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Promoting the emotional well-being of staff in care homes for older people

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Chapter One Systematic Review: Burnout interventions for care staff in long-term facilities for older people: A systematic review update

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Abstract

Background

Carers for older people in long-term care facilities are at risk of developing burnout due to their exposure to occupational stressors. Studies investigating interventions to reduce burnout in care staff have yielded inconsistent results and further research has been recommended.

Aims

To identify and evaluate the effectiveness of burnout interventions in care staff employed in long-term care for older people.

Method

CINAHL, EMBASE, MEDLINE, ASSIA, Cochrane Library, and Scopus were searched for research investigating burnout interventions from 2013-2020. The studies were quality rated using the Effective Public Health Practice Project Assessment Tool (Thomas et al., 2004).

Results

Twelve studies were included in the review. Five reported evidence for the efficacy of burnout interventions; however, study quality and design varied. A narrative synthesis summarised the results.

Conclusion

Limited evidence supported the use of combined interventions for reducing burnout in care staff. Implications and recommendations for future research are discussed.

Keywords: Burnout, care home, systematic review

Introduction

Projections have estimated that the global older people's population will reach 1.4 billion by 2030 (Ouellet & Walke, 2020) with predictions suggesting that a large number of older people will require long-term care provided in care homes (Lann-Wolcott et al., 2011).

Staff employed in long-term care facilities for older people often experience stressors including heavy workloads, exposure to death, and behaviours that challenge (Baker et al., 2015). Within the healthcare profession, occupational stressors have been associated with burnout (Ruotsalainen et al., 2014). There is considerable variability in how burnout is defined (Doulougeri et al., 2016). However, the World Health Organisation (2019) defined burnout as an occupational phenomenon resulting from chronic, unmanaged workplace stress. It is characterised by excessive emotional exhaustion (EE), mental distancing or work-related cynicism known as depersonalisation (DP), and reduced professional efficacy or personal accomplishment (PA).

Although there is currently no agreed consensus on how to diagnose burnout or classify its severity (Doulougeri et al., 2016) tools have been developed to measure levels of burnout in different occupational settings (Maslach et al., 1986). The Maslach Burnout Inventory (MBI) (Maslach et al., 1986) is the most widely used tool to measure burnout (Doulougeri et al., 2016) as defined by the World Health Organisation and incorporates three subscales of DP, EE, and lowered PA. Burnout has been reported across various health care professions (Ruotsalainen et al., 2014). However, research into its impact has yielded conflicting results. Burnout has been associated with staff turnover and poorer quality of care in nursing homes (White et al., 2020). In a longitudinal study, Costello et al. (2020) observed no predictive relationship between burnout and turnover. The authors asserted that burnout cannot be the only factor associated with turnover as they observed low mean burnout levels overall. Nevertheless, they acknowledged almost one third of participants reported high burnout levels and recommended burnout interventions to target high risk staff groups.

Interventions to reduce burnout have been developed and investigated across a variety of healthcare occupations (Van Wyk & Pillay-Van Wyk., 2010). Ruotsalainen et al. (2014) made tentative recommendations supporting the use of cognitive behavioural therapy (CBT) interventions, relaxation, and adapted work schedules to reduce staff burnout; however, the authors noted the overall evidence was of low quality. Van Wyk and Pillay-Van Wyk (2010) completed a systematic review and reported that long-term, intensive stress management interventions showed a positive impact on burnout. Nevertheless, they acknowledged the results were only sustained post follow-up when combined with additional booster sessions and recommended interventions should incorporate periodic refresher sessions. Spector et al. (2016) investigated the impact of staff training on outcomes in dementia care staff. The majority of included studies found no significant reduction in staff burnout; however, one high quality intervention found a sustained, significant reduction in EE (Jeon et al., 2012). The authors recommended that future research include longer follow-up points to determine if changes can be maintained over time.

Westermann et al. (2014) completed a systematic review investigating the impact of staff interventions on burnout in carers employed in long-term care facilities. The authors identified 16 studies published between 2000 and 2012 and reported that seven (44%) observed a significant reduction in staff burnout. Overall, the majority of randomised controlled trials (RCTs) (n=7, 70%) did not find evidence to support the interventions' effectiveness; however, they acknowledged weaknesses within their review process, noting their failure to utilise a formal quality appraisal tool and the possibility for publication bias due to their limited search strategy. Nevertheless, the authors recommended future research within the field focusing on longitudinal studies with long-term follow-up.

An initial scoping search found further studies investigating the impact of staff interventions on carer burnout published since Westermann and colleagues' initial review. Therefore, this review aimed to update and synthesise the literature investigating the impact of interventions on burnout in carers for older people in long-term or inpatient care since 2012.

Aims

- To identify studies published between 2013-May 2020 investigating the impact of behavioural, psychological, organisational, or educational interventions on burnout in staff in long-term or inpatient care for older people.
- To appraise the quality of the identified studies.
- To evaluate the effectiveness of the interventions on levels of burnout in staff.

Method

Search strategy

Online electronic databases CINAHL, EMBASE, MEDLINE, ASSIA, Cochrane Library, and Scopus were searched systematically using keywords and MESH terms where available. The searches were limited to 2013-May 2020. Manual searches of the Journal of Aging and Health and the International Journal of Older People Nursing were conducted alongside the reference list of a systematic review investigating care outcomes in long-term care facilities (Barbosa et al., 2017). The reference lists of the articles included in this review were also examined. Search terms were initially derived from Westermann et al. (2014); however, additional terms were developed based on a review by Spector et al. (2016) and in collaboration with a librarian, customised for each database (Table 1.). See Appendix 1.2 for an example of the full search strategy conducted in CINAHL.

Table 1. Search terms

Burnout	**Care setting**	**Intervention**
Burnout	Nurs* home	Intervention
Depersonalisation	Homes for the aged	Workplace intervention
Emotional exhaustion	Residential facilit*	Organisatio* intervention*
Professional burnout	Care home	Web-based intervention
Occupational stress	Assisted living facilit*	E-learning
Maslach Burnout Inventory	Residential care	Training
Oldenberg Burnout Inventory	Residential home	Staff training
Copenhagen Burnout Inventory	Long-term care	Staff education
	Rehabilitation facilit*	Occupational health
	Gerontologic* nurs*	Dementia
	Geriatric car*	Dementia training
	Geriatric nurs*	Dementia care mapping
		Cognitive behav* therap*
		Relaxation
		Mindfulnes*
		Resilienc*
		Acceptance-based intervention*
		Peer support
		Communication intervention*
		Person cent*
		Patient cent*
		Client cent*
		Supervision
		Emotion-orientated

		Validation therap* Reminiscence therap* Stimulation therap*

Inclusion criteria

- Quantitative or mixed method studies implementing staff interventions
- Staff providing direct care to older people including nurses, nursing assistants, support workers, direct care workers or any variation thereof
- Long-term settings including care homes, residential, nursing, or dementia facilities; or acute or long-term geriatric units in general hospitals
- Burnout measured using a validated tool
- Published in English speaking peer reviewed journals
- Between 2013-May 2020

Exclusion criteria

- Review papers, qualitative studies, case studies, case reports, conference abstracts, book chapters, protocols, dissertations
- Studies that include diverse healthcare professions without reporting details separately for participants in direct caregiving roles
- Studies investigating informal carers, home care staff, or care staff not specifically caring for older people
- Studies that do not utilise a validated burnout measure

Quality appraisal

All included studies were quality assessed using the Effective Public Health Practice Project Quality Assessment Tool (EPHPP) (Thomas et al., 2004) (Appendix 1.3) and its accompanying dictionary. This tool measures six components and assigns a ‘strong’, ‘moderate’, or ‘weak’ rating to each. A global rating is calculated depending on the number of ‘weak’ ratings allocated across the six individual components (strong=0, moderate=1, weak=2+). This tool has been recommended for use in systematic reviews appraising the quality of studies that utilise different designs (Deeks et al., 2003) and has good inter-rater reliability for global ratings of quality (Armijo-Olivo et al., 2012).

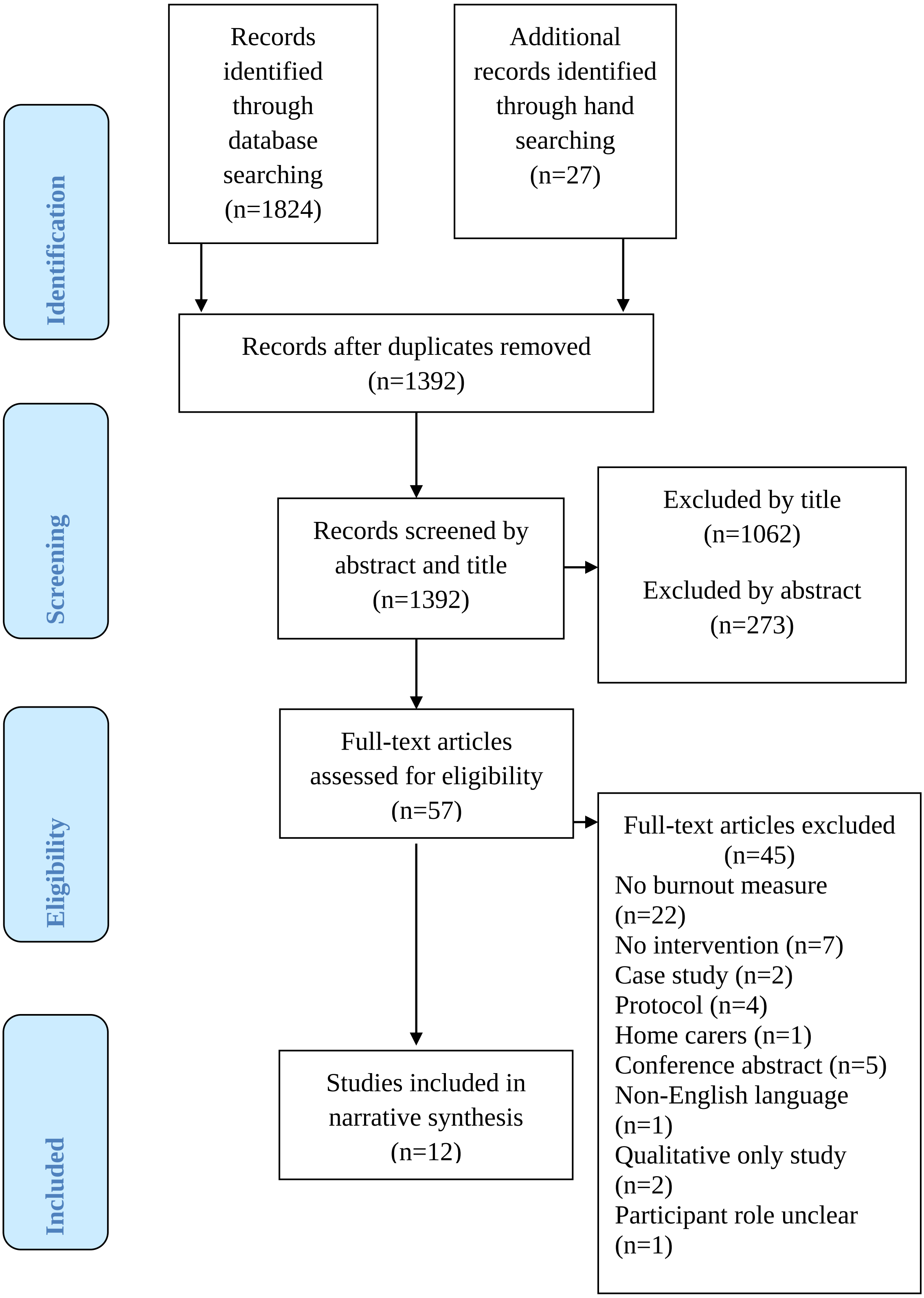
Data extraction

A data extraction tool was developed (Appendix 1.4) to collect information on each study’s characteristics, participants, recruitment, intervention, burnout measure, statistical analysis, and results. A meta-analysis was not considered appropriate due to the discrepancies in study design, methodology, and reporting of effect sizes; therefore, results are reported via a narrative synthesis.

Results

A full overview of the search and eligibility screening process is presented in Figure 1. A total of 1824 articles were initially identified through database searches. After duplicates were removed and the remaining titles and abstracts were screened, the eligibility criteria were applied to 57 full articles. A further 45 articles were excluded and the remaining 12 were included in the review. No articles identified by manual searches met the inclusion criteria.

Figure 1. PRISMA Flowchart of the article identification and selection process



Participant and settings

A summary of extracted data is presented in Table 2. A total of 1986 participants were reported across the 12 studies. Two articles reported on the same intervention at immediate and six-month follow-up, therefore the participants were not counted twice (Barbosa et al., 2015; Barbosa et al., 2016). There were 1230 (89%) female and 152 (11%) male participants reported; however, sex and professional demographic information was incomplete across a number of studies (n=3). The majority of participants were employed in a direct care role (n=1780, 98%). Participants were described as care staff (n=897), registered nurses (n=360), nursing aids or assistants (n=399), direct care workers (n=58), health care assistants (n=25), nursing students (n=29), nurses with a specification in geronto-psychiatric nursing (n=12), recreational therapists (n=17), allied health care professionals (n=4), charge nurses (n=1), managers (n=1), or care coordinators (n=1). The remaining were listed as ‘other’ or missing (n=21). All studies were conducted in long-term care facilities for older people.

Outcome measures

Six studies (Barbosa et al., 2015; Barbosa et al., 2016; Briones-Peralta et al., 2020; Clare et al., 2013; Ericson-Lidman & Åhlin, 2017; Livingston et al., 2019) measured staff burnout using the MBI (Maslach et al., 1986) or its adapted language variations. This tool has good reliability and validity (Doulougeri et al., 2016) and measures the three components of burnout: EE, DP, and PA. One study used the MBI but opted to omit the subscale of PA (Ericson-Lidman & Åhlin, 2017). Zwijsen et al., (2015) used the Utrecht Burnout Scale (Schaufeli & Van Dierendonck, 2000), a validated Dutch version of the MBI. Two studies (Dichter et al., 2017; Halek et al., 2020) used the Copenhagen Burnout Inventory (CBI) (Kristensen et al., 2005), a tool with high internal reliability that incorporates personal, work, and client-related burnout. Two studies (Dreher et al., 2019; Frey et al., 2017) used the

Professional Quality of Life tool (ProQOL) (Stamm, 2010). This tool has good construct validity and reliability and incorporates the subscales compassion satisfaction, burnout, and secondary traumatic stress. One study (Berendonk et al., 2019) measured burnout using the EE subscale of the Screening Instrument for Job Strain in Human Service Work (BHD) (Hacker & Reinhold, 1999). The BHD measures job dissatisfaction, EE, reactive shielding, aversion to clients, and lack of intrinsic motivation. It has evidence of validity in work strain measurement, and has good internal consistency across all subscales bar reactive shielding.

Quality Appraisal

The EPHPP tool (Thomas et al., 2004) was used to rate the quality of each paper. Six of the papers (50%) were co-rated by a second year PhD student independent of the review using the tool and its accompanying dictionary. The agreement between raters was initially 97%. After a discussion to resolve any discrepancies, agreement reached 100%.

A summary of each quality rating is available in Appendix 1.5. Three studies (Berendonk et al., 2019; Clare et al., 2013; Livingston et al., 2019) were globally rated as strong, three as moderate (Barbosa et al., 2015; Barbosa et al., 2016; Briones-Peralta et al., 2020), and six were rated as weak (Dichter et al., 2017; Dreher et al., 2019; Ericson-Lidman & Åhlin, 2017; Frey et al., 2017; Halek et al., 2020; Zwijsen et al., 2015).

Methodological strengths included utilising a RCT design (Barbosa et al., 2015; Barbosa et al., 2016; Berendonk et al., 2019; Clare et al., 2013; Halek et al., 2020; Livingston et al., 2019; Zwijsen et al., 2015), acknowledging and attempting to control for confounding variables (Berendonk et al., 2019; Barbosa et al., 2016; Clare et al., 2013; Dichter et al., 2017; Halek et al., 2020, Livingston et al., 2019; Zwijsen et al., 2015), and collecting data using outcome measures reported to be valid and reliable (Barbosa et al., 2015; Barbosa et al., 2016; Berendonk et al., 2019; Briones-Peralta et al., 2020; Clare et al., 2013; Dichter et al., 2017; Dreher et al., 2019; Ericson-Lidman & Åhlin, 2017; Frey et al., 2017; Halek et al., 2020; Livingston et al., 2019; Zwijsen et al., 2015).

Methodological weaknesses included high rates of attrition (Frey et al., 2017; Halek et al., 2020), failure to adequately report on withdrawals and drop-outs (Dichter et al., 2017; Ericson-Lidman & Åhlin, 2017; Zwijsen et al., 2015), failing to adequately report on the blinding status of participants or researchers (Dichter et al, 2017; Zwijsen et al., 2015), and utilising a recruitment method likely to result in selection bias (Dreher et al., 2019; Halek et al., 2020).

Study Characteristics

Studies were conducted across a range of geographical and cultural contexts. Three studies were carried out in Germany (Berendonk et al., 2019; Dichter et al., 2017; Halek et al., 2020), two were in Portugal (Barbosa et al., 2015; Barbosa et al., 2016), and two were completed in the United Kingdom (U.K.) (Clare et al., 2013; Livingston et al., 2019). The remaining studies were conducted in Spain (Briones-Peralta et al., 2020), the United States of America (U.S.A) (Dreher et al., 2019), Sweden (Ericson-Lidman & Åhlin, 2017), New Zealand (Frey et al., 2017), and the Netherlands (Zwijsen et al., 2015).

The duration of the interventions ranged from one week to 18 months. Dreher et al. (2019) conducted an intervention over one week where participants attended a 90-minute training presentation. Four studies reported on interventions that lasted eight weeks (Barbosa et al., 2015; Barbosa et al., 2016; Berendonk et al., 2019; Clare et al., 2013). Barbosa et al. (2015)

implemented an eight-week intervention where participants attended eight 90-minute training sessions with three days implementation support post session. Barbosa et al. (2016) reported on the same intervention but collected data at six months follow-up. Berendonk et al. (2019) conducted an eight-week intervention where participants received two days training followed by a six-week intervention phase. Clare et al. (2013) reported on an eight-week intervention where participants completed two 90-minute training sessions followed by a six-week supervised implementation phase.

Frey et al. (2017) conducted an intervention over six months where participating units received weekly input from a palliative nurse care specialist to review care goals and engage in coaching, education planning, role modelling care planning conversations, and debriefing. The intervention implemented by Halek et al. (2020) was conducted over seven months. Participants attended a six-hour training session followed by four three-hour supported case conferences and four one and a half hour unsupported case conferences. Livingston et al. (2019) implemented an eight-month intervention where participants attended six training sessions followed by a supervised implementation phase. The authors did not specify the duration of the sessions or the supervision period. The intervention described by Briones-Peralta et al. (2020) lasted nine months where participants attended monthly two-hour training sessions.

Three studies reported on interventions lasting at least one year (Dichter et al., 2017; Ericson-Lidman & Åhlin, 2017; Zwijsen et al., 2015). Ericson-Lidman & Åhlin (2017) implemented a yearlong intervention. Participants attended 12 Participatory Action Research (PAR) sessions lasting 90 minutes over the course of a year. Zwijsen et al. (2015) conducted an intervention over 17 months. Participants attended training sessions followed by an implementation phase.

The authors did not report the frequency or duration of the training or implementation phase. An intervention by Dichter et al. (2017) was implemented over 18 months. Two participants attended training over three days followed by one and a half days of observation sessions and five eight-hour observations.

Table 2. Study characteristics and quality rating

Author, (year), country, *quality rating*	**Design**	**Setting and staff participants**	**Intervention**	**Burnout measure**	**Main findings**
Barbosa et al. (2015) Portugal *Moderate*	Mixed methods RCT	Four aged-care facilities N=58 Direct care workers **Intervention**=27 *Mean age*=43.37 *Female*=27 (100%) **Control**=31 *Mean age*=45.90 *Female*=31 (100%)	Intervention over eight weeks **Intervention**=PCC based psycho-education training intervention combined with supportive component. Eight 90-minute weekly sessions and three days implementation support after each session. **Control**=Education-only intervention. Eight weekly sessions. **Data collected**=baseline, post-intervention	MBI (Portuguese)	Sig. reduction in EE score in intervention group (p=0.02) post intervention. Moderate effect size (η^2 partial=0.095) No sig. differences on DP (p=0.39) or PA (p=0.61)
Barbosa et al. (2016) Portugal *Moderate*	RCT	As above	As above **Data collected**=baseline, post-intervention, six-months follow-up	MBI (Portuguese)	Sig. increase in PA at six months in intervention group and reduction in control group (p=0.01). Moderate effect size (η^2 partial=0.08) No sig. differences on EE (p=0.87) or DP (p=0.43)
Berendonk et al. (2019) Germany	Mixed methods clustered RCT	20 long-term care facilities N=180	Intervention over eight weeks **Intervention**=Two days training on DEMIAN intervention. Six-week	EE measured by BHD	No sig. differences on EE (p value NR)

Strong		**Intervention**=84 *Mean age*=41.8 *Female*=70 (88%) Nurse=56 Health care assistant=4 Nurse student=15 Other=3 Geronto-nurse=3 **Control**=96 *Mean age*=38.5 *Female*=81 (85%) Nurse=69 Health care assistant=8 Nurse student=14 Other=1 Geronto-nurse=4	implementation phase to provide emotion-focused mini-interventions. **Control**=TAU **Data collected**=baseline, post-intervention		
Briones-Peralta et al. (2020) Spain *Moderate*	Single group pre/post	One nursing home N=36 Care workers *Mean age*=50.5 *Female*=28 (78%)	Intervention over nine months Monthly two-hour dementia specific training focusing on non-pharmacological therapies. **Data collected**=baseline, post-intervention	MBI (Spanish)	Sig. differences in EE (p=0.04) and DP (p=0.03) post intervention No sig. differences in PA (p=1) Effect size=NR
Clare et al. (2013)	Mixed methods	Four care homes	Intervention over eight weeks	MBI	No sig. differences across EE (p=0.99) DP (p=0.12), or PA (p=0.18)

U.K *Strong*	pilot clustered RCT	N=65 Care staff **Intervention**=29 *Mean age*=38.9 *Female*=22 (76%) **Control**=28 *Mean age*=38.8 *Female*=23 (82%)	**Intervention**=Two 90-minute training sessions on AwareCare observation tool and communication over two weeks. Six-week observation implementation and supervision sessions. **Control**=TAU **Data collected**=baseline, post-intervention		
Dichter et al. (2017) Germany *Weak*	Control clinical trial	Nine nursing homes N=155 Caregivers **Intervention A**=24 *Mean age*=45.7 *Female*=19 (79%) Nurse=7 Assistant=16 Geronto-nurse=1 **Intervention B**=28 *Mean age*=39.7 *Female*=21 (75%) Nurse=11 Assistant=15 Geronto-nurse=2 **Control**=32 *Mean age*=43.0 *Female*=25 (78%)	Intervention over 18 months **Intervention A**= >1 year experience of DCM. Two participants trained as DCM basic users over three days. 1.5 days observation sessions by in-house DCM trainer. Five-eight hour DCM observations, data analysis and report writing, feedback during formal caregiver meeting, written action plan, and plan implementation. **Intervention B**=No experience in DCM. Intervention as above. **Control**=TAU. 1.5 hour training on QOL rating tool **Data collected**=baseline, six-months follow-up, 18-months follow-up	CBI	Increase in burnout was observed across the two intervention groups and the control group sig. for time (p=0.02)

		Nurse=13 Assistant=17 Geronto-nurse=2			
Dreher et al. (2019) U.S.A *Weak*	Mixed methods single group pre/post	One veteran nursing home N=45 Nursing assistants *Mean age*=NR *Female*=42 (93%)	Intervention over one week 90-minute education presentation on compassion fatigue awareness and 14 self-care skills. The presentation was performed 14 times over the course of a week. **Data collected**=baseline, post-intervention, three-months follow-up	ProQOL burnout subscale	Sig. reduction in burnout subscale(p=0.04) post intervention and sustained at three-months follow-up Effect size=NR
Ericson-Lidman & Åhlin (2017) Sweden *Weak*	Single group pre/post	One residential-care facility N=29 Nurses=5 Care assistants=24 *Mean age*=52 *Female*=26 (90%)	Intervention over one year (performed twice) 12 PAR sessions lasting 90 minutes per unit. Incorporating problem-based learning to reflect on and respond to situations that resulted in staff troubled conscience **Data collected**=baseline, 12-months follow-up	MBI (EE and DP subscales)	No sig. differences across EE (p=0.45) or DP (p=0.72)
Frey et al. (2017) New Zealand *Weak*	Mixed methods single group pre/post	Two residential-care facilities N=27 Health care assistant=13 Registered nurse=5	Intervention over six months SHARE programme involving input from a palliative care nurse specialist: Assessment of care goals, coaching and role modelling, education planning, role modelling of advance care planning	ProQOL burnout subscale	No sig. differences on burnout subscale (p>0.05)

		Charge nurse=1 Care coordinator=1 Manager=1 Allied health=4 Missing=2 *Mean age*=NR *Female*=25 (93%)	conversations, debriefing, and reflection after a resident's death. **Data collected**=baseline, post-intervention		
Halek et al. (2020) Germany *Weak*	Stepped wedge cluster RCT	12 nursing homes N=473 **IdA**=169 *Nurse*=87 *Assistants*=82 **NEO**=265 *Nurse*=107 *Assistants*=158 *Mean age*=NR *Sex*=NR	Interventions over seven months **IdA**=Six-hour training on IdA model followed by four three-hour Case Conferences (supported) and four 1.5 hour Case Conferences (not supported) and use of an assessment instrument **NEO**= Six-hour training on NEO model followed by four three-hour Case Conferences (supported) and four 1.5 hour Case Conferences (not supported) **Data collected**=every three months at seven time points	CBI	IdA=Sig. difference in work-related burnout (p=0.03) between intervention and control phase Effect size=NR No sig. differences in personal-burnout (p>0.05), client-related burnout(p>0.05), or overall CBI (p>0.05) NEO=No sig. differences in work-related burnout (p>0.05), personal-burnout (p>0.05), client-related burnout(p>0.05), or overall CBI (p>0.05)
Livingston et al. (2019) U.K *Strong*	Cluster RCT	20 care homes N=492 Care staff **Intervention**=243 *Mean age*=43 *Female*=211 (87%)	Intervention over eight months **Intervention**=MARQUE six-session manual-based intervention followed by implementation and supervision period.	MBI	No sig. differences across EE (p=0.68), DP (p=0.07), or PA (p=0.52)

		Control=249 *Mean age*=44 *Female*=210 (84%)	**Control**=TAU **Data collected**=baseline, eight-months follow-up		
Zwijsen et al. (2015) Netherlands *Weak*	Stepped wedge cluster RCT	17 dementia special-care units N=380 Care staff=304 Therapist=17 Nursing assistant=42 Other/missing=17 *Mean age*=42 *Female*=369 (97%) N=NR calculated by author	Intervention over 17 months. New group commenced every four months **Intervention**=GRIP intervention. Training on detecting and reflecting on behaviour that challenges. Implementation phase focusing on detection and analysis of behaviour that challenges followed by development and evaluation of a treatment plan **Control**=TAU **Data collected**=baseline, mid-intervention, post-intervention	UBOS-C	No sig. differences across EE (p>0.05), DP (p>0.05) , or PA (p>0.05)

Key: BHD=Screening Tool for Job Strain in Human Service Work, CBI=Copenhagen Burnout Inventory, DCM=Dementia care mapping, DEMIAN=German Acronym for Promoting Positive Everyday Experiences for People with Dementia, DP=Depersonalisation, EE=Emotional exhaustion, GRIP= Grip on Challenging Behaviour Programme, IdA= Innovative Dementia-oriented Assessment, MARQUE= Managing Agitation and Raising Quality of Life in Dementia, MBI=Maslach Burnout Inventory, NEO= Narrative Approach Model, NR=Not reported, PA=Personal accomplishment, PAR=Participatory action research, PCC=Person centred care, ProQOL=Professional Quality of Life, QOL=Quality of life, RCT=Randomised control trial, Sig.=Significant, SHARE= Supportive Hospice Aged Residential Exchange, TAU=Treatment as usual, UBOS-C=Utrechtse Burnout Scale-C

Interventions

The interventions varied in terms of their aims and implementation; however, each was characterised as person-directed or combined. Person-directed interventions focused on self-care strategies. Combined interventions incorporated person-directed components with a work-directed approach that aimed to implement work practice or environmental changes.

Two studies utilised a person-directed approach either focusing on improving staff well-being through self-care training (Dreher et al., 2019) or increasing staff ability to manage work-related distress (Ericson-Lidman & Åhlin, 2017). Dreher et al. (2019) reported on a standalone 90-minute training intervention focusing on compassion fatigue awareness and self-care strategies. Ericson-Lidman & Åhlin (2017) implemented a yearlong PAR intervention, providing twelve 90-minute PAR sessions that utilised problem-based learning to reflect on and respond to situations resulting in staff troubled conscience.

Ten interventions utilised a combined approach focusing on addressing behaviour that challenges, resident quality of life (QOL), or palliative care. Three studies reported on staff interventions to address behaviour that challenges (Halek et al., 2020; Livingston et al., 2019; Zwijsen et al., 2015). The interventions encompassed staff training aiming to improve knowledge of challenging behaviour (Zwijsen et al., 2015) or combined challenging behaviour awareness and QOL strategies (Halek et al., 2020; Livingston et al., 2019).

Zwijsen et al. (2015) aimed to increase understanding of behaviour that challenges through implementing the ‘Grip on Challenging Behaviour Programme’ (GRIP). Staff were trained to identify and analyse behaviour that challenges to inform and implement treatment plans. Halek et al. (2020) utilised Case Conferences and assigned participants to one of two interventions, incorporating the innovative dementia-oriented assessment tool (WELCOME-IdA) or the narrative approach model (WELCOME-NEO). The interventions aimed to develop understanding of behavioural changes and develop tailored interventions for residents. They comprised a six-hour training session, followed by four three-hour supported Case Conferences, and four unsupported Case Conferences. Livingston et al. (2019) investigated the impact of a manual based training intervention ‘Managing Agitation and Raising Quality of Life in Dementia’ (MARQUE). Six training sessions were completed followed by an implementation phase and supervision sessions.

Six interventions (Barbosa et al., 2015; Barbosa et al., 2016; Berendonk et al., 2019; Briones-Peralta et al., 2020; Clare et al., 2013; Dichter et al., 2017) focused on improving resident QOL. Two studies (Barbosa et al., 2015; Barbosa et al., 2016) reported on the same sample and intervention. Among the intervention group, eight weekly 90-minute sessions combined person centred care (PCC) training and strategies to increase staff coping and self-care. Participants were supported with PCC implementation for three days after each training session.

Berendonk et al. (2019) provided two days training on DEMIAN ‘Promoting Positive Everyday Experiences for People with Dementia’, an intervention that aims to promote emotional attachment with residents. This was followed by an implementation phase lasting six weeks wherein staff completed and evaluated emotion-focused mini-interventions for residents. Briones-Peralta et al. (2020) offered monthly two-hour dementia training sessions over ten months. The training was focused on dementia psycho-education and non-pharmacological therapies. Clare et al. (2013) reported on an eight-week ‘AwareCare’ intervention that aimed to improve staff members’ ability to identify responsiveness in residents with severe dementia. Participants attended two 90-minute training sessions focusing on communication and use of the AwareCare observational tool. Dichter et al. (2017) investigated dementia care mapping (DCM) where two carers per unit attended four and a half days DCM training and compiled an action plan which was implemented by the caregiver team.

One study (Frey et al., 2017) aimed to improve the delivery of palliative care and implemented the educational ‘Supportive Hospice Aged Residential Exchange’ programme (SHARE). The intervention lasted six months and incorporated the consultation of a specialist palliative care nurse who engaged with care staff to develop care goals for palliative residents, facilitated discussions to improve palliative care skills and knowledge, role modelled advanced care planning conversations, and offered debriefing after a resident’s death.

Findings

Five studies reported evidence for the efficacy of burnout interventions (Barbosa et al., 2015; Barbosa et al., 2016; Briones-Peralta et al., 2020, Dreher, et al., 2019; Halek et al., 2020). One study implementing a person-directed intervention reported significant results. Dreher et al. (2019) observed a significant intervention effect with reduced scores on the burnout subscale of the ProQOL post-intervention. The reduction was observed at one-month and three-months follow-up (p=0.04). Effect sizes were not reported or calculable for this result.

Four studies investigating combined interventions reported significant results. Barbosa et al. (2015) reported reduced scores on the EE subscale of the MBI in the intervention group immediately after the intervention while control group staff reported increased scores (p=0.029) with a moderate effect size (η^2 partial=0.095). No significant differences were found across DP or PA scores post-intervention.

A six-month follow-up study (Barbosa et al., 2016) reporting on the same intervention observed a significant time interaction effect found at the PA subscale of the MBI. The intervention group showed immediate reduced PA scores that improved at six months. PA scores reduced over time for the control group (p=0.012) with a moderate effect size (η^2 partial=0.08). The authors reported reduced EE scores post-intervention and at six-months follow-up in the intervention group; however, the results were not significant.

Briones-Peralta et al. (2020) measured burnout using the MBI and observed significant reductions in the EE (p=0.0409) and DP (p=0.0387) subscales post-intervention. An improvement in PA scores was also reported but not significant. Halek et al. (2020) reported a significant reduction in the work-related burnout subscale of the CBI between control and intervention phases in the IdA cohort (p=0.032). No significant changes were observed across the personal and client-related subscales. Furthermore, no significant changes were observed between the control and intervention phases in the NEO cohort. Effect sizes were not reported or calculable for either study.

Interestingly, Dichter et al. (2017) reported that burnout levels increased in their two intervention groups between baseline and 18-months follow-up with a significant effect for time (p=0.02). The remaining studies found no statistically significant changes in staff burnout following intervention (Berendonk et al., 2019; Clare et al., 2013; Ericson-Lidman & Åhlin, 2017; Frey et al., 2017; Livingston et al., 2019; Zwijsen et al., 2015).

Discussion

This review aimed to identify and evaluate the effectiveness of interventions to reduce burnout in staff working in inpatient or long-term care for older people published since 2013, updating Westermann et al.'s (2014) review. Two person-directed interventions and ten combined interventions were identified, as defined by Westermann and colleague's categorisation system to aid comparisons and maintain consistency.

One study investigating person-directed interventions observed a significant effect on burnout (Dreher et al., 2019); however, they did not utilise a control group and failed to adequately consider the potential impact of confounding variables. Westermann et al. (2014) reported lower evidence supporting the efficacy for person-directed interventions and postulated that the absence of an organisational focus contributed to these findings.

Four combined intervention approaches were observed to have a positive impact on burnout. Barbosa et al. (2015) reported a significant reduction in EE post–intervention; however, this was not observed in the follow-up study (Barbosa et al., 2016). As the authors reanalysed the data obtained post-intervention after further attrition, the discrepancy is likely explained by the reduced sample size.

Briones-Peralta et al. (2020) observed a significant reduction in EE and DP scores; however, this study failed to use a control group, and reported a small sample size. Halek et al. (2020) reported a significant reduction in work-related burnout in the IdA cohort; however, this study was rated methodologically weak due to its recruitment process and high attrition rate. As no other significant effects in either cohort were observed, the findings appear to support Reuther et al. (2012) who found Case Conferences had no significant impact on staff burnout.

Dichter et al. (2017) reported staff burnout levels increased across their intervention and control groups with a significant time effect, contrasting with Jeon et al. (2012) who reported a significant sustained decrease in EE scores after implementation of a DCM intervention. The authors reported poor intervention adherence and postulated that the observed increase in burnout was due to an inadequate care environment, an antecedent to carer burnout.

The six remaining intervention studies reported no intervention effects which may be explained by a number of factors. Several studies reported low sample sizes, potentially resulting in reduced statistical power (Clare et al., 2013; Ericson-Lidman & Åhlin, 2017; Zwijsen et al., 2015). Treatment fidelity was impacted due to staff engagement issues (Clare et al., 2013; Dichter et al., 2017), the complexity and culture of the care environment (Berendonk et al., 2019; Dichter et al., 2017; Frey et al., 2017; Livingston et al., 2019), staff absenteeism (Clare et al., 2013); and low or ambivalent managerial support (Clare et al., 2013; Dichter et al., 2017; Frey et al., 2017; Livingston et al., 2019).

These findings are consistent with McCabe et al. (2007) who reported numerous challenges associated with conducting research in care homes and determined that managerial support is essential to ensure staff are encouraged to engage in new practices. Westermann et al. (2014) concurred with this assertion, citing the absence of managerial support as a barrier to intervention implementation.

Limitations

Efforts were made to develop a robust search strategy. However, given the inconsistencies in how burnout is defined, measured, and targeted by interventions in this field of research, there is the potential that relevant articles were missed and not incorporated into the review.

Furthermore, only English-language, peer-reviewed articles were included increasing the likelihood of publication and cultural bias.

Two included articles reported on the same intervention which may have overrepresented the paired studies’ findings within the synthesis. Nevertheless, both studies were included as the second publication observed different results post-intervention due to attrition, and reported follow-up results at six-months.

Consistent with previous reviews (Spector et al., 2016; Westermann et al., 2014), the included studies varied in terms of intervention, design, and quality, making comparisons difficult and limiting the generalizability of the results. Finally, a number of studies did not report effect sizes. Contacting the authors for additional data to calculate effect sizes independently would have allowed for more meaningful comparisons across significant results but time constraints did not allow for this to date.

Clinical implications and future research

This review found limited evidence supporting the effectiveness of interventions to reduce burnout in staff employed in long-term care facilities. Consistent with Westermann et al. (2014), four studies demonstrated some evidence supporting the effectiveness of combined interventions. However, recommendations for their implementation are tentative given the small sample sizes and methodological issues raised. Furthermore, only one intervention measured and demonstrated improvements at six-month follow-up (Barbosa et al., 2016). Future research should aim to recruit larger samples with long-term follow-up to determine whether any significant effects are sustained. Although time and labour intensive, utilising a systematic, targeted, and streamlined approach may result in a higher recruitment rate for care homes (Ellwood et al., 2018).

Four different instruments were used to measure burnout, making comparison of resulting scores difficult. Future research should consider utilising a consistent measure of burnout to enhance direct comparisons across studies (Ahola et al., 2017).

Complex organisational factors were reported to impact on intervention fidelity, suggesting researchers need to be adaptable and flexible when attempting to implement interventions in long-term care facilities. Poor managerial support was specifically identified as a barrier to intervention fidelity and reflected in previous literature (Spector et al., 2016; Westermann et al., 2014). This suggests that investment from management needs to be obtained to increase the likelihood of successful implementation of interventions and allow for adequate assessment of their effectiveness. Future research should aim to sustain intervention adherence by offering flexible and prolonged contact to participating facilities (Ellwood et al., 2018). Furthermore, given that managers of care facilities are often a group overlooked in research (Orellana et al., 2017), qualitative studies investigating manager perceptions into barriers and facilitators to intervention implementation would also be recommended.

Conclusion

The current review yielded mixed results. The majority of included studies did not report evidence supporting the efficacy of burnout interventions in staff employed in long-term care facilities for older adults; however, the results may have been affected by poor intervention fidelity and low sample sizes. A minority of included studies provided evidence to suggest that combined intervention approaches may be more effective than staff training alone given the incorporated organisational element. Furthermore, organisational factors such as managerial support may have an important impact on intervention fidelity. However, quality appraisal of these studies highlighted a number of methodological issues making it difficult to draw firm conclusions about the overall effectiveness of the interventions. Given the identified issues, higher quality research that considers barriers to intervention implementation with long-term follow-up is recommended.

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Chapter Two Major Research Project: Care home managers' experiences of managing staff compassion fatigue

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Plain English Summary

Care home managers' experiences of managing staff compassion fatigue

Background

Compassion fatigue is an emotional state that can reduce carers' ability to empathise and care for their patients. Research has found different reasons why carers might develop compassion fatigue. Compassion satisfaction is when carers experience positive feelings through helping others with difficult experiences. Managers have an important role supporting staff with compassion fatigue and promoting compassion satisfaction. However, there is not a lot research on how managers give this support.

Aims

The study aimed to explore the experiences of care home managers in how they manage compassion fatigue in staff teams. The study also aimed to understand what helped staff with compassion fatigue.

Methods

Six managers working in care homes for older people based in NHS Highland took part. The researcher recorded each interview and analysed what the managers said.

Results

The participants talked about how they support their staff. Their experiences were summarised into three themes: Navigating staff-resident relationships; Utilising manager resources; and Promoting satisfaction. The participants felt it was important to show empathy for staff, develop good working relationships, take care of their own needs, and make sure staff have training to help them feel more confident.

Summary

These findings give important insights into how managers try to support their staff teams. Their experiences suggest what helps protect staff from compassion fatigue and enables compassion satisfaction.

Abstract

Background

Compassion fatigue is associated with negative physical and psychological symptoms. Compassion satisfaction occurs when carers experience reward from helping others. Research has concluded that managerial support can protect against compassion fatigue; however, there is limited evidence exploring how older adult care home managers support their staff.

Aims

The study aimed to explore care home managers' experiences of mitigating compassion fatigue and promoting compassion satisfaction in their staff teams.

Method

Semi-structured interviews were carried out with six care home managers. The interviews were transcribed verbatim and analysed using Interpretive Phenomenological Analysis.

Results

Three superordinate themes were developed from the data: 1) Navigating staff-resident relationships; 2) Utilising manager resources; and 3) Promoting satisfaction.

Conclusions

The participants described their experiences validating and empathising with staff. They reflected on challenges, the need for relationship-based care, and highlighted staff training needs. Implications and recommendations are discussed.

Keywords: Compassion fatigue, compassion satisfaction, care home, manager

Introduction

Life expectancy and the number of people living with chronic health conditions is increasing, placing pressures on healthcare systems, and creating a demand for care home placements for older people with high dependency needs (Kingston et al., 2017). Retaining staff in long-term care facilities is challenging and a priority for managers (Hodgkinson et al., 2011) as high turnover can impact on patient care and reduce staff morale (Roche et al., 2015). Turnover has been associated with workload stress, job dissatisfaction, burnout (Halter et al., 2017), and compassion fatigue (CF) (Peters, 2018).

CF is a construct that has been associated with increased staff absenteeism, reduced judgement, and poorer patient care (Peters, 2018). CF is not well-defined in the literature and the term has interchangeably been described as secondary traumatic stress and vicarious traumatisation (Coetzee & Laschinger, 2018). It is related to burnout (Slatten et al., 2011) and occurs when carers experience disengagement and a reduced ability to empathise and adequately care for their patients (Coetzee & Laschinger, 2018). A number of models have been developed to understand CF (Coetzee & Laschinger, 2018). The compassion stress and fatigue model (Figley, 1995; 2002) emphasises that carer empathy is central to understanding CF. It theorises that empathic concern and the need to respond to distress can lead to compassion stress. Prolonged exposure, traumatic memories, and further life disruptions can result in the carer developing CF (Coetzee & Laschinger, 2018). However, this model was criticised for identifying empathy as the main precursor in the development of CF, when subsequent research linked empathy with positive patient outcomes (Coetzee & Laschinger, 2018). Stamm’s (2010) model argues that carer experiences are influenced by their clients and their personal and professional environments. These experiences can contribute to positive feelings associated with caring for others, or negative outcomes resulting in the development of CF. This model theorises CF as a term to describe combined burnout and secondary traumatic stress, which has been criticised for potentially blurring the boundaries of the construct (Coetzee & Laschinger, 2018).

Symptoms of CF have been found to be physical, behavioural, psychological, and spiritual (Peters, 2018). Within healthcare environments, Coetzee and Laschinger (2018) proposed that limited resources, receiving inadequate positive feedback from colleagues, and the carer’s personal response to distress are risk factors for CF. Conversely, self-care, implementing professional boundaries (Peters, 2018), and compassion satisfaction (CS) reportedly protect against CF (Sacco & Copel, 2018). CS is a construct describing the sense of fulfilment that carers experience from helping others through difficult periods (Sacco et al., 2015). It has been associated with higher quality of care and improved team cohesion (Sacco & Copel, 2018). Antecedents to CS include positive patient relationships, increased resilience, and collegial support (Sacco & Copel, 2018). Research has also highlighted the importance of the manager’s role in supporting staff in order to promote CS and mitigate against CF (Coetzee & Laschinger, 2018; Sacco & Copel, 2018).

The manager role is varied, stressful and associated with challenges including staffing difficulties, staff training needs, and increased patient complexity (Orellana et al., 2017). Although managers are integral to the running and organisational structure of care homes, there is limited research on this professional group (Orellana et al., 2017) and how they perceive their role in supporting their staff (Adams et al., 2018).

In summary, CF is a multifaceted construct that affects those in the helping professions resulting in reduced empathy and compassion (Coetzee and Laschinger, 2018). The importance of managerial support in recognising and addressing CF has been identified (Hunsaker et al., 2015). However, there is less research exploring how managers support their staff (Adams et al., 2018). Therefore, this study aimed to explore the experiences of care home managers in how they mitigate CF in staff teams. It sought their views on their ability to recognise and manage CF, promote CS, and identify barriers and facilitators to supporting staff.

Method

Design

This study utilised a qualitative design using one-to-one semi-structured interviews. Interpretive Phenomenological Analysis (IPA) was used to explore care home managers' experiences of CF and CS within their staff teams. IPA aims to examine how participants make sense of their lived experiences while simultaneously considering the influence of the researcher's interpretation (Smith & Osborn, 2015). IPA is based on the concepts of hermeneutics, the theory of interpretation; phenomenology, the study of experience; and idiography, the focus on and commitment to the particular (Smith et al., 2009). Therefore, IPA was selected as an appropriate methodology for this study as it aimed to explore how the participants understood, made sense of, and interpreted their experiences of managing CF within their teams, while considering the interpretive lens of the researcher. Furthermore, IPA is an established approach to data analysis in research investigating the experiences of health professionals (Handley & Hutchinson, 2013; Jarman et al., 1997; Stenfert & Smith, 2018). This study was reported in accordance with the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007) (Appendix 2.2).

Ethics

This study received ethical approval and was sponsored by NHS Highland Research and Development Department (Highland 1570) (Appendix 2.3). Participants provided written consent to take part in the study and were made aware that participation was voluntary and of their right to withdraw. Confidentiality and its limitations were explicitly addressed and participants were given pseudonyms to protect their professional anonymity. The option for follow-up support was available if participants displayed distress during the interview. Participants were informed that all data would be stored in accordance with General Data Protection Regulations (GDPR).

Recruitment and procedure

Participants were recruited through the Older People's Psychology Service in NHS Highland. Managers were identified through the Care Inspectorate website. Potential participants were contacted via telephone or email and provided with a participant information sheet (Appendix 2.4) and an overview of the study aims. Interviews were conducted at the participants' places of work. The researcher obtained written consent (Appendix 2.5) and completed the interview guided by a semi-structured interview schedule (Appendix 2.6). The interviews were audio-recorded and lasted between 35 and 57 minutes. The participants were provided with a debriefing form (Appendix 2.7) upon completion of the interview.

Participants

Managers of care homes for older people within NHS Highland were eligible provided they were employed in post longer than six months. They were excluded if they were not fluent in English or were employed in inpatient hospital settings. A total of 18 care homes were contacted. Ten did not respond to initial contact attempts. One manager was ineligible due to their length of time in post, two managers stated they were too busy to participate, and one declined to be audio-recorded. Six individuals participated in the study. Two participants were employed as manager and deputy manager in the same care home. See Table 1. for participant information. Pseudonyms have been omitted to reduce the likelihood that participants could be identified from the included quotations.

Table 1. Participant information

Participant	**Gender**	**Years in post**	**Care home provider**	**Nursing or residential**	**Role**
1	F	>10	NHS	Residential	Manager
2	F	>10	NHS	Residential	Deputy Manager
3	F	5-10	Not for profit	Residential	Manager
4	F	1-5	Not for profit	Nursing	Manager
5	F	1-5	NHS	Residential	Manager
6	F	>10	Private	Residential	Manager

Sample size

Purposive sampling was utilised to obtain a relatively homogeneous group of participants (Smith et al., 2009). Six participants were recruited, in keeping with Smith et al. (2009) who recommended a suitable sample size for doctorate level IPA is between four and ten interviews. The smaller sample size allowed for a closer examination of the participants' lived experiences, focusing on the depth and richness of the data as opposed to the breadth (Smith et al., 2009).

Analysis

The interviews were audio-recorded and transcribed verbatim by the researcher. IPA is an iterative process and, in keeping with guidance by Smith et al. (2009), the researcher re-read each transcript and listened to the audio-recordings to aid data immersion. Each transcript was annotated line by line at the descriptive, linguistic, and conceptual level. Following this, the researcher began the process of developing themes from the data while acknowledging and reflecting on their subjective interpretation. The researcher identified patterns across each transcript and linked the themes into superordinate clusters to create a higher order organisation. Excerpts of the analysis stage are included for transparency (Appendix 2.8).

Researcher Characteristics and Reflexivity

The researcher was female and employed as a Trainee Clinical Psychologist in the Older People's Psychology Service. Prior to this role they were employed in the care sector. None of the participants were known to the researcher before participating in the study; however, in order to ensure transparency they were made aware of the researcher's professional background and motivations for engaging in care home research.

The researcher's characteristics may have influenced what the participants felt comfortable sharing during the interviews, i.e. disclosures of incidents where the manager perceived the staff team to be struggling to manage stress, potentially impacting on the generation of data. Furthermore, within IPA, the principle of the 'double hermeneutic' refers to the researcher's active role in the process of analysis, wherein they acknowledge their own perspective in making sense of the participants' sense making and perceptions of their experiences.

The researcher reflected on their preconceived biases and considered how their characteristics may have influenced the interview process. They explicitly acknowledged their biases and reflected on the influence their past experiences had on their interpretation of the data during the process of developing emerging themes and the subsequent analysis (i.e. their perception that staff empathy can impact positively on care and staff outcomes). To aid reflexivity, the researcher kept a reflective diary to attend to their emotional responses, initial reactions, interpretations, thoughts, and initial queries. The researcher referred to this diary throughout the analysis to aid the on-going and iterative process of 'bracketing off' and challenging their assumptions. The researcher's supervisor was experienced with IPA methodology and had access to three transcripts and the researcher's initial coding and themes. Academic supervision was used as a reflective space to acknowledge, consider, and challenge the researcher's expectations throughout the analysis stage. For example the researcher used supervision to reflect on their interpretation of the participants' experiences of displaying empathy. The reflection was instrumental in the development and structuring of themes as it highlighted to the researcher the parallel processes evident throughout the participants' narratives.

Results

Three superordinate themes and six subordinate themes were developed during the analysis and are displayed in Table 2.

Table 2. Superordinate and subordinate themes

Superordinate themes	**Subordinate themes**
Navigating staff-resident relationships	*Offering empathy and perspective*
	Coping with confrontation
Utilising manager resources	*Learning from past experiences*
	Competence through professional development
Promoting satisfaction	*Building resilience*
	Prioritising resident relationships

Navigating staff-resident relationships: "As manager, you've got to be that middle"

Offering empathy and perspective

Throughout their narratives, the participants reflected on the process of empathising with staff. They discussed conveying emotional availability by offering staff a space to "*vent"* (Susan, 52) or talk openly about difficult experiences. Emma wondered if staff feel pressured to disregard difficult emotions at work and considered the risk of dismissing their distress through immediate problem solving. Instead, she described communicating to staff that she is listening and trying to understand their experience from a non-judgmental stance.

> *"You think 'I have to be positive, everything has to be great' but this gives them the permission to say 'it's not (pause) and this is what I'm not liking, and this is what I need fixed' so I think that helps and even just listening to people sometimes, and not trying to, to fix it or tell them they're wrong or tell them there's a better way of doing it."-Emma, 294*

Clare and Ruth highlighted that distress is an inevitable consequence of working in the care industry and described their practice of emotional validation. Ruth emphasised the value of providing staff with a space to explore their feelings. She reflected that offering emotional containment to staff reduces the likelihood that their frustration will inadvertently surface during interactions with residents. Furthermore, she reframed staff disclosures as an opportunity to reflect on the resident's perspective.

> *"Giving them a safe environment in which to say '(exhales deeply) she's doing my head in today' but as long as it doesn't impact on their practice … we'll sit down and have a chat about, she's having a bad day too she's sore … It's helpful to give a safe environment in which they can offload or (pause) or just talk about their feelings."- Ruth, 490*

However, four participants considered the barriers to providing containment and referred to a sense of dissonance between their own perceptions and the staff member's experience of distress. Clare described an internal dialogue wherein she tries to empathise with staff while acknowledging her own judgements. Her account demonstrated the parallels between her own experience of perspective taking and how she guides this process with staff to consider the residents' perspectives. She described putting aside her perceptions to take an objective stance of the situation. She then validated the staff member's interpretation before encouraging them to consider a more balanced perspective.

> *"We just try to … be compassionate and listen to people even though you're sitting there some days thinking (pause) but you just listen, so it's real to them and we can*

> *say 'I understand that's real to you, but do you really think that's the way it is?'"- Clare, 610*

Pamela conveyed compassion for staff experiencing "*genuine"* (278) difficulties and described promoting perspective-taking using "*tough love"* (86). She suggested this method helped her encourage staff to regain emotional control and reflect on their interpretation of a situation. Nevertheless, she spoke honestly about struggling with the discrepancy between her own perspective and the experiences of staff.

> "*That's difficult for me because what I would say is 'well actually you need to (pause) (sighs) you need to get a grip' ... So that's quite difficult but as manager you've got to be that middle, you know, you've got to (pause) show empathy for that person but at the same time you are trying to support and is it like tough (pause) being a bit tough love to get them through that next stage?"-Pamela, 68*

Pamela acknowledged her difficulties connecting with staff emotion that she perceived to be disproportionate to the situation. She expressed further frustration towards addressing *"playground nonsense"* (752) with staff or situations that divert her resources from *"serious issues"* (753). Her reflections concur with Emma's disclosure that she will *"turn around and snap"* (350) when under stress, suggesting that role pressures have the potential to reduce managers' capacity to empathically respond to staff. These depictions appear to mirror the participants' accounts where staff lost *"patience"* (Lyn, 115) with residents.

> *"We had a member of staff who (pause) … we knew there were things going on outside of work, emm she wouldn't speak to anybody … it resulted in her (pause) pushing the client"-Emma, 310*

This excerpt refers to an incident where a staff member's reduced capacity for stress tolerance at work led to a highly inappropriate interaction with a resident in their care. The apparent interplay between stress and problematic interactions suggest that managers have a responsibility to reflect on their own emotional responses to pressure alongside their staff members' needs.

Coping with confrontation

The participants reflected on their relationships with staff and considered the advantages of maintaining a positive working alliance where staff feel "*comfortable*" (Susan, 645) and able to avail of support. However, each participant alluded to difficult situations where they were obligated to confront problematic behaviour. Emma's account illustrated the tension resulting from balancing these competing priorities. She recalled her experiences of addressing unprofessional behaviour and reflected on the struggle to express her concerns without being interpreted as critical. Furthermore, she considered the additional challenges of navigating conversations with staff members who are unable to acknowledge their difficulties.

> *"It's difficult when (pause) somebody can't see … you're trying to help, you're not trying to criticise them or say they're a bad person, you're just trying to help them to realise that sometimes they're not quite (pause) (sighs) acting as they should"-Emma, 323*

Nevertheless, the participants fundamentally agreed that unprofessional behaviour needs to be addressed because of the impact on resident safety, regardless of their resulting experiences of discomfort.

> *"But at the end of the day that had to be dealt with through another channel because it actually impacted on somebody whose home this is"-Pamela, 351*

Lyn's account offered further insight into the dynamics between manager and staff relationships. She described having a mutually supportive and positive relationship with her staff team. However, she reflected on a personal struggle to confront a staff member whose interactions with residents were causing concern.

> *"She'd obviously already thought herself 'it's time for me to leave' you know? Which was good because I thought 'how do I cope, how do I deal with this now?' ... 90% of my staff come from [location redacted] and we all know each other so (pause) that, that can be difficult sometimes because I'm not just their boss but I'm a friend as well."-Lyn, 128*

She appeared to feel daunted by the prospect of confronting the staff member and expressed relief that they left employment of their own volition. Lyn's reflection highlighted an interesting perspective wherein the nature of working in a small, cohesive locality can impede the maintenance of appropriate boundaries. This can add a layer of complexity to the power dynamics between managers and staff, creating additional challenges when addressing problematic behaviour. Lyn alluded to feeling torn between her roles as a boss and a friend and illustrated the unintended consequences resulting from blurring personal and professional boundaries.

Utilising manager resources: *"I've got tools to hand"*

Learning from past experiences

The participants' reflections highlighted that providing emotional staff support can be a complex and uncertain process. While they depicted this responsibility as an integral part of their role, they considered their limitations in managing situations "*outwith [outside] your field"* (Pamela, 709). They discussed the resources that aid their efforts to support staff and valued the option to seek advice through their own managers, legal teams, or Occupational Health Services. However, four participants elaborated on how their communication and leadership style has been informed by their past experiences. They used powerful language to describe their own responses to the pressures of care work, feeling *"shaky, inadequate, un-capable, unconfident"* (Ruth, 844). Emma considered managing stress through her ability to "*self-reflect"* (672), a skill that has enhanced her awareness of her own feelings and allowed her to be more attuned to the needs of her staff, a connection also made by Ruth.

> "*I gradually, you know, came down to earth again and started to think 'always keep yourself safe'... I'm compensating now to ensure that staff ... feel safe, feel secure, emm, they're able to talk to me."-Ruth, 867*

Ruth's interview captured the emotional impact of an encounter from her past and she vocalised a subsequent sense of clarity, emphasising a need to prioritise her own safety in order to adequately support others. She considered how this incident contributed to her management style, wherein she represented herself as a containing, secure base willing to explore staff difficulties.

Competence through professional development

Alongside their past experiences, four participants considered how training has contributed to their professional development and influenced how they interact with staff.

> *"I was lucky enough to be part of the 'My Home Life' programme … if somebody realises themself, they're more likely to stop and look at it and think 'well I need to do something about that' whereas if I just sit and say 'well you're not doing that right today, so fix it' they'll be like (exhales) 'aye ok' (laughs)… It's not so I can fix something, it's so they can talk about it and … truly admit how they feel"-Emma, 256*

Emma expressed gratitude towards her inclusion in a programme that empowered her to be more "*vulnerable*" (591) and have curious conversations with staff that focus on self-reflection and emotional validation. She implied taking a directive approach would leave staff feeling criticised and dismissive of her concerns, whereas offering a reflective space encourages openness and the opportunity for collaborative problem solving. Clare considered how training enhanced her insight into the "*influence"* (188) of her role and informed how she communicates with staff, enabling her to have "*enquiring, positive conversations" (Clare, 920).* Ruth echoed these sentiments and considered how her training gave her an outline to have emotionally orientated, solution focused conversations, in spite of her distaste for conflict.

> *"I've got tools to hand ... I don't like conflict at all ... if have to put something forward to the team ... I kind of use these words ... say, pick three words, negative words, positive words ... explain to me, you know, why you're feeling* that way or why *this is happening ... what would you need to do to get to the positives?"-Ruth, 307*

These extracts demonstrate the impact training had on the participants' confidence to directly embrace difficult conversations, convey empathy, and maintain staff relationships.

Promoting satisfaction: *"It does make you feel good that you've done a good job"*

Building resilience

Resident safety was affirmed at the centre of each participant's narrative and was a major driver to ensure staff resilience is supported. The participants expressed concern over the "*vicious cycle"* (Emma, 151) that develops between emotionally unresponsive staff and distressed residents. Ruth considered the emotional impact of caring for people with multiple needs, describing her staff as a group of individuals committed to their roles. However, she acknowledged their resources are not inexhaustible.

> *"Our residents ... they're at different levels ... It is a hard job and the girls are so good at caring for them. But you know, they, they're limited resources, they get tired"-Ruth, 475*

Emma emphasised her role in building staff resilience and prioritising their training. She reflected that if staff have the "*basic knowledge"* (381) it makes doing their jobs "*ten times better"* (385). Susan echoed this sentiment and acknowledged her responsibility to ensure staff are supported to develop *"ownership"* (655) of their roles. She recognised that staff are best placed to take the lead when responding to stress and distress and suggested that if she was too directive, they would feel disempowered. She emphasised that staff should be encouraged to pursue professional development to cultivate problem solving skills and provide them with the confidence to manage difficult situations.

> *"We dinnae [don't] manage by dictating to anyone … they're staff working on the floor … they need to sort of … take control of a situation because they're the ones that are dealing with a situation … it's all very well for me to say 'we'll do this, or do that' … if they've got ownership of things and they feel more in control then, you know, I think situations do get resolved quicker"-Susan, 402*

Ruth also considered the development of emotional resilience and described a sensitive situation where a staff member was supported to contribute to care after the death of a resident. She offered the staff member control over the decision to participate and supported them to step outside their comfort zone by ensuring an experienced member of staff was there to model the process. This opportunity appeared to allow the staff member to complete an emotive role without being overwhelmed by their sadness, and facilitated the message that they can cope with further difficult aspects of their job.

> *"I said … 'you don't need to participate in that at all, only if you want to' … the lady had passed away and she (pause) wanted, with support, to dress the body. She was nervous, she was fearful, emm, so I had given her an experienced staff member and she was so thankful. She was still upset, she was crying but that's kind of natural too"-Ruth, 135*

Prioritising resident relationships

The participants considered their professional histories and recounted the aspects of caring they found particularly satisfying. The *"rewarding"* (Pamela, 641) nature of resident relationships was apparent in the participants' narratives and evidently informed how they encourage feelings of positivity in their staff teams. Clare and Susan considered how promoting resident quality of life contributes to staff feelings of reward. Clare reflected on the power of culturally embedded person-centred values where supporting residents *"to have a voice"* (992) empowers staff to have meaningful resident interactions and provide better care. Susan suggested she places a particular weight on ensuring staff feel confident to advocate for the residents' needs, leading to a sense of pride and accomplishment. Her account of the staff team's practice parallels her own positive experiences of providing high quality care where *"it does make you feel good that … you've done a good job"* (836).

> *"Going back to my lady that we spoke about earlier, managed to get her to a place that she was happy … that was just an amazing time for staff because they knew that they were part of her being the way she now was, compared to when she first came in … you could tell that they were so proud that they had been part of this team that had achieved this amazing outcome for this lady"-Susan, 688*

Conversely, Lyn communicated her loss of role satisfaction resulting from external pressures that she felt compelled her to prioritise paperwork over resident interactions. She described coming to terms with her frustration towards this edict after attending a workshop that validated her convictions that resident relationships should be a priority.

> *"I'm getting more of a, a happy medium now on (pause) what's expected of me … I did actually go to a workshop where the care inspectors put this on … he said … 'I know you managers have to do your paperwork' he said 'but I'm telling you I want to know that people are interacting with residents more' and I thought 'thank you' (laughs)"-Lyn, 402*

Despite Lyn's admission of losing role satisfaction, she described promoting rewarding feelings in her team by encouraging positive staff and resident interactions where they are *"laughing"* (282) and *"happy"* (284). Akin to the other participants, her previous experiences of role reward appear to have had an overarching influence on her drive to prioritise and develop resident and staff relationships.

Discussion

This study aimed to explore care home managers' experiences of managing CF and promoting CS in their staff teams. Three distinct superordinate themes emerged from the data: navigating staff-resident relationships through utilising manager resources thus promoting satisfaction, with the concept of empathy underpinning the participants' narratives. Figley (1995; 2002) postulated empathic concern as a key antecedent to the development of CF, while Coetzee and Laschinger (2018) argued that evidence has linked carer empathy with positive outcomes for nurses and patients. The participants' reflections suggest that empathy is a process that can help 'contain' staff distress, resulting in increased compassion and understanding for the residents' experiences. Their accounts of empathising with staff illustrated this process of emotional 'containment'. Overwhelmed carers who personalise resident distress will struggle to convey a therapeutic presence and facilitate a calm environment (Delgado et al., 2017). They are at risk of developing emotional dissonance, a construct associated with resident-directed abuse (Andela et al., 2018) wherein the carer's affect does not fit with their role-required emotional expression (Delgado et al., 2017). The findings highlight the managers' role in validating and containing staff distress, therefore reducing the occurrence of harmful staff-resident interactions. However, the participants revealed a further layer to the containment process. They reflected on their own needs for emotional safety and suggested a reflective and self-compassionate stance facilitates compassion for staff (Pipe et al., 2016). This account corresponds with Gilbert (2005) who considered self-compassion as a prerequisite for individuals taking on the role of an attachment figure, evidencing the managers' need to prioritise their own emotional needs in order to adequately contain staff distress.

The findings illustrated the dilemmas associated with blurred boundaries and staff confrontation. Addressing problematic staff behaviour was associated with discomfort and uncertainty. However, in keeping with guidance set by the Scottish Social Service Council (2019), the participants highlighted their duty to challenge poor care practice and ensure residents are protected from harm. Combatting poor staff interactions was a priority for the participants and they reflected on their efforts to encourage and model positive staff-resident relationships. Consistent with Owen and Meyer (2012), the participants considered relationship-based care to be fundamental to the residents' quality of life.

The analysis highlighted the value of professional development where managers ensure staff are adequately trained to improve their confidence (Scerri & Scerri, 2019) and resilience. Resilience in nursing has been found to protect against CF and improve professional quality of life (Delgado et al., 2017). The participants described taking a curious, non-directive stance to empower staff and improve their resilience, a leadership style informed through their own professional development. Three participants referred to ‘My Home Life’, a programme that aims to improve quality of life in care homes and promote the implementation of relationship-centred values (Owen & Meyer, 2012). Consistent with Penney and Ryan (2018), after engaging in this programme, the participants described improvements in their confidence, leadership ability, and communication skills.

Limitations

Two participants from the same care home were interviewed, resulting in a possible overrepresentation of this context. This facility was located in a relatively remote area of Scotland and both participants were included to help represent the perspectives of managers in areas less accessible to researchers. Including the perceptions of a deputy manager also reduced the homogeneity of the sample. However, this participant’s insight was highly relevant as their role involved frequent contact with staff alongside managerial responsibilities. Homogeneity was further affected by the inclusion of both nursing and residential homes operated by different care providers. Disparities across resident complexity, resources, and providers are representative of the care home industry (Orellana et al., 2017).

Finally this study may be subject to recruitment bias as it is possible that there were differences between the managers who opted to participate and those who refused. Managers of care homes experiencing high levels of stress or CF may have been less inclined to take part in research. Although offering a unique perspective of CF, the insights of the managers included in the analysis do not fully represent the spectrum of the phenomenon in its entirety.

Clinical implications

The study illustrated what managers have found helpful or challenging when attempting to combat CF and promote CS in their staff teams. The participants' accounts illustrated the complexity and variety of the manager's role. Organisational pressures take up a lot of the manager's time; however, the participants focused more on their roles as leaders and the challenges associated with promoting a relationship-based, supportive culture. Furthermore, their descriptions of barriers to empathy and compassion suggest that managers need their own emotional space before they can provide containment to others. Managers should be adequately supported through their organisations to avail of reflective supervision with additional input offered during stressful periods. The participants discussed the value of developing their skills in self-awareness, highlighting a potential role for Clinical Psychology Services to support reflective practice for care home staff and managers (Penney & Ryan, 2018).

Continued professional development and training was a recurring theme across the participants' accounts. This study highlights the importance of allocating time and resources for managers to attend training and programmes that improve their confidence in communication, leadership, and self-reflection. Considering the participants' emphasis on staff confidence, training for wider staff should also be prioritised. For instance, 'Psychological Interventions in Response to Stress and Distress in Dementia' training offered through NHS Education for Scotland (NES) is of particular relevance for care homes due to its focus on acknowledging and coping with distress in both residents and staff members.

Future research

CF has been identified across various caregiving professions (Coetzee & Laschinger, 2018). Therefore, this research could be extended to explore the perceptions of managers in inpatient facilities or care homes catering to different care home groups.

This study focused on managers' experiences of supporting staff teams to manage CF and promote CS; however, they were only able to offer their subjective perceptions. Given the parallels between staff and resident emotional support, future research exploring care staff and resident perceptions of manager empathy could add further insight into this process.

Finally, the participants perceived relatively low levels of CF in their teams. Therefore, purposive sampling could be utilised to explore and compare the experiences of managers of care homes experiencing high levels of staff CF, enriching the literature and offering an alternative perspective.

Conclusions

This study investigated the experiences of care home managers in how they support their staff to manage CF and promote CS. The participants described the complexity of their managerial roles and the pressures staff are exposed to in the care home environment. Participants reflected on the value of validating and empathising with staff distress and focusing on staff-resident relationships. They considered their own resources for coping with stress and acknowledged the need for continued professional development on communication, leadership, and reflective practice, to increase confidence and resilience.

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Appendices

Appendix 1.1: Submission Guidelines for Journal of Applied Gerontology

1. What do we publish?

1.1 Aims & Scope

Before submitting your manuscript to *Journal of Applied Gerontology*, please ensure you have read the Aims & Scope.

1.2 Article Types

Journal of Applied Gerontology is the official journal of the Southern Gerontological Society. It features articles that focus on research applications intended to improve the health and quality of life of older persons or to enhance our understanding of age-related issues that will eventually lead to such outcomes. We construe application to include original investigations or meta-analyses/systematic reviews that have significant clinical, policy, and/or practice implications. Rigorous studies of theoretical, conceptual, or methodological issues pertaining to research application are also welcome.

Journal of Applied Gerontology is highlighting submissions in three areas that will advance the state-of-the-art in applied gerontological /geriatric research: 1) studies that employ mixed methodologies (i.e., the integration of qualitative and quantitative data); 2) efforts that translate evidence-based research to clinical practice; and 3) policy evaluations that apply evaluation principles and methods to examine the implementation and effectiveness of a government or institutional policy or program. *Journal of Applied Gerontology* has a global and diverse circulation and intended audience; contributions from international scholars and across disciplines are encouraged.

Authors who wish to have their manuscripts considered as a highlighted mixed method, translational, or policy evaluation study should indicate this in a cover letter to the Editor-in-Chief.

1.3 Submission Blinding

To facilitate blind review, manuscripts and abstracts with no identifiers must be accompanied by a separate title page document with title, author(s), and affiliation(s), including complete mailing and e-mail address(es), Conflict of Interest (COI) statement, IRB protocol/human subjects approval numbers acknowledgements and funders. See sections 2.5, 2.6 and 4.1 below for further details.

The blinded manuscript should contain no identifiers (including but not limited to author name(s) or initials, institutions, Institutional Review Board (IRB) name or institution, protocol numbers, Conflicts of Interest (COI) statements, acknowledgments, funders, HIPAA identifiers or references to author(s)' previously published work that would reveal authors' identity). These required items will be added after manuscript acceptance.

Manuscripts submitted will be reviewed initially by editorial staff for conformance to blind review and formatting requirements.

1.4 Submission Format

Manuscripts must use the Publication Manual of the American Psychological Association (APA) (7th edition) format. See section 4 below for details on preparing your manuscript.

Please note the importance of bias-free language. *Journal of Applied Gerontology* has adopted the American Psychological and American Medical Associations Manuals of Style recommendation to avoid the terms "elderly/elders" and "seniors" and instead use "older adult" or "older person." Please refer to the APA Manual's section on bias-free language and the Reframing Aging Quick Start Guide for more information.

Manuscripts accepted for publication are subject to stylistic editing with the edited draft sent to the corresponding author for final review.

1.5 Writing your paper

The SAGE Author Gateway has some general advice and on how to get published, plus links to further resources.

1.5.1 Make your article discoverable

When writing your paper, think about how you can make it discoverable. The title, keywords and abstract are key to ensuring readers find your article through search engines such as Google. For information and guidance on how best to title your article, write your abstract and select keywords, see this page on the Gateway: How to Help Readers Find Your Article Online.

2. Editorial policies

2.1 Peer review policy

Journal of Applied Gerontology adheres to a rigorous double-blind reviewing policy in which the identity of both the reviewer and author are always concealed from both parties. Decisions on manuscripts will be made as rapidly as possible. Authors should expect to have reviewer's comments within approximately 6 weeks. In general, Editors will seek advice from two or more expert reviewers about the scientific content and presentation of submitted articles.

Journal of Applied Gerontology is committed to delivering high quality, fast peer-review for your paper, and as such has partnered with Publons. Publons is a third party service that seeks to track, verify and give credit for peer review. Reviewers can opt in to Publons in order to claim their reviews or have them automatically verified and added to their reviewer profile. Reviewers claiming credit for their review will be associated with the relevant journal, but the article name, reviewer's decision and the content of their review is not published on the site. For more information visit the Publons website.

The Editor or members of the Editorial Board may occasionally submit their own manuscripts for possible publication in the journal. In these cases, the peer review process will be managed by alternative members of the Board and the submitting Editor/Board member will have no involvement in the decision-making process.

2.2 Authorship

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(ii) Drafted the article or revised it critically for important intellectual content,
(iii) Approved the version to be published,
(iv) Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

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Appendix 1.2: Example of Full Search Strategy in CINAHL

CINAHL(Cumulative Index to Nursing & Allied Health) (EBSCOhost)

#	Query	Limiters/Expanders	Last Run Via	Results
S33	S18 AND S30	Limiters - Published Date: 20130101-20200431; Language: English Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	640
S32	S18 AND S30	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	1,531
S31	S18 AND S30	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	1,531
S30	S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	1,050,299
S29	TX supervision OR TX emotion-orientiated OR TX ‘’validation therap*’’ OR TX ‘’reminiscence therap*’’ OR TX ‘’stimulation therap*’’	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen -	31,744

			Advanced Search Database - CINAHL	
S28	TX ‘’person cent*’’ OR TX ‘’patient cent*’’ OR TX "client cent*"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	106,733
S27	TX communication intervention*	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	3,932
S26	TX resilienc* OR TX "acceptance-based intervention*" OR TX "peer support" OR TX "support* peer"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	24,367
S25	TX "mindfulnes*"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	8,806
S24	TX relaxation	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	19,842

			Database - CINAHL	
S23	TX "cognitive behav* therap*" OR TX "cbt"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	13,301
S22	TX dementia OR TX "dementia training" OR TX "dementia care mapping"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	74,793
S21	(MH "Occupational Health+")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	65,661
S20	TX ‘’e-learning’’ OR TX Training OR TX ‘’staff training’’ OR TX ‘’staff education’’ OR TX ‘’educat* staff’’	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	303,131
S19	TX intervention* OR TX workplace intervention* OR TX ‘’organi* intervention*’’ OR TX ‘’web-based intervention*’’	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	546,444

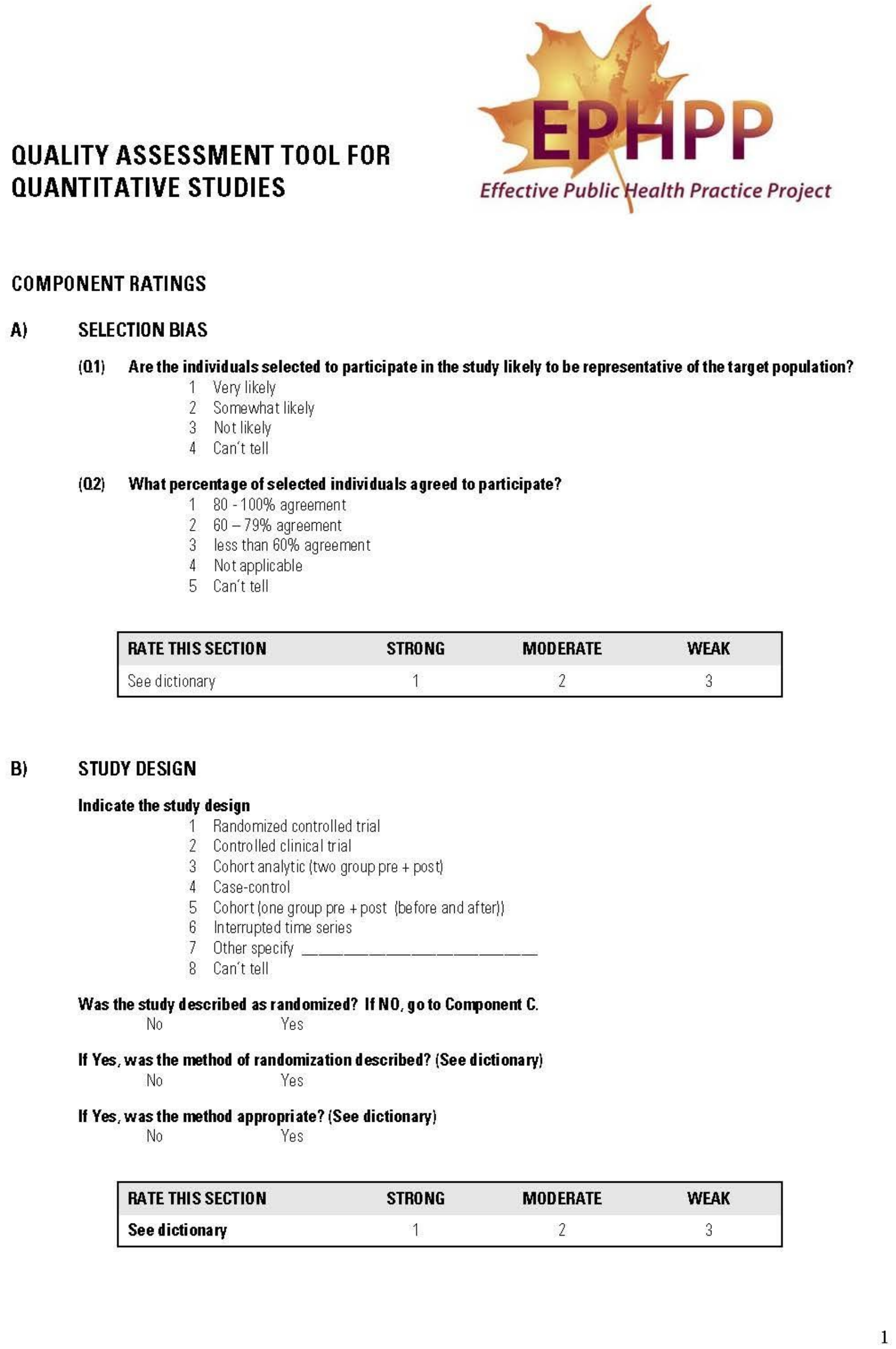
S18	S8 AND S17	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	1,733
S17	S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	205,492
S16	TX "geriatric car*" OR TX ‘’geriatric acute care’’ OR TX ‘’geriatric nurs*’’ OR TX "acute geriatric*" OR TX "gerontologic* nurs*"	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	34,561
S15	(MH "Gerontologic Nursing+")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	14,235
S14	TX ‘’rehabilitation facilit*’’	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	3,805
S13	TX assisted living facilit* OR TX ‘’residential care’’ OR TX	Expanders - Apply equivalent subjects	Interface - EBSCOhost	71,895

	‘’residential home*’’ OR TX ‘’long-term care’’ OR TX ‘’long term care’’	Search modes - Boolean/Phrase	Research Databases Search Screen - Advanced Search Database - CINAHL	
S12	TX ‘’residential facilit*’’ OR TX ‘’care home*’’ OR TX care-home*	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	82,216
S11	TX ‘’homes for the aged’’	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	4,621
S10	TX nurs* home*	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	75,808
S9	(MH "Nursing Homes+")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	29,169
S8	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases	33,300

			Search Screen - Advanced Search Database - CINAHL	
S7	TX ‘’Maslach Burnout Inventory’’ OR TX ‘’Oldenberg Burnout Inventory’’ OR TX ‘’Copenhagen Burnout Inventory’’	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	3,143
S6	TX ‘’occupational stress*’’	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	19,255
S5	TX ‘’professional burnout’’	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	11,691
S4	TX ‘’emotional exhaustion’’	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	2,242
S3	TX Depersonali#ation	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced	1,751

			Search Database - CINAHL	
S2	TX (burnout or burn-out)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	15,922
S1	(MH "Burnout, Professional+")	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	11,709

Appendix 1.3: Quality Appraisal Tool-EPHPP



QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

EPHPP
Effective Public Health Practice Project

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?

1 Very likely
2 Somewhat likely
3 Not likely
4 Can't tell

(Q2) What percentage of selected individuals agreed to participate?

1 80 - 100% agreement
2 60 – 79% agreement
3 less than 60% agreement
4 Not applicable
5 Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

B) STUDY DESIGN

Indicate the study design

1 Randomized controlled trial
2 Controlled clinical trial
3 Cohort analytic (two group pre + post)
4 Case-control
5 Cohort (one group pre + post (before and after))
6 Interrupted time series
7 Other specify ________________________
8 Can't tell

Was the study described as randomized? If NO, go to Component C.
No Yes

If Yes, was the method of randomization described? (See dictionary)
No Yes

If Yes, was the method appropriate? (See dictionary)
No Yes

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

1

C) CONFOUNDERS

(Q1) Were there important differences between groups prior to the intervention?

1 Yes
2 No
3 Can't tell

The following are examples of confounders:

1 Race
2 Sex
3 Marital status/family
4 Age
5 SES (income or class)
6 Education
7 Health status
8 Pre-intervention score on outcome measure

(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?

1 80 – 100% (most)
2 60 – 79% (some)
3 Less than 60% (few or none)
4 Can't Tell

RATE THIS SECTION	**STRONG**	**MODERATE**	**WEAK**
See dictionary	1	2	3

D) BLINDING

(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?

1 Yes
2 No
3 Can't tell

(Q2) Were the study participants aware of the research question?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	**STRONG**	**MODERATE**	**WEAK**
See dictionary	1	2	3

E) DATA COLLECTION METHODS

(Q1) Were data collection tools shown to be valid?

1 Yes
2 No
3 Can't tell

(Q2) Were data collection tools shown to be reliable?

1 Yes
2 No
3 Can't tell

RATE THIS SECTION	**STRONG**	**MODERATE**	**WEAK**
See dictionary	1	2	3

F) WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

1 Yes
2 No
3 Can't tell
4 Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell
5 Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	**STRONG**	**MODERATE**	**WEAK**	
See dictionary	1	2	3	Not Applicable

G) INTERVENTION INTEGRITY

(Q1) What percentage of participants received the allocated intervention or exposure of interest?

1 80 -100%
2 60 - 79%
3 less than 60%
4 Can't tell

(Q2) Was the consistency of the intervention measured?

1 Yes
2 No
3 Can't tell

(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?

4 Yes
5 No
6 Can't tell

H) ANALYSES

(Q1) Indicate the unit of allocation (circle one)

community organization/institution practice/office individual

(Q2) Indicate the unit of analysis (circle one)

community organization/institution practice/office individual

(Q3) Are the statistical methods appropriate for the study design?

1 Yes
2 No
3 Can't tell

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

1 Yes
2 No
3 Can't tell

GLOBAL RATING

COMPONENT RATINGS

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	**SELECTION BIAS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
B	**STUDY DESIGN**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
C	**CONFOUNDERS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
D	**BLINDING**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
E	**DATA COLLECTION METHOD**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	
F	**WITHDRAWALS AND DROPOUTS**	**STRONG**	**MODERATE**	**WEAK**	
		1	2	3	Not Applicable

<u>GLOBAL RATING FOR THIS PAPER (circle one):</u>

1	STRONG	(no WEAK ratings)
2	MODERATE	(one WEAK rating)
3	WEAK	(two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No Yes

If yes, indicate the reason for the discrepancy

1 Oversight
2 Differences in interpretation of criteria
3 Differences in interpretation of study

<u>Final decision of both reviewers (circle one):</u>

1 STRONG
2 MODERATE
3 WEAK

Appendix 1.4: Data Extraction Tool

Data Extraction Tool

Title:

Authors:

Year:

Country:

Study aims:

Study design:

Setting:

Inclusion/exclusion:

Staff characteristics:

- Job role:
- Mean Age:
- Gender:

Burnout measure:

Recruitment:

Intervention:

Statistical analysis:

Results:

Effect size:

Conclusion:

Strengths:

Weaknesses:

Quality rating:

Appendix 1.5: Quality Appraisal Table

Authors	**Global Rating**	Selection Bias	Study Design	Confounders	Blinding	Data Collection Methods	Withdrawal and Dropouts
Barbosa et al. (2015)	**Moderate**	Moderate	Strong	Weak	Moderate	Strong	Strong
Barbosa et al. (2016)	**Moderate**	Moderate	Strong	Strong	Weak	Strong	Strong
Berendonk et al. (2019)	**Strong**	Moderate	Strong	Strong	Moderate	Strong	Strong
Briones-Peralta et al. (2020)	**Moderate**	Moderate	Moderate	Weak	Moderate	Strong	Strong
Clare et al. (2013)	**Strong**	Moderate	Strong	Strong	Moderate	Strong	Strong
Dichter et al. (2017)	**Weak**	Weak	Strong	Strong	Weak	Strong	Weak
Dreher et al. (2019)	**Weak**	Weak	Moderate	Weak	Moderate	Strong	Moderate
Ericson-Lidman & Åhlin (2017)	**Weak**	Moderate	Moderate	Weak	Moderate	Strong	Weak
Frey et al. (2017)	**Weak**	Moderate	Moderate	Weak	Moderate	Strong	Weak
Halek et al. (2020)	**Weak**	Weak	Strong	Strong	Moderate	Strong	Weak
Livingston et al. (2019)	**Strong**	Moderate	Strong	Strong	Moderate	Strong	Strong
Zwijsen et al. (2015)	**Weak**	Moderate	Strong	Strong	Weak	Strong	Weak

Appendix 2.1: Submission Guidelines for Clinical Gerontologist

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- Original brief reports
- Conceptual Reviews
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- New and Emerging Professionals

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Original research reports

- Should be written with the following elements in the following order: title page; abstract; keywords; introduction, methods, results, discussion; and clinical implications (2-3 short bulleted points); acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list)
- Should be no more than 5000 words (not counting abstract, tables, figures and references).
- Includes randomized intervention studies, cohort observational studies, survey research, and studies of assessment or diagnostic tests. If describing scale development, please include a useable version of the scale as an appendix when possible. If not, please indicate where the scale can be obtained.

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- Should be no more than 2000 words (not counting abstract, tables, figures and references).

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- May include systematic reviews of the literature, meta-analyses, and/or manuscripts presenting new or revised theoretical models. All reviews should provide systematic, critical assessments of literature that yield conclusions of direct clinical importance to the behavioral health care of older adults.

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- Should be no more than 2500 words (not counting abstract, tables, figures and references).
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At the point of submission, you will be asked if there is a data set associated with the paper. If you reply yes, you will be asked to provide the DOI, pre-registered DOI, hyperlink, or other persistent identifier associated with the data set(s). If you have selected to provide a pre-registered DOI, please be prepared to share the reviewer URL associated with your data deposit, upon request by reviewers.

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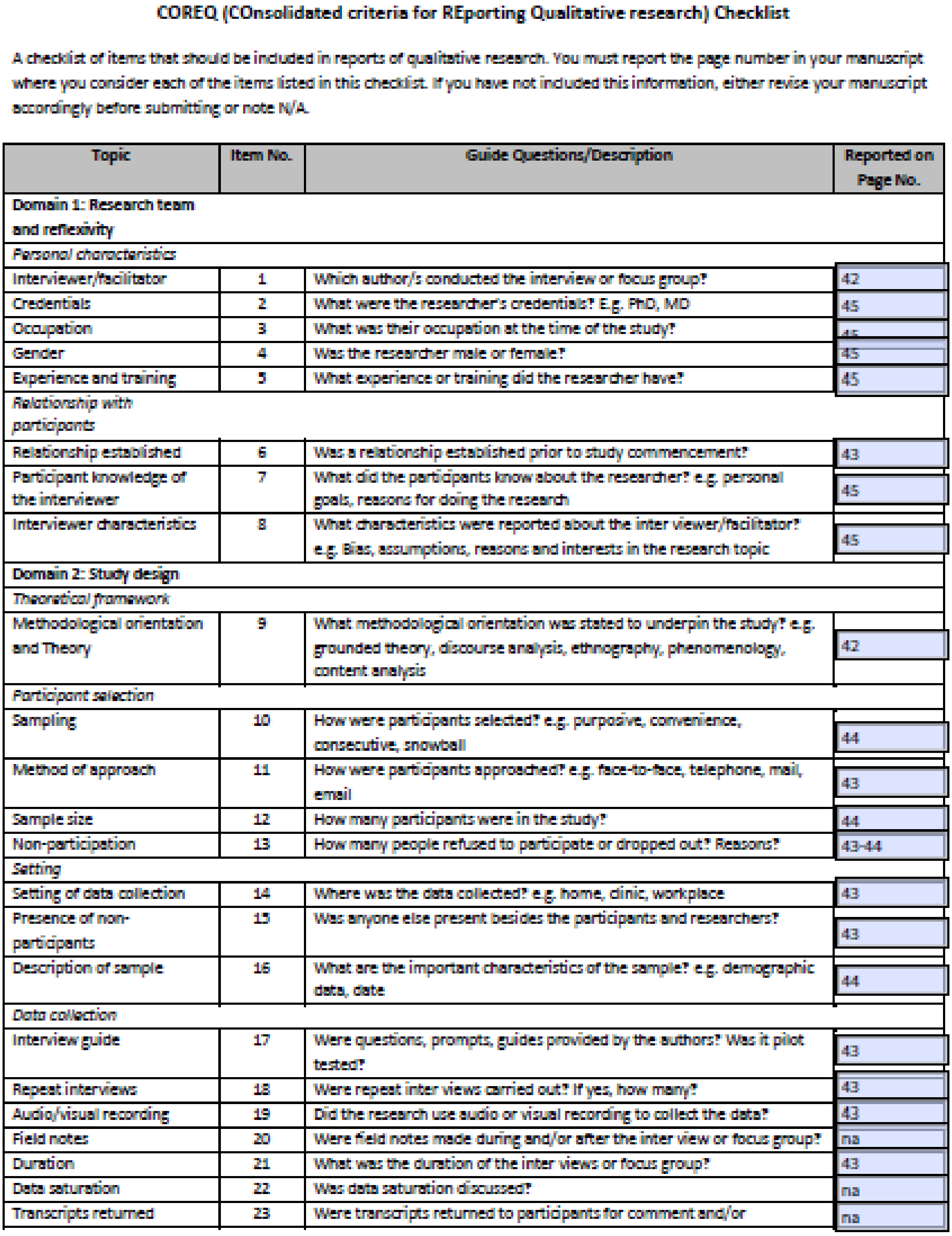
Updated 13-02-2019

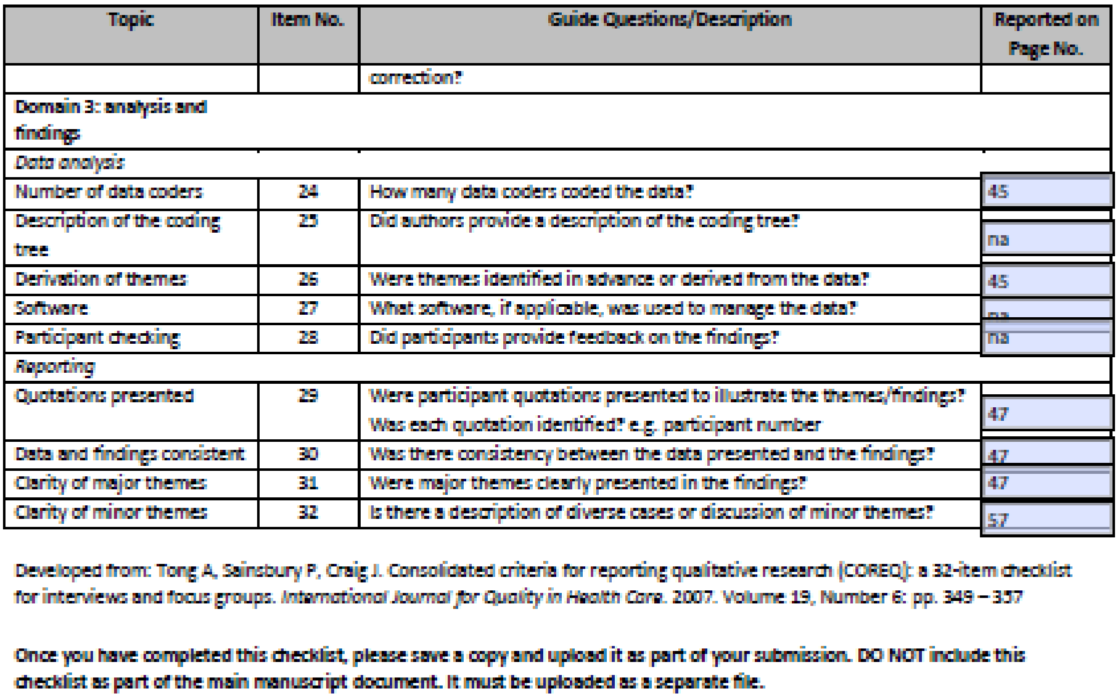
Appendix 2.2: CORE-Q



COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	42
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	45
Occupation	3	What was their occupation at the time of the study?	45
Gender	4	Was the researcher male or female?	45
Experience and training	5	What experience or training did the researcher have?	45
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	43
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	45
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	45
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	42
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	44
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	43
Sample size	12	How many participants were in the study?	44
Non-participation	13	How many people refused to participate or dropped out? Reasons?	43-44
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	43
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	43
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	44
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	43
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	43
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	43
Field notes	20	Were field notes made during and/or after the inter view or focus group?	na
Duration	21	What was the duration of the inter views or focus group?	43
Data saturation	22	Was data saturation discussed?	na
Transcripts returned	23	Were transcripts returned to participants for comment and/or	na

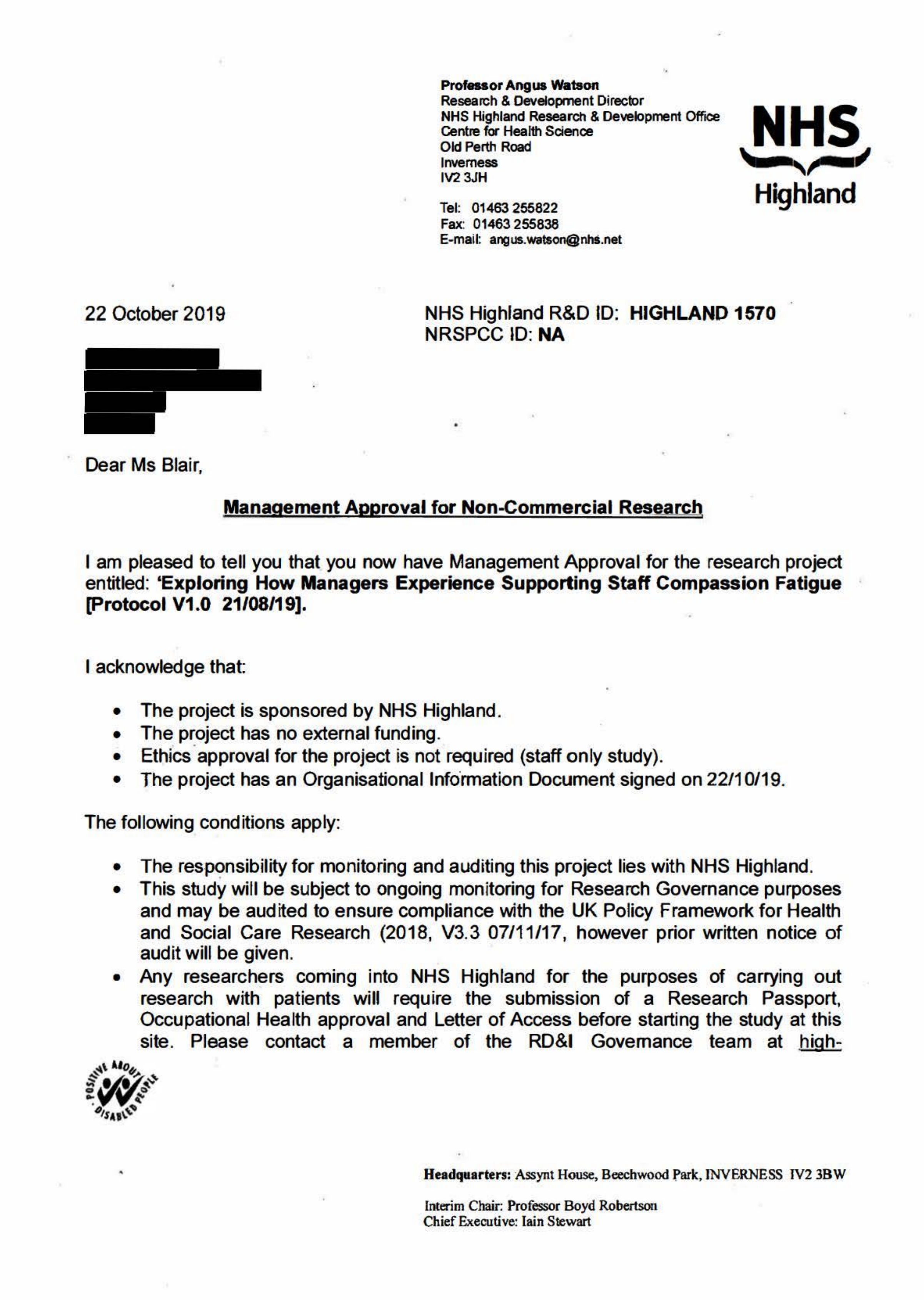


Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	45
Description of the coding tree	25	Did authors provide a description of the coding tree?	na
Derivation of themes	26	Were themes identified in advance or derived from the data?	45
Software	27	What software, if applicable, was used to manage the data?	na
Participant checking	28	Did participants provide feedback on the findings?	na
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	47
Data and findings consistent	30	Was there consistency between the data presented and the findings?	47
Clarity of major themes	31	Were major themes clearly presented in the findings?	47
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	57

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Appendix 2.3: Research Ethics Approval



Professor Angus Watson
Research & Development Director
NHS Highland Research & Development Office
Centre for Health Science
Old Perth Road
Inverness
IV2 3JH

Tel: 01463 255822
Fax: 01463 255838
E-mail: angus.watson@nhs.net

22 October 2019

NHS Highland R&D ID: **HIGHLAND 1570**
NRSPCC ID: **NA**

[redacted]

Dear Ms Blair,

Management Approval for Non-Commercial Research

I am pleased to tell you that you now have Management Approval for the research project entitled: **'Exploring How Managers Experience Supporting Staff Compassion Fatigue [Protocol V1.0 21/08/19].**

I acknowledge that:

- The project is sponsored by NHS Highland.
- The project has no external funding.
- Ethics approval for the project is not required (staff only study).
- The project has an Organisational Information Document signed on 22/10/19.

The following conditions apply:

- The responsibility for monitoring and auditing this project lies with NHS Highland.
- This study will be subject to ongoing monitoring for Research Governance purposes and may be audited to ensure compliance with the UK Policy Framework for Health and Social Care Research (2018, V3.3 07/11/17, however prior written notice of audit will be given.
- Any researchers coming into NHS Highland for the purposes of carrying out research with patients will require the submission of a Research Passport, Occupational Health approval and Letter of Access before starting the study at this site. Please contact a member of the RD&I Governance team at high-

uhb.nhshighlandresearchpassports@nhs.net for further assistance, if this is required.

- The paperwork concerning all incidents, adverse events and serious adverse events, thought to be attributable to participant's involvement in this project should be notified to the NHS Highland R&D Governance team. Please email documents to RD&I Facilitator at High-UHB.RandD@nhs.net.
- You are reminded that all amendments (minor or substantial) to the protocol and associated study documents should be copied to the NHS Highland Research and Development Office to obtain a R&D amendment approval letter. Guidance can be found at https://www.nhsresearchscotland.org.uk/services/permissions-co-ordinating-centre/permissions
- If applicable, monthly recruitment rates should be notified to the NHS Highland Research and Development Office, detailing date of recruitment and the participant trial ID number. This should be done by e-mail on the first week of the following month, to Debbie McDonald, Data Manager (debbie.mcdonald@nhs.net). Please quote your RD&I Highland reference number (Highland 1570).
- Please report any other changes in resources used, or staff involved in the project, to the NHS Highland Research and Development Manager, Frances Hines (01463 255822, frances.hines@nhs.net).

Please quote your RD&I Highland reference number (Highland 1570) on all correspondence.

Yours sincerely,

Frances Hines

Frances Hines
R&D Manager

cc PI j.blair.1@research.gla.ac.uk

Appendix 2.4: Participant Information Sheet

University of Glasgow | College of Medical, Veterinary & Life Sciences

NHS Highland

PARTICIPANT INFORMATION SHEET

1. Introduction

My name is Joanna Blair. I am a Trainee Clinical Psychologist studying at the University of Glasgow. You are being invited to take part in my final year research project which I will submit as part of my Doctorate in Clinical Psychology. The project is being supervised by Dr Naomi White, University Lecturer, University of Glasgow, and Dr Jane Billet, Clinical Psychologist, NHS Highland.

2. Study title

An exploration of the experiences of the Nurse Managers' role in managing compassion fatigue and promoting compassion satisfaction in older adult staff teams.

3. Invitation paragraph

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. If you decide to take part in this study, you will be given a copy of this Participant Information Sheet and the signed consent form to keep.

4. What is the purpose of the study?

This study aims to understand staff stress and wellbeing at work from the perspective of Nurse Managers in community settings for older adults. Research has sought to understand the impact of clinical work on staff in terms of ‘Compassion Fatigue’ and ‘Compassion Satisfaction’. Compassion fatigue has been described as emotional, mental, and physical exhaustion. People who experience compassion fatigue may feel tired, sad, and have feelings of hopelessness. Conversely compassion satisfaction refers to the positive feelings that occur as a result of helping others. In this study we are interested in the experiences of Nurse Managers supporting their staff working in nursing or residential care homes for older adults. In particular we are interested in exploring what helps reduce the risk of compassion fatigue and promotes compassion satisfaction.

5. Why have I been asked to participate?

You have been given this information sheet as you are currently listed as the registered Manager of a nursing care or residential care home for older adults.

6. Do I have to take part?

No. It is entirely up to you to decide whether or not to take part. We will be available to contact if you have any questions about participation before making your decision.

If you choose to take part you will be asked to sign a consent form and will be given a copy to keep. If you choose to take part and then decide to withdraw you can do so at any time without having to provide a reason. Furthermore, you can request that any information you provided prior to withdrawing be removed from the study.

7. **What will happen to me if I choose to take part?**
   If you choose to take part in the study, the researcher, Joanna Blair, will arrange to meet with you either at your place of work or a local NHS Highland community hospital at a time that is convenient. Once we meet, you will be asked to sign a consent form to confirm that you understand what is involved and agreed to proceed with the study. You will be asked to complete an interview which will last for approximately one hour. I will record the interview using a digital voice recorder.

   You can stop the interview at any time if you want to take a break or withdraw from the study. Once we have completed the interview, I will give you a debriefing form with a brief explanation of the study and my contact details.

8. **What are the potential disadvantages or risks to taking part in the study?**
   We do not anticipant any risk to you as a result of taking part in the interview; however, we acknowledge that we will be asking you to give up your time for approximately one hour. If at any point the interview becomes too emotive for you, you will have the option to take a break or discontinue the interview.

9. **What are the possible benefits of taking part?**
   There will be no direct benefits to you. We are interested in improving our understanding of Managers' experiences. These findings may be useful in the development of future services and suggestions for further research.

10. **Will my taking part in this study be kept confidential?**
    All information collected about you will be kept confidential. The researcher Joanna Blair will have access to this information. The study sponsor NHS Highland may also choose to audit the study and have access to your information. Any information about your name or place or work will be removed from the interview transcription and then replaced by a unique ID number. We may use anonymised, direct quotations from your interview in the final report; however, you, your place of work, or colleagues will not be identifiable from this information.

11. **What will happen to my data?**
    The interview will be recorded onto an encrypted digital recorder. I will transcribe this data verbatim. Any names, locations, or identifiable information will be removed from the transcript. The digital recording will be deleted once the study has ended. All information will be stored in a locked cabinet or password protected electronic files. The study will be written into a report and then submitted to the University of Glasgow as part of my thesis. The report will be uploaded to the University of Glasgow's research database 'Enlighten'. The report may be presented at research conferences and may also be submitted for publication to a scientific journal. All data will be stored in accordance with GDPR and local policies and kept securely for a period of ten years before being destroyed confidentially in line with the end of study protocol.

12. Who is organising and funding the study?

The study is being sponsored by NHS Highland Research and Development.

13. Who has reviewed the study?

The study has been reviewed by NHS Highland Research and Development and the University of Glasgow.

14. Contact for further information

If you have any further questions please contact Joanna Blair, Trainee Clinical Psychologist

Email: j.blair.1@research.gla.ac.uk
Tele: 01463 704686

If you would like to speak to an independent contact about the study please contact Dr Tom McMillan, Research Director at University of Glasgow.

Email: thomas.mcmillan@glasgow.ac.uk
Tele: 01412 110354

15. What if there is a problem with the study?

If you are unhappy with the study or have any concerns please let me know in the first instance and I will try to resolve the issue. If you are unsatisfied with this response you can make a formal complaint to NHS Highland feedback team.

Email: nhshighland.feedback@nhs.net
Tele: 01463 705997

16. If you would like to take part

If you decide to take part please contact me on 01463 704686 or via email j.blair.1@research.gla.ac.uk.

17. If you decide that you do not wish to take part

You do not have to do anything further.

I would like to thank you for taking the time to read this information sheet.

Appendix 2.5: Consent Form

University of Glasgow | College of Medical, Veterinary & Life Sciences

NHS Highland

Project Number: Highland 1570

Participant Identification Number for this trial:

Title of Project: An exploration of the experiences of the Nurse Managers' role in managing compassion fatigue and promoting compassion satisfaction in older adult staff teams.

Name of Researcher(s): Joanna Blair, Dr Naomi White, Dr Jane Billet

CONSENT FORM	Please initial box
I confirm that I have read and understood the Participant Information Sheet version 1 dated 21.08.2019.	☐
I have had the opportunity to think about the information and ask questions, and understand the answers I have been given.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	☐
I confirm that I agree to the way my data will be collected and processed and that data will be stored for up to 10 years in University archiving facilities in accordance with relevant Data Protection policies and regulations.	☐
I understand that all data and information I provide will be kept confidential and will be seen only by study researchers and regulators whose job it is to check the work of researchers.	☐
I agree that my name, contact details and data described in the information sheet will be kept for the purposes of this research project.	☐
I understand that if I withdraw from the study, my data collected up to that point will be retained and used for the remainder of the study.	☐
I agree to take part in the study.	☐

I agree to my interview being audio-recorded. ☐

I understand that the recorded interview will be transcribed word by word and the transcription stored for up to 10 years in University archiving facilities in accordance with Data Protection policies and regulations. ☐

I understand that my information and things that I say in an interview may be quoted in reports and articles that are published about the study, but my name or anything else that could tell people who I am will not be revealed. ☐

I agree for the data I provide to be anonymously archived in the UK data archive or other approved archiving facilities, and that other researchers can have access to this data only if they have scientific and ethical approval, and agree to preserve the confidentiality of this information as set out in this form. ☐

I agree that should significant concerns regarding my mental or physical health arise during my participation in the study that a member of an appropriate clinical team will be immediately informed. ☐

I understand that any criminal acts which come to light as a result of my participation in this study may have to be reported appropriately to the relevant authorities by the research team. ☐

______________________________	____________	________________________
Name of participant	Date	Signature
______________________________	____________	________________________
Name of Person taking consent (if different from researcher)	Date	Signature
______________________________	____________	________________________
Researcher	Date	Signature

(1 copy for participant; 1 copy for researcher)

Appendix 2.6: Interview Schedule

University of Glasgow | College of Medical, Veterinary & Life Sciences

NHS Highland

Interview Schedule

The goals for the interviews are to:

- Explore the experiences of Nurse Managers in how they recognise and manage compassion fatigue in staff teams
- Identify barriers and facilitators to promoting compassion satisfaction in staff teams

Below is a general outline for the interviews. There may be some minor amendments to the schedule throughout the process; however, the general outline will adhered to. The first part of the interview will focus on the experiences of Nurse Managers supporting staff with compassion fatigue. The second part of the interview will explore the experiences of Nurse Managers promoting compassion satisfaction among staff teams. The interviewer will use open ended and probing questions to collect information on the experiences and interpretations of the participant.

Interview preparation

Remind participant that participation is voluntary
Remind participant of confidentiality and its limitations
Remind participant that they can stop the interview at any time

Introduction

Thank you for agreeing to talk to me. My name is Joanna Blair. I am interested in compassion fatigue and how it impacts on the staff working in care and residential homes. I am specifically interested in how managers experience supporting and managing staff who may have compassion fatigue, and their experience of promoting compassion satisfaction. Compassion fatigue has been described as emotional, mental, and physical exhaustion. People who experience compassion fatigue may feel tired, sad, and have feelings of hopelessness. Conversely compassion satisfaction refers to the positive feelings that occur as a result of helping others.

Compassion Fatigue

- How have you recognised when a staff member is experiencing stress to the extent that it may be impacting on their wellbeing?
- In your experience what is the impact of staff stress?

(Possible prompts: On the staff member, on the service, on the residents or patients, on you as a manager?)

- What are your experiences of encountering and managing stress or compassion fatigue within your staff team?

(Possible prompts: What was difficult about this? What made it easier to address?)

- When acknowledging or trying to address staff stress or compassion fatigue, how did the staff members respond?

(Possible prompts: What went well? What was difficult?

Compassion Satisfaction

- How have you identified when staff members are experiencing a feeling of reward from their work?
- In your role as a nurse can you tell me about a time when you experienced feelings of positivity or reward from your role?
  (Possible prompts: What contributed to this feeling? Did anything ever get in the way of feeling a sense or reward or positivity about your role?)
- What aspects from your own experiences do you consider when promoting compassion satisfaction in the staff team you manage?
- What are the difficult aspects of promoting compassion satisfaction in the staff team you manage?
- How have your own experiences impacted on what you prioritise about patient care as a manager?

Appendix 2.7: Debriefing Form

University of Glasgow | College of Medical, Veterinary & Life Sciences

NHS Highland

Study title: An exploration of the experiences of the Nurse Managers' role in managing compassion fatigue and promoting compassion satisfaction in older adult staff teams.

Thank you for participating as a research participant in the study exploring your experiences of supporting staff teams. The study was interested in Compassion Fatigue and Compassion Satisfaction and how Nurse Managers support their staff teams.

If you have any questions regarding the study please contact a member of the research team:

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Tele: 01412 110354

Upon completion of the study a report will be compiled and submitted as part of the Primary Researcher's thesis to the University of Glasgow. The report will be available to access through the University of Glasgow's online research database Enlighten.

Thank you again for your participation.

Appendix 2.8: Example of Transcript and Analysis

Emergent themes	Transcript	Exploratory comments
Cumulative stress Loss of connection Need to give best	P: so if you’ve got someone showing a lot of stress and distress, if you then have somebody who has a fall, you know, if something like that happens and it’s one of those days where you just feel that .. you’re not getting anything done, you’re not getting anything finished, you’re not getting any time to sit and spend **with** the clients emm then you just kinda feel … that it’s not … you’ve not given your best and that’s, that’s where we need to try and .. step in through the day to see if they need support with anything to try and avoid that feeling when they go home.	High distress, reduces capacity for reflection Sense of failure, beating up self, feeling that you’re letting down the clients, no opportunity to engage Not giving best, indicated less than best isn’t good enough, struggle with good enough?
	I: mmm hmm	
Not being overwhelmed	P: you know, you want people to leave work thinking ‘exhales, you know today was a hard day but it’s fine’	Struggle with staff feeling they let people down Try to acknowledge the day but not let it overwhelm staff
	I: mmm hmm, mmm hmm	
	P: you know? So…	
	I: then link in with that person and…	
	P: yeah, yep	
	I: …give them that space? Ok … emm what aspects from your own experiences do you consider when promoting compassion satisfaction in the team that you manage?	
Keep in mind own experience of positivity	P: emm … I think it’s about .. reflecting myself on… the feeling you get when someone praises you, or compliments you, or says something nice, or you’ve done something really good… and even from, before this job,	

Reflect on own feelings Noting individual preferences Stress makes it harder to be positive Coping skills Find own way to cope Delegate/Prioritise Recognise need for self-compassion	when you used to work in your, your boss said ‘thank you’ to you before they left at the end of the day you know, yo-, you think ‘oh they do know who I am, they do know I work here, you know, and remember my name’ (laughs) you know, want other people to feel that they might not, they might be the kind of person that saying something like that to them doesn’t put them up nor down but then it makes you feel better you’ve said it I: mmm hmm P: (laughs) I: and you mentioned before when, when days are really stressful and you’re really stressed and there’s lots of things going on, how do you kinda tap into that reflection on, on days like that? P: it can be more difficult, yes emm but then you try and just… what I’ve said to the staff is ‘picture a big red button, and it’s a big pause button, and just press it and just take five minutes and just take deep breaths and just calm yourself…’ and I’m, I’m .. I’m the kind of person that I write lists, and I like to be organised and ok if something happens I can change it but I like to know… so it’s just a case then of re-looking at, right what needs done? What can I give to somebody else or put somewhere else or leave ‘till tomorrow emm and it’s just working through that and just, but pausing ... to recognise that, right ok ‘I’m feeling a bit stressed just now I need to get rid of this feeling so what can I do?’	Giving a sense that she considers her past experiences, what she valued as a carer, how can she give this feeling to the staff? Felt valued by her boss, wants to give this message to her staff, ‘remember my name’ sense that they are valued Wants to let others feel this, have that experience Individual differences Considers the impact on herself, feels it is the right things to do, why does it make her feel better? Because it is her role to make the effort? Laughs, sense of a small achievement? Noting that stress impacts of emotional reflection Visualises a stop, noticing when she becomes hooked or overwhelmed, noting need to recognise own stress and find a way to cope Organisation, finds this soothing, proactive, organised individual Reflecting on need to delegate Sense of reflecting on her own needs, again that ability to pay attention to own stress, sense she gives this message to staff get rid of feeling, hard to tolerate, put in a coping strategy

Appendix 2.9: Major Research Project Proposal

Name of Assessment: Major Research Project Proposal

Title: An exploration of the experiences of the Nurse Managers' role in managing compassion fatigue and promoting compassion satisfaction in older adult staff teams

Matriculation Number: 2356264b

Date of Submission: 21.08.19

Version Number: 1

Actual Word Count: 3378

Maximum Word Count: 3000

An exploration of the experiences of the Nurse Managers' role in managing compassion fatigue and promoting compassion satisfaction in older adult staff teams

Abstract

Background

Compassion Fatigue is phenomenon that impacts those in the helping profession and is associated with poorer patient outcomes. Research has identified factors associated with the development of compassion fatigue and promotion of compassion satisfaction in nursing and highlights the role of Nursing Managers. However, there is limited research on how this group support their staff teams.

Aims

To explore the experiences of care home Nurse Managers in how they mitigate compassion fatigue and promote compassion satisfaction in staff teams.

Methods

Semi-structured interviews with be conducted with between four to ten nursing home Managers to explore the experiences of this group in their role supporting staff teams. The data will be analysed using Interpretive Phenomenological Analysis.

Applications

This research may help develop an understanding of how Nurse Managers support their staff teams, and what interventions may be helpful in mitigating against compassion fatigue and promoting compassion satisfaction.

Introduction

Life expectancy and the number of people living with chronic health conditions are increasing, placing additional pressures on health and care systems (Office of National Statistics, 2015; Government Office for Science, 2016). Although the benefits of supporting older people in their own homes has been acknowledged (The Scottish Government, 2011), there is an increased demand for care home placements for older people with high dependency needs (Kingston et al., 2017). However, in the Scottish care home sector there is a recruitment crisis with care home nurse vacancy levels reaching 31% (Scottish Care, 2018).

Care homes can be stressful and demanding environments (Islam et al., 2017). Retaining staff in environments that support individuals with complex care needs can be challenging and is a priority for Nurse Managers (Hodgkinson et al., 2011). High turnover among health care professionals can impact on the quality of patient care and reduce staff morale (Roche et al., 2015). Staff absenteeism results in high patient-to-carer ratios and reduced job motivation (Baydoun, Dumit, & Daouk-Oyry, 2016). Factors associated with high staff turnover include perceptions of management (Gormley, 2011), workload stress, job dissatisfaction, and burnout (Halter et al., 2017; Koy et al., 2011).

Burnout is an emotional state defined by reduced personal accomplishment, depersonalisation, and emotional exhaustion (Maslach & Jackson, 1986). It has been associated with reduced patient satisfaction and work efficiency, and increased risk to patients (Fennessey, 2016; Marcum, Rusnak, & Koch, 2018). Compassion fatigue is a related construct associated with staff turnover (Sung, Seo, & Kim, 2012), reduced judgement, reduced empathy, and increased work days lost (Jenkins & Warren, 2012). Compassion fatigue has interchangeably been described by some authors as secondary traumatic stress and vicarious traumatisation (Kapoulitsas & Corcoran, 2015). It is related to burnout (Slatten, Carson & Carson, 2011) and occurs when carers experience disengagement and reduced ability to empathise and adequately care for their patients (Coetzee & Laschinger, 2018). Symptoms of compassion fatigue have been found to be physical, behavioural, psychological, and spiritual (Sinclair et al., 2017). Conversely, compassion satisfaction occurs when carers experience positive feelings when helping others through difficult or traumatic experiences (Sacco et al., 2015).

Factors that impact on the development of compassion fatigue include staff shortages, high workloads, blurred work life boundaries, feeling deskilled (Nolte et al., 2017), and organisational factors (Sinclair at el, 2017). Factors that protect against compassion fatigue and promote compassion satisfaction include self-care (Alkema, Linton & Davies, 2008) and setting professional boundaries (Melvin, 2012).

Coetzee and Laschinger (2018) identified a number of models developed to understand compassion fatigue. The compassion stress and fatigue model (Figley, 1995; 2002) asserts that carer empathy is central to understanding compassion fatigue. It theorised that empathic concern and the need to respond to distress can lead to compassion stress. Prolonged exposure, traumatic memories, and further life disruptions can result in the carer developing compassion fatigue (Coetzee & Laschinger, 2018). However, this model was criticised for identifying empathy as the main antecedent in the development of compassion fatigue, when subsequent research linked empathy with positive patient outcomes (Coetzee & Laschinger, 2018).

Stamm's (2010) model suggests that the carers' experiences are impacted by their clients and their personal and professional environments. These experiences contribute to either a positive or negative outcome of caring for others i.e. the development of either compassion satisfaction or compassion fatigue. This model theorises compassion fatigue as a term to describe combined burnout and secondary traumatic stress which could potentially blur the boundaries of the concept of compassion fatigue (Coetzee & Laschinger, 2018).

Coetzee and Laschinger (2018) assert that risk factors for developing compassion fatigue include a lack of resources, the carers' personal response to distress, and receiving inadequate positive feedback from themselves, client outcomes, and Managers and colleagues. The authors reported that compassion satisfaction was influenced by the Manager's ability to lead, support staff, and involve them in decision making (Coetzee & Laschinger, 2018) and recommend offering Nurse Managers adequate resources and training to support their staff teams.

Studies have addressed the importance of Manager support in managing compassion fatigue and promoting staff well-being (Hunsaker et al., 2015; Kelly et al., 2015). Therefore, Managers should have an understanding of the risk of compassion fatigue (Shingler-Nace, Gonzalez, & Heuston, 2018) and be adequately resourced to support staff (Coetzee & Laschinger, 2018). However, research shows that nurses do not always feel supported by those in leadership roles (Hayward et al., 2016).

The Nurse Manager role is stressful (Orellana, Manthorpe, & Moriarty, 2017) and associated with heavy workloads and limited resources (Labrague et al., 2017). Challenges facing care home Managers include staffing difficulties, staff training needs, and increased patient complexity (Orellana et al., 2017). Although the Nurse Manager role is integral to the running and organisational structure of care homes, there is limited research on this professional group (Orellana et al., 2017) and how they perceive their role in supporting their staff (Adams, Chamberlain, & Giles, 2018).

In summary, compassion fatigue is a multifaceted construct that affects those in the helping professions resulting in reduced empathy and compassion (Shingler-Nace et al., 2018). The importance of managerial support in recognising and addressing compassion fatigue has been identified (Hunsaker et al., 2015; Kelly et al., 2015). However, there is less research exploring how Managers support their staff (Adams et al., 2018). Therefore, the proposed study will explore the experiences of care home Nurse Managers in how they mitigate compassion fatigue in staff teams within their comprehensive managerial role.

Aims

The study aims to explore the experiences of care home Nurse Managers in how they mitigate compassion fatigue in staff teams. Semi-structured interviews will explore how participants perceived their ability when recognising and managing compassion fatigue, promoting compassion satisfaction, and will identify barriers and facilitators to supporting staff with compassion fatigue.

Plan of Investigation

Participants

Participants will be individuals working as a Registered Manager in private or NHS care homes for older adults located in NHS Highland.

Inclusion and exclusion criteria

Inclusion criteria will be individuals working as a Registered Manager for at least six months in either nursing or residential homes for older adults within NHS Highland. If issues arise recruiting an adequate number of participants in NHS Highland, potential participants will be recruited within the Greater Glasgow and Clyde Health Board and from NHS Highland care home facilities. Exclusion criteria will include individuals who are not fluent in English and Nurse Managers in inpatient hospital settings.

Recruitment and research procedures

Participants will be recruited through the Older Adult's Community Team in NHS Highland. A previously compiled list of nursing homes and residential homes will be consulted and identified Managers will be contacted via telephone to gauge interest in participating in the project. Potential participants will be provided with a research pack containing a cover letter, a participant information letter, and a copy of the consent form. Potential participants will be asked to contact the researcher by telephone or by returning the consent form via post to the researcher at Drumossie Unit, New Craig's Hospital, Inverness, NHS Highland. The researcher will contact the potential participants via telephone to ensure they meet the inclusion criteria, allow for additional questions, and arrange a time and location to conduct the interview. Interviews will take place either at the participant's place of work or at a local NHS community hospital. Informed written consent will be obtained. A one-to-one semi-structured interview will be conducted with each participant. The interviews will take approximately one hour and will be recorded on a digital voice recorder. The participants will be provided with a consent form, cover letter, and an information sheet giving a description of the proposed study. They will be informed that their identities will be anonymised and they will be given a debriefing form at the end of their interview. The debriefing form will thank the participants for their input and include the researcher's contact details. It will also provide an overview of the study, its aims, how the information will be disseminated, and where it can be accessed.

The interviews will be transcribed by the researcher verbatim, and the recordings will be deleted at the end of the study. All transcripts will be coded with a unique identification number to anonymise the data, and stored on an encrypted laptop provided by University of Glasgow. All paper copies of documents will be held in a locked cabinet situated at Drumossie Unit, New Craig's Hospital, Inverness NHS Highland.

Design

The study will utilise a qualitative design using one-to-one semi structured interviews. As the proposed study aims to explore Nurse Managers' experiences of compassion fatigue, the data will be analysed using Interpretive Phenomenological Analysis (IPA). IPA is a method of analysis based on the concepts of hermeneutics, phenomenology, and idiography (Smith, Flowers, & Larkin, 2009). IPA was chosen as appropriate for the project aims since it is an approach which seeks to examine and provide insight into the participants' lived experiences, how they attach meaning to their experience, and the impact of the researcher's interpretation of the participant's experience (Smith & Osborn, 2015).

Data analysis

The researcher will transcribe the digital recording of the interview verbatim and analyse the data using IPA in keeping with guidelines provided by Smith et al. (2009). The researcher will read the data numerous times and annotate it comprehensively in order to describe the content and begin to interpret the information. Following this the researcher will begin the process of developing themes emerging from the data while acknowledging and reflecting on their own subjective interpretation. The researcher will link the themes into superordinate clusters. The researcher will repeat the process for each transcript and identify the patterns that occur throughout each case, complete a summary table of each theme, and then continue the interpretation of the data. The data will not be co-analysed so as not to undermine the dual interpretive process of IPA (Pietkiewicz & Smith, 2014). However, the researcher will account for researcher bias by and attempting to 'bracket' their assumptions, keeping a reflective diary, and using supervision.

Justification of sample size

When using IPA at doctoral level, it is recommended to have between four and ten interviews (Smith, et al., 2009). The authors argue that IPA should focus on the quality of the data as opposed to the quantity, citing the benefits of centring on a focused, smaller number of cases when investigating the complexity of human lived experience. When no further themes emerge from the data, it will be assumed that saturation has been reached and no further participants will be recruited. However, with regard to obtaining data saturation, Brocki and Wearden (2006) argue that the iterative process of analysis in IPA makes this concept problematic.

Settings and equipment

Interviews will take place either at the participant's place of work or at a local NHS community hospital. A digital audio recorder will be required for recording the interviews and a laptop will be required to securely store the data.

Health and Safety Issues

Researcher safety issues

The researcher will conduct all interviews between Monday to Friday. The researcher will carry a mobile telephone and make a designated contact aware of their location. The researcher will schedule regular supervision with their field supervisor and provide them with a timetable of scheduled interviews and locations.

Participant safety issues

The researcher will ensure all questions are asked sensitively. As the researcher's questions may lead to an emotive discussion, any participant distress will be documented, and the researcher will offer the option of a break or discontinue the interview. The participant will be offered the opportunity for follow up support if required.

Ethical issues

Ethical approval will be sought from NHS Research Ethics Committee via the Integrated Research Application System (IRAS). Participants will be asked to provide written consent to take part in the study, assured of anonymity, the right to withdraw, and informed of confidentiality and its limitations with regard to risk of harm. It will be acknowledged that responses made by participants will be compiled into a report that will be made publicly available. All recorded and written information will be held and stored in accordance with the General Data Protection Regulation (GDPR).

Equipment and stationery costs

A digital recorder and encrypted laptop will be loaned from the University of Glasgow.

Time Table

MRP proposal	March 2019
Final approved MRP proposal	31st May 2019
Application for ethical approval	May-August 2019
Systematic review proposal	May-June 2019
Commence recruitment	September-October 2019
Interviews and analysis	September-June 2020
Write up	May-July 2020
Submission	July 2020
Viva	September 2020

Practical Applications

A better understanding of the experiences of Care Home Nursing Managers recognising and managing compassion fatigue will help identify barriers and facilitators to supporting staff teams, and promote compassion satisfaction. The final copy of the thesis will be available to access through Enlighten, University of Glasgow's Research database, disseminated to local care homes, and submitted to a relevant journal for publication.

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