MAJOR RESEARCH PROJECT

NAOMI LAW MA Hons

INDIVIDUAL AND ORGANISATIONAL CHALLENGES FOR PERSONALISED CARE ON AN INPATIENT WARD: THE STAFF TEAM PERSPECTIVE

Section A: Patient Experiences of Acute Psychiatric Care: A Systematic Review of the Literature and Consideration of Obstacles to Care

Word Count: 8000 (247)

Section B: Finding Compassion Within the Chaos: A Constructed Grounded Theory of Acute Psychiatric Staff Experiences

Word Count: 7998 (255)

Overall Word Count: 15998 (502)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

For submission to the Journal of Mental Health

APRIL 2014

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

I am very grateful to my research supervisors: Dr Sue Holttum and Dr Sharon Lines. I could not have completed this study without their invaluable knowledge, support and, most of all, their boundless enthusiasm for this subject area. My thanks also go to my family and friends, who so tirelessly listened, discussed, offered suggestions, and showed unwavering confidence in me and in the study from the outset. I am thankful to my Salomons colleagues in the Grounded Theory Study Group and for all the practical input and emotional support they offered. Most importantly, I would like to thank all the participants who gave up time in their busy, demanding schedules and were so generous in sharing their experiences with me. This research is dedicated to them and the rest of the NHS mental health staff whose passion, skill and commitment has been so inspiring to me throughout my training.

Summary of Major Research Project

Section A: A systematic review of the empirical research literature on patient experiences of acute psychiatric care, from publication of The NHS Plan (2000) to the present day. The background and political context to the inpatient setting and significance of patient experience is presented, followed by a systematic review of the extant literature on patient experiences of acute psychiatric care. Consideration is then given to contributions from the theoretical and empirical literature on potential obstacles to improving quality of acute psychiatric care. Finally, clinical implications and suggestions for future research are given.

Section B: A grounded theory study of staff experience on acute psychiatric wards. Semi-structured interviews were conducted with ten staff across a range of disciplines from seven acute psychiatric wards within one NHS Trust. A grounded theory was constructed and eleven categories identified. The model indicates that while staff are motivated to engage with patients, they are restricted by both practical and emotional demands. The findings are discussed in relation to existing research and both clinical implications and potential future research areas are considered.

Section C: Appendices.

Contents

Section A

Section B

List of Figures

List of Appendices

Section C

MAJOR RESEARCH PROJECT

NAOMI LAW MA Hons

Section A

Patient Experiences of Acute Psychiatric Care: A Systematic Review of the Literature and Consideration of Obstacles to Care

Word Count: 8000 (247)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

For submission to the Journal of Mental Health

APRIL 2014

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Terms

For the purpose of this review, the terms “patient” and “service user” will be used interchangeably to describe a person who uses mental health services, in order to reflect the frequent occurrence of both these terms within the research literature.

Abstract

The aim of this paper is to systematically review the empirical literature on patient experiences of acute psychiatric care, covering the period of significant NHS reform and stated commitment to individual patient need since The NHS Plan (Department of Health, 2000). The quality of acute psychiatric inpatient services has been under particular scrutiny during this time, and despite numerous policy documents and guidelines for compassionate care, claims have been made that little improvement has been seen by service users. Research on patient experiences is critically evaluated. Four distinct areas are covered and used to structure the review: Safety and the Ward Environment; Relationships with Staff; Power, Coercion and Integrity; and Service User Led Research. Following this, several contributions from the theoretical literature on what might be preventing improvement to acute psychiatric care services are considered, including psychoanalytic theory, a social psychological consideration of social context, a compassion-focused formulation and burnout. Finally, implications for further research and clinical practice are discussed, focusing on how to deliver the kind of care asked for by service users and break down the barrier between patient and staff groups.

Keywords: user experience; mental health, inpatient

1. Introduction

An essential component of UK NHS policy in recent years has been a stated commitment to delivering a service which is based on and informed by the individual needs of its patients. In 2000 the Labour Government set out a ten year plan designed to reshape the NHS, criticising its previous lack of patient-centred care and reports of variable quality (Department of Health, (DoH), 2000). The fault, it was suggested, lay not with uncaring staff, but with an outdated system, which required significant changes. This was particularly the case for acute psychiatric inpatient services; service user feedback highlighted serious concerns regarding lack of staff contact, meaningful activity, service user involvement, or care which maintained dignity (DoH, 2002).

1.1 Inpatient Settings

Psychiatric inpatient services have changed substantially over the last five decades as a result of "deinstitutionalisation"; the focus of mental health care shifting from large psychiatric institutions to local community-based services. In the UK this process began with Enoch Powell's Hospital Plan for England in the 1960s, and has now arguably reached completion, as well as being mirrored internationally (Lelliott & Quirk, 2004). While the benefits of allowing service users to remain connected to their communities and recover at home are clear, this shift arguably had a detrimental effect on the remaining inpatient services. As resources were concentrated elsewhere, the threshold for admission to acute psychiatric wards increased, whilst high demand for beds led to concerns that care could be compromised and inpatient services left with little direction or development (Bowers, 2005).

1.2 Patient Experience

The closure of long-stay psychiatric hospitals was welcomed by groups of service users and professionals who had been critical of the psychiatric system (Lakeman, McGowan & Walsh, 2007). Campaigns for improved conditions on wards and greater levels of

autonomy for psychiatric patients began to gather support from patient-only groups; the beginnings of the Service User Movement in mental health. With the formation of service user networks such as the UK Advocacy Network in the 1980s, service users began to find a voice which, although it began outside of mainstream health services, quickly started to influence both policy and practice within both the UK NHS and research arenas (Wallcraft & Bryant, 2003). This is evident in the significant increase in research which uses interview or questionnaire data on service user experiences, or the more recent development of user-led research (Walsh & Boyle, 2009), as well as the NHS Patient Survey Programme.

1.3 Current UK Political Context

Current government policy continues to stress the importance of placing the service user's needs above those of the professional or the system, as well as actively involving service users in their own care and assuring safety and dignity (DoH, 2011). The standards of Accreditation for Inpatient Mental Health Services (2010) state that all patients must be provided with needs-based therapeutic and social activities, including during evenings and weekends, as well as daily one-to-one contact with staff. However, it is not clear that practice always follows policy in this area, or that the changes that the NHS has undergone even make the realisation of such a scenario achievable. One method by which this can be evaluated is research which focuses on the experiences of service users in acute psychiatric settings, in order to consider what service users themselves want from inpatient staff and whether they are receiving it. The question of how to improve quality of care in inpatient settings is particularly salient following the recent inquiry into Mid Staffordshire NHS Trust (The Mid Staffordshire NHS Foundation Trust Inquiry, 2010). The subsequent Francis Report (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) explicitly stated the importance of attending to patient experience, both in the report itself and as a future improvement to the Trust's own problematic practices. Unlike The NHS Plan, the Francis

Report did attribute blame to individual staff members' lack of care and compassion as well as organisational failures. This led to Prime Minister David Cameron arguing for incentivised pay based on demonstration of compassion from nursing staff and the introduction of the three year Compassion in Practice strategy (DoH, 2012).

2. Aim of Review

Given the current political and clinical significance of both patient experience and quality of inpatient care, as well as the substantial changes that mental health inpatient services have undergone as part of broader NHS reform, a review of patient experiences of acute psychiatric care is warranted. This systematic review will evaluate the existing empirical research in this area since The NHS Plan. This will be followed by a consideration of both theoretical and empirical literature which explores some of the potential obstacles to delivering the improvements which both service users and policy call for. Finally, potential future research areas which may help us to understand more about these obstacles will be indicated.

3. Methodology

The terms Patient* / Client* / Service user* AND Inpatient* Ward* / Acute Psychiatric AND Experience* were entered into PsychInfo, MEDLINE, Web of Science and Google Scholar. Searches were conducted between September and December 2013. Articles published pre-2000 were excluded, to focus on patient experiences after publication of The NHS Plan. Studies were also excluded if conducted within a setting other than adult acute psychiatric, or if the aim of the study focused on one narrow aspect of patient experience e.g. seclusion. Non-UK studies were included in recognition that aspects of the inpatient experience such as staff-patient relationships and feeling treated with respect and dignity may be regarded as universal human needs (Rethink, 2012; Roberts & Boardman, 2013). International studies might also highlight the potential impact of service or cultural context.

Where service contexts were particularly divergent (e.g. involuntary admission wards), this has been stated, however, there may be limits to the conclusions possible to draw owing to potentially hidden differences in, for example, service ethos. Full details of exclusion criteria and search strategy are given in Appendices 1 and 2. All identified studies used qualitative methodologies, likely owing to the focus on patient experience, rather than aspects which might be better assessed quantitatively such as patient satisfaction. The quality of the studies was therefore assessed using Elliott, Fischer and Rennie's (1999) guidelines for qualitative research (Appendix 4).

4. Patient Experiences of Acute Psychiatric Care

Twenty three studies were identified (see Appendix 3) and will now be discussed in relation to four key themes drawn from the literature: Safety and the Ward Environment; Relationships with Staff; Power, Coercion and Integrity; and Service User Led Research. All studies are UK-based unless otherwise stated.

4.1 Safety and the Ward Environment

Six studies discussed themes of safety and the physical ward environment. Wood and Pistrang (2004) stated their perspective on the subject of patient safety clearly: It was concern at the increasing body of evidence suggesting that wards could be violent, unsafe environments that prompted their study. The authors employed two separate methods of credibility checks involving theme auditing by the second author and theme/quotation matching by the third author, although no respondent validity checks were carried out. Nine patients and seven staff were interviewed, the former group being the focus here and comprising five men and four women aged 26-61 (mean 43) with a range of diagnoses including depression, bipolar affective disorder, schizophrenia and personality disorder. Thematic analysis indicated that assault, intimidation and sexual harassment were not uncommon. Female patients, especially those with a history of abuse, felt uncomfortable with

mixed-sex wards and shared rooms. Staff were described as frequently unavailable or unwilling to help and practices such as seclusion and restraint with little perceived justification led to fear of staff as well as other patients. The authors recommended more reflective practice to enable greater responsiveness to patients' need for security, as well as providing single rooms.

Female patients' experiences were specifically attended to in a study by Cutting and Henderson (2002), in which focus groups and interviews were conducted with women who had used inpatient services. The authors did not state the number of participants, nor any demographic information, which makes it difficult to 'situate the sample' (Elliott et al., 1999) and put the data in context. Furthermore, although the stated method of analysis was grounded theory, little information was given on the process of analysis and the results were presented in several large tables with no elaboration, simply listing the five themes and associated categories with illustrative quotes. Themes included experiences of violence, feeling vulnerable, lack of cleanliness on the ward and an oppressive atmosphere, but no explanation was given as to how the categories related to each other or might be expressed theoretically.

Jones et al. (2010) focused on patient feelings of safety on psychiatric wards in a thematic analysis of 60 patient interviews. This included 36 men and 24 women aged 19-81 (mean 43), all of whom were current inpatients. Although the majority reported feeling safe on the ward, a significant number described bullying and coercion from other patients, often linked to alcohol and drugs trading on the wards. Patients also reported incidents of racism from both patients and staff and theft of possessions. They described strategies they used to keep themselves safe, such as keeping a distance from others, potentially resulting in more superficial relationships. This paper represents the qualitative arm of a larger study on patient

safety, and the analysis itself is rather superficial. There is no evidence of author reflexivity or credibility checks, and little sense of how the themes link together.

A recent paper by Stenhouse (2013) presented interviews with six men and seven women aged 18-65 years from one acute ward. A holistic analysis of each interview revealed themes of an expectation of safety from their own self-destructive thoughts, contrasted with threat felt from other patients. This threat from others, Stenhouse argued, could arise from awareness of dominant discourses around mental health and violence, which persist even in service users themselves – an example of self-stigmatisation. Patients also drew on gender discourses in their concern that only male nurses could protect them from such threat; these beliefs were compounded by the hospital practice of sending only the male nurses to attend to emergencies on other wards. Stenhouse stressed the need for trusting relationships between staff and patients, enabling fears to be discussed and reassurance offered. Focusing on the patient experience of safety in this paper allows a thorough exploration of this subject, with coherence across themes and a clear presentation of the overarching story. However, all participants were recruited from one ward, which limits the extent to which results may be seen as relevant to other contexts.

Other studies have presented more positive experiences of safety on wards, including a US study by Thomas, Shattell and Martin (2002) using descriptive phenomenological analysis. For this and all non-UK studies included it is important to note that differences in healthcare systems limit the findings' transferability to a UK context. Patients included five men and three women aged 23-58, with a range of diagnoses including depression, bipolar disorder and substance abuse. Bracketing interviews were used to make researchers aware of their own preconceptions, but these were not stated and no further credibility checks were described. The eight participants described the ward as a "refuge from self-destructiveness", allowing them to feel secure, and peer support thrived. Positive comments were also made

about the environment, which was described as clean and caring. However, patients reported superficial interactions with staff and a yearning for deeper contact; the authors noted that nurses were never referred to by name, and the closed nurses' office window represented this barrier.

Similar themes arose in a Norwegian study by Borge and Fagermoen (2008), who interviewed 15 patients; eight men and seven women aged 19-58 (mean 41) who had received a range of diagnoses including social phobia, depression, eating disorder and post-traumatic stress disorder (PTSD). Patients were encouraged to talk about positive as well as negative experiences and it is possible that this, along with the fact that the interviewers were staff members, may have biased results, which the authors acknowledged. Transcripts were analysed using Giorgi's (1997) phenomenological-hermeneutic approach. Patients spoke of a beautiful environment, with artwork, gardens and a church. The atmosphere was described as warm and familial, with a culture of equal treatment and acceptance. However, in the evenings the "passive patient" identity separated them from the busy nurses who had other roles to perform from within the closed ward office. The authors recommended that staff include more informal interaction outside of structured therapeutic time, as well as encourage patients to feel a sense of agency during leisure time. Although the description of the ward environment in these two studies might suggest differences in resources between these and NHS facilities, it is important to note that a resource-rich, nurturing environment is not sufficient – relationships with staff are a significant component of the inpatient experience.

4.2 Relationships with Staff

Although all the studies reviewed included the importance of staff-patient relationships, six studies identified this theme as highly significant. Using the same data as her 2013 paper on safety described above, Stenhouse (2011) looked separately at the concept of "Help" as part of the inpatient experience. The author identified an expectation from

patients that they would be helped whilst on the ward, and that this help would come through the development of relationships with the nursing staff. However, nurses rarely approached them to talk, leaving patients alienated and believing that nurses didn't care, or else drawing on narratives of staff shortage and administrative burden to explain nurse unavailability. This resulted in what Stenhouse described as "mutual avoidance", wherein patients relied on each other for support which, though sometimes effective, was difficult to manage emotionally. This is another clear and simple analysis which highlighted a potential mismatch between patient and staff expectations and a need for greater communication between the two groups. However, given that all participants were recruited from one ward and that nursing staff suggested potential participants to the researcher, it is likely that not all viewpoints were represented.

Also considering the concept of being helped, Koivisto, Janhonen and Väisänen (2004) interviewed nine patients in order to find out more about what patients described as helpful experiences on acute psychiatric wards in Finland. All patients were either on their first or second voluntary admission and were recovering from psychosis. Using Giorgi's phenomenological method, the authors identified two main categories: Protection from Vulnerability and Restructuring/Empowering the Self to Cope with Daily Life. Patients stressed the importance of the physical presence of nurses and their ability to monitor the situation and intervene if necessary to prevent harm to self or others. Furthermore, nurses were expected to convey understanding and respect, allowing patients to maintain integrity by supporting them to make free choices. Although patients did describe opportunities to speak to staff and be informed about their treatment, these interventions were seen as unstructured, unreliable and with unclear aims. A focus on positive experiences allows this study to be clear about what ideal care delivery might look like. However, there is little reflection as to what extent patients might have realistic expectations of care, or whether the

form of monitoring described is even desirable when considering the need to maintain a sense of self-efficacy and not to foster dependency during psychiatric admission.

Conversely, Moyle (2003) did consider the potential reasoning behind a managed distance in nursing care, drawing attention to a dichotomy between the close, intimate relationship expected by patients and the more distant relationship which nurses provided. Moyle interviewed seven patients (six women and one man aged 38-57 diagnosed with depression) in Australia, again using Giorgi's method, and questioned whether nurse training might make nurses fearful of creating dependency in patients. No credibility checks were described and the analysis appears to have been carried out by Moyle alone, which could affect its validity. Although the patients interviewed described receiving the kind of care they desired upon admission – constant staff presence, time to talk, reassurance and even physical embrace – this quickly changed. Subsequent nursing care was seen as purely symptom-focused which left them feeling like a diagnosis, rather than a person. Nurses would keep a distance, observing and reporting to other staff rather than involving or empowering the patient. Moyle questioned whether patient expectations are always reasonable, an important point which highlights a potential limitation of patient experience data; it is just one side of the provision of care, albeit a crucial one. Nevertheless, her recommendation of creating dialogues and debates of nursing practice between nurses and patients seems a viable means of addressing conflicting expectations, as well as potentially creating improved interactions.

Many studies of inpatient experiences focus on the nurse-patient relationship – this is understandable given that this staff group is based on the ward full-time, so arguably has the greatest potential to provide therapeutic care (Cameron, Kapur & Campbell, 2005). However, this risks marginalising the role that other staff play. Talseth, Jacobsson and Norberg (2001) chose to focus on Norwegian inpatients' experiences of physicians and conducted unstructured interviews with 21 patients (10 men, 11 women), using Ricoeur's (1976)

phenomenological-hermeneutic analysis. Each stage of analysis is well detailed and two opposing themes enable the results to be organised clearly into two potential approaches that patients perceived clinicians to use: Participating or Observing. The former approach was characterised by genuine and frequent contact with patients whereby the physician took them seriously and did not claim to have the "right" answer. The latter involved distance, a denial of personal experience in preference of medical theory or medication and an objectifying, controlling stance which left patients feeling rejected. Patients unsurprisingly preferred the participatory approach and the authors described how this allows them to feel confirmed as a person. The clarity of the analysis allows for a thorough explanation of why patients might have diverse experiences of inpatient care, which interactions patients found most beneficial, and why that might be. Using pseudonyms or another means of linking quotes to particular patients might have given more information on whether different patients might have had different experiences of the same clinicians, so as not to place all variability on clinician behaviour alone.

Crossley and Jones (2011) focused on the experience of shame in inpatient psychiatric care, upon which the relationships formed with staff can have significant influence. Although the authors conducted focus groups with both service users and staff, the results of the former groups only are discussed here. Five men and five women with previous inpatient experience and a range of diagnoses including schizophrenia, bipolar disorder, depression and personality disorder took part. Thematic analysis was used, but the authors gave little detail of the process and did not declare their own perspective, showing little evidence of reflexivity. Furthermore, in asking participants how their understanding of the term "shame" related to their experience of inpatient care, participants were prompted to talk about shameful experiences which may have discouraged the inclusion of more positive experiences. Patients spoke about a loss of adulthood and autonomy, provoked by

requirements to seek permission to go outside, or queuing up to receive medication. Ward rounds and continuous observation felt intrusive and exposing, and patients felt sensitive to potential disrespect from staff, such as being labelled a "bed-blocker". The authors noted that self-shaming as a result of societal stigma might influence how patients perceive staff treatment, but warned against practices which may inadvertently trigger this internal shame, such as enforced passivity, lack of activities and large, insensitive ward rounds.

The centrality of staff-patient relationships within the inpatient experience was powerfully conveyed in Thibeault, Trudeau, d'Entremont and Brown's (2010) study on the therapeutic milieu. The authors noted that ward milieu, or atmosphere, is a subject which has been overlooked in recent research, potentially resulting in increasingly rigid and oppressive ward environments. In this Canadian study, six inpatients (four men and two women aged 20-75) were interviewed by a research team made up of two clinicians and two service users. Ample evidence was given of reflexivity and a detailed description of the analytic process, using Heidegger's (1962) interpretive phenomenological analysis and team discussions to check the credibility of emerging themes. When asked to talk about the ward environment, patients automatically spoke about relationships, leading the authors to conclude that relationships create the meaning of the inpatient experience.

Results covered the themes of Connection, Restraint, Healing and Abandonment. Patients described staff who appeared disinterested and disengaged, although some were able to transcend the strict ward rules governing interaction e.g. coming out of the nurses' office to make conversation with patients. "Restraint" referred to staff holding back their presence, which afforded them power and control over patients as interaction became a "special" occurrence, valuable but unusual. Healing could take place, both in recreational activities and relaxation. However, this was bleakly contrasted with the effects of seclusion, both on those who experienced it and even on observers – leading to a sense of violated dignity,

punishment and dehumanising lack of agency. Illustrative quotes were well-chosen throughout to invite the emotional engagement of the reader with the patient experiences. The authors concluded that patients require a relationally-focused setting rather than a biomedical one.

4.3 Power, Coercion and Integrity

Unfortunately, many patients report experiences of feeling coerced and subjected to humiliating or dehumanising treatment by staff – particularly those in the seven studies reviewed in this section. Hughes, Hayward and Finlay (2009) interviewed twelve patients who had been hospitalised involuntarily. Although this may mean that the results are not as relevant for voluntary patients, this study seemed important to include. This is partly because although psychiatric admission rates overall are falling, detention under the Mental Health Act (2007) is rising in England: 50,408 detentions during 2012/13 which is a 4% increase on 2011/12 (Health & Social Care Information Centre, 2013). Furthermore, as demonstrated by the studies reviewed, experiences of coercion are common to both voluntarily and involuntarily admitted patients. Hughes et al. give detailed demographic information, describing the participants as five men and seven women aged 19-62 with diagnoses including bipolar disorder, personality disorder, schizophrenia and depression. Years of contact with mental health services ranged from 2-34 (mean 14.5) and number of previous hospitalisations ranged from 1-20 (mean 7.3). Thematic analysis suggested that patients' perceptions of self were mediated by their interactions with staff. The authors used pseudonyms, allowing quotes to be easily linked together. Those that described feeling ignored, being physically restrained or restricted in their ability to go outside the ward felt that it resulted in a loss of self-respect and self-efficacy, even post-discharge. Some with histories of childhood abuse found restraint particularly traumatic and could become aggressive in response. The majority also spoke negatively about medication, particularly

when physically forced to take it. The authors advocated greater use of "therapeutic risk taking" on wards; to avoid removing belongings and furniture as part of risk management which may be experienced as punitive. They also warned against contributing to "conflict cycles" as described by the patients who responded aggressively to use of physical force.

Rogers and Dunne (2011) ran a focus group with 10 former inpatients with a diagnosis of borderline personality disorder (BPD), including nine women and one man aged 21-45. The diagnostic homogeneity of the sample may limit the transferability of the findings, but a recent Cochrane Review estimated that up to 20% of psychiatric inpatients have a BPD diagnosis (Stoffers et al, 2012). The focus group was facilitated by ex-service users, but a thematic analysis was carried out separately by two assistant psychologists – these elements may have generated more honest, accurate data and potentially a more independent, unbiased analysis. Participants spoke about staff prejudice, sectioning being used as a threat (indicating a potentially small difference between 'voluntarily' and 'involuntarily' admitted patients) and their opinions being dismissed. Results were presented in a table with little elaboration or sense of the personal stories of the participants. Although some concrete recommendations were made e.g. 'voluntary admission' should not be presented as merely an alternative to sectioning, the reader is left with a somewhat superficial sense of participants' experiences.

Robins, Sauvageot, Cusack, Suffoletta-Maierle and Frueh (2005) focused specifically on distressing events on wards in the US. They interviewed 27 patients (16 men and 11 women), 18 of whom reported adverse events (but could arguably have been prompted to do so by the negative bias of the questions). A brief description of the method of analysis was given but with no specific methodology and little detail. Themes were organised into two main categories: The Hospital Setting, and Interactions with Staff. Interviewees described the constant threat of physical violence and the arbitrary nature of ward rules. Staff were accused

of treating patients impersonally, unfairly and even humiliating them. Several patients reported incidents which were very disturbing, including being left in a straightjacket for 24 hours (and urinating in their clothes as a result) and having cold water thrown over them to wake them up. The authors gave no indication of whether or how these allegations were followed up or the ethical framework in place for carrying out this study, which leaves the reader with great concern and unanswered questions. The authors' conclusions that it is important to call attention to the "little things" which may impact emotionally on patients seem wholly inadequate given the intensity of the incidents described.

Another US study was carried out by Shattell, Andes and Thomas (2008), interviewing 10 patients and 9 nurses (the focus here being data from the former group only). The patient group comprised six women and four men, with at least one diagnosis including depression, substance abuse, personality disorder, anxiety disorder and PTSD. Interviews were described as "phenomenological" but the analysis appeared to be thematic analysis, although this is not stated. Patients described feeling imprisoned and bored, with a lack of activities available to occupy them and being unable to go outside for days at a time. Again, arbitrary enforcement of rules was claimed, within a context of feeling controlled or bullied by punitive staff. Medication was seen as a means of enforcing compliance and powerlessness. Furthermore, patients expressed significant doubts about the benefits of treatment, which seemed assigned arbitrarily. Peer support was relied upon, whilst nurses remained locked away in their office. The picture painted is more reminiscent of a prison than a hospital, where caring seems to have been substituted for rigid rule enforcement and the importance of obtaining compliance rather than therapeutic relationships. Themes were well captured using quotes and examples, but there is a lack of clarity in the relationship between themes as well as no sense of the authors' perspective or credibility checks other than one presentation of results to a research group.

The three final studies in this section consider the possible effects of such coercive and powerless experiences on patients and how they might respond. Lilja and Hellzén (2008) interviewed ten participants (three men and seven women aged 32-64) who had been inpatients on Swedish psychiatric wards with a staff-patient ratio of 1:5 within the past five years. Asking former as opposed to current patients to tell their stories might influence results, particularly as participants were self-selecting, which may have resulted in participants with stronger views about their treatment volunteering. Results from a qualitative content analysis indicated largely negative experiences, including a ward environment devoid of intimacy; over-reliance on medication; arbitrary rules seen as deliberately creating distance between staff and patients; and physicians "steamrollering" patients into particular treatment. In response to this, patients attempted to regain control through different coping strategies: resignation, aggression or solidarity. Resignation could take various forms, such as sleeping all day or retreating into one's own world, although participants explained that this could sometimes be an act, put on for the staff. Other patients became aggressive as a means to power, and others stuck together in the absence of staff. Although there were some positive experiences of human patient-staff relating, participants overwhelmingly described a world in which they became passive, powerless and struggled to maintain an identity outside of "patient". Although results seemed very negative overall, both respondent validation and discussion with an independent colleague were used as credibility checks, indicating that the results shown are an accurate depiction of the experiences of those service users.

Johansson and Lundman (2002) focused on the experience of involuntary psychiatric care, conducting unstructured narrative interviews with five patients (three women and two men aged 27-49) in Sweden and using Ricoeur's phenomenological-hermeneutic analysis. Patients described inflexible rules and coercive treatments as well as staff violence which diminished patients' sense of human value and integrity. Protests were raised to this either

through formal legal channels or through physical resistance, but with little effect. Care was also described as being delivered without patient participation or basic information which left patients feeling dehumanised and ignored by staff. Some patients described more positive experiences, such as making decisions about their care, or being protected. Interestingly, involuntary care was sometimes seen as justifiable and did not have to involve coercion. Therefore the authors concluded that patients did see opportunities to be respected and cared for, contrasted by great losses of freedom, information and integrity. Given the small number of participants it would have been helpful to understand more of each patient's story, particularly in making sense of some contradictory themes; it was unclear how many patients reported each theme. Furthermore, although the authors stated that the interviewer's influence on the narratives should be taken into consideration, the fact that they did not declare their perspective makes it impossible to do this.

Johansson, Skärsäter and Danielson (2009) conducted a further Swedish study using interviews with ten patients and qualitative content analysis. Useful demographic information allows the reader to situate the sample; participants were eight women and two men with diagnoses including bipolar disorder, depression, anxiety disorder and anorexia nervosa. Patients had experienced between one and five previous admissions in the past six months (mean 1.9). The researchers' role was less clear as no evidence of reflexivity or the authors' position was given. Two main contradictory themes were identified – Getting Alleviation from Suffering and Being Exposed to Stress, demonstrating that the acute ward can evoke divergent reactions in patients. However, because it was not stated which patients reported which themes, the reader is left uncertain whether some reported both themes, or different patients had different experiences. When staff showed patients respect as a human being by being humble, patients felt strengthened, as they did by being active in their own care. The ward was described as a "place of refuge" that felt peaceful and pleasant. However, patients

also reported a lack of choice and feelings of dependency which led to them "fighting" with staff in order to have a voice. Patients felt trapped, under surveillance and were threatened with sectioning. The authors identified the feeling of being controlled as making the power differences between staff and patients highly visible. Patients either chose to accept this situation or attempt to resist, but were often not in a position to do so. This was experienced as undermining dignity, as well as undermining the alleviation of suffering also described.

4.4 Service User Led Research

Although experiences on wards often seem characterised by feelings of powerlessness, the service user movement has allowed some of that power to be reclaimed by service users taking up the positions of both participant and researcher. The following four studies are examples of research conducted by current or former service users. Walsh and Boyle (2009) argued for the importance of user-led research within a research culture which tends not to value the expertise of service user researchers and instead places randomised controlled trials at the top of the research hierarchy and service user opinion at the bottom (Haigh, 2012). The authors, who are themselves service user researchers, passionately put forward an alternative perspective, that user-led research has much to tell us, particularly when it comes to research on service user views of mental health care, and that such research can have ample experimental rigour. They provided a detailed description of their methodology – 55 service users across eight hospital sites (an impressive number for a qualitative study) took part in ten focus groups, although little demographic information was given which makes it difficult to situate the sample.

Content analysis was used to analyse transcripts with some credibility checks between authors using comparison and discussion, but no respondent validation. Patients spoke about the importance of personal time with staff which felt humanising, within a context of feeling controlled and powerless. They felt that staff prioritised hospital routines and medication over

patient needs and that most of their interaction with staff was limited to being observed, rather than engaged with. Patients also described a lack of information and communication regarding their treatment and poor patient involvement, which contributed to feelings of powerlessness. The paper ended with a list of recommendations from admission to discharge, advising greater levels of patient autonomy and information. These are useful conclusions but were surprisingly bureaucratic in nature (meetings, minutes, information, etc.), with little consideration of the more relational comments patients had made.

Gilburt, Rose and Slade (2008) presented another user-led participatory study, two of these authors being service users with experience of psychiatric admission. A focus group was conducted with ten patients, followed by unstructured interviews with a further nine (in total 10 men and nine women), covering 10 different hospitals between them, some participants having had multiple admissions. This represented a useful breadth of experience which increased the potential relevance of results. Thematic analysis established that the experiences described were situated within the context of relationships on the ward, with themes such as Communication, Coercion, Safety and Trust. A clear sense of how themes relate to each other was given, for example, if interaction with staff is characterised by threats, power abuse and forced medication then patients feel unsafe and lose trust. Problems with a lack of cultural competency and overt racism from both individual staff and the psychiatric system were identified. Patients described feeling trapped in a dirty, crowded hospital environment. The authors concluded that relationships mediate the inpatient experience, and the quality of communication mediates experience of relationships. Staff who communicated in a disrespectful, coercive or discriminatory way enforced a power imbalance which undermined any attempt at providing safety or therapeutic benefit. The authors' description of the ability of user-led research to empower the participants demonstrated how

such research can potentially generate more honest and personal data than research conducted by professionals without service user experience.

Users' Voices, a large-scale report by Rose (2001) in collaboration with the Sainsbury Centre for Mental Health, used a User-Focused Monitoring (UFM) approach, in which over 500 service users across England were interviewed. The 61 interviewers were service users themselves and were involved in every stage of the project, and Rose noted that participants reported feeling more relaxed and willing to open up once they knew that the interviewer was also a service user. A range of services and sites were covered, but for the purpose of this review only the data from Naseberry Court will be considered as this is an inpatient unit whereas the other sites included community services. Therefore it was not possible to identify which parts of the data pertained to inpatient services.

During this site visit 26 patients were interviewed and a discussion group held with six ex-patients – unfortunately no demographic information was given. Although the study used a mixed-methods approach, the site visit data are purely qualitative and no specific method of analysis was stated; the presentation of results was "discursive". Rose stressed the methodological rigour of the study, but the lack of information makes this difficult to assess. Results were presented according to the main areas of concern across all interviews: Patients felt they were not given adequate information on their treatment options or rights and so relied largely on other patients for this. They described feeling bored, over-medicated and ignored whilst the nurses attended to paperwork or talked to each other. Rose recommended user-led staff training to encourage greater understanding of the service user experience and called for significant improvements in both environment and therapeutic activity. This was an impressive, large-scale study and the consistency of results with other research implies its validity. However, the presentation of results could have been improved with the use of quotes or patient case studies to give the reader more of a sense of individual stories.

A second UFM project was conducted by Bristol Mind (2004) in which 76 former inpatients at three psychiatric hospitals in Bristol were interviewed – detailed demographics were given which help to situate the sample. Participants were 32 men and 42 women (two not stated), for 19 of whom this was their first admission. Depression was the most common diagnosis (25 patients) although bipolar disorder, schizophrenia and others were also given, and only 38 patients said they agreed with their diagnosis. Descriptive statistics on patient satisfaction were presented and qualitative data were analysed using thematic analysis, covering themes such as Staff, Environment and Treatment – nine in total. Illustrative quotes helped to bring the data to life and each section ended with clear recommendations based on patients' comments. In keeping with other research, patients described very mixed relationships with staff, largely dependent on whether they felt that staff cared for and respected them. Boredom and restrictions on freedom to leave the ward, even for those under voluntary admission, were raised as concerns, as well as a need for more space to express emotion and be seen as a person. The high demand for talking therapies was often not met, in favour of medication; often perceived as forced. Patients also reported a lack of available treatment information which resulted in them feeling disempowered. The report stressed the need for greater patient involvement in care planning and an increase in both meaningful and therapeutic activity, as well as a strengths-based approach from staff. This was a useful and comprehensive assessment of the needs of patients at these three hospitals, but the size of the report and the number of recommendations made (up to 30 at the end of each of the nine sections) felt overwhelming. Attempting to synthesise the themes into something more succinct would have been helpful.

4.5 Summary

Empirical evidence from both UK and international studies paints a rather bleak picture of inpatient services. Although there are examples of compassionate and

individualised care, the majority of service users report feeling powerless, bored and ignored by staff. Although the studies were conducted in a number of different settings, both NHS and international, the commonalities between inpatient experiences are striking, indicating that such relational issues are present regardless of, for example, resources or service values. Quality of the studies is varied, but one key issue within this body of qualitative research is a lack of reflexivity and willingness of the authors to declare their own perspective and consider how it might influence results. Qualitative research is particularly vulnerable to this form of bias due to the role the researcher has of both carrying out the interviews and interpreting the data, so a negative bias might have resulted from a lack of bracketing of assumptions and credibility checks. However, many studies did involve both respondent validation and independent audit from fellow researchers. Qualitative research does not seek to make generalisations, although it is nonetheless important to note that the small participant numbers which are typical across these studies limits the potential transferability of the findings to different settings. However, the fact that similar themes arose across different countries, settings and individuals speaks to the validity of the results presented. It is encouraging that there has been a recent increase in the number of studies on service user experiences which have been conducted by service user researchers. Although this might also risk bias based on the authors' own experiences, there is evidence that service user interview data collected by user interviewers is more valid in some ways than that collected by professional interviewers. For example, where there are negative experiences, these are more likely to be reported to another service user and less to a professional (Clark, Scott, Boydell & Goering, 1999).

5. Potential Obstacles to Care

Despite both service users and NHS policy increasingly highlighting the importance of meaningful activity and positive therapeutic engagement with staff, research on service

user experiences on acute psychiatric wards indicates that little improvement is being made. This section will consider some of the contributions from the theoretical and empirical literature which suggest why this might be the case, covering Psychoanalytic Theory, Social Context, Compassion-Focused Therapy and Burnout.

5.1 Psychoanalytic Theory

Winnicott's classic paper "Hate in the Countertransference" (1949) claimed that hateful feelings between a clinician and his/her patients are a normal aspect of therapeutic relationships, particularly with very disturbed and "regressed" patients whose intense need can be overwhelming. The exhaustion and resentment this provokes gives rise to hatred, which must be acknowledged and processed by the clinician if they are to avoid acting out their hatred on the patient by, for example, treating them cruelly. Inpatient services support some of the most disturbed patients within the healthcare system, therefore psychoanalytic theory has proved readily applicable to such environments in considering how staff might relate to patients.

Menzies-Lyth (1959) conducted interviews and observations with general nurses and drew on psychoanalytic theory to identify a number of defences, both individual and institutional, that the nurses employed to protect themselves against the anxiety generated by working with patients who were ill and dying. Defences included depersonalisation of patients; emotion denial; ritualistic task performance; checks and counter-checks; redistribution of responsibility; and avoidance of change. Considering these defences, it is apparent that employing such strategies would result in nurses who were emotionally and physically distant (e.g. locked in the nursing office), overly-concerned with administrative tasks and lacking in patient engagement and that this could persist regardless of policy changes – precisely the kind of complaints that service users have made. However, it is important to note that this study was conducted with general nurses several decades ago and

that this theory may no longer be as relevant to modern psychiatric services. Crichton (1998) notes that changes in hospital practices such as named keyworkers, MDT working, etc. may prevent staff now from employing many of these defences, but this may in fact result in increased and uncontained anxiety amongst inpatient staff who lack the provision of reflective supervision and training to manage this. It seems possible that without such defences, more acting out could take place, potentially leading to treatment of patients similar to that discovered at Mid-Staffordshire NHS Trust.

5.2 Effects of Social Context

Social context theories can also be helpful in considering modern day challenges to inpatient care. Paley (2013) argued that non-compassionate behaviour does not necessarily indicate lack of compassionate motivation. He acknowledged the intense pressure that NHS staff are under – lack of resources, efficiency drives, and increasing public scrutiny. This, he claimed, affects how situations are cognitively processed, as stress narrows the focus of attention and therefore reduces pro-social behaviour. As an illustration, Paley cited a study by Darley and Batson (1973) in which two groups of students at Princeton Theological Seminary were on their way to deliver a talk when they came across a man lying on the ground, clearly distressed. Of the first group 63% stopped to help, compared to 10% of the second group – the only difference between the groups being that the first had been told that they had plenty of time to get to the talk and the second were told that they were running late. Paley noted that more recent social psychology studies into pro-social behaviour have supported the theory that compassionate behaviour is not dependent on traits as much as context, and that a context such as the one in today's overstretched NHS is exactly the kind of context that would lead staff to neglect the distress of patients.

Farquharson (2004) also drew on social context to explain "How Good Staff Become Bad", considering how Zimbardo and colleagues' prisoners and guards experiment (Haney,

Banks & Zimbardo, 1973) demonstrated the abuses of power that can be provoked within institutional settings. This is particularly striking given that some inpatients in the studies reviewed above described feeling "imprisoned" and that staff could sometimes take on a prison guard role, applying arbitrary rules, restricting movement and, in some cases, acting abusively. Farquharson stressed that such institutional pressures are inevitable and do not in themselves indicate a "bad" institution, rather it is when these pressures are not acknowledged or addressed that they can result in poor treatment of patients by well-intentioned staff.

5.3 Compassion-Focused Formulation

Consistent with the above models, Kennedy (2013) addressed the claims of lack of compassionate care in the NHS by applying a compassion-focused formulation to qualitative data collected through supervision notes, non-participant observation of a ward round and an evaluation of a psychological staff intervention. Using a basic qualitative analysis to identify themes, Kennedy's formulation suggested that both individual and wider service pressures provoke both internal and external fears. The former include negative emotional responses and self-appraisals, and the latter include concerns about others' perceptions of them. In order to protect themselves from these fears, staff might employ coping strategies related to fight (over-control of patients), flight (behavioural or emotional avoidance of patients) or submission to threat (work overtime, target-focused). They might also become overly anxious and protective of patients or become over-active or "manic" in their approach to work. These strategies lead to various unintended consequences which might be detrimental to compassionate care, such as an admin-focus; burnout and increased sick leave; role confusion or conflict with patients or managers. Kennedy concluded that NHS services must take a more compassionate approach to their staff in order to allow them to do the same for their

patients, including providing greater reflective space, putting fewer threats and pressures on staff, and rewarding compassionate goals and behaviour.

5.4 Burnout

These conclusions could also be supported by the research literature on mental health staff's experiences of stress and burnout. Burnout is a concept operationalised by Maslach and Jackson (1981), comprising emotional exhaustion, lack of personal accomplishment and depersonalisation, and is often used as a proxy measure for morale in research. Prosser et al. (1999) surveyed 121 hospital and community staff and identified high levels of emotional exhaustion and high staff turnover, although also high job satisfaction and personal accomplishment. High burnout amongst NHS staff is a concern given the potential impact on psychological and physical wellbeing (Richards et al. (2006) note that sickness absence rates are relatively high amongst NHS staff) as well as on patient care. There is, however, disagreement in the literature about the extent to which burnout is a significant problem within the NHS; Bowers, Allan, Simpson, Jones and Whittington (2009) conducted a wide-scale questionnaire study across 136 acute psychiatric wards, concluding that morale is high amongst staff. Richards et al. (2006) note that this area is under-researched and largely comprised of poor-quality studies.

6. Implications and Future Research

The theories described above all have high intuitive explanatory value, but there is a lack of recent ecologically valid research within NHS services which might consider why service users continue to report a lack of compassionate, individualised care on acute psychiatric wards. This is particularly needed given the substantial changes that have been made to the NHS in the past decade, which may impact on the extent to which some of these theories remain applicable. One clear gap in the research literature is staff experience, which could be used to complement the patient experience research reviewed above in order to

better understand the obstacles to compassionate care. In recent years staff experience has increasingly been the focus of international studies (Johansson, Skärsäter & Danielson, 2013; Hummelvoll & Severisson 2001; Ward 2013) but UK studies on staff experiences have been scarce, and those conducted have tended to focus on Forensic settings (Kurtz & Jeffcote, 2011; Evans, Murray, Jellicoe-Jones & Smith, 2012). Staff voices may bring a unique perspective to the difficulties involved in providing good care to inpatients.

Given that there are likely to be factors at play which are invisible to both staff and inpatients, ethnographic methods such as participant observation, particularly when combined with interview or questionnaire data, could consider multiple perspectives and develop a common understanding. Also beneficial could be staff and patients undertaking collaborative action research in order to break down the barriers so often identified between these two groups. The Experience-Based Co-Design movement (Bate & Robert, 2006) is a relatively recent and exciting way of involving both staff and service users in service improvement, keeping patient experience at the forefront. This approach was utilised in 2012 on a mental health inpatient ward by Springham working with the service user group ResearchNet (Springham & Woods, 2014). Working together on developing inpatient environments which foster positive therapeutic relationships could be emotionally fulfilling for both sides, but could particularly support patient recovery.

It is clear that bringing failures in good care to public attention and developing further guidelines for how to treat patients with compassion and respect has not significantly altered the inpatient experience. It may even have increased the level of pressure on staff, leaving them feeling ashamed and criticised, compounded by press and public scrutiny which claims that staff are either incompetent or immoral. Perhaps it is time to treat both staff and patients with greater respect and compassion and work to increase our understanding of how to facilitate truly personalised inpatient care and positive patient and staff experiences.

7. References

Bate, P., & Robert, G. (2006). Experience-based design: From redesigning the system around the patient to co-designing services with the patient. Quality and Safety in Health Care, 15, 307-310. doi: 10.1136/qshc.2005.016527

Borge, L., & Fagermoen, M. (2008). Patients' core experiences of hospital treatment: Wholeness and self-worth in time and space. Journal of Mental Health, 17 (2), 193-205. doi: 10.1080/09638230701505996

Bowers, L. (2005). Reasons for admission and their implications for the nature of acute inpatient psychiatric nursing. Journal of Psychiatric and Mental Health Nursing, 12 (2), 231-236. doi: 10.1111/j.1365-2850.2004.00825.x

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

Bristol Mind (2004). User focused study of inpatient services in three Bristol hospitals. Retrieved from http://www.bristolmind.org.uk/files/docs/research/ufm-in-patient-report-2nd-ed.pdf

Cameron, D., Kapur, R., & Campbell, P. (2005). Releasing the therapeutic potential of the psychiatric nurse: A human relations perspective on the nurse-patient relationship. Journal of Psychiatric and Mental Health Nursing, 12 (1), 64-74. doi: 10.1111/j.1365-2850.2004.00796.x

Clark C., Scott, E., Boydell, K., & Goering P. (1999) Effects of client interviewers on client-reported satisfaction with mental health services. Psychiatric Services, 50 (7) 961-963.

Crichton, J. (1998). Psychodynamic perspectives on staff responses to patient misdemeanour. Criminal Behaviour and Mental Health, 8, 266-274. doi: 10.1002/cbm.266

Crossley, D., & Jones, A. (2011). Shame and acute psychiatric in-patient care. The Psychiatrist, 35, 408-412. doi: 10.1192/pb.bp.110.031666

Cutting, P., & Henderson, C. (2002). Women's experiences of hospital admission. Journal of Psychiatric and Mental Health Nursing, 9, 705-712. doi: 10.1046/j.1365-2850.2002.00516.x

Darley, J, & Batson, C. (1973). From Jerusalem to Jericho: A study of situational and dispositional variables in helping behaviour. Journal of Personality and Social Psychology, 27 (1), 100-108. doi: 10.1037/h0034449

Department of Health (2000). The NHS plan: A plan for investment, a plan for reform. London: National Health Service. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf

Department of Health (2002). Mental health policy implementation guide: Adult acute inpatient care division. London: National Health Service. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4069194.pdf

Department of Health (2011). No health without mental health: A cross-government mental health outcomes strategy for people of all ages. London: National Health Service. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Department of Health (2012). Compassion in practice: Nursing, midwifery and care staff, our vision and strategy. London: National Health Service. Retrieved from http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

Elliott, R., Fischer, C., & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. British Journal of Clinical Psychology, 38, 215-229. Retrieved from http://www.wider-mind.com/research/elliott_fischer_rennie_1999.pdf

Evans, K., Murray, C., Jellicoe-Jones, L., & Smith, I. (2012). Support staff's experiences of relationship formation and development in secure mental health services. British Journal of Forensic Practice, 14 (2), 104-115. doi: 10.1108/14636641211223666

Farquharson, G. (2004). How good staff become bad. In P. Campling, S. Davies, & G. Farquharson (Eds.), From toxic institutions to therapeutic environments: Residential settings in mental health services (12-20). London: Gaskell

Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. BMC Health Services Research, 8 (92). doi: 10.1186/1472-6963/8/92

Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. Journal of Phenomenological Psychology, 28, 235-261. doi: 10.1163/156916297X00103

Haigh, R. (2012). Being economical with the evidence. Group Analysis, 45 (1), 70-83. doi: 10.1177/0533316411425323

Haney, C., Banks, C., & Zimbardo, P. (1973). Interpersonal dynamics in a simulated prison. International Journal of Criminology and Penology, 1, 69-97.

Health & Social Care Information Centre. (2013). Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England, 2013. Retrieved from https://catalogue.ic.nhs.uk/publications/mental-health/legislation/inp-det-m-h-a-1983-sup-com-eng-12-13/inp-det-m-h-a-1983-sup-com-eng-12-13-rep.pdf

Heidegger, M., (1962). Being and time. London: Routledge.

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

Hummelvoll, J., & Severisson, E. (2001). Coping with everyday reality: Mental health professionals' reflections on the care provided in an acute psychiatric ward. Australian and New Zealand Journal of Mental Health Nursing, 10, 156-166. doi: 10.1046/j.1440-0979.2001.00206.x

Johansson, I., & Lundman, B. (2002). Patients' experience of involuntary psychiatric care: Good opportunities and great losses. Journal of Psychiatric and Mental Health Nursing, 9, 639-647. doi: 10.1046/j.1365-2850.2002.00547.x

Johansson, I., Skärsäter, I., & Danielson, E. (2009). The meaning of care on a locked acute psychiatric ward: Patients' experiences. Nordic Journal of Psychology, 63, 501-507. doi: 10.3109/08039480903118208

Johansson, I., Skärsäter, I.. & Danielson, E. (2013). The experience of working on a locked acute psychiatric ward. Journal of Psychiatric and Mental Health Nursing, 20 (4), 321-329. doi: 10.1111/j.1365-2850.2012.01919.x

Jones, A., & Crossley, D. (2008). "In the mind of another" shame and acute psychiatric inpatient care: An exploratory study. A report on phase one: Service users. Journal of

Psychiatric and Mental Health Nursing, 15, 749-757. doi: 10.1111/j.1365-2850.2008.01316.x

Jones, J., Nolan, P., Bowers, L., Simpson, A., Whittington, R., Hackney, D., & Bhui, K. (2010). Psychiatric wards: Places of safety? Journal of Psychiatric and Mental Health Nursing, 17, 124-130. doi: 10.1111/j.1365-2850.2009.01482.x

Kennedy, A. (2013). A compassionate formulation of task drift in mental health staff. Mental Health Review Journal, 18 (2), 73-82. doi: 10.1108/MHRJ-01-2013-0001

Koivisto, K., Janhonen, S., & Väisänen, L. (2004). Patients' experiences of being helped in an inpatient setting. Journal of Psychiatric and Mental Health Nursing, 11, 268-275. doi: 10.1111/j.1365-2850.2003.00705.x

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 (4), 245-258. doi: 10.1002/cbm.796

Lakeman, R., McGowan, P., & Walsh, J. (2007). Service users, authority, power and protest: A call for renewed activism. Mental Health Practice, 11 (4), 12-16. Retrieved from http://www.critical.freeuk.com/Lakeman.pdf

Lilja, L., & Hellzén, O. (2008). Former patients' experience of psychiatric care: A qualitative investigation. International Journal of Mental Health Nursing, 17, 279-286. doi: 10.1111/j,1447-0349.2008.00544.x

Maslach, C., & Jackson, S. (1981). Maslach Burnout Inventory. Consulting Psychologists Press: Palo Alto.

Mental Health Act (2007). Retrieved from http://www.legislation.gov.uk/ukpga/2007/12/contents

Menzies Lyth, I. (1959) The functions of social systems as a defence against anxiety: A report on a study of the nursing service of a general hospital. Human Relations, 13, 95-121.

Moyle, W. (2003). Nurse-patient relationship: A dichotomy of expectations. International Journal of Mental Health Nursing, 12, 103-109. doi: 10.1046/j.1440-0979.2003.00276.x

Quirk, A., & Lelliott, P. (2001). What do we know about life on acute psychiatric wards in the UK? A review of the research evidence. Social Science and Medicine, 53 (12), 1565-1574. doi: 10.1016/S0277-95360000457-3

Paley, J. (2013). Social psychology and the compassion deficit. Nurse Education Today, 33 (12), 1451-1452. doi: 10.1016/j.nedt.2013.05.011

Prosser, D., Johnson, S., Kuipers, E., Dunn, G., Szmukler, G., Reid, Y., Bebbington, P., & Thornicroft, G. (1999). Mental health, "burnout" and job satisfaction in a longitudinal study of mental health staff. Social Psychiatry and Psychiatric Epidemiology, 34, 295-300.

Ricoeur, P. (1976). Interpretation Theory: Discourse and the Surplus of Meaning. Texas Christian University Press: Forth Worth Texas.

Rethink (2012). The Abandoned Illness: A Report by the Schizophrenia Commission. Rethink.

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

Roberts, G., & Boardman, J. (2013). Understanding 'recovery'. Advances in Psychiatric Treatment, 19, 400-409.

Robins, C., Sauvageot, J., Cusack, K., Suffoletta-Maierle, S., & Frueh, B. C. (2005). Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. Psychiatric Services, 56 (9), 1134-1138. doi: 10.1176/appi.ps.56.9.1134

Rogers, B., & Dunne, E. (2011). "They told me I had this personality disorder…All of a sudden I was wasting their time": Personality disorder and the inpatient experience. Journal of Mental Health, 20 (3), 226-233. doi: 10.3109/09638237.2011.556165

Rose, D. (2001). Users' voices: The perspectives on mental health service users on community and hospital care. London: The Sainsbury Centre for Mental Health. Retrieved from http://www.centreformentalhealth.org.uk/pdfs/Users_voices.pdf

Shattell, M., Andes, M., & Thomas, S. (2008). How patients and nurses experience the acute care psychiatric environment. Nursing Inquiry, 15 (3), 242-250. doi: 10.1111/j.1440-1800.2008.00397.x

Springham, N., & Woods, A. (2014, Jan 7). Toolkit uses patient experiences to improve mental health services. The Guardian. Retrieved from http://www.theguardian.com/healthcare-network/2014/jan/07/mental-health-toolkit-improves-services

Stenhouse, R. (2011). "They all said you could come and speak to us": Patients' expectations and experiences of help on an acute psychiatric inpatient ward. Journal of Psychiatric and Mental Health Nursing, 18 (1), 74-80. doi: 10.1111/j.1365-2850.2010.01645.x

Stenhouse, R. (2013). "Safe enough in here?": Patients' expectations and experiences of feeling safe in an acute psychiatric inpatient environment. Journal of Clinical Nursing, 22, 3109-3119. doi: 10.1111/jocn.12111

Stoffers, J., Völlm, B., Rücker, G., Timmer, A., Huband, N., & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. Cochrane Database of Systematic Reviews, 8. doi: 10.1002/14651858.CD005652.pub2.

Talseth, A., Jacobsson, L., & Norberg, A. (2001). The meaning of suicidal psychiatric inpatients' experiences of being treated by physicians. Journal of Advanced Nursing, 34 (1), 96-106. doi: 10.1046/j.1365-2648.2001.3411729.x

The Mid Staffordshire NHS Foundation Trust Inquiry (2010). Independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009: Volume 1. London: The Stationery Office. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113447.pdf

The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). Report of the Mid Staffordshire NHS Foundation Trust public inquiry: Executive summary. Retrieved from http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

Thibeault, C., Trudeau, K., d'Entremont, M., & Brown, T. (2010). Understanding the milieu experiences of patients on an acute inpatient psychiatric unit. Archives of Psychiatric Nursing, 24 (4), 216-226. doi: 10.1016/j.apnu.2009.07.002

Thomas, S., Shattell, M., & Martin, T. (2002). What's therapeutic about the therapeutic milieu? Archives of Psychiatric Nursing, 16 (3), 99-107. doi: 10.1053/apnu.2002.32945

Wallcraft, J., & Byrant, M. (2003). The mental health service user movement in England. London: The Sainsbury Centre for Mental Health. Retrieved from http://www.centreformentalhealth.org.uk/pdfs/policy_paper2_service_user_movement.pdf

Walsh, J., & Boyle, J. (2009). Improving acute psychiatric hospital services according to inpatient experiences. A user-led piece of research as a means to empowerment. Issues in Mental Health Nursing, 30, 31-38. doi: 10.1080/01612840802500733

Winnicott, D. (1949). Hate in the countertransference. International Journal of Psychoanalysis, 30, 69-74.

Wood, D., & Pistrang, N. (2004). A safe place? Service users' experiences of an acute mental health ward. Journal of Community and Applied Social Psychology, 14, 16-28. doi: 10.1002/casp.755

MAJOR RESEARCH PROJECT

NAOMI LAW MA Hons

Section B

Finding Compassion Within the Chaos: A Constructed Grounded Theory of Acute Psychiatric Staff Experiences

Word Count: 7998 (255)

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

For submission to the Journal of Mental Health

APRIL 2014

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

Background: Criticism of NHS acute psychiatric care has been high within patient experience research, compounded by critical press coverage of inpatient wards. Government policy requires staff to deliver compassionate, personalised care, but there is little research considering staff's perspectives and experiences of the work.

Aim: This study aimed to construct a grounded theory of acute psychiatric staff's experiences, with particular attention to what might facilitate or block compassionate patient care.

Method: Semi-structured interviews were conducted with ten ward staff (three men, seven women) across a range of disciplines. Data were analysed using constructivist grounded theory.

Results: The model constructed captures the dynamic interactions between eleven categories: Being in a chaotic environment, Feeling limited, Struggling to improve without support, Building patient relationships, Enjoying the work, Staying vigilant, Taking an emotional toll, Putting up a barrier, Supporting each other, Seeing tensions and differences, and Acting as one team.

Conclusions: Staff described feeling motivated to engage with patients but restricted by practical and emotional demands. While support was provided by colleagues and formal structures, staff could not always make full use of them. Suggestions for future research and clinical practice include changes to practical demands on staff, as well as attitudes towards reflective practice.

Keywords: acute psychiatric; staff experience; compassion

1. Introduction

1.1 Political Context

At the close of 2013, an open letter signed by the leaders of ten NHS organisations called for an end to the blame and demoralisation perceived in much of the media coverage of healthcare that year (Hopson et al., 2013). Public scrutiny of NHS performance has been particularly acute following reports of poor patient care such as the Francis Report (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) and it is possible that this will have taken a toll on frontline NHS staff who have already been found to have poorer physical and mental health and higher sickness absence than other UK employees (Richards et al., 2006). Pressure might be felt particularly keenly by mental health staff, who have experienced significant changes both as a result of deinstitutionalisation (the transition from long-stay psychiatric hospital care to community-based services) and the increasing emphasis on individual patient need and experience being at the core of mental health services (Department of Health; DoH, 2011). Concerns have been raised that the quality of inpatient services have suffered as admission thresholds rise, efficiency savings lead to fewer beds and resources, and staff have been left with little capacity to create a therapeutic environment for patients (Lelliott & Quirk, 2004).

1.2 The Importance of Staff Experience

Despite increasingly detailed and comprehensive policy documents calling for personalised, compassionate care, substantial research into the acute psychiatric inpatient experience suggests that little improvement has been made (Walsh & Boyle, 2009). Evidence from “implementation science” suggests that blocks to translating policies into practice include lack of staff motivation or reward in doing so, as well as staff not feeling valued (Tansella & Thornicroft, 2009). Furthermore, where there are high rates of staff turnover and sickness, further challenges present themselves in training and re-training staff in the new

approach. Government policy initiatives such as the Compassion in Practice strategy (DoH, 2012) could be critiqued as another top-down measure which effectively locates the blame within individual staff themselves, demanding compassion without creating the kind of service environment where it is possible to be so (Spandler & Stickley, 2011).

Such obstacles point towards the importance of consulting NHS staff on their experiences and ensuring a supportive environment in which staff feel valued in their role and involved in its construction and adaptation. With evidence from the patient experience literature consistently demonstrating the central role that therapeutic relationships play in constructing the meaning of being an inpatient (Thibeault, Trudeau, d'Entremont & Brown, 2010), and on recovery from mental health problems (Priebe & McCabe, 2008), staff could be viewed as the primary mechanism by which patient experience can be improved. Therefore, learning more about staff experience and developing better ways to support mental health staff could have benefits for both staff and patient outcomes.

1.3 What is Known About Staff Experience?

Unfortunately the research literature on NHS staff experience is limited in scope. UK-based research has largely focused on the concepts of morale and burnout (operationalised by Maslach & Jackson (1981) as emotional exhaustion, lack of personal accomplishment and depersonalisation), although with variable quality and little consensus as to whether inpatient staff morale is high or low (Richards et al, 2006; Bowers, Allan, Simpson, Jones & Whittington, 2009). Ambiguity may arise from the fact that research seems to suggest high levels of job satisfaction and yet concurrently high levels of emotional exhaustion. Reid et al (1999) conducted semi-structured interviews with ward and community staff, thematic analysis finding that ward staff emphasised the rewards of contact with colleagues over patients, describing patient contact as stressful and unpredictable. Nursing staff in particular felt frustrated by the limits of their role, feeling powerless and with little time to do

therapeutic work and little incentive to do so. The authors warned that a possible effect of this could be a tendency to depersonalise patients, which is a common complaint from service users on wards (Hughes, Hayward & Finlay, 2009). Further research into the determinants of good staff morale by Totman, Hundt, Wearn, Paul and Johnson (2011) indicated that having clear roles and supportive managers allowed staff to manage stress, although practical constraints such as low staffing levels were perceived as threats to morale.

A compassion-focused formulation of NHS staff stress was recently put forward by Kennedy (2013) who argued that sources of external and internal threat can give rise to negative coping strategies such as over-work, an anxious and controlling approach to patients or avoidance. This could potentially lead to burnout or neglect of patient care but could be resolved through reducing the threat-level felt by staff (through a less punitive and pressured system) and increasing rewards. Paley (2013) has also defended NHS staff from recent accusations of lack of compassion by drawing a distinction between compassionate motivation and compassionate behaviour. He suggested that government strategies to build compassion in NHS staff are misguided as they assume a lack of motivation, whereas social psychological theory on the effect of social context indicates that stressful, time-pressured contexts affect cognitive processing such that pro-social behaviour is reduced, regardless of motivation. Therefore, he claimed, it is issues such as under-staffing and increasingly unwell patients which require intervention in order to change this context, not staff themselves.

Research with a more exploratory approach to inpatient staff experience has been conducted internationally. For example, Johansson, Skärsäter and Danielson (2013) interviewed staff about their experiences working on a locked ward in Sweden. They noted how a demanding work environment coupled with strong feelings of personal responsibility could cause staff to feel burdened, which might result in increased control of patients in order to evoke a sense of security.

Staff responses of over-control or even aggression have been framed by the psychoanalytic literature as evidence of uncontained anxiety; staff lacking the capacity to contain and process the projected anxiety of the patients and therefore 'acting out' that anxiety (Farquharson, 2004). A seminal study by Menzies Lyth (1959) on nursing staff experience also took a psychoanalytic approach, analysing data collected from interviews with general nurses. Menzies Lyth argued that both individual and organisational defences against the anxiety generated by nursing work acted to put up barriers between staff and patients rather than facilitating genuine engagement. This study was conducted in a very different NHS to the modern-day organisation, and subsequent NHS reforms such as the introduction of primary keyworkers might prevent staff from employing some of these defences as easily. Without an alternative outlet for anxiety, however, staff stress levels may have increased (Crichton, 1998).

Kurtz and Jeffcote (2011) used grounded theory to explore the experiences of forensic mental health staff, which are likely to have relevance to an acute psychiatric setting. Staff reported that the organisational elements of their work caused the most stress, although the authors suggested that much of the impact of patient-related stress may be unconscious. Struggling to resolve the custodial and therapeutic tasks within their roles was challenging for staff at an organisational as well as clinical level, and further ambivalence from society towards forensic services compounded this confusion.

Exploring the experiences of NHS nurses, Hall (2004) found evidence of similar contradictions in that nurses attempted to form therapeutic relationships with patients within a context of social control as the working norm. This was justified by an awareness of societal views on mental illness as being deviant and potentially dangerous; therefore nurses were tasked with enforcing control through observation and management of difficult behaviours. The role of the nurses was predominantly to exercise a power that they did not feel they had

and did not feel comfortable with. Hall emphasised the need for further research focusing on inter-professional acute mental healthcare.

1.4 Rationale for the Present Study

Although particular aspects of staff experience have been identified as potentially significant (e.g. staff roles and the emotional impact of the work), a coherent theory which takes both individual and organisational factors into account is needed. Exploratory research into staff experience could provide insight into potential obstacles to compassionate, personalised care from the perspective of the multidisciplinary team. Furthermore, a lack of theoretical literature in this area which can be applied to the current NHS limits the transferability of existing empirical research findings. The majority of recent qualitative research in this area relies on thematic analyses which do not provide theoretical explanations, are conducted in international settings, or focus exclusively on nurses.

1.5 Aims and Research Questions

The present study aimed to construct a grounded theory of staff's experiences of working on an acute psychiatric ward, with particular attention to what might facilitate or prevent the delivery of compassionate personalised care. The following research questions were used to guide the study and theory-building, but are not addressed individually in the Results section. They are derived from existing literature and were used as 'sensitizing concepts' (Strauss & Corbin, 1998). These enabled the researcher to narrow the focus of data gathering enough to make the research practicable, while remaining open to new areas of participant experience:

1) How do staff perceive their role with regards to service users on the ward?
2) What factors, both personal and organisational, seem to influence staff perception of their role?
3) What is staff's understanding of the emotional impact of their work?

4) What accounts do staff give of management of this impact, both individually and in the wider system?
5) Where staff perceive a mismatch between what they would like to achieve and what seems possible, to what do they attribute this mismatch, and under what circumstances have they been more and less able to achieve their 'ideal' way of working with patients on wards?

2. Method

2.1 Participants

Ten acute psychiatric ward staff agreed to take part in this study, comprising three men and seven women, aged 24-56 (mean age 39) and including a ward manager, a clinical charge nurse, two staff nurses, an agency nurse, two health care assistants (HCAs), a consultant psychiatrist, a psychologist and an occupational therapist (OT). Further demographics are given in Appendix 5. Staff with less than six months acute psychiatric ward experience were excluded to ensure a reasonable amount of experience to draw upon. Although inclusion was initially restricted to permanent staff, the emerging theory indicated that including data from an agency nurse would be beneficial; therefore this criterion was suspended for this one interview.

2.2 Design

The study used a non-experimental qualitative design, employing semi-structured interviews which were conducted and analysed using a grounded theory approach, within a constructivist framework (Charmaz, 2006). This approach is thought to be particularly suitable when there is a lack of existing theory in the area studied (Creswell, 2008), which is applicable here, as described above. It aims to give an interpretive description of how the participants involved constructed meaning from their experiences within the given context.

2.3 Interview Schedule

A semi-structured interview was developed from the research questions (Appendix 6), using open-ended questions and probes designed to give a conversational feel to the interviews in order to develop rapport and generate rich data (Willig, 2001). Explicit questions regarding challenges for the delivery of "compassionate personalised care" were not included, as it was considered that these might elicit rehearsed or impersonal answers given the frequent occurrence of these terms in current NHS policy. A pilot interview was conducted with a nurse, leading to the alteration of the wording of some of the questions. As the interviews progressed the interview schedule was adapted to focus more closely on areas most pertinent to the developing theory, as recommended by Birks and Mills (2011). Interviews lasted between 29 and 64 minutes (mean 48 minutes) and were audio-recorded, transcribed and anonymised by the researcher.

2.4 Procedure

Participants were recruited across seven acute psychiatric wards in one NHS Trust. The ward manager of each ward was initially contacted by phone and ward staff were informed about the study at a subsequent staff meeting, or via posters and information sheets distributed by the ward manager (see Appendices 7 & 8). Staff could opt-in and were given the opportunity to ask questions about the study before the interview. All participants chose to be interviewed at their place of work.

After five interviews had been conducted and categories began to be constructed from the data, theoretical sampling was used to develop the analysis. This involved identifying particular staff groups whose experiences might further develop the categories and contacting those individuals offering the opportunity to take part, again with the assistance of the ward managers. Recruitment continued until theoretical saturation was reached, defined by Strauss and Corbin (1990) as the point at which no new codes pertaining to the emerging categories

are identified in the data. The authors note, however, that such a goal is difficult to assess fully and that, particularly for a small-scale study such as this, 'sufficient saturation' (Strauss & Corbin, 1998) is adequate.

2.5 Data Analysis

Constructivist grounded theory views data analysis as an inductive process in which meaning is co-constructed by both participant and researcher, and emergent theory is 'grounded' in the data rather than imposed upon it (Charmaz, 2006). This process is enabled by 'constant comparison' (Glaser & Strauss, 1967), the technique of concurrent data collection and analysis, moving back and forth between the raw data and each subsequent level of coding in order to ensure that the emerging theory is true to the original data. The stages of analysis (Charmaz, 2006) followed were:

1) Initial Coding. Coding line-by-line, staying close to the data yet with a critical stance. Using 'active codes' (gerunds) where possible helped to capture processes in the data. In vivo codes, using the participants' own language, also helped to capture subjective meaning. This form of coding was used on the first three interview transcripts; analysis of subsequent transcripts began at focused coding.
2) Focused Coding. Re-coding using the most frequent or significant codes to synthesise larger sections of data. Coding at this stage is more conceptual, although still closely aligned with the raw data (see Appendix 9).
3) Theoretical Coding. Memo-writing and diagramming are used throughout analysis, but particularly at this stage in order to raise the focused codes into conceptual categories (see Appendix 10) by exploring the potential relationships between codes.

Constant comparison also involved going back to previous interviews and re-coding when new focused codes emerged in later interviews, in order to ensure that the developing theory was applicable to each participant.

2.6 Quality Assurance

Elliot, Fischer and Rennie's (1999) guidelines for qualitative research (see Appendix 4) were considered throughout in order to ensure quality. The guideline 'owning one's perspective' is particularly salient to constructivist grounded theory given the influence of the researcher's own values and assumptions on data interpretation. Although this is an integral part of the research process, the researcher should nonetheless be aware of their starting assumptions and consider their potential impact throughout the research process (Charmaz, 2006). In order to aid reflexivity, a colleague conducted a bracketing interview with the researcher (see Appendix 11), a reflective diary was kept throughout (see Appendix 13) and regular discussions were had with two supervisors and a grounded theory study group. The researcher made note of key assumptions held prior to beginning the research (see Appendix 12) in order to try to avoid undue influence of these on the results. These included a belief that ward staff are motivated to engage compassionately with patients but are under-supported and that more effective training and supervision may be needed to encourage reflection on the emotional demands of the work.

The research supervisors also checked individual codes and the emerging theory, looking to question possible assumptions and offer alternative interpretations. Respondent validation was obtained by sending all participants a results summary and requesting feedback (see Appendix 14). Three participants gave feedback and stated that the results reflected their experiences accurately. Finally, use of the constant comparison method and direct quotations from participants to encapsulate codes and categories (see Appendix 15) was aimed at maximising validity of the generated theory (Williams & Morrow, 2009).

2.7 Ethical Considerations

Ethical approval for the study was granted by the Canterbury Christ Church University Research Ethics Board (see Appendix 16) and R&D approval was granted by the

Trust involved (see Appendix 17). The study further adhered to the code of conduct specified by the BPS (2010) and HPC (2009). For example, informed consent was obtained from all participants (see Appendix 18) and following each interview participants were debriefed. Participants were reassured that all information would be kept confidential – only the researcher had access to securely stored non-anonymised data, and demographic information has been given for the group overall in order to prevent identification (see Appendix 5).

3. Results

Data analysis yielded eleven categories, which were organised into four areas: The Ward Context; External Pressures; Patients and Emotional Impact; and The Ward Team. A full table of categories and focused codes is presented in Appendix 15. A model was constructed showing the dynamic interactions between categories which captured staff members' experience of working on an acute psychiatric ward and the delivery of compassionate personalised care (see Figure 1).

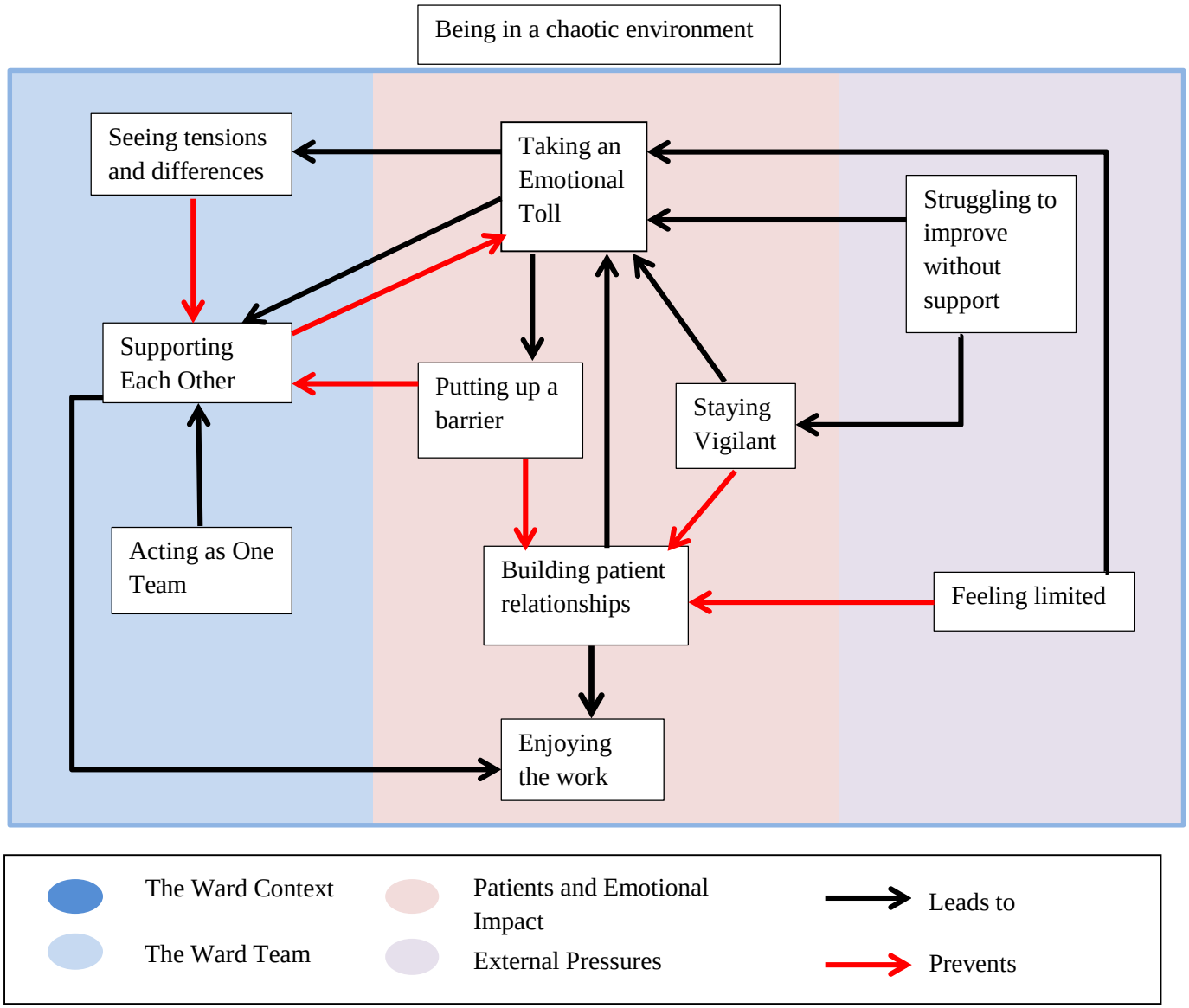


Figure 1: Theoretical Model of Acute Psychiatric Staff Experiences

3.1 The Ward Context

Being in a Chaotic Environment. The context of staff's experiences was an unpredictable environment in which constant change and disruption could make planning work challenging and feel stressful. The word "chaotic" was used by three participants to describe the ward, particularly when beds were oversubscribed and the ward was short-staffed. This was also acknowledged to have a negative effect on patients:

[Patients] need somewhere where they can feel safe and somewhere where they can

hopefully feel relaxed and that's often lacking because of the chaotic stuff that goes on on the ward (Psychologist, Lines 102-104)

Examples given included the need for patients to change beds or even wards at short notice due to overcrowding. Participants described aggression and violence as key features of the ward environment, where situations could escalate rapidly:

A pat*ient, um asked to go to the garden, the nurse said "Ok, just give me a few minutes for me to sign you out"* – there are processes we need to go through, but because it *wasn't done [snaps fingers] right there and then he went to his room, started smashing th*e room up, pulled the wardrobe door off (Clinical Charge Nurse, L306-310)

Ward-based staff experienced this source of stress more frequently and seemed resigned to it, whereas staff not based on the ward appeared much more shocked and shaken by such incidents.

Staff acknowledged the benefits of spending time off the ward, both for patients taking leave or going out into the community, and for staff who could have greater reflective and expressive space outside of the ward environment.

It plays a great impact to people's health. Y'know, going out in the community, y'know, staying indoors all day is like a prison, y'know, nobody wants to do that (Agency Nurse, L211-213)

Any opportunity for any team, and in my case the ward team, to spend more time in bonding activities or away days – *I don't think there are enough of them*[…]my guess is that *they nurture relationships which then encourage people to come out and say "This is distressing for me". (*Psychiatrist, L283-289)

3.2 External Pressures

Feeling Limited. Within this challenging context, staff felt under significant pressure as a result of restrictions in resources. This included staff shortage (and use of agency staff,

which was felt to increase pressure for the permanent staff who would need to supervise them), increasing administrative burden and taking on jobs which did not seem appropriate for their role. Nurses in particular felt restricted by administrative tasks which kept them in the office rather than with patients.

Well you just end up in the office and then the phone rings and you get something to do and then you need to find the bed for this person and then you need to find staff for *tomorrow and the phone rings again and the next thing you know you didn't get to have that* one-to-one with that *patient and they've gone out (Staff Nurse 2, L61*-64)

Staff were concerned about the impact this could have on patients and felt frustrated that they were not able to spend more time in a clinical role.

The pressure to find housing for patients post-discharge was a particular source of stress, and led to resentment from some staff who did not feel equipped to take on this role:

It's really frustrating as well. We're just so limited, we really are[…]*you're just left to* do it all yourself and like *I said I think because we haven't had any training so I'm still* learning as well (HCA 2, L114-122)

H*elping people with their social aspects is part of the job, but we're not housi*ng officers (Staff Nurse 2, L161-162)

Struggling To Improve Without Support. Staff felt aware of a pressure to improve efficiency on the ward, at all organisational levels:

I'm having to put them under pressure to do so much for very little, um, because I'm put under pressure as well. At the same time it's not my boss' or my line manager's fault, y'know, and it goes on (Ward Manager, L375-378)

Furthermore, it didn't always feel like the adequate support structures were there to enable this, rather staff were criticised for failures to achieve targets. Fear of "blame culture" seemed present in all areas of the organisation:

*I feel it's very much "you've got to cover your back, you've got to cover your back, if it's not documented it didn't happen"[…]*there's so much focus on nursing, poor nursing, so nurses are just so scared basically. And, is the new Fra- the Francis Report is now, you can be, um, you could go under the criminal justice system if things are not done right, y'know, there's so much now for you to lose your job that people are just, they are, they're panicking. (Clinical Charge Nurse, L215-235)

This fear was particularly heightened following serious incidents, in which some staff felt that internal inquiries were not conducted with enough sensitivity towards the staff involved.

Concerns were raised by some staff (although, interestingly, not nursing staff themselves) that nurses may feel less valued than other members of the team owing to lower pay or lack of gratitude, or that the training they receive might be inadequate in supporting them to engage in challenging clinical work.

I've sympathised with them and said "God it just feels like when you're a really really good nurse that you kind of get a lot put on you and you don't get much thanks for it" (OT, L509-511)

3.3 Patients and Emotional Impact

Building Patient Relationships. Almost all staff reported that clinical work with patients was the most enjoyable aspect of their job. There was an understanding that patients had diverse and individual needs and that any intervention would need to be tailored to that individual:

They *don't want to come to group but they might just want to sit and talk to* somebody, or just to go out and not have a deep conversation, just to go out for a bit of fresh air or down to the garden*[…]And then it's all about the actual person* and what they want to do (HCA 1, L102-106)

Staff talked about using listening skills to make patients feel heard and to connect

with the whole person. Part of this involved reflecting on their own practice and thinking about how to communicate more effectively with patients:

> Communication matters, the way you communicate with people can make people calm down*[…]*knowing where to stop, know your limitations and that's, it helps a lot (Agency Nurse, L110-113)

Staff also acknowledged the importance of providing structured activities, boundaries and encouraging the patients to support each other.

Enjoying the Work. Staff spoke about the huge rewards available from clinical work, including the opportunity to feel they had played a part in a patient's recovery and also the gratitude of patients and carers (sometimes in place of gratitude which some staff felt was absent from within their organisation).

> *I think it does mean a lot to a lot of people, and, um, that's when you do kind of feel* good about your *job, when you come out of it and people say, y'know, "Oh that was really nice, just sitting and chatting and just someone sort of listen for a bit" (HCA 2, L204-*207)

It was also notable that many staff spoke positively about the same aspects of the work that they had also described as potentially stressful, for example, the unpredictable work environment or the high workload.

> *So it's a relentless pace*[…]*I think on the positive side, I wouldn't like it otherwise! That's why I've chosen to work in an* inpatient setting. (Psychiatrist, L19-22)

Staying Vigilant. The other side to clinical work was an acute awareness of risk and clinical responsibility. Although senior staff such as the Ward Manager felt a particular personal responsibility, not just for patients but for the safety and actions of their staff, junior staff also felt the importance of keeping risk issues in mind.

Literally any patient on this ward is my responsibility. Um, whatever the staff do, whatever the doctors do (whether you believe that or not), whatever the OTs do, I have to kind of be responsible for that (Ward Manager, L86-88)

We are doing observation, continuous observation, observing patients*[…]*every time checking, to make sure they are alright, not harming themselves or posing any harm to themselves or others, so, it's a lot, a lot. (Agency Nurse, L94-99)

This awareness often translated into frequent checking and recording, which could take on a routine quality for staff and potentially turn patient interaction into a series of tasks to be completed:

Check all their physical eating and drinking, psychologically what they are expressing, what they are doing, thinking, we spend one-to-one with them on each shift to know what is going on in their head then we can write it down and to, to do their social relationships with other patients and staff and to check their treatment as well (Staff Nurse 1, L99-102)

Awareness of risk was particularly heightened following an incident, when staff workload would increase owing to further checks and so impact negatively on morale:

Initially it is actually demoralising to be honest, because like I said in the beginning *and I've said repeatedly* – all wards are very very busy, so before even any advice comes, any guidance comes, the first feeling *is "Work is going to get busier". And we'll need to make some extra checks, we'll need to be more vigilant.* (Psychiatrist, L466-469)

Taking an Emotional Toll. A number of the aspects of the work covered above impacted emotionally on staff. The Ward Manager described the combined burden of risk and blame culture in saying:

It's a very stressful job, I think, um, managing a ward is probably one of the most difficult things you could ever do. Because literally people's lives depend on you, in fact it's

the only job where if someone kills themselves it's your fault, let me put it that way. (Ward Manager, L263-266)

The one-to-one patient work could also evoke anxiety and guilt.

Say you've got a patient that's a potential risk of self-harm and suicide – you can probably feel a bit helpless at times, and worried.[...]*guilt maybe "Oh, I could've helped" if* they went and self-*harmed, "I spoke to them yesterday and they said they were fine* – why *didn't they tell me", y'know that sort of thing can be a bit* much. (Staff Nurse 2, L189-192)

Staff also spoke about occasionally feeling threatened by patients, particularly early on in their post or when they did not know that patient well yet.

Putting Up a Barrier. One potential consequence of this emotional impact seemed to be for staff to cut off from the painful aspects of the work. This was rarely spoken about directly, but was noticed by some, particularly those not based on the ward who saw nursing staff seeming unaffected by distressing events:

The really rare times I see something really distressing on the ward, like a restraint or someone getting really aggressive*[...]afterwards I'll be like "Are you ok?" to the nurses and they're just, most of them are just, whether they put a barrier up or what*ever, but I just think *the impact of seeing that regularly must be, I don't know (OT, L200*-204)

This lack of acknowledgement of emotional impact was also identified in senior management, for example, in the handling of incidents which could feel cold or even accusatory rather than supportive. Several staff also voiced concerns about staff not using the formal support structures that were available, deprioritising staff support or reflective practice groups due to workload, or being fearful of their own negative emotions:

I think it's just when you've got other things that you need to do more or you're worried about the consequences if you don't do them, you can see why – it does seem low down on the priority list (Psychologist, L452-455)

We talk so much about the stigma of mental illness, but I suspect we practice it on ourselves – *we have a kind of a blindness or a denial, don't accept, therefore don't see the* full detail. (Psychiatrist, L245-246)

Another barrier that staff described was between staff and patients – stress or anxiety leading staff to avoid or disengage from patients. Again, this was only described in others, or could be inferred from staff's comments, rather than any staff member noticing it in themselves.

I think that w*hen people are really, really busy, rushed off their feet, if they've got suddenly half an hour of downtime and things don't feel so busy, perhaps they're not rushing* to go and do more work, to go and talk to people[...]I see these people who seem too busy all *the time then suddenly I'll see them sitting in the communal area not engaging with patients* (Psychologist, L234-245)

Significantly, one nurse described a positive example of support being that if nurses began to feel anxious or upset about a patient they were keyworking, the solution would be to allocate that patient to another member of staff:

You can probably feel a bit helpless at times, and worried*[...]*Particularly, probably *not so much a patient that you haven't had for very long, but ones you've* built a relationship with over time[...]*if it did get to a point where you felt like that maybe it's time that that person wasn't your patient anymore and maybe someone else should try and take them on* (Staff Nurse 2, L189-201)

Another element of this category was staff feeling frustrated or angry with patients, particularly those felt to be not mentally unwell, but having "behavioural" problems.

You find a lot of personality disorder, alcohol, um substance misuse, dual diagnosis, um, kind of housing and benefits*[...]I'm not discriminating to say that all personality disorder or all drug and alcohol misuse patients come in for house benefits, it's not the case,*

it's just starting to feel like a large percentage of that client group is coming in for that reason. (Clinical Charge Nurse, L394-402)

Barriers between staff and patients were also apparent through distancing language, placing staff in observation or authority roles and depicting patients as passively needing to comply, rather than describing an equal relationship:

Well what the patient needs is to work with us as a team, not as a team, as a nurse, they need to just work with us, we need their compliance. They need to give us information of why they've come to us, and if we can't get that information from them usually we ask the family, but we need to get their consent before we ask the family. (Staff Nurse 1, L90-93)

3.4 The Ward Team

Supporting Each Other. An alternative response to the emotional demands of the job was to rely on support from colleagues – something all staff described as valuable. However, ideas about the meaning of "support" differed with many emphasising the importance of the physical presence of colleagues when managing an incident, as well as being able to offload to colleagues when stressed.

Well, there is support, like someone is challenging, ring for, just press that button and all the staff on the whole unit, because there are so many units here to come and support you, they will come then, instantly, y'know to come and help you deal with this situation. (Agency Nurse, L418-421)

I guess it's partly venting and talking about it, like I was saying, so you're not taking it home with you (HCA 2, L487-488)

The formal support structures available to staff were also generally found to be helpful, but staff noted that it was necessary to actively make use of these structures (and as described above, not everyone did so).

I was very naïve and I used to come into supervision and "Everything's fine, it's fine, I'm great", y'know, "Nothing's wrong, I'm perfect". Reality - very very different of course. Um, but now, especially being a charge nurse, I find supervision much more helpful[...]And then we have, um, reflective practice, um, and staff support[...]*So yeah, it's just, um, just* making use of them really, um, just making use of them. (Clinical Charge Nurse, L453-467)

Staff seemed to rely on colleagues to make them feel valued and appreciated in their role, whilst going to their managers for more practical problem-solving support or advice.

Seeing Tensions and Differences. A further consequence of the emotional toll on staff which also acted as a barrier to their ability to offer each other support was professional tensions and conflict within the team. The Ward Manager described this happening as a direct result of the pressure staff felt under:

Sometimes, because of the difficulties with the job, they tend to blame each other for the pressures[...]something gets missed, the shift coordinator will be blaming the other nurse[...]*because it feels so pressured, I want to see answers and things, they're often "Well it's your fault!" (Ward Manager, L453*-466)

Other staff felt aware of "them and us" splits within the team, for example, between senior and junior staff, or between professionals.

*You do find [junior staff] very resistant sometimes and they'll start talking and then cut themselves short because they're worried that we'll mayb*e go to management if they say anything (Clinical Charge Nurse, L537-539)

It's just occasionally there are some staff where you feed back to them and they just don't seem at all interested, or don't have time to be interested, maybe that's what it is, or hear it. (OT, L494-496)

A tension was also apparent between medical and therapeutic ways of thinking, with some staff feeling that nurses did not always value the importance of therapy in comparison to

medication. Some staff also described the psychiatrists as being in positions of authority with regards to making clinical decisions.

I think in terms of staff roles definitely so I think there's the clear hierarchy of the medics, the psychiatrists are in charge (Psychologist, L305-306)

It was also suggested that staff may defer to senior staff in clinical decisions to avoid taking responsibility, due to fear of blame if something went wrong.

Acting As One Team. There was some inconsistency between these descriptions of hierarchies and splits and a differing narrative from staff around unity in decision-making and equal valuing of staff.

*We're all sat there and the consultant always asks "How is so and so doing?" and he's not just, he values what you say, and he'll take that on board when he make*s his *decisions, and sometimes what I'm telling the consultant might be from what an HCA told me when they took someone out, so everyone's important, everyone has an* impact (Staff Nurse 2, L261-264)

Staff seemed to derive reassurance and security from seeing themselves as being within an equal and united team, even when there were elements which seemed to contradict that picture:

On the ward it's very much a team and there's a doctor who's ultimately responsible and you get a handover every morning, you can always hand over everything to the nurses, even though not everyone always seems that interested, but you still give them that *information, and you're very much part of a team* (OT, L298-301)

Positive teamworking, therefore, allowed some of the risk staff were managing to be shared and also to allow some of the between-colleague support described above.

You try to build a team around you, you try not to – because all you have, at the end of the day, is your team. Try not to have a divided team*[…]you're ab*le to kind of get some

stresses out and say you know what, this is my stress but at the same time I've got 17-20 other team members who can take up some of that burden (Ward Manager, L318-324)

4. Discussion

The constructed theory described above captures participants' experiences of working on an acute psychiatric ward and the perceived obstacles to the delivery of compassionate personalised care. A model was created to express the complex interactions between the clinical role, the emotional impact of the work, organisational processes and environmental demands. The key findings will be explored in the context of previous research and the study's limitations and implications discussed.

The categories of Struggling to Improve Without Support and Feeling Limited covered the most frequently cited sources of stress, with staff shortages being of particular concern. This was apparent within the research context also, as staff frequently declined to participate owing to workload, and several interviews had to be cut short as staff were anxious to return to work. Although the Francis Report (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) did acknowledge the impact of staffing levels on patient care, evidence from the present study supports Paley's (2013) argument that staff shortage and stressful ward environments could cause, rather than co-occur with, lack of compassionate behaviour. For example, staff described a pressure to deprioritise patient contact time as the penalties for falling behind on administrative tasks were significantly stronger.

Staff were most likely to identify Feeling Limited as their main clinical obstacle, i.e. lacking the time to talk with patients one-to-one. The model indicated that staff did not recognise anything to be facilitating their ability to build relationships with patients, perceiving only barriers. With regards to staff roles, results contradicted Reid et al (1999) who found little evidence of role conflict. Nursing staff in particular in this study seemed

most unsure of their role, as found by Hall (2004), although rather than questioning risk management practices, nurses interviewed criticised the dominance of administrative tasks. Nonetheless, they reported feeling valued and supported by colleagues, even though other participants were uncertain whether nurses always felt this way. Role clarity has been found to be a strong moderator between job demands and psychological strain, particularly when staff feel supported by colleagues (Bliese & Castro, 2000). Therefore, this finding fits with nurses' reports of feeling under stress, due not only to the pressure they felt under but their additional confusion and frustration over what constitutes a nursing role. Nurses nonetheless felt emotionally invested in their clinical role, which replicates findings from previous studies on burnout in which emotional exhaustion has been found to be high in mental health staff, but with concurrently high levels of personal accomplishment (Bowers, et al. 2009).

This emotional exhaustion seemed to be captured by the category Taking an Emotional Toll; all staff described routinely feeling stressed. Accounts of feeling anxious or scared were harder to elicit, and tended to be more readily identified by colleagues, suggesting that such feelings might be less acceptable to talk about openly, or might play an unconscious role, as suggested by Kurtz and Jeffcote (2011). Despite the significant changes to NHS services since Menzies Lyth's (1959) study on nurses, many of the defences she identified still seemed apparent within this study, described by Putting Up a Barrier and Staying Vigilant. Staff reported detachment and denial of feelings, particularly in nursing staff and in senior management, and accounts from nurses also resonated with Menzies Lyth's descriptions of ritualistic task performance and splitting up the nurse/patient relationship, particularly at the point at which a strong relationship had begun to develop, along with the risk of painful feelings. Similarly, Menzies Lyth's finding that such defences led to interpersonal conflict within the team, particularly between junior and senior staff, resonated here to some extent (Seeing Tensions and Differences), although not universally. In

this study, critical projections (Klein, 1959) were more readily identified in comments about senior management, whereas the ward team felt more equal and supportive. This could potentially be a consequence of changes to the traditional ward hierarchy and increased reflective practice for staff.

Kurtz and Jeffcote (2011) suggested that close-knit bonds between colleagues are at least partially driven by external threat, e.g. a risk-obsessed culture, and may benefit staff members personally but are of limited support to the work overall. This was reflected in the model, as Acting as One Team allowed staff respite from the threat of repercussions should an incident occur (a further defence identified by Menzies Lyth) and enabled staff to support each other which reduced the emotional toll. However, there was a limit to which support structures were used to facilitate open and reflective staff discussion, perhaps due to fear of revealing professional tensions or difficult personal feelings.

It was interesting to note that although there was evidence of these professional tensions (Seeing Tensions and Differences, including disagreements over treatment and negotiating hierarchies), these were not described as having an impact on the delivery of compassionate care. This may reflect the relative emphasis that staff gave to the ward team being unified, as described above. It is also possible that staff were reticent to speak freely about the potential clinical impact of these tensions, due to confidentiality fears and the high levels of performance scrutiny that NHS staff face; external obstacles to compassionate care may have felt safer to discuss.

The constructed model also reflects a relative lack of consideration of the potential impact of differing patient presentations, with the exception of differing levels of risk and housing needs. This may indicate a potential consequence of staff's preoccupation with practical or organisational issues in that patient differences, or the more subtle difficulties of the clinical work, were lost. It is possible that staff are not given enough encouragement to

reflect on these or notice their potential impact on staff's capacity to deliver compassionate care. It is also possible that, as above, staff did not wish to appear prejudiced against particular groups of patients in an interview situation.

4.1 Clinical Implications

There is a contradiction between requirements to prioritise compassionate patient care, and the realities of the working environment in which staff are attempting to achieve this. Strict penalties for failure to achieve efficiency targets and pressure on nurses in particular to document and administrate rather than engage causes direct clinical work to be given increasingly low priority. It seems inevitable that for staff to have the time and space to deliver personalised compassionate care, either staff shortages need to be addressed or the volume of administrative demands needs to be lessened, for example, employing staff to focus on bed management or shift cover in order to enable nurses to focus on direct care. Consideration also needs to be given to the extent to which nurses and HCAs should be managing issues such as housing. Few staff have been formally trained to do so, and yet are finding themselves in this role which can unfortunately lead to resentment of the patients who may be admitted largely due to social problems. Stronger links between social care and council services or specialist housing officers may assist in this, but acute psychiatric wards cannot act as emergency housing, either at admission or in delaying discharge.

Steps might also be taken to change the blame-focused, risk-dominated culture by which staff feel so restricted. As Kurtz and Jeffcote (2011) note, this requires consideration of the clinical, organisational and social aspects of staff experience as staff require support from all levels. Fear of repercussions restricts creative thinking, as found by Menzies Lyth (1959) when nurses stuck to rigid, ritualised tasks. It further resulted in staff avoiding clinical responsibility and even patient engagement, which could be damaging to patients and unrewarding for staff.

Provision of support structures seemed reasonable to most staff, but the study raised questions over whether and how these support structures are being used. Training of mental health staff pre-qualification as well as on the ward might greater emphasise the value of self-reflection and emotional expression and combat the "getting on with it" culture that seemed to contribute to barriers both within the ward team and between staff and patients. Such attitudes make it difficult for staff to fully take up and benefit from provisions such as Reflective Practice or Staff Support groups when qualified, due to fear of the consequences of such openness. Supervision, similarly, might be used not only as a space for reassurance and advice, but also to encourage staff to reflect on more difficult feelings about the clinical work within a safe space, which might reduce the need for defences against anxiety within patient engagement and allow staff to maintain relationships with challenging patients. This may require additional training for supervisors to bring more of a reflective focus to supervision.

Increased prioritising of reflective space might further enable support structures to have a greater facilitative effect on staff's capacity to build relationships with patients, rather than simply reducing their stress levels. Research on the benefits and mechanisms of reflection is limited, but there is some evidence for the potential of reflective space to improve clinical practice, and that such skills can be learned with adequate time and support (Mann, Gordon & MacLeod, 2009). The research literature on clinical supervision indicates that the potential benefits are significant for both staff well-being and patient care (Wheeler & Richards, 2007; Cummins, 2009), but that it requires commitment at all levels of the organisation to ensure consistency, which is often neglected due to conflicting time pressures or doubts about these benefits (Buss, Angel, Traynor & Gonge, 2011).

4.2 Future Research

Future research could be used to develop such training or supervision models and to

test their effectiveness in altering cultural attitudes to reflective practice and openness on wards, as well as clinical practice. A model such as the one constructed in this study could be used to enhance staff's awareness of how the different aspects of their work impact both upon their own wellbeing and upon their capacity to engage with patients, which might also improve staff motivation to address some of these issues as a priority. It would also be necessary to continue to conduct research which might build a case for commissioners for the prioritising of time, space and support for staff, including its beneficial impact on patient care. Furthermore, collaborative research undertaken by staff and service users on wards (such as Springham & Woods, 2014) aiming to change practices which both groups potentially find problematic e.g. lack of one-to-one time, could also break down barriers between these two groups.

4.3 Limitations

This was a qualitative study using a relatively small sample of 10 participants who, although recruited from seven different wards, all worked within the same NHS Trust; therefore transferability to other services is limited. There is also the possibility of self-selection bias. Lack of feedback from seven participants does not necessarily indicate disagreement with the results, but limits the usefulness of respondent validation in this instance. Given the nature of the subject matter, which was potentially sensitive and also likely involved unconscious processes and concerns, there are limitations to the use of the interview method to gather data. Where interpretations regarding unconscious processes were made, best efforts were made to validate these interpretations from different sources and to utilise self-reflective strategies to try to minimise bias. However, as part of the co-construction of the theory, the researcher's assumptions remain likely to have influenced these interpretations. Challenges to the researcher's initial assumptions were noted, for example, that practical demands seemed just as, if not more, crucial in acting as an obstacle

to compassionate care as a lack of emotional support, and that lack of emotional support itself need not come from lack of provision but lack of effective use. Such realisations strengthen the assertion that researcher bias did not unduly influence the outcome of this study.

5. Conclusion

This study presents a constructed theory of acute psychiatric staff's experiences, taking into account individual, organisational and broader social influences on the challenge of delivering compassionate, personalised care in the modern NHS. The model generated demonstrates the process of interactions between the clinical task and its emotional consequences, within the interpersonal context of the ward team and the broader external pressures and demands of a resource-scarce and unpredictable environment. Staff gain reward from building relationships with patients and with their colleagues, but can feel uncertain about the limits of their role and often do not feel equipped with adequate resources, training or support to maintain those relationships. The study highlights the importance of placing patient engagement as the highest priority within acute psychiatric wards, rather than a task which can only be attended to when time allows. It seems likely that long-term change in this area can be achieved only through collaboration across patients, frontline staff, commissioners and public bodies in order to make compassionate personalised care not just empty rhetoric but a realisable goal.

6. References

Birks, M., & Mills, J. (2011). Grounded theory: A practical guide. Thousand Oaks, CA: Sage Publications.

Bliese, P., & Castro, C. (2000). Role clarity, work overload and organisational support: Multilevel evidence of the importance of support. Work and Stress, 14, 65-73.

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

British Psychological Society (2010) Code of human research ethics. Leicester: BPS. Retrieved from http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethic.pdf

Buss, N., Angel, S., Traynor, M., & Gonge, H. (2011). Psychiatric nursing staff members' reflections on participating in group-based clinical supervision: A semistructured interview study. International Journal of Mental Health Nursing, 20, 95-101. doi: 10.1111/j.1447-0349.2010.00709.x

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

Creswell, J. (2008). Educational research: Planning, conducting, and evaluating quantitative and qualitative research. New Jersey: Pearson

Crichton, J. (1998). Psychodynamic perspectives on staff responses to patient misdemeanour. Criminal Behaviour and Mental Health, 8, 266-274. doi: 10.1002/cbm.266

Cummins, A. (2009). Clinical supervision: The way forward? A review of the literature. Nurse Education in Practice, 9, 215-220. doi: 10.1016/j.nepr.2008.10.009

Department of Health (2000). The NHS plan: A plan for investment, a plan for reform. London: National Health Service. Retrieved from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf

Department of Health (2011). No health without mental health: A cross-government mental health outcomes strategy for people of all ages. London: National Health Service. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Department of Health (2012). Compassion in practice: Nursing, midwifery and care staff, our vision and strategy. London: National Health Service. Retrieved from http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

Elliott, R., Fischer, C., & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. British Journal of Clinical Psychology, 38, 215-229. Retrieved from http://www.wider-mind.com/research/elliott_fischer_rennie_1999.pdf

Farquharson, G. (2004). How good staff become bad. In P. Campling, S. Davies, & G. Farquharson (Eds.), From toxic institutions to therapeutic environments: Residential settings in mental health services (12-20). London: Gaskell

Glaser, B., & Strauss A. (1967). The discovery of grounded theory: Strategies for qualitative research. NY: Aldine de Gruyter

Hall, J. (2004). Restriction and control: The perceptions of mental health nurses in a UK acute setting. Issues in Mental Health Nursing, 25, 539-552. doi: 10.1080/01612840490443473

Health Professions Council (2009). Standards of conduct, performance, and ethics. London: HPC.

Hopson, C., Porter, M., Mann, C., Tee, M., Gray, P., Baker, M., Warwick, C., Carter, P., Thompson, R., & Bailey, S. (2013, December 31) A new year must herald a new start for the NHS. The Guardian. Retrieved from http://www.theguardian.com/society/2013/dec/31/new-year-herald-new-start-nhs

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

Johansson, I., Skärsäter, I., & Danielson, E. (2009). The meaning of care on a locked acute psychiatric ward: Patients' experiences. Nordic Journal of Psychology, 63, 501-507. doi: 10.3109/08039480903118208

Kennedy, A. (2013). A compassionate formulation of task drift in mental health staff. Mental Health Review Journal, 18 (2), 73-82. doi: 10.1108/MHRJ-01-2013-0001

Klein, M. (1959). Our adult world and its roots in infancy. Human Relations, 12, 291-303.

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 (4), 245-258. doi: 10.1002/cbm.796

Lelliott P., & Quirk A. (2004). What is life like on acute psychiatric wards? Current Opinion in Psychiatry. **17** (4), 297-301.

Maslach, C. & Jackson S. (1981). The measurement of experienced burnout. Journal of Occupational Behaviour, 2, 99–113.

Mann, K., Gordon, J., & MacLeod, A. (2009). Reflection and reflective practice in health professions education: A systematic review. Advances in Health Sciences Education, 14, 595-621. doi: 10.1007/s10459-007-9090-2

Menzies Lyth, I. (1959) The functions of social systems as a defence against anxiety: A report on a study of the nursing service of a general hospital. Human Relations, 13, 95-121.

Paley, J. (2013). Social psychology and the compassion deficit. Nurse Education Today, 33 (12), 1451-1452. doi: 10.1016/j.nedt.2013.05.011

Priebe, S., & McCabe, R. (2008). Therapeutic relationships in psychiatry: The basis of therapy or therapy in itself? International Review of Psychiatry, 20, (6), 521-526. doi: 10.1080/0954026802565257

Reid, Y., Johnson, S., Morant, N., Kuipers, E., Szmukler, G., Thornicroft, G., Bebbington, P., & Prosser, D. (1999). Explanations for stress and satisfaction in mental health professionals: A qualitative study. Social Psychiatry and Psychiatric Epidemiology, 34, 301-308. doi: 10.1007/s001270050148

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

Spandler, H., & Stickley, T. (2011). No hope without compassion: The importance of compassion in recovery-focused mental health services. Journal of Mental Health, 20 (6), 55-66. doi: 10.3109/09638237.2011.583949

Springham, N., & Woods, A. (2014, Jan 7). Toolkit uses patient experiences to improve mental health services. The Guardian. Retrieved from http://www.theguardian.com/healthcare-network/2014/jan/07/mental-health-toolkit-improves-services

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1998). Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.). Thousand Oaks, CA: Sage

Tansella, M., & Thornicroft, G. (2009). Implementation science: Understanding the translation of evidence into practice. The British Journal of Psychiatry, 195, 283-285. doi: 10.1192/bjp.bp.109.065

Thibeault, C., Trudeau, K., d'Entremont, M., & Brown, T. (2010). Understanding the milieu experiences of patients on an acute inpatient psychiatric unit. Archives of Psychiatric Nursing, 24 (4), 216-226. doi: 10.1016/j.apnu.2009.07.002

The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). Report of the Mid Staffordshire NHS Foundation Trust public inquiry: Executive summary. Retrieved from http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

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

Walsh, J., & Boyle, J. (2009). Improving acute psychiatric hospital services according to inpatient experiences. A user-led piece of research as a means to empowerment. Issues in Mental Health Nursing, 30, 31-38. doi: 10.1080/01612840802500733.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. Counselling and Psychotherapy Research, 7 (1), 54-65. Doi: 10.1080/14733140601185274

Williams, E., & Morrow, S. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. Psychotherapy Research, 19 (4-5), 576-582. doi: 10.1080/10503300802702113

Willig, C. (2001) Introducing qualitative research in psychology: Adventures in theory and method. Buckingham: Open University Press

Winnicott, D. (1949). Hate in the countertransference. International Journal of Psychoanalysis, 30, 69-74.

MAJOR RESEARCH PROJECT

NAOMI LAW MA Hons

Section C

Appendices

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

For submission to the Journal of Mental Health

APRIL 2014

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix 1: Search Methodology

Search Strategy

The following databases were searched between September 2013 and December 2013: Psychinfo, MEDLINE, Web of Science and Google Scholar. Articles were restricted to those published from 2000 onwards, using The NHS Plan (2000) as a cut-off point.

The following search terms were used:

Patient* / Client* / Service user*

AND

Inpatient* Ward* / Acute Psychiatric

AND

Experience*

Exclusion Criteria

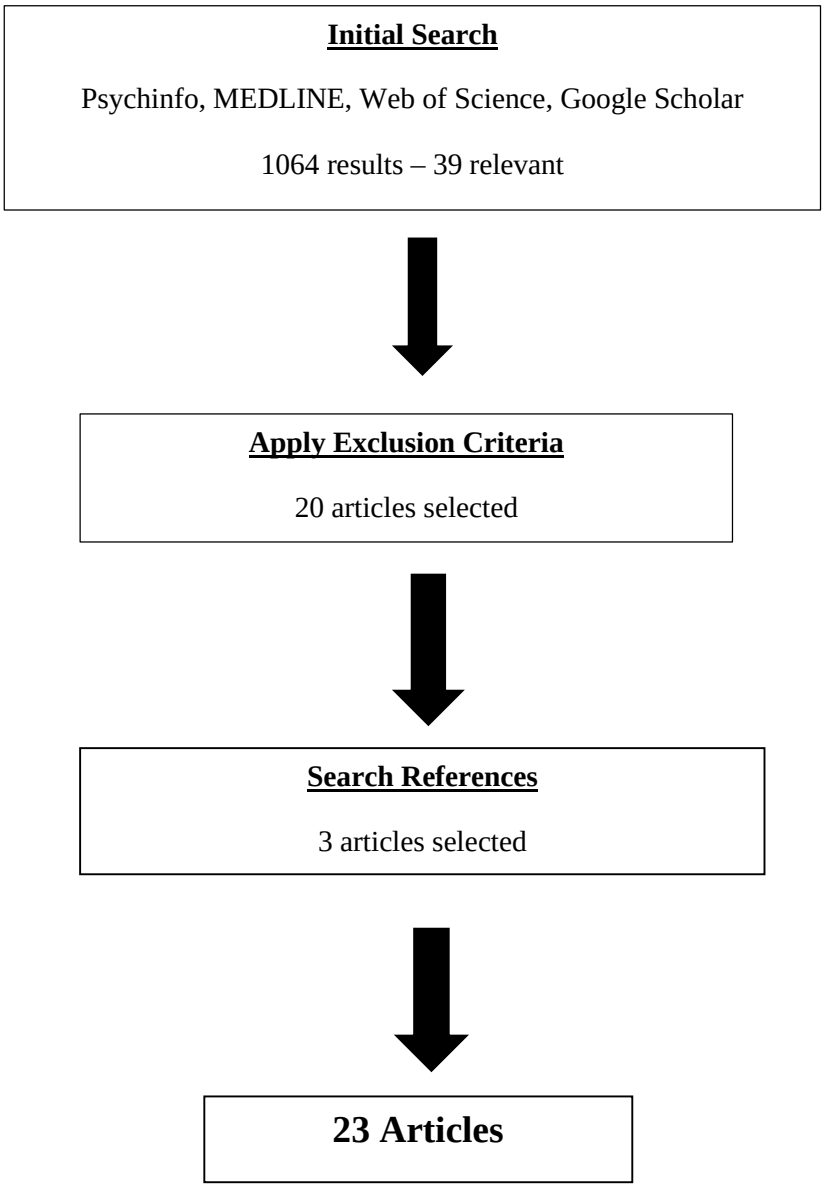
Studies were selected which looked at the experiences of patients on adult acute psychiatric wards, not adolescent, learning disability or forensic wards. Studies were excluded which were not written in English; which focused on a narrow aspect of the inpatient experience (e.g. seclusion), or a particular inpatient treatment (e.g. CBT), or a particular mental health problem (e.g. experiences of psychosis); which did not ask service users themselves for their experiences; or which provided quantitative data on patient satisfaction, rather than experience. Studies were also excluded if they looked at the experiences of both inpatients and outpatients but didn't present separate analyses. Two papers were identified which were by the same authors and using the same data, one being a more developed version of the other

(Jones & Crossley, 2008; Crossley & Jones, 2011). In this case, the decision was made to review the later paper only, as representing the most recent and highest-quality form of that study.

Search Process

Databases searched using the terms above initially yielded 1064 results. Upon reading the titles and/or abstracts, 39 of these were thought to be relevant. After applying the exclusion criteria outlined above, 20 of these were included. Searching the reference lists of these studies resulted in a further 3 studies which met inclusion criteria being identified. This resulted in 23 studies in total which met the inclusion criteria for review.

Appendix 2: Diagram of Search Process and Results



Appendix 3: Summary Table of Studies Reviewed

Study (Country)	Sample	Methodology	Main Findings
Wood & Pistrang (2004) A safe place? Service user experiences of a mental health ward (UK)	9 patients (3 men, 4 women) aged 26-61. Ethic identity: 6 White, 1 Black Carribean, 1 Black African, 1 Chinese) and 7 nursing staff (3 men, 4 women. Mean age 30, range 24-50. Ethnic identity: 5 White, 1 Black African, 1 Indian)	Semi-structured interviews. Thematic analysis.	Assault/Intimidation common. Mixed-sex wards/shared rooms an issue for women with history of abuse. Staff unavailable or threatening. Need for single rooms and reflective practice for staff
Cutting & Henderson (2002) Women's experiences of hospital admission (UK)	Women currently using, or who had previously used, psychiatric inpatient services. Number/demographic information not given.	Semi-structured interviews and focus groups. Grounded theory.	Experiences of violence; feeling vulnerable around male patients and staff; lack of cleanliness/privacy; oppressive atmosphere; peer support. Need for single-sex wards
Jones et al. (2010) Psychiatric wards: Places of safety? (UK)	60 inpatients (36 men, 24 women) aged 19 - 81. Ethic groups: 40 White, 11 Black, 6 Asian, 3 Other.	Semi-structured interviews. Thematic analysis.	Majority felt safe; reports of aggression, bullying, theft, racism; often linked to drugs/alcohol; patients had to devise strategies to keep self and posessions safe
Stenhouse (2013) Safe enough in here? Patients' expectations and experiences of feeling safe in an acute psychiatric inpatient ward (UK)	13 inpatients (6 men, 7 women) aged 18 - 65.	Unstructured interviews. Holistic analysis.	Expectation of safety from self and others; initially felt safe but then anticipated threat from other patients; expected staff to keep them safe; felt safer with male staff.
Thomas, Shattell & Martin (2002) What's therapeutic about the therapeutic milieu? (US)	8 inpatients (5 men, 3 women) aged 23 - 58.	Phenomenological interviews. Descriptive phenomenological analysis.	Hospital as a refuge from self-destructiveness; peer "therapy" most beneficial, but wanted deeper connection with staff and more therapeutic input to increase understanding/insight.

Borge & Fagermoen (2008) Patients' core experiences of hospital treatment: Wholeness and self-worth in time and space (Norway)	15 inpatients (7 men, 8 women) aged 19 - 58.	Semi-structured interviews. Giorgi's phenomenological-hermeneutic analysis	Aesthetic beauty of the environment and professionalism; self-worth and equality evoked through socialising with other patients and engaging in therapy with staff; leisure time evoked feelings of passivity and "patient" identity.
Stenhouse (2011) "They all said you could come and speak to us": Patients' expectations and experiencs of help on an acute psychiatric ward (UK)	13 inpatients (6 men, 7 women) aged 18 - 65.	Unstructured interviews. Holistic analysis.	Patients expected help to come through talking with nurses, but nurses always seemed too busy with "non-nursing" tasks; Peer support used instead, but could be very demanding
Koivisto, Janhonen and Väisänen (2004) Patients' experiences of being helped in an inpatient setting (Finland)	9 inpatients. No demographics given.	Semi-structured interviews. Analysed using Giorgi's phenomenological method	Care is protection from vulnerability and restructuring/empowering the self to cope with daily life. Physical presence of nurses, no coercion. Helpful but unstructured and unreliable.
Moyle (2003) Nurse-patient relationship: A dichotomy of expectations (Australia)	7 inpatients (1 man and 6 women) aged 38-57	Interviews (format not specified). Giorgi's phenomenological analysis	Patients received their most desired form of care (staff presence, time, reassurance) on admission but this soon diminished; nursing care was distanced, symptom-focused, not person-centred
Talseth, Jacobsson & Norberg (2001) The meaning of suicidal inpatients' experiences of being treated by physicians (Norway)	19 inpatients (10 men, 9 women)	Unstructured interviews. Ricoeur's phenomenological analysis.	Physicians used either a Participating Approach (being with patients, listening, trust, respect) or an Observing Approach (alone, prejudice, mistrust, disrespect for integrity)

Crossley & Jones (2011) Shame and acute psychiatric inpatient care (UK)	10 former inpatients (5 men and 5 women) aged 30-63. Also 14 staff members (6 men and 8 women) aged 20s - 55 - results for this group not presented in this review.	Semi-structured focus groups of either service users or staff. Thematic analysis	Patients experienced shame through loss of autonomy, intrusive observation and ward rounds, disrespect from staff. Self-stigma exacerbated sensitivity to staff treatment.
Thibeault, Trudeau, d'Entremont & Brown (2010) Understanding the milieu experiences of patients on an acute inpatient psychiatric unit (Canada)	6 inpatients (4 men and 2 women) aged 25-75.	Semi-structured interviews. Heidegger's interpretive phenomenological analysis.	Meaning of experience created through relationships. Staff could engage and confirm personhood, or disconnect and abuse power by holding back presence. Healing could occur through recreation and relaxation. Seclusion is traumatic, inhumane.
Hughes, Hayward & Finlay (2009) Patients' perceptions of the impact of involuntary inpatient care on self, relationships and recovery (UK)	12 current and former inpatients under section (5 men, 7 women) aged 19-62. Diagnoses: 6 bipolar affective disorder, 2 BPD, 2 schizophrenia, 2 depression. 2-34 years MH service contact. 1-20 previous hospitalisations. 1-10 compulsory hospitalisations. 0-7 years since last hospitalisation. 1 current inpatient, 11 outpatients.	Semi-structured interviews. Thematic analysis.	Perceptions of self mediated through staff interaction. Negative experiences led to loss of identity, negative self-concept. Restraint resulted in cycle of conflict. Relationships as the context for recovery.
Rogers & Dunne (2011) "They told me I had this personality *disorder…All of a* sudden I was wasting their time": Personality disorder and the inpatient experience (UK)	10 former inpatients (1 man and 9 women) with a BPD diagnosis. Aged 21-45.	Semi-structured focus group. Thematic analysis.	Staff prejudice about PD, not "real" MH. Sectioning used as a threat. Treated poorly if re-admitted. Opinions on treatment dismissed. Ward felt unsafe, lack of information given, boredom. Need more of a voice.

Robins, Sauvageot, Cusack, Suffoletta-Maierle & Freuh (2005) Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings (USA)	27 former inpatients (16 men and 11 women), mean age 46.7. 2/27 married. 22/27 high school education or less. 23/27 unemployed. 21/27 African American.	Semi-structured interviews. Thematic analysis.	18 reported an adverse experience. Threar of physical violence from both staff and other patients, arbitrary rules. Staff interactions were depersonalising and disrespectful.
Shattell, Andes & Thomas (2008) How patients and nurses experience the acute care psychiatric environment (USA)	10 patients (4 men, 6 women). Ethnicity: 3 black, 1 Latino, 6 white. Diagnoses: 1 BPD, 5 depression, 5 substance abuse, 4 bipolar disorder, 1 PTSD. Had spent 2-11 days on the ward. Previous admissions: 1-11. Also 9 nurses (all women) aged 46-76. Ethnicity: 8 white, 1 African American/Indian. Results for staff group not presented in this review.	Phenomenological interviews. Thematic Analysis	Patients felt imprisoned, bored, powerless - unable to go out and restricted by arbitrary rules. Skeptical about effectiveness of treatment, felt mainly about medication and compliance. Support from other patients, nurses stuck in office. Need more activity and interaction.
Lilja & Hellzen (2008) Former patients' experience of psychiatric care: A qualitative investigation (Sweden)	10 former inpatients (3 men, 7 women) aged 32-64. Hospitalised 2-20 years. Diagnoses: 2 psychosis, 4 PD, 3 mood disorder, 2 aspergers, 2 substance abuse	Semi-structured interviews using a thematic life-story method. Content analysis.	Cold, dull environment, no intimacy. Over-reliance on medication, lack of contact leading to loss of identity. Response was rebellion or passive adaptation. Patients are powerless, but some safety/respite.
Johansson & Lundman (2002) Patients' experience of involuntary psychiatric care: Good opportunities and great losses (Sweden)	5 former involuntarily-admitted inpatients (2 men, 3 women) aged 27-49.	Unstructured narrative interviews. Ricoeur's phenomenological hermeneutic method.	Restricted by inflexibe rules. Violence and inhumane treatment led to loss of integrity. Not involved in care decisions, no info given, patient not person. Some felt cared for/protected and listen to.

Johansson, Skarsater & Danielson (2009) The meaning of care on a locked acute psychiatric ward: Patients' experiences (Sweden)	10 patients (2 men, 8 women) aged 18-55+. Diagnoses: 6 bipolar disorder, 2 depression, 1 anxiety disorder, 1 anorexia. Previous admissions 1-23. 6 admitted voluntarily, 4 involuntarily.	Semi-structured interviews. Qualitative content analysis.	Two main contradictory themes: Getting Alleviation from Suffering (self-determination, support, refuge) and Being Exposed to Stress (dependence, feeling trapped). Power differences between patients and staff impossible to resist.
Walsh & Boyle (2009) Improving acute psychiatric hospital services according to inpatient experiences. A user-led piece of research as a means to empowerment (UK)	55 inpatients aged 16-68.	10 focus groups. Content analysis. User-led research.	Patients need one-to-one time with staff and to be treated like a human, not just a patient. Over-reliance on medication, arbitrary rules. Staff are controlling and unavailable, focus on observation not interaction. Need more patient involvement with care.
Gilburt, Rose & Slade (2008) The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK (UK)	19 former inpatients (10 men, 9 women) aged 25-60+. Ethnicity: 13 white British, white European 1, black British 3, asian British 2.	Focus group of 10 people, unstructured interviews with 9 people. Thematic analysis. User-led research.	Overall context of Relationships, plus 5 further themes of Communication, Safety, Trust, Coercion and Cultural Competency. If staff are coercive or unavailable, patients feel unsafe and lose trust. Lack of cultural competency or even overt racism from staff. Lack of freedom - like a prison. Negative environment. Respectful communication within positive relationships needed.
Rose (2001) Users' Voices (UK)	500+ patients, including 26 current inpatients and 6 former inpatients. No demographics given.	Interviews and a discussion group. No method of analysis stated, results presented discursively. User-Focused Monitoring approach.	Lack of info given to patients, lack of activities (boredom), over-reliance on medication, nurses have too much admin. Patients felt unable to complain, no voice/advocacy.

Bristol Mind (2004) User focused study of inpatient services in three Bristol hospitals (UK)	76 former inpatients (32 men, 42 women, 2 not stated), aged 16-61+. Sexual Orientation: 58 straight, 2 gay/lesbian, 2 bisexual, 2 not given. 57 had previous admissions. Diagnoses: 25 depression, 13 dual, 12 bipolar, 6 schizophrenia, 3 mania, 2 eating disorder, 2 PD, 8 other, 5 don't know/none. Agreement with diagnosis: 38 yes, 14 no, 12 don't know, 12 n/a	Semi-structured interviews. Thematic analysis. User-Focused Monitoring approach.	Some reported good relationships with staff, others felt ignored and disrespected. Patients felt bored, trapped, dehumanised. Too much medication, not enough therapy. Not involved in treatment, felt powerless.

Appendix 4: Elliott, Fischer and Rennie's (1999) Guidelines for Qualitative Research

A. Publishability Guidelines Shared by Both Qualitative and Quantitative Approaches

1. Explicit scientific context and purpose
2. Appropriate methods
3. Respect for participants
4. Specification of methods
5. Appropriate discussion
6. Clarity of presentation
7. Contribution to knowledge

B. Publishability Guidelines Especially Pertinent to Qualitative Research

1. Owning one’s perspective
2. Situating the sample
3. Grounding in examples
4. Providing credibility checks
5. Coherence
6. Accomplishing general vs. specific research tasks
7. Resonating with readers

Appendix 5: Participant Demograhics

Note: Demographics are given for the overall group to prevent identification of individual staff members.

Gender: 3 men, 7 women

Age: 24 – 56 (mean 38)

Ethnicity: 6 White British, 3 British/African, 1 British/Pakistani

Time worked on wards: 1 year – 21 years

Appendix 6: Interview Schedule

Demographic info to be asked prior to main interview: Gender, Age, Ethnicity, Job Title, Length of time worked on wards.

Nature of the Job and Role

First, I wonder if you could tell me a bit about your job – how would you describe it?

- What does it involve?
- Did you always want to be a _____? How did you end up being a _____?
- What were you expectations of the job?
- Have these been met? How/not?
- What would you say are your strengths as a ____?

What do you think are the most enjoyable aspects of your job?

What do you think patients on the ward need?

- Activities?
- Relationships?
- What is the ultimate goal? And how do you see your role in helping to bring this about?

How involved do you feel in providing those things?

- Would you like to be more involved?
- If so, what would need to happen to allow you to be? If not, why not?

Emotional Impact of the Work

Could you tell me a bit about what helps you do your job?

- What makes it easy/difficult?
- Could you give me an example of a challenging situation involving a patient?
- How did you handle it?

How do you manage the more difficult aspects of your job?

- Personal skills/resources? Support from others?
- Either at work or in spare time?

In an ideal world, what would you need to make doing your job easier?

According to a lot of the research and what is written about ward work, working on an inpatient ward can sometimes lead to distressing or difficult feelings for staff. I wonder, to what extent do you feel there is somewhere for staff to bring distressing/difficult feelings?

- If so, do you personally find these support provisions helpful? Why/not?
- If not, what do you think would be helpful to have available?

The Ward Team and Organisational Issues

How much support do you feel staff working at your level/in your role get from colleagues/managers/supervisors?

- What could be improved in these areas?

How well do you feel the staff team work together on your ward?

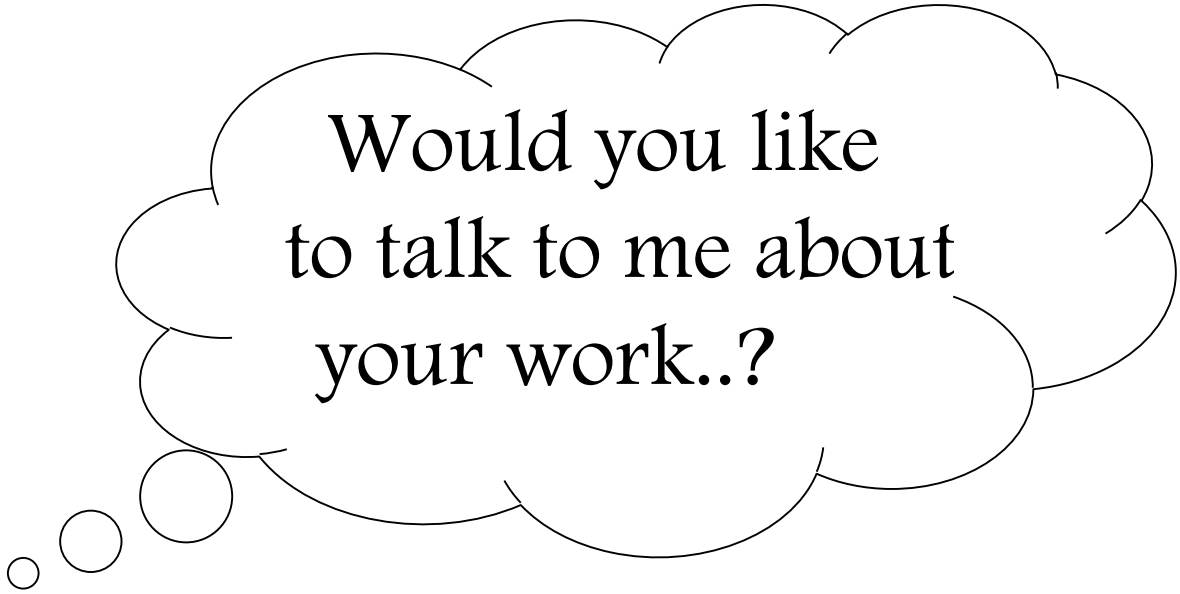
- Tell me about something you feel your team does well. Example?
- To what extent do you feel different staff roles are valued equally? Why/not?
- To what extent do you feel involved in clinical decisions? Why/not?

Is there anything else you feel it is relevant to say about what makes working with patients easy or difficult?

Or things that help or hinder you personally in working with patients?

Appendix 7: Flyer for Staff Recruitment

Flyer Version 2, 12th Dec 2012



I'm interested in talking to inpatient ward staff about their jobs as part of a study which aims to lead to a better understanding of and support for this complex role. You might have opinions on:

☆ what kind of person is best suited to this work

☆ what kind of team works most effectively together

☆ what is most important in working with patients during their time here...

I would love to hear about all these things and any other thoughts you have.

I will be conducting informal 1 hour interviews, either here or at _____ depending on your preference. For more information please get in touch with me at n.k.law1@canterbury.ac.uk or call and leave a message (specifying it is for me) on 03330117070.

Naomi Law, Trainee Clinical Psychologist

Canterbury Christ Church University

Appendix 8: Information Sheet for Staff

Staff Experiences on Inpatient Wards and Impact on Engagement

Hello. My name is Naomi Law and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Part 1 tells you the purpose of this study and what will happen to you if you take part.
Part 2 gives you more detailed information about the conduct of the study.

Part 1

What is the purpose of the study?

I am interested in speaking to staff who work on acute psychiatric wards about their experiences of the job, particularly with regards to engaging with service users and working within the ward team. This is to allow me to think about how staff might be better supported in their work

Why have I been invited?

I am approaching staff on all of_____ acute psychiatric wards to ask if they would like to take part.

Do I have to take part?

It is your choice if you would like to take part. You should feel free to read this information sheet and also ask me any questions you would like to before deciding whether to take part. If you do decide to, I will ask you to sign a consent form, however you are free to withdraw your consent at any time without giving a reason.

What will happen to me if I take part?

You will be invited to have an interview with me which will last about an hour and will involve questions about some of your experiences and opinions as a member of acute ward staff. You have a choice of whether you would like me to come to your workplace to do the interview in working hours (which I have your manager's permission to do) or to come to *Memorial Hospital Greenwich to give the interview outside of your shift/on a day off,* meaning no one at your workplace would know that you have given the interview. There is also the possibility of conducting the interview by telephone if this would be more convenient.

You do not have to answer any questions that you don't want to. The interview will be recorded but your identity will be anonymous in the final project write-up. If you do give any information in the interview which I think may identify you, I will not use it in the write-up. At the end of your interview I will ask if you would be willing in principle to be contacted at a later date to comment on a summary of my findings from the study. This is optional and can be done completely by post or email, and/or by telephone after you receive the summary, and will help ensure that I am interpreting the interview material accurately.

Expenses

Should you choose to come to _____, *y*our travel expenses to the interview will be paid, up to a maximum of £10.

What are the possible disadvantages and risks of taking part?

Taking part will take up some of your time, and it is possible that the interview will cover some issues about which you may feel uncomfortable, as it will include questions about what might be difficult about your work, as well as what is more easy or enjoyable.

What are the possible benefits of taking part?
It is possible that the interview will offer you a space to talk about your work with someone impartial and sometimes doing so can be experienced positively, although it is not directly intended to be helpful to you. Less directly, the study intends to contribute towards increased understanding of the issues affecting the work of acute ward staff, in order to benefit the wellbeing of both staff and service users in the acute ward setting.

What if there is a problem?
Any potential problems or complaints which may come up during the study will be addressed as detailed in Part 2 of this information sheet.

Will my taking part in the study be kept confidential?
Yes, as explained in part 2, all information given by you will be kept confidential.
This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?
If you withdraw from the study at any point before the final write-up your interview recording will be destroyed and not used in the write-up.

What if there is a problem?
If you have any concerns or complaints about the study, please ideally address them to me in the first instance (my email address is n.k.law1@canterbury.ac.uk). However, if you wish to speak to someone else my supervisor at the university, Dr. Sue Holttum, can be contacted at sue.holttum@canterbury.ac.uk.

Will my taking part in this study be kept confidential?
The interview you give will be recorded and stored on a password-protected usb stick which only I will have access to. When the interview is transcribed it will be anonymised and either an independent transcription service or I will complete the transcription. Only my lead supervisor, Dr Sue Holttum (who is not employed in _____) and I will have access to the anonymised transcripts. No identifiable information will be used in the final write-up, in which you will be given a pseudonym, although direct quotes will be used.

What will happen to the results of the research study?
I intend to submit the final report for publication to a psychology or mental health journal. If you would like a copy of the final write-up I am happy to email it to you if you give me your contact details.

Who is organising and funding the research?
The research is organised and funded by Canterbury Christ Church University.

Who has reviewed the study?
This study has been reviewed and approved by the Canterbury Christ Church University ethics panel. It has also been reviewed by two members of staff of Applied Psychology at the University who are independent from the project.

Further information and contact details
Further information about the study can be obtained by contacting me at n.k.law1@canterbury.ac.uk or leaving at message for me at 03330117070 (Please leave your name, contact number and give my name as this is a university research phoneline). You can also contact my lead supervisor Dr Sue Holttum at sue.holttum@canterbury.ac.uk.

Appendix 9: Example Transcript with Focused Codes

This has been removed from the electronic copy

This has been removed from the electronic copy

This has been removed from the electronic copy

This has been removed from the electronic copy

This has been removed from the electronic copy

This has been removed from the electronic copy

This has been removed from the electronic copy

Appendix 10: Examples of Memo-Writing

HCA 2

Both HCA 2 and Clinical Charge Nurse talked about housing but HCA 2 seems far more frustrated with the concrete lack of housing available for patients rather than frustrated with the patients themselves for misusing the ward (which was more the angle of CCN). HCA 2 uses the word "limited" a lot – a real feeling of being restricted, not knowing where to turn to, feeling poorly equipped (in either training or resources) for this role and so ending up frustrated.

Lines 191-203. This is really interesting – consideration of where the boundaries lie in the acute HCA role, but then feeling like there's just no one else there to take on this kind of role if they refuse to do it, so likely feeling guilty and persuaded to do it whether or not it's strictly their job.

Importance of taking people out: This is a theme that feels like it's come up a lot (certainly CCN, Ward Manager and HCA 1) and it's interesting because often wards seem to be contrasted with "community" services, as if they are two separate things catering for different needs, but from what staff are saying here there actually needs to be a great deal of community access and link up for patients on wards (and for staff too?). Maybe this isn't prioritised enough? I'm thinking of what HCA 1 said about that garden centre trip being dropped and changed and essentially sabotaged. Is there some kind of conflict going on between the more old school "confinement and medication (or even therapy)" approach and a more contemporary "keep patients connected, get them off the ward" approach to ward work? Reminds me of Goffman's Total vs Permeable institutions.

Lines 272-274. Interviewees are spontaneously mentioning psychology input as helpful in their day to day jobs. Lots of mentions of the reflective practice group so far. I don't know if this is influenced by the fact that they're talking to me, or how representative this Trust is (in my experience it is more psychology friendly than most – could also even be a selection bias of the interviewees as they are willing to talk to me!)

PROCESS: It's interesting how much laughter there is here – we are talking about something quite serious (needing time away from the stress and maybe even **di**stress of the ward) but we are speaking about it in quite a lighthearted way – defence?

Lines 534-537. This almost sounds like a confession – admitting to feeling scared. It's great that they were encouraged to say that and were able to say that but it does say something about how emotions are addressed (or rather, not addressed) in the typical ward environment when something so clearly frightening can happen and it seems to take a special effort to "admit" that you felt scared. Are professionals not supposed to feel scared? In a normal, personal capacity, if you were just out in public and something like this happened, surely you would feel scared? So why is fear more difficult to access on the ward?

Lines 605-635. This is a really difficult philosophical tension I think and it cuts so much into mental health stigma and how people with mental health problems (or not) are thought about and treated. Personality disorder as a choice, mental health as biologically-driven rather than behavioural or chosen, people being responsible (ethically? Legally?) or not responsible, taking responsibility or not. It is a really complex thing and I don't think as clear cut as is framed here.

Ward Manager

Lines 374-382. There is a real difference here in the understanding of my question about support for staff who are feeling stressed to the Agency Nurse's understanding – Ward Manager initially focuses entirely on emotional support, rather than practical. This could partly be a personality thing but I wonder if it's also affected by the job role and how the WM feels responsible for the pastoral overview of the ward, in comparison to the Agency Nurse who is not responsible for anyone else's wellbeing and didn't seem to struggle personally.

Lines 389-399. WM does then talk about the number of staff available, but I get the sense that WM's sticking with an emotional conception of this. It's the difference between "There is enough support – there are staff in other wards who could be called to an incident" and "There aren't enough staff therefore there is increased pressure on the staff that are here which is emotionally stressful for them". And also, as WM says, it feels stressful not being able to provide that support.

Lines 403-407. Similar to the CCN interview - senior management accusing them of not recording properly when things are going well – that sense of not being trusted, not being given enough freedom to decide what is best for the service, being under unfair levels of scrutiny that make them feel disrespected.

Lines 412-415. Also something similar here to the start of CCN and the audits being passed down the chain, but CCN acknowledging that it's not the manager's fault as they've been asked to do it by their manager, etc…Blame is passed upwards.

Lines 463-466. Whereas before WM was speaking about the unpredictability of mental health with regards to risk to self and keeping patients safe, now the focus is on an unpredictable potential threat, some hyperbole in "he could come here with an axe" I suspect, but the dramatic nature of the image conveys something of the stress of being thrown into a situation where you are asked to admit a patient with a violent history with no knowledge of their current risk level and no time to prepare for this.

Lines 497-526. Again this idea of a "blame culture", this time not leading to reluctance to engage in team clinical decisions (CCN) but a desire to point the finger at others when things are missed – seeing the fault in colleagues rather than in the pressures of the system. WM sees this as inevitable given the stress of the job but I wonder if this is really the case. Couldn't the job be pressured and yet e.g. management be blamed for overworking them when things are missed? To me it suggests a competitive edge, the fact that they choose to blame colleagues – could it be a worry that ultimately it might come down to you or the other person and you have to fight to save your job? Or is it just unsympathetic defensive thinking – lack of reflection, just blame the nearest person.

Appendix 11: Extract from Bracketing Interview

S: So, starting somewhere, just quickly, what was it do you think that made you go for this research?

N: Um…I think the, well I started getting probably really interested in inpatient wards in particular, I mean I've always been interested in staff dynamics, but I think there's something in particular about inpatient wards – I worked on one, but very…um, for a very short amount of time. It was when I was an honorary assistant, and I had like half a day a week, basically just one session with one client at a time on a ward. And I was supposed to be doing kind of CBT-based stuff with them. And yeah, I just found, it wasn't a very nice place to be, the ward, and there were a lot of things going on there that made me feel quite uncomfortable, and I was continually shocked by the way staff treated the patients on the ward. I felt people were not treated with a great deal of respect, that things were quite punitive. One particular incident that really shocked me was when I was working with one particular woman who was very depressed, and occasionally had quite psychotic elements to her depression, so she got quite paranoid. And she, when I came to visit her one time she was standing in the corridor with a nurse, and she was clearly just incredibly distressed. And when I came up to her, she said to me "They've been going through my room, people have been taking things from my room", and the nurse said to her "You're lying, stop lying to this woman, that's not true" and it felt to me like a complete misunderstanding of what was going on, and a real failure of empathy, y'know, and I was just really sort of…yeah, I think she in particular was really badly treated by the staff because she was very difficult to manage and so staff were quite forceful with her in a way I didn't particularly like. And it just got me to wondering what makes people who, I would assume for the vast majority, go into a profession where they genuinely want to help people, begin to act in ways which are bordering on abusive.

S: So that's why you chose this type of research, because of your experience on that ward?

N: Yeah, it felt to me like staff didn't particularly want to be around the patients. Patients were sitting around the common room with the TV on a lot of the time, and there wasn't a lot of noise, there wasn't a lot of interaction, there was a lot of sitting, and staff would sit in the staff room and do their notes, and it just felt like staff didn't get a lot of support, people were very overworked. And it felt like quite an unpleasant environment to be in, for both staff and service users, I think.

S: And you!

N: [laughs] Yeah, well I only had to be there an hour a week. But that meant that I felt in a very powerless position to do anything, because I raised some concerns with my supervisor, but I wasn't even a paid member of staff, I was like a voluntary member of staff who was there one hour a week with one person. And I was wary of doing that "psychologist" thing of sort of swanning in and saying "Oh, in my vast experience of this ward you're all rubbish" and then swanning away again! Um, so yeah it was a difficult position to be in, but it definitely got me more interested in how the culture of a workplace can really affect interactions between staff and service users, so not just how people individually, but also how the whole organisation can then affect dynamics.

S: Yeah, and I was just wondering, cos part of the bracketing thing is trying to work out where you're coming from with it. So it sounds like it was a really unpleasant experience for you and that you felt, you said this feeling of powerless, so that's why now you're like, no I don't want to be powerless, I want to do something about this!

N: Yeah, yeah I guess. I think wards are especially one of the…I know they get for example the worst level of complaints in terms of mental health services it tends to be the wards. And that's partly I think because people are the most distressed and most unwell, but I think there's obviously something not quite working there, and it seems to me that wards have come on the least, if you think about all the different types of mental health service and how different a lot of them are from the days of institutions, wards seem to retain some of that institutional feeling for me, and are kind of treating people less like individuals, more like sort of, um, yeah people losing their identity and basically being very heavily medicated rather than understood. I think. To be honest, I have experience of one ward and, as I said, I don't think it was a very nice place, so possibly not the most objective!

S: What do you think it is about you that made it so important for you to change this, compared to someone else? Why is it so important to you that people aren't treated this way? Y'know, your background, or where you come from – was it because you were on a psychology course at the time?

N: Um…I think…Yeah, I think it was…I don't know. I think it affected me because I…no, I don't know, it's hard to say. I think it was just not why I went into this profession. I think I had a lot of idealistic ideas about what I wanted to do as a psychologist, as a therapist, and that was my first psychology job, I was just out of uni, and I think I had all these lovely ideas about therapy being able to make people happier and make their lives better and just seeing how distressed the people on that ward that I was working with seemed to be was probably quite upsetting for me really, and I felt quite powerless, and really just quite out of my depth. My supervisor was pretty good, but she was very CBT, so she wasn't particularly reflective and our supervision was very kind of skills-based, so there was nothing around the emotional impact on me of this, of seeing these kind of things and how it was making me feel. And in a way I suppose I think this is possibly what's at the – this is where my assumptions come in! – but this is what's at the root of some of these problems, is a lack of supportive or reflective space for some of the staff that – it just really made me sort of think about how stressful that job must be, if it was affecting me that much by being there an hour a week, what must it be like to be there for a 12 hour shift.

Appendix 12: Key Assumptions Noted After Bracketing Interview

1) Situation for patients on wards is not good – needs to be fixed

2) Staff are under a lot of stress and have a lack of emotional support

3) Staff are, on the whole, doing their best. Not "bad staff"

4) Psychodynamic perspective – possible defences against anxiety

5) Both staff and service users on wards might feel powerless

6) It may be difficult to get people to speak truthfully in interviews (for fear of consequences)

Appendix 13: Research Diary

January 2012: Considering 2 potential research areas, both linked to inpatient ward staff as this is something I've been interested in studying further since my first experience of ward work as an honorary assistant in 2009. In discussion with potential supervisors via email and phone.

February 2012: Have decided to choose the study which looks at meaningful patient engagement on wards and what helps or hinders this. It is less fully worked up than the other study which may be a positive thing as I'll be able to shape it more, although it will require more work at the early stages. Supervisors confirmed and seem really enthusiastic which is good.

March – June 2012: Literature search. It seems like there was a lot of interest in this subject area after Menzies Lyth's study but there hasn't been so much recent research which is promising as the NHS has changed so much since then so hopefully it's time for some new approaches. Working on developing the proposal for the Review in June. Feel really excited about the study and enjoying working out the details and reading around the subject. A couple of other trainees are doing similar studies within the same Trust so I was a little worried initially about having enough participants, but have checked this with my external supervisor and she is confident we have the numbers.

June 2012: Proposal Review. Found this incredibly stressful – came as a bit of a blow after all my initial enthusiasm. Felt like they were asking me to make pretty fundamental changes to my project (research questions and model), some which I felt very confused about, which has made me doubt myself and wonder if it's a viable project after all. Scheduled an emergency meeting with my internal supervisor! Felt a little better after talking it through with her and will start on some of the alterations.

July 2012: Adapted the proposal in accordance with the review panel's suggestions. I've tried to justify my focus on staff more fully, as I do think that there is a lack of staff-focused research in this area currently, particularly with the changing demands of the NHS. I have also altered my research questions in a way which I hope gives them a clearer theoretical grounding. This was easier once I'd read a bit more about grounded theory and the idea of creating a model of psychological and organisational processes.

August 2012: Revised proposal approved – Phew! Still a little nervous about the fact that there are some doubts about the justification of the project – worried about getting to viva and still not being able to convince people that this is worthwhile! But my supervisors are being supportive and I do feel like there's the potential here for something valuable. Have started on the ethics form and also been in touch with Nikki Jeffcote who has conducted a similar study but on forensic wards to ask her about her interviews so I can think more about developing the interview schedule.

It can be difficult reconciling the practical and theoretical agendas of the study. Initially I think I was too focused on the former which was partly why my first review didn't go too well. I am trying to make it theoretically sound whilst also ensuring that I produce something clinically useful, which my external supervisor is also keen to achieve.

September 2012: Booked a place on the November Salomons ethics panel. Useful to be forced to think about the practicalities of recruitment and interviewing early, and my external supervisor has some useful knowledge around this area. Coming from more of a research

perspective, I'd assumed staff would be more concerned with confidentiality than practical convenience but she has convinced me otherwise!

October 2012: Did a mock interview with a family friend who's a nurse. This was incredibly helpful as she gave me so much good feedback on how I phrase questions and what a staff member might be thinking or feeling during the interview. I've realised that some of the things I'm asking about could really easily lead to someone feeling criticised or judged which could shut down the interview, so I've adapted the schedule to incorporate her feedback and confirmed this with my supervisors.

November 2012: Ethics approval given. That was much smoother than I anticipated. I have sent the R&D application to the Trust straight away as I'd like to get the green light for recruitment before the Christmas holidays.

December 2012: R&D approval given! No point in starting recruitment while most staff are on holiday, so plan to take a break over Christmas and start again in January.

January 2013: Emailed all ward managers to request that I attend a ward business meeting to tell staff about the project. Also did a bracketing interview with a colleague from placement - this was more helpful than I anticipated. I had already thought of some of the things we spoke about but she also asked me some questions I wasn't expecting and I had to think about my investment in the Psychodynamic perspective and how associated assumptions of that (hidden drives, anxiety, etc) might affect how I conduct the interviews as well as how I analyse the data. I also found that I'm coming into this from quite a negative angle (there is a problem here that needs to be solved...) and I must remember to allow the positive aspects of the job to be talked and thought about as well.

February 2013: Getting hold of ward managers by phone or email is a real challenge. I have managed to attend 5 business meetings but out of that I only have 1 potential interview candidate! This is a little unexpected and disappointing. On a few occasions hardly any staff have been present for the meeting. There seems to be a lot of absences, leave and just a lack of time to be involved in research. I am trying to find time to chase people up as much as possible but it can get demoralising. Still surprised about lack of staff concern over confidentiality in comparison to other things e.g. a staff member who asked if the study was being run by senior management – I reassured him (so I thought) that while I would be feeding back the results, it was not a management-led study and his response was “Oh, so the results will not change anything then”.

March 2013: Finally did my first interview! Thought it went pretty well – the participant was really chatty which helped, although I felt like I stuck a little too rigidly to my schedule and should have been listening more closely to what they were saying so that I could have let them lead the interview a bit more. I think this is probably down to nerves and I'll keep it in mind for next time. I transcribed it within the next few days and found that doing this myself was invaluable for thinking of ideas for the developing theory and reflecting on the experience. It'll be a lot of work but I don't want to use a transcription service (as I considered doing) as I think I'll lose the opportunity for that depth of reflection.

April 2013: Feel like I'm struggling a little with recruitment. Spoke to my external supervisor about it and she gave me some tips such as to offer ward managers specific dates I'm free to send to staff. I also consulted my internal supervisor who advised that after 5 or so interviews I can begin to sample more purposively based on the emerging theory, which I expect might be easier recruitment-wise as I can approach specific staff members.

I've bought and am reading Kathy Charmaz's Constructing Grounded Theory book which is really helpful for working out the practicalities of coding. I had a meeting with my internal supervisor where I brought the transcript of the first interview and we thought how I'd start to write initial codes for it. I've also been writing lots of memos and reflections on the interview. This feels a lot easier than writing the actual codes at the moment – grounded theory coding seems quite different to the kind of coding I'm used to from IPA and TA, which is making me feel a bit nervous and not very confident! I've started to code but it is really slow going. Have booked two more interviews.

Second and Third Interviews. When I arrived on the ward early to see if I could speak to anyone else before my scheduled interview I was told that there weren't many permanent staff working that day but that I could speak to an agency worker if I wanted to. I wasn't sure as initially I only wanted permanent staff who could talk about their particular ward and how the staff team worked, but given that my first interviewee had mentioned agency staff and how incorporating them into the team could be a particular challenge, I thought it would be useful to get the agency perspective. Glad I did as it was surprising. Third interview was with a ward manager which was again a different perspective and I am starting to relax and really enjoy the interviews. This means I'm more vulnerable to just falling into "having a chat" though, so I'm trying to keep Charmaz's guidance and my research questions in mind throughout! Able to move away from the interview schedule more when necessary now though.

Still struggling with coding, only managed a few pages of my first interview and it's hard to keep up with transcribing as well (esp as my typing is not the quickest!) so I asked for another meeting with my internal supervisor. She looked at some of my initial codes and we talked about how I could build on them and improve.

May 2013: Fourth Interview. This was a really interesting interview. As I left the ward the thought that came to me was "It felt like they were speaking my language" - they had trained as a counsellor so there was something in the way they thought and spoke about things that I really connected with. This was helpful to some extent, and they spoke about some difficult experiences which I really appreciated as I think it added another level to the data I've already collected. However, it occurred to me that I may have interviewed them better because I found them easier to understand than someone who comes from a more medical perspective, and I need to be careful that this doesn't bias how I interpret the results e.g. giving more weight to their viewpoint or valuing it more highly than other interviewees'.

Fifth and Sixth Interviews. Managed to grab two people who happened to be on shift on a ward. Really enjoyed the first – a very thoughtful and enthusiastic HCA who gave an excellent picture of the tensions of ward work – what the ward is for and not for, the line between nursing and social work. I felt confident talking to them, like I was able to come away from the schedule much more and pick up on interesting points they made. The sixth was less satisfying – the staff nurse only had 30 minutes so I felt a little rushed and also found it hard to get much depth out of the interview. They were naturally very practically-focused and it was a challenge to get any emotional or reflective info. I am starting to recognise repeat themes in interviews now which is encouraging – feel I'm getting a sense of what's important.

I am quite behind on my transcribing/analysing now so think I will take a break from recruitment while I concentrate on that side of things. Then I can choose who to approach for interviews based on the emerging analysis.

June 2013: I am finding the coding process really difficult – think I am generating too many focused codes but it's hard because I don't know what's going to come out of the data yet so don't want to miss anything out. I have asked for advice from my supervisor and also from the GT Study Group.

July-August 2013: This has been the most dispiriting period of the research so far as I have been so lacking in confidence regarding my coding. I think things are improving a little – I now have 5 interviews coded and have started on the 6th. I am trying to move slightly away from just what the data says now and think more conceptually and theoretically.

There is some interesting stuff coming out about blame culture and clinical responsibility, as well as about hierarchy and how staff relationships are managed. I'm trying to remember to keep my research questions in mind as well so I don't stray off base!

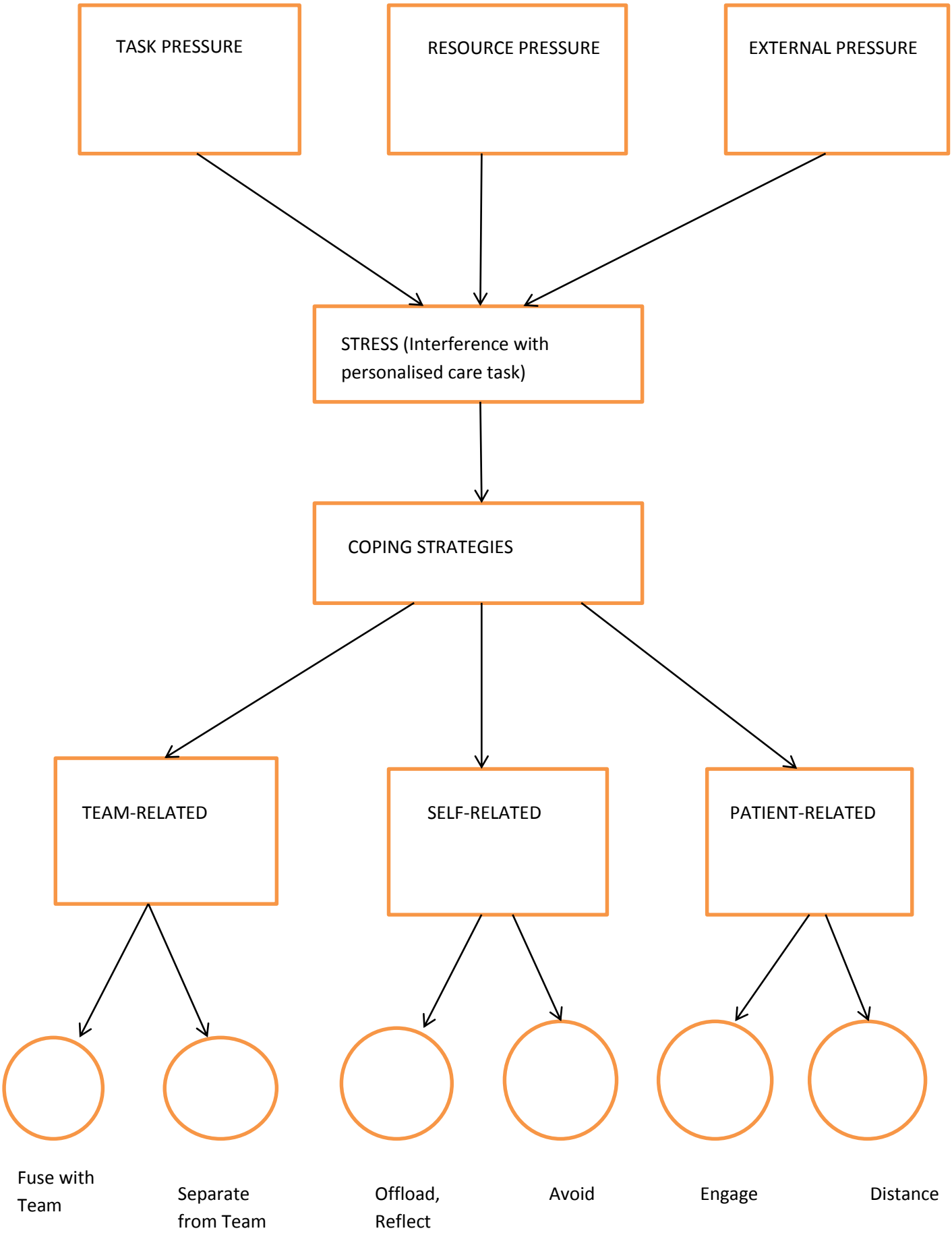
September 2013: Trying to get back into recruitment. Had a long talk with both my supervisors about my thoughts on possible emerging themes/categories and who I want to speak to next, using theoretical sampling to make sure I am testing out my hypotheses about the overall theory. I decided to interview a psychologist as ideas are emerging around both the place of therapy on the ward (and its tensions with the medical model) as well as ward hierarchy. I thought that a psychologist, as a therapist who is somewhat distanced from the ward team by virtue of being spread across several wards and also being a lone worker, but also being fairly high up salary-wise, might have some interesting reflections on both these themes.

Seventh Interview. I found it very easy to talk to the interviewee, and I had to make sure I remained in "interviewer mode" and didn't fall into just chatting about the profession! They had quite a lot to say regarding the ward milieu and organisational issues which was really helpful and interesting.

I have also arranged an interview with a Consultant in October – I imagine that they will also have an interesting perspective on issues such as the ward hierarchy and different levels of staff's involvement in clinical decisions. Learning from the psychologist interview, I will also try and encourage them to be self-reflective about their own role in the hierarchy and the dynamics of that role, rather than allowing them to take a purely "outsider's" perspective, which may be tempting.

I have emailed all the ward managers to request the names of the ward OTs (again, a therapeutic role) and to re-circulate to all nursing staff as I'd like to adapt my interview to test out some of the hypotheses I'm beginning to form.

October 2013: I think I finally have the beginnings of a model! Essentially I have three main areas of Stress which disrupt the task of providing personalised care: Task Stress (c.f. Menzies-Lyth and the anxiety that comes with risk management, sudden violence, feeling powerless, being responsible and feeling angry towards patients); Resource Stress (lack of staff, space, too much admin, lack of support) and External Stress (not feeling valued, an ambivalent relationship with senior management – wanting recognition but feeling scrutinised, esp after incidents, efficiency, blame culture, unsupportive outside agencies). Staff then employ various coping strategies to attempt to manage this stress: Team-Related (Either through fusion (bond together, share responsibility, value all equally, keep upbeat) or separation (Them and Us, professional boundaries, blaming each other, diminishing other roles)); Self-Related (Either open and reflective (Reflecting on own practice, sharing experience, offloading, utilising support structures) or withdrawn and judged/ avoidant (not using support structures, avoiding self-reflection); and Patient-Related (Either engaged and


TASK PRESSURE
RESOURCE PRESSURE
EXTERNAL PRESSURE
STRESS (Interference with personalised care task)
COPING STRATEGIES
TEAM-RELATED
SELF-RELATED
PATIENT-RELATED
Fuse with Team
Separate from Team
Offload, Reflect
Avoid
Engage
Distance

compassionate (empathic, involved, understanding, giving skills, encouragement), or distanced (MH vs behaviour, observing, avoiding contact, boundaries).

Note: I am trying not to be as rigid as to say that one way is right and the other is wrong, and each interviewee used a combination of these strategies from both sides. But I think that some of them are more conducive to patient engagement and individualised care than others. What could be interesting is to find out the mediating factors that influence why someone would choose to e.g. relate distantly rather than openly to patients, or fuse rather than separate from the team.

Eighth Interview. An OT with a really interesting perspective on how emotions are thought about and managed, both by individual staff members and in the wider system. Echoed a lot of the psychologist's points about a lack of engagement with patients due to overwork, as well as a disengagement from the emotional impact of the work. I am finding it really interesting that later interviews are involving a lot more commentary on how other staff groups (other than the interviewee's) might handle stress and be affected by things that happen on the ward. I need to find a way to incorporate this into the model and I would also really like to speak to another nurse so I can ask them directly about some of these comments.

After getting feedback from my internal supervisor I'm working on making the model less linear and closer to the data rather than existing theory – it's difficult not to get drawn back to the things I already know about e.g. primary task, stress, coping. I have also been going through each transcript and noting down the language each interviewee uses to describe the challenges and positives, as well as creating a rough model for each of them to make sure the overall model captures each individual accurately. Also ensures for constant comparison, as required by the GT method. Me and the other GT trainees have started a facebook discussion group to troubleshoot/discuss any issues we're having with analysis.

I've started planning Section A which I hope will give a detailed background to my study and think particularly about the SU perspective so that I keep their viewpoints in mind. Discussed this with both supervisors.

Ninth Interview. A Consultant Psychiatrist. I was interested to find that I felt a lot more nervous about this interview, and found myself being almost deferential – clearly the ward hierarchy is very present in MY mind at least! The consultant spoke very articulately and made some really interesting "overview" points given their managerial position, but it is starting to become clearer in my mind what different priorities senior and junior staff might have, and what things someone like the consultant, who is not based on the ward and does very little direct clinical work, might miss.

November 2013: After meeting with my internal supervisor I have written a more detailed structure of Section A which she has approved. Struggling with the model still, but getting a little clearer. Called round all the wards to begging for another nurse! I have basically reached saturation with the codes now, but I really would like to run some of the themes on stress leading to disengagement with both patients and emotional impact past a nurse, so it's not just from the psychologist and OT's perspectives. I have been in touch with the other GT trainees, doing some troubleshooting via facebook, and we plan to meet up at the end of this month to talk further.

Speaking with the other GT trainees was useful and I've got some good ideas of how to proceed with model development. Also started continued my literature searches for Section A and started to write the introduction.

December 2013: I've spent most of this month focusing on Section A and managed to get a draft to my internal supervisor which I'm pleased about. Even better – I called a ward that so far I hadn't recruited any staff from and the ward manager was incredibly helpful and I ended up being able to go in that day and interview a newly-qualified nurse which was great. The nurse gave what seemed to be a really crucial example of how the emotional impact of the work is handled – when nurses become particularly upset or anxious working with a patient, another member of staff takes over, rather than there being the space for any in-depth processing and support for that nurse.

That's 10 participants and I definitely seem to have reached sufficient saturation (but will confirm this once I analyse the transcript) so can now concentrate on building my model.

January 2014: Feedback from my supervsior on Section A was really positive. We also discussed the model and how I might be able to depict some of the complexity of it visually. I'm finding this difficult as I'm much more comfortable with words than images! So I showed her some "free-writing" (one of Charmaz's techniques for assisting with model development) of my thoughts on the model. She made a good point that I need to make a clearer space in the model for the emotional impact of the work (ironic that I've missed that, given what I've been finding out about how the emotional impact can be missed by staff!!), positive as well as negative. There's also an issue with one of my categories "Managing Risk" which might be a misleading title seeing as some of the codes within it are about staff feeling they're NOT able to manage risk. I will return to the data and try and find something closer to what interviewees actually said. There are also some codes there which might be better grouped under the ward environment.

We also wondered whether I might have a self-selection bias with regards to which staff wanted to be interviewed – recruitment was a struggle, and it's possible that, for example, nurses who might have some of the negative experiences with stress and emotional strain that the psychologist, psychiatrist and OT talked about wouldn't want to be interviewed.

February 2014: I tried talking through the model with my mum which was incredibly helpful as in going through it we were able to notice a few inconsistencies and things which needed to be clarified. She trained and works in social care so although she's not within the NHS she has some insight into care of vulnerable people and team dynamics which was useful. I've changed how a few of the categories connect to each other and also the position of some of the codes.

I met with my external supervisor to discuss her feedback on Section A and also the model. She had some good suggestions for current NHS inpatient policy to incorporate into it. She also thought that the model looked a little complicated. Thinking about it I've been experimenting with colour to try and demonstrate how the categories fall into 4 main areas: The Ward Context, The Ward Team, Patients & Emotional Impact, and External Pressures. I've emailed round a few options to both my supervisors and some friends and family to try and decide which version is best! I also had a Skype meeting with my internal supervisor – she thinks the model is ready and that I shouldn't simplify it any further as I would lose some of the complexity. Hooray! Now I just need to do some polishing and write up a summary of the results to send to participants for the respondent validation before I can start the write-up.

March 2014: Sent the results summary to participants – it will be interesting to hear their thoughts, although I am a little anxious given that some of my interpretations are based on things said indirectly in the data, or from other staff's perspectives. I hope they don't feel I've misrepresented them.

I have now sent two email reminders to participants but only three have sent me feedback - the Psychologist, the Psychiatrist and an HCA, all positive. I'm not sure what to make of this. I could take lack of negative feedback from the others as a good sign, or just think that I know how busy they all are and that maybe they just don't have time to email. If I had more time I would try to organise a follow-up focus group, but as it is I will just have to think about the possible implications of this.

Draft of Section B complete. Reading back through this diary makes the research process seem much clearer than it felt when I was in the middle of it all! I feel really grateful to the staff I interviewed for helping me with this project, and I really hope that it might be able to serve some purpose at least for that Trust with regards to support for staff in their engagement with patients.

Appendix 14: Research Summary Sent to Participants, Ethics Board and R&D

Individual and Organisational Challenges for Personalised Care on an Inpatient Ward: The Staff Team Perspective

Thank you for taking the time to be interviewed as part of this study. I am in the process of writing up and will be submitting the study in partial fulfilment of the Canterbury Christ Church University Doctorate in Clinical Psychology. As part of my write-up, I would like to hear your views on the research findings and how well they capture your experience of the work. Below is a summary of the study and its findings – please send any feedback you have to n.k.law1@canterbury.ac.uk. You can also leave me a message on 03330117070 with your feedback, or a good time to call you back if you'd prefer to have a conversation by phone (this will **not** be audio-recorded).

Aim

The study aimed to explore the experience of acute psychiatric ward staff, particularly with regards to engagement with patients and the potential challenges of delivering personalised care.

Methods

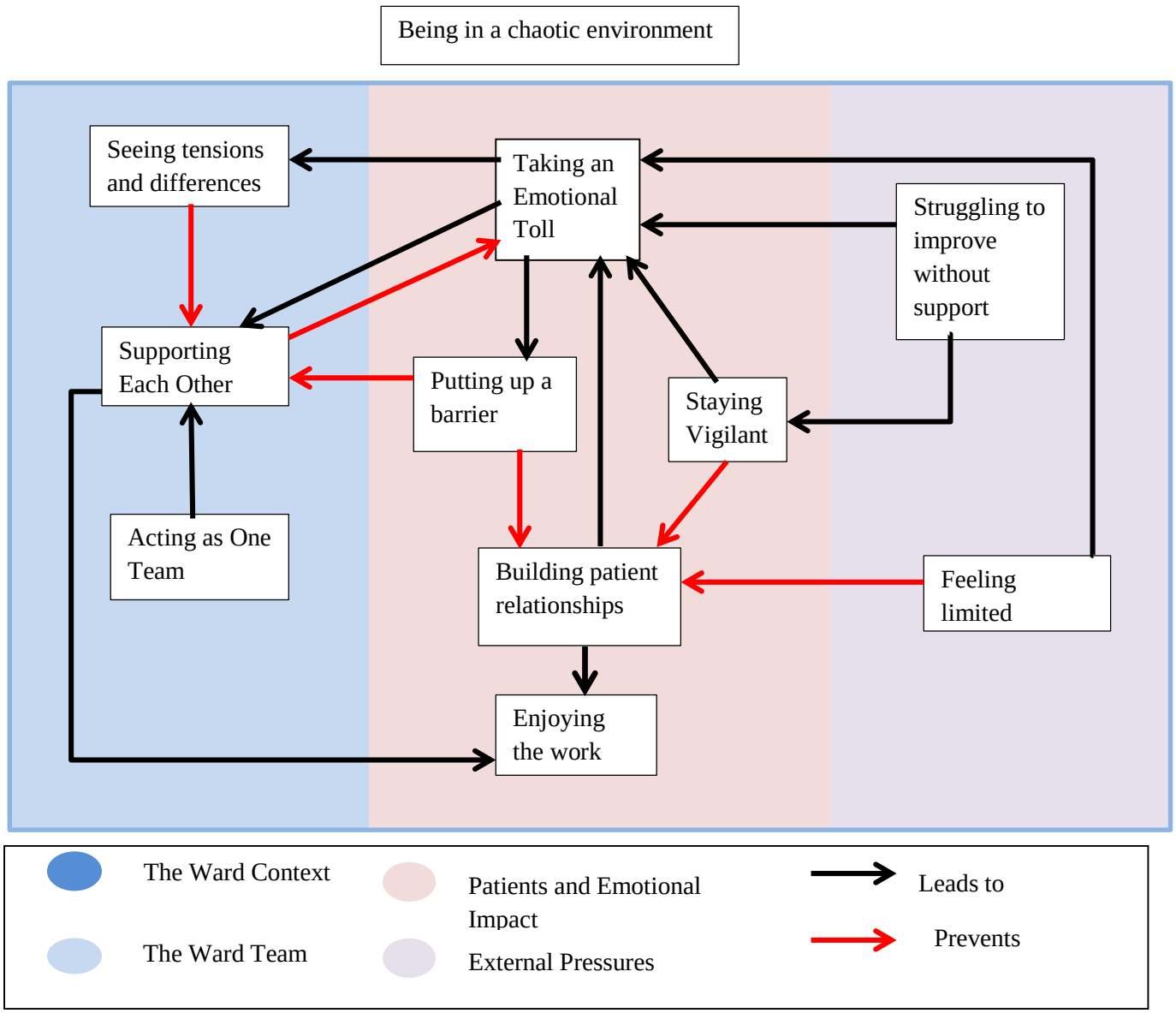
Semi-structured interviews were conducted with 10 participants. These included a ward manager, a clinical charge nurse, two staff nurses, an agency nurse, two HCAs, a consultant psychiatrist, a psychologist and an OT. Interviews were transcribed and analysed using grounded theory (Charmaz, 2006).

Results

Analysis of the data resulted in 11 categories which fall into 4 main areas as presented below: The Ward Context, The Ward Team, Patients & Emotional Impact, and External Pressures.

Area	Categories
The Ward Context	Being in a chaotic environment
The Ward Team	Supporting each other Seeing tensions and differences Acting as one team
Patients and Emotional Impact	Building patient relationships Taking an emotional toll Staying vigilant Putting up a barrier Enjoying the work
External Pressures	Struggling to improve without support Feeling limited

The diagram below shows how these categories interacted with each other.



Staff described a chaotic ward environment in which events were unpredictable, leaving it difficult to plan activities and potentially causing stress to both staff and patients, although it could also be stimulating. Violence and aggression could happen with little warning and the benefits of spending time off the ward were acknowledged. Staff also felt put under various external pressures, such as lack of resources, staff shortages and an increasing admin burden ("the nasty side" of the job) which particularly affected nursing staff.

Some staff described a pressure to act outside of their role, for example, trying to find housing for patients in order to achieve swift discharges when pressure on beds was high. The consensus was that the more senior you became, the less time you could spend with patients, who often lost out on contact time because of competing priorities. Chief amongst these was a pressure to improve efficiency, passed down from above and sometimes without the necessary management support to allow this to happen, leading to stress.

Some staff described a fear of "blame culture", particularly inquiries following incidents which could feel insensitive to the emotional impact on staff. Concerns were raised that nursing staff in particular might not feel valued, due to insufficient pay or praise for their work, or not prepared enough in training for more intensive and emotionally-demanding engagement with patients. Staff reported gaining huge reward and enjoyment out of building relationships with patients – using empathy, understanding and

communication skills to support personal recovery. However, such relationships could also be demanding, and there was little space to think about this, one nurse explaining that the favoured solution to a nurse feeling upset or anxious over a patient was to rotate the patient to work with someone else.

These demands were further exacerbated by continuous awareness of risk and the potential consequences of a lack of attention to risk. Staff who held clinical responsibility were very aware of that fact and the personal pressure it put on them. The importance of documenting, recording and checking was keenly felt, although it potentially served both to reassure staff and also to increase their workload, stress and anxiety.

One way that staff described responding to the emotional toll of the work was by distancing themselves, both from the emotional impact and to some extent from the patients. Staff noted that when some colleagues felt most stressed they seemed to avoid spending time with patients, or would become frustrated with patients as a result of the pressure they were under e.g. distinguishing between who was "genuinely" ill and who wasn't. This was also reflected in some staff describing patients as largely passive, there to be observed, or needing to comply with what was asked of them.

Some staff also described a "getting on with it" attitude to the work which could sometimes be seen as masking the negative emotional impact, and not engaging with the support structures available. This seemed most apparent for those who spent the most time on the ward, and potentially had the least opportunity to reflect on the impact of the work. This prevented staff from being able to support each other, whereas when staff were more open to sharing their emotional experiences this allowed far more mutual support which seemed a very important aspect of the work.

There were different conceptions of the word "support", which could be interpreted as emotional, or purely practical e.g. the presence of other staff members during an incident. Many staff did talk about the importance of supervision, reflective practice and staff support groups, but largely for the purposes of gaining reassurance and advice rather than having the space (or perhaps the time) to reflect on their experiences more deeply, although they were helpful in reducing stress. However, time pressures meant that these resources could be neglected in favour of other duties. Although "offloading" to colleagues was seen as crucial, there was also a sense in which a positive attitude should be maintained during challenging times, and it was hard to always express more negative emotions e.g. the psychologist described a comment from a nurse who said that it was only upon seeing the psychologist becoming upset at an emotional incident that she felt she could show her own sadness.

For most staff it was very important to feel they were within a close-knit team who made shared decisions and valued all roles equally. There was some disparity in whether this was always achieved, and some staff suggested that sharing decision-making could be important for diffusing individual responsibility for risk. There was evidence of splits within teams, sometimes between professions and sometimes between bands, and these were thought to be exacerbated by stress. Feeling under pressure could cause staff to retreat into their professional roles and potentially to undervalue the roles of others e.g. HCAs or Agency staff, although this was rare and staff largely described a supportive and collaborative team environment.

Any thoughts you have about these results, particularly whether or not this fits with your experience and ideas about the work, would be greatly appreciated. Thank you!

Appendix 15: Categories and Associated Codes with Selected Quotes

Area	Category	Focused Code	Selected Quote
The Ward Context	Being in a chaotic environment	Stress of ward environment	And the whole environment actually becomes stressful. You walk in and without even looking at the board or asking anybody you can sense it – that there are more people in the environment than it is used to. (Psychiatrist, L30-32)
		Needing to leave the ward	Many people want to go out, many of them, the majority want to go out. Hardly 2/10 that don't want to go out of this place! (Agency Nurse, L220-221)
		Acknowledging ward's negative effect on patients	*He's only 21, very bright and intelligent lad, y'know, let's not bring him into an environment where behaviours can be learnt. And let's not fail him so soon* (Clinical Charge Nurse, L366-368)
		Walking into an unpredictable environment	You can't plan anything actually because you might plan something one day and you come in the next day and it's completely impossible to do. (HCA 1, L169-171)
		Sudden aggression	*He's coming into my body space, put my head in an arm lock and rapidly* punched me, by the time the nurses could get in and separate us. (Psychiatrist, L298-300)
		Accepting aggression	Because aggression is something that you expect from mental health. (Staff Nurse 1, L243-244)

External Pressures	Feeling limited	Inconsistency blocking progress	We thought that some consultant was coming at half past 9 so we thought maybe they could write off some leave but then they didn't come so at the last minute we ended up just, only being able to take two (HCA 1, L191-193)
		Balancing care and resources	*So I'm going to have to balance between risk* and, um, making sure that the *finances are healthy, that I don't go over what I am expected to do, um, so it's* quite a tricky balancing job there. (Ward Manager, L97-100)
		"The nasty side"	Trying to find the time to do the things you think you ought to be doing as a *nurse, but you're too busy doing things you don't feel you should be doing. Like finding staff because you don't have enough staff to cover the next shift (Staff* Nurse 2, L41-43)
		Feeling pressure to work overtime	I used to be the kind of person that always worked an hour or two extra every day *in my job, so I guess similar to the nursing stuff, I'd do a lot of work and then do* a lot of the writing up stuff at the end of the day (Psychologist, L250-253)
		Seniority means low patient contact	I just feel the further you go up the less time you seem to spend with patients and the more time you seem to spend at the computer. (HCA 2, L47-48)
		Patients lacking attention needed	I think just for the nurses to be more accessible cos sometimes the patients, you *hear the comments "Oh they're always on the phone, they're always on that computer" (Clinical Charge Nurse, L181*-183)
		Lacking space	We end up in this situation, that there are 21, 22 people, whereas there are only 19 beds. So it gives you the impression – *it's really busy, all the time.* (Psychiatrist, L6-7)

		Acting outside of role	*"I just spent the last 2 hours doing admin-type work. And I haven't had a chance to speak to any patients in that time". And it's not really like what a nurse does, well it doesn't feel like it should be. (Staff Nurse 2, L46*-48)
		Needing more staff	Obviously we'd all like to have more staff, more staff on shift, more permanent staff. (HCA 2, L629-630)
		Using agency staff increases pressure	Two one-to-ones and a two-to-one – that in itself takes all of your staff so you need to be booking extra, y'know, you're getting strangers onto the ward that you're having to train up to your standards and work with as a team (Clinical Charge Nurse, L699-702)
		Lacking patient knowledge	One, that I really found difficult, there was a - you don't know this patient, you don't know them, you've just come in, there should be somebody who knew them before, yeah, that matters. (Agency Nurse, L314-316)
		Noticing mismatch between job ideals and reality	*I think it's fair to say that at least one of my* consultants might have unrealistic ideas about what nursing staff can do and how much time they can spend talking to their patients. (Psychologist, L169-172)
		Needing to release nurses	Try and take off some of the work, so we can release our staff nurses back out...it's about getting them out of the office and getting them back into what they trained to do (Clinical Charge Nurse, L165-168)
		Trying to manage competing demands	*If you've got a million things to do and you've got very little time to do it in, and you'll potentially know you're going to get, you're going to be in trouble if x, y and z isn't done, it must be hard. (OT, L127*-130)

	Struggling to improve without support	Feeling frustrated over pressure to find housing	*It is, um, it's very frustrating at times, and obviously if they genuinely haven't got anywhere to live that's all the more pressure to find somewhere and that's when* it comes on me (HCA 2, L101-103)
		Fearing blame culture	The management of nursing staff putting a lot of emphasis on ticking the right *boxes and I think there's quite a lot of a fear culture "If I haven't done this right and this right, I'll get blamed and I'll get in trouble" (Psychologist, L183*-186)
		Nursing staff not feeling valued	*They aren't paid well. So my observation is it's a fact of life that no qualified* nurse will be able to pay their bills unless they work bank shifts, so that is something fundamentally wrong in the system. The whole system in a way is in this collusion. (Psychiatrist, L386-388)
		Viewing nursing training as inadequate	*And sometimes I think it's because of their skills, their training, they really haven't had nearly as much training as we've had and the stuff we take for granted in how to listen to people, y'know, is not necessarily second nature to* many of the nursing staff. (Psychologist, L117-120)
		Lacking police support	Y'know, sometimes it's just difficult, once they sort of see there's a label of *"mental health" it's like, "Oh no, that's your problem, that's not something we can deal with", y'know. So I think* that's more a challenge. (HCA 2, L520-522)
		Feeling unsupported by management	*Sometimes it would be nice to say "You know what, well done!" (laughs) Cos let* me tell you, we had, there was a month where we had little incidents, right. Instead of saying *"Well done, you managed your patients well" it was "Hm, maybe you're not documenting right"! (Clinical Charge Nurse, L811*-814)
		Lacking adequate support	So yeah, there will never be enough support, but I think with [Trust] there is enough support for e*very staff to be able to do their job. Now I'm using the word "enough" in a very loose form, but there should be enough support. (Ward* Manager, L380-383)

		Passing pressure downwards	*Our manager might be told from her management "These audits need to* be *done", first port of call she'll ask maybe myself or the other charge nurses "Can you do these audits?" (Clinical Charge Nurse, L32*-34)
		Pressure following incidents	I think, again my opinion as well, but I think that sometimes this is seen as a *potentially punitive thing, it's like "Who's done something wrong?", rather than an opportunity to ask "How are you feeling about this, how are you coping with what's just happened?" (Psychologist, L599*-602)
		Trying to improve efficiency	Where there are gaps you need to go back to the staff and try to understand why *those gaps exist and get them back to, to those standards, so it's a constant, y'know, checking and looking for gaps, and bringing staff back to a particular* level of performance. (Ward Manager, L129-132)
		Providing structured activities	I think it has that more structure, they know that in the morning we start with exercise, then we have community meeting, then we have a group. And then if they want to do anything in between that, if they want a game of pool or they just want to do some colouring, or just somebody to talk to (HCA 1, L117-121)
Patients and Emotional Impact	Building patient relationships	Supporting personal recovery	*So we also, y'know, ensure that that is, um, g*iven to them, so, yeah, in a nutshell, *we don't lay too much emphasis on one, y'know, aspect of mental health* provision, we try to give all the services. (Ward Manager, L194-197)
		Building relationships with patients	*I guess it's kind of like a relatio*nship, a professional relationship with someone on the ward that they can confide in and who they can hopefully get some trust for, to help them, and they can feel comfortable to ask questions and let them *know how they're feeling. (Staff Nurse 2, L173*-175)
		Setting boundaries	You have to, you have to have, you have to be firm sometimes, you have to *obviously be caring and show you're caring but you also have to provide those* boundaries and put them in place in an environment like this, cos this is like their *home but it's a hospital as well, y'know, it's a fine line (HCA 1, L226*-229)

		Having empathy	And I like looking after people, yeah, I've got empathy, that is why I initially wanted to do it. (Agency Nurse, L37-38)
		Understanding patients as people	With the understanding and the hope that the more you can understand why a person might be doing things, understanding their background and things, the *more you're likely to have compassion for the person and interact with them* better. (Psychologist, L711-714)
		Seeing patients as lacking choices	*So yeah, it's just putting yourself, most people do not have those choices to make, they grow up in a very chaotic environment and it's just the way they know to* survive. (Ward Manager, L527-529)
		Making patients feel heard	I think as OTs you do tend to, not always but often, you tend to be able to develop quite a good rapport with someone and be able to have quite in-depth and lengthy conversations about things and really, people can confide a lot in you (OT, L46-48)
		Giving patients skills	And also I think they can kind of gain new skills sometimes, or pick up old skills, or just interact with people. (HCA 1, L299-300)
		Reflecting on own practice	*I think I might think "Did I deal with that right? Or did* that sound like I was *ignoring them?" So I think I, I think I'm quite good at self*-awareness. (HCA 1, L158-160)
	Enjoying the work	Valuing clinical role	Well, the most enjoyable part of my job is when I'm looking after patients. (Agency Nurse, L139)

		Feeling part of patient recovery	*It's just so nice to see people's journey, that's what lovely, and see people* moving on, and feeling like you were a little part of that, that you kind of might have helped them find some hope from somewhere. (OT, L167-169)
		Valuing patient and carer gratitude	You get lots of thank you cards from parents and carers so that means the most to us. That's what matters. (Clinical Charge Nurse, L828-829)
		Enjoying challenges of the work	*It's enjoyable because* no two days are the same, I enjoy the unpredictable nature *of the ward, the fact that even if you know what you're going to be doing in your session today it can be vastly different just because of what's happened in that patient's life in the past 7 days.* (Psychologist, L69-73)
		Maintaining indirect clinical involvement	The good news is you have an electronic system so, y'know, you're quite involved in terms of ward round decisions and stuff like that. Um, I take handover every morning when I come in, the first thing I do is take handover from staff (Ward Manager, L237-239)
		Controlling own time	I also think actually being able to have that time at the end of a group to talk to people – because I have my own time and I am able to manage my own time, I *am, as long as I'm doing my job, I'm given that time 9*-5 (HCA 1, L84-86)
		Gaining skills	If there is any, y'know, training going, involve, reading magazines, read internets, just going on and doing some search, read about the area you are involved in and then be patient as well with those you are supporting. (Agency Nurse, L231-233)
	Staying vigilant	Monitoring risk	*When I click on the patient and look at the history, the risk and go "Hmm",* y'know, we're dealing with something slightly different here, you now send emails, advise staff, or even look at the resources available given the kind of risk they pose. (Ward Manager, L251-254)

	Taking an emotional toll	Checking and recording	*Then you've got to document everything afterwards. Literally everything you do, interactions you have to document. So you've always got in the back of your head "I haven't got time cos I need to document everything I've already done!" (Staff* Nurse 2, L10-12)
		Struggling to manage violence	He did wanna hurt people, so obviously with someone that threatening we had no choice but to get them moved to a more secure environment...we also had to involve the police as well, move patients out of the area, the staff even were barricaded in the office for a certain amount of time (HCA 2, L438-443)
		Holding clinical responsibility	I mean every other thing can go wrong without any serious consequences but the clinical part of the job – you cannot allow it, y'know, to go wrong. (Ward Manager, L244-246)
		Feeling hurt by patient treatment	It could be the way you are approached by a patient, so badly even if you are *putting your effort to help the person, so those can make you feel "Oh, what have I done here?", y'know, "I've done everything to help the person see this".* (Agency Nurse, L355-358)
		Feeling powerless	Yes, we are powerless – *we've got to wait now, we've done everything, the risk of harming the patient is significantly more now if we're already into complex* interventions and mixing medicines or do this in a way, sometimes you just need to hold your nerve and wait. (Psychiatrist, L220-223)
		Worrying about risk	*Because of a night everything's quieter so you can't, um, even though you check people you're always a bit more worried in that anything people are gonna do they're probably happen of a night. So you went, I did, you come in with I* suppose more anxiety than during the day. (HCA 1, L546-549)
		Fearing attack	I was genuinely scared. He was a young man and he was very strong and big, and it was, it was very threatening. (HCA 1, L497-498)

	Putting up a barrier	Feeling stressed	There are some weeks where it can be a lot of duty senior nurse. And the stress of that is quite immense, I mean, I'm taking the bleep at 5 o'clock today, and I'm not looking forward to that (Clinical Charge Nurse, L93-95)
		Doubting yourself	You always do a kind of introspection: Maybe I should've done this, maybe I should've put them on a one-to-one, maybe I should've got the medics to write more medication, maybe I should've got to doctor or the psychiatrist to...So you ask yourself all those questions. (Ward Manager, L286-290)
		Getting on with it	*There are obviously stressful things that happen, it's expected...but that's not a bad thing because that's what you're here to deal with, those sort* of stressful things. (Staff Nurse 2, L83-85)
		Staff not using support structures available	I know it for a fact that the kind of counselling and other help services that we make available, I think that they are definitely as good as any of the mental health Trusts...The challenge really is some of the stigma that goes with all this. *I've no idea if people use it appropriately or not.* (Psychiatrist, L230-233)
		Noticing a lack of engagement with emotional impact	The frequency with which they *experience things like that it's just like a normal thing that they have to deal with, and that whether it really wasn't affecting them or whether it's that there is some kind of barrier, not kind of consciously, or* whether they are just kind of hardened (OT, L224-227)
		Needing patients' compliance	All they need to do is, the 30% again is their medication as well, they need to *continue complying with it at home. And maybe if they've been referred to* psychologists and their care coordinator as well then they need to continue at home. (Staff Nurse 1, L190-193)
		Distinguishing between MH and behaviour	It's just distinguishing whether it's part of a mental disorder or it's a behavioural thing, and some people have both. We have some people who have two diagnoses, they might have schizophrenia and they might have another diagnosis of personality disorder (HCA 2, L572-575)

The Ward Team	Supporting each other	Being misled by patients	But if you don't know the person at all, the first day, they take you as, y'know, they know that you don't know about them, they will continue to play their tricks (Agency Nurse, L321-323)
		Stress leading to disengagement from patients	*If people feel overworked or stressed, whether that probably affects it, or I don't know, I've certainly come, we probably all have, I've certainly come across people where I feel like "Do they actually care?" (OT, L102*-105)
		Getting stuck with "bed-blockers"	*We got stuck at one point with a lot of, um, it sounds so, with like "Bed Blockers". So…they just can't move from us because they're waiting for the beds* elsewhere, y'know, we went through a phase of having quite a lot on the wards (Clinical Charge Nurse, L815-819)
		Resenting housing-seekers for taking up resources	I mean, patients who come in wanting housing take up a lot of resources and a *lot of time, and it sometimes feels that those who are extremely unwell, they're* not getting as much as what they should be getting (Clinical Charge Nurse, L386-389)
		Needing to offload	*I did speak to, I did feel the need to, but I'm like that, I need to say stuff, I need to* get stuff out. And I think it was the ar*t therapist and she said "Oh god, that's awful" and I think that's enough really, just for someone to say, I suppose to be able to share it and not feel like you're holding it. (OT, L258*-261)
		Making use of support structures available	*Cos I'm a psychologist and I think we have supervision and we're used to using supervision to talk about this kind of stuff, so I think I'm quite able to do that in* supervision (Psychologist, L630-632)
		Relying on colleagues' support	You know sometimes you just work really well with people and it just happened to be that the nights we were on were people we all worked really well together so I think having their support was very good and that did help, and the rest of the staff were very supportive as well at that particular time. (HCA 1, L538-541)

		Receiving support from manager	*It's a meeting we normally have with our manager. So in case you have a* problem with anything, some policy that you think is not practicable, we do *discuss it and say "Why can't we think about this?" and if it's something that* they can review they will, if not we have to continue. (Staff Nurse 1, L208-211)
		Feeling supported by policies	Well the policy support us a lot as well, because the reason for that is there are *some things that you say to some patients that they will tell you "No no no, it's not like that, this is the way it is, I'm not going to have it this way", we get the* policy *and I can say "This is the Trust policy" (Staff Nurse 1, L202*-205)
		Maintaining good spirits at challenging times	And the whole time trying to be that positive role model, when you're not quite feeling positive yourself (laughs) about certain things, you've still got to be a positive role model for others. (Clinical Charge Nurse, L22-25)
		Feeling valued by others	Feedback from patients, I guess feedback from staff as well, not just my manager *but ward managers or the psychiatrists in charge of the ward. Y'know people are* very respectful and grateful for my work and polite and that kind of thing (Psychologist, L266-269)
		Staff bringing different perspectives	*We're coming from different perspectives and I suppose that was the point someone was making, that's why it's important to have different* people coming in and different things because you will, if we all did the same thing and looked *at exactly the same thing then it wouldn't work (OT, L497*-501)
	Seeing tensions and differences	Them and Us	Sometimes it feels like that, sometimes it does. Um, yeah, it can feel very much *"them and us" (Clinical Charge Nurse, L530*-531)
		Keeping professional boundaries	*Well I don't come to work to be friends with anyone, y'know, everyone's my* colleague (Clinical Charge Nurse, L531-532)

		Using blame to manage pressure	I mean a few people, might see you as an Agency – you know what an Agency is? *(laughs) it's not, anything that is not done properly "Oh it's an Agency", that's* what it is. (Agency Nurse, L248-250)
		Nurses not prioritising therapy	Sometimes, and not all nursing staff, but sometimes I don't think they see groups and more kind of talking to people, but especially groups as as important as the medical side of things. So I think that can sometimes be an issue. (HCA 1, L239-242)
		Doctors making decisions	The doctor will have gone through that 3 days, of all the documentation of the nurses, and that's when the doctor will make their decision (Staff Nurse 1, L107-108)
		Feeling unsure of place in the team	I do wonder sometimes, if *people wonder when you're not up there what you're doing, that maybe you're just doing nothing, maybe they don't realise all the* admin or that maybe you might be out doing something with someone. So I do wonder, I do think, there certainly is separation (OT, L78-81)
		Qualified staff resisting simpler tasks	Sometimes it does feel that the qualified staff think because they're qualified they can't make a bed. We were having that problem at one point, um y'know, and it was trying to get the message across *"Well, we went to university and we actually had a lecture on how to make a bed" (Clinical Charge Nurse, L737*-741)
	Acting as one team	Working as a team	Any time I do that and have admissions and have any crisis on the ward and the ward works as a team, *makes me reflect back and say "Hmm, it's not too bad* today...we worked as a team, even though there was a lot of work and things to *do, but as a team we were able to complete a lot" (Staff Nurse 1, L300*-304)
		Valuing all roles equally	*Here everyone's a team member and it doesn't matter if you're an HCA, a nurse* or even a doctor – we all work together and you all chat to each other as if *you're the same, I wouldn't talk any different to an HCA than I would a doctor* sort of thing, and vice versa. (Staff Nurse 2, L254-257)

		Sharing clinical responsibility	*So that people have a sense that there's a clearly-agreed marker when we're* going to review everything. So giving people a sense of safety – a sense of safety for the patient, which ultimately is *they're feeling safe that I've seen the patient* (Psychiatrist, L424-426)
		Making team decisions	And the doctor was very supportive, the team were very supportive, we all knew kind of what the plan was. Cos obviously if we weren't all in agreement then it could have gone very wrong, y'know, but everyone was very helpful and supportive of each other which made it obviously a lot easier (HCA 2, L457-460)

Appendix 16: Ethics Approval

This has been removed from the electronic copy

Appendix 17: R&D Approval

This has been removed from the electronic copy

This has been removed from the electronic copy

Appendix 18: Consent Form Given to Participants

Consent Form Version 2, 12th Dec 2012

Participant Identification Number for this study:

CONSENT FORM

Title of Project: Staff Experiences on Inpatient Wards and Impact on Engagement
Name of Researcher: Naomi Law

Please initial box

1. I confirm that I have read and understand the information sheet dated 12.12.12 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
3. I understand that transcribed and anonymised interview data collected during the study may be looked at by the lead supervisor Dr Sue Holttum. I give permission for this person to have access to my data.	☐
4. I agree that anonymous quotes from my interview may be used in published reports of the study findings	☐
5. I agree to take part in the above study.	☐

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Appendix 19: Journal of Mental Health Instructions for Authors

Journal of Mental Health is an international journal adhering to the highest standards of anonymous, double-blind peer-review. The journal welcomes original contributions with relevance to mental health research from all parts of the world. Papers are accepted on the understanding that their contents have not previously been published or submitted elsewhere for publication in print or electronic form.

Submissions

All submissions, including book reviews, should be made online at Journal of

Mental Health's Manuscript Central site at http/mc.manuscriptcentral.com/cjmh . New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count.

Manuscripts will be dealt with by the Executive Editor, Professor Til Wykes, Department of Psychology, Institute of Psychiatry, De Crespigny Park, London, SE5 8AF, United Kingdom. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process. The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

Book Reviews. All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information Services & Systems, Institute of Psychiatry, KCL, De Crespigny Park, PO Box 18, London, SE5 8AF.

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts. The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content. Keywords

Authors will be asked to submit key words with their article, one taken from the picklist provided to specify subject of study, and at least one other of their own choice. Text. Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Key Words, Main text, Appendix, References, Figures, Tables. Footnotes

should be avoided where possible. The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

Style and References. Manuscripts should be carefully prepared using the aforementioned

Publication Manual of the American Psychological Association , and all references listed must be mentioned in the text. Within the text references should be indicated by the author's name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al ., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. Magnetic Resonance Imaging, 18 , 351–355. b) For books:

Powell, T.J. & Enright, S.J. (1990) Anxiety and Stress

management . London: Routledge

c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G.Parry

& F. Watts (Eds.), A Handbook of Skills and Methods in Mental Health Research (pp. 75–89). London:Lawrence Erlbaum.

Illustrations should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text.

Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Accepted papers

If the article is accepted, authors are requested to submit their final and revised version of their manuscript on disk. The disk should contain the paper saved in Microsoft Word, rich text format (RTF), or as a text or ASCII (plain) text file. The disk should be clearly labelled with the names of the author(s), title, filenames and software used. Figures should be included on the disk, in Microsoft Excel. A good quality hard copy is also required.

Proofs are supplied for checking and making essential corrections, not for general revision or alteration. Proofs should be corrected and returned within three days of receipt.

Early Electronic Offprints. Corresponding authors can now receive their article by e-mail as a complete PDF. This allows the author to print up to 50 copies, free of charge, and disseminate them to colleagues. In many cases this facility will be available up to two weeks prior to publication. Or, alternatively, corresponding authors will receive the traditional 50 offprints. A copy of the journal will be sent by post to all corresponding authors after publication. Additional copies of the journal can be purchased at the author's preferential rate of £15.00/$25.00 per copy. Copyright. It is a condition of publication that authors transfer copyright of their articles, including abstracts, to Shadowfax Publishing and Informa Healthcare. Transfer of copyright enables the publishers to ensure full copyright protection and to disseminate the article and journal to the widest possible readership in print and electronic forms. Authors may, of course, use their article and abstract elsewhere after publication providing that prior permission is obtained from Taylor and Francis Ltd. Authors are themselves responsible for obtaining permission to reproduce copyright material from other sources.