 10.1111/jocn.12891

Chang, E. M., Daly, J., Hancock, K. M., Bidewell, J. W., Johnson, A., Lambert, V. A., & Lambert, C. E. (2006). The relationships among workplace stressors, coping methods, demographic characteristics, and health in Australian nurses. Journal of Professional Nursing, 22, 30–38. doi:10.1016/j.profnurs.2005.12.002

Charmaz, K. (2008). Reconstructing grounded theory. In P. Alasuutari, L. Bickman & J. Brannen (Eds.), the SAGE handbook of social research methods (pp. 461-478). London: SAGE Publications Ltd.

Charmaz, K. (2014). Constructing grounded theory (2nd ed.). London: SAGE Publications Ltd.

Coffey, M., & Coleman, M. (2001). The relationship between support and stress in forensic community mental health nursing. Journal of Advanced Nursing, 34, 397-407. doi: 10.1046/j.1365-2648.2001.01770.x

De Gucht, V., Fischler, B., & Heiser, W. (2003). Job stress, personality and psychological distress as determinants of somatization and functional somatic syndromes in a population of nurses. Stress and Health, 19, 195–204. doi: 10.1002/smi.975

Dennis, A. M., & Leach, C. (2007). Expressed emotion and burnout: the experience of staff caring for men with learning disability and psychosis in a medium secure setting. Journal of Psychiatric and Mental Health Nursing, 14, 267–276. doi: 10.1111/j.1365-2850.2007.01073.x

Department of Health. (2009). NHS health and well-being: Final report. Retrieved from: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_108907.pdf

Dey, I. (1999). Grounding grounded theory: Guidelines for qualitative inquiry (1st Ed.). San Diego, CA: Academic Press.

Duffield, C. M., Roche, M. A., Blay, N., & Stasa, H. (2011). Nursing unit managers, staff retention and the work environment. Journal of Clinical Nursing, 20, 23-33. doi: 10.1111/j.1365-2702.2010.03478.x.

Edward, K. L. (2005). The phenomenon of resilience in crisis care mental health clinicians. International Journal of Mental Health Nursing, 14, 142–148. doi: 10.1111/j.1440-0979.2005.00371.x

Elliott, K. A., & Daley, D. (2013). Stress, coping, and psychological well-being among forensic health care professionals. Legal and Criminological Psychology, 18, 187–204. doi:10.1111/j.2044-8333.2012.02045.x

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, 215-229.

European Commission. (2002). Guidance on work-related stress. Spice of life or kiss of death. Retrieved from: http://bookshop.europa.eu/is-bin/INTERSHOP.enfinity/WFS/EU-Bookshop-Site/en_GB/-/EUR/ViewPublication-Start?PublicationKey=CE2599851

Fagin, L., Brown, D., Bartlett, H., Leary, J., & Carson, J. (1995). The Claybury community psychiatric nurse stress study: Is it more stressful to work in a hospital or the community? Journal of Advanced Nursing, 22, 347-358.

Freudenberger, H. J. (1975). The staff burn-out syndrome in alternative institutions. Psychotherapy: Theory, research and practice, 12, 73-82.

García, G. M., & Calvo, J. C. A. (2011). Emotional exhaustion of nursing staff: influence of emotional annoyance and resilience. International Nursing Review, 59, 101–107. doi: 10.1111/j.1466-7657.2011.00927.x

Goncher, I. D., Sherman, M. F., Barnett, J. E., & Haskins, D. (2013). Programmatic perceptions of self-care emphasis and quality of life among graduate trainees in clinical psychology: The mediational role of self-care utilization. Training and Education in Professional Psychology, 7, 53– 60. doi: 10.1037/a0031501

Happell, B., Pinikahana, J., & Martin, T. (2003). Stress and burnout in forensic psychiatric nursing. Stress & Health, 19, 63-68. doi: 10.1002/smi.963

Hassard, J., Teoh, K., Cox, T., & Dewe, P. (2014). Calculating the cost of work-related stress and psychosocial risks: European risk observatory literature review. Retrieved from: https://osha.europa.eu/en/tools-and-

publications/publications/literature_reviews/calculating-the-cost-of-work-related-stress-and-psychosocial-risks

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, 324-40. doi: 10.1002/cpp.1834.

Hill, R. G., Rinaldi, M., Gilleard, C., & Babbs, M. (2003). Connecting the individual to the organization: Employers' response to stress in the workplace. International Journal of Mental Health Promotion, 5, 23–30. doi: 10.1080/14623730.2003.9721893

Itzhaki, M., Peles-Bortz, A., Kostistky, H., Barnoy, D., Filshtinsky, V., & Bluvstein, I. (2015). Exposure of mental health nurses to violence associated with job stress, life satisfaction, staff resilience, and post-traumatic growth. International Journal of Mental Health Nursing, 24, 403–412 doi: 10.1111/inm.12151

Jackson, D., Firtko, A., & Edenborough, M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. Journal of Advanced Nursing, 60(1), 1–9. doi: 10.1111/j.1365-2648.2007.04412.x

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

Johnson, D. W., & Johnson, F. P. (1987). Joining together: Group theory and group skills (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.

Johnson, H., Worthington, R., Gredecki, N., & Wilks-Riley, F. R. (2016). The relationship between trust in work colleagues, impact of boundary violations and burnout among

staff within a forensic psychiatric service. Journal of Forensic Practice, 18, 64-75. doi: 10.1108/JFP-03-2015-0024

Johnson, S., Lloyd-Evans, B., Howard, L. M., Osborn, D. P. J., & Slade, M. (2010). Where next with residential alternatives to admission? The British Journal of Psychiatry, 197, 52-54. doi: 10.1192/bjp.bp.110.081125

Johnson, S., Wood, S., Paul, M., Osborn, D., Wearn, E., Lloyd-Evans, B., … Killaspy, H. (2011). Inpatient mental health staff morale: a national investigation. Retrieved from: http://www.netscc.ac.uk/hsdr/files/project/SDO_ES_08-1604-142_V01.pdf

Jordan, T. R., Khubchandani, J., & Wiblishauser, M. (2016). The impact of perceived stress and coping adequacy on the health of nurses: A pilot investigation. Nursing Research and Practice, 5843256, 1-12. doi: 10.1155/2016/5843256

Kahlke, R. (2017). The qualitative quality conversation. Medical Education, 51, 3–10. doi: 10.1111/medu.13224

Kamphuis, J. H., & Emmelkamp, P. M. G. (2005). 20 years of research into violence and trauma past and future developments. Journal of Interpersonal Violence, 20, 167-174. doi: 10.1177/0886260504268764

Kelly, D., Lankshear, A., & Jones, A. (2016). Stress and resilience in a post-Francis world – a qualitative study of executive nurse directors. Journal of Advanced Nursing, 72, 3160–3168. doi: 10.1111/jan.13086

Koelsch, S., Boehlig, A., Hohenadel, M., Nitsche, I., Bauer, K., & Sack, U. (2016). The impact of acute stress on hormones and cytokines, and how their recovery is affected by music-evoked positive mood. Scientific Reports, 6, 1-11. doi: 10.1038/srep23008

Kurtz, A. (2005). The needs of staff who care for people with a diagnosis of personality disorder who are considered a risk to others. The Journal of Forensic Psychiatry & Psychology, 16, 399-422. doi: 10.1080/14789940500098475

Kurtz, A., & Jeffcote, N. (2011). 'Everything contradicts in your mind': A qualitative study of experiences of forensic mental health staff in two contrasting services. Criminal Behaviour and Mental Health, 21, 245–258. doi: 10.1002/cbm.796

Laschinger, H. K. S., & Leiter, M. P. (2006). The impact of nursing work environments on patient safety outcomes: The mediating role of burnout/engagement. The Journal of Nursing Administration, 36, 259–267.

Lazarus, R. S., & Folkman, S. (1984). Stress, Appraisal and Coping (1st Ed.). New York, USA: Springer Publishing Company Inc.

Leka, S., Griffiths, A., & Cox, T. (2004). Work Organization and Stress. Retrieved from: http://www.who.int/occupational_health/publications/pwh3rev.pdf?ua=1

Lim, J., Bogossian, F., & Ahern, K. (2010). Stress and coping in Australian nurses: a systematic review. International Nursing Review, 57, 22–31. doi: 10.1111/j.1466-7657.2009.00765.x

Ma, K. (2006). Attachment theory in adult psychiatry. Part 1: Conceptualisations, measurement and clinical research findings. Advances in Psychiatric Treatment, 12, 440–449. doi: 10.1192/apt.12.6.440

Mark, G. M., & Smith, A. P. (2012). Occupational stress, job characteristics, coping and the mental health of nurses. The British Psychological Society, 17, 505-521. doi:10.1111/j.2044-8287.2011.02051.x

Maslach, C., Jackson, S., & Leiter, M. P. (1996). Maslach Burnout Inventory (3rd ed.). Palo Alto, California: Consulting Psychologists Press.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. Annual Review of Psychology, 52, 397–422.

Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. Journal of Health Psychology, 11, 799-808. doi: 10.1177/1359105306066643

Morsiani, G., Bagnasco, A., & Sasso, L. (2017). How staff nurses perceive the impact of nurse managers' leadership style in terms of job satisfaction: a mixed method study. Journal of Nursing Management, 25, 119–128. doi: 10.1111/jonm.12448

Motowidlo, S., Packard, J. S., & Manning, M. R. (1986). Occupational stress: Its causes and consequences for job performance. Journal of Applied Psychology, 71, 618-629.

Myers, S. B., Sweeney, A. C., Popick, V., Wesley, K., Bordfeld, A., & Fingerhut, R. (2012). Self-care practices and perceived stress levels among psychology graduate students. Training and Education in Professional Psychology, 6, 55–66. doi: 10.1037/a0026534

Qi, Y. K., Xiang, Y. T., An, F. R., Wang, J., Zeng, J. Y., Ungvari, G. S., … Chiu, H. F. (2014). Nurses' work-related stress in China: A comparison between psychiatric and general hospitals. Perspectives in Psychiatric Care, 50, 27–32. doi: 10.1111/ppc.12020

Reid, Y., Johnson, S., Morant, N., Kuipers, E., Szmukler, G., Thornicroft. G., … Prosser, D. (1999). Explanations for stress and satisfaction in mental health professionals: a qualitative study. Social Psychiatry and Psychiatric Epidemiology, 34, 301-308.

Robertson, I. T., Cooper, C. L., Sarkar, M., & Curran, T. (2015). Resilience training in the workplace from 2003 to 2014: a systematic review. Journal of Occupational and Organizational Psychology, 88, 533-562. doi: 10.1111/joop.12120

Robertson, J., Hatton, C., Felce, D., Meek, A., Carr, D., Knapp, M., … Lowe, K. (2005). Staff stress and morale in community-based settings for people with intellectual disabilities and challenging behaviour: A brief report. Journal of Applied Research in Intellectual Disabilities, 18, 271–277. doi: 10.1111/j.1468-3148.2005.00233.x

Royal College of Nursing. (2009). Work-related stress: A good practice guide for RCN representatives. Retrieved from: https://www2.rcn.org.uk/__data/assets/pdf_file/0009/274473/003531.pdf

Royal College of Physicians. (2015). Work and wellbeing in the NHS: Why staff health matters to patient care. Retrieved from: https://www.rcpsych.ac.uk/pdf/RCP-%20WorkWellbeingNHS.pdf

Rutter, M. (1999). Resilience concepts and findings: implications for family therapy. Journal of Family Therapy, 21, 119–144.

Sandhu, D. K., Rose, J., Rostill-Brookes, H. J., & Thrift, S. (2012). ‘It’s intense, to an extent’: A qualitative study of the emotional challenges faced by staff working on a treatment programme for intellectually disabled sex offenders. Journal of Applied Research in Intellectual Disabilities, 25, 308–318. doi: 10.1111/j.1468-3148.2011.00667.x

Sarafis, P., Rousaki, E., Tsounis, A., Malliarou, M., Lahana, L., Bamidis, P., … Papastavrou, E. (2016). The impact of occupational stress on nurses’ caring behaviors and their

health related quality of life. BMC Nursing, 15(56), 1-9. doi: 10.1186/s12912-016-0178-y

Seligman, M. E. (1972). Helplessness. Annual Review of Medicine, 23, 407–412. doi: 10.1146/annurev.me.23.020172.002203

Shin, H., Park, Y. M., Ying, J. Y., Kim, B., Noh, H., & Lee, S. M. (2014). Relationships between coping strategies and burnout symptoms: A meta-analytic approach. Professional Psychology: Research and Practice, 45, 44 –56. doi: 10.1037/a0035220

Smith, J., Walshe, K., & Hunter, D. J. (2001). The “redisorganisation” of the NHS. BMJ, 323, 1262-1263. doi: 10.1136/bmj.323.7324.1262

Søndenaa, E., Lauvrud, C., Sandvik, M., Nonstad, K. & Whittington, R. (2013). Resilience and professional quality of life in staff working with people with intellectual disabilities and offending behavior in community based and institutional settings. Health Psychology Research, 1(1), e3. doi: 10.4081/hpr.2013.e3.

Spencer, L., & Ritchie, J. (2012). In pursuit of quality. In D. Harper & A. R. Thompson (Eds.), Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners (pp. 225-242). West Sussex, United Kingdom: John Wiley & Sons, Ltd.

Stewart, W., & Terry, L. (2014). Reducing burnout in nurses and care workers in secure settings. Nursing Standard, 28, 37-45. doi: 10.7748/ns2014.04.28.34.37.e8111

Totman, J., Hundt, G. L., Wearn, E., Paul, M., & Johnson, S. (2011). Factors affecting staff morale on inpatient mental health wards in England: a qualitative investigation. BMC Psychiatry, 11(68), 1-10. doi: 10.1186/1471-244X-11-68

Tusaie K., & Dyer J. (2004). Resilience: a historical review of the construct. Holistic Nursing Practice, 18, 3–10.

Wall, T. D., Bolden, R. I., Borrill, C. S., Carter, A. J., Golya, D. A., Hardy, C. E., … West, M. A. (1997). Minor psychiatric disorder in NHS trust staff: occupational and gender differences. The British Journal of Psychiatry, 171, 519–523.

Whittington, R., & Higgins, L. (2002). More than zero tolerance? Burnout and tolerance for patient aggression amongst mental health nurses in China and the UK. Acta Psychiatrica Scandinavica, 106, 37-40. doi: 10.1034/j.1600-0447.106.s412.8.x

Winstanley, S., & Whittington, R. (2002). Anxiety, burnout and coping styles in general hospital staff exposed to workplace aggression: a cyclical model of burnout and vulnerability to aggression. Work & Stress, 16, 302-315. doi: 10.1080/0267837021000058650

Wright, N., Zakarian, M., & Blake, H. (2016). Nurses' views on workplace wellbeing programmes. British Journal of Nursing, 25, 1208-1212. doi: 10.12968/bjon.2016.25.21.1208

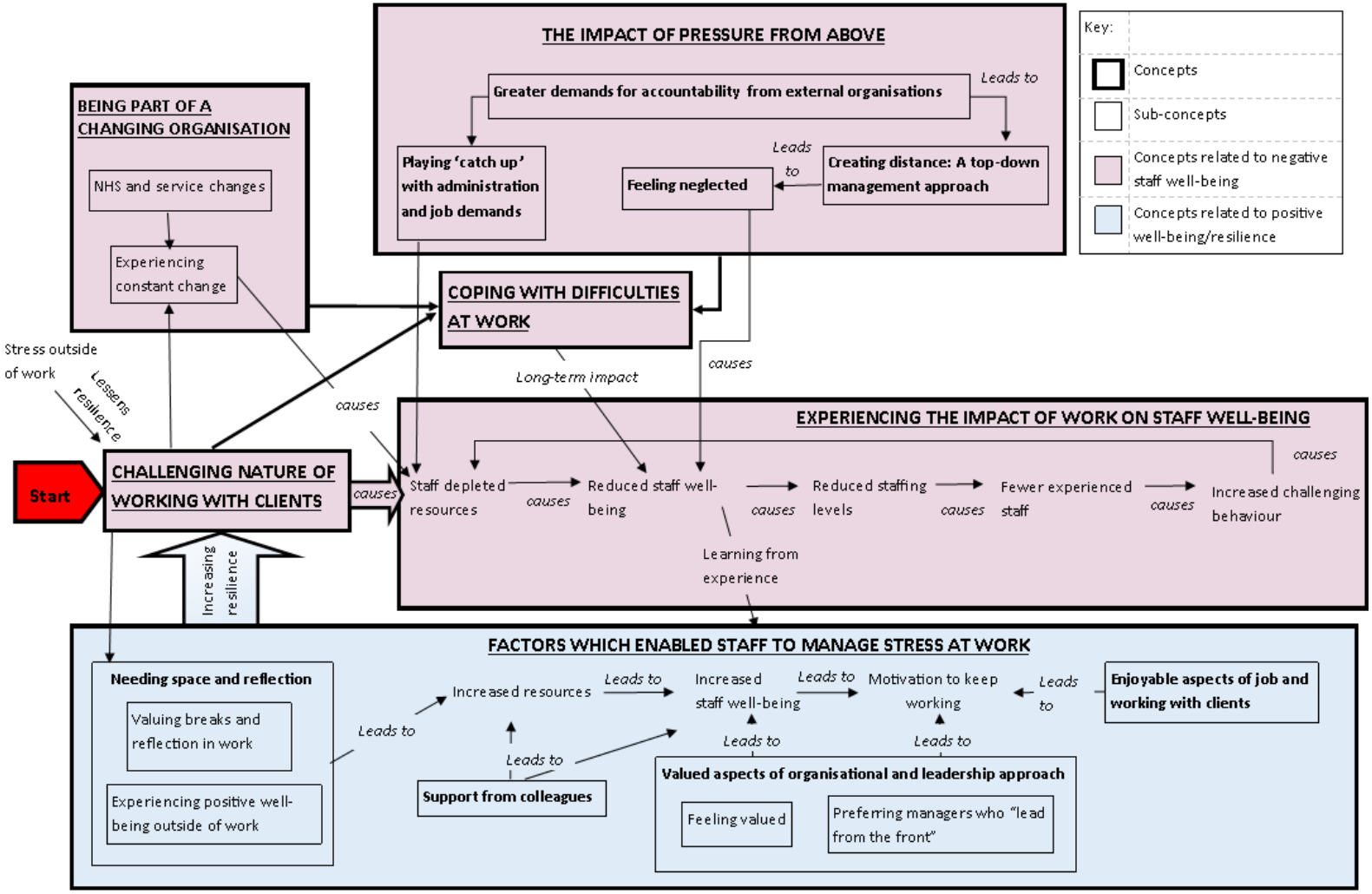


Figure 1. Model of staff perceptions of the factors contributing to resilience and well-being when working in secure services.

Table 1. Participants' job information.

Job title	Length of time working for the service
Occupational Therapy manager	27 years
Staff nurse	6.5 years
Support Assistant	1 year 4 months
Art Psychotherapist	12 years
Support Assistant	10 months
Clinical Leader	33 years
Staff nurse	8 years
Clinical Leader	9 months
Associate practitioner	20 months
Assistant Psychologist	3 years
Forensic Social Worker	10 years

APPENDICES

Appendix 2-A. Example of a coded transcript.

Transcript	Initial Codes	Focused codes
Interviewer: So how do you think it affects you, your well-being when for example you have got a situation where a client, you've got to say to them you can't go out and actually they've had quite a bad day, how does that affect your well-being?		
Participant: It's quite draining because especially because it's such a long day it's constant you just feel like completely drained like emotionally it's hard to not let it get to you aswell especially when you first start it's hard not to take things personally because obviously they're going to try and throw personal things at you and like abuse and things so just kind of have to take don't take it personally brush it off and try and leave everything that happens here here otherwise if you take it home and you end of taking it out on other people and you just sort of have to remember every time a service user lashes out at you and like is quite abusive towards you they always apologise afterwards and I mean it's dependent on the service user like some service users you have better relationships with so it's a bit upsetting sometimes when you feel like you've built up a good relationship with one of the service users and they sort of like quite abusive towards you but you just sort of like have to think it's like not personal like if it was the other way round and I was being told that I couldn't do something then obviously that would be upsetting cause they're like a grown person and especially because I'm like younger than them aswell sometimes it's difficult to keep that like authority there Time-frame [11mins] Interviewer: Yeah definitely.	Feeling drained when trying to motivate clients Experiencing negative impact on own emotions Trying to not take comments personally from service users Trying to leave negative experiences at work Being aware of projecting negative experiences onto people outside work Receiving apologies for being subject to abuse Experiencing better relationships with some service users Being upset when certain service users are abusive Being compassionate about reasons behind service user actions Finding age gap difficult when being authoritative	32. Experiencing impact of work on well-being 32. Experiencing impact of work on well-being 8. Distancing self 8. Distancing self 32. Experiencing impact of work on well-being 32. Experiencing impact of work on well-being 4. Experiencing positive aspects of clients 32. Experiencing impact of work on well-being 22. Making sense of client experiences 27. Feeling powerless
Participant: But erm you just have to try and have to not let it get it you really like some days it's going to be horrible and some days it's going to be really good so you just have to like take every day as it comes I think it helps when you work with really good staff as well like they can sort of	Trying to distance self from personal attacks from service users Experiencing ups and downs of work	8. Distancing self 32. Experiencing impact of work on well-being

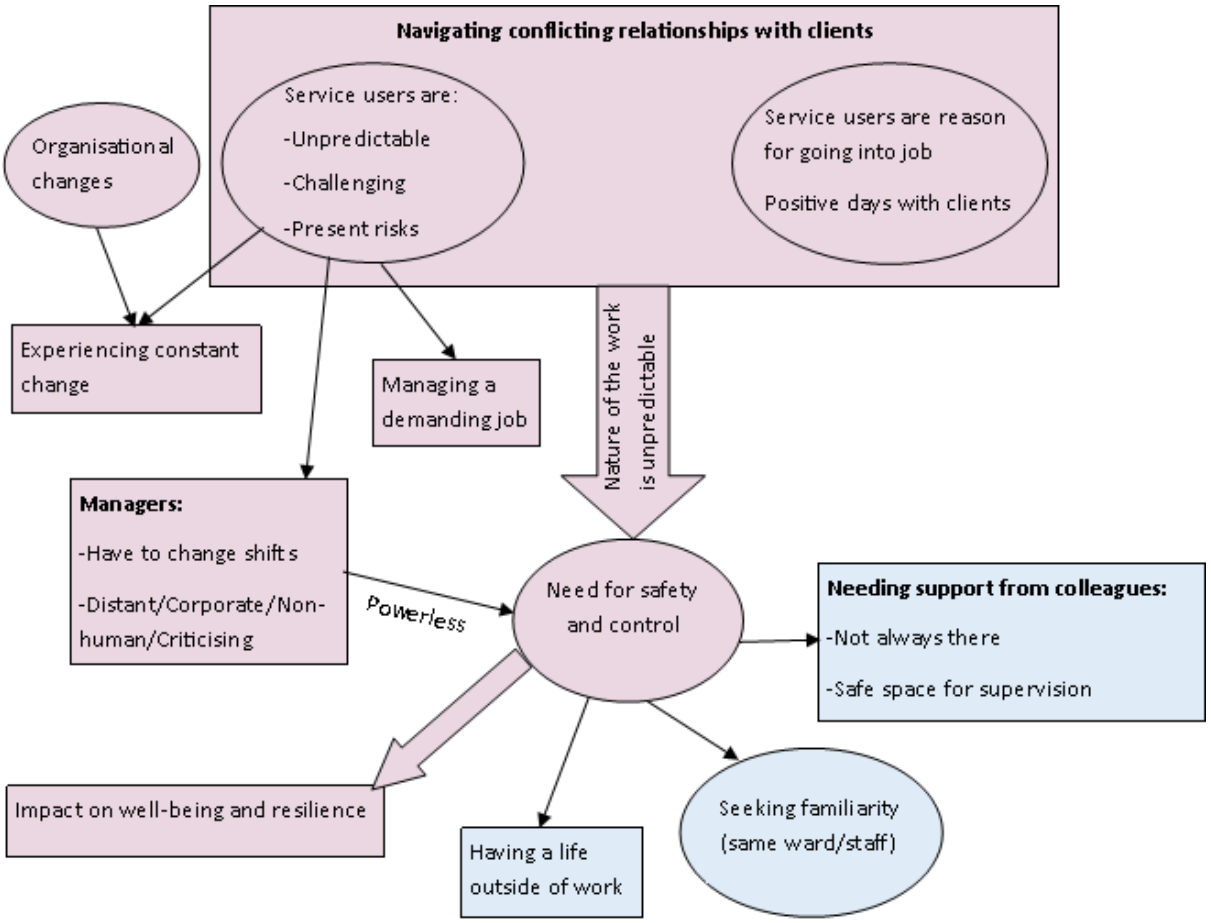
support you as well erm yeah and if the people around you are quite experienced as well that really helps definitely	Working alongside supportive staff is a positive aspect of work	6. Supporting one another
Interviewer: Okay so … can we go back to when you first came you sort of described that it was a little bit harder to not take it personal, can you think of a specific time when maybe if a service user in your words abuse towards or said something that maybe quite difficult, and it felt like maybe you did take it personally? [p: yeah] Can you think of a time when maybe you had?		
Participant: Yeah I can think of a few times but there's like a specific time where one service user he tends to like try to abscond er and cause I have quite a good relationship with him I used to take it quite personally he'd erm sort of had had a bad day felt like nothing was going his way basically just said like swearing and effing and jeffing and saying like do you know what I'm just going to run off because we live on like an open flat obviously if he wants to run off then I can't really do much to I can pull my blick and everything and do what I can but that's all I can do and obviously like run after him but yeah that day he was like running off and like swearing at me and telling me to get lost basically and just saying proper personal like "I hate you" "I've never liked you" "You've done nothing for me" and it's just really hard not to take that personally and also not to say anything back so you've sort of like got to hold you tongue a little bit like you kinda because you can't really get into a shouting match with them so that was difficult and then obviously you just think like all this effort that I've put in with this service user kind of like like what has it kind of gone to waste but it hasn't you just have to but that was like a hard day because he was personally insulting me and stuff when you feel like you've done loads for them but they're like saying basically you haven't helped me that sort of thing	Building up a positive relationship with a specific service user Taking insults personally Being threatened by a service user Being helpless against service users absconding Having limited options to prevent service users leaving Experiencing verbal abuse from a service user Being professional in spite of own reactions to being verbally abused Feeling unappreciated by service users Experiencing difficult days Experiencing challenges through putting effort into service users and being insulted	4. Experiencing positive aspects of clients 8. Distancing self 20. Experiencing challenges of working with service users 27. Feeling powerless 27. Feeling powerless 20. Experiencing challenges of working with service users 30. Invalidating self 36. Feeling unappreciated 32. Experiencing impact of work on well-being 36. Feeling unappreciated

Appendix 2-B. Example memo and clustering technique.

Memo following the first phase of interviews

Staff have very demanding jobs and work with incredibly challenging service users. The nature of the work is unpredictable and organisational difficulties mean that staff experience constant change. As a result of organisational pressures, managers and senior staff are critical of nursing and MDT staff as pressure increases. Staff feel criticised, anxious about uncertainty, unappreciated, unsupported but often experience feeling powerless against these challenges. All of this impacts on their well-being in and out of work and they cope by seeking safety through colleagues' support, preferring familiarity but also by distancing themselves from the work and invalidating their own feelings by ignoring how they feel and forcing themselves to get on with the job. Some staff have family support and have positive well-being outside of work which helps to improve their well-being and resilience.

Clustering during analysis following the first phase of interviews



Appendix 2-C. Summary of author guidelines for Journal of Advanced Nursing.

Empirical research - qualitative

Organising your manuscript:

Your title page should include the following information:

- Full title (maximum 25 words)
- Running head
- Author details: names (please put last names in CAPITALS), job titles and affiliations (maximum of 3 per author), qualifications (maximum of 3 per author, including RN/RM where appropriate)
- Acknowledgements (if applicable)
- Conflict of Interest statement
- Funding Statement

In general we do not include country names in published articles and therefore encourage you to omit these from your manuscript title.

Impact Statement

We ask all authors to prepare a short statement (approximately 100 words), using bullet points if necessary, on any impact you see your paper having in terms of patients, clinical practice, education, or wider social and economic issues. This will be seen by editors and reviewers and may be used for promotional purposes.

Main file, to include:

Abstract: 250 words. Your abstract should include the following headings: Aims (of the paper), Background, Design, Methods (including year of data collection), Results/Findings, Conclusion. The Aim should simply state: ‘To…”

Summary Statement: See the Summary Statement guidelines.

Keywords: A maximum of 10, including nurses/midwives/nursing.

Main Text: To include the headings below and references.

Tables and figures should be uploaded separately.

The main text of your report should include the following headings:

INTRODUCTION

Clearly identify the rationale, context, international relevance of topic.

Background

Present the conceptual or theoretical framework that guided the study, and where appropriate identifying and providing an overview of the conceptual model and/or theory. Identify and define key concepts. As appropriate, explain the connections between the conceptual model or theory and the phenonema of interest. Explain connections between study variables and support those connections with relevant theoretical and empirical literature. Provide a substantial, critical review of relevant theoretical and empirical literature. Identify the rationale for selection of the phenomenon studied. Note that simply stating that the phenomenon has not yet been studied is not sufficient, as some phenomena may be trivial and, therefore, are not worthy of study. Simply stating that it has not been studied in your country is also not acceptable. You should explain the potential added value of your study to existing knowledge.

THE STUDY

Aim/s

State the aims of the study as a narrative study purpose or as research questions, for example, 'The aim of the study was to…' If the study is about the 'experience' of a particular phenomenon, be as clear as possible about the aspect/s of the experience on which you wish to focus.

State a research question(s) appropriate for the methodology.

Design

Describe research design, for example, grounded theory, phenomenology, ethnography.

Sample/Participants

Identify the specific purposeful sampling strategy/strategies used–theoretical, maximum variation, extreme case. For example, 'A sample of Registered Nurses was recruited using maximum variation sampling for number of years of nursing experience.' Identify the inclusion and exclusion criteria. For example, 'The inclusion criteria were…', 'The exclusion criteria were…' Explain how participants were recruited. Identify the size of the sample and provide justification for participant numbers that addresses data saturation or another criterion. Detail of participants (gender, age, condition, peculiarities etc.), which can help readers to put the finding in context, should be provided. This can be listed in a table.

Data collection

Use subheadings for different types of data collection techniques if appropriate, e.g., interview guides, observation checklists. For example, 'Data were collected using an interview guide…', 'Focus groups were conducted …'. Describe each technique used to collect the data, such as interview guide questions, or observation checklist items. Include information about number and type of items and scoring technique, as well as interpretation of scores, if relevant. Pilot study – if done, what changes (if any) did this lead to for the main study?. Identify the period of data collection (e.g. between November 2008 - June 2009); usually this should be no more than 5 years before submission of the manuscript.

Ethical considerations

Identify any particular ethical issues that were attached to this research. Remember that there are specific ethical issues related to specific methods (e.g. interviews, observations). Provide a statement of ethics committee approval. Do not name the university or other institution from which ethics committee approval was obtained. State only that ethics committee approval was obtained from a university and/or whatever other organisation is relevant.

Data analysis

Describe the techniques used to analyse the data, including computer software used, if appropriate. For example, 'The data were analysed using NVivo Version X. The data were analysed using thematic content analysis…'.

Validity and reliability/Rigour

Describe procedures for assuring trustworthiness of qualitative data, including types of dependability and credibility used. If tools were developed for this study, describe the processes employed. Please ensure that you make reference to the literature on qualitative rigour in this section.

FINDINGS

Start with a description of the actual sample. For example: 'The study participants ranged in age from X to Y years…'

Present findings explicitly for each study aim or research question.

Use subheadings as appropriate.

Provide a brief summary of the findings. This should include the themes, stages or patterns (as appropriate). Then explain how each theme emerged and what each consists of (with relevant quotes from participants). Explain how the themes interrelate to produce a conceptual or theoretical understanding of the phenomenon you studied.

When using extracts of data from your study to illustrate a theme, ensure that you provide some way for the reader to link this to your participants. This could be by linking a table of demographics and pseudonyms to the data you use in the findings section. This enables the reader to link the words of the participant to their demographic details. It also allows the reader to judge how many of your participants are used in the findings and also that there is not, for example, over reliance on a small group of participants.

If your sample consisted of different groups (e.g. patients and nurses or nurses of different grades and position), the findings should reflect each of the groups.

When two or more methods (e.g. interviews and observations) are used in the same study, you should ensure that findings of both methods are reported adequately.

Use the literature in the findings section only if it informs or extends your analysis, not that it merely confirms what you found. This can be done in the discussion section.

DISCUSSION

Discussion must be in relation to the literature. Do previous research findings match or differ from yours? Do not use literature which only supports your findings.

Draw conclusions about what new knowledge has emerged from the study. For example, this new knowledge could contribute to new conceptualisations or question existing ones; it could lead to the development of tentative/substantive theories (or even hypotheses), it could advance/question existing theories or provide methodological insights, or it could provide data that could lead to improvements in practice.

Limitations

End with study limitations including but not confined to sampling considerations, trustworthiness and transferability of the findings.

CONCLUSION

Provide real conclusions, not just a summary/repetition of the findings.

Draw conclusions about the adequacy of the theory in relation to the data. Indicate whether the data supported or refuted the theory. Indicate whether the conceptual model was a useful and adequate guide for the study.

Identify implications/recommendations for practice/research/education/management or policy as appropriate, and consistent with the limitations.

References

References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information about APA referencing style, please refer to the APA FAQ. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one.

Journal article

Example of reference with 2 to 7 authors

Beers, S. R., & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. The American Journal of Psychiatry, 159, 483–486. doi:10.1176/appi.ajp.159.3.483

Ramus, F., Rosen, S., Dakin, S. C., Day, B. L., Castellote, J. M., White, S., & Frith, U. (2003). Theories of developmental dyslexia: Insights from a multiple case study of dyslexic adults. Brain, 126(4), 841–865. doi: 10.1093/brain/awg076

Example of reference with more than 7 authors

Rutter, M., Caspi, A., Fergusson, D., Horwood, L. J., Goodman, R., Maughan, B., … Carroll, J. (2004). Sex differences in developmental reading disability: New findings from 4 epidemiological studies. Journal of the American Medical Association, 291(16), 2007–2012. doi: 10.1001/jama.291.16.2007

Book edition

Bradley-Johnson, S. (1994). Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school (2nd ed.). Austin, TX: Pro-ed.

Edited Book

Hawkley, L. C., Preacher, K. J., & Cacioppo, J. T. (2007). Multilevel modeling of social interactions and mood in lonely and socially connected individuals: The MacArthur social neuroscience studies. In A. D. Ong & M. Van Dulmen (Eds.), Oxford handbook of methods in positive psychology (pp. 559–575). New York, NY: Oxford University Press.

Unpublished paper presented at a meeting

Lanktree, C., & Briere, J. (1991, January). Early data on the Trauma Symptom Checklist for Children (TSC-C). Paper presented at the meeting of the American Professional Society on the Abuse of Children, San Diego, CA.

Unpublished thesis

Willey, D. E. (1989). Interpersonal analyses of bulimia: Normal weight and obese. Unpublished thesis, University of Missouri, Columbia.

Electronic reference

Author, A. A. (2000). Title of work. Retrieved from http://blogs.edweek.org/edweek/civic_mission/2013/10/the_moral_limits_of_school_choice.html

Proceedings

Sloetjes, H., & Wittenburg, P. (2008). Annotation by category: Elan and iso dcr. Proceedings of the Sixth International Language Resources and Evaluation (LREC’08), Marrakech, Morocco.

Figures and tables

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Section Three: Critical Appraisal

A Journey of Learning to be a Grounded Theorist and Giving Staff a Voice

Word Count: 3998

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INTRODUCTION

The aim of this paper was to offer a critical reflection of my journey through this research project. Firstly, the decision-making process surrounding the design of the research study will be summarised. Secondly, I will explore my experience of giving staff an opportunity to share their opinions and experiences of well-being and resilience. Thirdly, my journey to becoming a grounded theorist will be reflected upon through the discussion of sampling, managing my assumptions within the research and building a model. Finally, I will share my reflections on the research journey retrospectively by discussing how the findings have informed my clinical practice and considering the findings within the existing literature base. Methodological considerations, strengths and limitations of the research are explored throughout.

DECIDING ON A PROJECT

My interest in the well-being of staff began whilst working as a support worker within a forensic medium-secure unit. I experienced first-hand the perceived dissonance between the needs of staff and the needs of service users. Witnessing staff feeling stressed and demotivated from the organisation was something I felt motivated to change in my future career as a clinical psychologist. When choosing a topic area for my thesis, I decided to pursue a project exploring staff well-being.

The need to preserve the well-being of National Health Service (NHS) staff in order to improve patient outcomes has been emphasised in the literature (Black 2012). However, this appears to be juxtaposed to NHS England's position highlighted in the recent document 'Putting patients first' (NHS England 2013). This document rightly posited that patient care should be the main focus within healthcare organisations, however the 11-point scorecard indicated that the well-being of staff was second priority (NHS England 2013). One would

argue that good patient care and staff well-being are inexplicably linked. Within the context of healthcare in the United Kingdom (UK) recently, there has been good reason for this move towards greater consideration of the needs of NHS service users, in light of the findings put forward in the Francis Inquiry regarding the 'failings' of care (Francis 2013). However, in the midst of this, it appears that the needs of staff have been forgotten; Kelly *et al*. (2016) have argued that in a "post-Francis world" (p. 3160) scandals related to quality of care puts increasing pressures on executive nurse directors and the consideration of resilience in managing such stressors is timely.

In pursing my interest in staff well-being, I consulted the literature base which illustrated how resilience has been shown to help staff to positively adjust to workplace adversity (Jackson *et al*. 2007). The concept of resilience appeared to be pertinent to the forensic setting in particular as forensic services are often acknowledged as dangerous and stressful environments (Jones *et al*. 1987). Previous research has highlighted the need to research resilience in staff working in forensic mental health settings (Søndenaa *et al*. 2013). Moreover, as there was a dearth of research exploring resilience and well-being within this setting, I decided to use a qualitative design as this mode of inquiry is helpful to research into areas where little has been known and explored (Strauss & Corbin 1998).

Resilience has been considered to be a dynamic concept (Rutter 2012). This meant that rather than simply identifying the factors which contribute to resilience and positive well-being, I was interested in how such mechanisms influenced staff well-being. Grounded theory is a qualitative approach which is based upon characterising processes or actions being explored (Creswell 1998). Moreover, as little was known about resilience and well-being within the forensic setting, the focus was on building a theory using an inductive approach rather than having 'a priori' assumptions (Glaser & Strauss 1967). Furthermore, commencing the project with my own subjective beliefs and experiences fitted with a constructivist

grounded theory approach as it acknowledges the researcher's involvement in the construction and interpretation of the data (Charmaz 2014). It has also been argued that resilience research has largely been studied from a positivist framework, however researching the social construction of resilience informed by people's views and contexts can add valuable understanding to this concept (Aburn *et al*. 2016).

GIVING STAFF A VOICE

In considering where to conduct interviews, I was aware of staff being under significant time-pressures and I was keen to give staff the opportunity to interview. This led to my decision to conduct interviews on working premises to maximise convenience for staff. However, this posed the ethical issue of confidentiality due to staff interviewing during the working day as there was the potential of staff being seen by their colleagues; this was highlighted to participants both in the participant information sheet and within the confidentiality explanation prior to the interview. Measures to minimise this were taken, for instance I did not disclose names of participants when I booked rooms.

One salient feature of staff accounts was a feeling of powerlessness against experiencing adversity within the workplace. I was struck with how staff felt they had little choice in this and how they felt that their voices went unheard. This became a significant finding across both the literature review and research paper, which was understood in terms of the concept of learned helplessness (Seligman 1972). At times, this made me reflect on whether the findings of this study would be 'heard' which I discussed in my reflective diary: "I feel quite hopeless about feeding back points and any changes happening". When making sense of this finding, I had to be cautious not to contaminate the data between the two papers. I took a number of steps to avoid this through the use of my reflective diary and draft reads from my supervisors.

During the interviews, many participants became tearful when recalling their experiences of challenges and stress at work. Although the interview questions were not designed to elicit difficult emotions, on reflection the nature of discussing challenges at work understandably brought up these feelings. The possibility that participants may have become upset by discussing the topic areas was highlighted in the participant information sheet. When participants did become upset, I stopped the interview to give participants time and space to experience these emotions whilst offering support in line with my role as a researcher. Participants were made aware that they did not need to continue with the interview should they wish not to. Time was also spent after the interview discussing the debrief form and signposting staff to additional support if necessary. I was mindful of balancing my role as a researcher and my role as a trainee clinical psychologist.

When consent was sought to continue the interview in adherence with ethical guidelines, all participants reported wanting to continue with the research interview. At the end of the interview, many participants reported that discussing difficulties at work was helpful. I sought to put participants at ease prior to and during the interview by thoroughly explaining the research interview process and perhaps this contributed to creating a safe place for staff to share their experiences. On reflection, perhaps the lack of perceived formal debriefing or supervision for staff meant that the research interview was a welcomed opportunity to reflect on some of the challenges at work. This was consistent with the findings of the present study and previous research whereby staff reported needing breaks and opportunities for reflection in work (Wright *et al.* 2016). A contributing factor in this could have been that interviews took place on working premises, and for some staff the interview took place within their working day. In future, I and other potential researchers should be mindful of the professional support systems that staff have in place before and after research interviews, in addition to considering the setting of the research interview.

LEARNING TO BE A GROUNDED THEORIST

My journey to becoming a grounded theorist began with apprehension due to having limited previous experience in using this methodology. My initial reflections included feeling overwhelmed which soon changed to feeling clearer as I began reading around the approach. I was aware of the potential issues of conducting a grounded theory study within the time constraints of my doctoral training, however I was keen to utilise the key features of the approach.

Traditional grounded theory methods suggest that literature around the topic area should be 'ignored' to avoid contaminating the emergence of data (Glaser & Strauss 1967). However, Ramalho *et al*. (2015) have argued that this is not realistic given that a literature review is needed for funding bodies and ethics committees. A constructivist grounded theory framework offers a more pragmatic approach to this issue by suggesting that researchers should allow previous research to "lie fallow" (Charmaz 2014, p. 307) until the categories have been developed. This was the approach I took, whereby I engaged critically with enough literature to develop a protocol and then suspended my reading until I had developed the conceptual categories.

In taking a break from the literature base, this enabled me to reflect on the experience of challenges within different healthcare settings and contexts. This evoked my interest in exploring research around nurse's experience of adversity within the emergency department (ED), and I noticed a consistent theme in the qualitative literature regarding the experience of violence and aggression within the ED. No previous attempts to review this literature had been conducted. Therefore, I decided to conduct a meta-synthesis of qualitative studies exploring staff experiences of violence and aggression in the ED.

Sampling

In line with grounded theory methodology, I interviewed staff in three distinct phases. This allowed me to follow areas of interest in initial data analysis to shape subsequent data collection and analysis which is consistent with theoretical sampling (Howitt 2010). After the first phase of interviews, support from colleagues was a prominent concept, however I was unclear about the mechanisms which underpinned this support. Additionally, at this point I had not obtained a staff nurses' perspective in the research. In the next phase of interviews, I sought greater clarity on the type of support which leads to positive well-being and when support from colleagues no longer fits, from a staff nurse's point of view.

In terms of sampling, one site was undergoing a merger with another trust which may have impacted on the uptake for this study. NHS trust mergers have been shown to have a significant impact on staff through feelings of negativity and demotivation (Cortvriend 2004). Initially, a greater number of staff opted in from this site compared to the other site. This could have been due to the significant organisational changes staff were experiencing which meant that participants who opted in from this site had more to say about resilience and well-being. In order to make the results more transferable, an email was circulated across the second site three times to maximise the potential pool of participants to invite to interview. This enabled me to recruit a total of 11 participants between the two sites.

One of the strengths of this research was the recruitment of staff both across a range of professional disciplines and management structure thus making the findings more transferable across various staff members.

Reflexivity

Reflexivity has been defined as the conscious revelation of researchers' beliefs and values as a deliberate attempt at self-scrutiny in relation to the research process, and has been considered as some of the "hallmarks of a good thesis" (Hellawell 2006, p. 483). Throughout

the process, I kept a reflective diary to remain reflexive and avoid influencing the data with my own pre-conceptions in line with constructivist grounded theory (Charmaz 2014). This diary captured my observations and assumptions in the design, collection, analysis and interpretation of staff experiences. The use of memos also facilitated this process.

During interviews, I endeavoured to develop a style of questioning which elicited mechanisms but did not impose my pre-existing assumptions. The term ‘resilience’ is a construct which currently has no universally accepted definition (Aburn *et al*. 2016). To avoid my own and participants’ assumptions regarding resilience, I asked broader questions about participants’ ‘ability to manage stress’ or factors which helped staff during difficult times, alongside examples of events to support participants’ beliefs. This enabled me to de-construct the meaning of participants’ narratives. This is consistent with a constructivist framework in that I elicited participants’ definition of terms, situations and events to understand their implicit meanings (Charmaz 2014). Moreover, asking “how” questions enabled me to gather rich data regarding the mechanisms and processes between concepts. Supervision was also a helpful forum for reflecting on different questions in addition to the use of a mock interview.

One particular challenge within this research was avoiding the use of technical language when interviewing staff within a professional context. Reflecting on this meant I had to consider my own position within the research. Such consideration led me to the debates surrounding the ‘insider’ and ‘outsider’ research, whereby ‘insiders’ are members of specified groups whereas ‘outsiders’ are non-members (Merton 1972). Being an NHS professional myself, I may have been considered an ‘insider’ which could have given rise to engaging in professional conversations with staff in addition to making assumptions about the meaning of the language participants used. Hellawell (2006) has suggested that the researcher is constantly shifting on a continuum between being an insider and an outsider. Breen (2007)

has argued that the dichotomy between insider/outsider is simplistic, and suggests that she was ‘in the middle’ when she researched an area in which she had observed other people experience. Within this research, I also considered myself to be ‘in the middle’ whereby I was able to fully immerse myself in staff experiences whilst maintaining the rigour of the research through conducting a detailed audit throughout and sharing analysis at regular intervals with my supervisors.

Another feature within my reflective diary was the consideration of the political and economic climate affecting healthcare and NHS services during the time in which the research was conducted. Interviews took place soon after the UK’s vote to leave the European Union (EU), which has created significant uncertainty for healthcare services in the UK particularly around NHS staffing and funding of services (McKenna 2016). With such uncertainty, this may have had an impact on how it felt to be a staff member working for the NHS at this time. These issues were present in some of the interviews:

> It's whether there will be an NHS by the time I retire in 5 years and I think there's a question mark about that… This hospital won't be here I don't suppose, I might still be a nurse somewhere else but I might not be that will mean that there will be a significant impact on my pension and all my projections of what my retirement might look like but Jeremy Hunt and … Theresa May she's not interested in that it's of no concern to her at all (Eric)

Being an NHS professional, I was acutely aware of my own assumptions and feelings surrounding such issues. My reflective diary was used to express and process my feelings after this interview:

> I feel upset about the state of the NHS future after that interview. I feel that the research is pointless and redundant but know that this is a reflection of the issues

discussed. One significant issue he talked about was nurses having an increasing workload due to CQC whilst facing more funding cuts and privatisation.

In light of this, I had to be cautious regarding my data around change, management and demands for accountability from external organisations. This was exacerbated by staff's use of the term 'management' which I came to learn was used interchangeably to mean any person perceived to be senior even if they were external to the organisation. I had to be clear during interviews about who staff perceived was driving the demands or changes. This resulted in separate categories of 'being part of a changing organisation' and 'the impact of pressure from above'. Objectively looking at the model, one may assume that these categories are explicably linked, however the theory was grounded in participants' data which conceptualised these issues as separate. Caution around language was also paramount during interviews; when staff used terms such as "corporate culture" and "tick-box" I had to clarify the meaning that participants attributed to these terms and how these impacted on their experience as a member of staff.

Building a model

In relation to the contentious issue of data saturation versus data sufficiency, Salaff (2001) posed the question "When have we collected enough data?" (p. 415) to highlight the subjectivity of data saturation posited in traditional grounded theory approaches. Salaff (2001) argues that current grounded theory approaches provide limited guidance around when to stop collecting data. When considering this issue within my own research, this brought me to Dey's (1999) notion of data sufficiency; this viewpoint also fit with the constraints of my doctorate. Thus, after 11 participants and a third phase of interviewing, enough data had been collected to construct a model.

In grounded theory, categories and sub-categories are often 'dimensionalised' and presented on a continuum (Creswell 1998). This was one area of challenge with the data within this study as the processes within and between categories and sub-categories were not linear. On reflection, attempting to represent my developing theory visually brought feelings of chaos and frustration at the time. I reflected on this in my diary: "I feel quite blank about the diagram and 'chaos' comes to mind – I think this is a reflection of perhaps how staff feel" (After 8th interview). The richness of the data were more suited to being described narratively initially, and the use of free writing was a helpful tool for developing the theory.

The end result was a precise account of the mechanisms and processes which influenced well-being and resilience in staff working within the forensic setting specifically. The results illustrated how staff resources were depleted through working with clients with challenging needs, working in a changing organisation and experiencing the impact of pressures from above. This had a negative impact on staff well-being. The findings also showed that staff's ability to manage such stressors within this setting were mitigated by the use of breaks and reflection, receiving staff support, having 'present' leaders and experiencing positive aspects of working with clients.

REFLECTIONS ON MY JOURNEY

There are numerous ways in which the findings of the present study have informed my future clinical practice. Firstly, being a trainee clinical psychologist and undertaking a thesis project which brought significant stress and tested my own resilience was experienced as ironic in the latter stages of the write-up. This brought me to my first learning point as the findings highlighted the importance of self-care in mitigating the impact of stress. In my future role as a clinical psychologist, I would look to promote self-care training within my workplace in addition to sharing psychological knowledge which would inform this induction training.

This study also enabled me to take a critical stance on the use of debriefs and formal supervision groups offered by clinical psychologists, and consider other ways to support multi-disciplinary professionals through reflective breaks.

The long-awaited reading around the literature regarding resilience enabled me to reflect on where the study findings fit in terms of the existing literature base. Previous attempts to define resilience have proved unsuccessful: it has been suggested that resilience is "not an all-or-none phenomenon" (Luthar *et al*. 1993, p. 713), and that it is a dynamic concept (Aburn *et al*. 2016). As reading around resilience was suspended until after the model was developed, I was interested to discover that some authors perceived resilience to be linked to personality and personal characteristics, whereas other researchers perceived resilience as a process of positive adjustment to a challenging environment (Masten 2011).

Previous research has shown that hardiness, defined as a strong commitment to oneself, a sense of meaning and an internal locus of control (Kobasa 1979) has been found to moderate the effects of stress (Ablett & Jones 2007). One conceptual model of resilience proposed by Soderstrom *et al*. (2000) suggested that hardiness and problem-focused coping strategies were found to positively influence perceived stress and illness. This model was a good fit for business workers, however as suggested by Kelly *et al*. (2016) caution must be taken when translating conceptualisations of resilience across domains. Specifically, problem-focused coping may not be possible within the forensic setting. This has been highlighted in previous research whereby staff working in forensic settings are considered to have limited control over their workload as institutions tend to place greater emphasis on routines and hierarchical systems (Søndenaa *et al*. 2013). Thus, the present model extends previous research by highlighting how staff can manage stressful situations when they have limited control, such as within the forensic setting. The consideration of the context in which staff made sense of resilience may be considered a strength of the research, as suggested by

Tusaie and Dyer (2004). These findings could be transferred across other situations to offer an understanding of how people can be resilient in circumstances which are beyond their control. Future research could provide support for this notion by exploring staff perceptions of resilience in similar settings such as mental health hospitals.

It should also be acknowledged that the influence of personal attributes was relatively absent within the model. In retrospect, had I engaged in more reading around resilience prior to developing the model, this may have helped me to gather more information from staff about the influence of personal characteristics on their ability to manage stress in the forensic setting. However, this could have also influenced my own pre-conceptions regarding the construct of resilience. Therefore, this could also be considered a strength of the research whereby the results were not 'contaminated' by the findings of prior research, but in fact it demonstrates that the results were grounded within the data of participants.

Due to the time constraints of conducting a grounded theory study as part of clinical psychology doctoral training, a full grounded theory study in its purest form was not feasible. To overcome this limitation, future research could recruit participants across a greater number of forensic sites and include more views of senior management to supplement existing research exploring resilience in executive nurse directors (Kelly *et al*. 2016).

The findings of the present study showed that staff could actively engage in activities to increase their ability to manage stress in situations when they had limited control, for instance through the use of breaks and reflection in addition to seeking support from colleagues. This is consistent with previous research which has concluded that nurses can actively participate in strengthening their own resilience to workplace adversity (Jackson *et al*. 2007). Therefore, based on the findings of the present study, future conceptualisations of resilience within the forensic setting or similar should take account of the following: (1) resilience is a dynamic concept, (2) resilience can increase a person's ability to cope with

stressors which are beyond their control, (3) and people can actively participate in activities which strengthen their resilience.

CONCLUSION

The findings of the present study offer new understanding regarding the mechanisms that influence staff well-being and resilience in the forensic setting which is a context relatively unexplored in the existing resilience literature base. Previous conceptualisations of resilience have highlighted personality in the ability to manage stressors. However, the current study extends previous research by proposing an understanding of how staff actively engaged in activities to improve their resilience in addition to being resilient when faced with uncontrollable challenges. The current study emphasised the need for education for staff regarding effective self-care strategies which are fundamental for staff working in forensic secure services. Future research exploring the role of resilience in other contexts whereby staff or people have limited control would provide further understanding of the construct. On reflection, the research journey has enabled me to highlight the importance of considering staff well-being as a way of positively impacting on client outcomes within the current turbulent political and economic climate of healthcare services in the UK.

REFERENCES

Ablett, J. R., & Jones, R. S. P. (2007). Resilience and well-being in palliative care staff: A qualitative study of hospice nurses' experience of work. Psycho-Oncology, 16, 733–740. doi: 10.1002/pon.1130

Aburn, G., Gott, M., & Hoare, K. (2016). What is resilience? An integrative review of the empirical literature. Journal of Advanced Nursing, 72, 980–1000. doi: 10.1111/jan.12888

Black, C. (2012). Why healthcare organisations must look after their staff. Nursing management, 19, 27-30. doi: 10.7748/nm2012.10.19.6.27.c9319

Breen, L. J. (2007). The researcher 'in the middle': Negotiating the insider/outsider dichotomy. The Australian Community Psychologist, 19, 163-174.

Charmaz, K. (2014). Constructing grounded theory (2nd ed.). London: SAGE Publications Ltd.

Cortvriend, P. (2004). Change management of mergers: the impact on NHS staff and their psychological contracts. Health Services Management Research, 17, 177–187. doi: 10.1258/0951484041485593

Creswell, J. W. (1998). Qualitative inquiry and research design: Choosing among five traditions (1st ed.). London: SAGE Publications Ltd.

Dey, I. (1999). Grounding grounded theory: Guidelines for qualitative inquiry (1st Ed.). San Diego, CA: Academic Press.

Francis, R. (2013). Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry. Retrieved from: http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Volume%201.pdf;

Glaser, B. G., & Strauss, A. (1967). The discovery of grounded theory: strategies for qualitative inquiry (1st Ed.). Chicago: Aldine Publishing Company.

Hellawell, D. (2006). Inside–out: analysis of the insider–outsider concept as a heuristic device to develop reflexivity in students doing qualitative research. Teaching in Higher Education, 11, 483-494. doi: 10.1080/13562510600874292

Howitt, D. (2010). Introduction to qualitative methods in psychology (1st Ed.). Essex, England: Pearson Education Limited.

Jackson, D., Firtko, A., & Edenborough, M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. Journal of Advanced Nursing, 60(1), 1–9. doi: 10.1111/j.1365-2648.2007.04412.x

Jones, J., Janman, K., Payne, R., & Rick, J. (1987). Some determinants of stress in psychiatric nurses. International Journal of Nursing Studies, 24, 129–144.

Kelly, D., Lankshear, A., & Jones, A. (2016). Stress and resilience in a post-Francis world – a qualitative study of executive nurse directors. Journal of Advanced Nursing, 72, 3160–3168. doi: 10.1111/jan.13086

Kobasa, S. C. (1979). Stressful life events, personality, and health: An inquiry into hardiness personality. Journal of Personality and Social Psychology, 37(1), 1-11.

Luthar, S. S., Doernberger, C. H., & Zigler, E. (1993). Resilience is not a unidimensional construct: Insights from a prospective study of inner-city adolescents. Development and Psychopathology, 5, 703-717.

Masten, A. S. (2011). Resilience in children threatened by extreme adversity: frameworks for research, practice and translational synergy. Development and Psychopathology, 23, 493–506. doi: 10.1017/S0954579411000198.

McKenna, H. (2016). Five big issues for health and social care after the Brexit vote. Retrieved from: https://www.kingsfund.org.uk/publications/articles/brexit-and-nhs

Merton, R. K. (1972). Insiders and outsiders: A chapter in the sociology of knowledge. American Journal of Sociology, 78, 9-47.

NHS England. (2013). Putting patients first. The NHS England business plan for 2013/14 – 2015/16. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf

Ramalho, R., Adams, P., Huggard, P., & Hoare, K. (2015). Literature review and constructivist grounded theory methodology. Forum: Qualitative Social Research, 16, 1-13.

Rutter, M. (2012). Resilience as a dynamic concept. Development and Psychopathology, 24, 335–344. doi:10.1017/S0954579412000028

Salaff, J. W. (2001). Book review: Grounding grounded theory: Guidelines for qualitative inquiry. Field Methods, 13, 414-417.

Seligman, M. E. (1972). Helplessness. Annual Review of Medicine, 23, 407–412. doi: 10.1146/annurev.me.23.020172.002203

Soderstrom, M., Dolbier, C., Leiferman, J., & Steinhardt, M. (2000). The relationship of hardiness, coping strategies, and perceived stress to symptoms of illness. Journal of Behavioral Medicine, 23, 311-328.

Søndenaa, E., Lauvrud, C., Sandvik, M., Nonstad, K. & Whittington, R. (2013). Resilience and professional quality of life in staff working with people with intellectual disabilities and offending behavior in community based and institutional settings. Health Psychology Research, 1(1), e3. doi: 10.4081/hpr.2013.e3.

Strauss, A., & Corbin, J. (1998). Basics of qualitative research: Grounded theory procedures and techniques (3rd ed.). Thousand Oaks, CA: SAGE Publications Ltd.

Tusaie K., & Dyer J. (2004). Resilience: a historical review of the construct. Holistic Nursing Practice, 18, 3–10.

Wright, N., Zakarian, M., & Blake, H. (2016). Nurses' views on workplace wellbeing programmes. British Journal of Nursing, 25, 1208-1212. doi: 10.12968/bjon.2016.25.21.1208

Section Four: Ethics Documents

Staff perceptions of the contributing factors related to psychological well-being and resilience when working in secure services

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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 perceptions of well-being and resilience in secure services

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)*

[x] 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)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

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):
This research study is a thesis project being undertaken by the student as part of their Doctorate in Clinical Psychology.

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

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 perceptions of well-being and resilience in secure services

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Staff perceptions of the contributing factors related to psychological well-being and resilience when working in secure services

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Mrs	Rebecca	Ashton
Address	Lancaster University Doctorate of Clinical Psychology Furness College Lancaster University		
Post Code	LA1 4YG		
E-mail	becky.ashton@lancaster.ac.uk		
Telephone	01524592970		
Fax			

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

Name and level of course/ degree:
Doctorate of 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	Smith
Address	Doctorate of Clinical Psychology		

	Furness College
	Lancaster University
Post Code	LA1 4YG
E-mail	i.smith@lancaster.ac.uk
Telephone	0152459282
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 Mrs Rebecca Ashton	☐ Dr Ian Smith

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
	Mrs	Rebecca	Ashton
Post	Trainee Clinical Psychologist		
Qualifications	BSc Psychology First Class		
ORCID ID			
Employer	Lancashire Care NHS Foundation Trust		
Work Address	Doctorate of Clinical Psychology		
	Furness College		
	Lancaster University		
Post Code	LA1 4YG		
Work E-mail	becky.ashton@lancaster.ac.uk		
* Personal E-mail	beckyashton88@gmail.com		
Work Telephone	01524592970		
* Personal Telephone/Mobile	07772841240		
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

[redacted]

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):	
Sponsor's/protocol number:	
Protocol Version:	3
Protocol Date:	09/05/2016
Funder's reference number:	FHMREC15062
Project website:	

Additional reference number(s):

Ref.Number Description	Reference Number
[redacted]	[redacted]

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.*

This study is exploring staff perceptions of the contributing factors to well-being and resilience when working in secure services. Within the current climate of healthcare and the National Health Service, there is increasing interest in the well-being and stress-levels of staff (Haynes, Wall, Bolden, Stride & Rick, 1999). Stress in the workplace has significant consequences for staff, patients and organisations (Firth-Cozens & Payne, 1999).

The aim of this research is to explore staff perceptions of their own well-being and resilience, and what is important or challenging to their psychological well-being at work. This study will use a qualitative approach to explore staff views about what influences psychological well- being and resilience when working in forensic secure services. Participants

will be ward-based staff working in [redacted] and [redacted]. Participants will be recruited through three concurrent methods: email, face to face during staff meetings and clinical staff working in the psychology team. It is hoped that 8-20 staff will be recruited and take part in semi-structured interviews lasting approximately 60 minutes, which will be analysed using constructivist grounded theory (Charmaz, 2014). Interviews will take place on-site at the participant's workplace at a time that is convenient for them. Participants will be asked open-questions about how they feel about their job and their perceptions of their own resilience and well-being. It is hoped that the results from the present study will help to inform services about how to best support the well-being of staff.

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, R&D office 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.

Recruitment
One potential pitfall is participant recruitment due to staffing on the wards; this will be overcome by arranging interviews at a time when is most convenient for staff. There will be no issues of coercion or any pressure put on staff to participate in the study by the chief investigator or staff working in the psychology department. The chief investigator will not access personal data for recruitment purposes.

Confidentiality
Participant confidentiality will be maintained throughout the project and once it has been submitted. All interview transcripts will be anonymised, and care will be taken when writing up to preserve anonymity of participants. At the beginning of the interview, the researcher will provide participants with a comprehensive explanation of confidentiality and will remind staff of their responsibility to maintain confidentiality of service users. Participants will be made aware that confidentiality will be breached if the researcher feels that there is a risk of harm or has concerns about the participant or another person. In the event of this, the relevant trust policies and procedures will be adhered to and advice will be sought from supervisors. For example, if a staff member discloses information that indicates their own poor practice, further detail will be sought and recorded, and this may result in the researcher or supervisor contacting the staff member's line manager. Regular meetings will take place between the researcher and supervisors which will provide a forum for discussion of any ethical or practical concerns.

There are no foreseen issues arising from the processing of identifiable data as long as the following is adhered to: Participant confidentiality will be maintained throughout the project and once it has been submitted. Confidentiality of participant data will be maintained by storing consent forms and other personal information using participant assignment numbers. These will either be stored in a locked filing cabinet in the research and development department of the relevant trust separate to audio data or at Lancaster University, depending on trust policy and procedure. Audio data and electronic copies of interviews will be stored and transferred electronically on Lancaster University's encrypted network. Audio-tape recordings will be transcribed anonymously. Anonymised typed copies of interviews with participant identifier numbers will be transcribed and analysed on the researcher's personal laptop under password protection and encryption.

On completion of the research project, research data will be stored in a locked cupboard at Lancaster University for ten years. The research coordinator will have responsibility for storing and deleting the data once I have submitted the thesis and completed my course. Confidential, personal data will be destroyed up to three months after the study is completed. Participants will be made aware that direct quotes will be used in the final report and that every effort will be made to ensure that the information used is not personally identifiable. Also, participants will be given the opportunity to use a pseudonym for the final report. Participants will be sent information about the overall findings of the study and can request a copy of the final report.

Anonymity
Participant anonymity will be considered throughout the project. In order to maintain anonymity, participants will opt in directly to the researcher so that the field supervisor is unaware of any potential participants. Moreover, participants will be given a choice to interview in or out of working time should they want to remain anonymous to their work colleagues.

Informed consent
Participants will be given time to consider whether they want to participate to ensure informed consent is obtained. Participants will be informed verbally and on the information sheet that they have a right to withdraw at any point up to two weeks after the interview.

Risks and burdens
It is not expected that participants will be placed in any discomfort or danger as a result of taking part. Participants will be given the choice as to whether to interview during or outside working hours, and at a time that is suitable for them to minimise inconvenience. It is not expected, however, participants may become distressed or upset when talking about their job or workplace and any negative experiences they may have had.

The interview questions will not be purposefully distressing or sensitive, although, the process of talking about work may elicit upsetting responses. If a participant becomes upset whilst being interviewed, they will be made aware that they can stop the interview at any time, and the interviewer will make a judgement about when to stop the interview. The researcher will use clinical skills to provide support for participants when they are upset and help to contain these emotions, particularly if they are returning to work after the interview. In this case, participants will be given the option whether they want to continue with the interview or stop it. The participants will be given a debrief sheet after the interview which will include details of workplace support and national counselling support should they feel they need it. Supervision will be sought by the interviewer to clarify any other means of supporting participants and to allow the researcher to debrief from the interview.

Participants can withdraw their participation in the study at any time, however they cannot withdraw their data from the study after two weeks. This is due to the difficulties of identifying participants once their data has been incorporated in the analysis process and appropriately anonymised using participant identifier numbers. Although in the case where a request is made after two weeks, every effort will be made to withdraw the data if possible.

Service-related issues
The services involved are in the process of being merged with another trust which could present difficulties and delays to the project. This potential issue will be overcome by using alternative secure services in the region and explore psychological well-being and resilience in staff more generally.

There are no conflicts of interest with this study.

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 aim of this research is to explore staff perceptions of the factors that contribute to resilience and well-being when working in secure services.

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

This research is interested in:
1.What do staff consider to be important regarding their psychological well-being when working in secure services?
2.What are staff perceptions of their own resilience and influencing factors when working in secure services?
3.What are the staff experiences and perceptions of challenges to psychological well-being at work?

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

Within the current climate of healthcare and the National Health Service (NHS), there is increasing interest in the well-being and stress levels of staff (Haynes, Wall, Bolden, Stride & Rick, 1999). Stress in the workplace has significant consequences for staff, patients and organisations (Firth-Cozens & Payne, 1999). Burn-out is a term used to describe the impact of work stresses on the individual (Freudenberger, 1975). Initial signs of burnout include exhaustion and fatigue, being physically run-down, difficulties sleeping and cynicism. Emotional exhaustion is another term which refers to a reduced ability to cope with job demands and a reduced ability to use psychological resources (Chana, Kennedy & Chessell, 2015).

Work stress and burnout is particularly prevalent within caring professions. The Department of Health's Boorman Review (DoH, 2009) demonstrated that a quarter of absences from work in NHS employees was due to stress, anxiety and depression. In particular, studies have shown high levels of burnout, expressed emotion and emotional exhaustion in staff working in secure settings specifically (Dennis & Leach, 2007). Moreover, studies have found that working with service users with a learning disability was associated with burnout (Innstrand, Espnes & Mykletun, 2002; Rose, Horne, Rose & Hastings, 2004). One study found that a quarter of staff working with this client group specifically, reported emotional distress and a third reported that they were likely to actively seek new employment in the next year (Robertson et al., 2005).

Research has shown that stress at work can have a significant impact on the individual, the organisation and patients. One study has shown that job stress, work demands and job control, significantly contribute to the presence of idiopathic chronic fatigue and irritable bowel syndrome in staff (De Gucht, Fischler & Heiser, 2003), although this was moderated by personality traits such as neuroticism. Consistently, stress at work is a major cause of low productivity, high absenteeism, and poor morale (Hill, Rinaldi, Gilleard & Babbs, 2003). Unsurprisingly, the impact of work stressors such as inadequate staffing, lack of support and poor relationships between doctors and nurses have been linked to lower quality of care (Gunnarsdottir, Clarke, Rafferty & Nutbeam, 2009; Aiken, Clarke & Sloane, 2002). Consistently, burnout and psychological distress has been linked to a reduction in nurses' caring behaviours (Laschinger & Leiter, 2006; Tourangeau et al., 2007).

Research has started to identify certain factors which contribute to psychological distress and burnout in general. In a longitudinal study of Canadian workers, it was found that psychological demands and job insecurity increased the risk of repeated episodes of psychological distress (Marchand, & Blanc, 2011). Studies have shown that perceived sources of stress when working with people with a learning disability and challenging behaviour were lack of resources, lack of staff support and low satisfaction with rate of pay (Robertson et al., 2005). Adequate staffing levels and support from managers (Aiken, Clarke & Sloane, 2002), and a supportive team (Lee & Kiemle, 2015) have been implicated in reducing burnout. Furthermore, both work stressors and personal factors including personality have been linked to burnout and psychological distress in nursing staff (Chana, Kennedy & Chessell, 2015). Thus, individual, personal factors are also important when trying to understand the contributing factors to psychological stress and burnout.

The importance of examining the multiple factors involved in psychological well-being at work including personality traits and coping strategies has been recognised (Garrosa, Rainho, Moreno-Jimenez & Monteiro, 2010). Consistently, family situation, social support, and personality has been shown to have an impact on psychological distress in the workplace (Marchand, & Blanc, 2011). Studies have shown a link between attachment style and coping strategies; those with insecure attachment styles were more likely to perceive stress negatively and have less adaptive coping strategies at work (Johnstone & Feeney, 2015). Moreover, higher rates of burnout have been found to be more likely in males employed in healthcare support worker roles (Dennis & Leach, 2007). Furthermore, Ablett and Jones (2007) conducted a qualitative study of nurses and healthcare staff working in palliative care, where staff burnout is relatively low which is an area which would be expected to be stressful in nature. They found a high degree of commitment and a sense of purpose was important to them in their work and they concluded that interpersonal factors such as hardiness and coherence were important in moderating the effects of stress.

In this way, the way staff cope with stressful situations has been shown to be important in psychological well-being and burnout. It has been found that there is a wide variety in staff's emotional responses and coping strategies when working with people with a learning disability on a sex offender treatment programme, such as, avoidance and the use of humour (Sandhu, Rose, Rostill-Brookers & Thrift, 2012). Nurses with better mental health used distancing coping strategies (Chang et al., 2006). Other coping strategies including problem-solving, positive reappraisal, seeking social support and cognitive coping strategies (self-regulation and self-attitude) have been shown to be negatively correlated with both emotional exhaustion and depersonalisation (Chana, Kennedy & Chessell, 2015). Whereas,

escape-avoidance, self-controlling and confronting coping strategies have been implicated in high burnout (Chana, Kennedy & Chessell, 2015; Chang et al., 2006). Therefore, more needs to be understood about these individual factors that contribute to burnout, stress and psychological well-being at work.

Attempts to understand this have led to a shift in the focus of research from a pathogenic paradigm focussing on psychological morbidity and burnout to a salutogenic paradigm focusing on health and well-being when faced with stressful situations. Thus, researchers have considered the antecedent factors that maintain a sense of well-being rather than the absence of psychopathology. In particular, studies have investigated the interpersonal factors that promote resilience; staff who were shown to be resilient were more likely to perceive the prospect of change in a positive way (Ablett & Jones, 2007). Staff resilience is an important factor in the ability of mental health nurses to cope with demanding situations and perception of life satisfaction (Itzhaki, Peles-Bortz, Kostistky, Barnoy, Filshtinsky & Bluvstein, 2015). Nurses who were exposed to violence did report greater work stress, but this was influenced by resilience and post-traumatic growth (Itzhaki et al., 2015). Currently, there is a distinct lack of studies examining resilience, social support, coping and appraisals in relation to caring behaviours (Chana, Kennedy & Chessell, 2015). Therefore, this study is exploring what staff perceive to contribute to resilience and well-being at work.

Although, little is known about the mechanisms that underpin psychological well-being and resilience in individuals. Qualitative approaches can be a helpful way to gather rich information that can offer insight in these processes and the meaning that staff attribute to certain notions such as well-being. In particular, grounded theory gathers rich data that can provide insight into participants' feelings in addition to the contexts and structure of their lives (Charmaz, 2014). Therefore, the current study will use constructivist grounded theory to explore staffs' perceptions of psychological well-being and resilience and what influences these concepts.

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:
This study will use a qualitative approach. Semi-structured interviews will be collected reiteratively and analysed based on Charmaz's (2014) guidance on constructing grounded theory.

Procedure:
Participants will be recruited into the study in three concurrent methods. Firstly, an email will be circulated by the researcher's field supervisor or local collaborator, to any potential participants in the trust, including a covering letter, an information sheet about the project, and an expression of interest form. Participants will be given the researcher's email and telephone details in order to opt into the study. Secondly, the researcher will attend staff meetings, such as staff handover, to recruit participants face-to-face using the materials described above. Thirdly, the researcher will attend psychology staff meetings to explain about the study, and these staff members will then give out the above materials to potential participants. For the latter two recruitment methods, participants will be given an additional opt-in method via post using a pre-paid envelope.

All participants will be given a minimum of 24 hours to consider participation, in order to gain informed consent, after which interviews will be arranged via telephone. On the telephone, the researcher will check with participants that they fully understand the study and the researcher will answer any potential questions. Once participants are happy to take part in the study, interviews will be arranged. Interviews will take place in rooms on-site at a time that is convenient with staff. The researcher's field supervisor will support with room bookings where possible.

At the beginning of the interviews, participants will be given a consent form to complete, including information about audio recording during the interview, and an explicit explanation of confidentiality. The interviews will last between 45-60 minutes, although this can be flexible depending on the individual. The semi-structured interviews will use a broad topic guide consisting of a list of open questions, including experiences of working in secure services, and perceptions of what facilitates or challenges psychological well-being and resilience. The interviews will be audio recorded by the researcher for transcription at a later date. Once the interviews have been completed, a debrief sheet providing details of contact details in the event of any distress caused by the interview, will be given to participants. Participants may also be asked to take part in a second interview, in order to clarify details from their first interview. Updated informed consent would be sought in this case.

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?

- ☐ 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.
The staff working in the psychology services may provide some informal consultation around the study, recruitment or interview questions. No other formal steps will be taken to involve the target participant group due to the challenges of asking staff during working hours. The participants will be sent information about the overall results of the study once it has been submitted. They will be made aware that they can ask for a full copy of the report once the study has been completed.

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
- [x] 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: 70 Years

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

Any ward-based staff working directly with service users in secure services including step-down services (Associated with forensic secure services) and staff who have been employed at the organisation for over six months will be included in the study.

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

Non-clinical staff or any staff who have worked in the organisation for less than six months will be excluded in the study.

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
Covering letter	1	0	5 minutes	Chief Investigator, Trainee Clinical Psychologist. Participant's workplace.
Participant information sheet	1	0	5 minutes	Chief Investigator, Trainee Clinical Psychologist. Participant's workplace.
Expression of interest	1	0	10 minutes	Chief Investigator, Trainee Clinical Psychologist. Participant's workplace.
Consent	1	0	5 minutes	Chief Investigator, Trainee Clinical Psychologist. Participant's workplace.
Semi-structured interviews	1	0	60 minutes	Chief Investigator, Trainee Clinical Psychologist. Participant's workplace at a convenient time.
Debrief	1	0	5 minutes	Chief Investigator, Trainee Clinical Psychologist. Participant's workplace.

A21. How long do you expect each participant to be in the study in total?

It is expected that participants will be involved in the study for a maximum of 12 months, however, it is likely to be significantly less than this.

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.

There are not expected to be any risks for participants by taking part in this study. It is not expected that participants will be placed in any discomfort or danger as a result of taking part. Participants will be given the choice as to whether to interview at their workplace during or outside working hours, and at a time that is suitable for them to minimise inconvenience. Participants will be reimbursed to the maximum value of £10 travel expenses if they decide to

interview outside of working hours and have to travel to their workplace just to interview. Participants may become distressed or upset when talking about their job or workplace and any negative experiences they may have had.

The interview questions will not be purposefully distressing or sensitive, although, the process of talking about work may elicit upsetting responses. If a participant becomes upset whilst being interviewed, they will be made aware that they can stop the interview at any time, and the interviewer will make a judgement about when to stop the interview. The researcher will use clinical skills to provide support for participants when they are upset and help to contain these emotions, particularly if they are returning to work after the interview. In this case, participants will be given the option whether they want to continue with the interview or stop it. The participants will be given a debrief sheet after the interview which will include details of workplace support and national counselling support should they feel they need it. Supervision will be sought by the interviewer to clarify any other means of supporting participants and to allow the researcher to debrief from the interview.

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

A24. What is the potential for benefit to research participants?

Although there are not any direct benefits to participants for taking part in this study, they may find the experience of talking during the interview to be positive and rewarding. It is hoped that the results from the study will help forensic secure services to better understand the contributing factors in psychological well-being and resilience as perceived by staff and inform services about how it may be best to support staff in the future.

A26. What are the potential risks for the researchers themselves? *(if any)*

It is not expected that there will be any risks to the researcher. The researcher will have no service user contact other than possibly meeting people in the grounds. The researcher will use a university email address and research mobile phone for speaking to participants. Regular contact and supervision will be sought between the researcher and supervisors to provide a forum for discussion should participants talk about anything that is potentially upsetting for them or the researcher.

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 social care or GP records, or review of medical records. Indicate whether this will be done by the direct care team or by researchers acting under arrangements with the responsible care organisation(s).*

All potential participants will be sent research materials providing information about the study either via email from the local collaborators, face-to-face by the chief investigator during staff meetings or staff working in the psychology department. Participants who consent to taking part will be recruited into the study.

If possible, the researcher will target different areas of the service with low and high rates of sickness. Supported by the local collaborator, the researcher will liaise with the human resources department of [redacted] to obtain information about wards areas with low and high rates of sickness, but no individual staff will be named by human resources or targeted for recruitment. Permission for this information has not yet been sought and if it is not possible to ascertain this information about general staff sickness levels, the research study will continue without it and it will not cause any problems to the research.

Personal data will not be accessed by anyone prior to recruitment. Only the participants can give the chief investigator personal data with consent.

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:
All potential participants will be given information about the study via email or in person by the chief investigator or staff working in the psychology department. Personal data will not be accessed by anyone prior to recruitment. Only the participants can give the chief investigator personal data with consent.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

◯ Yes ◉ No

A29. How and by whom will potential participants first be approached?

Participants will be recruited into the study in three concurrent methods. Firstly, an email will be circulated by the local collaborators to any potential participants in the trust, including a covering letter, an information sheet about the project, and an expression of interest form to consent to being contacted by the researcher.
Participants will be given the researcher's email to send the expression of interest form back and telephone details as another way to opt into the study. Secondly, the researcher will attend staff meetings, such as staff handover, to recruit participants face-to-face using the materials described above. Thirdly, the researcher will attend psychology staff meetings to explain about the study, and these staff members will then give out the above materials to potential participants. For the latter two recruitment methods, participants will be given an additional opt-in method via post using a pre-paid envelope.

If possible, the researcher will target different areas of the service with low and high rates of sickness. Supported by the local collaborator, the researcher will liaise with the human resources department of the relevant NHS Trusts to obtain information about wards areas with low and high rates of sickness, but no individual staff will be named by human resources or targeted for recruitment. Permission for this information has not yet been sought and if it is not possible to ascertain this information about general staff sickness levels, the research study will continue without it and it will not cause any problems to the research.

In line with constructivist grounded theory, it is expected that a staged approach to recruitment will take place. It is possible that participants will be asked to take part in a second interview in order to clarify details from their first interview; updated informed consent will be sought in this case.

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.

After participants have opted into the study or consented to being contacted via the expression of interest form, all participants will be given a minimum of 24 hours to consider participation, in order to gain informed consent, after which interview dates will be arranged via telephone. On the telephone, the researcher will check with participants that they fully understand the study and the researcher will answer any potential questions. Once participants give verbal consent to take part in the study, interviews will be arranged.

At the beginning of the interviews, participants will be given a consent form to complete, including information about audio recording during the interview, and an explicit explanation of confidentiality. Participants may also be asked to take part in a second interview, in order to clarify details from their first interview. Updated informed consent would be sought in this case.

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?

All participants will be given a minimum of 24 hours to consider participation, in order to gain informed consent, after which interview dates will be arranged via telephone.

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)*

As this research study is recruiting staff, it is not expected that participants will have any issues adequately understanding English as it is assumed that staff would have be fluent in English in order to do their job.

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:

The participant and all their data would be withdrawn from the study. No further intervention would be carried out with this participant.

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
- [x] Publication of direct quotations from respondents

- [ ] Publication of data that might allow identification of individuals
- [x] Use of audio/visual recording devices
- [x] Storage of personal data on any of the following:
  - [x] Manual files (includes paper or film)
  - [ ] NHS computers
  - [ ] Social Care Service computers
  - [ ] Home or other personal computers
  - [x] University computers
  - [ ] Private company computers
  - [ ] Laptop computers

Further details:
Participant confidentiality will be maintained throughout the project and once it has been submitted. Confidentiality of participant data will be maintained by storing consent forms and other personal information using participant assignment numbers. These will either be stored in a locked filing cabinet in the research and development department of the relevant trust separate to audio data or at Lancaster University, depending on trust policy and procedure. Audio data and electronic copies of interviews will be stored and transferred electronically on Lancaster University's encrypted network. Audio-tape recordings will be transcribed anonymously, and care will be taken when writing up to preserve anonymity of participants. Anonymised typed copies of interviews with participant identifier numbers will be transcribed and analysed on the researcher's personal laptop under password protection and encryption.

On completion of the research project, research data will be stored in a locked cupboard at Lancaster University for ten years. Confidential, personal data will be destroyed up to three months after the study is completed. Participants will be made aware that direct quotes will be used in the final report and that every effort will be made to ensure that the information used is not personally identifiable. Also, participants will be given the opportunity to use a pseudonym for the final report. Participants will be sent information about the overall findings of the study and can request a copy of the final report.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Confidentiality of participant data will be maintained by storing consent forms and other personal information using participant assignment numbers. These will either be stored in a locked filing cabinet in the research and development department of the relevant trust separate to audio data or at Lancaster University, depending on trust policy and procedure.

Audio data and electronic copies of interviews will be stored and transferred electronically on Lancaster University's encrypted network. Original recordings will be deleted from the digital recorder as quickly as possible once it has been transferred to the University's encrypted network. In the meantime, the recorder will be stored securely. Audio-tape recordings will be transcribed anonymously, and care will be taken when writing up to preserve anonymity of participants. Anonymised transcripts will be analysed on the chief investigator's personal laptop under password protection.

Confidential, personal data will be destroyed up to three months after the study is completed.

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.*

The investigator will adhere to policies and procedures in relation to confidentiality, namely NHS Code of Confidentiality and the Data Protection Act. Interviews will be transcribed anonymously, original recordings will be deleted from the digital recorder as quickly as possible once it has been transferred to the University's encrypted network. In the meantime, the recorder will be stored securely. File copies of audio recordings will be deleted once the project has been submitted and examined. Other research data may be retained for up to 10 years within the research department of the Doctorate of Clinical Psychology. The research coordinator will have responsibility for storing and deleting the data once I have submitted the thesis and completed my course.

Participants will be asked to give a pseudonym to ensure anonymity in the write up. All participant personal data will be kept separately to audio data to ensure confidentiality. Personal data will be stored in site files in the relevant NHS Trust Research and Development department in a locked filing cabinet or at Lancaster University which only the chief investigator and personnel from the research and development department will access.

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.*

Personal data will either be stored in a locked filing cabinet in the research and development department of the relevant trust separate to audio data or at Lancaster University, depending on trust policy and procedure which only the chief investigator and personnel from the research and development department will access.

The researcher's supervisors will have access to anonymised transcripts to check analysis. Only the research supervisor may listen to audio recordings of interviews, as the field supervisor may be able to identify the participants voice. Participants will be made aware of this in the participant information sheet and consent form.

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 data and electronic copies of interviews will be stored and transferred electronically on Lancaster University's encrypted network. Audio recordings will be transcribed anonymously. Anonymised copies of interviews with participant identifier numbers will be transcribed and analysed on the researcher's personal laptop under password protection and encryption. Anonymised printed copies of transcripts and the results from analysis will be accessed by the chief investigator's supervisors in order to inform analysis.

All personal data will be deleted up to three months after the end of the study. On completion of the research project, research data will be stored in a locked cupboard at Lancaster University for ten years. The research coordinator will have responsibility for storing and deleting the data once the chief investigator has submitted their thesis and completed their course.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Professor	Bill	Sellwood
Post	Programme Director		
Qualifications	PhD		
Work Address	Doctorate of Clinical Psychology		
	Furness College		
	Lancaster University		
Post Code	LA1 4YG		
Work Email	b.sellwood@lancaster.ac.uk		
Work Telephone	01524 593998		
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

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.*

On completion of the research project, research data will be stored in a locked cupboard at Lancaster University for ten years. The research coordinator will have responsibility for storing and deleting the data once I have submitted the thesis.

Personal data including consent forms will be destroyed up to three months after the study is completed. Original tape recordings will be deleted from the digital recorder as quickly as possible once it has been transferred to the University's encrypted network. In the meantime, the recorder will be stored securely. File copies of audio recordings will be deleted once the project has been submitted and examined.

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

A50-1. Will the research be registered on a public database?

◉ Yes ○ No

Please give details, or justify if not registering the research.
The intention is to publish the study in a public journal.
The researcher is unaware of any suitable public database on which to register the study.

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:*

- [x] Peer reviewed scientific journals
- [ ] Internal report
- [x] 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
- [x] Other (please specify)

The overall results from this study will be sent to participants and they will be made aware that they can request a copy of the research paper part of the thesis.
Verbal feedback of the results are likely to be given to psychology teams in the services. Feedback will also be given at research meetings for the research and development departments. The research and development department are likely to ask the chief investigator to consider which other members of staff would benefit from receiving feedback from the study. Careful consideration will be taken when deciding whom to feedback the results of the study to in relation to the organisations and staff teams more generally, particularly if some of the results may reflect negatively on the services.

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

Every effort will be made to ensure that direct quotations used from interviews will not identify participants.
Pseudonyms will be used in place of participant names in the final report. This will be made explicit to participants on the participant information sheet.

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.
The overall results from this study will be sent to participants and they will be made aware that they can request a copy of the research paper part of the thesis.

5. Scientific and Statistical Review

A54-1. 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
- [x] 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 project proposal was reviewed and feedback was provided by the Chief Investigator's research and field supervisors. The proposal was anonymously peer-reviewed by the research team at Lancaster University's Doctorate of Clinical Psychology Exam board and given approval. The project was reviewed by Lancaster University's Research Ethics Committee and given full approval.

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:	20
Total international sample size (including UK):	0
Total in European Economic Area:	0

Further details:
It is expected that 8-20 participants will take part in this study. This project will recruit a targeted sample of ward-based staff working in [redacted] using a purposive sampling method.

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.*

The number of participants is in line with recommendations from Guest, Bunce, Johnson (2006) who suggest that 12 interviews should suffice for most researchers. Moreover, Charmaz (2014) argues that a small sample can produce in-depth interviews of lasting significance.

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.

Semi-structured interviews will be analysed using constructivist grounded theory (Charmaz, 2014). This method is a systematic, yet flexible way of collecting and analysing qualitative data in order to construct theories. It begins inductively but then becomes an iterative process of going back and forth between the data using comparative methods. Data collection and analysis are consciously combined, with initial analysis used to shape future data collection, and this is likely to involve revision of the interview schedule. Thus, recruitment will be conducted in stages, until the data has reached saturation point. The three stages of analysis include:
1. Initial analysis: coding
2. Developing codes: the method constant comparison
3. Core analysis
A constructivist epistemologist position will be subscribed to, in order to recognise the potential influence that the researcher has during the study and on the findings. The chief investigator's supervisors will be involved in checking some aspects of analysis.

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

[redacted]

Title Forename/Initials Surname

[redacted]

Fax

[redacted]

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:

If Other, please specify:

Contact person

Name of organisation Lancaster University

Given name [redacted]

[redacted]

Is the sponsor based outside the UK?

◯ Yes ◉ No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

☐ 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]	[redacted]	[redacted]
[redacted]	[redacted]	
[redacted]	[redacted]	
	[redacted]	
	[redacted]	
[redacted]	[redacted]	
[redacted]	[redacted]	
[redacted]	[redacted]	
[redacted]	[redacted]	

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: 01/06/2016
Planned end date: 01/06/2017
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 researcher supervisor and research director for Lancaster's University Clinical Psychology Doctoral programme will monitor the conduct of the research. The local collaborator will also be responsible for ensuring professional and ethical conduct of the research. Both the researcher's supervisors will review all aspects of the final report in addition to providing feedback on initial codes and analysis.
Participants will be made aware that if they have any complaints or issues with the research then they can contact the Research Director at Lancaster University Doctorate of Clinical Psychology.

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	
IN1	◉ NHS site ○ Non-NHS site	Forename	Ashton
		Middle name	Angharad
	Country: England	Family name	Rebecca
		Email	becky.ashton@lancaster.ac.uk
		Qualification (MD...)	BSc Psychology
	Organisation name [redacted]	Country	UNITED KINGDOM

Post Code [redacted]

IN2

(●) NHS site
( ) Non-NHS site

Country: England

Organisation name [redacted]

Forename	Ashton
Middle name	Angharad
Family name	Rebecca
Email	becky.ashton@lancaster.ac.uk
Qualification (MD...)	BSc Psychology
Country	UNITED KINGDOM

Thesis protocol – Version 4 (20/06/2016)

Staff perceptions of the contributing factors related to psychological well-being and resilience when working in secure services

Researcher: Rebecca Ashton (Trainee Clinical Psychologist, Lancaster University)

Supervised by [redacted] and Dr Ian Smith (Senior Lecturer, Doctorate of Clinical Psychology Lancaster University)

Introduction

Within the current climate of healthcare and the National Health Service (NHS), there is increasing interest in the well-being and stress levels of staff (Haynes, Wall, Bolden, Stride & Rick, 1999). Stress in the workplace has significant consequences for staff, patients and organisations (Firth-Cozens & Payne, 1999). *Burn-out* is a term used to describe the impact of work stresses on the individual (Freudenberger, 1975). Initial signs of burnout include exhaustion and fatigue, being physically run-down, difficulties sleeping and cynicism. Emotional exhaustion is another term which refers to a reduced ability to cope with job demands and a reduced ability to use psychological resources (Chana, Kennedy & Chessell, 2015).

Work stress and burnout is particularly prevalent within caring professions. The Department of Health's Boorman Review (DoH, 2009) demonstrated that a quarter of absences from work in NHS employees was due to stress, anxiety and depression. In particular, studies have shown high levels of burnout, expressed emotion and emotional exhaustion in staff working in secure settings specifically (Dennis & Leach, 2007). Moreover, studies have found that

working with service users with a learning disability was associated with burnout (Innstrand, Espnes & Mykletun, 2002; Rose, Horne, Rose & Hastings, 2004). One study found that a quarter of staff working with this client group specifically, reported emotional distress and a third reported that they were likely to actively seek new employment in the next year (Robertson et al., 2005).

Research has shown that stress at work can have a significant impact on the individual, the organisation and patients. One study has shown that job stress, work demands and job control, significantly contribute to the presence of idiopathic chronic fatigue and irritable bowel syndrome in staff (De Gucht, Fischler & Heiser, 2003), although this was moderated by personality traits such as neuroticism. Consistently, stress at work is a major cause of low productivity, high absenteeism, and poor morale (Hill, Rinaldi, Gilleard & Babbs, 2003). Unsurprisingly, the impact of work stressors such as inadequate staffing, lack of support and poor relationships between doctors and nurses have been linked to lower quality of care (Gunnarsdottir, Clarke, Rafferty & Nutbeam, 2009; Aiken, Clarke & Sloane, 2002). Consistently, burnout and psychological distress has been linked to a reduction in nurses' caring behaviours (Laschinger & Leiter, 2006; Tourangeau et al., 2007).

Research has started to identify certain factors which contribute to psychological distress and burnout in general. In a longitudinal study of Canadian workers, it was found that psychological demands and job insecurity increased the risk of repeated episodes of psychological distress (Marchand, & Blanc, 2011). Studies have shown that perceived sources of stress when working with people with a learning disability and challenging behaviour were: lack of resources, lack of staff support and low satisfaction with rate of pay (Robertson et al., 2005). Adequate staffing levels and support from managers (Aiken, Clarke & Sloane, 2002), and a supportive team (Lee & Kiemle, 2015) have been implicated in

reducing burnout. Furthermore, both work stressors and personal factors including personality have been linked to burnout and psychological distress in nursing staff (Chana, Kennedy & Chessell, 2015). Thus, individual, personal factors are also important when trying to understand the contributing factors to psychological stress and burnout.

The importance of examining the multiple factors involved in psychological well-being at work including personality traits and coping strategies has been recognised (Garrosa, Rainho, Moreno-Jimenez & Monteiro, 2010). Consistently, family situation, social support, and personality has been shown to have an impact on psychological distress in the workplace (Marchand, & Blanc, 2011). Studies have shown a link between attachment style and coping strategies; those with insecure attachment styles were more likely to perceive stress negatively and have less adaptive coping strategies at work (Johnstone & Feeney, 2015). Moreover, higher rates of burnout have been found to be more likely in males employed in healthcare support worker roles (Dennis & Leach, 2007). Furthermore, Ablett and Jones (2007) conducted a qualitative study of nurses and healthcare staff working in palliative care, where staff burnout is relatively low which is an area which would be expected to be stressful in nature. They found a high degree of commitment and a sense of purpose was important to them in their work and they concluded that interpersonal factors such as hardiness and coherence were important in moderating the effects of stress.

In this way, the way staff cope with stressful situations has been shown to be important in psychological well-being and burnout. It has been found that there is a wide variety in staff's emotional responses and coping strategies when working with people with a learning disability on a sex offender treatment programme, such as, avoidance and the use of humour (Sandhu, Rose, Rostill-Brookers & Thrift, 2012). Nurses with better mental health used distancing coping strategies (Chang et al., 2006). Other coping strategies including problem-

solving, positive reappraisal, seeking social support and cognitive coping strategies (self-regulation and self-attitude) have been shown to be negatively correlated with both emotional exhaustion and depersonalisation (Chana, Kennedy & Chessell, 2015). Whereas, escape-avoidance, self-controlling and confronting coping strategies have been implicated in high burnout (Chana, Kennedy & Chessell, 2015; Chang et al., 2006). Therefore, more needs to be understood about these individual factors that contribute to burnout, stress and psychological well-being at work.

Attempts to understand this have led to a shift in the focus of research from a pathogenic paradigm focussing on psychological morbidity and burnout to a salutogenic paradigm focusing on health and well-being when faced with stressful situations. Thus, researchers have considered the antecedent factors that maintain a sense of well-being rather than the absence of psychopathology. In particular, studies have investigated the interpersonal factors that promote resilience; staff who were shown to be resilience were more likely to perceive the prospect of change in a positive way (Ablett & Jones, 2007). Staff resilience is an important factor in the ability of mental health nurses to cope with demanding situations and perception of life satisfaction (Itzhaki, Peles-Bortz, Kostistky, Barnoy, Filshtinsky & Bluvstein, 2015). Nurses who were exposed to violence did report greater work stress, but this was influenced by resilience and post-traumatic growth (Itzhaki et al., 2015). Currently, there is a distinct lack of studies examining resilience, social support, coping and appraisals in relation to caring behaviours (Chana, Kennedy & Chessell, 2015). Therefore, this study is exploring what staff perceive to contribute to resilience and well-being at work.

Although, little is known about the mechanisms that underpin psychological well-being and resilience in individuals. Qualitative approaches can be a helpful way to gather rich information that can offer insight in these processes and the meaning that staff attribute to

certain notions such as well-being. In particular, grounded theory gathers rich data that can provide insight into participants' feelings in addition to the contexts and structure of their lives (Charmaz, 2014). Therefore, the current study will use constructivist grounded theory to explore staffs' perceptions of psychological well-being and resilience and what influences these concepts.

Current study

The aim of this research is to explore staff perceptions of the factors that contribute to resilience and well-being when working in secure services. The main research questions are:

1. What do staff consider to be important regarding their psychological well-being when working in secure services?
2. What are staff perceptions of their own resilience and influencing factors when working in secure services?
3. What are the staff experiences and perceptions of challenges to psychological well-being at work?

Method

Participants

Participants will be ward-based staff working in forensic secure services. Any ward-based staff working directly with service users in secure services including step-down services (Associated with forensic secure services) and staff who have been employed at the organisation for over six months will be included in the study. Non-clinical staff or any staff who have worked in the organisation for less than six months will be excluded in the study.

This project will recruit a targeted sample of direct clinical staff working in forensic secure services. The study will use a purposive sampling method and recruitment will take place between June-December 2016. It is expected that 8-20 participants will take part in this study. It is expected that a staged approach to recruitment will take place.

Supported by the local collaborator, the researcher will liaise with the human resources department to obtain information about wards areas with low and high rates of sickness, but no individual staff will be named by human resources or targeted for recruitment. Permission for this information has not yet been sought and if it is not possible to ascertain this information about general staff sickness levels, the research study will continue without it and it will not cause any problems to the research.

Demographic details that will be obtained prior to interview include age, gender, ethnicity, years working for organisation, ward(s) that the staff member works on, how long they have worked on the ward, and job title. Any demographic information that could potentially reveal the identity of participants will not be reported. Participants will be recruited through three concurrent methods: email, face to face during staff meetings and through the psychology team staff. Participants will take part in semi-structured interviews, which will be analysed using constructivist grounded theory (Charmaz, 2014).

Design

This study will use a qualitative approach. Semi-structured interviews will be collected reiteratively and analysed based on Charmaz's (2014) guidance on constructing grounded theory.

Procedure

Participants will be recruited into the study in three concurrent methods. Firstly, an email will be circulated by the researcher's field supervisor, or local collaborator, to any potential participants in the trust, including a covering letter (See Appendix 1), an information sheet about the project (See Appendix 2), and an expression of interest form (see Appendix 3). Participants will be given the researcher's email and telephone details in order to opt into the study. Secondly, the researcher will attend staff meetings, such as staff handover, to recruit participants face-to-face using the materials described above. Thirdly, the researcher will attend psychology staff meetings to explain about the study, and these staff members will then give out the above materials to potential participants. For the latter two recruitment methods, participants will be given an additional opt-in method via post using a pre-paid envelope.

All participants will be given a minimum of 24 hours to consider participation, in order to gain informed consent, after which interviews will be arranged via telephone. On the telephone, the researcher will check with participants that they fully understand the study and the researcher will answer any potential questions. Once participants are happy to take part in the study, interviews will be arranged. Interviews will take place in rooms on-site at a time that is convenient with staff. The researcher's field supervisor and local collaborator will support with room bookings where possible.

At the beginning of the interviews, participants will be given a consent form to complete, including information about audio recording during the interview (See Appendix 4), and an explicit explanation of confidentiality. The interviews will last between 45-60 minutes, although this can be flexible depending on the individual. The semi-structured interviews will use a broad topic guide consisting of a list of open questions, including experiences of working in secure services, and perceptions of what facilitates or challenges psychological

well-being and resilience; see Appendix 5 for further details. The researcher will consult with staff and supervisors around useful topics and questions. Interview questions will also evolve through the analyses of initial interviews. The interviews will be audio recorded by the researcher for transcription at a later date. Once the interviews have been completed, a debrief sheet (See Appendix 6) providing details of contact details in the event of any distress caused by the interview, will be given to participants. Participants may also be asked to take part in a second interview, in order to clarify details from their first interview. Updated informed consent would be sought in this case.

Confidentiality of participant data will be maintained by storing consent forms and other participant personal information using participant assignment numbers. These will be stored in a locked cupboard either in the research and development department of the NHS Trust or at Lancaster University depending on the NHS Trust that participants are recruited from. Audio data and electronic copies of interviews will be stored and transferred electronically on Lancaster University's encrypted network, after which audio recordings will be immediately deleted from the digital recorder. Audio recordings will be transcribed anonymously. Anonymised typed copies of interviews with participant identifier numbers will be transcribed and analysed on the researcher's personal laptop under password protection and encryption. Once the project has been submitted and examined, the file copies of audio-tape recordings will be destroyed. On completion of the research project, research data will be stored in a locked cupboard at Lancaster University for ten years. Once the researcher has submitted the thesis, the research coordinator will have responsibility for storing and deleting the data. Personal data including consent forms will be destroyed up to three months after the study is completed. Participants will be made aware that direct quotes will be used in the final report and that every effort will be made to ensure that the information used is not personally identifiable. Also, participants will be given the opportunity to use a pseudonym for the final

report. Participants will be sent information about the overall findings of the study and can request a copy of the final report.

Proposed analysis

Semi-structured interviews will be analysed using constructivist grounded theory (Charmaz, 2014). This method is a systematic, yet flexible way of collecting and analysing qualitative data in order to construct theories (Charmaz, 2014). It begins inductively but then becomes an iterative process of going back and forth between the data using comparative methods (Charmaz, 2014). Data collection and analysis are consciously combined, with initial analysis used to shape future data collection, and this is likely to involve revision of the interview schedule. Thus, recruitment will be conducted in stages, until the data has reached saturation point. The three stages of analysis include:

1. Initial analysis: coding
2. Developing codes: the method constant comparison
3. Core analysis

A constructivist epistemologist position will be subscribed to, in order to recognise the potential influence that the researcher has during the study and on the findings.

Practical issues

Interpreters will not be required for this research project as it is expected that staff members would already be fluent in English. There may be some stationary expenses for printing research materials and pre-paid envelopes. A research mobile will be required for potential participants to contact the researcher. Any costs associated with the project are expected to be covered by Lancaster University's Doctorate of Clinical Psychology course. Other practical issues may include room bookings; it is anticipated that the researcher's field supervisor

would support with this. Arranging interviews with staff will need to be convenient for staff's working hours, which may need to be re-arranged if a difficult situation arises on the ward in which they work. Another practical issue may be gaining access to rooms into buildings which are secure.

Ethical concerns

Confidentiality.

Participant confidentiality will be maintained throughout the project and once it has been submitted. All interview transcripts will be anonymised, and care will be taken when writing up to preserve anonymity of participants. At the beginning of the interview, the researcher will provide participants with a comprehensive explanation of confidentiality and will remind staff of their responsibility to maintain confidentiality of service users. Participants will be made aware that the researcher cannot ensure that their participation will be confidential as interviews will take place on work premises during work time. Every effort will be made to keep their participation confidential including booking rooms through field supervisor or local collaborator and ensuring that no one can see into rooms where interviews are taking place.

Participants will be made aware that confidentiality will be breached if the researcher feels that there is a risk of harm or has concerns about the participant or another person. In the event of this, the relevant trust policies and procedures will be adhered to and advice will be sought from supervisors. For example, if a staff member discloses information that indicates their own poor practice, the researcher will seek further information to clarify details and whether this is a risk issue or not, then the researcher will pass on this information to their supervisors, and this may result in the researcher or supervisor contacting the staff member's

line manager. Regular meetings will take place between the researcher and supervisors which will provide a forum for discussion of any ethical or practical concerns.

Anonymity.

Participant anonymity will be considered throughout the project. In order to maintain anonymity, participants will opt in directly to the researcher only so that the field supervisor is unaware of any potential participants. Moreover, participants will be given a choice to interview in or out of working time should they want to remain anonymous to their work colleagues.

Informed consent.

Participants will be given time to consider whether they want to participate to ensure informed consent is obtained. Participants will be informed verbally and on the information sheet that they have a right to withdraw at any point up to two weeks after the interview.

Timescale

Please see table 1 for proposed timescale for thesis project.

Table 1. Proposed timescale for project.

	Project
Dec 2015	Submit proposal form and thesis contract and action plan
Feb 2016	Submit feedback form. Write research protocol and complete other ethics forms.
4th March 2016	Submit ethical application to University
March 2016	Submit to R+D
April - May 2016	Ethical and R+D process
End of May 2016	Predicted ethical and R+D approval
June – December 2016	Data collection

June 2016– January 2017	Data analysis
July – October 2016	Introduction/method of literature review to submit at the end of October
October – December 2016	Introduction/method of research paper
February – March 2017	Results/Discussion of research paper and literature review
April 2017	Two drafts of critical appraisal
May 2017	Submit thesis

The potential pitfalls of the project could be difficulties with participant recruitment due to staffing on the wards. Thus, interviews will take place at a time when is most convenient for staff. Also, the services involved are in the process of being merged with another trust which could present difficulties and delays to the project. This potential issue will be overcome by using alternative secure services in the region and explore psychological well-being and resilience in staff more generally.

References

Ablett, J. R. & Jones, R. S. P. (2007). Resilience and well-being in palliative care staff: A qualitative study of hospice nurses' experience of work. *Psycho-Oncology, 16,* 733–740. doi: 10.1002/pon.1130

Aiken, L. H., Clarke, S. P. & Sloane, D. M. (2002). Hospital staffing, organisation and quality of care: cross-national findings. *International Journal for Quality in Health Care, 14,* 5–14. doi:10.1067/mno.2002.126696

Begat, I. & Severinsson, E. (2006). Reflection on how nursing supervision enhances nurses' experiences of well-being related to their psychosocial work environment. *Journal of Nursing Management, 14,* 610–616.

Chana, N., Kennedy, P. & Chessell, Z. J. (2015). Nursing staffs' emotional well-being and caring behaviours. *Journal of Clinical Nursing, 24,* 2835–2848. doi: 10.1111/jocn.12891

Chang, E. M., Daly, J. W., Hancock, K. M., Bidewell, J., Johnson, A., Lambert, V. A. & Lambert, C. E. (2006). The relationships among workplace stressors, coping methods, demographic characteristics and health in Australian nurses. *Journal of Professional Nursing, 22,* 30 – 38.

Charmaz, K. (2014). *Constructing grounded theory*. (Second edition). Sage publications Ltd: London.

De Gucht, V., Fischler, B. & Heiser, W. (2003). Job stress, personality and psychological distress as determinants of somatization and functional somatic syndromes in a population of nurses. *Stress and Health, 19,* 195–204. doi: 10.1002/smi.975

Dennis, A. M. & Leach, C. (2007). Expressed emotion and burnout: the experience of staff caring for men with learning disability and psychosis in a medium secure setting. *Journal of Psychiatric and Mental Health Nursing, 14*, 267–276.

Department of Health (2009). *NHS Health and Well-being*. Leeds: DoH. Retrieved 26/02/2016 from: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108799.

Edward, K. L. & Hercelinskyj, G. (2007). Burnout in the caring nurse: learning resilient behaviours. *British Journal of Nursing, 16,* 240–242.

Firth-Cozens, J. & Payne, R. L. (1999). *Stress in Health Professionals* (eds.). Wiley: Chichester.

Freudenberger, H. J. (1975). The staff burn-out syndrome in alternative institutions. *Psychotherapy: Theory, research and practice, 12*(1), 73-82. Retrieved from PsycINFO database.

Garrosa, E., Rainho, C., Moreno-Jimenez, B. & Monteiro, M. J. (2010). The relationship between job stressors, hardy personality, coping resources and burnout in a sample of nurses: A correlational study at two time points. *International Journal of Nursing Studies, 47,* 205–215. doi:10.1016/j.ijnurstu.2009.05.014

Gunnarsdottir, S., Clarke, S. P., Rafferty, A. M. & Nutbeam, D. (2009). Front-line management, staffing and nurse–doctor relationships as predictors of nurse and patient outcomes. A survey of Icelandic hospital nurses. *International Journal of Nursing Studies, 46,* 920–927. doi:10.1016/j.ijnurstu.2006.11.007

Haynes, C. E., Wall, T. D., Bolden, R., Stride, C. & Rick, J. E. (1999). Measures of perceived work characteristics for health services research: test of a measurement model and normative data. *British Journal of Health Psychology, 4*, 257–275. Retrieved from PsycINFO database.

Hill, R. G., Rinaldi, M., Gillleard, C. & Babbs, M. (2003). Connecting the individual to the organization: Employers response to stress in the workplace. *International Journal of Mental Health Promotion, 5,* 23–30. Retrieved from PsycINFO database.

Innstrand, S., Espnes, G. & Mykletun, R. (2002). Burnout among people with intellectually disabled persons: a theory update and an example. *Scandinavian Journal of Caring Sciences, 16,* 272–279. Retrieved from PsycINFO database.

Itzhaki, M., Peles-Bortz, A., Kostistky, H., Barnoy, D., Filshtinsky, V. & Bluvstein, I. (2015). Exposure of mental health nurses to violence associated with job stress, life satisfaction, staff resilience, and post-traumatic growth. *International Journal of Mental Health Nursing, 24,* 403–412. doi: 10.1111/inm.12151

Johnstone, M. & Feeney, J. A. (2015). Individual differences in responses to workplace stress: the contribution of attachment theory. *Journal of Applied Social Psychology, 45*, 412–424. doi: 10.1111/jasp.12308

Laschinger, H. K. S. & Leiter, M. P. (2006). The impact of nursing work environments on patient safety outcomes: The mediating role of burnout/engagement. *The Journal of Nursing Administration, 36,* 259–267. Retrieved from PsycINFO database.

Lee, A. & Kiemle, G. (2015). ‘It’s One of the Hardest Jobs in the World’: The Experience and Understanding of Qualified Nurses Who Work with Individuals Diagnosed with

Both Learning Disability and Personality Disorder. *Journal of Applied Research in Intellectual Disabilities, 28,* 238–248. Doi: 10.1111/jar.12125

Marchand, A. & Blanc, M. E. (2011). Occupation, work organisation conditions and the development of chronic psychological distress. *Work, 40,* 425–435. doi: 10.3233/WOR-2011-1254

Robertson, J., Hatton, C., Felce, D., Meek, A., Carr, D., Knapp, M., Hallam, A., Emerson, E., Pinkey, L., Caesar, E. & Lowe, K. (2005). Staff stress and morale in community-based settings for people with intellectual disabilities and challenging behaviour: a brief report. *Journal of Applied Research in Intellectual Disabilities, 18,* 271–277. Retrieved from PsycINFO database.

Rose, D., Horne, S., Rose, J. & Hastings, R. (2004). Negative emotional reactions to challenging behaviour and staff burnout: two replication studies. *Journal of Applied Research in Intellectual Disabilities, 17,* 219–223. Retrieved from PsycINFO database.

Sandhu, D. K., Rose, J., Rostill-Brookes, H. J. & Thrift, S. (2012). 'It's Intense, to an Extent': A Qualitative Study of the Emotional Challenges Faced by Staff Working on a Treatment Programme for Intellectually Disabled Sex Offenders. *Journal of Applied Research in Intellectual Disabilities, 25,* 308–318. Doi: 10.1111/j.1468-3148.2011.00667.x

Tourangeau, A. E., Doran, D. M., McGillis Hall, L., O'Brien Pallas, L., Pringle, D., Tu, J. V. & Cranley, L. A. (2006). Impact of hospital nursing care on 30-day mortality for acute medical patients. *Journal of Advanced Nursing, 57*(1), 32–44 doi: 10.1111/j.1365-2648.2006.04084.x

Appendix 4-A

Covering Letter/Email- Version 3, 09/05/2016

Lancaster University Doctorate in Clinical Psychology
Furness College
Lancaster University
LA1 4YG

Date: [insert date]

To whom this may concern,

Research project: Staff perceptions of well-being and resilience in secure services

My name is Becky Ashton and I am a trainee clinical psychologist studying at Lancaster University. I would like to invite you to take part in a research study about what you think affects your well-being at work. You have been invited to take part in this research study as you work at [insert service name]. Please take the time to read the enclosed participant information sheet about the study and decide whether you would like to participate.

The service has kindly allowed me to send the information about the study to you, so I do not have your contact details. Therefore, if you decide that you would like further information or are interested in participating then you can complete the **expression of interest form** and either email it back to me (becky.ashton@lancaster.ac.uk) or post it using the pre-stamped envelope. Alternatively, you can contact me on [insert mobile number].

Yours sincerely,
Becky Ashton
Trainee Clinical Psychologist Email: becky.ashton@lancaster.ac.uk

Appendix 4-B

Participant Information Sheet - Version 4, 20/06/2016

Lancaster University

IRAS project ID: 204890

Staff perceptions of well-being and resilience in secure services

My name is Becky Ashton and I am a trainee clinical psychologist studying at Lancaster University. I would like to invite you to take part in a research study that is asking staff about their views on what affects well-being at work. You have been invited to take part in this research study as you work at [insert service]. Please take the time to read the information about the study and decide whether you would like to participate.

What is the study about?

This study is exploring staff views about what contributes to well-being and resilience when working in secure services. I am really interested in finding out more about what you think has influenced your well-being and resilience at work. In particular, I am interested in what has positively contributed to your well-being or resilience at work, and what has challenged this. This study may help to inform services about how to best support staff when working in these services.

Do I have to take part?

No it is your choice whether you would like to participate. If you choose not to take part then this will not affect you or have any consequences in your job in any way.

What will happen if I take part?

Once you have read the information sheet, it is entirely your choice as to whether you would like to take part in the study. If you are interested in taking part, I will invite you for an interview in a room where you work at a time which is best for you. The interview will take approximately one hour, but this will depend on how much you have to say. You will be asked questions about your views of your own well-being and resilience, and what has influenced this. The interview will be audio-recorded and this will be analysed to make sense of your ideas compared to other staff. As part of this, I will ask you to sign a consent form to state that you are happy to participate.

What are the benefits of taking part?

By taking part you will help the services to better understand the contributing factors in psychological well-being and resilience as perceived by staff working in forensic secure services. It is hoped that this study may help to inform services about how to best support staff when working in these services in the future.

What are the risks of taking part?

There are no risks anticipated with participating in this study. After your interview, I will give you information about different services you can contact if you are upset and feel that you would like further support.

Will my information be kept confidential?

All your personal data will be kept confidential and only I can access this data. Your consent forms and any personal information you have provided will be kept separate to your audio data. Your interview will be audio-recorded, which will be transcribed anonymously. All other data, including the interview transcripts will also be anonymised and the research team can access this information. Electronic copies of interviews will be kept under password protection. On completion of the research project, printed copies of interviews will be stored in a locked cupboard at Lancaster University for ten years. All your personal data including audio recordings will be destroyed once the study has completed.

Direct quotes will be used in the final report and every effort will be made to ensure that the information used is not personally identifiable. Also, if you take part then you can choose a pseudonym which is another name whereby your real name cannot be identified.

Although every effort will be made, it is not possible to ensure that your participation is confidential as the interviews will take place on work premises during the working day. There will be occasions when confidentiality of information cannot be maintained. This is specifically if you tell me information that identifies that you or another person are at risk of harm or highlights issues with another staff members' practice. In this situation I would have a duty to inform other people in order to keep you and others safe. Where possible, this will be discussed with you first.

What if I want to withdraw from the study?

You are free to withdraw from the study anytime without giving any reason. You can withdraw your data up to two weeks after interview although every effort will be made to withdraw the data after this point. If you withdraw, your data will be destroyed and it will not be used in the study.

What will happen to the results of the study?

The results of the study will be written up in a report forming part of my thesis project and submitted to Lancaster University Doctorate of Clinical Psychology. The report is likely to be published in a journal in the future. I may also tell the services about my findings. You will be given a summary of the overall findings and you are welcome to request a copy of the report.

How can I take part?

The service has kindly allowed me to send the information about the study to you, so I do not have your contact details. Therefore, if you are interested in taking part in this study or you have any further questions about the interview then please complete the **expression of interest form** and either email this back to me (**becky.ashton@lancaster.ac.uk**) or via post using the pre-paid envelope. Alternatively, please contact me on [**insert research mobile number**].

What if I have any concerns about the project?

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; Tel: (01524) 593998

Research Director; Email: b.sellwood@lancaster.ac.uk

Division of Health Research

Lancaster University

Lancaster

LA1 4YG

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

Professor Roger Pickup Tel: +44 (0)1524 593746

Associate Dean for Research; Email: r.pickup@lancaster.ac.uk

Faculty of Health and Medicine

(Division of Biomedical and Life Sciences)

Lancaster University

Lancaster

LA1 4YG

Thank you for taking the time to read this information sheet.

Becky Ashton (Trainee Clinical Psychologist)
Lancaster University Doctorate in Clinical Psychology
Furness College
Lancaster University
LA1 4YG

Email: becky.ashton@lancaster.ac.uk
Telephone: [insert research mobile number]

Appendix 4-C

Expression of interest form - Version 3, 09/05/2016

Lancaster University

Staff perceptions of well-being and resilience in secure services

Name: _____
Job title: _____
Age: _____
Gender: _____
Ethnicity: _____
Where do you work (including ward name)?
_____
How long have you worked here? _____

I would like to find out more information about this research project. Please contact me on:

Telephone number_____

Email_____

It is best to contact me (days/times):
_____
_____

Signed: _____

Date: _____

Appendix 4-D

Consent form -Version 4, 20/06/2016

IRAS project ID: 204890

Lancaster University

Staff perceptions of well-being and resilience in secure services

	Please tick
I consent to take part in this research project.	☐
I confirm that I have read and understand the participant information sheet. I have been given at least 24 hours to consider the information, in addition to having the opportunity to ask questions and received adequate answers.	☐
I understand that my participation is voluntary and that I am free to withdraw my data up to two weeks after my interview without giving any reason.	☐
I understand that the interview will be audio taped and then made into an anonymised written transcript. Hard copies of anonymised transcripts will be stored in a locked cupboard in the researcher's home whilst analysed. Audio recordings will be encrypted once transferred to a computer.	☐
I understand that I may get upset by some of the topics but I do not have to discuss anything I do not want to.	☐
I understand that anonymous direct quotations may be used in the write up of this study and my identity will be kept anonymous and I agree to this.	☐
I understand that the research data collected during the study may be looked at by the researcher's supervisors at Lancaster University and [redacted]. These supervisors will not have access to your personal information. I give my permission for these two individuals to access this information in order to contribute to analysis.	☐
I understand that if I disclose any information that indicates harm to myself or others including issues with a staff member's practice the interviewer will pass this information on to the relevant people. Where possible, this will be discussed with me first.	☐
I am aware that the results of this study may be submitted for publication at some point in the future and I agree to this.	☐

I am aware that all material will be erased from the tape once transcribed and that anonymised research data will be destroyed after 10 years ☐

I know that I can ask for the tape recording to be stopped at any time and I can ask for the information to be deleted. ☐

Name (please print): _____

Signed: _____ Date: _____

Person taking consent:

Name (please print): _____

Signed: _____ Date: _____

Appendix 4-E

Interview schedule - Version 2, 09/05/2016

Staff perceptions of well-being and resilience in secure services

- ✓ **Introduce myself formally**
- ✓ **Introduce project:** Provide adequate explanation of the project and answer any questions.
- ✓ **Confidentiality:** Before we start, I need to tell you about confidentiality. Everything we talk about today and the information you have given me is completely confidential between us with a few exceptions. Although every effort will be made, it is not possible to ensure that your participation in this study is confidential because this interview is taking place on work premises during the working day. If you tell me something where I am worried about you or another person coming into any harm then it is my duty to inform other professionals in order to keep you and other people safe. This includes concerns about another staff members' practice. In this event, I would talk to you first wherever possible. Also, my supervisors at the University and in the psychology team here will have access to anonymised copies of some of my participants' interviews, just to make sure that what I do is of high quality and not distressing for participants. Also, it is important that you are aware that it is your responsibility to maintain the confidentiality of the service users and staff members that you work with whilst doing this interview. When I write up the results of this study pseudonyms, a non-identifiable name, and direct quotations will be used. I will ensure that any details used will not identify you or other participants. It is also important to make you aware that it is likely that the research project will be published as a research article.

- ✓ **Consent:** Check that the participant gives verbal consent to taking part in study. Provide the participant with a copy of the consent form and ask them to sign it.
- ✓ **Preamble:** Thank you for agreeing to participate in this interview. I would like to have a discussion with you about your thoughts and perceptions of what influences psychological well-being and resilience at work. I am interested in your thoughts about your own well-being and resilience, what you think has positively influenced your well-being and resilience, and what has challenged it. I would like to begin by asking you questions. If you are not comfortable with answering any questions, this is okay and you do not need to respond. All your responses are confidential and will not affect your job in any way.
- ✓ **Examples of Questions:**

Experience of job role

- Can I start by asking you about your job?
- What types of things do you do on a daily basis?
- How often do you have contact with service users?
- How would you describe your experience of working with service users?
- What were your expectations of your role or working here before you started?
- Do you enjoy your job?
- What is good about it?
- What is less enjoyable about it?
- How do you feel about where you work?
- What do you think about the team around you?
- What are your thoughts about the organisation?
- How would you describe your role in the team?
- How do you think working within this team or place influences the job that you do?

About you

- What motivated you to do this type of work?
- How would you describe yourself as a person?
- What qualities are important for working in this place?
- What qualities do you possess that help you to work here?
- What do you personally feel is challenging or difficult about working here?
- What do you do to manage stressful situations here?
- How would other people perceive that you cope with situations that arise at work?

Experiences whilst working

- Can you think of a significant positive experience whilst you've been working here?
    - Why was this experience significant for you?
    - How did you feel at the time?
    - What did you do at the time?
    - What did you do after?
- Can you think of a significant difficult or challenging experience whilst you've been working here?
    - Why was this experience significant for you?
    - How did you feel at the time?
    - What did you do at the time?
    - What did you do after?

Specific questions about psychological well-being and resilience

- What do you think about your own psychological well-being?
- What do you think influences it?
- What helps?
- What reduces your well-being in and out of work?

- What do you think resilience means?
- Would you consider yourself to be resilient?
- What tells you that you are resilient?
- What makes it hard to be resilient?

Appendix 4-F

Debrief form - Version 3, 09/05/2016

Lancaster University

Staff perceptions of well-being and resilience in secure services

Thank you for taking part in this study. Your participation was highly valued and we hope that you found sharing your thoughts and ideas to be positive and rewarding. Your experience will give insight into what influences psychological well-being and resilience when working in secure services, in order to inform services of how to best support staff in the future.

What happens next?

I will transcribe your interview anonymously and then make sense of ideas across different participants. The results of the study will be written up as part of my thesis project and submitted to Lancaster University Doctorate of Clinical Psychology. The report may be published in a journal in the future. I may also present my overall findings to the service. You will be given a summary of the overall findings and you are welcome to request a copy of the final report.

If you found that you are upset after taking part in the interview then please feel free to contact your occupation health department [whereby you can be referred to a confidential counselling service within the trust].

Alternatively, you can contact either Samaritans on 116 123 (24 hours a day, 365 days a year), or your own GP if you feel that you would like further support.

Thank you again for taking part in this study.

Becky Ashton (Trainee Clinical Psychologist)
Lancaster University Doctorate in Clinical Psychology
Furness College
Lancaster University
LA1 4YG

Email: becky.ashton@lancaster.ac.uk
Telephone: [insert mobile number]

Appendix 4-G
FHMREC Letter of Approval

Applicant: Rebecca Ashton
Supervisor: Ian Smith
Department: Health Research
FHMREC Reference: FHMREC15062

19 May 2016

Dear Rebecca,

Re: Staff perceptions of the contributing factors related to psychological well-being and resilience when working in secure services.

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 University Research Ethics Committee (UREC), 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 (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 the Diane Hopkins (01542 592838 fhmresearchsupport@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,

Dr Diane Hopkins
Research Development Officer

CC Ethics@Lancaster; Professor Roger Pickup (Chair, FHMREC)

Appendix 4-H
Letter of HRA Approval

Health Research Authority

Mrs Rebecca Ashton
Lancaster University Doctorate of Clinical Psychology
Furness College
Lancaster University
LA1 4YG

Email: hra.approval@nhs.net

1 July 2016

Dear Mrs Ashton,

Letter of HRA Approval

Study title:	**Staff perceptions of the contributing factors related to psychological well-being and resilience when working in secure services**
IRAS project ID:	**204890**
Sponsor	**Lancaster University**

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

Participation of NHS Organisations in England

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

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

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical 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

and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- 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.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **204890**. Please quote this on all correspondence.

IRAS project ID	204890

Yours sincerely

[redacted]

Assessor

Email: hra.approval@nhs.net

Copy to: *Dr Diane Hopkins (Sponsor contact)*

[redacted] *(Lead NHS R&D contact)*

Participating NHS organisations in England

IRAS project ID	204890

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	*Version*	*Date*
Contract/Study Agreement [Contract and Action Plan]	1	18 December 2015
Contract/Study Agreement [Schedule of events]	1	20 June 2016
Contract/Study Agreement [Statement of Activities]	2	01 July 2016
Covering letter on headed paper [Covering Letter]	3	09 May 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of insurance]	1	01 August 2015
Interview schedules or topic guides for participants [Interview Schedule]	2	09 May 2016
IRAS Application Form [IRAS_Form_02062016]		02 June 2016
Letter from sponsor [Letter from sponsor]	1	19 May 2016
Participant consent form [Participant Consent Form]	4	20 June 2016
Participant information sheet (PIS) [Participant Information Sheet]	4	20 June 2016
Research protocol or project proposal [Thesis protocol]	4	20 June 2016
Summary CV for Chief Investigator (CI) [CV for chief Investigator]	1	26 March 2016
Summary CV for supervisor (student research) [Supervisor CV]	1	26 February 2016
Summary CV for supervisor (student research) [Supervisor CV]	1	17 February 2016

IRAS project ID	204890

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations*, *capacity and capability* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study: Mrs Rebecca Ashton (becky.ashton@lancaster.ac.uk, 01524592970).

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	The sites have not been listed at Part C, however it has been confirmed that it is expected that the participating NHS organisations will be [redacted]
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	The statement of activities and schedule of events will act as the agreement between the sponsor and participating NHS organisations.

IRAS project ID	204890

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			Although formal confirmation of capacity and capability is not expected of all or some organisations participating in this study (see *Confirmation of Capacity and Capability* section for full details), and such organisations would therefore be assumed to have confirmed their capacity and capability should they not respond to the contrary, we would ask that these organisations pro-actively engage with the sponsor in order to confirm at as early a date as possible. Confirmation in such cases should be by email to the CI and Sponsor confirming participation based on the relevant Statement of Activities and information within this Appendix B.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No funding will be provided to participating NHS organisations.
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
6.1	NHS Research Ethics Committee favourable opinion	Not Applicable	No comments

Section	HRA Assessment Criteria	Compliant with Standards	Comments
	received for applicable studies		
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

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.
There is one site-type. Interviews with ward-based staff will take place at the participating NHS organisations. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England 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. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.
The HRA has determined that participating NHS organisations in England **are not expected to formally confirm their capacity and capability to host this research,** because the research will

involve 60 minute interviews with between 8 and 20 ward-based staff which may take place outside of working hours. A local member of staff will be also required to facilitate recruitment by circulating a study information pack to potential participants by email.

- The HRA has informed the relevant research management offices that you intend to undertake the research at their organisation. However, you should still support and liaise with these organisations as necessary.
- Following issue of the HRA Approval letter, and subject to the two conditions below, it is expected that these organisations will become participating NHS organisations 35 days after issue of this Letter of HRA Approval (no later than **5th August 2016).**
    - You may not include the NHS organisation if they provide justification to the sponsor and the HRA as to why the organisation cannot participate
    - You may not include the NHS organisation if they request additional time to confirm, until they notify you that the considerations have been satisfactorily completed..
- You may include NHS organisations in this study in advance of the deadline above where the organisation confirms by email to the CI and sponsor that the research may proceed.
- The document "Collaborative working between sponsors and NHS organisations in England for HRA Approval studies, where no formal confirmation of capacity and capability is expected" provides further information for the sponsor and NHS organisations on working with NHS organisations in England where no formal confirmation of capacity and capability is expectations, and the processes involved in adding new organisations. Further study specific details are provided the *Participating NHS Organisations* and *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections of this Appendix.

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 the minimum expectations for education, training and experience that PIs should meet (where applicable).
A local collaborator will be required at participating NHS organisations where members of the external research team will be conducting study activity on NHS premises. GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
A Letter of Access will only be required if members of the research team will be conducting study activity in patient-care areas of the participating NHS organisations. No Disclosure and Barring Service or Occupational Health checks will be needed where a Letter of Access is required.

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Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.
• The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN