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An investigation into Stress and Coaching-needs in the National Health Service and UK Hospices

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**Thesis submitted in the partial fulfilment of requirements for the
Degree of Doctor of Coaching Psychology**

Department of Psychology

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ABSTRACT

This thesis explores the issues around stress in the UK Health Service, with a particular focus on stress in the Hospice Service and the benefits of a group coaching intervention for this staff group. Section A provides an introduction to the thesis, explaining the rationale behind the choice of research and how the different sections link together. Section B reports on the research aspects of this thesis which exists of three phases. Phase 1 is a cross-sectional study to assess the levels of stress and the main work-stressors as experienced by members of staff working within two hospices in the UK. Phase 2 is a qualitative study using two focus groups, one at each hospice, to obtain a deeper understanding of the findings of phase 1. Phase 3 is an evaluation of a brief group coaching intervention for stress management, which has been informed by the findings of phase 1 and 2. The theoretical framework of the coaching intervention was Cognitive Behavioural Coaching (CBC). Section C of the thesis presents a case study of a one-to-one stress-coaching intervention. This study also uses CBC as its theoretical framework and uses the same coaching format as was used in the group coaching session described in section B. Using the same model for both the group and one-to-one coaching intervention provides an opportunity to explore the versatility and usefulness of CBC within the context of stress coaching. The critical literature review presented in section D of the thesis examines the effectiveness of traditional stress management programmes used within the nursing profession, which provides a base-line for the development of an effective coaching intervention. The findings of this thesis add to the current understanding of stress in the UK hospice service and provide the foundations of a new approach to staff support and stress management within the Health Service using a CBC coaching model.

Section A: Introduction to Thesis

The main theme of this Thesis is about stress in the Palliative Care Service and the benefits of a group coaching intervention for this staff group. The researcher took on this project to ascertain the current levels of stress as experienced within the hospice service where she works as a Consultant Clinical Psychologist. After having observed regular expressions of stress and strain in the form of verbal comments, non-verbal behaviours and signs of physical and emotional exhaustion, it was felt that this staff group could benefit from a coaching intervention to help them deal with the pressures presented within this service. Prior to being able to offer a coaching intervention it was felt however, that a thorough and objective investigation needed to be done into the actual levels of stress, rather than to rely on subjective observations. This approach would also give an opportunity to explore the possible stressors within this service, which would facilitate the formulation of tailor-made coaching intervention to the specific needs of this staff group.

An initial literature review revealed that stress related illness has been identified as the second highest cause of sickness absence in the NHS accounting for 30% of lost time, and among nurses the prevalence of stress is about three times the national average (Health and Safety Commission, 2005). Research also suggests that working in the palliative care service can bring its own specific issues in relation to work-stress, due to the continuous confrontation with loss and grief, and working in a highly emotionally charged environment. There are relatively few studies on stress in care givers in the palliative care service and the results of these studies often contradict each other. These findings reinforced the idea that an objective investigation into the experienced stress and stressors within the hospice service was needed, in order to contribute to the evidence in this field.

In order to deal with the potential stressful work environment of the hospice service it was felt that the method of using a group coaching session would be useful to meet these needs. Many North European and North American organisations have introduced programmes to help employees cope with their stress. Literature shows that stress management is mainly associated with techniques to reduce symptoms of stress or to facilitate relaxation (see , Van der Klink, Blonk, Schene & van Dijk, 2002). The stress model presented by Vingerhoets (2004) in relation to health behaviour (see figure 1), shows that there are many moderating variables which could be tapped into to positively influence the stress response. In contrast to the methods commonly used to manage stress symptoms, coaching offers individuals the opportunity to work on these moderating variables. By taking this approach, the individual can get to the root of the issues which are causing stress and help uncover permanent preventative solutions (Hearn, 2001).

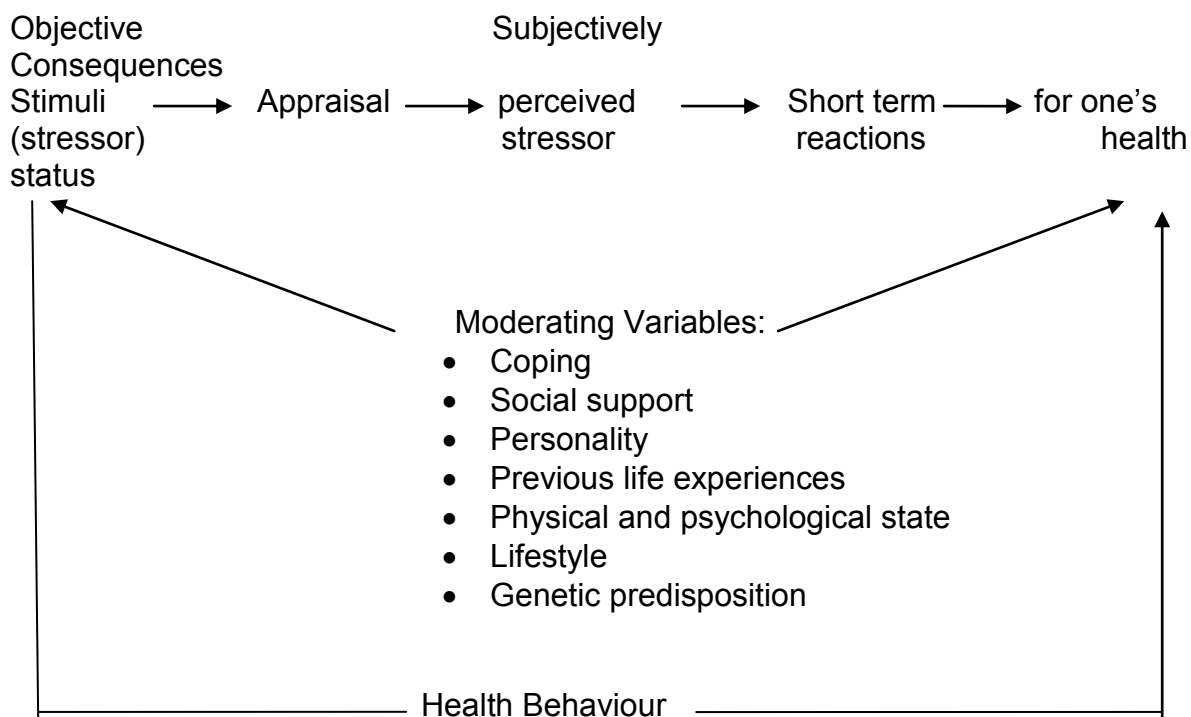


Figure 1: Moderating variables of stress (Vingerhoets, 2004)

Section B of this Thesis reports on the findings of the research into stress in two UK hospices and an evaluation of the usefulness of a brief coaching intervention. This research comprises of three phases. Phase I is a cross-sectional study to assess the levels of stress and the main stressors as experienced by members of staff working within these two hospices. The measures used for this phase were the DASS-21 (Depression Anxiety Stress Scale), the HSE (Health and Safety Executive) Stress Indicator Tool and a Demographic questionnaire looking at “years in Palliative Care work”, part-time or full-time employment, age, locality and professional group 1 (clinical staff) or 2 (support staff). Phase II of the project comprises of a qualitative study with the purpose of obtaining a deeper understanding of the stressors as indicated by phase I. Two focus groups were held, one at each hospice. Phase III of this research project was an evaluation of a brief stress-coaching intervention. The coaching intervention was informed by the findings of phase I and II. This phase of the research explores the use of cognitive behavioural coaching (CBC) to influence and enhance coping ability for this staff group with a view to increase perceived control and reduce overall stress. CBC has been adapted from the methodological framework of cognitive behavioural therapy (Neenan & Palmer, 2001; Neenan & Dryden, 2002), which was originally developed by Beck (1976) and Ellis (1994). The effectiveness of cognitive behavioural therapy has now been well proven in the clinical field, and it has become the first choice of therapy recommended by NICE (National Institute for Health & Clinical Excellence) for many psychological and psychiatric disorders. Results from initial research into the effectiveness of cognitive behavioural techniques in the field of coaching are promising (eg. Green, Oades & Grant, 2006). Grbic and Palmer (2006) found in a randomised controlled trial that stress was significantly reduced amongst middle managers after using a cognitive-behavioural self-coaching manual. However, cognitive behavioural coaching is still being developed and further research is needed to evaluate its benefits. The objectives of this session were to help members of staff understand the nature of stress, to identify stress management strategies using a cognitive-behavioural coaching model and develop a personal plan for managing work related stress.

Furthermore, the findings of this part of the research aim to contribute to the evidence base of using a CBC model for group coaching in the health service.

Section C of this Thesis presents a case study on an one-to-one stress-coaching intervention, using the same CBC model as was used for the group-coaching session described in Section B. This study was chosen to highlight the versatility of the use of CBC coaching within an organizational context and to add to the knowledge of the use of stress-coaching interventions. As coaching psychology is a relatively new specialty within psychological theory and practice, it was felt that it would be useful to use one larger case study rather than two shorter ones, in order to be able to provide a thorough explanation of the theory underpinning the choices of intervention throughout this study. The study also provided an opportunity to reflect on some of the differences between therapy and coaching and to reflect on the learning processes in relation to the theory and practice of coaching psychology.

Section D of this Thesis presents a critical literature review: "Which Stress Management Programmes are most effective for Nursing Staff and Student Nurses?" The topic of this review was chosen in order to form a base-line understanding to inform the development of the coaching intervention as described in section B of this Thesis. The coaching model presented in section B has not been researched within palliative care or the nursing profession. It was reasoned that the process of developing an effective coaching intervention would benefit from the existing evidence base already collected within the health service in relation to stress management. The knowledge obtained from this review therefore links directly to section B of this Thesis as it underpins the development of effective coaching interventions tailored to the NHS of the future.

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Section B: Research

An investigation into the levels of stress within the UK hospice service and an evaluation of the usefulness of a brief stress-coaching intervention.

Chapter 1: Introduction

1.1 Overview

This Chapter provides background information about work-related stress, palliative care and stress management interventions. Paragraph 1.2 presents a section on work-related stress, which starts with the definition of stress, followed by an explanation of the differences between pressure and stress. After this the prevalence of work-related stress will be explored as well as the prevalence of stress in the NHS, followed by an exploration of the costs of stress. Paragraph 1.3 will cover the different aspects of palliative care, starting with a definition of palliative care, followed by an historical background overview and an exploration of the literature related to stress in palliative care. Paragraph 1.4 will address stress prevention interventions and the different levels on which this can be applied within an organization. The literature related to coaching will be explored in paragraph 1.5, and the chapter finishes with a clarification of the aims of this study in paragraph 1.6, the research questions in paragraph 1.7 and the Hypotheses in paragraph 1.8.

1.2 Work Related Stress

1.2.1 Definition of stress

A critical evaluation of the use of the term “stress” both in the lay and the professional literature reveals that there is a serious lack of agreement with respect to the terminology (Vingerhoets, 2004). Sometimes the word stress is used to refer to situations, stimuli and conditions that may trigger emotional reactions and distress, at other times it may refer to the reactions or responses of a person to challenging situations. Some research suggests that it is the source, rather the amount of stress that differs. For example, Power and Sharp (1988) found that death and dying and inadequate preparation to meet the emotional demands of patients and their families (psychological environment stressors), were significantly greater stressors for hospice nurses while conflict with other nurses and workload (physical and social environment stressors) were greater stressors for learning disability nurses. The Health and Safety Executive (HSE, 2001) define stress in terms of strain: “the adverse reaction people have to excessive pressure or other types of demand placed upon them”. The concepts of appraisal and coping are often central within stress research. Palmer, Cooper & Thomas, (2003, p.2) provide a cognitive definition, “*stress occurs when the perceived pressure exceeds an individual’s perceived ability to cope*”. A commonly used definition of workplace stress is the New Zealand definition which states: “Workplace stress is the result of the interaction between a person and their work environment. For the person it is the awareness of not being able to cope with the demands of their work environment, with an associated negative emotional response” (Occupational Safety and Health Services (OSH, 2003). Palmer (2008) provides us with a comprehensive model of workplace stress, which describes the interaction between the potential work stressors as identified by the Health and Safety Executive (2001), the symptoms of stress and the negative consequences of stress for the organization (see figure 2, reproduced with permission of the author). This thesis draws on one of the most influential models of stress known as the transactional theory of stress (Lazarus & Folkman, 1984). Lazarus and Folkman (1984) define stress as: “*a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and*

endangering his or her well-being". This model emphasizes the relationship between the individual and the environment recognises stress as a dynamic process between the stressors and the ability to cope (Cooper, Dewe, & O'Driscoll, 2001).

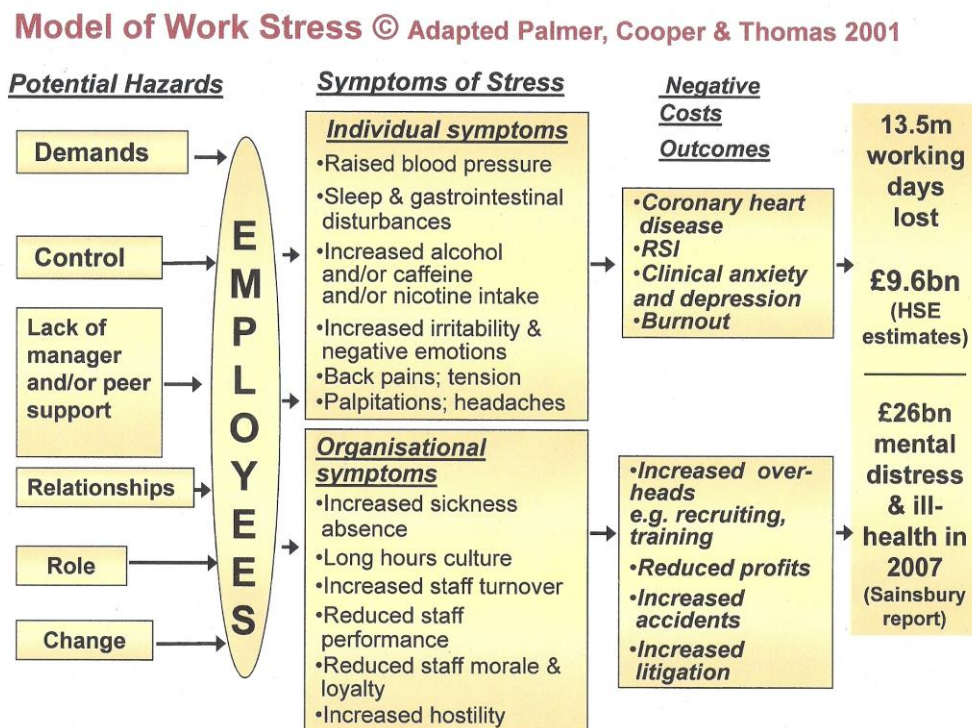


Figure 2: Model of Work Stress by Palmer and Cooper (Palmer, 2008)

Within the context of stress prevention programmes, a cognitive model of stress is often used as its theoretical framework. The cognitive model shows how self- or emotional management is possible (Palmer, 2003). It includes an appraisal phase and the psychological, behavioural and physiological responses to the perceived stress. This model promotes the use of a cognitive- intervention strategy to challenge unhelpful perception of the external stressors.

1.2.2 Pressure and stress

Research has shown that there is a real physiological difference between pressure and stress. Yerkes and Dodson (1908) established an empirical relationship between arousal and performance, which is also known as the Yerkes-Dodson law. This law indicates that there is a pressure curve in the shape of an inverted U, which shows that performance increases with a certain amount of physiological or mental arousal but decreases when the arousal becomes too high. The upward leg of the inverted U can be viewed as the energizing effect of arousal or pressure, the downward leg is associated with the negative effects of arousal which is associated with stress. Palmer and Cooper (2007) suggest that there is an optimum level for experienced pressure and that the right amount of pressure allows for an effective and creative state of mind. However, too much pressure leads into the experience of stress and can lead to anxiety and burnout. Too little pressure on the other hand can lead to boredom.

The experience of stress is complex and subjective and the experience of stress is not directly proportional to the stressful event. Changes in physiology are known as “stress reactivity”, and vary enormously between people (Ogden, 2004). Clow (2004) therefore argues the case for the identification of biological markers to measure the impact of stress and to provide quantifiable evidence of the benefit of stress management interventions. Most work that seeks to identify reliable biological marker of stress responses is focused upon the hormone cortisol. This response has been the subject of much research. In particular it has been shown that large cortisol responders are more likely to have low self-esteem (Pressner, Hellhammer & Kirschbaum, 1999; Kirschbaum, Prussner, Stone, Federenko, Lintz, *et al.*, 1995) and are less likely to habituate following repeated exposure to the same stressor (Kirschbaum *et al.*, 1995). Importantly it has been demonstrated that the size of the cortisol response to a standard stressor can be influenced by interventions like transcendental meditation and cognitive behavioural therapy (MacLean, Walton, Wenneberg, Levitsky, Mandarin, *et al.*, 1997; Gaab, Blattler, Menzi, Pabst, Stoyer, *et al.*, 2003; Facchinetti, Tarabusi, & Volpe, 2004)

1.2.3 Prevalence of work-related stress

Stress, depression and anxiety has been reported to be the second most prevalent work-related health problem in the UK (Jones, Huxtable & Hodgson, 2005). Self-reported information on the prevalence of work-related stress in the UK has been collected through several large surveys, including the Self-reported Work-related Illness (SWI), Psychosocial Working Conditions (PWC) and the Stress and Health at Work (SHAW) study, undertaken in 1998. The surveys on SWI all indicate that stress and related conditions are the second most commonly reported group of work-related ill-health conditions after musculoskeletal disorders. SWI06/07 estimated that work-related stress, depression or anxiety affected 530 000 people in Great Britain, with an estimated 13.8 million lost working days. This represents an estimated average of 30.2 working days lost per year per affected case and makes stress, depression or anxiety one of the largest contributors to the overall estimated annual days lost from work-related ill-health in SWI06/07. Looking at the results from the SWI surveys over several years, the data indicates an increase in the incidence rate between SWI95 and SWI01/02. Subsequently there was no change in incidence rate between SWI01/02, SWI03/04 and SWI04/05, with a fall between SWI04/05 and SWI05/06 followed by a rise in SWI06/07 back to incident rates of the same order as 2002/01. The Stress and Health at Work (SHAW) study conducted in 1998 estimated that 1 in 5 of the British working population believed their job was extremely or very stressful. The more recently conducted PWC surveys estimated that 16.5% in 2004, 15.2% in 2005, 12% in 2006, and 13.6% in 2007 of British workers believed their jobs were extremely or very stressful.

1.2.4 Prevalence of stress in the NHS

The Health and Safety Executive (HSE) has identified “Healthcare” as one of the five priority sectors where work related stress is most reported as being a major cause of absence. Approximately 1.3 million people work in the NHS and the National Audit Office found stress related illness to be the second highest cause of sickness absence in the NHS accounting for 30% of lost time. Among nurses the prevalence of stress is about three times the national average (Pascoe, 2005). The Annual NHS staff survey run by the Healthcare Commission (the independent

inspection body for both the NHS and independent healthcare) reports that work-related stress has fallen from 35% in 2005 to 33% in 2006, then stayed at 33% in 2007 and now has fallen to 28% in 2008 (Healthcare Commission, 2008). This still means however, that more than one in four employees still report feeling stressed in relation to their NHS work.

Various authors emphasise the presence of stressors in NHS organisations. The cross-cultural studies of Aziz (2004) and Sonneck & Wagner (1996) revealed that health care professionals are highly exposed to various stressors which might cause the deterioration of physical and mental well-being and lead to suicides. Myerson (1990) and Tattersall, Bennett, and Pugh (1999) found that one of the most cited source of stress was the lack of time to solve important matters. The other stressors were organisational and work-related conflicts, workloads, lack of autonomy, negative feedback from authorities, and high expectations and demands from patients. Interesting inferences were made by Rout & Rout (1997), who found in their cross-cultural research on stress among British and Canadian general practitioners, that British participants reported higher level of work stress with higher level of somatic anxiety and greater level of alcohol consumption. However, over recent years the NHS has become more and more committed to the improvement of work conditions, and supporting the (mental) health of the employees. The NHS Plan (Department of Health, 2000) introduced the Standard which makes it clear that every member of staff in the NHS is entitled to work in an organisation which can demonstrate its commitment to more flexible working conditions which gives staff more control over their own time. The Standard also requires NHS employers to prove that they are investing in improving diversity and tackling discrimination and harassment. The Improving Working Lives policy (Department of Health, 2000) aims to support organisational cultural change to embed good Human Resources practices at the heart of service delivery. As a further sign of this commitment, Health Secretary Alan Johnson, in February 2008, called upon the NHS employer to go further in their efforts to improve the health and well-being of their staff. He also highlighted the importance of a healthy work-life balance. Speaking at the British Heart Foundation's Well at Work Conference in

London, Mr Johnson outlined a number of measures employers and Government could take to promote good health to employees, including initiatives to promote health and well-being in the workplace; closer collaboration to identify potential health risks; and further support for those returning to the workplace (Unite, 2008).

1.2.5 Age and gender

The HSE has examined the differences in prevalence of work-related illness for younger and older workers. Four sources were used to collect this information: the Self-reported Work-related Illness surveys of 1995 (SWI95) and 1998/99 (SWI98/99); surveillance reports for the three years 1998-2000 from the Occupational Disease Intelligence Network (ODIN); and the Self-reported Work-related Conditions Survey of 1995 (SWC). In this analysis 'younger' means age 16-44, and 'older' age 45-64 (for the SWI data: 45-59 for women). It was found that work-related illnesses were generally higher for the 45+ group. The SWI95 also suggests evidence of a higher prevalence of stress, depression and anxiety amongst the older age group.

The HSE collects data of occupational stress through their occupational disease surveillance schemes (THOR). The highest proportion of cases reported, both by occupational physicians and psychiatrists, occurred in the age groups 35-44 and 45-54 years. The estimated prevalence rates of self-reported work-related stress from SWI05/06 were also highest among these two age categories. Taking both surveillance schemes together over the years 1999 to 2006, more male cases were reported than female. However, this represents a pattern of more male cases being reported by psychiatrists and more female cases by occupational physicians. SWI05/06 data indicate a higher incidence rate among females. The male prevalence rate has been going down over recent years.

1.2.6 Personality factors

Literature suggests that there are marked individual differences in vulnerability to stress. Some individuals appear to be highly resilient even when engaging in challenging tasks, whereas others are sensitive to even modest demands (Costa,

Somerfield & McCrae, 1996; Suls, 2001; Zeidner, 1998). Several personality traits have been linked to stress, of which Type A behaviour/hostility and Neuroticism stand out as having received particular interest. The behaviour of individuals classified as Type A, is described as impatient, irritable, hostile, job involved and competitive, whilst a Type B individual is characterized by a relative lack of these characteristics (Cooper & Bright, 2001). O'Driscoll (2001) argues that research into the mediators between Type A personality and strain outcome is inconclusive, which supports the findings of Ganster and Schaubroeck (1991) who suggest that there is more evidence that Type A personalities are more at risk for physiological indicators of strain than for either psychological or work related distress.

Neuroticism is one of the "Big Five" personality dimensions. Personality researchers have proposed that there are five basic dimensions of personality. Evidence of this theory has been growing over the past 50 years, including the work of Norman (1963) and McCrae and Costa (1985). The Five Factor Model (Big Five) of personality is widely used in research as a basis for assessment of stress vulnerability (Costa, Somerfield & McCrae, 1996). While there is a significant body of literature supporting this five-factor model of personality, researchers don't always agree on the exact labels of each dimension. However, the five categories are usually described as: **Extraversion:** This trait includes characteristics such as excitability, sociability, talkativeness, assertiveness, and high amounts of emotional expressiveness. **Agreeableness:** This personality dimension includes attributes such as trust, altruism, kindness, affection, and other pro-social behaviors. **Conscientiousness:** Common features of this dimension include high levels of thoughtfulness, with good impulse control and goal-directed behaviors. Those high in conscientiousness tend to be organized and mindful of details. **Neuroticism:** Individuals high in this trait tend to experience emotional instability, anxiety, moodiness, irritability, and sadness. **Openness:** This trait features characteristics such as imagination and insight, and those high in this trait also tend to have a broad range of interests. Research (Bolger, 1990; Costa, Somerfield & McCrae, 1996) suggests that people high on Neuroticism tend to adopt ineffective coping strategies when subjected to stressful conditions. However, some researchers like

Lazarus and Folman (1984) dispute the emphasis on the role of personality in the context of stress and coping, and argue that the stressful situation rather than the individual's personality is the main influence on the coping response.

Other personality traits which are not included within the above categorization but are considered to overlap considerably with the major personality dimensions, are the factors Locus of Control (Rotter, 1966) and Hardiness (Kobasa, 1997). Individuals high on Internal locus of Control are considered to be more resistant to stress as they exert greater effort to control their environment and seek and use information more effectively (Phares, 1976). According to hardiness theory, hardiness is believed to be a buffer against stress due to its characteristics of commitment, the belief in control and the belief that change in one's life is to be expected and that this can be beneficial (Maddi & Kobasa, 1991).

1.2.7 The costs of stress

The Sainsbury Centre for Mental Health (2007) states that at any one time one worker in six will be experiencing depression, anxiety or problems relating to stress. It also states that the total cost to employers of mental health problems among their staff is estimated at nearly £26 billion each year, with £8.4 billion a year spent on sickness absence, £15.1 billion a year lost to reduced productivity at work, and £2.4 billion a year spent on replacing staff who leave their jobs because of mental ill health.

Stress is one of the biggest problems in the British workplaces, with the cost to the British economy estimated at £9.6 billion per year (HSE, 2007a). Statistics released by the Health and Safety Commission (HSC) show a dramatic increase in the number of workers suffering from work related stress in Great Britain. The number of workers who had sought medical advice for what they believed to be work related stress increased by 110,000 to an estimated 530,000 (HSE, 2007b).

The impact of occupational stress is significant both to the employee and the organisation. For the individual, the experience of stress affects lifestyle factors like

food habits (Conner, Fitter, & Fletcher, 1999; Baucom and Aiken, 1981), smoking (Metcalfe, Smith & Wadsworth, 2003; Carey, Kalra, Carey, Halperin & Richard, 1993) alcohol consumption (Metcalfe *et al.*, 2003; Heslop, Smith, & Carroll, 2001) and exercise (Metcalfe *et al.*, 2003; Heslop *et al.* 2001), which in turn link to cardiovascular disease, digestive problems and other serious diseases like cancer (Ogden, 2004; Cooper, Cooper & Eaker, 1988). There is now much evidence to suggest that there are a multitude of biological processes that mediate the pathway between stress and various disease states (Mackay, Cousins, Kelly, Lee & McCaig, 2004). For the individual it causes risks to physical health (Sapolsky, 2003; O'Connor, O'Connor, White & Bundred, 2000; Parkes, Mendham & von Rabenau, 1994) as well as their mental health (DeJonge, Dormann, Janssen, Dollard, Landeweerd *et al.*, 2001). For the organisation the costs are also high. As work-related stress is a major cause of occupational ill health it causes high sickness absence, and affects job satisfaction, job performance and staff turnover. There is now a body of research demonstrating the relationship between work factors and ill health (Mackay, Cousins, Kelly & McCaig, 2004; Stansfeld, Head, & Marmot, 2000). Sutherland and Cooper (2000) state that organizations neither understand nor make enough effort to calculate the damaging costs of stress in the workplace. Anderson, Litzenberger, & Plecas (2002) believe that tackling stress need not cost a lot of money. They state that the cost of one person taking six months off on sick leave could equal the cost of a counselling service. They also state that staff who receive counselling are more likely to stay at work.

1.2.8 Organisational Stressors

According to Moore and Cooper (1998), stress needs to be dealt with by looking at the causes and not by simply patching up the “injured soldiers” of the workplace. Stein (2001, cited in Mullins, 2002) claims that occupational stress may not be triggered from one single source, but by a build up of various different events taking place in an employee’s life. It is also claimed (Cox, Randall, & Griffiths 2002; Holmlund-Ryttonen & Strandvik, 2005) that the interface of work related stressors and home life factors is likely to influence the experience of occupational stress.

Commissioned by the HSE, Cox (1993) reviewed the literature on work-related stress and emphasised that there exists a growing consensus on the definition of stress as a psychological state with both cognitive and emotional components. He included the notion that stress entails a sequence of events that include the presence of demand, a set of evaluative processes through which that demand is perceived as a threat. He developed a hazard-based taxonomy which included job-content and job context factors. The findings from this review as well as from other HSE-funded studies and workshops, were used to obtain an inventory of work related stressors, which were then used to develop standards for good management, also known as the “Management Standards”. The initial stressor areas identified by HSE were: Demands, Control, Support, Relationships at work, Role, Change and Culture. As the work developed, the stressor Culture was dropped and its aspects were incorporated into the remaining six stressor areas. More recently the stressor Support has been split into Peer Support and Managers’ Support bringing the total areas of stressors back to seven. Below is a summary of the seven stressor areas.

Demands

The key area of Demands Includes issues like workload, work patterns, and the work environment (HSE, 2004b). The standard is to achieve that the employees indicate that they are able to cope with the demands of their jobs, and that systems are in place locally to respond to any individual concerns. This entails that the organisation provides employees with adequate and achievable demands in relation to the agreed hours of work, that people’s skills and abilities are matched to the job demands, Jobs are designed to be within the capabilities of employees, and employees’ concerns about their work environment are addressed.

Control

The area of Control refers to how much say the person has in the way they do their work. The standard is that employees indicate that they are able to have a say about the way they do their work and that systems are in place locally to respond to any individual concerns. To achieve this, employees should, where possible,

have control over their pace of work, and should be encouraged to use their skills and initiative to do their work. Additionally, employees should, where possible, be encouraged to develop new skills to help them undertake new and challenging pieces of work, the organisation should encourage employees to develop their skills, employees should have a say over when breaks can be taken, and employees should be consulted over their work patterns.

Support

This key area includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues. The standard is that employees indicate that they receive adequate information and support from their colleagues and superiors and that systems are in place locally to respond to any individual concerns. This should be achieved through providing policies and procedures to adequately support employees and through systems that enable and encourage managers to support their staff. Furthermore, systems need to be in place to enable and encourage employees to support their colleagues and employees need to know what support is available and how and when to access it. Also, employees need to know how to access the required resources to do their job and receive regular and constructive feedback.

Relationships

This key area includes promoting positive working to avoid conflict and dealing with unacceptable behaviour. The standard is that employees indicate that they are not subjected to unacceptable behaviours, e.g. bullying at work, and that systems are in place locally to respond to any individual concerns. To achieve this, organisations should promote positive behaviours at work to avoid conflict and ensure fairness and employees should be encouraged to share information relevant to their work. The organisation needs to have agreed policies and procedures to prevent or resolve unacceptable behaviour and systems should be in place to enable and encourage managers to deal with unacceptable behaviour. Additionally systems should be in place to enable and encourage employees to report unacceptable behaviour.

Role

This key area refers to whether people understand their role within the organisation and whether the organisation ensures that the person does not have conflicting roles. The standard is that employees indicate that they understand their role and responsibilities; and that systems are in place locally to respond to any individual concerns. This should be achieved by ensuring that the organisation, as far as possible, places compatible requirements upon the employees, and provides information to enable employees to understand their role and responsibilities. The organisation should also ensure that, as far as possible, the requirements it places upon employees are clear and that systems are in place to enable employees to raise concerns about any uncertainties or conflicts they have in their role and responsibilities.

Change

This key area refers to how organisational change (large or small) is managed and communicated in the organisation. The standard is that employees indicate that the organisation engages them frequently when undergoing an organisational change, and systems are in place locally to respond to any individual concerns. The organisation can achieve this through providing employees with timely information to enable them to understand the reasons for proposed changes and by ensuring adequate employee consultation on changes and provides opportunities for employees to influence proposals. Additionally, employees are made aware of the probable impact of any changes to their jobs, if necessary, employees are given training to support any changes in their jobs, employees are aware of timetables for changes and employees have access to relevant support during changes.

1.2.9 Research background for the six HSE stressor domains

The six stressor domains are closely related to each other and research often include two or more domains to understand their relationship with the development of stress. For instance, control and demand are often investigated within the same study (For instance the Whitehall II study, Stansfeld *et al.* 2000 and Head, Mrtikainen, Kummari, Kuper & Marmot, 2002). The Whitehall II study (Stansfeld *et*

al., 2000) found a negative relationship between low reported control at work and mental as well as physical health. Important research into the relationship between demands and control was also conducted by Karasek (1979). He developed the Demand/Control model, which focussed on the interaction between the objective demands of work (for example volume of work and deadlines), and the employees perceived control (decision latitude, job autonomy and skill use) to meet these demands. Karasek, Triantis and Chaudhry (1982) further developed this model and highlighted the importance of support (in the form of peer support and supervisors support) and found that high levels of social support were predictive of better mental health. The three components of this model (demands/control and support) interact in a variety of ways causing different work characteristics. For instance jobs with high demand and low control can cause reason for concern as it has been associated with psychological strain (Karasek, 1979), whilst the combination of high demands and high control does not cause these risks and in fact can provide a favourable working condition (Kasarek & Theorell, 1990). Overall, research supports the view that reported high demands have a positive correlation with reported high strain. However, a literature review by Rick, Thomson, Briner, O'Regan & Daniels (2002) found some contradicting results for the relationship between workload and strain, where some studies reported a positive correlation for this relationship and others did not find such relationship.

Social support has been defined as the availability and quality of an employee's relationship with supervisors, co-workers, family and friends and the amount of positive consideration and task assistance received from them (Mackay *et al.* 2004). Mackay *et al.* (2004) report that social support has a beneficial effect on worker performance and well-being, particularly when it is being received from supervisors and is sometimes seen as a buffer against the effects of stress on ill-health (Frese, 1999). Stansfeld *et al.* (2000) highlighted the protective effects of social support and control over work in relation to experienced physical and mental health. The importance of social support was confirmed by Head *et al.* (2002) who found that adverse changes in the levels of reported social support was associated with reduced mental health.

Role ambiguity and role conflict have been reported as potential causes of strain (Bond, Flaxman, & Loivette, 2006; O'Driscoll & Beehr, 1994). Role ambiguity refers to the unpredictability of the consequences of one's own role performance with a lack of information needed to perform the role (Mackay *et al.*, 2004). The Omnibus surveys by the HSE (2004b; 2005) concluded that higher levels of role stressors positively correlated with reported job strain. In addition to the need for clarity of roles and reduction of role conflict within the concept of managing stress at work, effective Change management has also become a vital component within the current organisational processes. Oswick, Grant, Michelson and Wailes (2005) highlight a shift of emphases in organizational change due to environmental imperatives. Their paper reveals a move from problem-centred, discrete interventions to a focus on continuous improvements. Burnes (1996) argues that the ability to manage change is now recognized as a core organizational competence, and this is reflected in the large number of books and articles devoted to prescribing how success in this area can be achieved. Lewin (1951) proposed that change ensued from the competition between driving and restraining forces. In other words, when a change is instigated, some forces drive and facilitate it while others create resistance to it. The required change can be achieved by decreasing the restraining forces and increasing the facilitating forces. Mackay *et al.* (2004) argue that there are many studies examining the relation between stress and change and that great difficulties are often reported due to badly managed organizational change. The HSE advocates that change management programmes should include bottom-up consultation to facilitate effective change management. When changes are introduced within the context of the working system and with active employee involvement, significant improvements in mental health can occur (Mackay *et al.* 2004).

1.3 Palliative Care

1.3.1 Definition of palliative care

The National Institute of Clinical Excellence (NICE, 2004) has defined palliative care as:

"the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness, in conjunction with anticancer treatment" (p20).

1.3.2 Historical background of palliative care

Over the past forty years, palliative care has emerged as a specialised field. Landmark dates in the development of palliative care include the opening of the first hospice, St. Christopher's Hospice in London in 1967 under the leadership of Cicely Saunders. Much of the theory and structure of modern hospice care in the UK can be credited to her. Palliative care was recognised by the Royal College of Physicians as a specialty in 1987 and since then the number of consultants and doctors in palliative care training schemes has increased dramatically. Doctors in the palliative care sector now work full time as an integrated part of the multi-professional care team. Over the last few years, the need to further develop quality palliative care services has received increasing attention. This has recently resulted in a Government commitment of an extra £50 million a year for three years from 2003/04, exclusively for specialist palliative care services. This increase represents an increase of nearly 40% in NHS funding (Department of Health, 2002).

The National Council for Hospice and Specialist Palliative Care Services has developed the Minimum Data Set (MDS) in 1995 with the aim to provide quality, comprehensive data about hospice and specialist palliative care services in the UK (except Scotland) on a continuing basis. In their survey for 2004/05 the National Council for Palliative Care (2006) identified 184 units (including designated

palliative care wards within general hospitals) and 2,678 beds. The units varied in size from 2 to 48 beds with a mean of 14 beds. Almost 30% of admissions were repeat admissions and the majority of discharges (86%) were to the patient's own home, with 5% to hospital and others to nursing/residential homes. Just over half the admissions ended in death. The average length of stay was 13.4 days, ranging from 6.7 to 27.5 days. The larger units tended to have a longer length of stay. With regards to the diagnoses, the survey showed that 94.7% of patients were diagnosed with cancer, and the remaining patient group were diagnosed with other life threatening illnesses like HIV/AIDS and motor-neuron disease. Although the inclusion criteria for palliative care are changing and are becoming more inclusive of other life threatening and chronic conditions, the MDS statistics (The National Council for Palliative Care, 2006) show that the majority of In-patients in palliative care units suffer from cancer related illnesses.

1.3.3 Stress in Palliative Care

Working in the palliative care service brings its own specific issues in relation to work-stress. People who are drawn to work in a hospice environment often show an abundance of caring concern for those they serve (Fitzgerald, 2002). This may have an impact on professional boundaries causing blurring of roles and an increased sense of responsibility within the caring role. Fitzgerald (2002) states that:

“Because compassionate care giving is an essential component in hospice care, the hospice worker has a unique challenge of coping with loss on a regular basis. It is fully expected that every hospice patient will die and leave behind a grieving family. Providing hospice care requires staff and volunteers to become an intimate part of their patients’ lives. Sharing one’s dying, making the remaining time meaningful, providing care for the entire family, and giving so much of oneself is an immense undertaking. In the midst of intimate and intense care giving, hospice workers often forget to take care of themselves....It is not enough to take vacations. It is essential

to have a lifestyle that incorporates manageable stress-reducing techniques...”.

Working with patients who are diagnosed with terminal illnesses can be potentially stressful as it brings with it an awareness of personal vulnerability and mortality, it threatens the sense of omnipotence and brings a repeated need to deal with feelings of loss and grief. As the palliative care services evolved over the years, so emerged a recognition of the need to “get to know the patient” to provide the best possible care (Luker, Austin, Caress, & Hallett, 2000). Whilst it can be argued that the effort to get to know the patients is a positive step towards the provision of best patient care, it also has the potential to cause increased levels of stress amongst the staff as it invites a deeper level of “emotional involvement”. There are relatively few studies on stress in care givers in the palliative care service. An early study by Lyall, Vachon, and Rogers (1980) found that three months after the opening of a palliative care unit, the nurses studied had distress scores on the Goldberg General Health Questionnaire comparable to a group of newly widowed women, and almost twice as high as those found in women newly diagnosed with breast cancer. Following up from this, Vachon (1987) gave some early insight into the stressors experienced by staff working within the palliative care service. In her study on “Occupational Stress in the Care of the Critically Ill and the Dying, and the Bereaved”, she identifies many perceived stressors ranging from environmental stressors to role stressors, to patient illness stressors and stressors around the interactions with the families of the patients. She states that feelings of depression, grief and guilt constituted the single greatest manifestation of stress across the professional groups in her research, and found that some caregivers may be particularly vulnerable to this due to an overinvestment in the caregiver role. More recently, Payne (2001) conducted a research into the predictors of burnout among hospice nurses. She found that the level of burnout amongst this nursing group was low. However, the factors of “death and dying”, “conflict with staff”, “accepting responsibility and higher nursing grade contributed to emotional exhaustion. This study also showed that stressors made a greater contribution to burnout than demographic factors. Isobel Allen (Policy Studies Institute, 2001) did an extensive

qualitative study on Stress among Ward Sisters and Charge Nurses and identified some of the major causes of stress in the NHS workplace, including: erosion of autonomy/lack of control over work, rigidity in the hierarchy, doing tasks below grade, lack of the right tools, increased in-patients' expectations, increased administrative duties, isolation from other team members and lack of management support.

Disagreement exists as to whether the work of palliative care nurses is more stressful than the work of other nurses. Munley (1985) and Gray-Toft and Anderson (1986-1987) found that hospice nursing is particularly stressful because it involves having to constantly cope with loss and grief. In contrast, Mallet et al. (1991) found that hospice nurses experienced significantly less overall stress than other nurses and had significantly lower scores on the Maslach Burnout Inventory (MBI, Maslach & Jackson, 1981) than critical care nurses. With regards to burnout, again the findings are somewhat conflicting. A number of studies have reported a positive association between stressors and burnout in hospice nurses (Mallet et al., 1991). However, Masterson-Allen, Mor, Laliberte, and Monteiro (1985) found there was no relationship between these factors among hospice nurses. . It needs to be noted though that the conflicting results from different studies might be explained by the difficulties around the conceptualisation and definition of the word "stress". A critical evaluation of the use of this term both in the lay and the professional literature reveals that there is a serious lack of agreement with respect to the terminology (Vingerhoets, 2004). Sometimes the word stress is used to refer to situations, stimuli and conditions that may trigger emotional reactions and distress, at other times it may refer to the reactions or responses of a person to challenging situations. Some research suggests that it is the source, rather the amount of stress that differs. For example, Power and Sharp (1988) found that death and dying and inadequate preparation to meet the emotional demands of patients and their families (psychological environment stressors), were significantly greater stressors for hospice nurses while conflict with other nurses and workload (physical and social environment stressors) were greater stressors for learning disability nurses. This might indicate that there are individual differences such as ways of

coping that mediate the potentially negative impact of nursing work. Subjective appraisal and coping strategies have been identified as factors that mediate the stress response (Lazarus & Folkman, 1984; Palmer, Cooper & Thomas, 2003).

The above overview of literature highlights conflicting information about the amount of stress and causes of stress as experienced by hospice staff. Additionally, the research on hospice stress is quite dated which emphasizes the need for an up to date understanding of the current organizational and environmental processes which could feed in to the experience of stress. This research therefore aims to give an up to date understanding of current stress in the hospice service and its related stressors, but also aims to explore coaching as a possible strategy to influence and enhance coping ability with a view to manage work-related stress.

1.4 Stress prevention interventions

The literature review above has highlighted the costs associated with stress and the need for effective stress management strategies within the organization. Ivancevitch, Matteson, Freedman & Phillips (1990) identified three categories into which stress management strategies can fall. Firstly there is the option of looking at the worksite stressors and attempting to reduce these. Secondly, there is the option of helping employees to modify their appraisal of a potentially stressful situation and the final step is to help employees to cope more effectively with the consequences of stress. In addition, programmes associated with these targets can focus on the individual, the organisation or the individual/organisation interface. Ivancevitch *et al.* (1990) point out that existing research has concentrated mainly on individual interventions, focussing on stressor appraisal and coping strategies rather than situational stressors. Cooper (2006) differentiates between primary, secondary and tertiary levels of intervention to reduce or manage work related stress. Primary interventions focus on strategies relating directly to environmental circumstantial aspects of the workplace. Stressor reduction programmes can target five major categories of stressors (Payne, 1980; Jenkins,

1988; Arnold, 1991): 1) Factors intrinsic to the job - e.g. poor physical working conditions, long hours, shift work, work overload (quantitative and qualitative), work under-load, new technology, physical danger, person-environment (P-E) fit and job satisfaction; 2) Role in the organisation - e.g. role ambiguity, role conflict and responsibility (for people and things); 3) Career development - e.g. over-promotion, under-promotion, status incongruence, lack of job security and thwarted ambition; 4) Relationships at work - e.g. the quality and degree of social support from colleagues, superiors and subordinates; and 5) Organisational structure and climate - e.g. "office politics", lack of effective consultation, lack of participation in the decision-making process and restrictions on behaviour. A difficulty related to stressor reduction interventions is that there is little evidence to suggest that they cause a significant reduction in absenteeism (Murphy, 1988). However, Karasek (1990) undertook a large scale, cross-sectional survey of white-collar workers in Sweden and did find a relationship between stressor reduction and absenteeism. Some of his participants had experienced job redesign programmes aimed at improving productivity, and others had not received such programme. The results show that as a whole the absence rates had increased, however workers who had redesigned jobs with more control had significantly lower absence rates (and significantly lower risk of illness) than those whose control had decreased. This research therefore highlights the importance of job control (or perception of control) in relation to stressor reduction and job-redesign initiatives.

Secondary interventions refer to the individuals' resources to deal with stress. Successful programmes include relaxation training (including biofeedback), meditation, exercise, smoking cessation, hypertension screening/control, nutritional counselling, selective medical referrals, cognitive appraisal training, goal-setting and time-management training (e.g. Manuso, 1980; Bruning & Frew, 1987). Fielden and Peckar (1999) highlight the usefulness of cognitive coping strategies, designed to help individuals reduce the degree of perceived stress. They suggest cognitive reframing techniques to change the meaning of the situation, to manage unpleasant thoughts and/or to re-interpret the information in a more positive or realistic way. Randolfi (1997) believes that to resist stress one must "strengthen

the body”, this can be done through “good health habits, exercise and nutrition”. Stress resistance can be increased by a diet which is rich in fruit, vegetables, and whole grain and by avoiding excessive consumption of tobacco, alcohol, and caffeine.

The tertiary interventions work on a more therapeutic level where stress management is part of a treatment approach using counselling and Employee Assistance Programmes (Cooper and Cartwright, 1997). The choice of whether to use 'in-house' or 'out-of-house' counselling services can be a crucial one (Lisle & Newsome, 1988). In-house counseling is more likely to indicate management commitment, be better informed and thus may help reduce specific areas of stress, some employees may not trust the confidentiality and therefore may lose out on accessing this service. External services do not suffer from such confidentiality problems, and are attractive to small organisations to ensure round the clock availability. An additional benefit of external counseling services is that they are viewed as being 'professional'. The drawback of external counselling, however, is that it is separate from the organizational context and therefore is more likely to be reactive rather than proactive.

Most stress prevention and management programmes focus on the secondary and tertiary levels (Cooper & Cartwright, 1997; Levi, 1999). The European Union's Directorate-General for Employment and Social Affairs has given guidance on managing work-related stress (1999). It states that stress is inevitable but it is not inevitable that stress is prolonged, recurrent and/or causes intense distress. The guidance focuses on the primary prevention of work-related stress and ill-health, rather than on its treatment. It reviews the options for action at the various levels and advocates a multifaceted approach to stress prevention at work and describes a low-cost approach to stress prevention, using diagnostic measures and primary, secondary and tertiary prevention approaches targeting both individuals and the organization.

1.5 Coaching

1.5.1 Definition of Coaching

Coaching can be described as a specific form of conversational process between a coach and a coachee, with the aim to give the coachee space to develop through a process of reflection and renewed understanding (Stelter, 2007). Stelter (2007) continues to say that in this dialogue the coach must take on a position in which he or she is aware of the risk of inadvertently influencing the process of co-creation. This self-knowledge is the basis for a professional attitude and work ethics. The term coaching has become very popular over recent years. This popularization has highlighted the need for a clear definition of the term as well as clarification of its purpose and application. As coaching is applied within a wide variety of contexts it is proving difficult to find a clear concise definition. The Association for Coaching (AC) - the UK's main professional association for coaches - gives different definitions for specific coaching areas (AC, 2007):

Personal/Life Coaching: *"A collaborative solution-focused, results-orientated and systematic process in which the coach facilitates the enhancement of work performance, life experience, self-directed learning and personal growth of the coachee."*

Executive Coaching: *"As for personal coaching, but it is specifically focused at senior management level where there is an expectation for the coach to feel as comfortable exploring business related topics, as personal development topics with the client in order to improve their personal performance."*

Corporate/Business Coaching: *"As for personal coaching, but the specific remit of a corporate coach is to focus on supporting an employee, either as an individual, as part of a team and/or organisation to achieve improved business performance and operational effectiveness"*

Speciality/Niche Coaching: *"As for personal coaching, but the coach is expert in addressing one particular aspect of a person's life e.g. stress, career, or the coach is focused on enhancing a particular section of the population e.g. doctors, youths."*

Group Coaching: *“As for personal coaching, but the coach is working with a number or individuals either to achieve a common goal within the group, or create an environment where individuals can co-coach each other.”*

Due to the recent growth of the coaching psychology speciality, it has also been important to define the terms coaching psychology and psychological coaching. Coaching psychology has been defined by Grant (2006), as *“the systematic application of behavioural science to the enhancement of life experience, work performance and well-being for individuals, groups and organizations who do not have clinically significant mental health issues or abnormal levels of distress”*. Palmer and Whybrow (2006) give voice to a definition of psychological coaching as *“a coaching approach which borrows from the techniques used within the psychological therapies and transforms these techniques to fit the coaching contexts”*. Examples of psychological coaching are Cognitive-behavioural coaching (CBC), Multimodal coaching, Rational Emotive Behaviour Coaching and coaching using Neuro-linguistic Programming (NLP).

1.5.2 Research on coaching outcomes

The majority of published research on coaching has addressed work performance coaching within large organisations (Sparrow, 2007). Over the last ten years several reviews of the academic literature on coaching have been published (see Grant 2003, Grant and Cavanagh, 2004; Stober & Grant, 2006). Particularly the Evidence Based Coaching Handbook (Stober & Grant, 2006) and the Handbook of Coaching Psychology (Palmer & Whybrow, 2006) can be seen as milestones in the development and application of evidence based coaching. However, coaching outcome research is still in its early stages and most reviews report that there is still a lack of definite evidence on causal relationships between coaching and positive outcomes (Greif, 2007). A fundamental difficulty of coaching outcome research is the extreme heterogeneity of issues, problems and goals (Greif, 2007). It is suggested that more evaluation studies are needed as well as clinical trials with randomised clinical and control groups (Grant & Cavanagh, 2004). Additionally, more research on group coaching is needed as opposed to the more

commonly published single case studies. Greif (2007) argues that it is difficult to identify outcome measures which are applicable to the whole range of coaching interventions. Each coaching intervention stands on its own with its own specific qualities adjusted to the individual. For instance, Laske, (2007) argues that coaching outcome is ultimately decided by the Frame of Reference (FoR) of the coach as well as the coachee, which is determined by his or her developmental profile. This makes the use of a standardised assessment tool very difficult which in turn hampers the collection of scientific proof as it hinders replication of the studies and the ability to compare results.

Despite the above mentioned difficulties many studies have been published reporting positive outcomes of coaching interventions. In their literature review, Grant and Cavanagh (2004) focussed on peer-reviewed psychological journals and found that a total of 128 papers had been published since 1937. They identified five overlapping thrusts to coach-specific research: (a) discussion articles on internal coaching conducted by managers with direct reports; (b) the beginnings of more rigorous academic research on internal coaching and its impact on work performance; (c) the extension of research to include external coaching by a professional coach as a means of creating individual and organisational change, (d) the beginning of coaching research as a means of investigating psychological mechanisms and processes involved in human and organisational change; and (e) the emergence of a theoretical literature aimed at the professional coach. They also found that three primary means of reporting and investigating coaching have been used throughout these five phases: descriptive articles; empirical evaluations based on case studies; and empirical evaluations based on group studies.

Several studies have been published, drawing on a variety of theoretical models. For instance, Diedrich (1996) reported on a case using a systems perspective, while Kiel, Rimmer, Williams, and Doyle (1996) presented a case study using a psychodynamic perspective. Richard (1999) presented a case study using multimodal therapy and Foster and Lendl (1996) published four case studies using eye movement desensitisation and reprocessing (EMDR, Shapiro, 1989). Cognitive

behavioural frameworks were also presented including the work of Anderson (2002) and Richard (1999), who presented a cognitive and behavioural framework for executive coaching. Results from other research into the effectiveness of cognitive behavioural techniques in the field of coaching are promising (Grant, 2001; Libri & Kemp, 2006; Green, Oades, & Grant, 2006; Grbcic and Palmer, 2006, Palmer & Gyllensten, 2008). Grbcic and Palmer (2006) found in a randomised controlled trial that stress was significantly reduced amongst middle managers after using a cognitive-behavioural self-coaching manual. Howatt (2000) discussed the use of Reality Therapy and Choice Theory as a framework for coaching, and Page (2003) offered contributions from Adlerian perspectives. Furthermore, multi-model coaching has been identified as a useful framework for coaching (Palmer and Whybrow, 2006).

There are limited publications on group coaching however, some group-based empirical evaluations were published by Graham, Wedman, and Garvin-Kester (1993) and Olivero, Bane and Kopelman (1997). Particularly the Olivero, Bane, and Kopelman (1997) study is worth mentioning as it focused on evaluating the additional effectiveness of coaching in comparison and in addition to skills trainings. However, although the study was group based, allowing for qualitative analysis, there was no control group.

Grant and Cavanagh (2004) also report large-scale studies and particularly mention the study of Smither, London, Flautt, Vargas, and Kucine (2003) who did a quasi-experiential field experiment of the impact of coaching on 404 senior managers who received 360 degree feedback and coaching. Although some methodological shortcomings have been identified for this study, the results show that feedback and coaching enhanced performance and re-evaluation scores on the 360 tool. Furthermore, Wageman (1997) found that coaching was a critical factor in the development of superb self-managed teams, and Norlander, Bergman, and Archer (2002) investigated the relative stability of personality characteristics and the effectiveness of a 12-month coaching program with 15 employees of an insurance company and found that, as expected, many personality traits remained

stable, but individuals' emotional stability was enhanced, their norms and values were reinforced and their openness to new experiences improved. This study indicates that some personality traits are indeed flexible and responsive to coaching interventions. With regards to life coaching, Grant (2003) published the first peer-reviewed empirical evaluation of the impact of life coaching and found that life coaching was effective in facilitating goal attainment and well being.

1.5.3 Models of coaching

There are several coaching models which could be used to structure coaching sessions. Many popular coaching models were not originally presented as being explicitly grounded in the broader and established knowledge base and were presented in an atheoretical manner (Cavanagh & Grant, 2005). However, there is increasing awareness among coaches of the need to ground their practice in a solid theoretical understanding and empirically tested models (Grant & Cavanagh, 2004). The GROW model (Whitmore, 1992) is probably one of the most widely used models, GROW being an acronym of: **G**oal, **R**eality, **O**ptions, **W**hat is to be done, **W**hen, by **W**hom and the **W**ill to do it.. Another popular model is known as the CIGAR model (Centre for Coaching, 2007). This acronym stands for: **C**urrent Reality, **I**deal Outcome, **G**aps, **A**ction and **R**eview. The Co-Active model has also been a commercially successful and popular coaching model (Cavanagh & Grant, 2005). It was developed by Whitworth, Kimsey-House and Sandahl (1998) and Irwin and Morrow (2005) present a theoretical analysis of this model which helps it being grounded in a theoretical framework. The Co-Active model uses a 5-star configuration within a circle as its visual presentation. The points of the star link to 5 main qualities which the coach aims to use: Listening, Intuition, Action/Learning, Self Management and Curiosity. Within the Co-Active style of coaching the coachees are viewed as the expert of their whole life and have the answers to their own life questions. It is the coach's role to help them access those answers. Central to this approach is the alliance between the coach and the coachee which is designed at the outset of the coaching relationship.

In the coaching literature, the coaching relationship is often viewed as the vehicle for change (Gyllensten & Palmer, 2007). A sound and supportive relationship within the coaching process which gives opportunity to safely explore thoughts, feelings and experiences is reported to be crucial to the success of the coaching intervention (Gyllensten & Palmer, 2007; Waslyshyn, 2003; Wales, 2003). Gyllensten & Palmer (2007) found in their study on the coaching relationship that unless a good relationship was developed in the coaching, relevant achievements would not be made. This study also highlights the need for transparency of the coach as this helped the coachee to feel fully included in the coaching process and more inspired to take part in the coaching process.

In addition to the above mentioned models which are used within the broader field of coaching, coaching psychology also draws on models which have their roots in psychological therapy. Examples of these models are the Cognitive Behavioural Coaching (CBC) model, and the multimodal coaching model. Within the framework of CBC, sub-models are often used like the ABC sub-model (A=activating event, B=beliefs and C=consequences) or the SPACE model (S=social circumstances, P=physical signs & symptoms, A=action, C=cognitions and E=emotions).

1.5.4 Coaching Psychology

The International Coach Federation Survey (2007) estimates that there are at least 30.000 people working as coaches worldwide in an estimated global two billion per annum market (Fillery-Travis & Lane, 2006). Garman, Whiston and Zlatoper (2000) argue that licensed psychologists do have unique skills to bring to the coaching relationship, however organizations and coachee's rarely understand the unique contribution psychologists can make (Passmore & Gibbes, 2007). The fact that coaching psychology is starting to get recognition amongst the psychology community was evident when the British Psychological Society's Special Group in Coaching Psychology was established in 2004. The aim of the special interest group was to promote the development of coaching psychology at an academic and practitioner level, to develop ethical standards, and to foster a voice for psychology within the broader coaching arena (Palmer & Whybrow, 2005).

Coaching psychology is now a fast growing specialty which integrates a range of theoretical models (Whybrow & Palmer, 2006).

1.5.5 Coaching and Psychotherapy

Coaching and psychotherapy are similar in some respects: both approaches use knowledge of human behaviour to motivate behavioural or emotional change using interactive counselling techniques. However, there are major differences in the process and focus of the sessions and the level of professional responsibility (Starr, 2003 p11, p39). One of the main differences between coaching and psychotherapy is that coaching aims to enhance performance or one's life experience rather than primarily treating dysfunctionality (Grant, 2001b). Psychotherapy, on the other hand, is a health care service focusing on identifying and treating diagnosable psychological disorders. In coaching the coachee sets the agenda for the sessions and each session is geared towards achieving a specific goal. Each session goal in turn is geared towards achieving an overall goal which is identified early on in the coaching contract. In this way, coaching is about enhancing individuals' abilities to self-regulate and move systematically towards goal attainment (Grant, 2001b). In coaching it is assumed that the coachee is capable and best placed to find their own solutions. Coaching therefore characterized by a Socratic questioning style, which promotes insight and better rational decision making (Neenan & Palmer, 2001). Through the use of Socratic questioning the coachee is encouraged to identify their own, individually suited, strategies and solutions.

A further difference between coaching and psychotherapy is that coaching often occurs within an organizational context. This means that the manager has been involved in the arrangement of the coaching contract or is at least aware of the coaching taking place. Subsequently, confidentiality issues may be more complicated than those most frequently encountered in psychotherapy. Skill is being required from the coach to ensure that the individual coaching goals are in line with the organizational coaching goals.

1.5.6 Coaching in Palliative Care

Within this research, coaching is recognised as a tool to help members of staff manage their stress, and develop their full potential within the context of ongoing professional development. Historically, coaching had been used in a business context as a remedial process, which is sometimes referred to as “Performance Coaching” (Leimon, Moscovici & McMahon, 2005). However, with the recognition of the benefits of ongoing professional development, a different type of coaching has emerged, often referred to as “Coaching for Excellence”. This type of coaching operates from the assumption that employees are already fully established and successful at what they are doing, but would benefit from structured support with - and reflection on their practice. The goal of this type of coaching is to help sustain the high standards already achieved, to support staff in their professional development and facilitate the ongoing process of assuring best practice. Due to the specific stressors associated with the delivery of palliative care as described above, it would appear that a tailor-made coaching programme designed to help staff manage the stressors effectively, could be of value to ensure staff well-being and effective patient care.

1.6 Aims of the study

The first aim of the study is to gain an understanding of the overall levels of stress experienced by members of staff working in the two hospices in Northamptonshire. The second aim of the study is to obtain an understanding of the causes of stress as well as the coping strategies used to manage stress in the hospice environment. The final aim of the study is to use the knowledge obtained from the first two aims, to develop a tailor made group-coaching programme to suit the hospice and palliative care service.

1.7 Research questions

Phase 1:

- 1) How do the levels of perceived stressors amongst the hospice staff compare with the Management Standards set by the Health and Safety Executive (HSE)?
- 2) How do the levels of stress, anxiety and depression of the hospice staff compare with the levels of the general population?
- 3) Which specific stressors can be identified as most prominent amongst the hospice staff?

Phase 2:

- 4) What are the perceived stressors amongst the hospice staff?
- 5) Which (if any) coaching needs can be identified for the hospice staff?

Phase 3:

- 6) What is the perceived usefulness of a brief stress-coaching intervention for the hospice staff?

1.8 Research hypotheses

1.8.1 Hypotheses related to phase 1

1. The hospice staff will score below average on the HSE Stress Indicator Tool in comparison to the Management Standards set by HSE on at least 4 of the 7 subscales of the HSE Stress Indicator tool. This hypothesis will be tested for the different sub-groups: a) All Hospice staff, b) All Hospice 1 staff, c) Hospice 1 Clinical staff, d) Hospice 1 Support staff, e) All Hospice 2 staff, f) Hospice 2 Clinical Staff and g) Hospice 2 Support Staff.
2. The hospice staff will score higher on the three sub-scales of the DASS21 (depression, anxiety and stress) than the general population (indicating a higher level of depression, anxiety and stress amongst the staff group). This hypotheses will be tested for the sub-groups: a) All Hospice staff, b) Hospice 1 staff, c) Hospice 2 Staff.

3. Members of staff scoring low on the HSE Stress Indicator Tool (indicating a higher level of stressors/hazards in the workplace), will score higher on the DASS-21 (indicating a higher level of depression, anxiety and stress). For each sub-scale of the DASS-21 a minimum of one stressor domain of the HSE Stress Indicator tool will have a significant negative correlation.

1.8.2 Hypotheses related to phase 2 and 3

Phase II and III are qualitative studies which, for that reason do not have hypotheses attached to them.

Chapter 2: Method

2.1 Overview

In this chapter the methods used for the different phases of the research will be explained. Paragraph 2.2 will give details of the design of the research, followed by an explanation of the rationale behind the chosen methods in paragraph 2.3. Following this, the inclusion and exclusion criteria will be given in paragraph 2.4, and the recruitment strategies will be explained in paragraph 2.5. Paragraph 2.6 will give information about the methods used to collect the data, followed by an explanation of the process of data analysis in paragraph 2.7. The chapter finishes with an overview of ethical considerations including the mandatory process of obtaining ethical approval by the Ethics Committees and Research and Development Departments.

2.2 Design

This research project exists of three phases. Phase 1 is a cross-sectional study to assess the levels of stress and the main stressors as experienced by members of staff working within the hospices. In this phase, a one-point assessment has been done using three measures, the DASS-21 (Depression Anxiety Stress Scale, see Appendix 1), the HSE (Health and Safety Executive) Stress Indicator Tool (see Appendix 2) and a Demographic questionnaire (See Appendix 3.). The data was collected anonymously. Descriptive statistics as well as multiple regression were used to analyse the data. The dependent variables were Depression, Anxiety, Stress and Negative Affect, measured by the DASS-21. Predictor variables were the seven HSE stressors and the demographic variables “place of work” and “Years working in palliative care”.

Phase 2 is a qualitative study with the purpose of obtaining a deeper understanding of the stressors as identified in phase 1. Two focus groups have been held, one at each hospice. Each focus group lasted about 1 hour and was facilitated by an external facilitator. The data was analysed using the methodology of Grounded Theory. Microsoft Word and the computer programme Atlas ti were used to analyze the data.

Phase 3 exists of an evaluation of a brief stress-coaching intervention which has been designed to address some of the findings of phase 1 and 2. Initially it was intended to hold only two group sessions, one at each hospice. However, in response to participants' requests, four separate sessions were held to accommodate demand. The group coaching interventions used cognitive behavioural coaching (CBC) as its theoretical framework and each session lasted about 2 hours. The data was analysed using the methodology of Grounded Theory. Microsoft Word and the computer programme Atlas ti. (Scientific Software Development GmbH, 1993-2003). were used to analyze the data. For information on the structure of the Stress-Coaching Session see Appendix 27. Also please see appendices 28 for stress management plan, appendix 29 for stress management worksheet, and appendix 30 for the handouts of the workshop.

2.3 Rationale for the chosen methods

Phase 1 was designed to achieve the first aim of the study and part of the second aim. It provides initial data on levels of experienced strain, as well as an indication of the risk factors related to occupational stressors. The choice to use quantitative data in this phase was based on the fact that this would provide the opportunity to compare data between the two hospices and between different staff groups. It was also judged to be the most time efficient way to obtain maximum information on perceived stressors and strain as well as providing an opportunity to explore the relationship between strain and the different stressors and demographic factors. Although the HSE Management Standards Indicator Tool can be used as a

standalone measuring tool, the HSE emphasizes that the results of the survey alone can only provide an indication of performance in managing work-related stress. The results should therefore be confirmed and employees should be given the opportunity to discuss and explore any issues brought up by the survey. The same applies for the data of the DASS-21; it gives an indication of the overall perceived levels of strain, the questionnaire does not give any information about the perceived causes. It was therefore felt that, to provide explanations and to add meaning to the findings of phase 1, a second phase was needed to provide a deeper, qualitative investigation in order to understand and fully appreciate the factors which mediate work-related strain in the specialist field of palliative care. In addition to the above information, another deciding factor for using qualitative data in phase 2 was that the initial literature review had revealed that there is limited information on hospice staff's perceptions of stress and stressors within the hospice environment. To analyze this qualitative data the method of Grounded Theory was chosen.

Grounded Theory is a method which was originally developed by Glaser and Strauss in "The Discovery of Grounded Theory" (1967). One of the major differences between Grounded Theory and other qualitative methods is its emphasis on theory development. Theory consists of plausible relationships proposed among concepts and sets of concepts. Grounded Theory methodology is designed to guide researchers in producing theory that is "conceptually dense". Strauss and Corbin (1994) argue that the emphasis is not on individual situations or cases, but on discovering process. Charmaz (2001) defines it as a method which provides systematic inductive guidelines for gathering, synthesizing, analysing, and conceptualizing qualitative data to construct theory. The process of data collection and data analysis is closely intertwined, with the use of the "constant comparison method" (Strauss and Corbin, 1998). This method implies that analysis of data is a constant process and starts as soon as some data has been collected. Further data collection is informed by previous analyses. As categories emerge, new samples are added to increase diversity. Bryan (2001) explains that this process is continued until no new or relevant data is distracted

from the samples and “theoretical saturation” has occurred. A “grounded theory” is discovered, developed, and provisionally verified through systematic data collection and analysis of data. Therefore, data collection, analysis and theory stand in reciprocal relationship with each other rather than the researcher starting with a theory and trying to prove it. This clarifies why, unlike most other research methods, Grounded Theory starts with data collection. From the first set of collected data categories are identified which will inform further data collection. Data can be gathered from various sources of which interviews and observations are the most common. Procedures used to conceptualize data are non-statistical sampling (Scharzman & Strauss, 1973), coding, the writing of memos, and the diagramming of conceptual relationships. As grounded theory is an inductive examination of data and it is used in areas of research where little or no prior knowledge exists, it became clear that it would be a suitable approach to explore the concepts, perceptions and processes around stress in the hospice service, as expressed in the focus groups.

The HSE mentions that the use of focus group is a suitable means to achieve additional data to complement the questionnaire. Focus groups are defined by Kitzinger (1994: cited in Pope & Mays, 1999) as “a form of group interview that capitalises on communication between research participants in order to generate data”. Focus groups allow for discussions on fairly defined topics but does allow for an interactive group construction of meaning (Bryman 2001). This makes the use of focus groups very suitable for the methodology of grounded theory (Dick 2002). Within social research focus groups have become widely used for qualitative research methods.

Several factors influenced the decision to use focus groups rather than one-to-one interviews. It was felt that the use of focus groups would allow for an open discussion between the participants. As the investigation of stress and stressors has both individual and organization aspects, group discussions would allow for an exploration of these issues from different angles which facilitates the production of rich data of the emerging topics. Unlike the use of individual interviews, the

discussions within the focus groups would provide opportunities for disagreement between the participants which can help with gaining a better understanding of the reasons behind the expressed viewpoints (Kitzinger, 1994). Furthermore, Wilkinson (1998) suggests that focus groups are more naturalistic than one-to-one interviews as they more closely reflect the ways in which meanings are constructed in everyday life. A potential difficulty when using focus groups is the risk that “pre-existing styles of interaction or differences in status may contaminate the session (Bryman, 2001). However, it was felt that the benefits of using focus groups outweighed the negatives and would provide the richest data for this research.

To evaluate the usefulness of the coaching intervention of phase 3, a combined approach of rating scales and qualitative data was used. The rating scales before and after the session gave a measure of perceived improvement in coping ability whilst the qualitative data again gave deeper insight into the perceived improvement as well as an overall indication of the perceived usefulness of the intervention in the context of managing stress. Suchman (1967) gave an early definition of evaluation as a method for determining the degree to which a planned programme achieves its desired objective. Evaluations are essentially indistinguishable from other research methods as they can make use of a range of research strategies (Robson, 1993). As the goal of an evaluation strategy is often to assess the value of an intervention as well as an aid to improve the programme which is being evaluated, it was perceived as the most useful approach to assessing the usefulness and effectiveness of the coaching intervention. Literature suggests that there are many evaluation models (Robson, 1993). The approach used in this research is a combination of a formative evaluation and a summative evaluation. The formative aspect of the evaluation is intended to help develop the programme and the summative aspect concentrates on assessing the effects of the programme.

2.4 Participants inclusion and exclusion criteria

To be able to collect enough data within a “contained environment” the following inclusion and exclusion criteria were selected.

Inclusion criteria: Included were all paid members of staff working within and based at the two hospices in Northamptonshire (i.e. Nurses, Doctors, Social work team, MacMillan nurses, Occupational therapists, Physiotherapists, Music therapist, admin staff and other support staff).

Exclusion criteria: Excluded were volunteers and members of staff of the palliative care service based outside the hospices as it was reasoned that volunteers would experience different levels of stress and stressors than paid staff.

2.5 Recruitment

2.5.1 Recruitment for phase 1

Recruitment for phase 1 was achieved through obtaining a list with the names of all members of staff working within the hospices from the service manager. All members of staff were sent an Invitation Letter (see Appendix 4), a Participant Information Sheet (see Appendix 5.), a copy of the DASS-21 (see Appendix 1), a copy of the HSE Stress Indicator Tool (see Appendix 2) and a copy of the Demographics Questionnaire (see Appendix 3), by internal mail. Members of staff were asked to return the questionnaires using internal mail or hand delivery, to the researcher’s office within 1 month.

2.5.2 Recruitment for phase 2

Recruitment for phase 2 was done through the use of posters (see Appendix 6) which were placed on the notice boards at both hospices. The posters were pinned up for about one month after which it was expected that all members of staff would have been aware of the focus groups and would have had an opportunity to respond. The posters gave a brief outline of the purpose of the focus group, where they were going to be held, the dates and times of the planned groups and contact details for further information. Members of staff who showed interest in taking part

were given an information pack which include a Participant Information Sheet with Reply Slip (see Appendix 7). A maximum of 8 participants per group were allowed to participate and the selection was done on a first come first serve basis. Although the optimum size of a focus group is deemed to be between six to twelve, smaller groups are suggested when participants are likely to have a lot to say or are very involved in the topic (Morgan 1998, cited in: Bryman 2001). Prior to the start of the group, participants were asked to sign a consent form.

2.5.3 Recruitment for phase 3

Recruitment for phase 3 was achieved in the same way as described for phase 2 (see Appendix 8 and 9). A maximum of 10 participants were allowed per group and the selection was done on a first come first serve basis. Participants were again asked to sign a consent form prior to the start of the sessions.

It was made clear in the Participant Information Sheets that all participation in this project was entirely voluntary and all participants could withdraw from the project at any stage without encountering adverse effects and without having to give any explanations.

2.6 Data Collection

2.6.1 Data collection phase 1

Data collection for phase 1 was done anonymously through the use of two standardised questionnaires: the DASS21 (Depression Anxiety Stress Scale) and the HSE (Health and Safety Executive) Stress Indicator. The questionnaires were sent to all staff working for the two hospices in Northamptonshire (n= 132). In addition to the standardised questionnaires, a brief demographic questionnaire was included to collect relevant demographic data. Extreme caution was taken to obtain relevant information without compromising anonymity.

The DASS-21

The DASS (Lovibond & Lovibond, 1995) is a 42-item, set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress. The DASS21 is a short version of the DASS, using 7 items per scale. The Depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, and lack of interest/involvement, anhedonia, and inertia. The Anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The Stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient. Subjects are asked to use 4-point severity/frequency scales to rate the extent to which they have experienced each state *over the past week*. Scores for Depression, Anxiety and Stress are calculated by summing up the scores for the relevant items. The DASS is based on a *dimensional* rather than a *categorical* conception of psychological disorder. The assumption on which the DASS development was based (and which was confirmed by the research data) is that the differences between the depression, the anxiety, and the stress experienced by normal subjects and the clinically disturbed, are essentially differences of degree. The DASS therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD. However, recommended cut-offs for conventional severity labels (normal, moderate, severe) are given in the DASS Manual (Lovibond & Lovibond, 1995). The reliability of the DASS has been reported as excellent, with adequate convergent and discriminant validity (Crawford and Henry, 2003). Lovibond and Lovibond's reported alpha values for the DASS-21 from a student sample (N = 717) are .81 for depression, .73 for anxiety, and .81 for stress. In a clinical sample, Clara, Cox, and Enns (2001) reported high levels of internal consistency for the DASS-21 with alpha values of .92 for depression, .81 for anxiety, and .88 for stress. The DASS-21 was chosen for this research as it is increasingly the tool of choice within coaching research, and would for this reason provide data which could be used to compare findings with other coaching research projects.

The HSE Stress Indicator Tool

The HSE Stress Indicator tool is a 35-item questionnaire relating to the six key stressor areas: demands, control, support, relationships, role and organizational change. The Management Standards comprise a series of 'states to be achieved', which are statements of good practice. It provides a broad indication to organisations of how their workforce rate their performance in managing the risks associated with work related stress (Health and Safety Executive, 2001). The HSE Stress Indicator tool has been reported to be a reliable and valid risk assessment tool of workplace stressors in the UK (Cousins, Makay, Clarke, Kelly, Kelly, *et al.*, 2004). The HSE recommends that all workers are included in the study if the numbers are fewer than 500, to provide data accurate to at least 5%. It is important to note that the results only provide an indication of performance against Management Standards, and the outcome will need to be discussed and explored with the employer and employees (see Phase II).

Demographic Questionnaire

Based on the above literature review, it was felt that several variables could influence the levels of perceived stress. To enable the study of the relationship between these variables and perceived stress, a Demographic Questionnaire was designed (please see Appendix 3). The demographic variables measured in this questionnaire are: Years in Palliative Care work, Part-time or Full-time worker, Age, place of work and professional group 1 (clinical staff) or 2 (supportive staff).

2.6.2 Data collection phase 2

Data collection for phase 2 was achieved through the use of two focus groups (+/- 1 hour each), one held at each hospice. The focus groups were facilitated by someone other than the researcher and independent from the Northamptonshire palliative care service. The sessions were audio recorded and additional notes were taken by an independent secretary who also transcribed the recordings to ensure anonymity. The focus groups were guided by a prompt list (see Appendix 10) to ensure that the same main issues were covered in each focus group. In this style of group facilitation flexibility is essential for the discovery of the participant's

own framework of meanings and to allow unexpected concepts to emerge (Britten cited in Pope and Mays 1999). Therefore, the questions on the prompt list may not follow a set order, in order to encourage participants to expand on the emerging topics or responses.

2.6.3 Data collection phase 3

The original plan had been to collect data from 2 groups of participants, one at each hospice. However, due to popular demand, permission had been asked and granted by the LREC (see Appendix 15) to hold two further groups. Therefore, 4 coaching sessions have been held in total. The data was collected using an evaluation questionnaire which had a scaled question on perceived stress over the last month, and scaled questions on pre- and post perceived level of skill to manage stress. In addition to these scaled questions, open evaluative questions were used to assess the perceived usefulness of the session (see Appendix 16).

2.7 Data analysis

2.7.1 Data analysis for phase 1

The data of the DASS-21, the HSE tool and the Demographics Questionnaire were analysed using a variety of methods, Descriptive statistics were obtained from the DASS-21 and the data was compared with the norms provided within the questionnaire manual. The DASS-21 analyses were done for the sub-groups: all staff, clinical staff and support staff. For the analyses of the HSE Indicator Tool, the above sub-groups were also used, but further sub-groups were created by comparing the results of the two hospices with each other using all staff at each hospice, clinical staff at each hospice and support staff at each hospice. The data from these analyses were compared with the management standards as set by the HSE.

Using SPSS, four separate multiple regressions were used to analyse how the seven HSE stressors and demographic variables predict job related strain: depression, anxiety, stress and negative affect.

2.7.2 Data analysis for phase 2

The data from the focus groups was analysed using the transcripts of the audio recordings. The independent note taker and transcriber was asked to take out any identifying information. Grounded Theory was used as the methodological framework. The software Atlas ti. was used to analyse the data. A system of coding was developed and relevant concepts and commonalities in the transcripts were identified as categories. A “grounded theory” is discovered, developed, and provisionally verified through systematic data collection and analysis of data. Therefore, data collection, analysis and theory stand in reciprocal relationship with each other rather than that the researcher starts with a theory and would try and prove it. Procedures used to conceptualize data are non-statistical sampling (Scharzman & Strauss, 1973), coding, the writing of memos, and the diagramming of conceptual relationships. For an in depth description of the process of analyses, please see chapter 4.

2.7.3 Data Analysis Phase 3

The analysis of data of phase 3 was conducted in two stages. The first stage existed of the analysis of the scaled questions:

Prior to session:

- 1) How high/low would you rate your average stress as experienced over the last month?
- 2) How skilled do you feel in managing your stress?

After session:

- 1) How skilled do you feel to manage your stress?

This information gave a base-line summary as well as an overall measurement of improvement.

For the analysis of the open questions, the software Atlas ti. was used. A list of all the responses to each question was imported into this programme and a process of coding was used similar to the process used for the analysis of phase 2. The system of coding was more straight forward than used in phase 2, as there was considerably less data to analyse. The content of the data also was less rich than that obtained in phase 2, due to the difference in approach to data collection. Grounded theory again was used as its theoretical framework. For an in depth description of the process of analyses, please see chapter 5.

2.8 Ethics

2.8.1 Ethical Approval

Ethical approval was required from the NHS Local Research Ethics Committee (LREC) as well as the Research and Development departments of the Northamptonshire Teaching PCT, Northampton Health Trust and City University. This approval was sought and granted by all four organizations (see Appendices 11,12,13 and 14).

2.8.2 Ethical considerations

The research had brought up several ethical issues which mainly related to the fact that the researcher worked as a Consultant Clinical Psychologist within the two hospices, which could conflict with the role of researcher. It was considered that:

- Members of staff may feel under pressure to participate in the project. It was made clear in writing to all potential participants that participation in the research is on a voluntary basis and no negative consequences for refusing to participate shall follow. Factors which may reduce staff's anxiety about this issue are:
 1. The researcher was not part of the line-management of the staff group and was not part of any staff performance reviews.
 2. The nature of the research is to identify and deal with stress. Informal communications with staff members had highlighted the need for this

and it was expected that this project would be valued amongst staff members.

- Members of staff who agreed to participate may have concerns about possible negative consequences as a result of their participation. It was anticipated that the chance was very low that participants would experience any negative consequences due to their participation in this project. In the unlikely event of participants feeling negatively affected by their participation, they were offered individual follow-up sessions/support to identify and resolve the issues which were causing concern or distress. In case it seemed necessary and appropriate, additional help would have been offered through the Occupational Health Department or through a referral to their GP. The above mentioned procedures and safety nets were explained to the participants in the Participant Information Sheets.
- Members of staff may have concerns about confidentiality and anonymity. The procedures around confidentiality and anonymity are discussed in the next section. The procedures around confidentiality were explained to the participants in the Participant Information Sheets.

2.8.3 Confidentiality and anonymity

It was made clear in the Participants' Information Sheets (see Appendices 5,7 and 9) that all research materials would be dealt with confidentially and no references would be made to identifiable individual participant information at any stage within the research process or within the Thesis. Nor would any identifiable information relating to participants be published. Although anonymity was compromised during phase 2 and 3 of the project, trust and confidentiality were paramount. The staff team were made aware of the researcher's confidentiality boundaries in the participant information sheets and on the consent form (see Appendices 17 and 18). Individual patient information which might have come up during the focus groups or coaching interventions, were to be dealt with confidentially and no

reference to individual patients were to be made at any stage of the research process or within the Thesis and publications.

All identifiable research information and materials were to be locked away in a NHS filing cabinet to which the researcher was the only key holder. Collected data was coded and stored on two USB sticks (one for back-up) and a home computer was used to process the data. No identifiable information was stored on the USB sticks. All identifiable research material were to be destroyed after the successful completion of the Doctorate course. Raw research data were only to be accessible to the university supervisors and the researcher.

2.8.4 Informed Consent

To ensure that all participants were fully informed about the project, written information was given to them in the form of a Participant Information Sheet, prior to their decision to participate, with details of the research and procedures. After having read this information and prior to the start of the focus groups and coaching sessions, all participants were asked to sign a Consent Form (see Appendices 17 and 18).

2.8.5 Dissemination of research outcome

As it is important to communicate the results to the management team and the employees, two presentations were held. The presentations reported on the findings and proposed some changes on the level of organizational functioning. Both presentations were open to all members of staff working within the palliative care service, including the participants.

Chapter 3: Results Phase 1

3.1 Overview

In this chapter the results of phase 1 will be given. The chapter starts with an overview of the response rate and descriptive statistics of the participants. Paragraph 3.3 will present the results of the DASS-21 questionnaire and paragraph 3.4 will present the results of the HSE stress indicator tool. This is followed by the results of the Multiple Regression in paragraph 3.5. The chapter closes with an exploration of the hypotheses in paragraph 3.6.

3.2 Response rate and Demographic Data

A total of 132 questionnaires were sent out, 88 to hospice 1 and 44 to hospice 2. In total 91 participants (69%) completed the forms. For Hospice 1 the response rate was n=61 (70.5%) and for Hospice 2 the response rate was n=29 (66%).

During the time of data collection for phase 1, only three members of staff were male. A large percentage of staff was aged between 41 and 50 years old (n= 40, 44%), followed by staff over 50 years old (n=31, 34%), followed by staff aged between 31 and 40 years old (n=14, 15%), Followed by staff aged between 21 and 30 years old (n=6, 7%). No members of staff were younger than 21 (see Figure 3.).

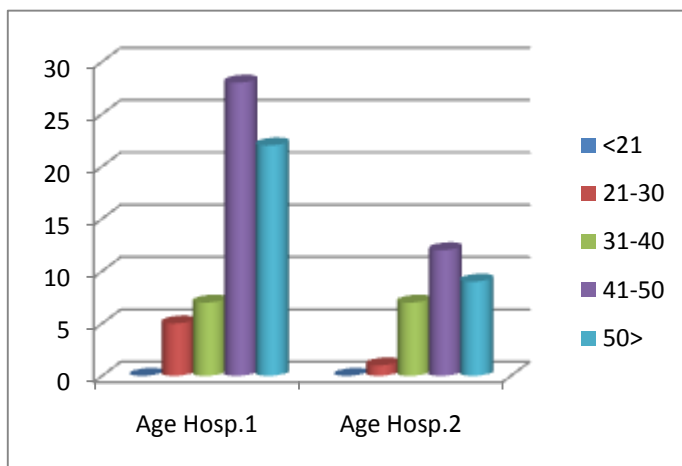


Figure 3: Number of Participants per age range for each hospice

Nearly one third of staff working in the two hospices had been working in palliative care for more than 10 years (n=28, 31%), followed by staff having worked in palliative care between 4 and 8 years (n=21, 23%), closely followed by staff who have worked in palliative care between 2 and 4 years (n=20, 22%), followed by staff who have worked in palliative care between 8 and 10 years, as well as staff who worked less than 2 years in palliative care (n=11, 12% each) (see figure 4.)

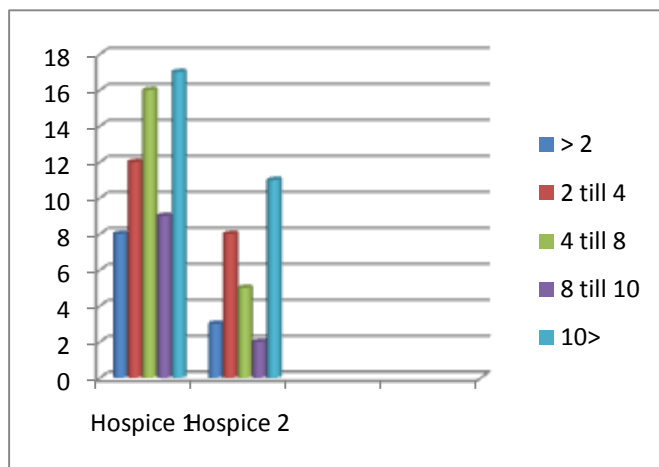


Figure 4: Number of Participants in relation to years working in palliative care for each hospice

During the time of data collection the service employed 33 full-time staff (36%) and 58 part-time staff (64%) (see figure 5).

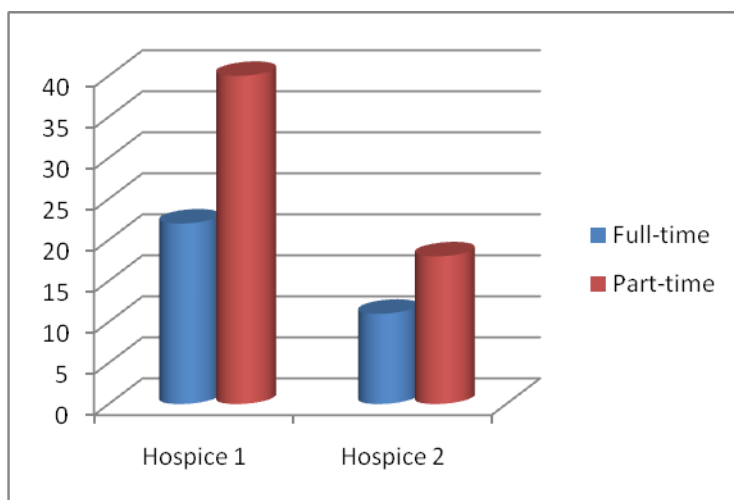


Figure 5: Number of full-time and part-time workers at each Hospice

In total 80 (88%) members of staff were employed in clinical roles and 11 (12%) members of staff were employed in supportive roles (see figure 6).

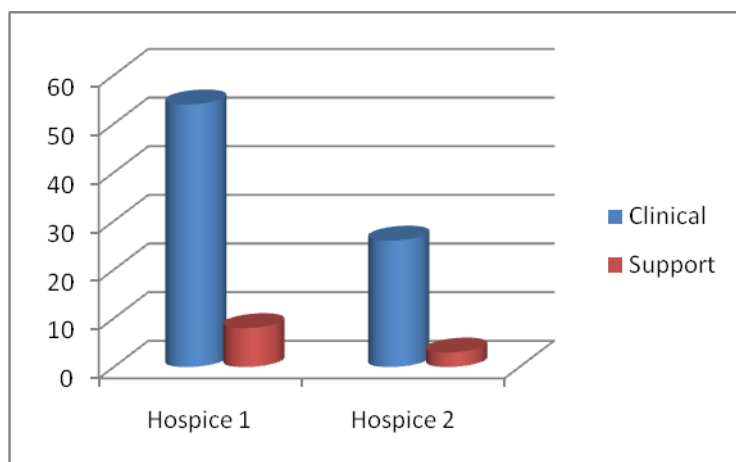


Figure 6: Number of Clinical Staff and Support Staff at each Hospice

3.3 Results of the DASS-21

Several analyses were conducted on different sub-groups of the participants. Table 1, 2 and 3 show the descriptive statistics of the findings. Table 1 shows the analysis for both hospices together, Table 2 shows the analysis of hospice 1 plus the sub-groups “clinical staff” and “support staff”, and Table 3 shows the analysis of hospice 2 plus the sub-groups “clinical staff” and “support staff”.

Table 1: Summary of participants' DASS-21 scores for all staff at both hospices

	Depression		Anxiety		Stress		Negative Affect	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
All staff N=91	6.07	6.52	3.97	5.4	9.41	6.88	19.52	16.47

Table 2: Summary of participants' DASS-21 scores for staff at hospice 1

	Depression		Anxiety		Stress		Negative Affect	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
All staff N=62	6.18	6.50	4.11	7.70	10.23	6.66	20.58	16.76
Clinical N=54	6.87	6.70	4.37	5.76	10.54	6.90	21.85	17.18
Support N=8	1.50	3.33	1.25	1.49	8.25	4.83	11.00	7.56

Table 3: Summary of participants' DASS-21 scores for staff at hospice 2

	Depression		Anxiety		Stress		Negative Affect	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
All staff N=29	5.86	6.67	3.66	4.84	7.66	7.13	17.24	15.90
Clinical N=26	5.08	5.97	3.31	4.73	7.08	6.86	15.53	14.39
Support N=3	12.67	10.07	6.67	5.77	12.67	9.02	32.00	24.25

Two sets of norms are available to compare the findings of Phase 1 with. There are the original norms as provided in the DASS manual (Lovibond & Lovibond, 1995). However, further to an email conversation with Peter Lovibond (date: 15/12/2007, see Appendix 19) there is evidence that the UK population means are lower than the US population means (Henry & Crawford, 2005). Norms given by Henry & Crawford could therefore be more accurate and appropriate for the UK population. Henry & Crawford also include Negative Affect as an additional variable , which is the total sum of all three scales scores.

Hospice 1

Comparing the scores with the UK norms, the overall scores for hospice 1 are slightly above the norms with the clinical staff scoring substantially higher than the norms on all three sub-scales but the scores of the support staff scoring below the UK norms. T-tests were conducted for all staff at hospice 1, using the observed means, standard deviations and number of participants and comparing these with the UK norms. The results of the t-tests were:

Depression: $t(1854) = 0.5226$ $p < 0.5$

Anxiety: $t(1854) = 0.4540$ $p < 0.5$

Stress: $t(1854) = 0.7140$ $p < 0.3$

Negative Af.: $t(1850) = 0.6920$ $p < 0.3$

The t-tests showed that there was no significant difference between the observed means and the norms, indicating that the depression, anxiety, stress and Negative Affect of the staff group at hospice 1 do not differ significantly from the general UK population.

Hospice 2

Comparing the scores of hospice 2 with the UK norms, the overall scores are very close to the norms, except Stress, which scored lower than the norms. The scores for the clinical staff are below the norms but the scores for the support staff are much higher than the norms. T-tests were conducted for all staff of hospice 2,

using the observed means, standard deviations and number of participants and comparing these with the UK norms. The results of the t-tests were:

Depression: $t(1821) = 0.1383$ $p < 0.5$

Anxiety: $t(1821) = 0.0908$ $p < 0.5$

Stress: $t(1821) = 1.1472$ $p < 0.2$

Negative Af.: $t(1821) = 0.4491$ $p < 0.4$

The results showed again that there was no significant difference between the observed means and the norms, indicating that the depression, anxiety, stress and Negative Affect levels of the staff group at hospice 2 do not differ significantly from the general population.

In their DASS manual, Lovibond and Lovibond give a cut-off score for moderate, severe and extremely severe presentations of depression, anxiety and stress (see table 4). It needs to be noted that the participants listed under the different DASS categories come from the same sample.

Table 4: Cut-off points for DASS-21 as used in this research

	Mild	Moderate	Severe	Extremely Severe
Depression	10	13	20	27
Anxiety	7	10	15	20
Stress	14	18	26	34

Henry & Crawford (2005) do not provide us with cut-off points for these sub-scales. The analyses of severity of depression, anxiety and stress were therefore completed using the cut-off points given by Lovibond and Lovibond (see table 3). As their norms were slightly higher than the UK norms, the actual result percentages may be slightly higher than is indicated in table 4.

The results show that Mild Depression is found in 9.9% of staff (n=9) working in both hospices, with 11.3% (n=7) in hospice 1 and 6.6% (n=2) in hospice 2. Moderate Depression is found in 16.5% of staff (n= 15) working in both hospices, with a higher percentage in hospice 2 (20.7%, n=6) than hospice 1 (14.5%, n=9). Severe Depression was found in 3 members of staff for both hospices (2.2%) with 2 members (3.2%) of staff in hospice 1 and 1 member (3.4%) of staff in hospice 2. Nobody scored as Extremely Severely depressed. Mild anxiety was found in 3 members of staff in both hospice (3.3%) with two members (3.2%) in hospice 1 and 1 member (3.4%) in hospice 2. Moderated anxiety was found in 11% of all staff (n=10), with 6 members (9.7%) of staff from hospice 1 and 4 members of staff (13.8%) of hospice 2. Severe anxiety was found in 3 members of all staff (3.3%), all working in hospice 1. Extremely Severe Anxiety was found in 3 members of staff (3.3%), with 2 members (3.2%) working in hospice 1 and 1 member (3.4%) working in hospice 2. Mild stress was found in 16 members of all staff (17.6%) with 14 members (22.6%) working in hospice 1 and 2 members (6.2%) working in hospice 2. Moderate stress was found in 9 members of all staff (9.9%) with 7 members (11.3%) working in hospice 1 and 2 members (6.9%) working in hospice 2. Severe stress was found in 2 members of all staff (2.2%) with 1 member (1.6%) of staff working in hospice 1 and 1 member (3.4%) working in hospice 2. Nobody reported to be extremely severely stressed. Please see table 5, 6 and 7 for result scores and percentages. Table 5 shows the results of both hospices together, Table 6 shows the results for hospice 1 and Table 7 shows the results for hospice 2.

Table 5: Percentages of clinical levels of strain Both Hospices

N=91	Mild	Moderated	Severe	Extremely Severe
	n-%	n-%	n-%	n-%
Depression	9 (9.9%)	15 (16.5%)	3 (3.3%)	0
Anxiety	3 (3.3%)	10 (11%)	3 (3.3%)	3 (3.3%)
Stress	16 (17.6%)	9 (9.9%)	2 (2.2%)	0

Table 6: Percentages of clinical levels of strain Hospice 1

N=62	Mild	Moderated	Severe	Extremely Severe
	n-%	n-%	n-%	n-%
Depression	7 (11.3%)	9 (14.5%)	2 (3.2%)	0
Anxiety	2 (3.2)	6 (9.7%)	3 (4.8%)	2 (3.2%)
Stress	14 (22.6%)	7 (11.3%)	1 (1.6%)	0

Table 7: Percentages of clinical levels of strain Hospice 2

N=29	Mild	Moderated	Severe	Extremely Severe
	n-%	n-%	n-%	n-%
Depression	2 (6.9%)	6 (20.7%)	1 (3.4%)	0
Anxiety	1 (3.4%)	4 (13.8%)	0	1 (3.4%)
Stress	2 (6.9%)	2 (6.9%)	1 (3.4%)	0

Figure 7, 8 and 9 (see below) show the percentages of severity of depression, anxiety and stress for hospice 1.

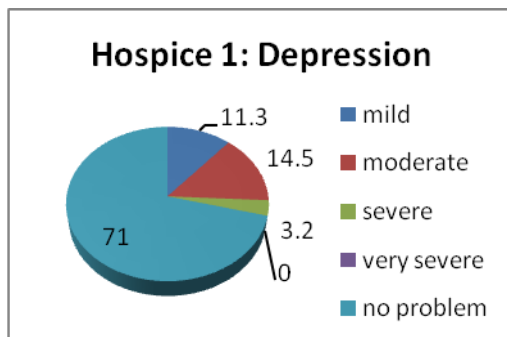


Figure 7: Pie Chart of percentages of Depression at Hospice 1

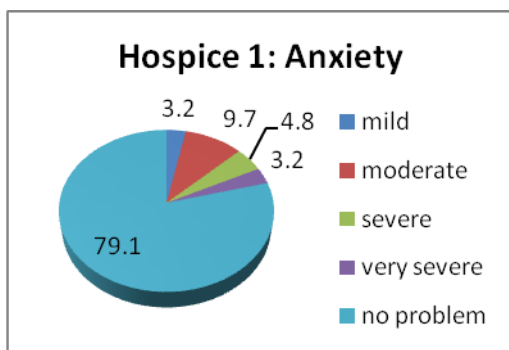


Figure 8: Pie Chart of percentages of Anxiety at Hospice 1

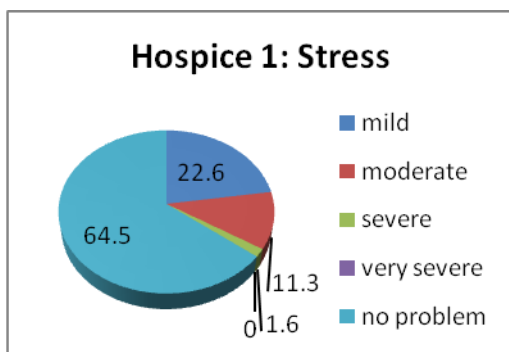


Figure 9: Pie Chart of percentages of Stress at Hospice 1

Figure 10,11 and 12 (see below) show the percentages of severity of depression, anxiety and stress for hospice 2.

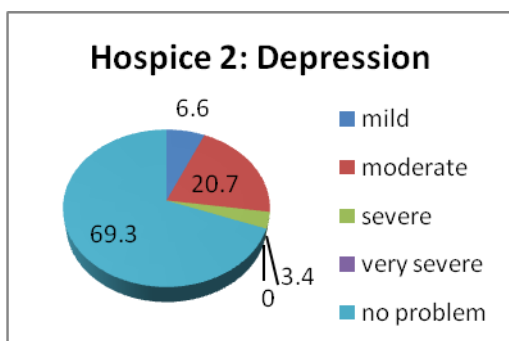


Figure 10: Pie Chart of percentages of Depression at Hospice 2

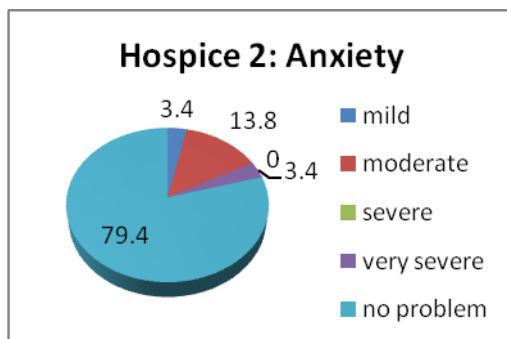


Figure 11: Pie Chart of percentages of Anxiety at Hospice 2

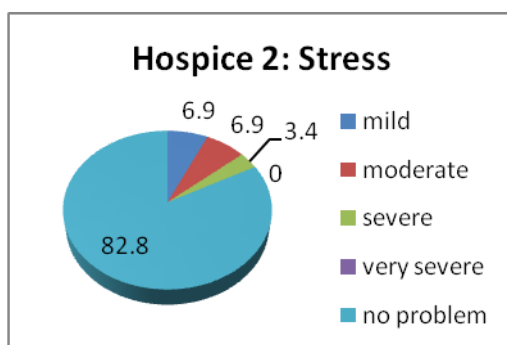


Figure 12 Pie Chart of percentages of Stress at Hospice 2

3.4 Results from the HSE Stress Indicator Tool

Several analyses have been conducted for the different sub-groups of staff. Below are the results for hospice 1 and hospice 2. The HSE tool give norms, using colour coding to indicate the percentile intervals of the results (see figure 13)

	Doing very well – need to maintain performance Represents those at, above or close to the 80 th percentile [†]
	Good, but need for improvement Represents those better than average but not yet at, above or close to the 80 th percentile [†]
	Clear need for improvement Represents those likely to be below average but not below the 20 th percentile [†]
	Urgent action needed Represents those below the 20 th percentile [†]

Figure 13: HSE Stress Indicator Tool colour coding for percentiles

Overall, the HSE results for both hospices show that Demands, Managers' Support, Relationships and Change are areas which are in clear need of improvement (but not below the 20th percentile) and Role is an area that needs urgent attention (being below the 20th percentile). Control and Peer Support were the only areas that came up as good, but could still benefit from further improvements (see table 8). The analysis also brought up that 8 participants reported to be always, often or sometimes bullied.

Table 8: HSE results for both hospices: All Staff

	Results	Suggested Interim Target	Suggested Longer Term Target
Demands	3.25	3.50	4.25
Control	3.50	3.83	4.33
Managers' Support	3.65	4.00	4.60
Peer Support	4.11	4.25	4.75
Relationships	3.96	4.25	4.75
Role	4.27	4.60	5.00
Change	3.19	3.67	4.00

Looking at the scores for hospice 1 for All Staff, the results are very similar to the scores above. They show that Demands, Managers' Support, Relationships and Change are still "yellow areas" which are in clear need of improvement, but Control now scores worse and has become a "yellow area" scoring as "in clear need of improvement". The area of Role remains a "red" area that needs urgent attention (see table 9).

Table 9: HSE results for Hospice 1: All Staff

	Results	Suggested Interim Target	Suggested Longer Term Target
Demands	3.13	3.50	4.25
Control	3.47	3.83	4.33
Managers' Support	3.60	4.00	4.60
Peer Support	4.07	4.25	4.75
Relationships	3.94	4.25	4.75
Role	4.23	4.60	5.00
Change	3.10	3.67	4.00

Separating the scores for the staff group at hospice 1 into Clinical and Support Staff, the results show that the Clinical staff score lower than the Support staff, indicating that for Clinical staff the areas that need improvement are Demands, Control, Managers' Support, Relationships and Change, with Role again scoring as a "red" area which needs urgent attention. For the Clinical staff Peer Support is the only area that scores as "good". The Support staff score "good" on Control Managers' Support, Peer Support and Change, but need improvement in areas of Demands, Relationships and Role (see table 10 and 11)

Table 10: HSE results for Hospice 1: Clinical Staff

	Results	Suggested Interim Target	Suggested Longer Term Target
Demands	3.10	3.50	4.25
Control	3.38	3.67	4.33
Managers' Support	3.52	4.00	4.60
Peer Support	4.06	4.25	4.75
Relationships	3.93	4.25	4.75
Role	4.20	4.60	5.00
Change	3.09	3.67	4.00

Table 11: HSE results for Hospice 1: Support Staff

	Results	Suggested Interim Target	Suggested Longer Term Target
Demands	3.34	3.50	4.25
Control	4.10	4.33	4.33
Managers' Support	4.26	4.00	4.60
Peer Support	4.11	4.25	4.75
Relationships	3.96	4.25	4.75
Role	4.47	4.80	5.00
Change	3.67	4.00	4.00

Looking at the results for hospice 2, areas that are “yellow” and need improvement are Demands, Managers’ Support, Relationships and Change. Role again scores as a “red” area which needs urgent attention. Control and Peer Support are the only areas that score as “good” (see table 12).

Table 12: HSE results for Hospice 2: All Staff

	Results	Suggested Interim Target	Suggested Longer Term Target
Demands	3.46	3.75	4.25
Control	3.56	3.83	4.33
Managers' Support	3.74	4.00	4.60
Peer Support	4.19	4.25	4.75
Relationships	4.00	4.25	4.75
Role	4.35	4.80	5.00
Change	3.36	3.67	4.00

Separating the results for hospice 2 into Clinical staff and Support staff, the results show that the Clinical staff score “good” in most areas, but with Relationships and Change scoring as “yellow” and needing improvement, and Role again scoring as “red” and needing urgent attention. The Support Staff however score much lower, with Peer Support and Control being the only areas that score as “good”. Managers’ Support, Role and Change score as “yellow” and thus are areas in clear need of improvement and Demands and Relationships scoring as “red”, needing urgent attention (see tables 13 and 14).

Table 13. HSE results for Hospice 2: Clinical Staff

	Results	Suggested Interim Target	Suggested Longer Term Target
Demands	3.54	3.75	4.25
Control	3.52	3.83	4.33
Managers' Support	3.80	4.00	4.60
Peer Support	4.21	4.50	4.75
Relationships	4.10	4.25	4.75
Role	4.33	4.80	5.00
Change	3.37	3.67	4.00

Table 14: HSE results for Hospice 2: Support Staff

	Results	Suggested Interim Target	Suggested Longer Term Target
Demands	2.73	3.13	4.25
Control	3.94	4.17	4.33
Managers' Support	3.20	3.60	4.60
Peer Support	3.92	4.25	4.75
Relationships	3.08	3.75	4.75
Role	4.60	5.00	5.00
Change	3.22	3.67	4.00

3.5 Results from the Linear Multiple Regression

Four separate linear multiple regression analyses were conducted, one for each dependent variable (as continuous variables) : depression, anxiety, stress and Negative Affect. The “enter” method was used which is also known as a simultaneous regression method, which means that all the predictor variables were tested at once. This method is used when there is no theoretical evidence to suggest that certain variables are more important predictors than others.

3.5.1 Predictor Variables

There are many considerations to take into account when deciding on the number of predictor variables to be included into the regression. The most important considerations are the number of participants, and the theoretical grounding of the predictor variable. Field (2005, p172)) points out that there are many rules in relation to deciding the number of predictor variables, but it has been suggested that a ratio of 10 : 1 or 15: 1 is acceptable for most research. As this research has only 91 participants, it was decided to limit the number of predictor variables to a maximum of nine. As the main focus of the study was to identify the relationship between the HSE stressors and perceived strain, it was decided to include all seven HSE stressor domains (as continuous variables). However, after having checked the assumptions for the regression model, it appeared that multicollinearity existed between the scales “Manager’s Support” and “Change”. After long deliberation it was decided to exclude “Manager’s Support” (see paragraph below). An inspection of the relevant demographic factors lead to the decision to include “place of work” and “number of years in palliative care” as additional predictor variables. Place of work was chosen as the two hospices were located in different areas of the county, using individual work practices. The number of years in palliative care was chosen as the second demographic variable to be included, as literature suggests that stress has an accumulative effect on emotional wellbeing (see Chapter 1). To adjust for non-linearity, the sub-categories of the variable “years in palliative care” were reduced to three groups: less than 4 years, between 4 and 10 years, and longer than 10 years.

3.5.2 Multiple Regression 1: Depression

Using the above mentioned method and predictor variables, a significant model emerged: $F(8,82) = 2.810$, $p < 0.01$. The strength of the model was moderate with $R^2 = 0.215$. The HSE variable Change was found to be a significant predictor of Depression (Beta = -2.684, $p < 0.01$). The direction of the relationship showed that participants feeling uncomfortable about the change processes in the organization are at greater risk of depression. The variables, Demand, Control, Peer Support, Relationships, Role, Location and Years in Palliative Care were not significant predictors in this model (see table 15).

Table 15: Dependent Variable - depression

Model		Unstandardized Coefficients		Sig.
		B	Std. Error	Std. Error
1	(Constant)	19.884	6.547	.003
	demand	-.897	1.140	.434
	control	.803	1.036	.440
	peer support	-.630	1.566	.688
	relationships	1.580	1.346	.244
	role	-2.160	1.339	.110
	change	-2.684	.985	.008
	location	.674	1.362	.622
	years in palliative care	-.318	.828	.702

3.5.3 Multiple Regression 2: Anxiety

Using the same method and predictor variables as above, a non significant model emerged:

$F(8,82) = 1.536$, $p = 0.158$. All of the predictor variables were therefore found to be not significant in the prediction of anxiety amongst this staff group (see table 16).

Table 16: Dependent Variable - anxiety

Model		Unstandardized Coefficients		Sig.
		B	Std. Error	Std. Error
1	(Constant)	8.458	5.937	.158
	demand	-1.591	1.033	.128
	control	-.185	.939	.844
	peer support	1.792	1.420	.211
	relationships	1.302	1.221	.289
	role	-.837	1.214	.493
	change	-1.744	.893	.054
	location	.236	1.235	.849
	years in palliative care	-1.188	.751	.118

3.5.4 Multiple Regression 3: Stress

Using the above mentioned method and predictor variables, a significant model emerged ($F(8,82) = 3.382, p < 0.01$). The strength of the model was moderate with $R^2 = 0.248$. The HSE variable Demand was found to be a significant predictor of Stress ($Beta = -3.73, p < 0.01$). The direction of the relationship showed that participants experiencing high demands in the organization are at greater risk of experiencing stress. The variables, Control, Peer Support, Relationships, Role, Change, Location and Years in Palliative Care were not significant predictors in this model (see table 17).

Table 17: Dependent Variable - stress

Model		Unstandardized Coefficients		Sig.
		B	Std. Error	Std. Error
1	(Constant)	30.407	6.980	.000
	demand	-3.730	1.215	.003
	control	.506	1.104	.648
	peer support	-.440	1.670	.793
	relationships	.673	1.435	.640
	role	-.853	1.427	.552
	change	-1.502	1.050	.157
	location	-.696	1.452	.633
	years in palliative care	-1.093	.883	.220

3.5.5 Multiple Regression 4: Negative Affect

Using the above mentioned method and predictor variables, a significant model emerged ($F(8,82) = 2.697$, $p < 0.05$). The strength of the model was moderate with $R^2 = 0.208$. The HSE variables Demand and Change were found to be a significant predictors of Negative Affect: Demand ($\text{Beta} = -6.533$, $p < 0.05$), Change ($\text{Beta} = -5.781$, $p < 0.05$). The direction of the relationship showed that participants experiencing high demands in the organization and participants who were uncomfortable about the change processes in the organization are at greater risk of experiencing Negative Affect. The variables, Control, Peer Support, Relationships, Role, Location and Years in Palliative Care were not significant predictors in this model (see table 18).

Table 18: Dependent Variable - negative affect

Model		Unstandardized Coefficients		Sig.
		B	Std. Error	Std. Error
1	(Constant)	59.175	17.241	.001
	demand	-6.533	3.001	.032
	control	1.260	2.727	.645
	peer support	1.265	4.124	.760
	relationships	2.782	3.545	.435
	role	-3.908	3.526	.271
	change	-5.781	2.594	.029
	location	.746	3.586	.836
	years in palliative care	-2.527	2.182	.250

3.5.6 Assumptions Check

Multicollinearity

Multicollinearity is assessed by looking at the correlation Matrix and the Collinearity Statistics. It is stated (Field, 2005) that the correlations between predictor variables should not exceed .7 and the Tolerance values should be $>.1$ or $.2$. When the VIF is greater than 10 then there is cause for concern but if the average VIF is substantially greater than 1 then the regression may be biased (Bowerman & O'Conner, 1990). The assessment of multicollinearity showed that the correlation between the variables Manager's Support and Change was .797, but the Tolerance values were $>.2$. One VIF score for Manager's Support was 3.928 which is lower than 10 but could be interpreted as substantially higher than 1. After having sought some statistical advice on this, the suggestion was made to run two regressions, the first one with just Change or Manager's Support as predictors, and the second regression with both predictors. Multicollinearity would be diagnosed if the second model did not explain much extra variance compared with the first model. This assessment showed that the difference in variance between the two models was very small. The decision was therefore made to exclude Manager's Support from the regression analyses.

Linearity and Homoscedasticity

The assumption of Linearity states that it is assumed that the relationship that is being modelled should be linear. If this assumption is violated then there are limitations to the generalizability of the findings. The assumption of Homoscedasticity states that at each level of the predictor variables the variance of the residual terms should be constant.

Linearity was checked by plotting each of the dependent variables against each of the independent continuous variables. If the graph points form a random cloud evenly arranged around 0 than the assumption is met (For an example, see Figure 14).

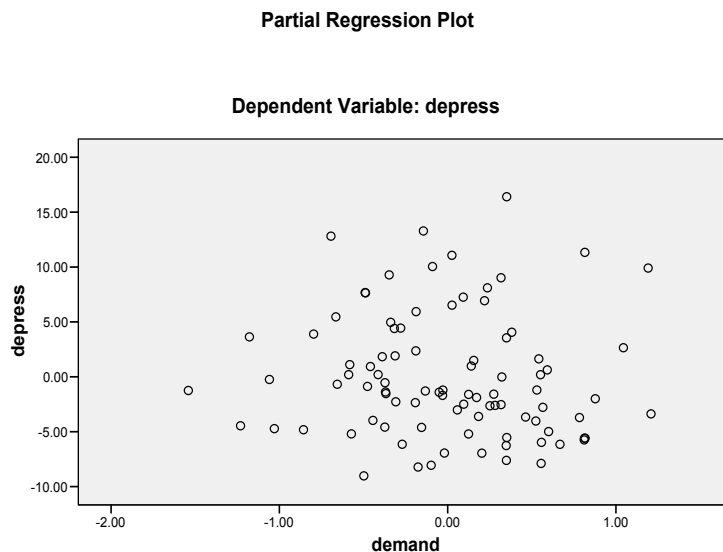


Figure 14: Linearity Assumption Check between the dependent variable Depression and the independent variable Demand

Homoscedasticity was checked by plotting the Residuals against the Predicted variable for each model. If there is no apparent relationship between them than the assumption is met (For an example, see Figure 15)

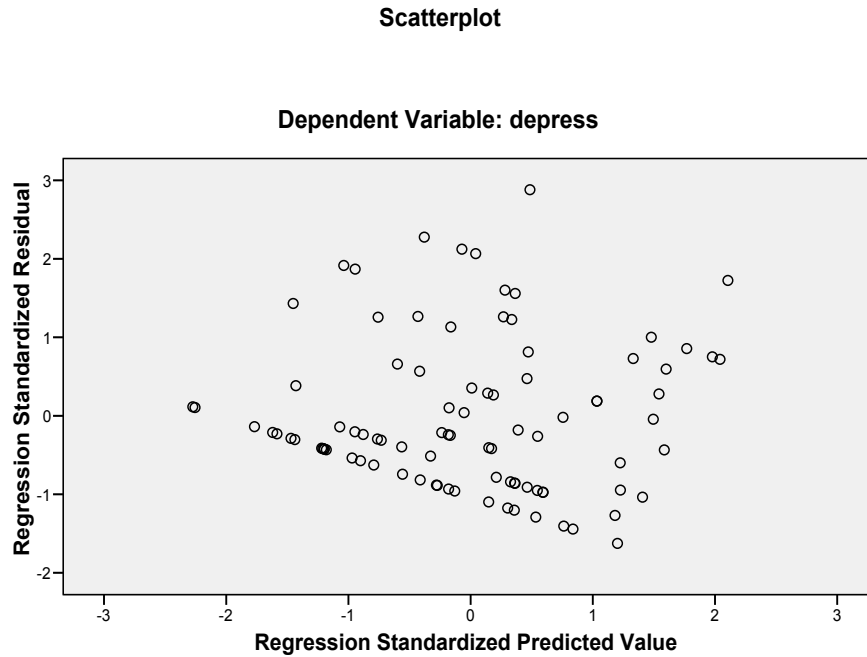


Figure 15: Homoscedasticity Assumption Check for Dependent variable Depression

Normally distributed errors

This assumption states that the residuals in the model are random, normally distributed variables with a mean of 0. This assumption was checked by examining the Normal P-P Plot. The measured points need to sit on the diagonal line or closely to it (For an example see Figure 16).

Normal P-P Plot of Regression Standardized Residual

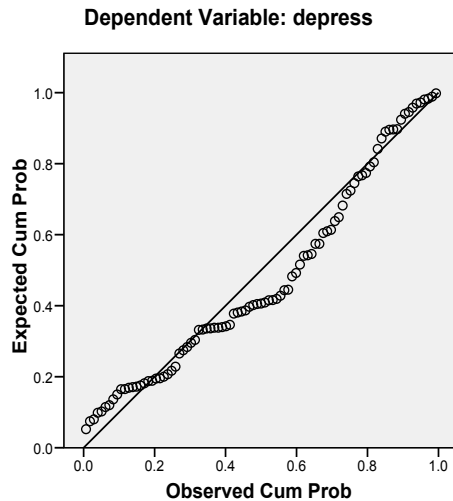


Figure 16: Assumption Check for Normally distributed errors for the dependent variable Depression

After having checked all the assumptions it was felt that they were sufficiently met to proceed with the interpretation of the data.

3.5.7 Power Calculation

An A-Priory sample size calculation was done after the research proposal had been finished.. Having set α at 0.05, the effect size at 0.15 (medium,) the statistical power at 0.8 and the number of predictor variables at 9, the sample size was calculated at 113. However, as the total population was $n=132$ it seemed unrealistic to expect a response of 113 participants (86%). As it was not possible to add to the numbers of staff and within the context of this research being an explorational study it was decided to go ahead with it and achieve the highest possible response through the use of reminders. Reminders of the project and the value of staff's participation were given in the shape of verbal prompts during multi-disciplinary meetings and handover meetings. Using this method and after having given staff much encouragement to fill in the questionnaire, the response rate was 91 (69%). A Power calculation was done to assess if sufficient power was

achieved to detect any effects. A value between .8 or more would be needed to achieve this. For each model a power calculation was done using the R square, with $\alpha=0.05$, and sample size 91. The number of predictor variables at this stage had reduced from 9 to 8.

The results show that for:

Model 1 (depression) the power was 0.95

Model 2 (anxiety) the power was 0.71

Model 3 (stress) the power was 0.98

Model 4 (Negative Affect) the power was 0.94

The results show that Model 1, 3 and 4 were strong enough to detect any effects and Model 2 was too weak to detect any effects.

3.6 Hypotheses

Testing the Hypotheses for Phase 1:

Hypothesis 1: *The sub-groups of hospice staff, will score below average on the HSE Stress Indicator Tool in comparison to the Management Standards set by HSE on at least 4 of the 7 subscales of the HSE Stress Indicator tool.* This hypotheses will be tested for the different sub-groups: a) All Hospice staff, b) All Hospice 1 staff, c) Hospice 1 Clinical staff, d) Hospice 1 Support staff, e) All Hospice 2 staff, f) Hospice 2 Clinical Staff and g) Hospice 2 Support Staff.

The results show that for sub-group:

- a) 5 out of the seven subscales scored below average. *For this sub-group therefore the experimental hypothesis was accepted.*
- b) 6 out of the seven subscales scored below average. *For this sub-group therefore the experimental hypothesis was accepted.*
- c) 6 out of the seven subscales scored below average. *For this sub-group therefore the experimental hypothesis was accepted.*
- d) 3 out of the seven subscales scored below average. *For this sub-group therefore there was no evidence to reject the null hypothesis.*

- e) 5 out of the seven subscales scored below average. *For this sub-group therefore the experimental hypothesis was accepted.*
- f) 3 out of the seven subscales scored below average. *For this sub-group therefore there was no evidence to reject the null hypothesis.*
- g) 5 out of the seven subscales score below average. *For this sub-group therefore the experimental hypothesis was accepted.*

Hypothesis 2: *The hospice staff will score higher on the three sub-scales of the DASS21 (depression, anxiety and stress) than the general population (indicating a higher level of depression, anxiety and stress amongst the staff group).*

The results show that no significant differences were found for each hospice staff group. *Therefore there was no evidence to reject the null hypothesis.*

Hypothesis 3: *Members of staff scoring low on the HSE Stress Indicator Tool (indicating a higher level of stressors/hazards in the workplace), will score higher on the DASS-21 (indicating a higher level of depression, anxiety and stress). For each sub-scale of the DASS-21 a minimum of one sub-scale of the HSE Stress Indicator tool will have a significant negative correlation.*

The results for the DASS-21 subscale Depression showed that one sub-scale of the HSE Stress Indicator tool (Change) had a significant negative correlation. *Therefore the experimental hypothesis was accepted.*

The results for the DASS-21 subscale Anxiety showed that no sub-scale of the HSE Stress Indicator tool had a significant negative correlation. *Therefore there was no evidence to reject the null hypothesis.*

The results for the DASS-21 subscale Stress showed that one sub-scale of the HSE Stress Indicator tool (Demand) had a significant negative correlation. *Therefore the experimental hypothesis was accepted.*

The results for the DASS-21 subscale Negative Affect showed that two sub-scales of the HSE Stress Indicator tool (Demand and Change) had a significant negative correlation. *Therefore the experimental hypothesis was accepted.*

Chapter 4: Analysis of Phase 2

4.1 Overview

This chapter describes the analysis of phase 2 of the research, which is a qualitative study using two focus groups. In paragraph 4.2 details will be given of the group sizes and demographic factors. Following this, paragraph 4.3 will give an account of the process of analysis and the formulation of the first codes. Bryman (2001) highlights the need for process transparency in qualitative research which has led to the use of a narrative approach to the reporting of the results. This is to ensure maximum transparency of the methods used- and decisions made along the way. The final categories, sub-categories and concepts are listed in paragraph 4.4 followed by a discussion on the reliability and validity of the process used in paragraph 4.5. In paragraph 4.6 the core category will be identified. The chapter finishes with a description of the concepts and sub-categories of this section of the study.

4.2 Group Size and Demographics

A total of 6 people participated in each focus group. All participants were female. Focus group 1 consisted of a mixed group of professionals: 3 nurses, 1 occupational therapist, 1 occupational technical support worker and 1 doctor. Focus group 2 consisted of all nursing staff ranging from newly qualified staff to very senior staff.

4.3 The Process of Analysis

4.3.1 Initial Coding

Prior to the start of the first focus group the prompt list was discussed with the focus group facilitator to ensure that the questions were still suitable for the purpose of

the investigation and connected with phase 1 of the research. After careful examination of the questions it was decided to keep the prompt list as it originally was designed. The transcript of focus group 1 (hospice 2) arrived prior to the start of focus group 2 and I read through the findings to check if the prompt questions needed adjusting. After careful consideration it was decided to keep the questions the same to allow for a systematic investigation into the differences and similarities between the two hospices. The analysis of focus group 1 started once both transcripts had been received (see Appendix 20 and 21 for transcript of both focus groups). The transcript was carefully read, and consideration was given to what was actually being said. Once a basic understanding had been achieved of the main themes the transcript was imported into the computer programme Atlas.ti. Using this programme, the transcript data was coded in a line by line manner, whilst the following questions were considered: “What is going on here?”; “What is this person saying?”; “What do these actions and statements take for granted?”; “What process is at issue here?”, and “How is the process influenced or changed?” The purpose of line by line coding was to ensure that an objective perspective was kept without getting immersed in the participants’ world-view as it forces you to look at the data anew (see Appendices 22 and 23 for initial codes of focus group 1 and 2). Line by line coding was judged to be a suitable way to start the analysis as it has been reported as a very useful method for analyzing detailed data about fundamental empirical problems or processes (Charmaz, 2006, p50). During this process a large number of “in vivo” codes began to emerge, highlighting discrete concepts expressed in the language of the participants. “In vivo” codes provide us with the basic units on which the emerging theory is “grounded” (Straus and Corbin, 1998). Additionally some abstract codes emerged which described the meaning of what had been expressed by the participants, using a reflective method rather than the participants’ own words.

4.3.2 First categories

Following the initial coding, a process of focussed coding started. Focussed coding refers to a process of synthesizing and finding explanations for larger segments of data. This is achieved by sifting through the large number of codes and selecting

the most significant and/or frequently used codes, in a way that makes most analytic sense to help categorize the data (Charmaz, 2006, pp87-88). To help achieve this, networks of the codes were constructed within Atlas.ti. The method used for the construction of the networks was to collect all the codes that seemed to relate to one theme and move them to the network sheet. The most appropriate and most frequently used codes were then selected and linked together to form meaningful and logical connections. During this process a constant comparative method (Glaser & Straus. 1967) was used to ensure that the links accurately reflected the participants' intended meaning. The themes of the networks that emerged from focus group 1 were: Feeling Valued, Commitment Conflict, Roles, Role Stress, Change, Team Support and Training. Figure 17 shows an example of a network (For all the initial networks please see the networks in Atlas.ti, saved on the USB stick which accompanies this thesis)

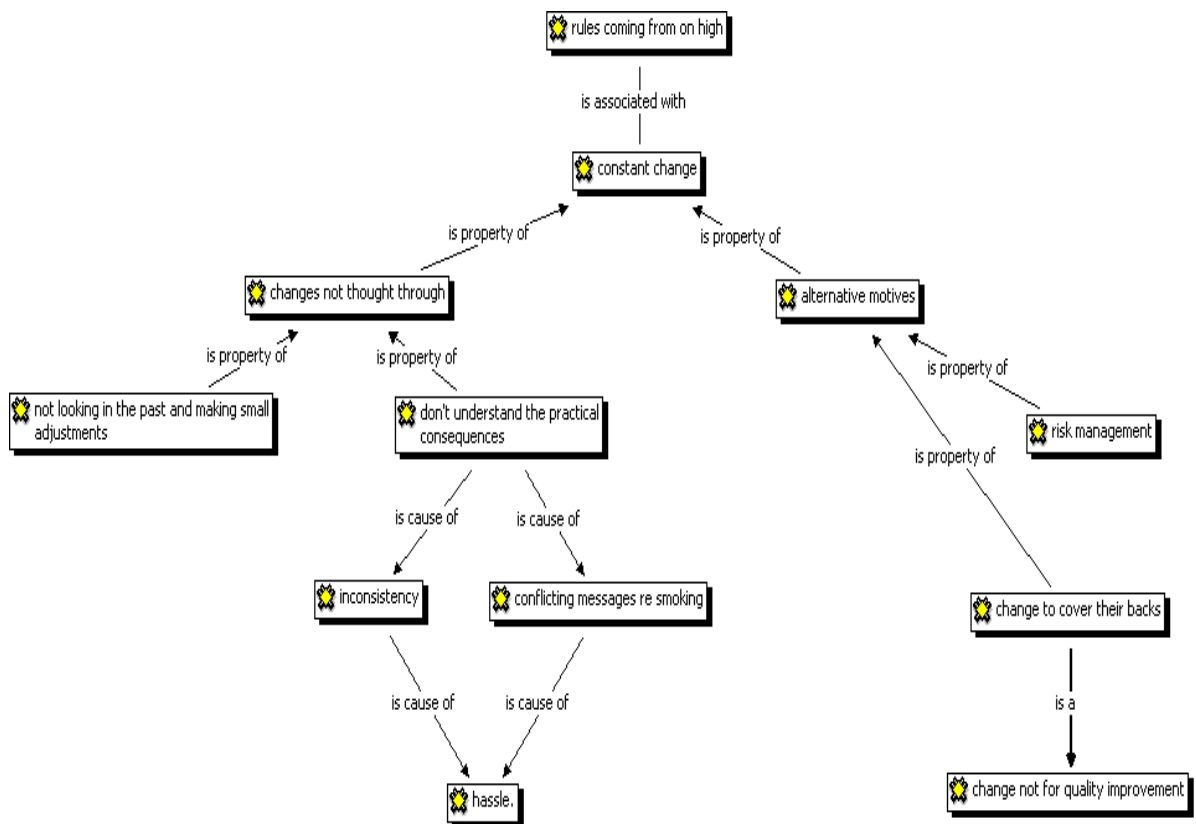


Figure 17: Example of Network for the category Change for focus group 1

Once the focussed coding and construction of networks for focus group 1 was completed, the analysis of the data from focus group 2 was started. Consistent with the philosophy of Grounded Theory, coding is an emergent process where unexpected ideas come to the fore. Codes and categories can then be compared with each other once a body of data has been analysed (Charmaz, 2006). Therefore a decision was made to analyse the second transcript without referring to the networks of focus group 1, to allow a natural emergence of themes. A similar process of analysis to focus group 1 was used for focus group 2. The networks that emerged from this group were: Role Stress, Coping, Managers' Support, Demands, Peer Support and Change.

4.3.3 Development of final codes and Categories

After the networks had been developed for each focus group, a third stage of analysis started which is called axial coding (Straus & Corbin, 1998). When using axial coding connections between categories and sub-categories are highlighted and the properties and dimensions of a category are identified. The networks of both hospices were compared on similarities and differences. Some of the networks covered the same themes but had been given different titles. The network titled "Feeling Valued" for Focus group 1 was renamed "Managers' Support", "Role Stress" was renamed "Demands", and "Team Support" was renamed "Peer Support". For focus group 2, the network "Coping" was re-named "Self-Care" and "Role Stress" became "Emotional Demands". These processes of comparison lead to the formulation of the final categories and sub-categories for each focus group. For focus group 1, the network "Commitment Conflict" was merged with Managers' support. For focus group 2, the network "Training" was merged with "Demands" and "Emotional Demands" became a sub-category of "Demands". This process shaped the final categories of each hospice. The categories for both hospices now were: Change, Demands, Peer Support and Managers' Support. The findings for Hospice 1 (focus group 2) had brought up one extra category called Self Care and additionally had provided some new concepts for each category (see Appendix 24 for the categories per hospice and their sub-

categories). Paragraph 4.4 shows the final categories, sub-categories and concepts of the analysis for both hospices combined.

4.4 Final Categories

In this paragraph the final categories, sub-categories and concepts are given.

Category 1: Demands

Below are the categories, sub-categories and concepts of the category Demands.

Figure 18 shows the hierarchical structure of the sub-categories.

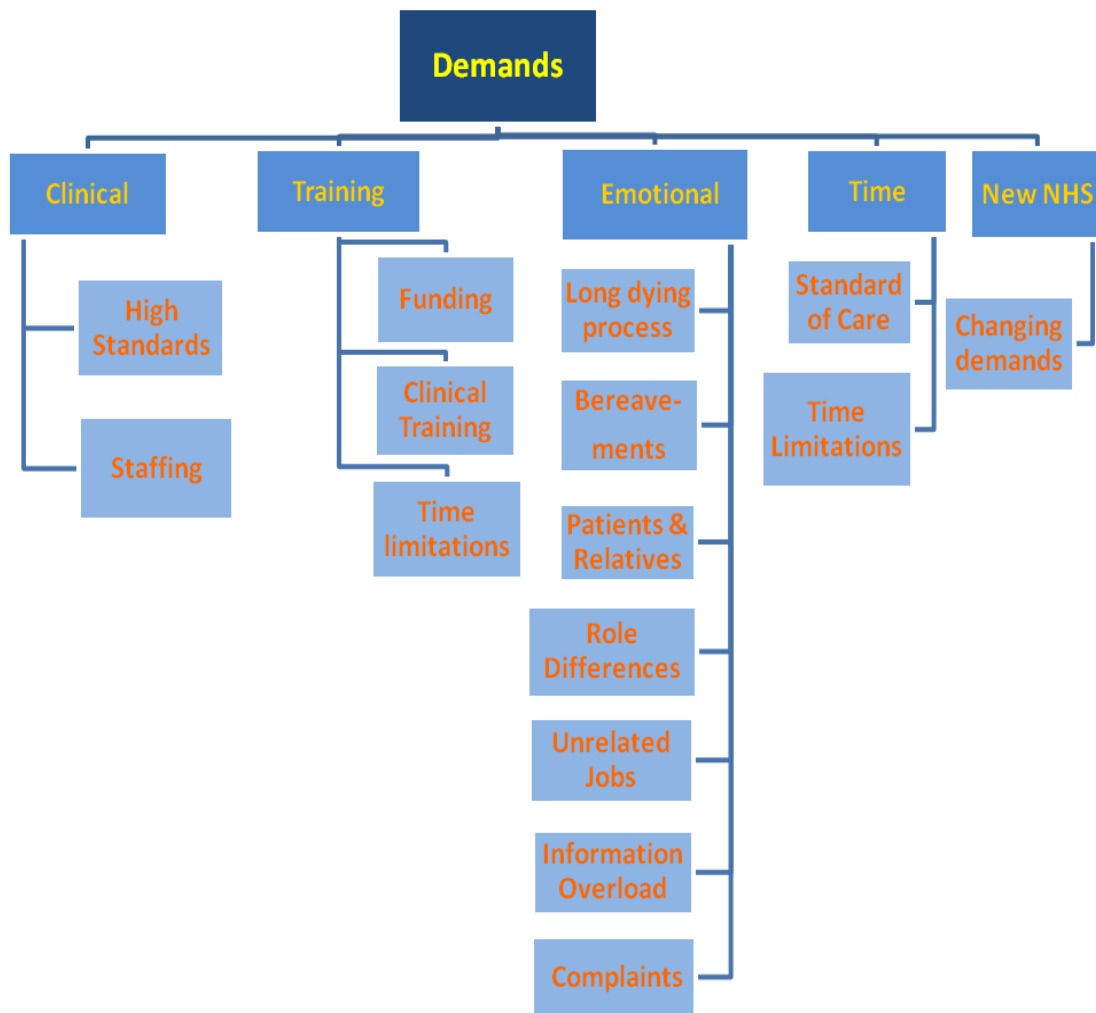


Figure 18: Hierarchical structure for the sub-categories of the category Demands

Table 19 shows the sub categories and concepts of the category Demands

Table 19: Sub-Categories - Demands

Clinical *High standards - Difficult for new staff - Nurses are excellent - Best patient care - Good death - Personality - Accumulation of stressors - Commitment - Very precise rules - Going the extra mile - Self sacrifice - Commitment conflict 24 hour care *Staffing - Short staffed - Restricted in doing my best - Compromise of quality Training *Funding - Lack of funding	Emotional *Long dying process - Getting emotionally involved - Inner conflict *Personal bereavements *Patients and Relatives - Large families - Complex needs - Being in the middle - Age - Children - Patients' decisions - Emotional involvement - Emotional distancing - Expectations - Being taken for granted - Anger - Agitation - criticism - Vulnerability - MND patients - Constraints - Frontal lobe changes - No plan - Accumulated stress - Going the extra mile - Commitment conflict - Patients' and families' expectations - Own expectations - Managing emotional demands *Role differences - Different emotional demands - Qualities *Unrelated jobs - Smoking - Police people *Information overload - No stress free zone *Complaints - Unfair complaining - Impacts on team

*Time limitations - Time limitations - Lack of time for clinical training - Not trained properly - Not enough trained staff - Too many mandatory courses New NHS *Changing demands - New philosophy of care - Keeping hospice full - Faster pace - High demands - Hospice reputation	Time *Standard of Care - Not following through - No second chances *Time limitations - Not time to self-care - Volume of work - Compromising - Stress accumulation - Change of mindset - Can't maintain the old standards
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Category 2: Change

Below are the categories, sub-categories and concepts of the Category Change.

Figure 19 shows the hierarchical structure of the sub-categories.

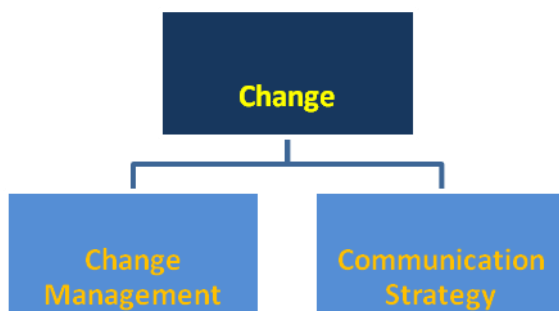


Figure 19: Hierarchical structure for the sub-categories of the category Change

Table 20 shows the sub-categories and concepts of the category Change

Table 20: Sub-Categories - Change

Change management Changes happen too quickly New Consultant Many constraints Changes not thought through Not understanding Practical consequences Ulterior motives Inconsistencies	Communication strategy No effective communication strategy Need to know the rationale Resisting change Having no say Powerless Part time workers miss info Not comfortable asking

Category 3: Peer Support

The category Peer Support does not have any sub-categories, but does have the following concepts:

Great team
Strong peer support
Encouraging people to talk
Being human
Listening to new staff
Looking out for each other
Stability

Category 4: Managers' Support

Below are the sub-categories and concepts of the category Change. Figure 20 shows the hierarchical structure of the sub-categories.



Figure 20: Hierarchical structure for the sub-categories of the category Managers' Support

Table 21 shows the sub-categories and concepts of the category Managers' Support.

Table 21: Sub-Categories - Managers' Support

Higher management Decisions made remote from unit They are not aware They don't care Don't feel valued Don't feel considered NHS causes stress Need recognition Bad Agenda for Change management	Local management One way conversation Self protection Don't feel appreciated Don't feel supported Being able to ask questions Failing Poor listening skills In same boat They need more support

Category 5: Self - Care

Below are the sub-categories and concepts of the category Self-Care. Figure 21 shows the hierarchical structure of the sub-categories.

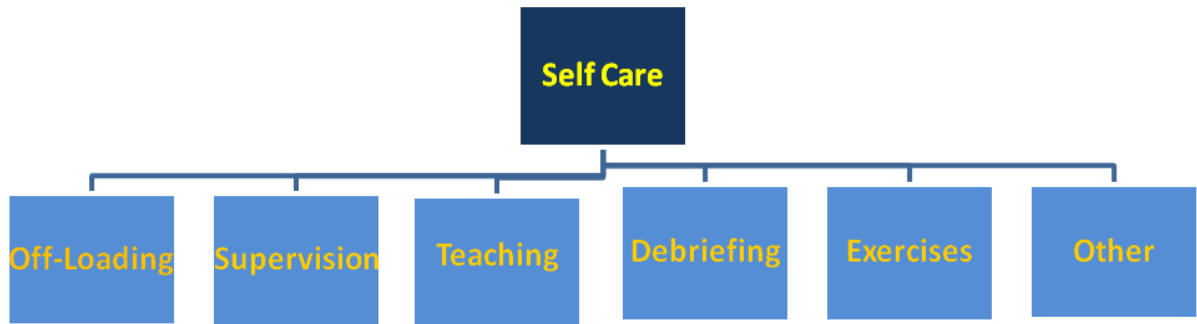


Figure 21: Hierarchical structure for the sub-categories of the category Self Care

Table 22 shows the sun-categories and concepts of the category Self-Care.

Table 22: Sub-Categories - Self Care

Off-loading Forget to look after yourself Pressure on colleagues Being over-loaded Supervision Clinical supervision Important Encouraged Not fully understood Don't trust confidentiality Time limitations Work philosophy Teaching sessions Teaching sessions Debriefing Debriefing No debriefing Worry	Exercise Gym Punch bag Other strategies Time management Handing over Dissociation techniques Cognitive strategies Awareness of personalities Glass of wine Coping Humour Experience Normalizing Finishing task Recognition of importance of self care Looking for other jobs

4.5 Reliability and Validity

Within literature on the “grounding” of qualitative research, validity receives more attention than reliability. Reliability refers to criteria which are set to assess the methods used in the qualitative research. The quality of recording and documenting the data is central to this, as well as how interpretations are made. The question of validity can be summarised as “a question of whether the researcher sees what he or she thinks he or she sees” (Kirk & Miller, 1986). Over the last three decades many publications have analyzed the intimate relationship between the research process and the findings it produces. As a result of this, we now understand much more about the complexities and nuances of the qualitative research process and how this bears on the issue of validity (Altheide & Johnson, 1994). The issue of validity in qualitative research is complex, and has been the topic of much debate. Several researchers have attempted to formulate and reformulate the concept of validity (Mishler, 1990; Wolcott, 1990a; Lather, 1993). Wolcott (1990a) has suggested nine points to guarantee validity, which are: 1. The researcher should listen as much as possible and refrain from talking; 2. produce accurate notes; 3. start writing in the early stages of research; 4. provide readers with clear and sufficient information to allow them to make their own inferences and follow the researchers train of thought; 5. the report should be complete; 6. the report should be truthful; 7. the researcher should receive feedback on the findings and present the findings to relevant others in the field; 8. the presentations give a balanced account; 9. the presentations should be accurate. This research has been conducted with the intention to adhere as closely as possible to the above mentioned guidelines. Furthermore, in order to maximise the reliability of the coding system, an independent member of staff was asked to code a sample of the transcripts, in order to check on consistency in the coding system. This person was given a list of the codes and the names of the categories. The person was then asked to identify which category they felt each code belonged to. This process resulted in an agreement rate of 90% of the codes (please see Appendix 25).

4.6 Identification of the Core Category

The core category is the central phenomenon around which all other categories are based (Straus & Corbin, 1990). The core category connects all the categories in a new way and in doing so, it generates a story line which not only tell an analytic story but also move the story towards a theoretical direction (Glaser, 1978 p72). Whilst examining the above categories, it became clear that the core category of the above categories was the category Demands. Figure 22 shows how the four other categories connect to the core category Demands.

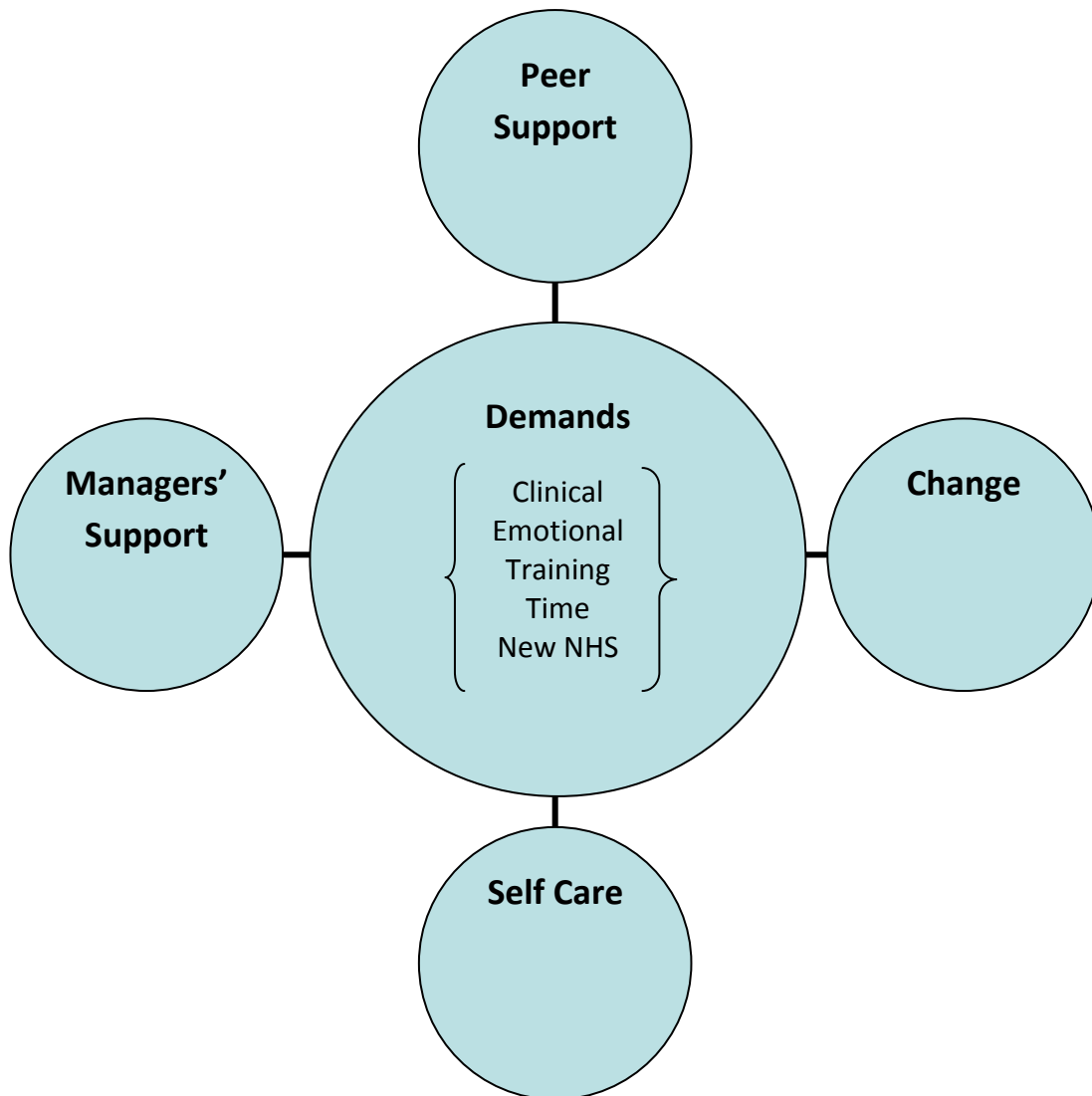


Figure 22: The core category Demands in relation to all other categories

Figure 22 shows that all sub-categories of the core category Demands relate to Peer Support, Change, Self Care as well as Managers' Support. For instance, Peer Support relates directly to how the staff manage with Clinical, Emotional, Training and Time demands, which are all interlinked with the philosophy of the New NHS. The category Change relates to the fact that Clinical work has changed which has an Emotional impact on staff. Additionally, Training demands have changed and increased, as well as Time demands, which all relates to changes in the New NHS. Managers' Support relates the Demands, as without the right support from the managers the areas of Clinical work and Emotional demands would be directly affected, as would the Training needs and perceived Time pressures. Additionally it relates to the New NHS as this brings challenges to the staff which need to be addressed and supported by the managers and leaders within the teams. Finally, the category Self Care relates to the sub-categories of Demands as all five sub-categories represent areas of "pressure" which require attention, regulation and stress/emotional management.

4.7 Description of Categories

In this section a description will be given of the categories and sub-categories with their ranges and dimensions. The concepts will be illustrated using quotes from the original data. Quotes are referenced to the transcripts of the focus groups using the symbols "[.,,...]". Between the brackets there will be two numbers; the number before the comma refers to focus group 1 or 2, the number after the comma refers to the line number(s) of the transcripts (For full transcripts of the interviews see Appendices 20 and 21). A discussion of the findings and their links to relevant literature will be addressed in chapter 6.

Core Category: Demands

The core category Demands has five sub-categories: Clinical Demands, Emotional Demands, Training Demands, Time Demands and New NHS Demands. Below is a description of the sub-categories.

Sub-category: Clinical Demands

This sub-category refers to the demands associated with the clinical. It has two further sub-categories: High Standards and Staffing. The concepts in the sub-category High Standards refer to the pressure experienced by staff to keep up the exceptionally high standards within the hospice service. Although the staff clearly want to keep up the high standards by providing excellent care and doing their best to provide a “good death”, the high standards occasionally feel a little petty: “ *But I was saying that I had been out for so long that when I came back it was one of the hardest things for me, not the nursing, but getting the right things in the right bin*” [2, 742-744], and “*There have been some changes with CDs and stuff now that seems so petty*”[2,375]. The high standards could trigger an accumulation of stressors which new staff in particular have found at times rather daunting: *I’m fairly new here and I’m very aware of the extremely high standards and that’s quite a lot to come into actually even though you can set that for yourself when you walk into an environment and you are part of it that can be quite daunting....* [2, 236-239]. Personality was another concept that emerged under High Standards as staff felt that having a certain personality was needed to work in this environment, referring to the fact that hospice work is demanding and that it takes commitment and vocation to deliver the high standard of care. As part of this sense of commitment, it was mentioned that “going the extra mile” and the difficulty of finding a balance between commitment and self-care was sometimes difficult. This could cause conflict, particularly as staff had started to feel unappreciated by the higher NHS management (see category Managers’ Support): “*.....half of you really want to do a really good job and half of you says “why bother I’m not being paid for it” so it’s that conflict and there is always someone wanting more*” [1,130-132]. The second sub-category under Clinical Demands refers to staffing issues. This sub-category covers the issues related to being short staffed and the effect that this is having on the quality of care. Members of staff mentioned that they felt they often could not do as good a job as they would have liked because of staffing shortages, which had a negative effect on their sense of fulfilment at the end of the working day.

Sub-category: Emotional Demands

The second sub-category of the core category Demands is called Emotional Demands. The concepts under Emotional Demands refer to the processes associated with hospice care which are particularly emotionally demanding. Further sub-categories here are: a lengthy dying process, personal bereavements, patients and relatives, role differences, unrelated jobs, information overload and complaints. Participants mentioned that dealing with patients who were going through a long slow dying process was particularly demanding as there was more opportunity to get emotionally involved in their situation and with their family members. This could cause inner conflicts as a part of them wanted the situation to end because of the emotional turmoil it was causing them as well as the patients and their families, and part of them wanted to continue to provide the best possible care: *but there can be times when I actually really kind of dread to see a patient who is still here because they may have taken quite a long time to die and there is that feeling, which goes against what we as human beings want which is the best and we want to have nice kind thoughts about people so we try and I kind of repress that don't we*" [2, 242-245].

Personal bereavements emerged as another sub-category for which one participant had mentioned that she had sought counselling to help her manage the emotional consequences of her work. Patients and Relatives was the third sub-group addresses the emotional demands around dealing with patients and relatives. Concepts under this sub-group relate to difficult family dynamics with complex needs and high expectations of the patients as well as their family members and/or carers. Members of staff mentioned feeling sometimes as "piggy in the middle" and becoming overly emotionally involved. It was noted that no training had been received on "emotionally distancing". Additionally, angry patients and/or relatives were perceived as emotionally demanding as was working with younger patients and patients who had young children: *"Like you said, anger's one thing, we are not used to people being angry as such at us and that is quite difficult then when they are"*[1, 263-264] and *"I think you can identify with some people can't you, the age of the children and things. Certain people just catch you*

unawares sometimes [1, 260-261]. Patients with motor-neuron disease stood out in terms of complex needs. Overall, the participants felt that it was important to learn to manage the emotional demands of these complex situations as well as manage their own expectations.

Role differences emerged as the fourth sub-category. The concepts in this sub-category refer to the different emotional demands associated with different roles in the teams. Staff working more on a practical level with the patients (occupational therapists and physiotherapists) and work in the community, were mentioned as having less emotional involvement with the patients and were therefore less vulnerable to becoming overly emotionally involved: *"...most of my patients are in the community so I don't really have an opportunity to build a relationship with them so I don't come across the sort of problems you do with building up the relationship with the relations because if you see a relation then you are talking about what you are about to do so it's on a busy kind of level so you don't necessarily have the emotional side of it....* [1, 331-334]. It was recognised that different roles require different personal qualities to deal with emotionally challenging situations. A further sub-category was Unrelated Jobs. The concepts in this category refer to the additional tasks that staff have been asked to do, which were seen to be outside their normal clinical duties. Having to "police" people on the no smoking policy of the hospice premises was given as an example of this frustration: *"....but they can't smoke in here, then the two patients go outside and smoke, sit on the bench and you think that's okay but no they can't sit there because it causes smoke upstairs so they smoke inside and you have to tell them they can't so they go out to the main road and smoke so then you are saying what if they collapse on the path and it looks awful them smoking on the path but no we will have to assess the situation as it arises for each patient. And you think for God's sake* [1,507-512].. The sixth sub-category is Information Overload. The concepts in this category refer to the fact that staff feel there is an increasing demand on their resources in terms of new policies and non-clinical training courses. It was felt that there were too many notices and other reminders and that there was no stress free zone as notices were pinned up even on the toilet door:

“There are notices everywhere and that seems, on bad days, to really get to people[1,489].

A final sub-category of Emotional Demands was Complaints. This sub-category covers the concepts which relate to receiving complaints about the service. Members of staff felt that complaints were often made unfairly as everyone always tried their hardest to provide the best service possible. It was felt that complaints were often directed towards only one member of the team whilst the care had been a team effort. This again was felt as unfair, and therefore complaints would have an emotional impact across the whole team: *“...if it was a complaint and we had done something really wrong and that patient has suffered I think that’s different but when people just complain about nick picky things and cause a problem for other people in the team it does spread across the team” [1,294-296].*

Sub-Category: Training

The category Training as three further sub-categories: Funding, Lack of clinical training and Time Limitations. Participants mentioned that there seemed to be a lack of funding, particularly for clinical training: *“The training budget of £1500 for the whole year for the whole unit is just ridiculous and you want to upgrade your skills and stuff like that [2, 919-920].* Even though there was a high expectation for them to do non-clinical training the lack of funding for clinical training meant that they often felt under trained to do certain procedures. Because not enough staff were trained in specific procedures (like for instance catheter care) it was also felt that a burden was placed on the staff who were sufficiently trained: *“Of course you do, otherwise it causes more stress if you are on a shift and can’t do it and there is only one person that can do it well that causes so much stress during that shift doesn’t it” [2, 922-923].*

Sub-Category: Time

The category Time has two further sub-categories which are Standard of Care and Time Limitations. The concepts of the sub-category Standard of Care refer to the wish to maintain high standards but having to compromise due to lack of time.

Particularly the issue of “not being able to follow through” was brought up, referring to the fact that tasks cannot always be finished properly or conversations have to be cut short because of other acute demands on their time: *“I had a very, very stressful time quite recently when we were extremely busy, it was one of those shifts where you couldn’t finish off anything, you were going to see a patient and the bell would ring and then the doctor would ask you to do something and the phone was ringing, it was just an horrendous shift.....”* [2,205-208] and *“....because we want to give excellent care, and I have been in situations before where I have been in a room with a patient who hasn’t opened up before and you are getting clues that they want to talk and bells are going and I have had to physically walk away and then to go home and had tears streaming and thinking that was awful you know, I wanted to stay with that patient but again its time.”* [133- 137]. The sub-category Time-limitations refers to the concepts relating to the high volume of work and the effects this is having on the ability to look after yourself in terms of stress management and reflection (see the category Self Care).

Sub-Category: Changing Demands of the New NHS

Concepts of this category refer to the new philosophy of care which links strongly to issues around commissioning and having to keep the hospice beds full. Participants mentioned that this has caused a faster pace with higher demands on their professional and emotional resources. *“I was told that we were going to keep the hospice full all the bed would be full because that was from above, that was the way it was going to be and I mean when I first started here we weren’t always full and that was nice because we had a couple of empty beds and shifts were a bit easier and that sort of thing but a few weeks ago it seemed that as soon as a patient went home we were filling the beds up again and it was like we hadn’t got time to really catch your breath before the next lot are in”* [2, 427-432]. Additionally, these changes are causing an increasing discrepancy between the hospice reputation as it still exists in the community and the type of care that the hospice is able to deliver under the new NHS regulations.

Category: Change

This category has two sub-categories: Change Management and Communication Strategy. Below is a description of the sub-categories.

Sub-category: Change Management

The concepts under Change Management relate to the nature of change as it is introduced into the hospices. It was mentioned that changes happen too quickly and that the consequences of the changes are not thought through prior to the implementation. Participants felt that the changes were proposed by people remote from the units who did not understand the practical consequences of these changes: *“There’s too many changes, changing for change sake and if you’ve been in the NHS a long time you’ve seen all these things and its just going around in circles”* [1, 446-448] and *“That’s an example (smoking regulations) of the rules coming from on high that don’t work especially on the ground floor”* [1, 519-520]. It was also felt that change was imposed for ulterior motives, not with the purpose of improving patient care, but rather to manage risks.

Sub-category: Communication Strategy

The concepts under the sub-category Communication Strategy relate to the process of how change is communicated to the staff group. The participants felt that there was no effective communication strategy and that the rationale behind the changes was not always clear: *“.....there’s a reason for them but when you are told “well that’s just the way we are going to do it” “well this is the reason” or, I don’t know, I’m the sort of personality who that has to know why in order to get my head right.....”* [2, 376-378]. Particularly for part-time workers this had been a problem as they would return to work after a few days and had not been informed about the changes that had been made: *“.....I don’t work full time so I can probably go five days without being here and something has changed when I get back and I don’t know why or I might find a piece of paper just stuck high up somewhere which I probably wouldn’t see unless I just stood there, and nobody else can tell you why.....”* [2, 390-392]. It was also mentioned that not all staff feel comfortable with

asking for clarification. Additionally, it was felt that staff's opinions were not taken into account when introducing change processes.

Category: Peer Support

This category does not have any sub-categories but has a number of concepts that relate to peer support. Participants mentioned that peer support was very strong and the sharing of experiences was encouraged: *".....the team here is very supportive, we get a lot of support, its upsetting, some of the patient care, but you can within the team support each other through those issues.."* [1, 24-26] . Peer support was also used as a benchmark to check that the experience was seen as a human response to the circumstances: *"I think it's just encouraging people to talk and I think sometimes you can hear somebody else being honest that they don't like patients and they get really angry with them, and I don't like them and then other people think "oh so it's alright then" you know its just being honest really"* [2, 638-640], and: *"Because there is that, from all the relatives, that we are all angels and we are fantastic and if you kind of slip from that and think "actually I don't like some of my patients" you know what I mean, that's just being human"* [2, 642-644]. A strong sense of "looking out for each other" was expressed and listening to newly qualified staff was seen as important, to learn from their fresh look at the situation as well as to support them in their transition from being a student nurse to being a full staff member. It was mentioned that having a stable team with staff who knew each other for a long time was a real benefit to developing good peer support.

Category: Managers' Support

This category has two sub-categories: Higher Management and Local Management. Below is a description of the sub-categories.

Sub-category: Higher Management

The concepts under Higher Management relate to the experience of working for the NHS and the leadership within the broader NHS context. Participants felt that

decisions were made remote from the unit without understanding the local implications. It was felt that the higher management did not care very much about the staff's personal welfare and the participants expressed not feeling valued or considered: *".....that's the way the NHS is these days but I think although I feel valued by the team, I do not feel valued by the management structure and I feel you are a number - just do the job."* [1, 31-33]. This in itself could cause commitment conflict (see Category Demands: sub-category Clinical Demands). It was felt that the leadership within the broader NHS was the cause of significant stress: *"it's more dealing with management and their attitudes towards you that is the problem, and I can't see that improving"* [1, 26-27].

Sub-category: Local Management

The concepts in the sub-category Local Management refer to the experience of managers' support within the hospices themselves. It was felt that there is a one way communication pathway which has the purpose of risk management and self-protection: *" In the past there was a two way conversation between the management and the rest of the team but that gone, it's a one way direction now and that's part of the problem but I can't see that changing"* [1, 440-442]. Participants felt that they were not always listened to effectively which could do a lot of damage and made them feel un-appreciated and un-supported: *"... I just thought "how am I going to cope with everything" and I just broke down and went to her the following day and explained why I felt like that and it was awful because she said "is it hormonal", and I said I felt like I'm in a shell, and I was absolutely devastated by that and from that moment I thought I'm not even going to discuss this here because if that's what you think that's really terrible"* [2, 164-168].

Category: Self-Care

The category Self-Care covers the concepts relating to the management and processing of stressful events and emotionally charged situations. This category has six sub-categories: Off-loading, Supervision, Supportive Teaching sessions, Debriefing, Exercise and Other. Below is a description of the sub-categories

Sub-category: Off-loading

The concepts within the sub-category Off-loading refer to issues around the need for off-loading and the sharing of experiences with one's colleagues, and also the extra burden this might give to the colleagues who are themselves already feeling the pressure of working in this emotionally charged environment. Generally off-loading and sharing with colleagues is seen as a positive thing, but occasionally it can also feel as a little too much to cope with: *"....we are so good at listening to people that you find yourself not only dealing with patients but being offloaded on to all the time and you are just thinking "please just leave me alone I don't need this as well"* [2, 112-114]

Sub-Category: Supervision

The concepts within the sub-category Supervision relate to supervision as an important tool within a self-care strategy. Other concepts relate to the time limitations and the frustration of having to cancel appointments due to lack of time: *"...it is meant to be protected time you know you can come off the ward and have your clinical supervision, but I've cancelled about seven sessions with my clinical supervisor because you just cannot get off the ward...."* [2,484-486]. A work philosophy where the staff members put themselves last or feel they let the team down if they take time out for supervision also adds to this frustration. It was also reported that not everyone understands the concept of supervision and that not everyone trusts the confidentiality aspect of in-house supervision.

Sub-category: Supportive Teaching Sessions

The third sub category is Supportive Teaching Sessions. This was particularly mentioned in focus group 1 (hospice 2) where staff felt very supported in the fact that they could ask for teaching sessions on certain topics to help their confidence: *"....if we have anything clinical we are not sure about the doctors will do a teaching session so all those things we can, within reason, sort out for ourselves..."* [435-436].

Sub-category: Debriefing

The fourth sub-category is Debriefing. The concepts in this category are contradictory, as participants of hospice one expressed a need for debriefing as this was not happening enough and if it happened, it was on an ad hoc basis: *we are very good here at supporting each other in terms of talking about it and trying to debrief, we don't necessarily do sit down debriefs maybe as often as we would like to, but we do try and talk it through and try and help each other to be a bit better*" [2, 77-80]. Participants of hospice two felt very supported in this way, by having regular debriefing sessions as well as when the need arises: *"When we have had particularly tough times if we have had things that have been particularly unsettling from a patient or relative then A. has done some debriefing sessions we've ask her to come or if it's still ongoing she has come along and given us a session and given us strategies on how to cope with that or what to look for and how to respond to some of it and that's been helpful* [1, 235-338].

Sub-category: Exercise

The fifth sub-category is Exercise. The concepts within this category relate to strategies people have used (or wish to use) to manage their stress: *"I go to a gym, well I haven't been for ages, but there is a punch bag and I was really going at it and in the end I punched this punch bag into the wall and I was like. I felt great afterwards"* [2, 629-630]

Sub-category: Other

The final sub-category of Self Care has been named Other. Concepts within this category did not fit into the previous sub-categories but still had a significant importance in managing the work related demands. The concepts range from Good Time Management and learning to Hand Over, to using Cognitive and Dissociation techniques to manage acutely demanding situations: *".....it was difficult and I mean personally I tend to, like you say, compartmentalise things, I tend, I can physically feel like I'm in a shell, like an egg....."* [2, 152-153]. Other strategies that were mentioned were: having a sense of humour, having a glass of

wine, being aware of- and having an understanding of the different personalities within the team, and having experience.

Chapter 5: Analysis of Phase 3

5.1 Overview

This Chapter describes the results of phase 3 of the research. Data was obtained pre and post the stress coaching session using an evaluation questionnaire. In paragraph 5.2, details will be given of the group sizes and demographics. Following this, the process of analysis of the scaled questions will be described in paragraph 5.3, and the process of analysis of the open questions will be described in paragraph 5.4. As mentioned before, it is important to ensure transparency of the process of analysis (Bryman 2001). A narrative approach has therefore been adopted to the reporting of the results.

5.2 Group size and demographics

A total of 4 groups were held after it emerged that several members of staff had been interested in participating in the first two groups but for different reasons had not been able or willing to do this. The make-up of the four groups differed considerably:

Group 1 existed of 5 participants with a mixture of backgrounds: a health care assistant, two nurses, a physiotherapist and student. The group was held at hospice 2

Group 2 existed of 5 nurses. This group was held at hospice 1

Group 3 existed of 4 members of the support staff at hospice 1

Group 4 existed of 4 members of the Community Nurse Specialists (also known as Macmillan nurses)

All participants were female.

5.3 Analysis of Scaled Questions

Question1 : *How high/low would you rate your average stress as experienced over the last month?*

(scale: very low/low/medium/high/very high)

Table 23 and 24 show the average levels of experienced stress over the last month. The results show that no participants reported to have experienced very low stress or very high stress. One (5%) participant reported having perceived low levels of stress, 12 participants (67%) reported having experienced medium levels of stress and 5 participants (28%) reported having experienced high levels of stress.

Table 23: Scores of experienced stress

Group 1	Group 2	Group 3	Group 4
High	Medium	High	High
High	Medium	Medium	High
Medium	Medium	Medium	Medium
Medium	Medium	Medium	Medium
Medium	Low		

Table 24: Summary of Perceived Stress levels

	Very low	Low	Medium	High	Very High
n (%)	0	1 (5%)	12 (67%)	5 (28%)	0

Question 2: *How skilled do you feel in managing your stress?*

(scale: not at all/a little/mediumly/quite skilled/very skilled)

Tables 25, 26 and 27 show the scores of experienced skill in managing stress before and after the coaching session. The results show that 4 participants (22%) felt only a little skilled at the start of the session, 7 participants (39%) felt medium

skilled at the start of the session, 7 members (39%) felt quite skilled at the start of the session. No participant reported feeling not at all skilled or very skilled.

Table 25: Scores of experienced skill in managing stress

Before Session - After Session			Before Session - After Session		
Group 1:			Group 2:		
Quite	-	Very	Medium	-	Very
Quite	-	Very	Medium	-	Quite
A Little	-	Medium	Medium	-	Medium
A Little	-	Quite	Medium	-	Quite
Medium	-	Medium	Quite	-	Quite
Group 3:			Group 4:		
A Little	-	Medium	Medium	-	Quite
Quite	-	?	Quite	-	Quite
Quite	-	Medium	A Little	-	Medium
Quite	-	Medium	Medium	-	Quite

Table 26: Summary of Perceived skill in managing stress at start of the session

	Not at all	A little	Medium	Quite skilled	Very skilled
n (%)	0	4 (22%)	7 (39%)	7(39%)	0

Table 27: Summary of Perceived skill in managing stress after the session

	Not at all	A little	Medium	Quite skilled	Very skilled	Missing Value
n (%)	0	0	7 (39%)	7(39%)	3(17%)	1

Table 28 shows the perceived improvement after the coaching session

Table 28: Perceived Improvement

	Improvement	Stayed the same	Worsened	Missing value
N (%)	11 (61%)	4 (22%)	2 (11%)	1

5.4 Analysis of Open Questions

5.4.1 Coding

The analysis of the open questions of phase 3 started with listing all the answers to the questions by group. This information was then imported into the computer programme Atlas ti. The process of coding used was similar to the process used for the analysis of data of phase 2. The answers to the questions were carefully read, and consideration was given to what was being said. The coding was once again done in a line by line manner. During this process a number of “in vivo” codes began to emerge, highlighting discrete concepts expressed in the language of the participants, and also some abstract codes were used which described the meaning of what had been expressed by the participants, using a reflective method rather than the participants’ own words.

5.4.2 Categories

Following the process of coding, categories were identified using the title of each question. All codes belonging to each main category/question were then transported to the network sheets and a process was started of sifting through- and connecting the most significant and/or frequently used codes, in a way that made most analytic sense to help categorize the data (Charmaz, 2006, pp87-88). As the data was not as dense and rich as the data obtained from phase 2, the process of analysis was less complex and did not involve the re-formulation of categories. Also, because of the small numbers of participants in each group, it was felt inappropriate to construct individual categories for the different groups as in-depth comparisons of similarities and differences between the groups would not be

reflective of the larger hospice staff group. However, an eye-ball inspection confirmed that over all, the different groups had similar experiences, sometimes expressed in different wording.

Below are the categories, sub-categories and concepts of phase 3.

Category 1: Most useful

Below are the categories, sub-categories and concepts of the category “Most Useful”. Figure 23 shows the hierarchical structure of the sub-categories.

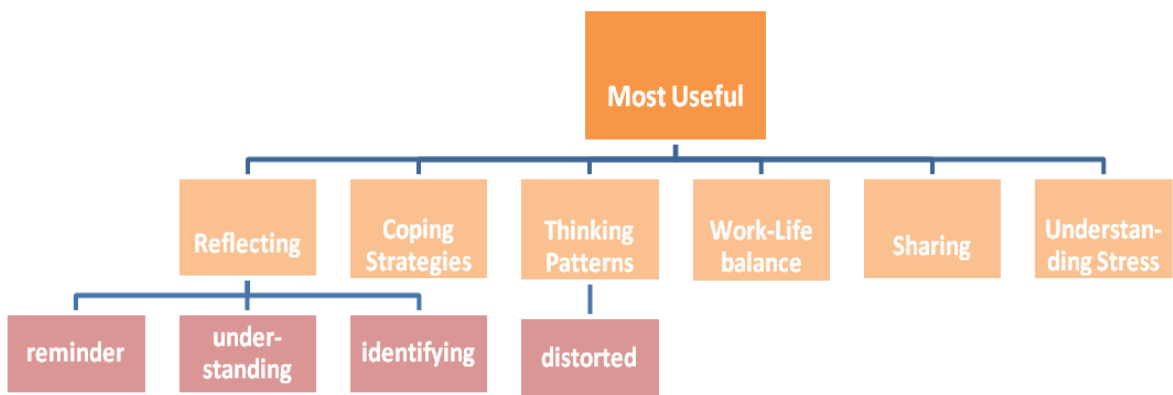


Figure 23: Hierarchical structure for the sub-categories of the category “Most Useful”

Table 29 shows the sub categories and concepts of the category “Most Useful”.

Table 29: Sub-Categories – Most Useful

Reflecting *Reminder - need for managing stress - keeping things in perspective *Understanding - thought patterns - how to challenge *Identifying/recognizing improvements Coping Strategies Coping statements Learning about coping strategies Thinking Patterns *Distorted thinking patterns - To identify - Increased self awareness - Turning things round - Realization: - I can accept and move on - I am in control	Work-Life Balance Prioritize Sharing Sharing: Open discussion Listening to views Not the only one Understanding Stress Sources of stress Understanding stress processes
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Category 2: Least useful

Because of the small size of this category, the statements have been described as concepts rather than sub-categories. Below are the concepts of the category “Least Useful”. Figure 24 shows the hierarchical structure of the concepts.

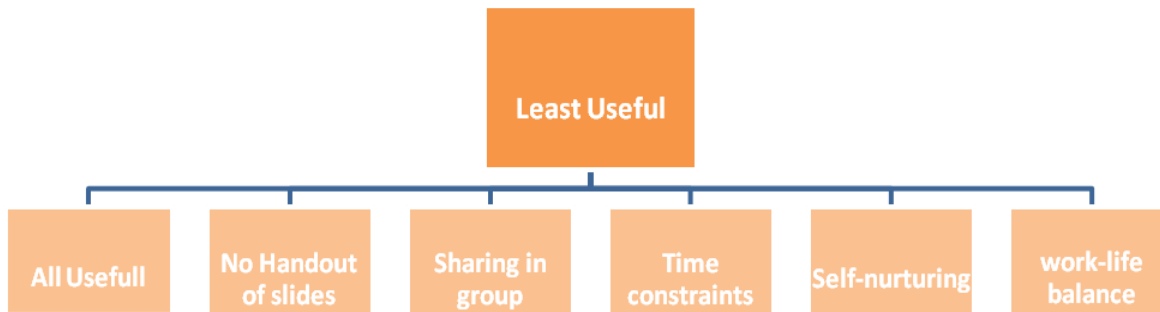


Figure 24: Hierarchical structure for the concepts of the category “Least Useful”

Table 30 shows the concepts of the category “Least Useful”.

Table 30: Concepts – Least Useful

Least Useful
*All useful *Handout - No handouts of slides (Consolidation and Reflection) *Sharing in group - Tentative about sharing personal information - OK about sharing work-related issues *Time constraints: - More depth *Self nurturing activities - Amusing *Work-Live balance - Already changed it

Category 3: Ability to challenge negative self-appraisal

Below are the categories, sub-categories and concepts of the category “Ability to Challenge”. Figure 25 shows the hierarchical structure of the sub-categories.

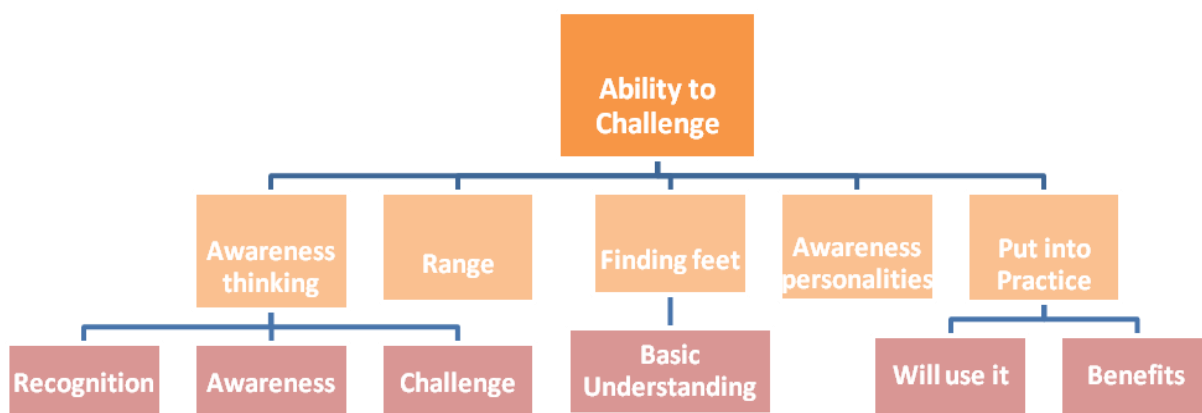


Figure 25: Hierarchical structure for the sub-categories of the category “Ability to Challenge”

Table 31 shows the sub categories and concepts of the category “Ability to Challenge”.

Table 31: Sub-Categories – Ability to Challenge

Awareness of negative thinking *Awareness: Depends on situation and mood Impact of negative thoughts *Recognition Ability to recognise distorted thinking Listen to my thoughts *Challenge Able to Challenge Able to put things into perspective Putting thoughts to one side Still finding my feet *Basic understanding Have seen the map Begun to realize More able than before Need to reflect on it Is a start	Putting into practice *Will use it Hope I will use it Will use stress coaching *Benefits To improve reactions Becoming a stronger person Manage better Find solutions Reduce procrastination Awareness of sub-personalities Insight into why Using the personality types Range Unsure Feel more able A bit more confidently Most able

Category 4: Confidence in implementing coaching plan

Below are the categories, sub-categories and concepts of the category “Confidence”. Figure 26 shows the hierarchical structure of the sub-categories.

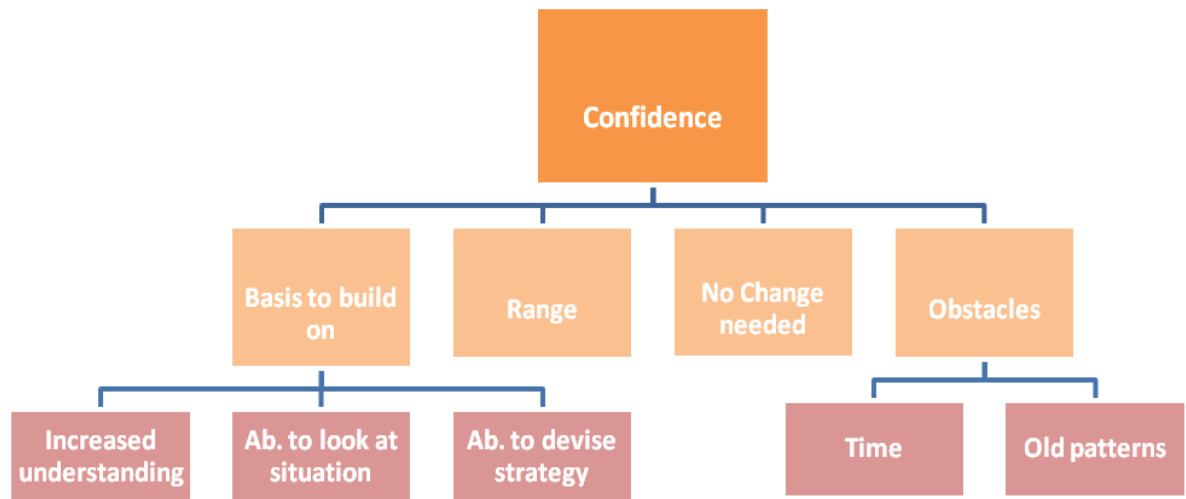


Figure 26: Hierarchical structure for the sub-categories of the category “Confidence”

Table 32 shows the sub categories and concepts of the category “Confidence”.

Table 32: Sub-Categories - Confidence

basis to build upon Increased understanding Ability to look at situation Ability to devise a strategy -Use clear model in future -Set aside more “me” time -Invest in more exercise -Coping strategy statements Obstacles *Time It will take time Need to implement to gain confidence *Old patterns Easier to slip into old patterns: Risk of failure Difficult to try again	Range Fairly confident Quite able Quite confident Confident Very Confident Depends on people and situation No change needed Current Strategies work

Category 5: Interest in future sessions

Below are the categories, sub-categories and concepts of the category “Future Sessions”. Figure 27 shows the hierarchical structure of the sub-categories.

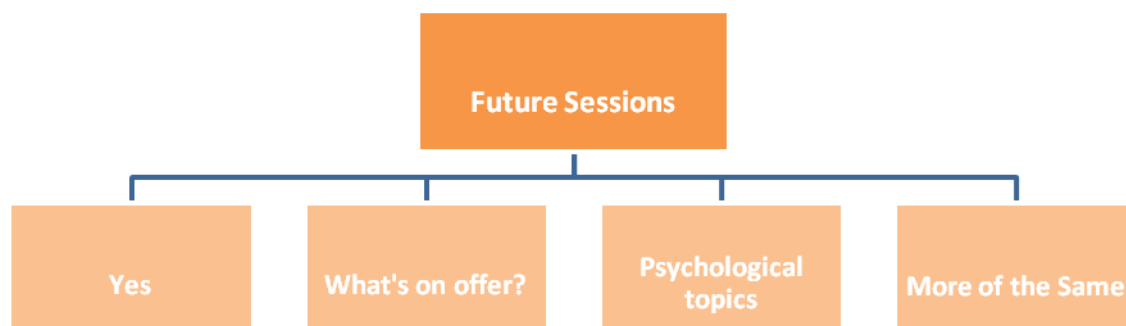


Figure 27: Hierarchical structure for the sub-categories of the category “Future Sessions”

Table 33 shows the sub categories and concepts of the category “Future Sessions”.

Table 33: Sub-Categories – interest in future sessions

Interest in future sessions
*Yes *What is on offer? *Psychological topics: - Anger in the hospice setting - Strengths and weaknesses - Stress management - Coping strategies - Family dynamics - Changing “extreme” emotions caused by stress - Cognitive Behavioural *More of the same: - Great to reflect - Over too soon - Cognitive Behavioural - Thinking patterns

Category 6: Additional comments

This category does not have any sub-categories, but does have the following concepts:

Thoroughly enjoyed it
Interesting session
very useful
Practical
Thought provoking
Wish it had been available sooner
An “investment” of time
To use and continue to use
Reassurance

5.5 Description of Categories

In this section a description will be given of the categories and sub-categories with their ranges and dimensions. The concepts will be illustrated using quotes from the original data. Quotes are referenced to the transcript of the coaching sessions using the symbols “[...,...]”. Between the brackets there will be one number referring to the line number of the transcript (see Appendix 26). A discussion of the findings and their links to relevant literature will be addressed in chapter 7.

Category: “Most Useful”

The category “Most Useful” covers the concepts relating to what the participants found most useful about the coaching session. This category has six sub-categories: Reflecting, Coping Strategies, Thinking Patterns, Work-Life Balance, Sharing, Understanding Stress. Below is a description of the sub-categories

Sub-category: Reflecting

This sub-category refers to comments made about the reflective aspects of the coaching session. It has three further sub-categories: Reminder, Understanding and Identifying/recognizing. The concept in the sub-category Reminder refers to the fact that it was important to be reminded of the need to manage stress effectively: *“Reminder to keep things in perspective”* [21]. The concepts of the sub-category Understanding refer to the importance of reflecting on understanding thought patterns relating to stressors: *“Reflecting on stresses in life and how to cope”* [18] and *“The ability to look closely at myself and how to handle situations”* [29]. The sub-category Identifying/Recognizing refers to the ability to be more reflective on sources of stress, the identification of strategies to reduce stress and the identification of improvements once the stress management strategy is in place: *“Becoming more aware of sources of stress and identifying methods of reducing it”* [35] and *“Identifying improvements with coping strategies”* [30].

Sub-category: Coping Strategies

This category has two concepts: the Coping Statements Handout and the Learning Process relating to Coping Strategies: *“Learning about coping strategies”* [36] and *“Distorted thinking patterns and coping statements”* [11].

Sub-category: Thinking Patterns

The concepts in this sub-category refer to distorted thinking patterns to identify them, to becoming more aware of them and to influence them in a positive way: *“Being able to identify thinking patterns”* [7], *“Distorted thinking patterns and beginning to recognize them in myself”* [34] and *“to realize that I am in control of my thoughts and reactions and I can accept and move on”* [33].

Sub-category: Work-Life Balance

Work-Life balance is only a small category as it has not been referred to very often by the participants. It covers one concept: Prioritizing, which refers to the need to prioritize areas in life that need more work or attention.

Sub-category: Sharing

Several participants expressed that they felt the process of sharing thoughts and experiences in itself was beneficial. The sub-category has four concepts which refer to sharing, being able to have open discussions: "*Being able to discuss situations openly within the group*" [9] , to listen to each others' views: "*Listening to views on how to deal with stress*" [25] and to realize that they were not the only one struggling with stress: "*That I am not the only one feeling stressed*" [19].

Sub-category: Understanding Stress

The concepts in this category refer to understanding the sources and processes of stress. Participants mentioned that they found it useful to have a greater understanding of stress: "Very helpful to help understand what is happening when stress levels begin to rise and especially how it can help cope" [27].

Category: "Least Useful"

The category "Least Useful" covers the concepts relating to what the participants found least useful about the coaching session. This category has six concepts: All useful, Handout, Sharing in group, Time constraints, Self nurturing activities, Work-Life balance. Many participants reported that they had found all of the session useful. One person mentioned that she would have found it useful to have had a handout of the PowerPoint presentation slides to be able to reflect and consolidate the learning. Another person mentioned that she found the sharing of more personal information in the group quite difficult but felt ok about sharing issues relating to work: "*Tentative about sharing personal info, ok about sharing work-related issues*" [65]. Two people mentioned time constraints as an issue: "*Not enough time! Would have liked to have gone into some areas in more depth, such as coping strategies*" [50]. The list of self-nurturing activities was mentioned by two participants as being less useful, although a comment was made that it had been amusing to read them. Finally, one person mentioned the topic of Work-Life balance as less useful, as she had already made adjustments: "*Work-Life balance, because I have changed it!*" [72].

Category: Ability to Challenge Negative Self-Appraisal

The category “Ability to Challenge” covers the range of comments made about participants’ perceptions on their own ability to challenge negative thinking patterns. This category has five sub-categories: Awareness of negative thinking, Still finding my feet, Putting into practice, Awareness of sub-personalities and Range.

Sub-category: Awareness of negative thinking

This category covers the concepts relating to becoming aware of “negative” thinking patterns, which of course is the first step towards the successful challenging of overall negative self-appraisal. Awareness of negative thinking as three further sub-categories: Awareness, Recognition and Challenge. The concepts relating to the sub-category Awareness relate to “becoming aware of” the impact of negative thoughts: *“More awareness of impact of negative self-thoughts that worsen a situation”* [111], and also an awareness that negative thoughts can depend on situations and moods:. The concepts under the sub-category Recognition cover the ability to recognise distorted thinking and to listen to one’s thoughts: *“I feel more able – equipped with being able to recognize distorted thinking – is at least a start”* [127]. These concepts assume a slightly more active involvement of the person than the concepts listed under the sub-category Awareness. The third sub-category Challenge covers the concepts that require still more active involvement than the previous concepts as these refer to the ability to actively challenge the thoughts and to manage to obtain a more objective perspective on stressful situations: *“I feel more aware of negative thinking and therefore will recognize it and be able to challenge”* [107].

Sub-category: Still finding my feet

The concepts within this category refer to participants’ experience of having obtained a basic understanding of the process of recognising thought processes and stress management strategies but needing to reflect further on the learning: *“A bit more confidently, although I am still finding my feet in other areas at work”* [96]

and “ *I feel like I have seen the map and need to go away, ponder it in detail and walk it out, before it will make real sense to me*” [132].

Sub-category: Putting into Practice

This sub-category covers concepts relating to actually using the self-coaching (CIGAR) model as presented in the session and the benefits this will deliver. There are two sub-categories: Will use it and Benefits. Many participants reported that they will use at least certain aspects of the coaching model: “*I will use the stress coaching literature and apply it to future stressful situation*” [101]. The concepts listed under the sub-category Benefits range from “improving on how to react to situations” to “managing better”, “becoming a stronger person” and “reducing procrastination”: “Not sure – hope I will use the tools and daily if necessary- to improve my reactions” [115], “*I feel like I will be able to manage better because I before realized I was doing it*” [110], “*Most able. I will endeavour to be more positive in my thinking which will hopefully make me a stronger person*”, and “*It will help me put things in perspective and find ways to resolve a situation rather than procrastinate!*” [117].

Sub-category: sub-personalities

This is a small sub-category with only two concept in it. These concepts relate to having insight into “why”, and using the personality types to help understand thinking patterns: “*Session has given me insight into why I think as I do using the personality types*” [116] and “*I now feel more able to challenge negative self-appraisal by being more aware of sub-personality groups and thought processes*” [129].

Sub-category: Range

The sub-category Range provides information on the range of perceived ability to challenge negative self-appraisal. The concepts range from being unsure if she would be able to challenge, to feeling more able and a bit more confidently, to feeling most able.

Category: Confidence in implementing coaching plan

The sub-categories and concepts listed in this category refer to the participants' confidence in their own ability and motivation to implement the self-coaching plan as presented and developed during the session. This category has four sub-categories: Basis to build on, Obstacles, Range and No change needed.

Sub-category: Basis to build upon

This subcategory has three main concepts which refer to increased understanding, the ability to look at situation and the ability to devise a strategy: *"Understanding a little better what is happening during a stressful situation will now enable me to devise a strategy to use"* [164] and *"I feel I will be able to look at any situation, work or at home, and put what I have learnt into action"* [167].

Sub-category: Obstacles

The concept in this sub-category refer to perceived obstacles which may interfere with the successful implementation of the coaching plan. There are two further sub-categories: Time and Old Patterns. The sub-category Time refers to some participants' experience that they will need more time to implement the plan in order to gain confidence in using it effectively: *"I think it will take time to get out of the habit of being too hard on myself"* [145] and *"I know that by implementing the plan, I will gain a lot more confidence in that area and others also"* [143]. The concepts under Old Patterns relate to the risk of slipping back into old patterns, the risk of failure and the difficulty with trying again if "failure" would occur: *"I am not sure how well I will be able to implement things (...) when easier to slip into old patterns"* [177], *"Of course there is a risk my plan may go pear shaped. Then it will be difficult to try again"* [147].

Sub-category: Range

This sub-category lists the range of responses related to how confident participants felt in implementing the coaching plan. The concepts range from "fairly confident" to "quite able, quite confident, confident, to very confident. One person also mentioned she felt it depended on people and situations around her and her mood

at the time: “I feel fairly confident, but depends on situation, people around me and my mood” [147].

Sub-category: No change needed

This very small category only has one concept referring to participants’ comments that their own (previous) strategies work and no change is really needed: “Feel quite able to use a plan as such –now reassured that I am doing pretty ok” and “*I think I will although I find my current strategies work*”.

Category: Interest in future sessions

This category reflects the participants’ answers relating to their thoughts on future sessions. The category has four sub-categories: Yes, What’s on Offer, More of the same, and Psychological topics. The sub-categories Yes and What’s on Offer do not have any further concepts, but a large percentage of participants indicated that they would be interested in future sessions. The sub-category More of the same includes concepts that refer to participants’ positive experiences regarding the session and the perception that it was over too soon: “*Yes, the same session. I found it very interesting*” [202]. The concepts under Psychological Topics range from Anger in the hospice setting, to strength and weaknesses, stress management, coping strategies, family dynamics, and extreme emotions as a result of stress: “*Understanding how to not let situations have such an effect on me personally, and dealing with emotions*” [208].

Category: Additional Comments

The concepts in this category sum up the participants additional comments at the end of the session. These comments overall reflect a very positive experience and include: “thoroughly enjoyed it”, “interesting session”, “very useful”, “practical”, “thought provoking”, “wish it had been available sooner”, an investment of time”, to use and continue to use, and reassurance: “We all dealt with situation differently- having reassurance that anger can be good and not feeling it is wrong” [252].

Chapter 6: Discussion Phase 1 and 2

6.1 Overview

Contra to expectation, the results of the DASS-21 show that the hospice staff does not score significantly higher than the general population on depression, anxiety and stress. This is surprising due to the potential risks associated with working in an environment where staff have to support patients with life-changing decision making challenges, and supporting patients and their families/carers through highly charged emotional processes related to their illness, death and bereavement. These processes can evoke feelings of failure and guilt, as well as feelings of helplessness (Lynn, 1992; Goldstein & Leigh, 1999), which pose a potential risk for the experience of stress. In the discussion below, the different variables and aspects of the results will be explored in relation to existing research evidence, in order to allow a full understanding to emerge of current stressors and possible buffering factors in these two hospices.

6.2 Discussion of Findings

6.2.1 Demographic variables

At the point of assessment, 88% of staff were employed in clinical roles and 12% were employed in supportive-administrational roles. The first thing to notice when taking a closer look at the demographic data, is that nearly all staff working in this service are female. The HSE contracted a research on occupational stress and demographic factors including gender (Contract Research Report 311/2000). The results showed that in the majority of analyses, the stress levels for males and females were similar. The exceptions were that there were higher proportions of males than females in the high reported stress category in those with no secondary school qualifications and the lowest salary group. In contrast, there were higher proportions of females than males in the high reported stress category in social class III.2, all the salary groups except the lowest and in the full-time employment

group. In contrast to this, Gyllensten and Palmer (2005) concluded in their review of the literature on “The role of gender in workplace stress” that much of the research, with some exceptions, indicated that women reported higher levels of stress compared to men. This was also shown in the research by Matud (2004) who conducted a study on gender differences in stress and coping in a sample of 2816 people (1566 women and 1250 men) between 18 and 65 years old, with different socio-demographic characteristics. After adjusting for socio-demographic variables, the women scored significantly higher than the men in chronic stress and minor daily stressors. Although there was no difference in the number of life events experienced in the previous two years, the women rated their life events as more negative and less controllable than the men. The findings also suggested gender differences in 14 of the 31 items listed, with the women listing family and health-related events more frequently than the men, whereas the men listed relationship, finance and work-related events. This study also highlighted the differences in coping styles between the genders, as the women scored significantly higher than the men on the emotional and avoidance coping styles and lower on rational and detachment coping. The men were found to have more emotional inhibition than the women. And the women scored significantly higher than the men on somatic symptoms and psychological distress.

A further point to notice when looking more closely at the demographic data is the fact that the majority of staff work part-time. Directgov, the official government website for citizens (2008) states that: *“A part-time worker is someone who works fewer hours than a full-time worker. There's no specific number of hours that makes someone full or part-time, but a full-time worker will usually work 35 hours or more a week”*. The Part-time Workers (Prevention of Less Favourable Treatment) Regulations 2000 came into force on 1st July 2000 (Statutory Instrument 2000 No. 1551) The regulations ensure that part-timers are not treated less favourably in their contractual terms and conditions than comparable full-timers, unless different treatment is justified on objective grounds. The reasons why people choose to work part-time are varied, and could range from wanting to have a good work-life balance to having other, additional caring responsibilities.

The demographic variables of this research did not allow for investigation of the reasons why a large percentage of this staff group had chosen to work part-time. However, it did investigate the link between part-time/full-time employment and the variables of the DASS-21. The regression model used to analyze the correlation between the different variables did not include the variable part-time or full-time employment. However, the concept of working part-time did come up in the focus groups as a challenge. It was mentioned that part-time workers were sometimes faced with changes which were made during their days off, and the communication strategies were not always in place to ensure that part-time staff were informed in a timely manner.

Part-time employment is logically linked with individuals taking up dual roles. Research suggests that individuals assuming dual roles as family and professional care givers may be particularly at risk to increased stress, reduced life satisfaction and declined physical and mental health. Ross, Rideout and Barton (1994) found that nurses who work part-time often experience conflicts related to time commitment and role, with spillover of work issues into their home life and visa versa. A large percentage of staff working in the hospices (78%) was aged 41 or over and nearly all staff were women. Research on caregiving has estimated that 14% of women between the ages of 40 and 69 have at least one living parent (Rosenthal, Matthews & Marschall, 1989) and that 14% of women aged between 40 and 64 provide at least 3 hours of assistance per week to a parent (Spitze & Logan, 1990). Santos, Carroll, Cox *et al* (2003) found in their study on inpatient nurses' stress, strain and coping that nurses born between 1946 and 1964 (Baby Boomers) had significantly worse scores on stress and strain sub-scales than other age cohorts. They recommended that staff in this age group would benefit from specific support to manage the many competing demands related to their age range, both professionally and personally.

The above research summary on working hours, age, gender and stress does not provide us with insight into why the hospice staff does not seem to experience higher levels of stress than the general population. Some of the findings of the

focus groups however might give us some probable answers to this. Within the sub-category Clinical Demands, it was mentioned that having a “certain personality” was required to do the palliative care work and although there was no elaboration on the specific qualities, it was hinted that it takes people with commitment and vocation to deliver high quality palliative care as well as the willingness to “go the extra mile”. The fact that nearly one third of staff (31%) had worked in palliative care for more than 10 years might support the notion that this staff group experience a vocational commitment to this type of work. The above would suggest that people working in palliative care attach at least some of their identity to their work. This is not surprising, as the nursing profession has traditionally placed great emphasis on the development of moral character. Approaches to cultivating moral character predominated in textbooks written during the 19th and early 20th century. Lees (1874, cited in Bradshaw, 2000) expanded on the purpose of nursing as the paramount duty of civilization, concerning issues of life and death, and in which nurses were privileged to be involved. She listed the qualities nurses should learn in training school as: cleanliness, neatness, obedience, sobriety, truthfulness, honesty, punctuality, trustworthiness, quickness and orderliness. The nurse was also to be patient, cheerful and kindly. Nurses’ personality factors are therefore traditionally perceived as inseparable from their professional competence (Bradshaw, 2000). Personality factors have been much researched in the context of perception and management of stress. Personality is a complex set of unique psychological qualities that affect individual behaviour across situations and over time (Zimbardo & Weber, 1994). The Five Factor Model of personality, or the Big Five, was developed by McCrae and Costa (1985) and is widely used to measure personality. It uses five dimensions: Openness, Conscientiousness, Extraversion, Agreeableness, and Neuroticism. In terms of how the different personality factors relate to nursing qualities, it is suggested (Lin, Chiu, & Hsich, 2001) that Openness is positively correlated with Assurance, Conscientiousness is positively correlated with reliability, Extraversion is positively correlated with Responsiveness, and Agreeableness is positively correlated with Assurance and Empathy. The personality factor that has received most attention with respect to stress and coping is neuroticism (Bolger & Zuckerman, 1995).

Neuroticism refers to emotional (in)stability. Those who score high on neuroticism are therefore at higher risk of experiencing anxiety, depression, anger, worry and self-consciousness (Barric & Mount, 1991; McCrae & John, 1992). Cimboric Gunther, Cohen. & Armeli (1998) investigated the role of neuroticism in every step of the stress and coping process as outlined by Lazarus and Folkman (1984) and related this to the appraisal of daily stressful experiences. They found a relationship between high neuroticism and being caught up in a web of negative behaviours, cognitions and moods, that manifest on a daily basis. Within the nursing context, neuroticism could therefore have a significant impact on the quality of patient care (Teng, Hsu, Chien & Chang, 2007; Allen & Mellor, 2002). The current study did not include an exploration of personality factors. However, as the participants reported relatively low levels of perceived depression, anxiety and stress, it may be suggested that neuroticism is relatively low amongst this staff group. Future exploration into the buffering factors of stress experience, including an investigation into the personality factors amongst this staff group would therefore be useful.

Several researchers have identified that people entering palliative care work may do this with high ideals and expectations (Vachon, 1987; Landsdown, Pike & Smith., 1990, Fisher, 1991). In contemporary nursing education, Watson, Deary and Lea (1999) found that student nurses lost some of their idealism within twelve months of starting the training but it has also been suggested (Day, Field, Campbell & Reuter, 1995) that student nurses adapt their approach to a more realistic style of nursing but retain their idealism at the end of their educational programmes. The image of being a dedicated and selfless person may therefore continue to underpin the personality characteristics of the nursing profession, which may define the quality of role perception. Research into the quality of role experiences proposes that the quality of role experience (problems and rewards) is an important factor to the experience of well-being (Barnett & Baruch, 1985; Froberg, Gjerdingen & Preston, 1986) and in this way could offer a buffer mechanism to the potentially stressful work demands of the nurse in general, and the palliative care nurse in particular. In addition to the above explored

conceptualization of the nursing profession, the palliative care nurse/professional, due to the nature of the work, may also be inclined to view their work as very meaningful. Joseph (2007) found that engagement in meaningful work is negatively correlated with stress, which would support the findings of this research.

6.2.2 DASS-21, HSE Stress Indicator Tool and Focus Groups

The analyses of the DASS-21 showed that there was no significant difference between the observed means of the measurements and the norms given for the UK population. This indicates that at time of measurement, the levels of depression, anxiety, stress and Negative Affect for the staff groups at both hospices did not differ significantly from the general UK population. When comparing the scores of the two hospices, it shows that they have very different scores on the DASS-21 sub-scales. In relation to the UK norms, the overall scores for hospice 1 are above the norms with the clinical staff scoring substantially higher than the norms. The overall scores for hospice 2 are very close to the norms. The scores for the clinical staff are below the norms but the scores for the support staff are much higher than the norms. As mentioned in chapter 3, the number of support staff is too low to make a meaningful interpretation of the results. In this discussion the focus will therefore be on the clinical staff group in relation to the HSE scores and the data from the focus groups.

In summary then, the results for Clinical Staff on the DASS-21 show that the levels of depression, anxiety, stress and negative affect are higher at hospice 1 than hospice 2. Looking at the HSE scores for Clinical Staff at each hospice, the results confirm a difference between the two hospices. Hospice 1 scores lower on Demands, Control and Managers' Support, with these areas scoring as yellow: "in clear need of improvement". The scores of Hospice 2 on these factors fall in the blue category and scored as "good", but with room for improvement. The scores for Relationships and Change show to be "in clear need of improvement" at both hospices and the scores on "Role" fell in the red category at both hospices, meaning that they are in urgent need for attention. Peer Support was the only

factor that Clinical Staff at both hospices scored as “good” (but with room for improvement).

As the stressor domains Demands, Control and Managers’ Support are the three areas in which the hospices differ on the HSE standards, an exploration will follow of the focus group data to gain a deeper understanding of the differences and similarities between the two hospices on these stressor domains.

Demands

The stressor domain Demands refers to issues around workload, work patterns and work environment. When comparing the data of the focus groups on this stressor domain, it becomes clear that hospice 1 has many more categories and sub-categories on this subject than hospice 2 (see Appendix 24). The stressor domain Demands is a central theme within this research, as the analyses showed it to be the core category to which all other categories are linked. It was also the only HSE stressor domain which was found to be a significant predictor of stress. It is clear from the number of sub-categories and concepts that the topic of “demands” has been discussed in much greater detail at hospice 1 than hospice 2. At closer investigation, it appears that the two focus groups differ in the amount of time spent on- and the depth of experience of three particular areas within the overall category Demands. These areas are: 1) maintaining high standards and managing patients’/carers’ expectations, 2) emotional demands, 3) training demands and limitations.

Referring to expressed experience of maintaining high standards and managing expectations, the staff participating in the focus group at hospice 1 spent much more time talking about these topics. They mentioned that it is often difficult to maintain those high standards and attribute this mainly to staff shortages. Staff mentioned that this left them feeling that the quality of care was compromised which in turn left them feeling unfulfilled. It is unclear from the focus group data if the concept of staff shortages refers to “feeling permanently understaffed”, or to a temporary situation of staff shortage due to sick leave and/or staff turnover.

Although the required staffing levels, as employed by the hospice services used for this research, are overall met, the Healthcare Commission (2005) reports that there are no standard ratios or formulae for staffing levels. This means that budgets are set according to local judgement and cost constraints. Comparing staffing levels between Trusts is complex because of differences in service needs. Comparison between hospice services presents an additional challenge, as funding is often split between NHS and voluntary resources, using different ratios for each individual hospice service. Due to the fact that the services used for this research have a relative high level of NHS funding (75%), this will have a negative impact on the staff ratio to patients. A further factor which plays a part in the decision of nurses to patient ratio is the level of dependency of the patient group. The term “dependency” has been used to measure the number of nurses needed to meet the needs of hospice patients in relation to their dependency status (Birch, Fisher, Grey, Veitch, & Williams, 1997). As part of the dependency measure it needs to be noted that the nature of hospice nursing expands beyond the walls of the hospital and home environment as it aims to provide holistic nursing care, including support to family members and/or carers.

In addition to the relative low levels of staffing in comparison with hospice services primarily funded by voluntary resources, the hospices used for this research also have reported high levels of sickness absence and staff turnover. The consequence of this is a higher incidence of the use of bank staff which can have a negative effect on team cohesiveness and consistency of care.

The participants at hospice 1 mentioned that they felt that the hospice work had changed and that the volume of work had increased which created time pressures and a perceived reduction in quality of care. Due to the current emphasis within the NHS on targets as well as meeting commissioners expectations, work in a primarily NHS funded hospice has had to change. Management has had to adopt a more businesslike approach to care giving. To be able to maintain a place within the “palliative care services market” and to stay ahead of competition, hospices have started to move towards becoming specialist palliative care units, providing short-

term care (Enes, Lucas, Aberdeen, & Lucioni, 2004). This fits in with the current trend towards care in the community, where generalist palliative care is delivered in all care settings by GPs, district nurses, nursing home staff and non-specialist health care professionals working in acute hospitals. Within this model, the patient admitted to a specialist palliative care unit is expected to be discharged as soon as the symptoms are managed or “under control”, and patients are not imminently dying.

As hospice services are changing towards acute and specialist units, so is the need to change the traditional reputation of the hospice service which still can be found in the community. Patients and relatives/carers often come into the hospice with expectations which cannot be met within the current climate of NHS service provision; looking for a service where they can find respite (Bramwell, Mackenzie, Laschinger & Cameron 1995) and where they can spend as much time as they wish, to rebuild some strength or to stay until their dying day. Managing these expectations was highlighted as a difficulty by the participants of the focus group at hospice 1.

The preparation for discharge, either to their home or to a nursing home, where patients’ medium to longer-term nursing needs can be met, can sometimes be complex and time consuming due to practical limitations, but also due to service users’ expectations and preconceptions about the nature and duration of care offered by the hospice service. The transition from the hospice to a nursing home can often be particularly difficult for patients and their families/carers due to a feared reduction in quality of care and/or the emotional conflict that this may stir up. Evidence suggests that the health of elderly patients can be negatively affected by the move from a hospice to a nursing home (Pertou & Obenchain, 1987; Porock, Martin, Oldham & Underwood, 1997; Scott, 1997; Warden, 1998). This may not only influence the patients’ and/or their families’ decision to be moved, it can also create a sense of unease amongst the staff group (Fallon & Dunlop, 2002). As it is part of the tasks of the nursing staff to facilitate this transition, this can add to the

pressure experienced by staff members as expressed in the focus group at hospice 1.

The management of time pressures and expectations of the patients and their families/carers as well as the staff's own expectations of a high standard of care was mentioned in both hospices, however more profoundly so at hospice 1 than hospice 2. The expectation of high standard of care can be viewed in the context of perfectionism. Theorists have argued that perfectionism can be viewed as having two dimensions: maladaptive perfectionism and adaptive perfectionisms (Fost, Heimberg, Holt, Mattia & Neubauer, 1993; Slaney, Ashby & Trippi, 1995). In this context, maladaptive perfectionisms, also known as "evaluative concerns perfectionism", includes having unrealistically high standards, striving for excellence motivated by avoiding negative evaluations from others, and the inability of obtaining satisfaction from one's own performances (Enns & Cox, 2002). Adaptive perfectionism, also known as "personal standards perfectionism", relates to the setting of realistically high standards motivated by one's own needs and achieving satisfaction from one's own achievement (Hamachek, 1978). Evidence suggests (Blankstein & Dunkley, 2002; Kilbert, Langhinrichsen-Rohling & Saito, 2000) that maladaptive perfectionism is positively associated with negative mood states like anxiety and depression, whilst personal standards perfectionism does not correlate significantly to these mood states (Blankstein & Dunkely, 2002; Miquelon, Vallerand, Grouzet & Cardinal, 2005), or even shows to have a negative correlation to psychological distress (Aldea & Rice, 2006). As this study did not include questionnaires to measure the different aspects of perfectionism it is difficult to identify with certainty which type of perfectionism is expressed predominantly within the services. The focus groups mention the issue of perfectionism as sometimes being a negative factor which is imposed upon them by the nature of the service, like having to follow very precise and sometimes petty rules. However, perfectionism is also being referred to in terms of achieving personal standards as both hospices refer to the fact that hospice staff often "want to go the extra mile" to give best care. At first glance one would expect to see a raised level of depression, anxiety and stress in these services due to the high

level of perfectionism needed to deliver very high standards of care. However, it appears from the focus groups that personal standards perfectionism has either masked or overruled the occurrence of negative mood states. A further factor which could have positively influenced the experience of negative mood states is the fact that the teams report having very good peer support. Kawamura & Frost (2004) found in their study on “Self-concealment as a mediator in the relations between perfectionism and psychological distress”, that a tendency to conceal negative personal information may be a significant contributor to the distress experienced by those with maladaptive perfectionism. Having good peer support may facilitate the disclosure of perceived negative experiences in relation to failure to achieve unrealistically high standards, which then moderates the experience of stress in a positive way.

A further difference between hospice 1 and hospice 2 can be found in their expressed experience of the emotional demands associated with direct patient care. Within the focus group at hospice 1, much time was spent on the emotional aspects of caring for patients who are dying. The participants mentioned a variety of patient factors which have the potential to increase the chance of them becoming more emotionally involved. They mentioned for instance that it was difficult to care for a patient who was going through a very slow dying process. This would cause them inner conflicts as their work philosophy is to celebrate life and to help patients sustain a reasonable quality of life for as long as possible. However, in circumstances where the quality of life is severely compromised and the dying process is long and drawn out, inner conflict would occur as their compassionate side would want the patient to be relieved from their suffering. Glaser and Strauss (1965) distinguish 'quick' and 'slow' dying trajectories, noting that deaths which occur over a relatively short time-span seem easier for doctors and nurses to cope with, but not for family and friends. The staff at hospice 1 also reported more explicitly on patient factors like Age and dealing with Young Families. The emotional impact of caring for young patients was also highlighted by Glass & Rose (2006), who found in their qualitative study that many nurses grappled with making meaning of the young lives that were being “lost”. Within this focus group,

additional challenges were expressed around the care of patients diagnosed with Motor Neuron Disease. As the definition of palliative care has broadened beyond the cancer diagnosis to include other life-threatening diseases and long-term conditions, patients with neurodegenerative conditions and their families are increasingly benefiting from hospice services (Borasio, Voltz & Miller, 2001). Neurodegenerative conditions are progressive, with no known cure and often long periods of dependency (Kristjanson, Tøye & Dawson, 2003). Therefore meeting the needs of these patients and their carers can often be a long, extensive and complex process which needs constant adjustment in response to progressive deterioration and impact on family life (Gruenewald, Higginson, Vivat. & Burman, 2004; Jenkinson & Fitzpatrick, 2001)

The final major difference between hospice 1 and hospice 2 was the area of perceived training limitations. Training demands was a topic brought forward particularly by the focus group at hospice 1, where participants felt very strongly that staff did not have the opportunity to be trained effectively on a clinical level due to lack of funding. Staff at hospice 1 expressed stress and sadness around not having enough staff on some shifts to provide specialist trained interventions like catheter care to patients and felt this compromised best patient care. Participants at hospice 2 also mentioned the need for training, but the focus of their discussion was aimed at frustration of having to do a significant number of mandatory training courses which in their perception does not relate to clinical care but rather serves as a risk management mechanism for the broader NHS. They did not express the same amount of distress around lack of specialist clinical training and the potential impact this was having on patient care.

Control

The stressor domain Control refers to issues related to how much say people feel they have in the way they do their work. It is an area that did not get much mention within either focus group. An exploration of the sub-categories of the data of both focus groups did not directly refer to the concept of control so it needs to be

concluded that the focus groups did not provide additional information on issues around control or the perceived lack of it at hospice 1.

Managers' Support

The stressor domain Managers' support refers to the level of encouragement, sponsorship and resources as provided by the management within the organisation. At first glance, the sub-categories of hospice 2 out way the sub-categories of hospice 1 on the category Managers' Support. However, on deeper investigation, it becomes clear that within the discussions held by the focus group at hospice 2 a deeper discussion emerged on the issues associated with "higher management". In other words, participants expressed their thoughts and feelings about working within the broader NHS and expressed feeling undervalued and not considered within the overall running of the NHS. The experience of working in the NHS in a broader context was not brought up in Hospice 1. Both hospices also addressed the topic of Managers' Support within the direct context of the palliative care service, with four concepts listed under each hospice. Both focus groups mentioned that they felt unsupported by their local management and not listened to. The focus group at hospice 1 mentioned that particularly new staff feel unsupported as their mentoring needs were not always met. This showed to be a particular issue for newly qualified staff who joined the team. Bradby (1990) described some of the emotional challenges faced by newly qualified nurses starting their work on the wards. He reported that they described "being overwhelmed, feeling lost, bewildered, strange and useless". These findings were supported by Kelly and Matthews (2001) who also found that nurses who were moved from their usual clinical areas in which they were confident, experienced uncertainty and insecurity about their new role. Rasmussen, Norberg & Sandman Rasmussen (1995) identified that new hospice nurses often hold idealistic expectations about patient care and struggled to reconcile the conflict between their ideals and the reality of hospice nursing. It therefore transpires that role transition needs to be managed carefully and new members of the team need to feel supported by senior members in order to facilitate this process. Literature suggests that mentorship can potentially aid the process of role transition

(Andersen, 1990, Earnshaw, 1995; Cahill, 1996; Philips, Davies. & Neary, 1996a,b; Smith & Gray, 2001). Security and role modelling are aspects of mentoring which are valued by student nurses in their clinical training (Earnshaw, 1995; Cahill, 1996, Philips *et al.*, 1996a,b). As making transitions can be a challenging process which forces the person to adopt changes in identity, role, relationships, ability and expectations, it seems paramount that social support as well as professional support is offered to each new member of staff, recently qualified and experienced staff alike. Mentorship can offer this support, however allocation of mentors needs to be considered carefully, as arbitrary allocation can lead to personality clashes or a reluctance from the mentor's perspective, which can lead to ineffective mentorship (Earnshaw, 1995; Cahill, 1996; Philips *et al.* 1996a,b,; Smith & Gray, 2001). Within this model of working it is suggested that mentors receive support themselves as the role of mentor can be complex, presenting potential conflicts between the different roles (Atkins & Williams, 1995).

Another issue brought up by hospice 1 within this context was the fact that they felt unsupported in their training needs. It was mentioned that staff feel the need to participate in continued professional development but due to time- and financial pressures were prohibited from doing courses they found interesting or necessary for the maintenance of high quality care. Their reason for being dissatisfied with the local management therefore indirectly seemed to relate again to the potential threat of reduced quality of direct patient care. This differs qualitatively from the concepts found under "local management" (support) at hospice 2, where the emphasis seemed to be on feeling un-appreciated due to the fact that the management were thinking of their own interest and "safety" first, rather than providing effective support to staff when needed.

Summarizing the above, it appears that the focus group data support the HSE findings on the perceived stressor domain Demand, with Hospice 1 expressing qualitative and quantitative different aspects in relation to maintaining high standards and managing patients'/carers' expectations, their experience of emotional demands, and their experience of training demands and limitations. The

data from the focus groups did not give any further insight into the fact that hospice 1 scored poor on the stressor domain “Control”. However, the data on Managers’ Support provided some valuable information on why the participants at hospice 1 scored poorer on this stressor domain than hospice 2; it appeared that staff at hospice 1 again had concerns about maintaining the high standards related to direct clinical care, which links in with the findings of the focus groups under the stressor domain Demands.

Continuing the comparison of the two hospices, the results show that two of the HSE stressor variables, Change and Relationships, scored as “in clear need of improvement” at both hospices. In the following paragraphs an exploration will follow of each stressor variable.

Change

The stressor domain Change refers to how organisational change is managed and communicated within the organisation. Within this study, Change is the only variable that came up as a significant predictor of Depression. Both focus groups spent some time discussing the issues relating to change. Both focus groups mentioned that they felt that change was not managed very effectively with particular focus on the poor communication strategies that left people feel out of the loop, with decisions being made for them rather than with them. Particularly at hospice 1, staff felt that the reasons for change were not always explained effectively which caused them to resist change and feel powerless. It was also noted that part-time staff often miss out on information due to the poor communication strategies. The focus group at hospice 2 expressed that they felt that the practical implications of (sometimes seemingly small) changes were not thought through and that the staff then struggled with implementing and complying with “orders from above”, which caused distress. At hospice 2 there was also a strong feeling that change processes were not “open and honest” and that there were ulterior motives behind the scene of which they were not informed. Literature suggests that organizational changes that take place without employees’ significant input tend to lead to unwanted distress amongst the workforce

(Anderson-Connolly, Grunberg, Greenberg, & Moore, 2002). Other than the fact that poor communication strategies causes distress amongst this staff group, it also poses limitations to the effective management of the increasing competitive pressures faced by the healthcare services. The Social Exchange Theory and Equity Theory (Johnson, Selenta & Lord, 2006) proposes that members of an organization will compare their contributions to the organization with the compensation received from the organization, which in turn influences the level of commitment to the organization. It is also suggested (Lu, Chang & Wu, 2007) that higher organizational commitment correlates with better job performance. Kelemen & Papasolomou-Doukakis (2004) emphasize that an organization needs to have an effective internal exchange between itself and its employees (also referred to as effective internal marketing), before it can successfully respect, and meet the needs of its external customers. Barnes Fox and Morris (2004) suggest that internal marketing helps an organization to attract and retain outstanding employees and improve the capability of an organization to satisfy the needs of internal and external customers. Furthermore, Bell, Menguc and Stefani (2004) and Bernstein (2005) identify that internal marketing positively influences organizational commitment as it promotes positive mood states like feelings of pride in the work. Good communication strategies are therefore of vital importance to ensure the feeling of well-being and commitment of the staff group, but also to ensure high quality of service delivery to the service users.

The focus group at hospice 1 also spent quite a significant amount of time discussing the overall changes in palliative care, with heavier pressures on staff to work at a faster pace, with a higher volume of work. Within this category it was again highlighted by the participants at hospice 1, that these changes meant that patient care was compromised. It was mentioned that this meant that staff needed to adjust to these changes as they are here to stay, and that an adjustment of mindset was needed to continue to obtain fulfilment from the work. The apprehension around “dying becoming an acute event”, was also a theme in the research conducted by Bruce and Boston (2008). Participants of this study reported seeing the quickening pace of palliative care as an obstacle to supporting

the dying process as it contradicts the sense of slowing down and withdrawal associated with the dying process. These changing demands within the palliative care service as a whole was not mentioned to the same degree within the focus group at hospice 2. Both focus groups however felt that “rules come from up high”, which meant that a sense of exclusion was experienced at both hospices with regards to the processes of change

Relationships

The stressor domain Relationships refers to positive working conditions to avoid conflict and dealing with unacceptable behaviour. Neither focus group gave reference to this stressor variable. However, the HSE results did disclose that eight people felt bullied to some degree at the time of measurement. The ratio of reported bullying as reported at both hospices was equal. A report commissioned by the Department of Health (2005) prepared by an external equality and diversity company contains an analysis of bullying and harassment in the NHS. The report states that 27% of staff working in Acute and Specialist Trusts, and 22% of PCT staff have felt bullied, which is a higher percentage as found in the current study. However, based on the findings of this report, there are several indicators inferring that the hospice service may be at risk of developing a bullying culture. The report highlights “Leadership”, “Change”, “Team Working” and “Culture” as the main organizational factors associated with bullying. It states that extreme authoritarian or laissez-faire management styles (Leadership) have been directly linked with increased psychological bullying as well as organizational restructuring (Change). In terms of team working it reports that this can benefit the organization, however, “enforced” team working can provide a fertile ground for conflict development and aggressive competition for limited rewards. The organizational climate can play a huge part in the development of a culture that either tolerates or rejects bullying. Looking at the results of phase 1 and 2 of the current research in relation to these four areas of risk, it becomes clear that this service is at risk of developing a bullying culture. The HSE results of the current study identified the stressor areas “Leadership” and “Change” as in clear need of improvement, which was supported

by the data of the focus groups. Furthermore, team working may be affected by the fact that the reward obtained through looking after dying patients and their families differs from- and are more limited in relation to- the rewards obtained through working in other areas of the health service. The rewards obtained from working in palliative care are usually related to the facilitation of a “good death”, whilst the rewards obtained from other areas in the health service usually relate to the facilitation of improved health. Within the current changes within the palliative care service, the facilitation of a “good death” is perceived by the staff as “under threat”, which may be an extra challenge for staff in terms of the rewards reaped from their challenging work duties. Finally, the report also states that role conflict and role ambiguity can play a part in the development of a bullying culture. It states that employees perceiving contradictory expectations, demands and values in their job are more likely to be victims of workplace bullying. The fact that the HSE stressor variable “Role” was flagged up as an area in urgent need of attention, may therefore be another indication that these hospice services are at risk of developing a bullying culture. The stressor domain of “Role” is explored in the following paragraphs.

Role

The stressor domain Role refers to whether people understand their role within the organisation and whether the organisation ensures that the person does not have conflicting roles. As mentioned above, “Role” was flagged up as the worst stressor domain within the HSE analyses, with both hospices scoring as “in urgent need of attention”. Hardy and Conway (1988) classified role stress for healthcare professionals in different dimension; role conflict, role ambiguity, role overload, role incompetence or over-qualification, and role incongruity. Role stress has been shown to have a significantly negative correlation with career satisfaction in nurses (Hoffman & Scott, 2003). A meta-synthesis study on role development and effective practice of specialists (including nurse practitioners and clinical nurse specialists) conducted by Jones (2005), found that inter-professional relationships and role ambiguity are the most important factors that could enhance or hinder role performance. Similar findings were reported by Bull and Hart (1995), who

found that inadequately delineated role functions, unrealistic expectations and limited recognition of clinical expertise complicated role performance. Although the analyses of the focus groups did not specifically produce a category related to roles, a number of concepts within the other categories do refer to this. Within the category Change at hospice 1, concepts related to “changes in palliative care” clearly refer to changes in roles due to the emerging “new philosophy of care”. Within these changes, staff report feeling uncomfortable with the new philosophy which has caused their roles to change. The shift towards a faster pace of work with a perceived reduction in quality of care has changed their roles from the caring, loving, patient person that traditionally was associated with the nursing profession, to a highly specialised and “efficient” practitioner. One could argue that this is a shift from quality to quantity, or from human and “motherly” to more clinical and more distant. This is likely to contradict the role expectations that were inherited from the original nursing teachings and the vocational aspects that the palliative care staff bring to the job. The participants at hospice 2 did not express the same amount of distress around the changing palliative care service, but they did mention the increasing number of rules which are brought down “from above”, of which the consequences were not thought through. These would impact on their daily clinical work and in doing so, would also influence the perception of their roles. A particular mention was made about the “unrelated jobs” (to their normal clinical roles) which they were asked to do, like “policing” patients and their families/carers with regards to the no-smoking policy. Although the findings of the HSE tool show that the stressor area Role needs urgent attention, limited information has been obtained from the focus groups as to which specific dimension(s) of role stress is responsible for this result. Further investigation into this area is therefore recommended so that an effective management approach can be identified and applied to address these issues.

Peer Support was the only stressor domain that Clinical Staff at both hospices scored as “good” (but with room for improvement). Below is an exploration of the data as produced by the focus group.

Peer support

The stressor domain Peer Support refers to the encouragement and support received by peers. The discussions in the focus groups at both hospices referred to the concepts around peer support. Both hospices emphasized the importance of good team working and, in line with the HSE data, confirmed that they experienced their team support as very good. The focus group at hospice 1 highlighted the importance of sharing information with your peers so that staff feel supported and “normal” in their reaction to stressful situations. They mentioned that team members actively encourage each other to talk when something is bothering them, in order to off-load some of the pressure. The focus groups mentioned that no specific forums have been established within the hospices to facilitate peer support. Rather, peer support is given and received informally as and when needed. Several studies (Coffey & Coleman, 2001; Jenkins & Elliott, 2004; Glassberg, Eriksson & Norberg, 2007) identified that higher levels of peer support were related to lower levels of emotional exhaustion. According to Schaufeli and Enzmann (1998), peer support groups can potentially provide a broad range of support aspects, including emotional, instrumental and informational support. Maslach and Goldberg (1998) also promote the use of peer-support groups as they offer an opportunity to receive emotional comfort, new insights, and a forum for receiving personal rewards and recognition. They also feel that it may be a much needed source of humour, optimism and encouragement “when the going gets tough”. However, it was also mentioned that the process of off-loading to each other could also sometimes be experienced as “an extra pressure”, when the emotional demands of the working day were challenging. The focus group at hospice 2 highlighted the fact that the structure within the team did not feel as hierarchical, which helped them to support each other. As in hospice 1, the staff at hospice 2 also reported the importance of “looking out for each other”, offering support when a team member was observed to be struggling.

Other than the above mentioned HSE stressor domains, the focus group at hospice 1 also produced a category on Self-Care. This category overlaps in some

ways with some of the stressor domains, but the number of concepts under this category warranted this category to be recognised as an independent area of exploration.

Self-Care

The category Self-Care refers to the activities and strategies adopted by members of staff, in order to manage the practical and emotional demands of their work. Due to the pressures associated with nursing, it is recognised that nurses need to value and enhance their own health and well-being, as well as having the capacity to care for their patients' well-being (Rose & Glass, 2008). Riley (2003) defined self-care as "a matter of giving oneself permission to take the time, to make the commitment, and to negotiate the roadblocks. The practice of effective self-care is not only viewed as essential for the benefit of the nursing staff, Uno and Ruthman (2006) argue that it is also important in terms of being a role model for the patients. However, self-care was not rated as very important amongst the participants of the focus groups. One of the first things that was mentioned was the fact that staff "forget to look after themselves". There appears to be a work ethos which means that "patients come first" and the staff's own needs will be compromised if/when patients' care is perceived as more urgent. Due to the nature of the work, this will often cause conflicts, as patients' needs will be more urgent than their own needs, most of the time. These findings contrast the findings of Glass, and Rose (2008), who found that self-care was regarded as important and even essential to nurses' ability to perform their job. The participants of this research however were community nurses only, for whom "team pressure" and "cultural expectations" may not bear so heavy on their ability to embrace self-care mechanisms. Participants of the focus groups of the current research did not include community nurses. The focus group at hospice 1 highlighted the importance of supervision as a way of looking after yourself. However, they also expressed ambivalence around this, due to lack of understanding about the purpose of supervision. Proctor (1991) identified three main functions of supervision, namely: normative, formative and restorative. Normative supervision refers to the giving of advice in order to promote high quality of care and to reduce

risks. Formative supervision focuses on helping nurses to develop their skills and knowledge base, and restorative supervision refers to the giving of personal support to help the supervisee cope with the pressures of their work. The data obtained from the focus group discussions showed that supervision was often seen as a luxury, to off-load and find support, which could only be engaged in if/when the time would allow it. Participants mentioned that staff would sometimes feel frowned upon if they would leave the team for an hour to receive their supervision. In these circumstances supervision would be seen as an “indulgence” rather than a necessary self-care activity to allow for reflection and the processing of emotionally challenging experiences. Research into the effectiveness of supervision has been contradictory, with qualitative data acquired through interviews reporting positive results using supervision, but quantitative data not supporting these findings (Butterworth, Carson, White, Jeacock, Clements *et al*, 1997). Teasdale, Brocklehurst and Thom (2001) found that nurses appeared to be using clinical supervision for reflection on action and using informal networks for more immediate support and advice. They highlight the need for maintaining a range of both formal and informal support for nurses, rather than opting exclusively for clinical supervision.

A further aspect that was brought forward within the context of Self-Care, was the opportunity to debrief after a stressful event. The process of debriefing is based on crisis intervention theory and is reviewed by the Cochrane Reviews (Rose, Bisson, Churchill & Wessley, 2002) as consistently and misleadingly viewed as a form of counselling or psychotherapy. It is intended to be offered as a single-session, offering immediate psychological assistance to survivors of all kinds of traumatic events (Sijbrandij, Olff, Reitsma, Carlier & Gersons, *et al.*, 2006). Lam, Ross, Cass, Quine and Lazarus (1999) argue that high and long term trauma exposure is detrimental to the mental health of the nurses and suggest that nursing staff who have high exposure to trauma would benefit from support services such as debriefing. Staff mentioned that debriefing was not something that happened officially very often. However, they expressed that they felt debriefing was something that happened “in the corridor” on an ad hoc basis, as and when

needed. On this level debriefing was perceived as valuable, however, official debriefing sessions were mentioned as also needed, particularly when dealing with very complex cases, for instance when dealing with patients who have Motor Neuron Disease.

The focus group at hospice 1 brought up some further aspects related to Self-Care including physical exercise, good time management and cognitive strategies like using dissociation techniques. For instance, one member of the group mentioned that she tries to compartmentalize as a strategy to stop her from feeling overwhelmed by keeping control over how much she allows herself to emotionally engage in at one time. She also mentioned using an image of putting a shell around her, like being in an egg, to control the emotional influx of the situation she is dealing with. The fact that dissociation techniques can positively affect coping ability is supported by the work of Healy and McKay (2000), who found that a negative relationship exists between the use of disengagement strategies and intensity of emotional distress.

6.3 Research Questions for Phase 1 and 2

Below is a summary of the findings in relation to the original research questions as stated in Chapter 3.

Phase 1, Question 1:

How do the levels of perceived stressors amongst this staff group compare with the Management Standards set by the Health and Safety Executive?

Several analyses have been conducted on the data obtained from the HSE Stress Indicator Tool: All Staff at both hospices, All Staff at each hospice, Clinical Staff at each hospice and Support Staff at each hospice. Due to the small numbers of support staff in this service, the above discussion has mainly focussed on the clinical staff group. Comparison between the two hospices showed that the two hospices scored different on the stressor domains Demands, Control and

Managers' Support, with hospice 1 scoring below average and "In clear need of improvement" whilst hospice 2 scored as "Good". Both hospices scored below average on Relationships and Change, which are areas that need attention in comparison to the HSE standards. Both hospices scored below the 20th percentile on Role, which shows this is an area that is in need of urgent attention. The stressor domain Peer Support was the only stressor domain on which both hospices scored as "Good". Neither hospice scored as "Doing very well" on any of the domains, which means that there is room for improvement at both hospices, even if they scored as "Good" on one or more domains.

Phase 1, Question 2:

How do the levels of stress, anxiety and depression of this staff group compare with the levels of the general population?

In contrast to expectation, the results of the DASS-21 showed that the staff group did not differ from the general population on stress, anxiety and depression. Within the above discussion some potential buffering factors have been explored to explain these findings.

Phase 1, Question 3:

Which specific stressors can be identified as most prominent amongst this staff group?

The results show that the stressors identified by the HSE Stress Indicator Tool, differ at each hospice. At hospice 1, all of the HSE stressor areas except Peer Support have been identified as prominent, with stressor domain Role being the most prominent. At hospice 2, three stressor domains have been identified as prominent amongst this staff group, namely, Relationships, Change and Role, with Role again being the most prominent..

Phase 2, Question 4:

What are the perceived stressors amongst this staff group?

Looking at the qualitative data obtained from the focus groups, there were similarities between this data and the data found in phase 1 of the study as well as

similarities found between the two hospices. However, some differences were also found between the two hospices. The analyses of the results brought the category Demands to the fore as the core category. The topic of demands had been discussed at both focus groups as a stressor area. In comparison hospice 1 differed from hospice 2, spending more time on- and expressing more concerns about the maintenance of high standards within the changing NHS environment and managing the patients' and their families/carers' expectations. The focus group at hospice 1 also expressed more emotional demands, particularly related to direct and complex patient care, than the focus group at hospice 2. Both focus groups spent time discussing training demands. The perceived stressor at hospice 1 on this topic was the limitations associated with clinical training due to limited financial and time resources. This differed from hospice 2, where participants expressed frustration with the large amount of mandatory training courses which they felt were difficult to fit into their daily schedules.

A further stressor that emerged from the focus groups was the area of Managers' Support. Both focus groups discussed "lack of support" and "not feeling listened to" as a stressor within the service. At hospice 1 the lack of support related particularly to newly qualified staff and also their clinical training needs which they perceived as a stressor in relation to the threat of reduced quality of care for the patients. At hospice 2 on the other hand, the stressor of not being supported and listened to related more to their thoughts and feelings about working within the broader NHS and they expressed feeling undervalued and not considered within the overall NHS management strategy. On a local management level, this stressor expressed itself in terms of staff feeling that management would only support them if their own interest and "safety" was not at stake. In this way, the staff at hospice 2 expressed a deeper sense of feeling unsafe as they did not feel secure in the knowledge that the management would back them up or at least support them, if/when mistakes would happen.

Consistent with the findings of the HSE Stress Indicator Tool, Change came up in both focus groups as a stressor. Staff felt that changes were not communicated

effectively and that they were not consulted enough on the proposed changes. The stressors related to Change link closely to staff feeling “imposed” to do tasks which they either do not fully agree with, not fully understand and/or not fully trust.

Finally, a stressor area which did not come up as a category on its own, but was interwoven within some of the other category was Role Change. Staff expressed that they struggled with the new emerging philosophy within palliative care which asked of them to work at a faster pace with a perceived reduction in the quality of patient care. In this context staff expressed a sense of discomfort around the increasing number of rules “imposed upon them”, which contradict to some extent their original vision of the nursing role.

Phase 2, Question 5:

Which (if any) coaching-needs can be identified for this staff group?

Within the context of coaching, it is important to remember that coaching is aimed at psychologically healthy people who wish to improve on specific areas of their functioning. The results from the DASS-21 show that this staff group overall does not present with unhealthy levels of depression, anxiety and stress, which makes them a suitable group to explore the coaching options. The results from the HSE Stress Indicator Tool and the focus groups show that this palliative care service has a number of stressor areas in which improvement is possible and advisable. Some of these improvements are clearly on the level of organizational functioning, and need to be addressed by the management structure directly. However, there are other areas of improvement which would be suitable and advisable for the individual members of staff and the staff group as a team. In the paragraph 6.5, recommendations will be given for changes on an organizational level. For individuals however, the main coaching- needs appear to be around managing the increasing and varied practical and emotional demands of the job.

The results from the HSE Stress Indicator Tool as well as the focus groups highlighted the very demanding practical and emotional aspects of working within the palliative care service. Although staff perceive themselves as “coping with the

situation”, the elaborate discussions around this topic, particularly at hospice 1, warrants a coaching intervention to support staff in their *coping strategies*. Due to the perceived low priority area of *self-care*, participants would benefit from a coaching intervention which would also include *an educational aspect* on the long-term effects of stress on health, and the importance of “making time and space for the self” to manage the ongoing demands that are inherent to working in palliative care. Within the context of coping strategies to manage demands, it is also important to highlight the need for a good work-life balance. A final aspect where coaching needs can be identified in relation to managing practical and emotional demands, is the area of *personality factors*. The data of the focus groups highlighted that the staff group within palliative care aim for perfectionism which, when not obtained (and it seldom is), can cause stress and upset. Additionally, there was a sense of “feeling victimized” by the palliative care management and the NHS as a whole, which can cause a feeling of disempowerment amongst the staff group. It was therefore felt that an exploration of the personality factors related to the Perfectionist, Worrier, Victim and Critic, as proposed by Bourne (2005) would be useful within the coaching strategy, to facilitate a process of insight and empowerment.

6.4 Limitations

6.4.1 Limitations phase 1

There are several limitations to this study. First, even though phase 1 of the study was anonymous, the fact that the researcher worked as a Consultant Clinical Psychologist within the service may have influenced the participation in this research. The participants may have felt vulnerable to their identity being recognised. Although the researcher did not have any line-management responsibilities at the time of data collection, staff may have felt unsure about the researcher’s relationship with the senior management team and in that way unsure about the purpose of the research. They may also have felt unsafe that their identity would be found out and disclosed to the senior management team.

Second, as this phase is a cross-sectional study the results only give a one-off snapshot of stress in these two hospices. Third, due to the correlational design of the study it is not possible to claim causality. Fourth, a further limitation is that all the participants were self-selected which means that they are not necessarily a true representation of the staff group as a whole. It is for instance possible that the people who felt most stressed or under pressure, did not feel they had the energy or the time to fill in the questionnaires. Stress is associated with elevated levels of arousal in order to cope with the demands of an ongoing situation (Cooper, Dewe & O'Driscoll, 2001), which in turn can cause exhaustion if not enough "respite" is found to relieve the stress (Westman & Eden, 1997). Alternatively staff who were experiencing most stress might have felt more inclined to participate to make sure that their voice was being heard. A final limitation is the fact that the HSE states that the Indicator Tool can only provide an indication of performance in relation to work-related stress and the issues raised need to be explored in more detail with the staff members. The HSE suggests that one way of achieving this is through the use of focus groups.

6.4.2 Limitations phase 2

The first limitation mentioned above in 6.4.1, which relates to the fact that the researcher worked as a Consultant Clinical Psychologist within the service, also applies to phase 2. In addition to this limitation, the participants of phase 2 were self-selected, which means that they were not necessarily a true presentation of the staff group as a whole. The self-selected participants may for instance have been more stressed than the other members of the hospice staff group, or may have differed in assertiveness levels or other personality traits. A further limitation of this phase is that the names of the participants were known to the researcher. Although the groups were facilitated by an external person, the participants may have adjusted their discussion points to ensure their opinions were not recognised by the researcher.

6.5 Recommendations for Organizational Intervention

The findings of the study have highlighted some stressor areas which cannot just be addressed on an individual basis, but rather, need to be addressed on an organizational level. For instance, the fact that eight participants reported that they felt always, often or sometimes bullied, is something that needs to be addressed on this level. Even though the NHS has clear policies on bullying, it appears that at least some members of staff do not feel “safe” enough to bring their situation to the attention of the managements. The fact that members of staff might not feel “safe” enough to bring their concerns to their superiors has been supported by other findings of the study. Managers’ Support scored below average on the HSE Tool, and received considerable attention within the focus groups. In the focus groups it was mentioned that staff did not feel supported or listened at by their managers and also mentioned that new staff did not get the opportunity to bring in new ideas. Although it is not explicitly mentioned within the focus group, a link could be made between new staff not feeling listened at by their superiors or senior members of staff, and the occurrence of perceived bullying. The first recommendation is therefore for the leaders within this organization to explore and review the strategy in relation to Management Support. The findings indicate that the culture in the hospices could benefit from a revised style of Management Support, where staff receive a clear message that their issues around bullying will be dealt with effectively and fairly and a further clear message that the hospice is open to receiving new ideas and suggestions in relation to organizational functioning as well as patient care. In this way a new work ethos could be cultivated where reflective practice and innovation is welcomed and supported. This would have a direct positive effect on staff’s perceived well-being, but also would yield indirect benefits to the quality of team working and the quality of patient care. Linking closely in with the above is the topic of general communication strategies. The focus groups highlighted that staff feel dissatisfied with the communication strategies used within the organization and often feel left out of the loop. A second recommendation is therefore for the organization to review their communication strategies and explore strategies that give a strong message of inclusion and a willingness to listen to staff views.

The stressor area of Role is another area where there is an urgent need for review and change within the organization. A recommendation related to this area is to do some work with the different teams to explore people's perceptions of their roles and to clarify responsibilities and boundaries. This seems particularly significant within the context of the changing demands on the staff relating to the changing work-philosophy within palliative care and the service delivery within the NHS overall.

A final recommendation for service development relates to the issues around supervision. Although supervision is recognised as important at some level, this area still seems to be riddled with misconceptions due to lack of understanding of the nature and purpose of supervision as well as a cultural inheritance where staff have not learnt to reflect on- and take serious their own needs. The fact that supervision benefits staffs' resilience to deal with heavy emotional challenges, benefits their own learning and development and in doing so benefits patients' care, has not been recognised amongst this staff group let alone valued. A renewed emphasis on reflective practice by the organization, which could include supervision as well as group work, is therefore highly recommended as a necessary step towards an effective hospice environment that reflects best practice.

6.6 Future Research

Even though the study found some significant correlations between the HSE variables Change/Managers' support and Demand on the one side and the sub-scales of the DASS-21 (depression, stress and negative affect) on the other side, the regression models showed to be weak. Further research is therefore needed to investigate potential other mediators in the prediction of the different aspects of strain, like personality factors, locus of control and psycho-social factors. Also, as research in the area of stress in the hospice service continues to provide conflicting

results and the sample size of this study was relatively small, it would be useful to repeat the study with a larger sample size. Finally, the results of the HSE tool showed that the stressor “Role” scored as in urgent need of attention at both hospices. The information obtained from the focus groups however gave little insight into the factors that were contributing to these scores. It would therefore be useful to do further research into this stressor variable as perceived by the different professional groups within these services.

6.7 Conclusion

This part of the study has investigated the levels of depression, anxiety and stress amongst the hospice staff. Contra to expectation the staff group of this palliative care service did not score significantly higher on depression, anxiety and stress than the general population. Despite these findings, the results of HSE Stress Indicator Tool showed that there are several stressor areas that need improvement (Demands, Managers’ Support, Relationships and Change) and one area which is in urgent need of improvement (Role). The data from the focus groups provided more qualitative information on the HSE stressor areas Demand, Managers’ Support, Change and Role, and also provided valuable information about Peer Support which was scored as Good on the HSE tool and reported as Very Good within the focus groups. The fact that Peer Support was reported as very good in both hospices, and the fact that Peer Support has been known to offer a buffering effect to perceived stress, may provide an explanation to why this staff group did not report higher levels of stress within their potentially stressful work environment. A further explanation can be found in the fact that this staff group perceive their work as very meaningful, which again can offer a buffering to perceived stress.

The data showed that there were differences between the two hospices with hospice 1 scoring higher on the DASS-21 and lower on the HSE Stress Indicator Tool. The information from the focus groups confirmed these differences between the hospices and provided further insight into the perceived stressors. The results

from the HSE Stress Indicator Tool as well as the focus groups highlighted the very demanding practical and emotional aspects of working within the palliative care service. Although staff perceive themselves as “coping with the situation”, the elaborate discussions around this topic, particularly at hospice 1, warrants a coaching intervention to support staff in their *coping strategies*. Due to the perceived low priority area of *self-care*, participants would benefit from a coaching intervention which would also include *an educational aspect* on the long-term effects of stress on health, and the importance of “making time and space for the self” to manage the ongoing demands that are inherent to working in palliative care. Within the context of coping strategies to manage demands, it is also important to highlight the need for a good work-life balance. A final aspect where coaching needs can be identified in relation to managing practical and emotional demands, is the area of *personality factors*. The data of the focus groups highlighted that the staff group within palliative care aim for perfectionism which, when not obtained (and it seldom is), can cause stress and upset. Additionally, there was a sense of “feeling victimized” by the palliative care management and the NHS as a whole, which can cause a feeling of disempowerment amongst the staff group. It was therefore felt that an exploration of the personality factors related to the Perfectionist, Worrier, Victim and Critic, as proposed by Bourne (2005) would be useful within the coaching strategy, to facilitate a process of developing insight and empowerment.

Chapter 7: Discussion Phase 3

7.1 Overview

Following the findings of phase 1 and 2, a coaching programme was designed to meet the identified coaching needs. A discussion of the findings of this coaching intervention can be found in paragraph 7.2. Following this, the research questions for phase 3 are answered in paragraph 7.3 and the limitations of this part of the study are discussed in paragraph 7.4. The chapter finishes with an exploration for future research in paragraph 7.5 and a conclusion in paragraph 7.6.

7.2 Discussion of Findings

7.2.1 Demographic factors

Four separate coaching sessions were held, two groups consisted of 5 participants and two groups existed of 4 participants. Research suggests that students learn and retain the information better, when working in small groups (Sorcinelli, 1991). Stress coaching within the health service fits in with the problem-base learning (PBL) model which has found popularity within medical education over the last 40 years (Colliver, 2000). The PBL approach is based on active learning in small groups, with clinical problems used as the stimulus for learning. In their discussion on tutorial-group size, Dolmans, van den Hurk, Wolfhagen and van der Vleuten (1996), argue that PBL works best when the groups are kept small with a maximum of eight participants. They reason that working in smaller groups facilitates the process of elaboration and self-regulation, which are important aspects of working within a coaching context. They further point out that group dynamic may be adversely affected if groups are large, as it is more difficult to maintain positive interactions within such groups and participants' individual contributions will be less visible. This again emphasizes the need to keep the group size small when working within a group coaching context. It had been the original intention to recruit for- and deliver one coaching session at each hospice. However, during the recruitment period of this phase, it was brought to the

researcher's attention that some members of staff at hospice 1 felt apprehensive about putting their name on the list, as they felt there would be a certain amount of stigma attached to their participation. The core feature of stigma is that a stigmatized person has an attribute that conveys a devalued social identity within a particular context (Crocker, Major, & Steele, 1998). The stigma around stress continues to exist due to the lack of clear definition of the concept of stress and the fact that it is often associated with "psychological ill health" (Health and Safety Executive, 2006).

Other members of staff expressed informally that they felt they did not fit into the group, as they came from another professional background. These informal developments lead the researcher to seek permission from the local ethics committee to increase the number of groups from 2 to 4, by developing 2 extra coaching sessions one specifically for the support staff and one for the Community Nurse Specialists. Although these additional groups were opened up for staff working at both hospices, only staff from hospice 1 chose to attend these sessions. At hospice 2, no difficulties around group mix or stigma had come to the researcher's attention, and the participants were of a mixed professional background.

7.2.2 Discussion of the data obtained from the Scaled Questions

Of the 18 members of staff who participated in the coaching sessions, 67% rated their level of stress over the past week as Medium, and 28% rated their stress levels as high. None of the participants rated their stress as Very High and only 1 participant rated their stress as low. The relatively high stress levels amongst the participants was not surprising, as participation in these groups was self-selected and it is more likely for people to be interested in attending this type of intervention when they believe they could benefit from it.

When participants were asked to scale their perceived ability to manage their stress prior to the start of the session, most people (14) reported to feel Medium or Quite Skilled (78%). Nobody reported feeling Very Skilled or Not At All Skilled, and

4 participants reported feeling only A Little Skilled. These results are somewhat surprising, considering that a large percentage of participants had rated their stress as medium to high at the start of the session.

The perceived improvement after the session was promising, with 61% reporting that they felt Improved in their ability to cope with stress. In total 22% of the participants reported that they felt the same when rating their coping ability, and interestingly 2 people (11%) reported that they felt less able to cope with their stress than at the start of the session. The people who reported this reduction in perceived level of skill both came from the Support Group and they both reduced their perceived level of skill from Quite to Medium.

7.2.3 Discussion of Open Questions

Despite the fact that this part of the research yielded less dense information than the data obtained from the focus groups in phase 2, valuable information was obtained from the emerging categories and concepts.

The first category Most Useful, highlighted the benefits of the reflective practice. The process of reflection is not a new concept (Kolb 1984). Its aim is to help students obtain the maximum benefit from practice-based learning (Bines 1992). Atkins and Murphy (1993) identified three stages within the process of reflection. The first stage is characterised by an awareness of uncomfortable feelings and thoughts arising from the realisation that one's present knowledge base does not sufficiently explain current events. The second stage is a critical analysis of the situation which focuses on feelings as well as knowledge. The student emerges from this analysis into the third stage which involves the development of a new perspective on the situation. Schon (1983) elaborated on this by introducing the concepts "reflection in action" and "reflection on action". Reflection in action involves reflecting on behaviour as it happens in order to make the next action the most appropriate. Reflection on action is described as a cognitive 'post mortem', in which the practitioner reviews actions and the knowledge which underpins them (Greenwood, 1993). Greenwood cautioned that unless reflection in action is linked

with adequate coaching by someone able to observe practice and check the conceptual repertoire that underpins it, it may lead to the consolidation of inappropriate action sequences by the student. He also warned that reflection on action may be distorted by the tendency of students merely to articulate the conceptual models that they assume the teacher will want to hear.

Due to the high working demands of this staff group, little time is available or prioritized for reflective practice with the consequence that staff do not have- or take the opportunity to stand back and evaluate the different work situations from a more dissociated perspective. Participants reported that they valued the opportunity to reflect on their stress, as it gave them an understanding of their current situation and opportunities to look for strategies to improve their situation. The coaching session incorporated a small section on teaching about stress, which was mentioned as a useful aspect of the session by several participants. Further sub-categories under the main category “Most Useful” related to learning about coping strategies and using coping statements as well as gaining an understanding about distorted thinking patterns and how to restructure these to more helpful ways of thinking. Having the opportunity to share experiences in the group also was mentioned as a positive aspect of the coaching experience, in order to learn from other members of the group and to help feel less isolated with the experienced stress. However, the concept of sharing in the group was also brought up by one participant as a difficult aspect of the coaching experience when the sharing was related to more personal situations rather than work situations. Overall, most participants reported that the coaching session had been useful on all aspects, however several participants mentioned that they would have liked to spend more time on the issues presented in the coaching session to gain a deeper understanding of the concepts and to help integrate the learning on a deeper level. A few participants mentioned that they felt the “Self-nurturing activity sheet” as least useful, although it was perceived as an amusing aspect of the coaching session. It was the researcher’s experience that it was certainly a helpful aspect within the coaching session, as it facilitated a light-heartedness early on in the session which seemed to help the overall participation and openness of the

participants early on in the session. In this way, the discussion about self nurturing activities could be perceived as a “warming up” exercise with the additional benefit of reviewing light hearted activities which could facilitate the objective of maintaining a healthy work-life balance. The aspect of Work-Life balance overall received good feedback. Only one person reported that she did not find this section very useful as she had already made adjustments in this area and had clearly found a suitable balance between her work- and home life.

The sub-categories under the category “Ability to challenge negative or distorted thinking”, overall point towards participants experiencing that they had a greater awareness of the strategies available to them. In coaching context this is a positive outcome, as a broadened sense of awareness is an important development within the coaching process (Whitmore, 2003). They also reported a willingness and need to practise the learned information, but realized that more work was needed to integrate the concepts presented to them. Participants reported the need for further practise, which fits in with the cognitive behavioural coaching model, which emphasizes sustained effort and commitment in order to achieve the desired benefits (Neenan & Dryden, 2002). The perceived benefits from practising the aspects of the coaching session ranged from practical improvements like finding new solutions and reduce procrastination, to improvements on an emotional level like perceiving themselves as becoming “a better” person due to the application of the coaching session in everyday life.

This coaching session was seen as a starter point, which was also reflected in the category on Confidence regarding the implementation of the overall future self-coaching strategy which was one of the aims of the coaching session. As with the above category on perceived confidence on challenging distorted thinking patterns, participants here also reported that there was further work to do to integrate the learning. However, they did report that they felt more able to look at the situation and to devise a strategy by using the presented CIGAR model. Participants recognised that they would have to overcome certain obstacles like time restrictions and old/familiar coping patterns which they could fall into. One person

reported that she felt that she did not need the self-coaching strategies as presented in this session, as she felt her current strategies worked well enough for her.

Overall, the participants were very interested in the topic of further coaching sessions, with a broad range of topics suggested by them under the category Future Sessions. In alignment with the above findings regarding the need for consolidating the material presented in the session, a number of participants suggested that it would be useful if future sessions would cover the same topics that had been covered in this session. Some suggestions were related to specific situations that could present themselves in the hospice service, like difficult family dynamics or anger in the hospice setting. Others suggested topics related to cognitive behavioural aspects of self-coaching like thinking patterns and coping strategies and further stress management strategies.

The coaching session was perceived very positively, with participants reporting that they found it enjoyable, useful, interesting, practical, thought provoking, and an investment. One participant also reported that she felt that the learning in the session was more than a one off occasion, and that she would aim to use it and continue to use it in the future. No participants reported any negative comments in the final category of “Additional comments”.

7.3 Research Questions for Phase 3

Below is a summary of the findings in relation to the original research questions as stated in Chapter 3.

Phase 3, Question 1:

What is the perceived usefulness of a brief stress-coaching intervention for this staff group.

The above discussion of the coaching session has highlighted that this staff group can benefit from coaching. The Brief stress-coaching intervention received very positive feedback and 60% of participants reported that they felt that their ability to manage their stress had improved after the session. However, the results also showed that many participants did feel they needed to consolidate the process of self-coaching through application of the theory in their daily life. Most of the participants did not feel fully confident that they could successfully apply the teachings without further practice and possible follow-up sessions. It therefore appears that a brief stress-coaching session is useful to help staff become aware of their stress-coaching needs and to lay a foundation for the theory and practice of self-coaching. To achieve longer term benefits and more profound improvement, it is therefore recommended that follow-up sessions are offered, to consolidate the learning and to help integrate a self-coaching strategy into the participants' lives.

7.4 Limitations

The main limitation to this phase of the research is that this session was not facilitated by an external facilitator. Participants may therefore have reported their perceptions and achievements more positively in order not to “upset” the researcher. This may have skewed the outcome data towards the positive end of the spectrum. A second limitation in relation to this is the fact that participants may have adjusted and/or limited their level of participation and disclosure in the group due to the fact that the researcher was known to them as a senior team member. This may have hindered the learning process to some extent. A further limitation is that this part of the research did not use standardized measuring tools and did not use follow-up measurements to evaluate longer term benefits. This makes the generalization of the outcomes difficult and does not give answers to the sustainability of the perceived benefits of a brief group coaching intervention. Finally, the number of groups used for this study was small, which again limits the generalizability of this study.

7.5 Future Research

The evaluation of the coaching session has been useful to provide an early understanding and indication of the usefulness of a brief coaching intervention within this health setting. However, due to the small number of groups no generalizations can be made from the findings. It is therefore recommended that this study be duplicated in other hospices and/or health settings to increase understanding and generalisability. Additionally it would be useful to assess the perceived usefulness of the current coaching intervention including follow-up sessions using standardized questionnaires, in order to obtain a more objective outcome measure in conjunction with the qualitative data of open questions. Furthermore, to ensure the collection of objective data, future groups should be facilitated by someone other than the researcher.

7.6 Conclusion

The results from phase 1 and 2 of this study have highlighted the very demanding practical and emotional aspects of working within the palliative care service and had brought to the fore the following areas where coaching could benefit this staff group: *coping strategies*, *self-care*, *education on the effects of stress*, *work-life balance* and *understanding personality factors*. Due to the time-pressures and shift arrangements of this staff group, the coaching session needed to be brief with the aim of providing immediate practical benefit to the staff in their ability to manage stressful situations. Taking the above into consideration, the study aimed to assess if a brief coaching intervention would benefit this staff group in the management of their challenging and potentially stressful work demands. The results of the study show that the participants overall felt very positive about the session and that an initial foundation had been established in relation to the understanding- and application of the self-coaching model as presented in the session. However, although some benefits had been reported after this session and the participants overall reported an improvement in their perceived ability to manage their stress, further follow-up sessions are needed and recommended in order to consolidate the learning and integrate the self-coaching model in everyday (working) life.

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Appendices

Appendix 1: DASS-21

DASS₂₁

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Appendix 2: HSE Tool

HSE INDICATOR TOOL for Work Related Stress

	Never	Seldom	Sometimes	Often	Always
1 I am clear what is expected of me at work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2 I can decide when to take a break	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3 Different groups at work demand things from me that are hard to combine	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
4 I know how to go about getting my job done	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5 I am subject to personal harassment in the form of unkind words or behaviour	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
6 I have unachievable deadlines	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
7 If work gets difficult, my colleagues will help me	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8 I am given supportive feedback on the work I do	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9 I have to work very intensively	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
10 I have a say in my own work speed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11 I am clear what my duties and responsibilities are	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12 I have to neglect some tasks because I have too much to do	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
13 I am clear about the goals and objectives for my department	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
14 There is friction or anger between colleagues	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
15 I have a choice in deciding how I do my work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
16 I am unable to take sufficient breaks	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
17 I understand how my work fits into the overall aim of the organisation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
18 I am pressured to work long hours	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
19 I have a choice in deciding what I do at work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
20 I have to work very fast	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

21	I am subject to bullying at work	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
22	I have unrealistic time pressures	Never ☐ 5	Seldom ☐ 4	Sometimes ☐ 3	Often ☐ 2	Always ☐ 1
23	I can rely on my line manager to help me out with a work problem	Never ☐ 1	Seldom ☐ 2	Sometimes ☐ 3	Often ☐ 4	Always ☐ 5
24	I get help and support I need from colleagues	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
25	I have some say over the way I work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
26	I have sufficient opportunities to question managers about change at work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
27	I receive the respect at work I deserve from my colleagues	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
28	Staff are always consulted about change at work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
29	I can talk to my line manager about something that has upset or annoyed me about work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
30	My working time can be flexible	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
31	My colleagues are willing to listen to my work-related problems	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
32	When changes are made at work, I am clear how they will work out in practice	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
33	I am supported through emotionally demanding work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5
34	Relationships at work are strained	Strongly disagree ☐ 5	Disagree ☐ 4	Neutral ☐ 3	Agree ☐ 2	Strongly agree ☐ 1
35	My line manager encourages me at work	Strongly disagree ☐ 1	Disagree ☐ 2	Neutral ☐ 3	Agree ☐ 4	Strongly agree ☐ 5

Thank you for completing the questionnaire.

Appendix 3: Demographic Questionnaire

By Addy Hackett

Version 1: 17/06/07

Research Title: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Please tick the appropriate box

1) How many years have you worked in palliative care?

- Less than 2 ☐
- Between 2 and 4 years ☐
- Between 4 and 6 years ☐
- Between 8 and 10 years ☐
- Longer than 10 years ☐

2) Do you work: **part-time** ☐ **Full-time** ☐

3) Do you work: **at Cransley** ☐ **Cynthia Spencer** ☐

4) Which age-group are you in?

- Younger than 21 ☐
- Between 21 and 30 ☐
- Between 31 and 40 ☐
- Between 41 and 50 ☐
- Older than 50 ☐

5) Please tick if you are a:

Nurse, Doctor, member of the Family Work Team, Physiotherapist,
Occupational Therapist, Music Therapist or Welfare Rights Officer ☐

Or other member of the clinical staff

Please tick if you work in: Admin or other supportive service ☐

Appendix 4: Invitation Letter Phase 1

Invitation Letter

Phase 1

17/06/07: version 1

Invitation to participate in the research project:

An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Dear Colleague,

I would like to invite you to participate in a research project which I am doing as part of my Doctorate (Top-Up) degree in Coaching Psychology at City University.

Please find enclosed a Participant Information Sheet, 3 questionnaires and a reply envelope. The information sheet will give you details about this project. Participation is entirely voluntary, and it is important to read this information carefully before making your decision. If you decide to participate in Phase 1 of this research, please return the questionnaires to me in the envelope provided at your earliest convenience. If you have any further questions or need additional information, please feel free to contact me directly, by phone or by e-mail.

I would like to thank you for your time reading this information.

Yours sincerely,

Addy Hackett
Consultant Clinical Psychologist
Lead Psychologist for Northamptonshire Palliative Care Services
Based at: Cransley Hospice and Cynthia Spencer Hospice
Tel: [REDACTED]
Mobile: [REDACTED]
e-mail: [REDACTED]

Appendix 5: Participant Information Sheet Phase 1

Participant Information Sheet: Phase 1

(Version 3: 05/09/07)

Research Title: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Invitation

You are invited to participate in Phase 1 of the 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. Talk to others about the study if you wish.

- Part 1 tells you about the purpose of this study and what is asked from you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Please feel free to ask me if there is anything that is not clear or if you would like more information.

PART 1

What is the purpose of the study?

As part of my Doctorate (Top-Up) study in Coaching Psychology at City University, I am doing an investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Working with patients who are diagnosed with terminal illnesses can be potentially stressful as it brings with it an awareness of personal vulnerability and mortality; it threatens the sense of omnipotence and brings a repeated need to deal with feelings of loss and grief. As the palliative care services evolved over the years, so emerged a recognition of the need to “get to know the patient” to provide the best possible care. Whilst it can be argued that the effort to get to know the patients is a positive step towards the provision of best patient care, it also has the potential to cause increased levels of stress amongst the nursing staff as it invites a deeper level of “emotional involvement”. There are relatively few studies on stress in care givers in the palliative care service, and disagreement exists as to whether the work of the hospice nurse is more stressful than the work of other nurses.

This research project will consist of three phases. Phase 1 is a quantitative study to assess the levels of stress and the main stressors using questionnaires. Phase 2 of the project is a qualitative study using focus groups with the purpose of obtaining a deeper understanding of the stressors as indicated by Phase 1, and Phase 3 will exist of a one-off coaching session accessible to all members of staff working in the two hospices in Northamptonshire. This phase will be evaluated on its effectiveness using an evaluation questionnaire.

Why have I been chosen to participate in Phase 1?

To get meaningful data from this study, it is important to recruit as many participants as is possible within this service. Therefore, all members of the staff teams at Cynthia Spencer Hospice and Cransley Hospice have been invited to participate in Phase 1 of the study.

Do I have to take part?

No. Participation in this project is entirely voluntary and you may withdraw from this project at any time, and without giving a reason. A decision to not take part, or to withdraw at any time, will not cause any negative consequences. You also may refuse to answer any questions which are felt to be too personal or intrusive.

What will I need to do if I take part in Phase 1?

You will be asked to fill in the enclosed 3 questionnaires and to send these back to my office in the enclosed envelope within one month after you have received this information. The 3 questionnaires are: the DASS21, the HSE Stress Indicator Tool, and a Demographics questionnaire to obtain other relevant information for the analysis of the research data.

The DASS 21 (Depression, Anxiety and Stress Scale) is a set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress. The DASS scale has been developed to measure stress in “normal subjects” rather than measuring psychological disorders. It will give an indication of “normal”, “moderate” or “severe” stress, as experienced by the work force. The questionnaire will take about 5 minutes to complete.

The HSE (Health and Safety Executive) Stress Indicator tool is a 35-item questionnaire relating to the six stressors identified in the Management Standards on Work Related Stress. The questionnaire will take about 13 minutes to complete.

Permission has been granted from the manager to fill in these forms during work hours during times when work pressure is low.

What are the possible disadvantages and risks of taking part?

It is envisaged that the risks of participating in this project are very low. The detailed information on this is given in Part 2.

What are the possible advantages of taking part?

Information gathered from the research will be used to develop a coaching programme to support staff in the management of work-related stress. Within the current climate of change and uncertainty within the NHS, it is felt that an appropriate coaching programme would benefit all employees. However, due to the specific stressors associated with the delivery of palliative care, it would appear that a tailor-made coaching programme for this specialist service within the NHS could be of particular benefit to its members of staff.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. The details are included in Part 2.

Contact Details

Please feel free to contact me if you wish to discuss this project further.

Addy Hackett
Consultant Clinical Psychologist
Lead Psychologist for Northamptonshire Palliative Care Services
Based at: Cransley Hospice and Cynthia Spencer Hospice
Tel: [REDACTED]
Mobile: [REDACTED]
e-mail: [REDACTED]

This completes Part 1 of the Information Sheet. If the information in Part 1 has interested you and you are considering participating, please continue to read the additional information in Part 2 before making any decision.

PART 2**What are the possible disadvantages and risks of taking part?**

The demographic questionnaire has been designed to minimise the chance of identification. There are only two broad professional groups: clinical or non-clinical staff. Because the staff group is quite large, the chance of identification is very small. However, there is still a small chance of identification. In the unlikely event that identification is still possible, this will be dealt with confidentially.

What if there is a problem?

It is anticipated that the chance is very low that participants will experience any negative consequences due to their participation in this project. However, if you incur any distress following your participation in this project you are encouraged to contact Addy Hackett directly (details at bottom of this document) as soon as possible to discuss your thoughts and feelings in confidence. If any issues remain unresolved following this meeting, Addy Hackett will explore a further plan of action with you which could involve:

- Creating an environment where you are encouraged to talk, both formally and informally, to your manager or another person in the management chain.
- Reminding you that you can speak to trade union representatives, the Occupational Health Department, Human Resources or your GP.

If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure.

Will my taking part in this study be kept confidential?

Participants' information will be dealt with confidentially and no references will be made to identifiable individual participant information at any stage within the research process or within the dissertation, nor will any identifiable information relating to participants be published. Although anonymity is compromised during phase II and III of this project, trust and confidentiality are paramount. Individual patient information which might come up during the focus groups or coaching interventions, will be dealt with confidentially and no reference to individual patients will be made at any stage of the research process or within the dissertation and publications.

All identifiable research information and materials will be locked away in a NHS filing cabinet to which I am the only key holder. Collected data will be stored on two USB sticks (one for back-up) and a home computer will be used to process the data. No identifiable information will be stored on the USB sticks. All identifiable research material will be destroyed after the successful completion of the Doctorate course. Raw research data will only be accessible to my university supervisors and me.

Study outcome

It is important to keep the team members updated on the progress and results of the study. Therefore, two presentations at each hospice are planned; the first one will take place after Phase 1 and 2 have been completed, the second presentation will take place after Phase 3 has been completed. During this presentation the final results and recommendations will be communicated. Both presentations are open to all members of staff working within the palliative care service, including the participants. The findings of the different stages of the study will be published in relevant journals. No identifiable information will be disclosed at any stage of the research.

Who is organising and funding the research?

The research is organised and funded by Addy Hackett

Who has reviewed the study?

The study has been reviewed and approved by City University as well as the NHS Local Research Ethical Committee and the relevant R&D Departments.

Thank you very much for reading this, and if you wish to discuss this project in more detail please do not hesitate to contact me.

Addy Hackett

Consultant Clinical Psychologist

Lead Psychologist for Northamptonshire Palliative Care Services

Based at: Cransley Hospice and Cynthia Spencer Hospice

Tel: [REDACTED]

Mobile: [REDACTED]

e-mail: [REDACTED]

Appendix 6: Posters for Phase 2

You are invited to attend a focus group

Focus Group

This focus group is part of a research project by Addy Hackett

Title of the research: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Focus Group Purpose: The purpose of the focus group is to gain an understanding of the overall levels of stress and the causes of stress as experienced by members of staff working in the hospice service in the two hospices in Northamptonshire.

Duration: 1 Hour

Facilitator: Sarah While, Clinical Psychologist (Peterborough Palliative Care)

Date/Time: Thursday 14th February at 2.00pm

Venue: Teaching Room 1

Maximum Participants: 8

Your thoughts and experiences are important!

for more information please contact me:Addy Hackett

Consultant Clinical Psychologist

Lead Psychologist for Northamptonshire Palliative Care Services

Based at: Cransley Hospice and Cynthia Spencer Hospice

Tel: [REDACTED]

Mobile: [REDACTED] or e-mail: [REDACTED]

You are invited to attend a focus group

Focus Group

This focus group is part of a research project by Addy Hackett

Title of the research: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Focus Group Purpose: The purpose of the focus group is to gain an understanding of the overall levels of stress and the causes of stress as experienced by members of staff working in the hospice service in the two hospices in Northamptonshire.

Duration: 1 Hour

Facilitator: Sarah While, Clinical Psychologist (Peterborough Palliative Care)

Date/Time: Thursday 7th February at 2.00pm

Venue: Cransley Hospice Teaching Room

Maximum Participants: 8

Your thoughts and experiences are important!

for more information please contact me:

Addy Hackett

Consultant Clinical Psychologist

Lead Psychologist for Northamptonshire Palliative Care Services

Based at: Cransley Hospice and Cynthia Spencer Hospice

Tel: [REDACTED]

Mobile: [REDACTED] or e-mail: [REDACTED]

Appendix 7: Participant Information Sheet Phase 2

Participant Information Sheet: Phase 2

(Version 3: 05/09/07)

Research Title: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Invitation

You are invited to participate in Phase 2 of the 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. Talk to others about the study if you wish.

- Part 1 tells you about the purpose of this study and what is asked from you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Please feel free to ask me if there is anything that is not clear or if you would like more information.

PART 1

What is the purpose of the study?

As part of my Doctorate (Top-Up) study in Coaching Psychology at City University, I am doing an investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Working with patients who are diagnosed with terminal illnesses can be potentially stressful as it brings with it an awareness of personal vulnerability and mortality; it threatens the sense of omnipotence and brings a repeated need to deal with feelings of loss and grief. As the palliative care services evolved over the years, so emerged a recognition of the need to “get to know the patient” to provide the best possible care. Whilst it can be argued that the effort to get to know the patients is a positive step towards the provision of best patient care, it also has the potential to cause increased levels of stress amongst the nursing staff as it invites a deeper level of “emotional involvement”. There are relatively few studies on stress in care givers in the palliative care service, and disagreement exists as to whether the work of the hospice nurse is more stressful than the work of other nurses.

This research project will consist of three phases. Phase 1 is a quantitative study to assess the levels of stress and the main stressors using questionnaires. Phase 2 of the project is a qualitative study using two focus groups (one in each hospice) with the purpose of obtaining a deeper understanding of the stressors as indicated by Phase 1, and Phase 3 will exist of a one-off coaching session accessible to all members of staff working in the two hospices in Northamptonshire. This phase will be evaluated on its effectiveness using an evaluation questionnaire.

Why have I been chosen to participate in Phase 2?

To get meaningful data from this study, it is important to recruit as many participants as is possible within this service. Therefore, all members of the staff teams at Cynthia Spencer Hospice and Cransley Hospice have been invited to participate in Phase 2 of the study. However, a maximum of eight participants are able to attend each focus group and participation will be on a first come first serve basis.

Do I have to take part?

No. Participation in this project is entirely voluntary and you may withdraw from this project at any time, and without giving a reason. A decision to not take part, or to withdraw at any time, will not cause any negative consequences. You also may refuse to answer any questions which are felt to be too personal or intrusive.

What will I need to do if I take part in Phase 2?

You will be asked to attend the focus group scheduled for (Date)... at (Time).... To be held at

A focus group is a form of group interview with the purpose of discussing a specific topic and in doing so, generating data for research. The focus group will be guided by a prompt list to ensure that all relevant data will be obtained. Focus groups have become widely used within social research and are commonly used by qualitative researchers. The topic for this focus group is "stress in the workplace". It is hoped that a discussion will take place where people can express their thoughts and feelings about this topic and generate some ideas and strategies to address stress-related issues. The information gathered will be used to inform the content of a stress-coaching session for all members of staff in Phase 3 of this project. The focus group will last for about 60 minutes and will be run by an independent facilitator. A second independent facilitator will be present to take notes. The notes taken during this session will be anonymous and any identifiable information will be taken out by the "note-taker" prior to handing the notes over to the researcher.

The questions on the prompt list will be:

1. What are some of the issues that could cause you stress at work?
2. Do you think there are specific emotional challenges for people working within palliative care?
3. Can you describe the coping strategies you would use to manage work related stress? (anonymous examples)
4. What would be useful to you to help reduce the levels of work-related stress?

You will be asked to sign a consent form prior to the start of the focus group.

Please note that the maximum number of participants for each group will be 8, and the selection will be done on a first come first serve basis.

What are the possible disadvantages and risks of taking part?

It is envisaged that the risks of participating in this project are very low. The detailed information on this is given in Part 2.

What are the possible advantages of taking part?

Information gathered from the research will be used to develop a coaching programme to support staff in the management of work-related stress. Within the current climate of change and uncertainty within the NHS, it is felt that an appropriate coaching programme would benefit all employees. However, due to the specific stressors associated with the delivery of palliative care, it would appear that a tailor-made coaching programme for this specialist service within the NHS could be of particular benefit to its members of staff.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. The details are included in Part 2.

Contact Details

Please feel free to contact me if you wish to discuss this project further.

Addy Hackett
Consultant Clinical Psychologist
Lead Psychologist for Northamptonshire Palliative Care Services
Based at: Cransley Hospice and Cynthia Spencer Hospice

Tel: [REDACTED]

Mobile: [REDACTED]

e-mail: [REDACTED]

This completes Part 1 of the Information Sheet. If the information in Part 1 has interested you and you are considering participating, please continue to read the additional information in Part 2 before making any decision.

PART 2**What are the possible disadvantages and risks of taking part?**

As the focus groups are facilitated by someone other than the researcher and notes are taken anonymously, the chance of identification is very small. In the unlikely event that identification is still possible, this will be dealt with confidentially.

Please note that in the unlikely event that gross malpractice were to be revealed, the researcher would have the duty to break confidentiality and report to the manager.

What if there is a problem

It is anticipated that the chance is very low that participants will experience any negative consequences due to their participation in this project. However, if you incur any distress following your participation in this project you are encouraged to contact Addy Hackett directly (details at

bottom of this document) as soon as possible to discuss your thoughts and feelings in confidence. If any issues remain unresolved following this meeting, Addy Hackett will explore a further plan of action with you which could involve:

- Creating an environment where you are encouraged to talk, both formally and informally, to your manager or another person in the management chain.
- Reminding you that you can speak to trade union representatives, the Occupational Health Department, Human Resources or your GP.

If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure.

Will my taking part in this study be kept confidential?

Participants' information will be dealt with confidentially and no references will be made to identifiable individual participant information at any stage within the research process or within the dissertation, nor will any identifiable information relating to participants be published. Although anonymity is compromised during phase II and III of this project, trust and confidentiality are paramount. Individual patient information which might come up during the focus groups or coaching interventions, will be dealt with confidentially and no reference to individual patients will be made at any stage of the research process or within the dissertation and publications.

All identifiable research information and materials will be locked away in a NHS filing cabinet to which I am the only key holder. Collected data will be stored on two USB sticks (one for back-up) and a home computer will be used to process the data. No identifiable information will be stored on the USB sticks. All identifiable research material will be destroyed after the successful completion of the Doctorate course. Raw research data will only be accessible to my university supervisors and me.

Study outcome

It is important to keep the team members updated on the progress and results of the study. Therefore, two presentations at each hospice are planned; the first one will take place after Phase 1 and 2 have been completed, the second presentation will take place after Phase 3 has been completed. During this presentation the final results and recommendations will be communicated. Both presentations are open to all members of staff working within the palliative care service, including the participants. The findings of the different stages of the study will be published in relevant journals. No identifiable information will be disclosed at any stage of the research.

Who is organising and funding the research?

The research is organised and funded by Addy Hackett

Who has reviewed the study?

The study has been reviewed and approved by City University as well as the NHS Local Research Ethical Committee and the relevant R&D Departments.

Thank you very much for reading this. If you wish to participate in the focus group, please return the reply slip to me within the next 10 days. If you wish to discuss this project in more detail please do not hesitate to contact me.

Addy Hackett
Consultant Clinical Psychologist
Lead Psychologist for Northamptonshire Palliative Care Services
Based at: Cransley Hospice and Cynthia Spencer Hospice

Tel: [REDACTED]

Mobile: [REDACTED]

e-mail: [REDACTED]

Reply Slip

Yes, I would like to attend the focus group scheduled for (date/time)..... to be held at
.....

Name (Print):

Date:

Please return reply slip to: Addy Hackett, Consultant Clinical Psychologist at Cransley Hospice or
Cynthia Spencer Hospice.

Appendix 8: Poster for Phase 3

Phase 3 POSTER (Version 1: 17/06/07)

You are invited to attend a coaching session on **Work-related Stress**

This session is part 3 of a research project by Addy Hackett

Title of the research: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Puopose of the Session: Information that was gathered in part 1 and 2 of this project are being used to design a brief stress-coaching intervention in the two hospices in Northamptonshire. The purpose of this session is to evaluate the effectiveness of this stress-coaching session.

Duration: 2 hours

Date/Time:

Venue:.....

Maximum Participants: 10 (first come first serve)

If you are interested in attending please contact me for an information pack.

Addy Hackett

Consultant Clinical Psychologist

Lead Psychologist for Northamptonshire Palliative Care Services

Based at: Cransley Hospice and Cynthia Spencer Hospice

Tel: [REDACTED]

Mobile: [REDACTED]

e-mail: [REDACTED]

Appendix 9: Participant Information Sheet Phase 3

Participant Information Sheet: Phase 3

(Version 3: 05/09/07)

Research Title: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Invitation

You are invited to participate in Phase 3 of the 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. Talk to others about the study if you wish.

- Part 1 tells you about the purpose of this study and what is asked from you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Please feel free to ask me if there is anything that is not clear or if you would like more information.

PART 1

What is the purpose of the study?

As part of my Doctorate (Top-Up) study in Coaching Psychology at City University, I am doing an investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Working with patients who are diagnosed with terminal illnesses can be potentially stressful as it brings with it an awareness of personal vulnerability and mortality; it threatens the sense of omnipotence and brings a repeated need to deal with feelings of loss and grief. As the palliative care services evolved over the years, so emerged a recognition of the need to “get to know the patient” to provide the best possible care. Whilst it can be argued that the effort to get to know the patients is a positive step towards the provision of best patient care, it also has the potential to cause increased levels of stress amongst the nursing staff as it invites a deeper level of “emotional involvement”. There are relatively few studies on stress in care givers in the palliative care service, and disagreement exists as to whether the work of the hospice nurse is more stressful than the work of other nurses.

This research project will consist of three phases. Phase 1 is a quantitative study to assess the levels of stress and the main stressors using questionnaires. Phase 2 of the project is a qualitative study using two focus groups (one in each hospice) with the purpose of obtaining a deeper understanding of the stressors as indicated by Phase 1, and Phase 3 will exist of a one-off coaching session accessible to all members of staff working in the two hospices in Northamptonshire. This phase will be evaluated on its effectiveness using an evaluation questionnaire.

Why have I been chosen to participate in Phase 3?

To get meaningful data from this study, it is important to recruit as many participants as is possible within this service. Therefore, all members of the staff teams at Cynthia Spencer Hospice and Cransley Hospice have been invited to participate in Phase 3 of the study. However, a maximum of 10 participants are able to attend each coaching session and participation will be on a first come first serve basis.

Do I have to take part?

No. Participation in this project is entirely voluntary and you may withdraw from this project at any time, and without giving a reason. A decision to not take part, or to withdraw at any time, will not cause any negative consequences. You also may refuse to answer any questions which are felt to be too personal or intrusive.

What will I need to do if I take part in Phase 3?

You will be asked to attend the group stress-coaching session scheduled for (Date)... at (Time).... To be held at

The stress-coaching session will be an interactive session, and the objectives will be to help members of staff understand the nature of stress, to identify stress management strategies using a cognitive-behavioural model and develop a personal plan for managing work related stress.

The session will be facilitated by Addy Hackett, Consultant Clinical Psychologist, and will last for 2 hours. You will be asked to sign a consent form prior to the start of the session. You will also be asked to provide a rating on your average stress as experienced over the last month, prior to the start of the session, and give a rating on how skilled you currently feel in relation to stress management. These ratings will range from very low to very high. After the session has finished you will be asked to complete the evaluation questionnaire.

Please note that the maximum number of participants for each group will be 10 and the selection will be done on a first come first serve basis.

What are the possible disadvantages and risks of taking part?

It is envisaged that the risks of participating in this project are very low. The detailed information on this is given in Part 2.

What are the possible advantages of taking part?

Within the current climate of change and uncertainty within the NHS, it is felt that an appropriate coaching programme would benefit all employees. However, due to the specific stressors associated with the delivery of palliative care, it would appear that a tailor-made coaching programme for this specialist service within the NHS could be of particular benefit to its members of staff to help manage work-related stress.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. The details are included in Part 2.

Contact Details

Please feel free to contact me if you wish to discuss this project further.

Addy Hackett
Consultant Clinical Psychologist
Lead Psychologist for Northamptonshire Palliative Care Services
Based at: Cransley Hospice and Cynthia Spencer Hospice

Tel: [REDACTED]

Mobile: [REDACTED]

e-mail: [REDACTED]

This completes Part 1 of the Information Sheet. If the information in Part 1 has interested you and you are considering participating, please continue to read the additional information in Part 2 before making any decision.

PART 2**What are the possible disadvantages and risks of taking part?**

As the coaching sessions are facilitated by the researcher, who is also part of the multi-disciplinary team, there is a chance that participants may be concerned about possible negative consequences as a result of their participation. Participants are reminded that all information shared within the group will be dealt with confidentially and no references will be made to identifiable individual participant information at any stage within the research process or within the dissertation, nor will any identifiable information relating to participants be published. Although anonymity is compromised during phase 3 of this project, trust and confidentiality are paramount. Participants can be reassured that no negative consequences shall follow due to their participation.

Please note that in the unlikely event that gross malpractice were to be revealed, the researcher would have the duty to break confidentiality and report to the manager.

What if there is a problem

It is anticipated that the chance is very low that participants will experience any negative consequences due to their participation in this project. However, if you incur any distress following your participation in this project you are encouraged to contact Addy Hackett directly (details at bottom of this document) as soon as possible to discuss your thoughts and feelings in confidence. If any issues remain unresolved following this meeting, Addy Hackett will explore a further plan of action with you which could involve:

- Creating an environment where you are encouraged to talk, both formally and informally, to your manager or another person in the management chain.

- Reminding you that you can speak to trade union representatives, the Occupational Health Department, Human Resources or your GP.

If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure.

Will my taking part in this study be kept confidential?

Participants' information will be dealt with confidentially and no references will be made to identifiable individual participant information at any stage within the research process or within the dissertation, nor will any identifiable information relating to participants be published. Although anonymity is compromised during phase II and III of this project, trust and confidentiality are paramount. Individual patient information which might come up during the focus groups or coaching interventions, will be dealt with confidentially and no reference to individual patients will be made at any stage of the research process or within the dissertation and publications.

All identifiable research information and materials will be locked away in a NHS filing cabinet to which I am the only key holder. Collected data will be stored on two USB sticks (one for back-up) and a home computer will be used to process the data. No identifiable information will be stored on the USB sticks. All identifiable research material will be destroyed after the successful completion of the Doctorate course. Raw research data will only be accessible to my university supervisors and me.

Study outcome

It is important to keep the team members updated on the progress and results of the study. Therefore, two presentations at each hospice are planned; the first one will take place after Phase 1 and 2 have been completed, the second presentation will take place after Phase 3 has been completed. During this presentation the final results and recommendations will be communicated. Both presentations are open to all members of staff working within the palliative care service, including the participants. The findings of the different stages of the study will be published in relevant journals. No identifiable information will be disclosed at any stage of the research.

Who is organising and funding the research?

The research is organised and funded by Addy Hackett

Who has reviewed the study?

The study has been reviewed and approved by City University as well as the NHS Local Research Ethical Committee and the relevant R&D Departments..

Thank you very much for reading this. If you wish to participate in the coaching session please return the reply slip to me within the next 10 days. If you wish to discuss this project in more detail please do not hesitate to contact me.

Addy Hackett
Consultant Clinical Psychologist
Lead Psychologist for Northamptonshire Palliative Care Services
Based at: Cransley Hospice and Cynthia Spencer Hospice

Tel: [REDACTED]

Mobile: [REDACTED]
e-mail: [REDACTED]

Reply Slip

Yes, I would like to attend the stress-coaching session scheduled for (date/time)..... to be held at.....

Name (Print):

Date:

Please return reply slip to: Addy Hackett, Consultant Clinical Psychologist at Cransley Hospice or Cynthia Spencer Hospice

Appendix 10: Prompt List

Prompt list for focus groups

Addy Hackett

(Version 1: *version 1: 17/06/07*)

Research title: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Questions:

1. What are some of the issues that could cause you stress at work?
2. Do you think there are specific emotional challenges for people working within palliative care?
3. Can you describe the coping strategies you would use to manage work related stress? (anonymous examples)
4. What would be useful to you to help reduce the levels of work-related stress?

Appendix 11: Ethical Approval LREC



National Research Ethics Service

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 2

Research Ethics Office
Derwent Shared Services
Laurie House
Colyer Street
DERBY
DE1 1LJ

Telephone: [REDACTED]
Facsimile: [REDACTED]

10 September 2007

Mrs Addy P Hackett
Consultant Clinical Psychologist
Northamptonshire Teaching PCT
Cynthia Spencer Hospice
Manfield Health Campus
Kettering Road, Northampton
NN3 6NP

Dear Mrs Hackett

Full title of study: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.
REC reference number: 07/H0402/49

Thank you for your letter of 31 August 2007 and email of 5th September 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered by the Alternate Vice Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	AB/110242/1	16 August 2007
Investigator CV		07 July 2007
Protocol	1	17 June 2007
Covering Letter		07 July 2007
Letter from Sponsor		03 July 2007
Questionnaire: Coaching evaluation form	1	17 June 2007
Questionnaire: Demographic	1	17 June 2007
Questionnaire: HSE Indicator Tools	Validated	
Questionnaire: DASS21	Validated	
Letter of invitation to participant	Phase 1 - V1	17 June 2007
Letter of invitation to participant	Phase 2 - V1	17 June 2007
Letter of invitation to participant	Phase 3 - V1	17 June 2007
Participant Information Sheet: Phase 3	Version 3	05 September 2007
Participant Information Sheet: Phase 2	Version 3	05 September 2007
Participant Information Sheet: Phase 1	Version 3	05 September 2007
Participant Consent Form: Phase 3	Version 3	05 September 2007
Participant Consent Form: Phase 2	Version 3	05 September 2007
Response to Request for Further Information	Email	31 August 2007
Prompt list for focus groups	1	17 June 2007
Advert	Poster V1 (phase 3)	17 June 2007
Advert	Poster V1 (phase 2)	17 June 2007
Supervisor's CV		03 July 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from
<http://www.rdforum.nhs.uk/rdform.htm>.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

<https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx>

We value your views and comments and will use them to inform the operational process and further improve our service.

07/H0402/49

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



Chair

Email: 

Enclosures: Standard approval conditions (SL-AC2)

Copy to: Dr Jacqui Farrants
City University

Appendix 12: Ethical Approval R&D Department

Northamptonshire tPCT



Leicestershire, Northamptonshire and Rutland
Primary Care Research Alliance

6th Floor
St John's House
30 East Street
Leicester
LE1 6NB

27/09/07

Letter Ref: RA0686

LNR PCRA - 0686 (Please quote this reference on all correspondence)

Mrs Addy Hackett
Cynthia Spencer Hospice
Manfield Health Campus
Kettering Road,
Northampton
NN3 6NP

Dear Mrs Hackett

**An investigation into the levels of stress within the hospice service and
an evaluation of the effectiveness of a brief stress-coaching
intervention.**

We are pleased to advise you that, under the authority delegated to us as the designated RM&G PCT (hosted by Leicester City PCT) for the three PCTs in Leicestershire, Northamptonshire and Rutland, PCT approval for the above research project is now in place. We therefore advise that approval from the Leicestershire, Northamptonshire and Rutland Primary Care Research Alliance to carry out your study within Northamptonshire tPCT is now granted.

It is required, under the terms of the Research Governance Framework, that all researchers undertaking work within an NHS organisation, which impacts upon patient care must have an NHS contract for the term of the research study. ***Therefore The Leicestershire Northamptonshire and Rutland Primary Care Research Alliance (LNR PCRA) will require study researchers to hold an honorary contract with the LNR PCRA in order for the study to take place in the Leicestershire, Northamptonshire and Rutland primary care sector.*** It is the responsibility of the Chief Investigator to ensure that all study staff have a valid contract in place with the LNR PCRA before they start work within the Primary Care Trusts of Leicestershire, Northamptonshire and Rutland. Please note that this applies when there is ***any*** change in the research staff working in the primary care sector for the duration of the study. Requests for honorary contracts need to be made to the LNR PCRA office, address as above.

Could you please ensure that any interim or final reports, protocol amendments or any documents that require submission to a REC are channelled through this office. In addition can any adverse event relating to this study be reported to us, please. We will undertake to forward any documentation to the REC as well as advise the relevant PCT/s in accordance with Research Governance requirements.

Please also be aware that, where required under NHS obligations, we will submit details of this study to the National Research Register to log PCT involvement in this study. The Alliance is also currently implementing new systems for research governance on behalf of local PCTs, so the study may be subject to some follow up and/or auditing during its field work stage.

May I take this opportunity to wish you the very best of luck with this study.

Yours sincerely

A large black rectangular redaction box covering the signature of the Research & Development Manager.

Research & Development Manager

cc. Dr Farrants, City University

Appendix 13: Ethical Approval Northamptonshire Health Trust

RECEIVED
09 AUG 2007

NORTHAMPTONSHIRE HEALTHCARE NHS TRUST

RESEARCH GOVERNANCE

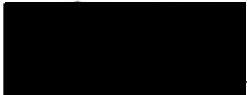
Management Approval for NHS Research

Name of researcher: Addy Hackett

Title of project: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Name of research sponsor: Dr Jacqui Farrants, City University

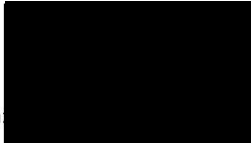
The following have been obtained for this project:

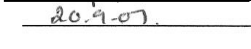
		N/A	YES	NO	Date
1.	REC Approval	☒	☐	☐	<u>1/1/07</u>
	1.1 MREC	☒	☒	☐	<u>16/8/07</u>
	1.2 LNR RECs	☐	☒	☐	
2.	Entry onto research database of Northamptonshire Healthcare NHS Trust	☒	☐	☐	
3.	Pharmacy registration with NHT	☒	☐	☐	
4.	Indemnification for research by: <u>City University</u>	☐	☒	☐	
5.	I confirm that I hold a contract (honorary/substantive) with the Trust PLEASE DELETE AS APPROPRIATE	☒	☐	☐	
6.	I confirm that payment will be made by: _____ for any tests, use of equipment or facilities (e.g. rooms)	☒	☐	☐	
7.	I agree to work within the policies and procedures of the Trust:- 				

Signed: _____

Date: 7/08/07

I agree that this research project may take place involving the patients, carers and staff of Northamptonshire Healthcare NHS Trust.

Signed: 

Designation: 

Date: 20.9.07

DR. A.
MB.
MEE.
CONS.

Copy: One to researcher, One to Clinical Governance Support Team

C:\Documents and Settings\AHackett\My Documents\coaching research\management approval form.doc

Appendix 14: Ethical Approval City University



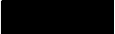
Department of Psychology
School of Social Sciences

Northampton Square
London EC1V 0HB
T +44 (0)20 7040 8580
F +44 (0)20 7040 8580

www.city.ac.uk



3 July 2007

Dear 

Project Title: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention

I confirm that I fully support the above research to be carried out by Addy Hackett as part of her Doctorate in Psychology at City University. I believe Addy to be a committed researcher with the ability to carry out this piece of work. City University will sponsor the research and has the appropriate indemnity insurance to cover the research.

Yours sincerely,



Dr Jacqui Parrants
Research Supervisor

Appendix 15: LREC Permission for Expansion



National Research Ethics Service

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 2

1 Standard Court
Park Row
Nottingham
NG1 6GN

Tel: [REDACTED]
Fax: [REDACTED]

24 June 2008

Mrs Addy P Hackett
Consultant Clinical Psychologist
Cynthia Spencer Hospice
Manfield Health Campus
Kettering Road, Northampton
NN3 6NP

Dear Mrs Hackett

Study title: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.
REC reference: 07/H0402/49
Amendment number: 1
Amendment date: 13 June 2008

The above amendment was reviewed at the meeting of the Sub-Committee of the REC held on 19 June 2008.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Protocol	2	13 June 2008
Notice of Substantial Amendment (non-CTIMPs)	1	13 June 2008

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority.
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.

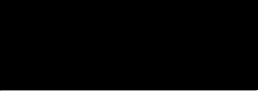
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/H0402/49:

Please quote this number on all correspondence

Yours sincerely



Miss 
Committee Co-ordinator

E-mail:



Enclosures

List of names and professions of members who were present at the meeting and those who submitted written comments

Copy to:

Dr Jacqui Farrants, City University
R&D office for NHS care organisation at lead site – N-PCT

Appendix 16: Evaluation Questionnaire Phase 3

Evaluation Form of Stress-Coaching Session

(Version 1: 17/06/07)

Facilitator and Researcher: Addy Hackett

Research: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Date of Session:

Venue:

Prior to session:

How high/low would you rate your average stress as experienced over the last month?

very low ☐ Low ☐ medium ☐ high ☐ very high ☐

How skilled do you feel in managing your stress?

not at all ☐ a little ☐ mediumly ☐ quite skilled ☐ very skilled ☐

After session:

How skilled do you feel to manage your stress?

not at all ☐ a little ☐ mediumly ☐ quite skilled ☐ very skilled ☐

What have you found most useful of the coaching session?

What have you found least useful of the coaching session?

How able do you now feel to challenge negative self-appraisal? (please explain)

**How confident do you feel you will implement your personal stress-coaching plan?
(please explain)**

**Would you be interested in attending future sessions?
If so, which topics would you like to be addressed?**

If not, please explain your reasons:

Any other comments:

**Many thanks for your participation
Addy Hackett**

Appendix 17: Consent Form Phase 2

CONSENT FORM Phase 2

Version 3: 05/09/07

Title of Project: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Name of Researcher: Addy Hackett

I agree to take part in the above City University research project. I have had the project explained to me and I have read the Participant Information Sheet, which I may keep for my records.

Please circle your answer

- | | |
|---|----------|
| 1. I confirm that I have read and understood the information sheet dated 05/09/07 (version3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | Yes/ No |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without being penalised or disadvantaged. | Yes / No |
| 3. I understand that the researcher will have to break confidentiality and take appropriate action if evidence of malpractice is discovered | Yes / No |
| 4. I understand that anonymous direct quotes may be used in the dissertation and publications and give my consent for this. | Yes / No |
| 5. I agree to maintain confidentiality of the views of other participants and other private or sensitive information that is shared during the meeting. | Yes / No |
| 6. I agree to take part in Phase 2 of this study | Yes / No |

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.

Name of ParticipantDate.....Signature

ResearcherDate Signature
.....

1 for participant; 1 for researcher

Appendix 18: Consent Form Phase 3

CONSENT FORM Phase 3

Version 3: 05/09/07

Title of Project: An investigation into the levels of stress within the hospice service and an evaluation of the effectiveness of a brief stress-coaching intervention.

Name of Researcher: Addy Hackett

I agree to take part in the above City University research project. I have had the project explained to me and I have read the Participant Information Sheet, which I may keep for my records.

Please circle your answer

- | | |
|---|----------|
| 1. I confirm that I have read and understood the information sheet dated 05/09/07 (version3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | Yes/ No |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without being penalised or disadvantaged. | Yes / No |
| 3. I understand that the researcher will have to break confidentiality and take appropriate action if evidence of malpractice is discovered. | Yes / No |
| 4. I understand that anonymous direct quotes may be used in the Thesis and publications and give my consent for this. | Yes/No |
| 5. I agree to maintain confidentiality of the views of other participants and other private or sensitive information that is shared during the meeting. | Yes / No |
| 6. I agree to take part in Phase 3 of this study | Yes / No |

I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.

Name of ParticipantDate.....Signature

ResearcherDate Signature
.....

1 for participant; 1 for researcher

Appendix 19: Email correspondence with [REDACTED]

Dear Addy,

You have correctly administered the DASS21 so there does seem to be a discrepancy between the mean scores and your expectations. One part of the explanation may be lower scores in general in the UK population (see Henry & Crawford, British J of Clinical Psychology, 2003). Regarding suppression of scores, this is entirely possible as the DASS is a completely transparent instrument -

I don't think you need to adopt a psychodynamic model because it could simply be conscious under-reporting. Another possibility is non-random participation – perhaps the highly stressed individuals were less likely to participate for some reason?

Finally, I guess it's possible your sample is not really very distressed. Maybe they're working hard but feeling useful and in control?

Best wishes,

[REDACTED]

From: Addy Hackett [mailto:[REDACTED]]
Sent: Monday, 3 December 2007 12:13 AM
To: [REDACTED]
Subject: Advice on unexpected DASS21 outcome

Dear [REDACTED]

I am doing research into stress in the Hospice service in the UK. From observing this staff group and from their informal verbal reports, it appears that they are experiencing quite a lot of stress. However, the DASS21 shows actually that the scores are below the norms as stated in your manual.

I doubled the scores on the individual scales and the mean scores are:

Anxiety: 3.8 which is well below the norm mean of 4.8,

Depression 6.05, which is a little below the norm mean of 6.14 and

Stress: 9.3, which again is below the norm mean of 10.29

The total staff group: n=132

Respondents: n=89 (= 67.4%)

I am pretty sure that there is stress amongst this staff group but somehow it did not show up using the DASS. I have reflected on this in my psychology supervision and we thought that this might be explained in psychodynamic terms of "having to defend against stress and depression". The staff group is working with people who are dying which is, in comparison, always worse than their own "little" problems. So there might be a denying of their own feelings going on. Also, there is a strong philosophy of having to serve the patients and improve their quality of life, which takes away attention from oneself. Last week I had a long conversation with one of the nurses who reported to me that they had an immensely difficult week again, with hardly any breaks and high levels of stress (mainly due to low staffing levels in her opinion). I mentioned to her the low results

of the research and she found that very surprising. I am going to conduct some focus groups to see if I can tease out some reasons why the results seem to be conflicting with the reality. I am wondering if you have come across this phenomenon yourself or if you have any other explanation for the unexpected results. I attach the SPSS score file and outcome file for your information.

I would very much welcome your thoughts on this.

Many thanks,

Addy

Consultant Clinical Psychologist

Lead Psychologist for Northamptonshire Palliative Care Services

Northamptonshire Teaching PCT

Appendix 20: Transcript Focus Group 1

(see next pages)

1 S What do you perceive to be some of the issues that could cause stress within a palliative
2 care setting and also organisationally as well?
3

4 4 I actually don't find the palliative care setting a problem to work in – it's well supported here,
5 it's a pleasant environment, we have got extra equipment and things, but it's the bigger picture –
6 it's the NHS that causes the stresses, generally I'm not stressed here but last year it was the A&C it
7 just makes you feel not considered, you are just a body and this week there was an incident that's
8 made me feel the same way, with a colleague who has been here a long time and who is
9 absolutely excellent and you just feel sometimes that people are not valued as people and it's all
10 structure and stick to rules and I don't believe you can stick rigidly to rules, and I was thinking
11 today that in industry you would be rewarded for the job that you did, you would be promoted and I
12 know that can't happen but I just think people generally, not here because this unit is lovely, but I
13 think that because it's such a huge organisation that people further on don't really care what sort of
14 job you do and are not aware and in the end you think why put the extra effort in, which most
15 people here do. It's very sad
16

17 S So it's more the external body dictating.
18

19 4 Yes, and you find some people stick rigidly to the rules, it's covering your backs all the time
20 and I don't think that's a good way of working – be sensible, try to stick within boundaries but I
21 think you need occasionally to step out of those boundaries, there are times you need to but some
22 managers don't think that way and just want to protect themselves. Very sad.
23

24 6 I would agree with that, I think it's as you say, the team here is very supportive, we get a lot
25 of support, it's upsetting, some of the patient care, but you can within the team support each other
26 through those issues, it's more dealing with management and their attitude towards you that is the
27 problem, and I can't see that improving.
28

29 4 No I can't see an improvement.
30

31 6 It's always blamed on the bigger picture and that's the way the NHS is these days but I
32 think although I feel valued by the team, I do not feel valued by the management structure and I
33 feel you are a number – just do the job.
34

35 4 It is sad in the health service in general isn't it because you need people that want to be
36 there and do the job as well as possible, and I think most people here would go the extra mile and I
37 found in my last job, in the end, I felt why bother why not just stick to the rules and then I will not
38 get into deep water when you have gone just that little bit further and something just happens and
39 there is no support. It's sad.
40

41 3 It's the constant change, the constant changes, you are being sent to do one thing and then
42 before you have even finished that it's "oh that's changed we are going to do it this way" and then
43 you find out it's all to do with being sued, it's not to improve patient care, it doesn't improve your
44 setting or your job or the team's job it just saves them from being sued by one body or another for
45 something that you might or might not have done.
46

47 S The rationale doesn't seem to be based on the day to day workings of the unit you work in.
48

49 4 It's like the Conflict Resolution course – most of us have been working in the health service
50 for years and suddenly we all have to go on a Conflict Resolution training course and you know
51 that it's just to cover the backs of the management in case something happens. That's what it
52 feels like more and more as the time goes on.
53

54 3 And that seems to go along with the No Smoking Policy so if you see people outside
55 smoking you will now be able to police that as part of the unit and part of the Trust, well sorry we
56 have other things to do and it's just another unnecessary thing because we don't have a lot of
57 conflict within the unit and if we do we are all together and we deal with it.

58
59 S What do other people think?
60
61 5 I think stress is caused by the pressure of everything that's what is expected, it's not just
62 looking after the patients which is our main aim, it's what is expected of us to do in our own time
63 really. E-learning will take you two hours to do on the computer and this will take you another two
64 hours so it's not just the work here it's everything else that comes with it these days.
65
66 3 That's right because you couldn't take those two hours out of your shift to come along and
67 do an e-learning programme because there isn't the staff to cover so you do it at home and then
68 you have to take the time back and then you don't get your time back and that's quite stressful
69 because as soon as you've done one there are more on the notice board, I think there are four up
70 now all taking between 1 and 4 hour to do.
71
72 S So it feels pressured to keep up what you are professionally required to do.
73
74 5 It's not professionally required to do, it's what the NSH require us to do, it's not the
75 professional bodies.
76
77 4 It's like manual handling you do it constantly and I know things change, but everyone is
78 expected to go on it every year it's just to cover backs isn't it.
79
80 3 We've got 14 mandatory courses for the year and like you said most of them are to cover
81 their backs so if you hurt your back, "oh you've done manual handling", so you can't sue the Trust,
82 you've done the training now how to use the equipment - and that's what it comes down to.
83
84 6 When you do this mandatory stuff where's the time for other professional development on
85 the clinical side - you end up doing it in your own time - which from a clinical point of view I don't
86 mind, but is it appreciated?
87
88 S It's appreciated by your peers and your colleagues but when it goes up a tier or to
89 management outside this physical building you feel that's where the problems start, it seems to be
90 quite impersonal.
91
92 2 Yes the team here is absolutely fantastic and I find the stress level for me is more the
93 relatives as apposed to patients, I think the stress levels you have to go through just generally to
94 comfort them as they are getting more and more agitated, but the person in the bed you don't get
95 the stress level from that person its nearly always, I find, the patients relatives.
96
97 S It's the emotional demands by the relatives.
98
99 2 Yes very much so.
100
101 S Working with the relatives?
102
103 2 Yes not always, there are some different aspects of it that I find more stressful than
104 patients, well some patients anyway.
105
106 3 I think sometimes we are our own worst enemies because we keep giving and giving don't
107 we and then people come to expect that especially if someone has been in a little while and you do
108 a bit more and a bit more and they expect a bit more and I think that's when they take it all for
109 granted and suddenly you are a cross between a hotel and what you are supposed to do with the
110 patient - the lines get a little blurred
111
112 2 Going back to what you said about covering everybody's back, I had an incident a long time
113 ago where somebody kicked me but when I went to fill out a report it turned out that I was in the
114 wrong place, I shouldn't have been there and that's what I find completely and utterly frustrating

115 that at the end of the day it's my fault I should not have been there and that's what I find really
 116 difficult, again they were covering their backs I was in the wrong place so I couldn't have sued –
 117 not that I was going to but it's the fact that I should have been further up the bed.
 118
 119 5 Someone kicked me once – yes you.
 120
 121 S So it's a bit about the kind of management style of pressures that they put you under, and
 122 that comes under the organisational potential stress that people can feel when they are in a job,
 123 but also in palliative care there is the emotional side of thing and obviously some people can talk
 124 about the support and helping each other out but there is also that emotional drain.
 125
 126 2 Yes but you are supported, everyone is supported it's a fantastic place this is for that.
 127
 128 1 Can I just say that where I feel under pressure, its because as you say, you want to do
 129 everything or give everything to everybody and you go that extra mile and I'm going through the
 130 A4C and there's a query about my banding and half of you really want to do a really good job and
 131 half of you says "why bother I'm not being paid for it" so it's that conflict and there is always
 132 someone wanting more. Its having/wanting to do everything for everybody and not having enough
 133 hours in the day to do everything for everybody and like today I have just been on a visit where she
 134 wants a basket to go with her walker and its like ok I'll pop that back later but that's going to take
 135 me 20 minutes on the way home to drop that basket off and it's the feeling ok to say "no I'm not
 136 going to make it today" without feeling you have let someone down or yourself down because
 137 you've not done it today, its pressure of workload but also the level of expectation that I put on
 138 myself or I allow other people to put it on me.
 139
 140 6 Do you think that's the way the NHS is now, I never used to question how much extra I put
 141 in and the rest of it as I felt appreciated and want to help the patient but in today's world of the NHS
 142 and the feeling you are just a number to do the job, I question sometimes whether I should go that
 143 extra mile for the patient because you don't feel appreciated like you once were.
 144
 145 1 Yes, that why I have this conflict in my head between "I will do it" and "no I'm not going to
 146 do" it as I'm not paid to do it and I'm removed a bit from the managerial structure you were talking
 147 about so I feel that I get support from her so I don't get that kind of unsupported situation but when
 148 you are doing all of this and getting paid the same as somebody who is doing considerably less
 149 with a lot less responsibility you think well why should I and its in my own mind that I want to do
 150 well and want to do a really good job etc etc but on the other hand I think "sod it". And that's
 151 incredibly frustrating.
 152
 153 4 That's sort of going back to industry - being paid by results but you are stuck in a band here
 154 until someone decides that actually you need to be rebanded.
 155
 156 1 Yes and somebody seems to be taking months and months to think about something that
 157 looks incredibly straight forward and an easy decision for anybody else to make but that's what
 158 happens in the health service.
 159
 160 S Seeing a need and wanting to meet it.
 161
 162 1 Yes
 163
 164 S Sometimes that becomes a bit overwhelming or there are other pressures that you are
 165 trying to balance and similarly the emotionally meeting the needs of the patients and balancing up
 166 the you being ok and them being ok.
 167
 168 3 Yes I think the other thing is that we have had big changes in this unit, I think the people
 169 who work here have stayed supportive of each other, but before you were probably praised for
 170 what you had done and told you had made the right decision but if you hadn't it was discussed and
 171 told yes you've done the right thing but next time if you do such and such a way, or this way would

172 have been another way around it, you've all done well but now its all rather negative feedback now
 173 there is hardly any positive feedback from a little bit higher but there is quite a lot of negative, you
 174 don't communication well or you don't do this or you don't do that and you know when you are all
 175 working well together and you all going along the same you are probably losing you're way a bit
 176 but if some could just say "oh you are doing well" like we used to have, I think that would help
 177 people.
 178
 179 S Its appreciation isn't it.
 180
 181 3 It doesn't feel that you are appreciated and that's the new management style isn't it as well
 182 as people. It's probably the style of management.
 183
 184 4 Yes I think it's a problem across the whole of the palliative care service.
 185
 186 S There seems to be a bit of consensus that the support on the ground floor level seems to
 187 be quite a helpful coping strategy, can you explain that a little bit more because its obviously quite
 188 good, we have covered quite a bit that isn't so great but we don't seem to have unpicked what is
 189 good, what does help you.
 190
 191 2 From my point of view if I'm stressed about anything, say patient/relative and you get
 192 stressed and you get into that stressful emotion then you know you can go to one of your
 193 colleagues and you just talk about it and that is, to me, what is super everybody is supportive of
 194 what you do in that - probably I'm not saying that right but.
 195
 196 6 Its not higherachacle either is it on the ground level.
 197
 198 2 No, there are doctors and nurses but there is not the "oh I'm a doctor" and this is where we
 199 are very lucky there is the occasional one because I'm only an HCO but there is in some places
 200 and there is some occasionally here that come through that treat us like that, doctors, but in
 201 general we are very very lucky because we are treated the same.
 202
 203 S It sounds is if your contribution is valued.
 204
 205 2 Yes without being patronising, all you need is for someone to say "good morning, you
 206 alright" to just be recognised if you know what I mean.
 207
 208 3 Yes we can always discuss things with each other anything at all if the nurses are on a shift
 209 and its an out of hour shift we usually discuss most things with each other and if during the day
 210 when the doctors are here we usually discuss it with them probably too much sometime but we can
 211 go to each other and say we are not happy about that, what do you think.
 212
 213 5 It's recognising stress in your colleagues isn't it as well.
 214
 215 6 It's probably because we are a fairly stable team we've know each other fairly well for
 216 years. It can be a negative thing sometimes but not here.
 217
 218 S So it's being able to off load on a kind of ad hoc basis, sounds like it happens kind of not
 219 formally.
 220
 221 4 Its not even just about work it can be anything from the outside, people are still supported
 222 and checked on and then we have got a psychologist as well so we've got supervision with Addy.
 223
 224 S So there's the informal ad hock conversation when you have just come out of a tuff session,
 225 a tuff chat with a relative and you kind of wonder if it went well.
 226
 227 2 You just say to one of the nurses "oh so and so happened there" and if you were really
 228 upset then you would take somebody off and sit down, have a cup of tea and then go back.

229
230 5 It's being aware of the triggers with work colleagues you know someone might be upset by
231 that situation and so you would offer to do that so that they don't have to.
232
233 2 It's keeping an eye on colleagues and that is why its so wonderful.
234
235 3 When we have had particularly tuff times if we have had things that have been particularly
236 unsettling from a patient or relative then Addy has done some debriefing sessions we've ask her to
237 come or if it's still on going she has come along and given us a session and given us strategies on
238 how to cope with that or what to look for and how to respond to some of it and that's been helpful.
239
240 S So there a bit of informal checking with each other, a bit of off loading but also there is
241 some formal things as well if needed and then you mentioned supervision – is that across the
242 board as well.
243
244 4 Its across the county supervision, we have it once a month with Addy.
245
246 3 We started up supervision in fact we have a lovely board about supervision but it's the
247 same old thing it's time - to take time out to be able to do it is the difficult thing and for group
248 supervision which would be easier as there are more people around, but it needs people to come
249 in on their own time which causes difficulties.
250
251 S Are there other things - I mean someone has mentioned it a couple of times, the difficult
252 situations with relatives and you are looking to take over - are there certain palliative care
253 situations that are more stressful to others.
254
255 6 I think it's the angry patients and relatives, that's quite hard.
256
257 2 Situations vary so much don't they, what would stress one person one day probably
258 wouldn't do another day, nothing is plain sailing.
259
260 4 I think you can identify with some people can't you, the age of the children and things.
261 Certain people just catch you unawares sometimes.
262
263 3 Like you said, anger's one thing, we are not used to people being angry as such at us and
264 that is quite difficult then when they are.
265
266 S Is that what you mean by angry – when it's directed at you?
267
268 5 Yes if it's directed at the situation or anything that's fine it's when it's directed at you.
269
270 6 Which you know is probably related to what has been going on and you try and deal with
271 that but it's that initial thinking "oh gosh is this going to be difficult". It's stressful when you are
272 involved in that. Usually you can resolve things but it's those one that you don't ever resolve that -
273 up until a few years ago I had never had a complaint against me and then I had a complaint and I
274 think that changed my perception of things and its taken me a long time to put that in the past
275 really. Because once you've had a complaint it's easy to view every consultation as a potential
276 problem.
277
278 S Being more aware of the possibilities.
279
280 6 Although you know anyone can complain until it happens to you and you have to deal with
281 it that is hard.
282
283 S It also bring up your comment on seeing the need, giving all the time and you mentioned it
284 as well, the constantly giving and wanting to make things better and yet someone comes along
285 very angry and upset and potentially might complain.

286
287 3 I think that impacts on others as well because if you know someone like we know H and
288 with the best will in the world no body could complain about H so if somebody does that impacts on
289 everybody else because you think "how could they" and then you feel "that person doesn't deserve
290 that" and then you don't know whether you are going to get the flack if it happened in the clinic and
291 then if that patients come in as an inpatient and then their relatives begin to call somebody else
292 and then you sort of notice that everybody who goes in moans about this, that and the other and
293 you think "well that's not fair" and how can they then complain and say stuff because its not
294 justified, if was a complaint and we had done something really wrong and that patient has suffered
295 I think that's different but when people just complain about nick picky things and cause a problem
296 for other people in the team it does spread across the team and there's nothing I could say to H
297 that could make a difference. That impacts across everybody then.
298
299 S Do other people feel that as well – kind of vulnerability – apart from the angry patients are
300 there others similar - patients perhaps seem to be very hard to get things right.
301
302 1 I see our role as being a bit different to that don't you. We're very much in and out aren't
303 we and don't really build those kind of relationships especially with relations.
304
305 4 I haven't felt threatened here. Once or twice I have felt uncomfortable, we have had a
306 couple of inpatients that we have all struggled with, they struggled at home and they have been in
307 here and struggled in here. I think the other thing is that if you know that everybody is having the
308 same sort of problem then you would assume that actually a complaint would go no further, but the
309 sad thing is that somebody has to go through something like that when its obvious its not valid or
310 justified and you think somewhere along the line someone would think "hang about" this family has
311 caused everybody stress and unhappiness along the way so why has one person been picked out
312 to be complained about, but again its just another incident and they don't look at how it actually
313 worked and that everybody has struggled. It's like being able to speak openly about things just
314 about everyone in our unit I feel I can say what I think and in meetings I feel I can say what I think
315 but there are certain people now in the organisation I would be fearful of how things came back at
316 me and I think that's sad that you can't just tell people what your worries are and your concerns
317 about how something has happened without feeling how that might come back at you at a later
318 date, I might get into nasty trouble and I hate feeling like that.
319
320 S So again different from the working ground floor but that kind of being able to say pretty
321 much how you feel here but that could be different elsewhere.
322
323 4 Yes and that's fine with everyone here and all the doctors I feel I could just approach
324 anybody here and the manager of the service I feel I could say anything to her as well but there are
325 people in the service whom I couldn't and I feel that's really sad that people can't express
326 themselves its not as if we are running around shouting and screaming and swearing you should
327 be able to say what you think if you've got a problem.
328
329 S Are you saying there is a difference between the inpatient bit and you dipping in and out.
330
331 1 Yes well most of my patients are in the community so I don't really have an opportunity to
332 build a relationship with them so I don't come across the sort of problems you do with building up
333 the relationship with the relations because if you see a relation then you are talking about what you
334 are about to do so it's on a busy kind of level so you don't necessarily have the emotional side of it
335 because you are in there and do what you have to do and then you are out again, so I don't find it
336 sort of emotionally stressful because of the nature of the work.
337
338 4 I would agree that it's a lot different here and it's the end of life stuff that I don't think I could
339 handle.
340
341 1 You would go in nearer end of life than I would so I'm very much in on a purely practical
342 basis to what you have been and done before so I don't feel that emotional weight given the

343 potential of a very emotional areas to work in and people say how do you manage to work and I
 344 say I don't know really because it doesn't affect me like that and I don't know if it should or not but
 345 you do your practical work and then come out and so I don't come across that kind of emotion.
 346

347 6 I think from the nurses point of view as well compared to the doctors the emotional side is a
 348 bit more you get the brunt of that side from the patients and relatives. As a doctor you go in you do
 349 the medical side of it and then withdraw and for ourselves that's very difficult to withdraw.
 350

351 2 The nurses going in after you have probably given bad news and then they have to go
 352 back in and pick the pieces up from that don't they.
 353

354 S You are perhaps the ones also there in the middle of the night, you know 24 hours.
 355

356 3 I think something recently we have had quite a bit of which seems to come in spates is
 357 quite a lot of young people have die who had got younger children and we probably won't have any
 358 more for months now and but we've just had quite a few and as much as you've been trained and
 359 know what you are supposed to say and you can do this and do that with children but when
 360 children come up to you and you are trying to do that and they come out with something and you
 361 are sitting there thinking I know what I've got to say but I can't say it and you've got that lump there
 362 and they are standing there so innocently and saying those things and you don't say the things you
 363 are supposed to say because you just can't. And I think people have sort of had that as a problem
 364 lately and we had some around Christmas time and 'S' and I both sat with this little girl and then
 365 she came out with something and floored us both and we both were just fighting not to be in tears
 366 because she was so matter of fact and sitting there and we were thinking poor little girl and
 367 afterwards we both said we knew what to say but we just couldn't get it out as we both would have
 368 cried if we had of done and she was sat there a picture of innocence and just coming out with it like
 369 children do and you can't guess they are going to say that you can't second guess what they are
 370 going to come out with next and then they come out with something and you just can't and that's
 371 been difficult and then that passes by and you don't get any children for ages or you get them and
 372 there are what you expect and it all goes ok and then you get hit again and it's the little ones they
 373 are so matter of fact.
 374

375 6 I think that's it when they are of similar age to you, it hits home.
 376

377 5 One of the doctors said recently that they have actual training during their training about
 378 how to keep therapeutic relationships and not letting yourself get personally involved but as nurses
 379 I can't remember in my training having any training like that - I asked one of the students who said
 380 she hadn't but she had been trained to not get emotionally involved.
 381

382 S One of the questions that is also on here is about the ways, considering the difficulties that
 383 we have come up with, that can be put in place like support networks, or training or coaching, are
 384 there certain ideas that you might have and would that be one of them - how do people feel about
 385 obviously you have heard that
 386

387 3 I think its something that always catches you out though because I think emotionally
 388 although sometimes its really tough everybody does manage and cope with it don't they, you do
 389 get through it and you do and there is always going to be an odd time when something is going to
 390 'oh' and you couldn't have been prepared of it or its going to catch you out.
 391

392 5 I think people have different coping strategies, I know how I cope with things whereas
 393 somebody else might go home and drink a bottle of wine or something like that, that's their way of
 394 coping, there's nothing formal in place as we are not all the same, we don't all do the same.
 395

396 4 It's not good talk because you know when people talk from a trained point of view don't you,
 397 as well as the certain phrases and you think 'oh hang about they've been on a training course'.
 398

399 6 And that therapeutic phrase sends me a bit cold actually because I think in this field yes
400 you mustn't, its harmful taking everything home with you and I'm not advocating that but I think
401 you've got to give some of yourself to do this kind of work.
402

403 5 I think rather than have a 'therapeutic relationship' its working out how to manage your
404 feelings in relation to your work and I suppose there are different ways of saying it but that phrase
405 just makes me feel cold it's a new cultural image and that comes through people who go into
406 working with medicine, therapies or nursing because they wanted to work with people
407

408 6 Yes you have got to have people who are scientific but may be this type of work wouldn't
409 be for them.
410

411 2 Saying things like that you do find that, we haven't had any recently, but you get a lot of
412 student nurses that come through who are very academic but they haven't got people skills and
413 you sometimes can't teach that sort of thing can you, its either there or its not. They are alright
414 when they sit at their desk and do their writing but they have also got to do the other side which
415 some of them don't seem to want to do.
416

417 6 Or they don't cope with it when they do.
418

419 2 We've not had any like that recently.
420

421 4 You tend to chose to come into palliative care and if you wanted to do something more
422 academic you would chose to go into a different area.
423

424 S Thinking of the emotional issues you have been talking about, the kind of work related
425 organisational stresses, are there certain things that you might like help with to manage/cope a bit
426 better.
427

428 4 The problem I find is the stuff that's out of your control, you can't change things in the
429 organisation and you can see lots of things that you think don't work well but you can't do anything
430 about - there is nothing I can think of here that would make it work that much better, I think it's the
431 peer support that works really really well.
432

433 3 I agree with that because if we find we have learning needs, Addy will always do a debrief
434 she will always do anything if there is something difficult she will always talk to us we can go in as
435 a group or singly if we have anything clinical we are not sure about the doctors will do a teaching
436 session so all those things we can, within reason, sort out for ourselves and its those things that
437 you will do, but its those things that are put on you when we don't have any say about it and you
438 can't moan about it because you'll do it anyway and they are the things that are out of our control.
439

440 6 In the past there was a two way conversation between the management and the rest of the
441 team but that gone, it's a one way direction now and that's part of the problem but I can't see that
442 changing.
443

444 4 I think it depends on who you have got in the post a lot.
445

446 5 There's too many changes, changing for change sake and if you've been in the NHS a long
447 time you've seen all these things and its just going around in circles and you think why didn't you
448 listen the first time round now its all this infection control thing its absolutely rubbish because if they
449 had carried on how they were and just made some small changes instead of the drastically
450 different direction, we wouldn't have the problems we have now.
451

452 4 It seems that new people come in and don't look at what has happened in the past, if they
453 looked at what had happened and adjusted it but they don't they start all over again.
454

455 5 I remember going to a teaching session about MRSA and before that we used to be really
456 strict about hygiene and God forbid if you dare touch anything if you hadn't washed your hands
457 and we went to this MRSA teaching session and we were saying what about this and what about
458 that and we've always done it like this and they said no that's old fashioned don't worry about that
459 now all of a sudden shock horror there's MRSA everywhere and we've got to do this and that but if
460 you had carried on doing that in the first place we wouldn't be in the mess we are in now and it's
461 just people have made so many changes and now we have got back to square one and back to
462 basics to get everything cleaned and that's something we used to do all the time anyway.
463

464 S You mentioned that it used to be a two way conversation and now you say it's more one
465 way – you feel you have lost a voice. On that level you can see that it would be good to have
466 some changes but difficult to see how that could happen, but on a working colleague day to day
467 basis it doesn't sound as if there is too much to add.
468

469 1 Because I think we feel it's already there to an extent.
470

471 4 The worry is that we will lose some of it because of all that's going on at a higher level
472 because they don't care about the person who does the job really well and if they lose that person
473 they will just get someone else in and you could end up with a totally different feel and that's the
474 worry.
475

476 2 Some people are in it for the day to day, it's a wage at the end of the week and then you
477 get others who are in it because they really enjoy what they are doing.
478

479 4 Yes, you should be keeping people like that not letting them go or making them feel they
480 have to go it's sad.
481

482 3 I think somebody the other day said it, that if you are a bit worked up it probably would have
483 this sort of impact, somebody went to the staff toilet and came out and said "you can't even go to
484 the bloody toilet in peace" because the back of the toilet door is covered with things saying can you
485 attend this or can you attend that on such and such. There are notices everywhere.
486

487 4 Information overload.
488

489 3 There are notices everywhere and that seems, on bad days, to really get to people.
490

491 4 I have to say that's the only time I read the notices.
492

493 3 It's the same as me – but is nothing sacred. The straw that broke the camels back.
494

495 S We are coming to the end and obviously we have shared quite a number of things, the
496 organisational stresses, the emotional stresses, the angry patients, the complaining patients, the
497 emotional relatives, the different stresses between the end of life scenario as well as the slightly
498 different dip in dip out, and not really feeling there is definitely more of that or less than that apart
499 from the two way conversation with management higher up than the management of the hospice,
500 but there is nothing you really want more or less of. Is there anything else people would like to add
501 I don't want people to walk out thinking there were burning issues we haven't discussed, so is
502 there something.
503

504 3 I think perhaps inconsistency is the other thing – the no smoking rule – no one is allowed to
505 smoke, if you see somebody outside you must stop them, get rid of all the ashtrays – two patients
506 come in who like to smoke, and then there's this well you want them to smoke if they want to
507 smoke because they are dying so if they want a last cigarette why can't they have it but they can't
508 smoke in here, then the two patients go outside and smoke, sit on the bench and you think that's
509 okay but no they can't sit there because it causes smoke upstairs so they smoke inside and you
510 have to tell them they can't so they go out to the main road and smoke so then you are saying

511 what if they collapse on the path and it looks awful them smoking on the path but no we will have
512 to assess the situation as it arises for each patient. And you think for Gods sake.
513

514 2 At one time smokers were not allowed here they were to go to Cynthia Spencer but that
515 didn't go down well.
516

517 6 It's the incidentals.
518

519 5 That's an example of the rules coming from on high that don't work especially on the
520 ground floor.
521

522 6 The management don't have to sit there with the patient who wants his last fag. If you are
523 sitting out there in uniform you will be disciplined because we are taking them out for a cigarette
524 and we are not supposed to.
525

526 S It goes back to what you were saying about seeing a need and wanted to meet that need
527 but something else pulling you back.
528

529 3 And then on another day someone come in from on high who is fed up with telling people
530 they can't smoke and says well just leave them, so then when another patient who smokes comes
531 in the whole viscous thing starts again, and you can't win.
532

533 4 They all sit out now.
534

535 6 But it's those sort of things.
536

537 3 They cause so much hassle.
538

539 2 Is sounds so trivial when you say it, but it does cause quite a problem.
540

541 3 Its on going, its every day because that patient want to smoke every day not just once a
542 day or once a week but then the relatives go out to smoke and you have to go out and tell them
543 they can't smoke but the patient can.
544

545 S I suppose that's their coping strategy and we've talked about your coping strategies that
546 have all kind of flowed into each other, you mentioned some might go home and have a glass of
547 wine.
548

549 3 We would like to say to stressed relatives go outside and have a cigarette and then come
550 back in as we have done before but now we can't say that.
551

552 5 Laughter is another coping strategy especially in here -- someone from the PCT was taking
553 photographs of all the different areas in the NHS and they said this was the happiest place they
554 had been.
555

556 2 We have a laugh and as you say that's another coping strategy.
557

558 3 We do have a laugh and are sometimes told to shut up because we are too noisy.
559

560 2 But also the patients like it don't they because there is not a glum atmosphere, there's a
561 happy atmosphere.
562

563 3 A relative said the other day that it was a bit loud so we tried to be a bit quieter and a
564 patient came out and said 'what's the matter this place has got an eerie silence we like it when you
565 laugh'. They said that at the moment in their family there was no laughter with what they were
566 going through but we like to hear you laughing.
567

568 2 It does bring laughter to their face doesn't it.
569
570 6 I think it's the realisation that life goes on.
571
572 S A bit like the camera crew they realise that it's not a sad, depressing place.
573
574 6 We've actually had people say they can feel the atmosphere as soon as they walk in the
575 door they can feel the calm nice atmosphere.
576
577 3 One of the managers that we had previously came in one morning and said something was
578 really wrong, the buzz had gone, and on that particular morning one of the staff members whose
579 husband had died recently had just visited, but that person walking in knew straight away and
580 wondered what had happened.
581
582 S And is that similar for you guys coming into work.
583
584 2 Yes it's nice because you don't feel 'oh I'm going to work' you feel happier.
585
586 3 It's the only social life I get.
587
588 6 I think everyone feels the same from the domestics up, there are no levels. If you go to
589 KGH the staff all look miserable, there are no smiles.
590
591 S Thank you everybody
592
593
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Appendix 21: Transcript Focus Group 2

(see next pages)

1 S I'm Sarah I'm a Clinical Psychologist in Peterborough working in palliative care one day
2 hospice, four days hospital. Addy is not sitting in, I'm here to keep the anonymity.
3

4 S What do you feel are some of the issues that could cause you stress at work or do cause
5 you stress at work? (pause)
6

7 7 Lack of time to be able to do the job that you want to do and so a lot of time you do
8 basically run out of time so you can go home feeling unfulfilled and thinking that you haven't
9 actually done your job properly although you know you have done your best, but I think time is
10 always an issue.
11

12 S Is that because there is too much to do or because the work that you do do is so
13 unpredictable, what it is about the lack of time, what causes that?
14

15 7 I think because we set high standards and you want to maintain those and the whole
16 hospice has got much busier and we do a lot more than we did say 14 years ago when I first
17 started, it's a different place but we still try to maintain the same kind of, for me anyway, the same
18 kind of standard and sometime you know you should to be down in one room doing something but
19 you just can't get there so it's the volume of work.
20

21 3 And the unpredictability, I would say as well, because you can come in when you think it's
22 going to be quite quiet and then all of a sudden a patient takes a turn for the worse and then all hell
23 can break loose and it gets very busy so yes the unpredictability I would say.
24

25 6 I think for me it's sometimes just dealing with the emotional impact of what is happening at
26 that time and for me personally if I come in feeling quite stressed or fragile because of things
27 outside then I can sometimes be faced with things that I hadn't expected and although you do try
28 and deal with it in a professional role you are aware that it is still hanging around when you have
29 left because you haven't had time to debrief or actually take on board what it's actually done to you
30 it's only when you get outside that suddenly you all, cave in.
31

32 S Do you think that's the nature of working within palliative care, within the hospice, that kind
33 of emotional aspect of it.
34

35 6 You are working with people who are dying and it's not just the patients it's the whole family
36 dynamics that go with it and its recognising as well how it impacts on you personally because we've
37 all lost people, I've had lots of losses and I think it's not sometimes taken into account how it's
38 affecting you emotionally. I think there is a big difference with dealing with patients who are at the
39 end of their life and all that it encompasses and family members who all struggle in different ways
40 so it's trying to balance lots of different things and when you are dealing with a family who are all
41 handling it slightly differently and you find yourself just in the middle of maybe four or five all
42 looking to you and you are thinking, well, what do you do, you do your best and we hope that's ..
43 it's all you can do.
44

45 S So there's the high standards, the time limitations to get the high standards, the emotional
46 component of working within this setting and not only with the patients but with the wider extended
47 family connotation so quite a number of pressures really.
48

49 4 I think there is a realisation or even an expectation that palliative care is death, dying and
50 sad and that we should all be like that and it isn't and for me that's why I chose to be here, but it's
51 50% of what we do all this emotional stuff, and often we can give the patients what we think they
52 need and eventually what they do need. The family are in a different place sometimes and they
53 can pull you away from the patient and we can tell them we are here for them and they are as
54 important to us as the patient but we must not lose sight of the patient, that is the number one, but
55 we also mustn't lose sight of ourselves, and I've had lots of bereavements and had lots of
56 counselling and that's 50% of the job, occasionally that gets difficult for me but what stresses me
57 more and in terms of time, not being allowed to follow through because of time constraints and

57 more and in terms of time, not being allowed to follow through because of time constraints and
 58 sometimes other constraints, and things like if you are the co-ordinator, and you have a student
 59 and there are new staff and you've got needy patients, dividing yourself up equally and trying to
 60 serve everybody well and I just come back to well the patient is number one the student will be
 61 here tomorrow, the new staff member, if I explain it to her, hopefully will accept it and I can deal
 62 with that maybe another day, but you do have to try and section it off.

63
 64 S Prioritise.

65
 66 4 You have to prioritise but I huff and puff and say what I think and I don't go out of here
 67 particularly stressed and I think I am lucky for that reason but sometimes six months down the line
 68 when you have had a lot of difficult deaths with difficult families at a time when you are short
 69 staffed, when you have students, you can sometimes think that "I feel a bit low, why is it" but you
 70 know why it is you kind of work it out.

71
 72 S It's the accumulation, the emotional side of things and perhaps at the end of the day not
 73 realising until you are on the way home that today was a bit tough but not hitting you until a bit later
 74 or after six months it's that cumulative effect of "why do I feel low".

75
 76 4 Oh God it's been a really tough summer no wonder we are all feeling a bit low or something
 77 like that, but if you find a reason then you can pick yourself up, and I think we are very good here
 78 at supporting each other in terms of talking about it and trying to debrief, we don't necessarily do sit
 79 down debriefs maybe as often as we would like to, but we do try and talk it through and try and
 80 help each other to be a bit better but sometime you find that you are doing that to quite a few
 81 people and then "whose going to do that for me" and "hang on a minute I ought to find some time
 82 for me".

83
 84 6 I do personally think that some people do struggle and don't take the time off, do come to
 85 work and if you work within a very small team, which I do, you can find that, on top of looking after
 86 the patients and doing everything else, you are very acutely aware that they are very emotionally
 87 fragile and so you are aware of maybe trying to take them out of a situation which might make it
 88 even worse because you have to get through shifts and sometimes I don't think people
 89 acknowledge that they have to look after themselves and you almost feel a pressure to come into
 90 work because of staff shortage because if you don't come in it puts pressure on other people but
 91 by people constantly coming when they are stressed it's not doing anybody any favours basically.

92
 93 4 They become the 17 and 18 patient on the ward. (laughter). But you are emotionally
 94 carrying them.

95
 96 6 But there is this thing that you just keep coming because you know you are short staffed
 97 and where are you going to get staff, the same people keep filling in shifts and things like that and I
 98 know we are here to look after patients but we forget to look after ourselves.

99
 100 4 It's important, especially in palliative care, that you do need to recognise and look after
 101 yourself as well.

102
 103 S It sounds like certain people can acknowledge that and other people that acknowledge that
 104 and do it and then other people who don't do either.

105
 106 4 And some people who don't acknowledge it at all and trying to get them to acknowledge it
 107 because they are not achieving and they are under functioning and they are stressing you and
 108 themselves and they are getting worse day in day out, week in week out and you know you can go
 109 to your managers about that but unless the person actually says themselves how they are feeling
 110 and admits it, it becomes a very difficult situation for all concerned.
 111

112 6 Or, we are so good at listening to people that you find yourself not only dealing with
 113 patients but being offloaded on to all the time and you are just thinking "please just leave me alone
 114 I don't need this as well" but how do you turn around and say that you know forget about that we
 115 are in work now.

116
 117 "Go and get yourself a shrink, you need it love"
 118

119 6 Because you can't deal with it all, I find that when I come to work and as soon as I put my
 120 uniform on I can deal with things that I can deal with in work that I could not outside of work. But
 121 I'm also aware that it can get out of kilter. So it's a sort of coping mechanism.

122
 123 2 Its how you deal with very, very emotional and stressful situations.

124
 125 4 For me as soon as I put my uniform on I can forget everything outside.

126
 127 3 I do that, put your uniform on and leave home at home and then deal with what you have to
 128 at work and then go out the door and think "oh I've got to go back to that again".
 129 Compartmentalise is the way to do it.

130
 131 5 I can do that a lot of the time but then, like you were saying, if things are going wrong at
 132 home then that makes it even harder to do that, the high standards and I think we all come to this
 133 job, we chose this sort of work for a reason because we want to give excellent care and I have
 134 been in situations before where I have been in a room with a patient who hasn't opened up before
 135 and you are getting clues that they want to talk and bells are going and I have had to physically
 136 walk away and then to go home and had tears streaming and thinking that was awful you know, I
 137 wanted to stay with that patient but again its time. I think we have all been in that situation, I'm
 138 certainly not alone, it's just being pulled and it's not just one family, often you could be dealing with
 139 three families at one time and you are literally going from one really intense situation to another, to
 140 another and then you've got the doctors rounds or something else.

141
 142 S It's also the emotional demands in different rooms and different areas.

143
 144 4 I have to say if I am seizing a moment like that, I will stay and do that and let the bells ring
 145 unless it's an emergency bell, and hope that they don't go on for too long because you have to
 146 seize the moment sometimes, I think it's really, really important.

147
 148 5 The situation I was thinking of was on the late shift, and two were on their break, and it had
 149 been going on too long, and I couldn't give myself to that person because my mind was thinking,
 150 you know, and they would have picked up on that so it would not have been a good situation, but I
 151 never got that moment back again and of course that stayed with me for a long time and then she
 152 died and it was, you know, it was difficult and I mean personally I tend to, like you say,
 153 compartmentalise things, I tend, I can physically feel like I'm in a shell, like an egg, you know I can
 154 be the most awful situations on the doctors rounds you know you can here young people taking
 155 about their children and what they are doing to do after they die etc and be professional and stand
 156 there and think it's a surreal situation and then occasionally that shell gets a little thin just
 157 depending upon how many shifts you've had and the staffing levels and its all those -

158
 159 S It's that cumulative effect.

160
 161 5 Yes. I did once go to a senior staff member about this because I did have like a, I had
 162 always kept things together but one particular morning the night staff told me that two of my
 163 patients had died and one family was a huge, huge family, spilling out all over the place and
 164 needed lots of time and I just thought "how am I going to cope with everything" and I just broke
 165 down and went to her the following day and explained why I felt like that and it was awful because
 166 she said "is it hormonal", and I said I felt like I'm in a shell, and I was absolutely devastated by that

167 and from that moment I thought I'm not even going to discuss this here because if that's what you
168 think that's really terrible.

169
170 S Obviously you've come across a number of stresses, the practical side, the emotional side,
171 the high standards, the time constraints, the wanting to do X and Y is happening and Z and all of
172 that pressure and I suppose I am wondering if that comes under what Addy has under palliative
173 care perhaps related, but then you are picking up on the organisational mood, the kind of
174 management structure, support wise that you don't have too many organised debriefings, but that
175 its kind of informal but supporting each other but then I am wondering about the organisational
176 pressures or stresses.

177
178 5 That was quite damaging to me, I went and I just thought that if that was a man saying it to
179 me it shouldn't be any different but I was thinking what an awful thing to say and it was actually
180 really insulting.

181
182 4 Did you address that later with that person?

183
184 5 No I didn't.

185
186 4 Would you again? On reflection do you think you could address that.

187
188 5 May be.

189
190 4 Could you have said "can we talk about it another time".

191
192 5 I wish in hindsight, it was just that I wanted to forget this, I wanted to protect myself
193 because I just thought I'm not getting anywhere, I'm not going to open myself up any more if that's,
194 the person seemed very good and was listening and the only one thing she said was that, and I
195 just thought no but at the time I wish I had said "that is so unprofessional, not helpful at all".

196
197 4 But that's still with you.

198
199 5 Yes.

200
201 4 So you still need to deal with it.

202
203 S What are other people's experiences of having to....

204
205 3 I had a very, very stressful time quite recently when we were extremely busy, its was one of
206 those shifts where you couldn't finish off anything, you were going to see a patient and the bell
207 would ring and then the doctor would ask you to do something and the phone was ringing, it was
208 just an horrendous shift, and we had had a death in the morning, which had been sorted and then
209 we had had a very poorly patient who had come in and within an hour they had died, and we didn't
210 know anything about the patient and we were trying to find out more information, we had given
211 them an injection to make him more comfortable and I had taken a phone call from the district
212 nurse to say yes we had received the patient and he was ok at the moment, as I hadn't realised he
213 had died at that point, and took down a lot of history that we didn't have, went in to tell the doctors
214 that we had some more information on the patient and he said "oh he has just died" and I just burst
215 into tears. I was so frustrated that I hadn't had time to go back and check that the injection had
216 worked, he died on his own in a side ward and that was just, for me really horrible, but I have to
217 say that I had total support from everybody around me, I don't think they could see why I was so
218 upset at the time but once I had explained that and I had lots of opportunity to talk about it and tell
219 my managers and I felt very, very supported. I went home obviously still upset, had a glass of
220 wine, but it is part of the job but I just felt I wasn't a good nurse because I hadn't been able to do
221 the job I would have liked to have done because I've got high expectations but, you know, he didn't
222 die in pain and he was comfortable but I would have like to have done it differently. That was hard.

223
224 4 I think that person also was offered a bed the day before and declined it and then the next
225 day he got worse and so maybe if we had had him the day before then nobody would have
226 suffered that.

227
228 S Some things are out of your control aren't they.
229

230 3 Yes they are and it was the straw that you know, if they day hadn't gone like the way it had
231 gone then I would have coped a bit better but in the end it was tears and that was obviously what I
232 needed as an individual, it's silly but hey we've all done it. I did get the right support and I did talk
233 about it, it will stay with me because it was an experience that I guess you might come across
234 again, but frustrating I think more than anything, I was frustrated, but that caused stress.
235

236 2 Can I say something that I think is linked to the high standards, I'm fairly new here and I'm
237 very aware of the extremely high standards and that's quite a lot to come into actually even though
238 you can set that for yourself when you walk into an environment and you are part of it that can be
239 quite daunting and that is wonderful and that is obviously why I have chosen to be here but there is
240 something I have thought about a long time and that is that we do strive for high standards and we
241 do want to get the absolute best for our patients but there is also an element of, this is quite difficult
242 and I don't know how, I've talk to people in the past, but there can be times when I actually really
243 kind of dread to see a patient who is still here because they may have taken quite a long time to
244 die and there is that feeling, which goes against what we as human beings want which is the best
245 and we want to have nice kind thoughts about people so we try and I kind of repress that don't we.
246 Actually it can be very difficult to come in, to all intense and purposes and want that patient to die
247 because you see the family struggling and we ourselves as nurses can struggle and think "oh they
248 are still here".
249

250 3 I have done that, I've work in palliative care many years ago as well when I was in the Air
251 Force and I remember walking through the corridor and I could look up and see some of the
252 windows and I knew that this particular, it was a horrible death it was long and drawn out process
253 the flowers and everything were still up on the window and I knew, I had been off for seven days,
254 and I walked through there and looked up and my heart sank because I knew that patient was still
255 there, still going and feeling awful for feeling those thoughts, you are absolutely right and you do
256 and I tell you where it happens here when you come up the stairs and you see the name on the
257 door, the relatives that are still there and you think how can they still be going and again I admit my
258 heart sometimes sinks.
259

260 2 And how can I face looking after them again.
261

262 4 I think that is the double edged sword because part of that is your own self protection, if I go
263 in today and they have gone I know that I don't have to meet that patient and those relatives again
264 because that's touching my sole and we have to give of ourselves in palliative care and yet you are
265 not supposed to get involved but we are involved because we are very much in their lives.
266

267 2 Absolutely, I appreciate that but what I would say is that it is quite difficult to acknowledge
268 isn't it that we kind of.
269

270 3 I would never have said that to anybody, I would never have said "oh gosh you still here"
271 but you are right, you think it – like this morning. (laughter).
272

273 6 And to the most difficult patients when the anxiety and stress levels start going up and there
274 is a lot of, you can just sense it when we get a lot of MMD patients in here because they are in
275 here for a long length of time and they are demanding in so many different ways and their families
276 are and you know why and you think yes I understand all that but when you've had them you can
277 just tense, everybody is just, and then you get comments coming backwards and forwards and
278 mixed messages, mixed communication, and I would probably say that most patients with MMD

279 have resulted in a lot of anger, frustration, letters going backwards and forwards, complaints being
 280 put in and it's never ever been addressed yet. We were supposed to have addressed it last time
 281 but it didn't happen and it will happen again because there is no plan put in place, there is no
 282 opportunity to just go through it all and everybody be honest and open about how difficult it has
 283 been and I think that, it's always just head in the sand, its over, they've gone, thank God for that,
 284 lets just get on with it, it happens every time they come in.
 285
 286 7 Until the next time.
 287
 288 6 And it does happen and then it's worse as it brings up the bad feelings of what happened
 289 before because its all just there under the surface.
 290
 291 4 I offered to do a debrief on the last one and was happy to do that and facilitate it, but it
 292 appears that we were too busy at the time with everything that was going on and then it's fallen by
 293 the wayside, but that opportunity is still there, I am MMD the link nurse. But I see them at home
 294 and its just as bad at home as it is here (laughter).
 295
 296 Its already built up before they have come in.
 297
 298 S Again it sounds like there was some emotional difficulty there you know or that kind of not
 299 having a plan and all those difficult things and then offering debriefing but yet going back to the
 300 there's no time, so again is that, do you feel that there is more organisationally or management-
 301 wise they could do more to support you in some of the stresses that have come up already or do
 302 they put more.
 303
 304 4 The difficulty with these sorts of patients it is horrendous also we don't always recognise
 305 the cognitive changes, because they get frontal lobe changes, and usually by the time they come
 306 in here and we are getting lots of this bizarre behaviour and then over protective behaviour by their
 307 nearest and dearest we are then beginning to say "I think there are frontal lobe changes here" and
 308 its kind of too late, we try and look for it and we try and talk about it but we do get blanked by the
 309 patients and when they come in here 90% of them are in their end stage and there is guilt from the
 310 relatives because they wanted to keep them at home, they couldn't do it but we've got to do it a
 311 damned sight better and I'm quite open as the link nurse and say we won't always get it right, we
 312 can only do the best we can do and that won't necessarily meet up to what you want but it doesn't
 313 stop them banging on the door, it doesn't stop them demanding and the stress levels do go very,
 314 very high and the difficulty with them is in the daytime they may take two hours to get up, washed,
 315 dressed and done and there are six of us, at night there is four of them and that takes two people
 316 almost as long sometimes to put them to bed and just when you have got them to bed there is
 317 more of a problem and so it builds and builds and goes from shift to shift and they are an incredibly
 318 difficult section of patients to look after and it is recognised but it doesn't make it any easier and
 319 yes we should do some more debriefs but I don't think we are going to change those patients
 320 because that is how they are with that disease, we have got to get better at handling it and helping
 321 each other to handle it I think is the base line.
 322
 323 S Again it's going back to the standards and those standards would apply to all of those
 324 patients as it sounds as a number of people have mentioned those standards come very much
 325 inherently from yourselves wanting to, you come into this job because of what you want to give to
 326 palliative care and giving the excellent care and things like that that you have all said, and I am just
 327 wondering as well are the standards also coming from above about what you do or are these
 328 standards mainly coming from within you guys?
 329
 330 7 I think there is probably an expected standard of care and, I well, it's probably hard for me
 331 to say to any senior members of staff, but I certainly wouldn't say that I don't think anybody isn't
 332 absolutely trying their best and I think its recognised that the senior members of staff do know what
 333 it is like because I actually work on the ward which I feel is an important place for me to be so I
 334 know that people are trying to do their best so I'm kind of in the same situation as them as well so I

335 don't, myself, feel under pressure, in fact I've been advised by a doctor that sometimes you have
 336 given yourself too high standards and sometimes you might have to accept instead of being here
 337 all the time you sometimes they might not be here which is fine but I've got to get there, you know,
 338 I mean if we are really busy I say you don't have to do wash people from head to foot every day
 339 but so long as they are comfortable, they are not in any pain they are not distressed we don't have
 340 to polish them every day, we do that because we want to do something for them, but obviously
 341 there is a lot more like I said and sometimes you have just got to be there and seize the moment
 342 and I can remember going back 10 years when I was on nights a patient wanted to speak to me
 343 and I was just about to sit and talk to him the emergency bell went, I left him, I went back and he
 344 said its too late now and that was 10 years ago and I can still remember that happening. I'm sure
 345 the patient died but I can remember I just felt I sank because I felt I had let him down but you were
 346 running to a bell and I have said to myself well that happens and it will happen again and keep on
 347 happening and I know I'm doing my best.

348
 349 3 You did your best at that time and that is what we have to remember sometimes
 350

351 7 And like you say I go home and I deal with home and I come to work and I deal with work
 352 and I think I have got quite a good switch, I do go home sometimes and worry and I will always go
 353 home, I'll go home tonight from the late shift and ring up because I will forget to say something and
 354 once I have made that phone call I'm fine I've said it now.
 355

356 3 And isn't that quite like a debrief on the way home because I do that and I think oh I've got
 357 to sort that out, you don't sit there all evening and worry about it, once you have decided that you
 358 need to ring back and say something it is just like a little debrief. It's like running a tape back about
 359 the shift
 360

361 4 Some of this is also about change though, and the change of management and how we
 362 manage the change within the hospice, without team or within ourselves because palliative care is
 363 changing, I've only been here seven years and its changed, you've been here a damn sight longer
 364 and we don't get time to keep up with that change sometimes in that way, that new philosophy of
 365 care and how it is moving and changing in that here in the hospice in the years that its been here
 366 all the tic, all the massage, all the sitting down and talking, all the taking the families to a room, our
 367 pace is different and we have been very luck to have it within palliative care until say within the last
 368 five years the way the NHS has changed and the way the care has changed as a result and we've
 369 got to change our mindset to that but our patients and the patients in Northamptonshire, Cynthia
 370 Spencer is, is, is, is, is also part of the standards and so we have an educational role about that as
 371 well to say this is what we can do, it may not be the best, but it's the best it's going to get but if that
 372 is better than you have had at home that has got to be your starting point and we kind of have to
 373 tell ourselves that as well, I think and remember that, and sometimes the management of change
 374 is too fast, "from today we are going to do" as apposed to the "the begging of next month" and why.
 375 There have been some changes with CD's and stuff now that's seems so petty, the post "Shipman"
 376 there's a reason for them but when you are told "well that's just the way we are going to do it" "well
 377 this is the reason" or, I don't know, I'm the sort of personality who that has to know why in order to
 378 get my head right to say "okay I may not like it, its stupid but the rationale is" its this stupid idiot
 379 Shipman who if he was still alive I would like to punch in the head but in actual fact he has already
 380 done away with himself because he has made our lives so difficult and its difficult enough and
 381 those niggledy piggledy stresses probably annoy me more than what I have to do with my patients
 382 than what we have to do here as a team because they just seem so frivolous compared to what we
 383 do.
 384

385 6 It's communication.

386
 387 S From the top down, from the kind of higher up, policy changes that are being implemented.
 388

389 6 If you know why or are given the opportunity to ask why and you get an answer for it but its
 390 just when its not communicated properly so you just get half of it, and because I don't work full time

391 so I can probably go five days without being here and something has changed when I get back and
 392 I don't know why or I might find a piece of paper just stuck high up somewhere which I probably
 393 wouldn't see unless I just stood there, and nobody else can tell you why because there were big
 394 changes when our consultant started and that raised a lot of stress levels because people were
 395 unaware of why he was making those changes, why machines were different and I think if you
 396 know you may not agree with them but I just think it would help with the change process.
 397

398 S You can see where someone is coming from or see what they are trying to get to.
 399

400 6 Yes, it's the rationale behind it.
 401

402 S And perhaps if you have the opportunity if you don't agree with it to say something?
 403

404 6 I'm quite happy to say what I think, yes, some people are not for various reasons and you
 405 have to accept that and there are those people who can ask or put themselves forward in an
 406 awkward or difficult situations to find out why, others will not and they will be the one who will find
 407 change very, very difficult and resistant to change. Change is upsetting for everybody but some
 408 can embrace it, some can resist it, it just depends what you chose to do with it.
 409

410 4 It depends what the change is.
 411

412 6 Yes and for what reason, is it for the right reason.
 413

414 4 The consultant is always happy to be questioned, likes to be questioned, but the consultant
 415 is not available to the night staff nor available to any of us 24/7 and the consultant now, being very
 416 different to the other consultant, has got so many constraints upon her as well that the same thing
 417 happens to her as happens to us. It just seems that within health service now you know that the
 418 consultant management, the matron management have things pushed down from them and in
 419 order for them to deal with the next thing they have got to deal with they are pushing it down to us
 420 (clicking of fingers) with no great explanation or no time to say can we sit down and can talk about
 421 this, can we discuss about it, can we discuss it and draw up some ways of going about it.
 422

423 S So you feel it's a one way conversation, there isn't a two way communication about it, its
 424 passed down but there is little opportunity to question, its that kind of being told that these changes
 425 are happening and there isn't much follow on by which you can.
 426

427 3 I think that is evident with what I was told that we were going to keep the hospice full all the
 428 bed would be full because that was from above, that was the way it was going to be and I mean
 429 when I first started here we weren't always full and that was nice because we had a couple of
 430 empty beds and shifts were a bit easier and that sort of thing but a few weeks ago it seemed that
 431 as soon as a patient went home we were filling the beds up again and it was like we hadn't got
 432 time to really catch you breath before the next lot are in and that's from above and I don't think
 433 anyone has questioned that it was "well this is the way its going to be" who would you question.
 434

435 S It sounds as if that creates a bit of stress as well.
 436

437 4 We would all want to keep the hospital beds full but also tied in with that we were incredibly
 438 short staffed even the director/manager was saying "I'm oh so grateful for everything you have
 439 done, you know its been really, really difficult days and nights" there were four or five of us on a
 440 shift you know and three turning up when you were used to like 7, 4, 4 and we would be going on
 441 sometimes 4, 3, 3 but it didn't make in any easier because it went on all throughout the summer
 442 just as you think its getting its better off you go again and then we have to keep the beds open
 443 whatever the staffing is and that's is difficult because then you can't maintain your standards, then
 444 you can't maintain what you want to do and then your stress levels rise as well as physically having
 445 to do more because there are less of you and that's, that's the build up.
 446

447 7 The reason I was given why the beds had to be kept filled was because of the management
 448 structure up there had changed and trying from my point of view to try and be spokesperson for the
 449 staff because I know how everyone is feeling because I feel like it myself, believe me, and "it's the
 450 beds have got to stay full" because its payments by results and we will lose the service and I said
 451 is there any leeway and I was told no and that was the bottom line. (lots of chat). I came out of the
 452 meeting feeling and I thought you know although you can ask all you like its, this is the way it is
 453 that's it. I almost felt like well you can like it or not.
 454

455 4 But then there are less of you then mistakes happen and then you are taken to the
 456 cleaners, it doesn't make any difference whether there is a mistake when there is two of you on
 457 duty or four of you on duty, you do exactly the same job, the consequences are the same for you
 458 as an individual and same stress levels.
 459

460 S So those pressures or the standards don't come not only from inside of you but all of those
 461 things to meet as well and perhaps knowing the consequences. My next question will be, it has
 462 come up a little bit as we've gone along, but how do you guys cope or manage on a personal or
 463 professional basis, there has been mention of debriefs but perhaps not so often as you would like
 464 because of time, there's the kind of informal chatting or offloading to other people but knowing as
 465 well that that can have its emotionally pressures if that person is more vulnerable than you might
 466 like a staff member to be.
 467

468 4 Look at us we are all fat and grey (laughter - lots). Chocolate.
 469

470 Lots of chat
 471

472 5 When I've, I think coming from, because I've only been qualified a year and before that I
 473 was a qualified counsellor and I counselled children for five years now, I thought that was fairly
 474 stressful and I coped fairly well because I had supervision every week which was fantastic and
 475 then I came into this environment and found it very, very difficult, I've never known such a stressful
 476 job and I think it was because I was so self-aware, now whether that's a natural thing through
 477 training in the past, that I found it very difficult that we didn't have any supervision or debriefing and
 478 just left out there on your own and people would snatch quick debriefings in the treatment room as
 479 you were squeezing by the dryer and
 480

481 4 Bastard, bastard, bastard (laughter)
 482

483 5 And that was quite bizarre and so I personally have clinical supervision, mind you I have
 484 only had two session because we are so busy, because it is meant to be protected time you know
 485 you can come off the ward and have your clinical supervision, but I've cancelled about seven
 486 sessions with my clinical supervisor because you just cannot get off the ward and one particular
 487 time I went I said look I am going to my clinical supervision, I've got to go, and when I came back,
 488 everyone was lovely and the staff here very supportive, but you know I came back and they said
 489 "oh have you had your little de-stressing session" and I was like well it wasn't really like that but it
 490 was really constructive and I found it helped and I'm a great advocate for it and I will say to people
 491 when they are talking in the treatment area "you know you've got clinical supervision, you've got to
 492 go for it, even though I have only had two sessions (!), but I found that very, very helpful.
 493

494 S So are you all entitled to that.
 495

496 Yes and encouraged.
 497

498 S But its not mandatory.
 499

500 No, its not mandatory but its...
 501

502 2 Historically in nursing it tends to be after an event instead of an on-going thing so people
 503 tends to do it, would you agree, that my experience.
 504

505 4 Hysterically rather than historically. (laughter)
 506

507 3 I don't know about clinical supervision because I'm and old nurse who has come back into it
 508 after 16 years and I'm sitting here thinking what is clinical supervision but didn't like to ask in case
 509 everyone thought I was a bit thick.
 510

511 6 I'll explain it, I have supervision every six weeks because it's important, either in a group or
 512 individually, it's up to you.
 513

514 3 Okay, who with?
 515

516 6 With senior management.
 517

518 4 Therapy for the therapist.
 519

520 7 There's a list of supervisors.
 521

522 3 Okay.
 523

524 S Okay, it sounds as if that's something that might be useful, but the next question, because I
 525 am aware of the time, is what would be helpful to help reduce those levels of stress? Obviously
 526 there might be, like you, and the chances are, if you are wondering what is clinical supervision
 527 there are probably other people in the building that are probably asking the exact same question if
 528 it was mentioned and how to access it so I suppose one to the things might be about making
 529 people more aware of what support/structures are available. It sounds like there are people who
 530 find that helpful and perhaps find the debriefing helpful.
 531

532 6 You do but it's making time.
 533

534 5 There were teaching sessions explaining about it and again it's an individual thing, you
 535 have got to be proactive and find out about it yourself and I think its really, really important but I
 536 think its easier for you doing nights to come in earlier.
 537

538 I come in earlier before I go to work, that's when P is willing to do it for me.
 539

540 5 Were as I would, well okay, I suppose I could come in specifically for it but I live quite a long
 541 way away and my supervisor said "no it's protected time" and she gets annoyed when I cancel it
 542 but she doesn't understand that I've got to hand over and we got the time etc, etc and it is
 543 frustrating but it is important to sort it.
 544

545 S It sounds like having that more protected, but also having, I suppose it sounds like when
 546 you went back on the ward the kind of understanding of where you were wasn't quite where you
 547 thought you were.
 548

549 5 I felt a little bit of, because I was walking away from quite a busy situation, I felt guilty.
 550

551 4 I was just going to say that, was that your perception or the perception of the people where
 552 were on the ward as well.
 553

554 5 Probably a little bit of both. I did feel a little bit of like "oh, I'm going to clinical supervision"
 555 and then you get a comment, but it wasn't done in a malicious way it was "oh do you feel more de-
 556 stressed" and I just said "well I'm very pleased I went" and it was true I was very pleased I went

557 and they were fine and no one was scathing but I felt a little bit of guilt for going and maybe a little
 558 sense of "oh for God's sake we've got things to write" and etc, etc but sometimes you've just got to.
 559
 560 4 Philosophy of the workplace to encompass the ...
 561
 562 Absolutely
 563
 564 S There are people who acknowledge the need to take care of themselves and do something
 565 about it and perhaps other people who struggle with that acknowledgement and other people who
 566 don't quite see the role of taking care of yourself and in that perhaps putting clinical supervision, so
 567 perhaps there are different people for different things. There's the driving home and the de-briefing
 568 and calling up and passing on information and somebody mentioned a glass of wine.
 569
 570 3 Me. A glass of wine (lot of chat)
 571
 572 AA meetings. (laughter)
 573
 574 6 You've got to be able to laugh (lots of agreement) and that is even in the worse situation
 575 when someone has just died or whatever – warped sense of humour or whatever.
 576
 577 7 I just think like she was saying that she couldn't spare the time to go and sort of look after
 578 herself and I think having that time will come with experience because I know that I could stop here
 579 until 10.00pm at night and there would still be loads to do and I always try to say to people that its
 580 24 hour care that we give and if you don't finish it you must hand it over and its alright to say when
 581 you hand over well I haven't finished this admission, I haven't finished this discharge and I'm
 582 handing it to you now and its alright, its acceptable, its alright to do it.
 583
 584 3 That is said and it's never once, well in my experience, never once has anyone "tut, no time
 585 for that". No somebody actually said to me the other day well it's 24 hours and you must pass it
 586 on.
 587
 588 7 Well it's taken me a lot of years to get to that, a long time to think "I haven't done it but the
 589 late shift are coming on and I've worked right up really hard and I couldn't have got that job in so I
 590 shall have to hand it on".
 591
 592 4 It's also personalities about that because if you are the sort of personality that can hand it
 593 over, I am a finisher and I get berated for being here after 3.00pm but if I stay for another 20
 594 minutes and I get that done and I get it finished then I am not stressed but I get stressed if people
 595 keep saying "are you going, are you going, are you done, are you handing it over" you are three
 596 quarters through a continuing health funding form and its not that easy to hand some things over
 597 but then also I'm conscious that if I am here doing it I'm not trusting that they can do it, it's just
 598 easier and quicker for me to do it and my stress on that is I want to go and I want to do it if they
 599 shut up and just leave me to it I'll be an awful lot better and "oh my God are they thinking that they
 600 can do it just as well as me and for crying out loud just get out the building" but now I just think well
 601 you tell me if that's the case and that it.
 602
 603 3 Isn't that funny that's your perception because I never think that about you I always think
 604 exactly what you said that you want to get that done and that's you doing that I would never say to
 605 you "are you going home" because you would say "look I've really got to go, I'm going to have to
 606 leave that" that's my perception of you.
 607
 608 4 But that is your personality, S will say and joke, one of my managers used to continually tell
 609 me that because she wanted to protect me, she now understands more that I have to do that, the
 610 Myers Briggs Personality Awareness here was very, very useful.
 611
 612 S Was that a workshop or something.

613

614

Yes, perhaps we should have another one.

615

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4 Above to below, below to above, you know, top up, bottom down and I think everyone should have the opportunity to do it and we should do another one because it really brings out a awful lot of this stuff and is very, very useful. I embrace the philosophy of clinical supervision but I don't have it within the Trust, I wouldn't have it within this building as I don't trust the confidentiality of a lot of people within the NHS within that because I have trouble with issues longstanding because of incidents but I feel I am not doing right by myself or the organisation by not having supervision but there are other ways to de-stress and its not a bottle of wine, I don't drink do I.

6 I do it by cycling home and I get there really fast. (lots of chat).

4 You used to kick lamp posts so it's a lot better isn't it because your feet are not so sore now. (laughter)

7 I go to a gym, well I haven't been for ages, but there is a punch bag and I was really going at it and in the end I punched this punch bag into the wall and I was like. I felt great afterwards.

4 I spoke about having a punch bag in here actually.

S I was thinking that are there things, apart from that workshop that you mentioned, there is I suppose raising the awareness of what support is available, is there other things you think that could be done to help with stress levels or work pressures.

6 I think it's just encouraging people to talk and I think sometimes you can hear somebody else being honest that they don't like patients and they get really angry with them, and I don't like them and then other people think "oh so it's alright then" you know its just being honest really.

2 Because there is that, from all the relatives, that we are all angles and we are fantastic and if you kind of slip from that and think "actually I don't like some of my patients" you know what I mean, that's just being human.

6 Yes you are all in the treatment room and you say "oh not that bugger again", but you wouldn't say it.

2 I think it's the acknowledgement of that, that we are all human and I certainly noticed it coming from a very different environment and its just perfect here and that's what the relatives think, that's how everybody sees it you know.

7 Because I sometimes actually want to say I'm really, really sorry you are in this situation but I haven't done it to you, you know, and they are like well is it happening like that, why isn't that done, why can't you make them better and you get so frustrated and I'll be honest and say I haven't given you cancer and sometimes that has gone through my mind because I'm there doing my best and especially sometimes as people can be very rude to us, very rude.

4 But then you have to say "I'm not here to be spoken to like that"

7 I do.

4 I said to a newly diagnosed MMD patient on Tuesday whose daughter wanted me to see him, she didn't need me to see her actually, but you know I was talking about all sorts of things and how she had had her diagnosis and I just said "I'm really sorry this is happening to you, and I'm very sorry I can't cure it, all we can do is help you on your journey through this disease", and "thank you very much for coming" and the bottom line was that was all I said.

669 S It sounds like those sorts of angry, rude patients and their relatives are the ones.
670
671 6 I think listening to those who have just started here because if we have been here too long
672 we have got used to the system, you don't actually see things that could easily be changed to
673 make things better for you because you just carry on don't you and I think it's really important for
674 people just starting here are listened to because they see things through fresh eyes and we have
675 been doing so many years and I think that is really important.
676
677 2 I was going say actually because I know that over the last few weeks there have been a
678 problem with beds and not having enough staff but when you are in a different environment and
679 you can see that it looks like there is only seven patients but when you are here and there are
680 seven patients it's incredibly difficult it can be physically very demanding which I don't think people
681 realise how much you work here, I've certainly discovered, that but when you are stuck in the
682 General or the community and you think (whisper), and there are people there whom have been
683 waiting quite a long time who can be kind of saved by the hospice, there is that kind of feeling of
684 we'll get rescued. I'm coming at it from a very different kind of angle and actually I must say since
685 I've been here, going home I actually feel so its um feels like a real luxury for me to go home and
686 not worry because I just know all the patients will be looked after so well and that's a real luxury to
687 me to actually feel that because the care is so good, the nurses are excellent, and everything is
688 done to such a high standard for the patients – I know I'm saying high standard again but its really
689 important.
690
691 S But also brings back about your 24 hour thing that you can go home and the care will
692 continue.
693
694 2 I you still think oh I didn't do this or I didn't do that but as nurses we think like that but its
695 very contained here, that's how I certainly feel.
696
697 4 I do sometimes tell myself that as busy as it is or however bad it is here it can be a hell of a
698 lot worse on the medical words at NGH or KGH when people are dying in a corner bed.
699
700 2 Absolutely.
701
702 S It's kind of relative because other things that have come up is kind of telling yourself
703 statements like "I might not have done X, Y, Z but I have done A, B, C and D, E" and there is that
704 kind of self kind of telling yourself that you do actually do your best.
705
706 4 But there is an expectation that you will do A, B, C, D, E, F, G, and H and A, B, C, D, E, F
707 and G by the management G, H, I, J, by the patients relatives and in actual fact A, B and C was all
708 they had before they came here and that's the thought I think we have to hang on to as well as put
709 our own house in order, every time just centre on that.
710
711 7 Well I was on shift a few weeks ago and they were all trained staff it was a very busy shift
712 and the menus didn't get done (laughter) and four days later I was told and I said "all I can say is
713 I'm so sorry that the menus didn't get done, I forgot about them" I thought I didn't forget to do them
714 on purpose in fact I just forgot to do them because I had got an admission, someone had died and
715 it just went out of my head because as qualified members of staff we don't tend to do the menus
716 and I was pulled up for it and I apologised and I thought well.
717
718 4 There was something this week as well that a member of the domestic staff had
719 inadvertently gone into a room where a patient had died and didn't know they had died and was
720 doing the flowers, doing the dusting and doing whatever and then a notice appeared, it happened
721 with the night staff at about 6.00 in the morning, we took over, they went in and then this notice
722 appeared and I said I don't know what that notice mean it said "if a patient dies or something can
723 you put a notice in the kitchen", and I'm thinking "what!" "if you are the co-ordinator" well I will do
724 but if I'm the co-ordinator I haven't a clue why, they are going to come to me and say why have you

725 put this notice in the kitchen, so that looks like a communication thing but there was a knee-jerk
 726 reaction and the bottom line is how long has person A worked in this building and how often has
 727 that happened to him or her.
 728

729 7 I was just going to say that, its doesn't happen all the time.
 730

731 4 Just once, I'm really sorry because we do try very hard, sorry that happed to you but glad
 732 you brought it to our attention, we will try and do it better, but you don't have to change the bloody
 733 system because it was alright before that – that's what it was.
 734

735 S You wanted to say something.
 736

737 2 I think some of the things that have been flagged up and as a new member of staff I kind of
 738 feel that it does feel, I did feel that I can't put that in the wrong bin, (lots of chat), you know this is
 739 the way its done and that is not a criticism at all but you've got to do it this way, there's a notice for
 740 that and I really found the first week and I'm an experienced nurse, but I was like (lots of chat).
 741

742 3 Somebody will tell you and I'm mentioning no names. (lots of chat and laughter). But I was
 743 saying that I had been out for so long that when I came back it was one of the hardest things for
 744 me, not the nursing, but getting the right things in the right bin.
 745

746 7 I've even taken something out of a bin because I had put it in the wrong one.
 747

748 4 I've put a CD in the bin. (laughter)
 749

750 2 Its another stress to worry about isn't it and actually it's quite, it not petty in some respect
 751 but there are more things in the scheme of things.
 752

753 In the bigger picture.
 754

755 4 Like an under culture isn't it of standards for...
 756

757 S Rules and regulations and standards.
 758

759 4 Trying to maintain the old standards in the new hospice, I don't mean building but in the
 760 new world in the year 2007 as apposed to the year 1966 is incredibly difficult and some things
 761 have to give and we kind of think they are the things that really ought to give but you can get your
 762 knuckles rapt for that and sometimes you think "boo hoo" and sometimes you think "sod it".
 763

764 2 I was a student here 12 years ago and it's quite interesting for me to come back and see
 765 you know.
 766

767 7 I bet you've seen a big change.
 768

769 2 Yes I can see a lot of changes but I think, I mean everybody knows whose been working
 770 with me over the past few weeks, I think its such a privilege to work here because we are able to
 771 do you know, I'm going to say.....because we keep doing it, you know I've only been here a few
 772 weeks but it keeps coming up.
 773

774 6 Its giving the care that you would want for your relative, your father and its just the basic
 775 thing, they are fed, they are cared for, there is someone there, its just basic forget about the high
 776 tech stuff its just the basic being there with them.
 777

778 2 But I've been in situations where that's not the case.
 779

780 3 I think it's a privilege to work here too that's how I feel and I've been here about 18 months
781 all in all, sounds a long time now, and I've noticed a change since I started but I feel it's a privilege
782 to work here having worked, having been out for such a long time and I think that's really good that
783 you are new coming in and feeling like that because that brings a breath of fresh air into the place
784 which is good.
785
786 2 Conversely it makes me feel really quite guilty about the other patients who are not getting
787 care.
788
789 Yes, yes you start to think about them.
790
791 2 But they are the patients who are waiting to come in when we are really busy and there
792 aren't enough beds.
793
794 4 The flip side of that is, we in the hospice aren't the angels, and are very good at what we do
795 and forgetting our colleagues are doing their best they can in the situations that they are in as well
796 and I am no different to any of my colleagues down at NGH who have not got that patient for 24
797 hours or 12 hours or whatever because they must be going home so stressed because they
798 haven't done this or that and that's why it's a privilege to work here.
799
800 2 I don't know how some of the nurses who are in an acute Trust can actually muster up the
801 energy to come back the next day.
802
803 Absolutely
804
805 6 They get nothing but criticism from the relatives and patients. We don't get criticism very
806 often and when we do you remember.
807
808 4 And when we do get criticism I think we take it so to heart because we are so much about
809 making this dying experience a good death and it's the good death bad death and we are making it
810 as good as we can, but when is a death good.
811
812 2 Who's it good for?
813
814 6 The thing is you can't repeat it can you, that's it its gone, you've got one chance and
815 somebody is left with those memories whether they be good, bad or indifferent.
816
817 4 And you responsible for that.
818
819 S It sounds as if you are left with memories as well.
820
821 Yes, and you can't change them.
822
823 S I am aware that we are coming up to an hour so thank you very much for staying a bit extra,
824 is there any burning things that people haven't said that they really wanted to come to say I just
825 wanted to make sure there was a last kind of..
826
827 4 This is what we need more of (all in agreement). When I looked at these, I wrote a few
828 notes down, and I haven't looked at them since purposely, but inconsistencies is one of them and I
829 think that is down to the medical staff situation where "this patient will go to a nursing home, no
830 they wont, or yes they will stay and we will do this and no they wont do that" and even
831 inconsistencies when we have new medical staff and I'm thinking of the problems we had with the
832 head and neck we knew where we were going, we knew what medication we were giving, we knew
833 the PRNs and then suddenly it changed and the patients suffered and I suffered and the family
834 suffered and some of those inconsistencies where ever they occur, that particularly was medical
835 but again with admissions and discharges, how we are working, how the beds are full,

836 inconsistencies do, I was going to say annoy me rather than stress me, but I find them difficult, you
 837 don't know where you are going just when you think you know where you are going it changes.
 838

839 S Thank you for that, is there anything else you've got down. I just want to make sure people
 840 don't walk away thinking oh I wish I had said that, it might happen anyway.
 841

842 3 Can I just say that it's not a whole bottle of wine you know when I go home (laughter). Well
 843 not every day.
 844

845 4 The manager is taking notes! (laughter)
 846

847 7 Just very quickly, when, I've probably said this before, we've got lots of new staff and we
 848 really hope they are going to stay because there has been a time when we've had new staff come
 849 in and they have left and you are thinking "oh my God why aren't people staying" and I have this
 850 conversation before, but what happens when all of us oldies retire and people haven't stayed, do
 851 you know what I mean, that experience might be gone, because quite honestly its like when you
 852 are ill yourself you want to be looked after in a place like this.
 853

854 4 I think of all that bloody hard work I've invested in that person and now they have sodded
 855 off. (laughter)
 856

857 7 Its trying to retain staff and find out why they are leaving is it because they feel
 858 unsupported.
 859

860 S Its not only looking after the patients and their families but also wanting to try and recruit
 861 key/good staff.
 862

863 3 I would also like to say that I think it does depends very much on the individual as well, I
 864 think that all of us here are very open and able to talk and we can discuss what's gone on and talk
 865 about it amongst ourselves and help is there is what I am trying to say, you can go into the office,
 866 you can say "this has happened", its down to individuals or there might be something that, like you
 867 were saying, you don't feel comfortable to open up and then they go home stressed, so its about
 868 your personality and that you can't change I suppose, I'm a big talker I will tell anybody anything if
 869 they will listen so for me that's good but it might not be everybody's strategies.
 870

871 7 I must go, I'm on the lates.
 872

873 Lots of laugher and chat.
 874

875 5 I must say that when I first started here I was here as a student for five months and then got
 876 promoted to staff nurse and literally went straight into it and people were forgetting that it was a
 877 new totally role and I didn't feel happy, wasn't happy and it came down as like you said, we had
 878 new staff started at the same time as me and they have all gone and I'm the only one left and it
 879 came down to feeling unsupported, if the truth be known, and I had to go into the matron's office
 880 when I had my little break down on that particular morning when I was so upset and I said to her "I
 881 feel totally undervalued, you have never ever had me in the office to see how I'm getting on" I
 882 mean that to me is just terrible I mean you know not to say, not just to me because I was new but
 883 everybody should be asked how they are getting on, is there any training bla-de-bla. I've just done
 884 my IV training after going on and on about it and these things just make you feel undervalued.
 885

886 S Its the kind of checking up rather than the once a year appraisal.
 887

888 5 Yes and I had to ask for that and I still haven't had that, you know things like that and its
 889 just all these little things made me feel undervalued and I'll admit that I'm still looking, I still look on
 890 the Intranet for other jobs as much as you know its all this again the high standard of care the type
 891 of personalities we are and I put myself under that stress because of the type of personality I am

892 and I want to do my best and I feel I can't always do that and you know we are great as a team, but
 893 from up above we should be getting more support.
 894

895 3 I would like to think and say that was just a phase and it shouldn't go on like that because
 896 its such a shame I think having observed the time, because I was here about the same time and
 897 knowing what was going on, you see I'm a bank nurse so I'm not actually on the staff and I see it
 898 from an outsiders point of view as well, but I think its probably more to do with staffing levels than
 899 and you were thrown in at the deep end, you know a newly qualified member of staff that shouldn't
 900 really have happened.
 901

902 4 I mean it's a hell of a transition anyway, its really difficult and you expect a lot of yourself
 903 but there has also been a great deal of difficulty with the reconfiguration with the PCTs and the way
 904 the NHS is and for getting onto catheter courses and IV courses and the stress it puts on us, I was
 905 doing the doctors round one Monday with a student and there was catheterisation that needed
 906 doing and blood that needed to go up and nobody else in the building could do any of those and
 907 then the blood fridge wouldn't work and I had to deal with all of those things and I just had to
 908 prioritise but the thing is the training.
 909

910 5 All I got was its going to cost £75, now in my mind I said "well if you are quite happy for me
 911 to be on the ward and not be able to function properly as a staff nurse well that's fine" and actually
 912 its not my issues that its costing £75 and it's the fact that she thought I was going to move on and
 913 somebody else would benefit and I said "no because if I move on somebody else, without any
 914 questions, will send me on that course". Well things are a bit better but I have had to make a lot of
 915 noise which is not really in my personality I have found it very difficult to go into the office
 916 especially with someone who is not overly approachable in my mind so I'm not, I find that very
 917 difficult to do so I will let things dwell and fester a little bit and then it will get too much.
 918

919 6 The training budget of £1500 for the whole year for the whole unit is just ridiculous and you
 920 want to upgrade your skills and stuff like that.
 921

922 3 Of course you do, otherwise it causes more stress if you are on a shift and can't do it and
 923 there is only one person that can do it well that causes so much stress during that shift doesn't it.
 924

925 4 And then I don't go off on time.
 926

927 2 Have you seen the notice about being de-skilled, you gain skills in other ways.
 928

929 5 We are worried about being de-skilled but also okay I've done the IV training but actually it
 930 wasn't appropriate for here, and I didn't get out of it what I expected to as in clinical skills and then I
 931 had to get signed off three times and I've only been signed off once so I'm still not and actually I
 932 feel quite nervous now as I am not au fait with the Baxter Pump because I haven't had the change
 933 to do it properly and I just want to get on with it and feel confident and I wouldn't do something if I
 934 didn't feel confident and I'm worried I will be put in that situation that I have to do it without having
 935 the proper teaching.
 936

937 S The sort of mentoring after the initial course.
 938

939 5 Because the course wasn't about clinical skills it was stuff about infection and you know if
 940 you see a canular is bloody change the dressing and I'm sat there thinking "lets get down to the
 941 nitty gritty".
 942

943 4 There are two things there aren't there, there is how the lack of budget and lack of training
 944 is deal with and the budget and lack of training that is available, there are two things and if one is a
 945 bit better the other is a bit easier to take from where I stand, mine is a bit easier to take because
 946 the back lash on many a shift will fall on me as well as other people not just me, but there are two
 947 separate elements to that isn't there I think.

948
949 S Thank you all for coming.
950
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952
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961

Appendix 22: Codes for Focus Group 1

Codes focus group 1, Hospice 2

a pleasant environment a two way conversation a wage at the end of the week able to discuss things able to speak to team members AfC agitated all staff feel happy. always get through it angry patients angry patients and relatives being aware of each other's triggers being paid by results being trained better than working in general hospital big changes build a relationship building a relationship brings problems calm atmosphere can't handle end of life stuff can't prepare for it can't change things catch you unawares sometimes. causes problems change not for quality improvement change to cover their backs changed attitude changes not thought through changing for change sake chose to come into palliative care commitment complaints are difficult to come to terms with complaints change your perspective concerns about speaking to some people conflict about how much to commit conflicting messages re smoking constant change courses to cover their backs covering their backs	debrief debriefing sessions decisions made are remote from unit different roles have different levels of involvement difficult for doctors to withdraw doctors get training in therapeutic relationships doesn't feel like work don't always get time back don't care don't feel able to speak to some people don't feel appreciated don't feel considered don't feel valued by the management structure don't understand the practical consequences don't care about the person emotion catches you out emotional demands by relatives everyone is treated the same expectation on myself extra equipment feel able to speak to the manager feel valued by the team feeling ok about saying "no" feeling powerless feeling sorry feeling vulnerable to patients/relatives behaviour felt uncomfortable frustratingly long time for decisions generally not stressed give some of yourself given bad news going around in circles going the extra mile harmful hassle. high expectations
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hits home. hotel service how far do you go to please others how to manage your feelings I'm not being paid for it identifying with certain patients impact of complaints on others impacts across the team in past more positive feedback inconsistency individual coping strategies individual differences in coping industry Information overload. is nothing sacred. It's very sad its all structure Its having/wanting to do every.. Its on going just get someone else in knowing what you are supposed to say known each other for years lack of time to do supervision Laughter as coping strategy less commitment let patient down letting yourself down looking after patients is main aim looking out for each other lost a voice. lots of other tasks management is the problem more rewarded in industry my own expectations need a little recognition need for flexibility new management style new NHS- you are just a number NHS causes stress NHS requirements not professional body no emotional burden no hope for change no problem to work in no stress free zone no stress from patients	no support no time for clinical learning no training in emotional distancing not learning from the past not appreciated not as much emotionally affected not as much end of life stuff not aware not enough staff to cover not feeling safe to speak my mind not feeling supported not felt threatened here not hierarchical not scientific not thought through not used to angry people not valued as people nothing formal in place notices everywhere now more negative feedback nurses don't get training in keeping therapeutic relationships nurses get the brunt nurses more emotionally involved than doctors nurses pick up the pieces nursing has become more academic one person gets picked on one way conversation our own worst enemies out of our control-difficult out of your control own initiative not appreciated palliative care is not academic patient care can be upsetting patients'/family's expectations peer support on issues outside work peer support works well people skills are needed perceiving potential problems physical therapy jobs police people powerless to make a change pressure of workload problem across palliative care
--	--

problem starts outside this building protecting themselves psychological support reality is different than what was taught. realize that life goes on really enjoy the work really gets to people. recognizing stress in colleagues relating to them on an active level is easier retaining good staff rules coming from on high similar age to you social life some personal involvement is needed sounds so trivial stick to rules sticking your neck out strategies on how to cope stress experiences differ from day to day stress is an individual thing stress through relatives strong peer support stuck in band supervision supervisory support taking things home teaching support team is approachable team is fantastic team is stable team is very supportive team support the bigger picture the patients like it there's a happy atmosphere things might come back to you this work needs a certain type of person time shortage too many changes training demands training to cover their backs unfair complaining unfairness of complaints unrelated jobs unsupported situation	useless changes want to do a really good job we are not all the same We do have a laugh We have a laugh we keep giving and giving well supported when anger does not get resolved when it's directed at you. why bother within team support working after hours working with children you are just a body young people
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Appendix 23: Codes for Focus Group 2

Codes focus group 2, Hospice 1

"petty" rules and regulations 24 hour care 50% of work is emotional stuff a death A glass of wine a lot of anger a personality that can hand over a surreal situation able to do the job that you want accumulation of stressors accumulated stress acknowledging that we are human add hoc debriefs aiming for best patient care always kept things together an horrendous shift annoying niggledy piggedly stresses anxiety and stress levels high awful situations balancing different things be honest and open being a finisher being able to laugh being honest being in a shell being in the middle being offloaded on being taken to the cleaners being there for patient is most important being used to the system can't maintain the old standards .. can't maintain your standards can't change personalities can't maintain your standards cancelling it is frustrating care is much better than in general hospitals care is time consuming caused unnecessary stress change change for the right reason.	change happens too fast change is not communicated effectively change of machines changes are happening too quickly chose this work for a reason clinical supervision clinical supervision seen as de-stressing session cognitive changes compartmentalise things complaints complex demands complex demands from families consultant not always available consultants role has changed couldn't finish off anything criticism is hard to take CSH has a reputation damaging deal with home deal with work dealing with poor managers' support debriefing is needed depends what the change is dividing your time is difficult didn't feel a good nurse didn't get support different personalities manage stress differently difficult for all concerned difficult to acknowledge difficult to tell a colleague do your best doctors requests doing my best doing our best don't have to face them again don't like certain patients don't trust the confidentiality here double edged sword embrace change
--	--

emotional impact emotional response emotional struggle for nurses emotional switch encouraged encouraging people to talk everybody should be asked how they are getting on exercise expectations from above expected standard of care expecting a lot of yourself experience helps with learning to self care explanations would help with the change process failing managers' support family dynamics family in "different place" than patient family members feel undervalued. feeling awful feeling great afterwards feeling guilty. feeling unfulfilled find out about it yourself finding a reason helps finishing loose ends for what reason forget to look after ourselves frustration get my head right get really angry with them getting worse over time getting stressed gives inner conflict giving high standard care go to a gym good at peer support guilt from the relatives guilty about the other patients had a glass of wine had to ask for support has to know why have done your best have to prioritise	have to change our mindset having to do more he didn't die in pain he was comfortable high demands from managers, relatives and patients high demands from relatives and patients high emotional demands high expectations from relatives high standards home life impacts on ability to deal with work stressors home stress has an effect on work life hospice nursing has got busier hospice work has changed how many shifts how to face the work how training requests are dealt with I did talk about it I felt very, very supported I put myself under that stress.. I want to do my best I was frustrated I'm in a shell I've never known such a stress.. important to sort it inconsistencies incredibly difficult incredibly short staffed involvement unavoidable it is horrendous it is part of the job it's a hell of a transition it's an individual thing It's communication it's protected time its about your personality its really difficult its really, really important just being human just get half of it keep the hospice full keep the hospital beds full knowing you are not alone in feeling certain emotions
--	---

lack of budget lack of emotional care causes upset Lack of time lack of training that is available large families more emotionally demanding lasted a long time laughing even in the worse situation learn to hand over learn to put boundaries on yourself learn to time manage left feeling still upset less stressed when allowed to finish letters going backwards and fo.. like a debrief likes to be questioned listening to new staff is important long and drawn out process long dying process long dying process can be difficult looking after yourself is important looking for other jobs lots of this bizarre behaviour.. low staffing levels made me feel undervalued management are in the same boat managing change managing emotional demands managing patients' anger many constraints upon her may not agree medical staff change their minds meeting high standards for new comers is difficult mistakes happen MND patients most difficult patients must pass it on my heart sank Myers Briggs Personality Awareness is useful name sign still up need more managers' support need opportunity to ask why need supervision need to be assertive	need to compromise sometimes need to educate the local population need to find out why new staff are leaving need to improve need to know the rationale behind it new consultant raised stress new philosophy of care new staff's perceptions bring a breath of fresh air new staff appreciate it here new staff feeling unsupported NHS courses no debriefing no one questioned it no plan no proper job no second chances no self care causes pressure on colleagues no time for debriefing no time to catch our breath no time to check no time to debrief no time to reflect nor available to any of us 24/.. not all staff understand what supervision is not always recognised not been addressed.. not being allowed to follow through not communicated properly not enough appropriately trained staff causes stress not enough time for supervision not enough training about clinical skills not enough training money not every one feels comfortable asking not everyone feels comfortable to open up not just the patients not mandatory not supported in clinical training needs not supported in training needs not supposed to get involved off loading helps older patients are easier one chance opening up is important
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opportunity to talk other constraint.. other ways to de-stress our pace is different over loaded own high expectations palliative care is changing part-time workers patient died on his own patients own choices influence care outcome payment by result causes pressure peer support peer support very good people can be very rude people don't realize how busy we are personal bereavements personalities Philosophy of the workplace phone ringing poorly patient arrives without info powerlessness pressure because of being short staffed privilege to work here punch bag quite daunting really difficult times reason for working here reasons not communicated effectively recognition of emotional impact reconfiguration with the PCTs regrets relatives are over protective relatives put you on a pedestal remind ourselves of that as well repress that resisting change restricted in doing my best ring up rules by higher management structure run out of time seeking support seizing the moment is important self care is needed self care not acknowledged	self protection senior nurses need to be on the ward senior nurses understand shell gets thin shifts were a bit easier Shipman has made our lives so difficult so good at listening some things have to give sometimes go home and worry staying long term still better than at home stress about not being trained properly stress management through putting things in perspective stress management through rationalizing striving for high standards struggle in difference ways supervision as a remedial intervention supervision is important supervision not fully understood supposed to have addressed it symptoms are recognised too late t may not be the best talking about their children teaching sessions tell my managers that caused stress that is wonderful that was hard that was nice the bell would ring the best it's going to get the care is very good compared with the General Hospital the change of management + consultant The consultant is always happy.. the family struggling the high standard of care the last five years the nurses are excellent the patient is number one the right support the type of personalities we are the way the care has changed the way the NHS is
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then it's worse they are not achieving they couldn't do it they get frontal lobe changes they go home stressed they see things through fresh eyes they wanted to keep them at home things that could easily be changed this is quite difficult This is what we need more of thrown in at the deep end time and effort wasted time constraints time is an issue time is easier for night staff time pressure affects emotional care time pressures can make you feel down too high standards touches my soul try to maintain high standards under the surface uniform helps to compartmentalise uniform serves as a "boundary" uniform serves as "boundary" unpredictability very precise rules very stressful time volume of work walking away from busy situation want that patient to die want to have nice kind thought.. want to maintain high standards wanting to create a good death wanting to create good memories we are great as a team we have no say we have to give of ourselves we have to keep the beds open we set high standards we want to give excellent care.. we weren't always full we won't always get it right whatever the staffing who's perception of guilt is it?	who gives supervision to whom? will happen again wondering how to cope work demand limits supervision opportunities working in the general hospital is difficult worry about new staff leaving you can't repeat it you don't say it you have got to be proactive you think it young people your stress levels rise
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Appendix 24: Categories per hospice

Change

<u>Hospice 1</u>	<u>Hospice 2</u>
<i>Change</i> Changes in Palliative care New philosophy of care Payment by result Faster pace Having to do more Keeping hospice full Change of mindset Compromising Can't maintain the old standards Change of management Changes happen too quickly Communication strategy Not communicated effectively *Need to know the rationale *Reasons not communicated effectively *Resisting change *Having no say *Powerless *Part time workers miss info *Not comfortable asking New Consultant Many constraints Answering questions	<i>Change</i> Changes not though through Not understanding Practical consequences Ulterior motives Both hospices state "rules come from up high"

Peer Support

<u>Hospice 1</u>	<u>Hospice 2</u>
<i>Peer support</i> Great team Peer support very good Encouraging people to talk Being human Listening to new staff	<i>Peer support</i> Strong peer support Not hierarchal Looking out for each other Team is stable Other support *debriefing *teaching *supervision

Managers' support

<u>Hospice 1</u>	<u>Hospice 2</u>
<i>Managers' support</i> Failing Poor listening skills New staff feel unsupported Not supported in training needs	<i>Managers' support</i> *Higher management Decisions made remote from unit Not aware Don't care Don't feel valued Don't feel considered NHS causes stress Need recognition One way conversation *Local management One way conversation Self protection Don't feel appreciated Don't feel supported

Demands

<u>Hospice 1</u>	<u>Hospice 2</u>
<i>Demands</i> *High standards - Difficult for new staff - Nurses are excellent - Best patient care - Good death - Personality *Staffing - Short staffed - Restricted in doing my best - Compromise of quality - Feeling unfulfilled *Changing demands - Hospice work has changed - Volume of work - High demands - Compromising - Stress accumulation - Less time - Not time to self-care - Hospice reputation - Very precise rules Emotional demands *Time pressure - Not following through - Want to give excellent care - No second chances *Long dying process - Getting emotionally involved - Inner conflict *Personal bereavements *Family dynamics - Large families - Complex needs - Being in the middle *Patient factors - Age	<i>Demands</i> *Patient and Relatives - Emotional involvement - No training in emotional distancing - Expectations - Anger - Vulnerability *Emotional Demands - Going the extra mile - Commitment conflict - Patients/family expectations - Own expectations - Managing emotional demands *Role differences - Different emotional demands - Qualities *Unrelated jobs - Smoking - Police people *Information overload - No stress free zone *Complaints - Unfair complaining - Impacts on team *Training demands - Time limitations

Children Own decisions *MND patients Complex demands Constraints Demands from relatives Frontal lobe changes No plan Accumulated stress *Training demands Lack of funding Lack of clinical training Time limitations Not trained properly Not enough trained staff New NHS	
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Self Care

<u>Hospice 1</u> <i>Self Care</i> *Self Care Forget to look after yourself Pressure on colleagues Off loading Being over-loaded *Supervision Important Encouraged Not fully understood Don't trust confidentiality Time limitations Work philosophy *Teaching sessions *Debriefing No debriefing Worry *Exercise Gym Punch bag	(cont.) *Other strategies Time management Handing over Dissociation techniques Cognitive strategies Awareness of personalities glass of wine
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Appendix 25: Triangulation Sheet

Triangulation Sheet (Researcher)	Code name
S What do other people think? 5 I think stress is caused by the pressure of everything that's what is expected, it's not just looking after the patients which is our main aim (1), it's what is expected of us to do in our own time really. E-learning will take you two hours to do on the computer and this will take you another two hours so it's not just the work here it's everything else that comes with it these days. 3 That's rights because you couldn't take those two hours out of your shift to come along and do an e-learning programme because there isn't the staff to cover so you do it at home and then you have to take the time back and then you don't get your time back and that's quite stressful because as soon as you've done one there are more on the notice board (2), I think there are four up now all taking between 1 and 4 hour to do. S So it feels pressured to keep up what you are professionally required to do. 5 It's not professionally required to do, its what the NSH require us to do, it's not the professional bodies (3). 4 It's like manual handling (4) you do it constantly and I know things change, but everyone is expected to go on it	1: CLINICAL DEMANDS - Best Patient Care 2: TRAINING: Too many mandatory courses 3: New NHS – high demands 4: NEW NHS – high demands

every year (5) it's just to cover backs (6) isn't it. 3 We've got 14 mandatory courses for the year (7) and like you said most of them are to cover their backs (8) so if you hurt your back, "oh you've done manual handling", so you can't sue the Trust, you've done the training now how to use the equipment - and that's what it comes down to. 6 When you do this mandatory stuff where's the time for other professional development on the clinical side (9) - you end up doing it in your own time – which from a clinical point of view I don't mind, but is it appreciated (10)? S It's appreciated by your peers and your colleagues but when it goes up a tier or to management outside this physical building you feel that's where the problems start, it seems to be quite impersonal. 2 Yes the team here is absolutely fantastic (11) and I find the stress level for me is more the relatives (12) as apposed to patients, I think the stress levels you have to go through just generally to comfort them as they are getting more and more agitated (13), but the person in the bed you don't get the stress level from that person its nearly always, I find, the patients relatives. S It's the emotional demands by the relatives. 2 Yes very much so. S Working with the relatives? 2 Yes not always, there are some different aspects of it that I find more stressful than patients, well some patients	5:TRAINING – too many mandatory courses 6:MANAGERS' SUPPORT – self protection 7: TRAINING – too many mandatory courses. 8:MANAGERS' SUPPORT – self protection 9: TRAINING – lack of time for clinical training 10:MANAGERS' SUPPORT –don't feel appreciated 11: PEER SUPPORT - great team 12:EMOTIONAL DEMANDS – relatives 13:EMOTIONAL DEMANDS – agitation
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anyway. 3 I think sometimes we are our own worst enemies (14) because we keep giving and giving (15) don't we and then people come to expect (16) that especially if someone has been in a little while and you do a bit more and a bit more and they expect a bit more (17) and I think that's when they take it all for granted (18) and suddenly you are a cross between a hotel and what you are supposed to do with the patient – the lines get a little blurred 2 Going back to what you said about covering everybody's back, I had an incident a long time ago where somebody kicked me but when I went to fill out a report it turned out that I was in the wrong place, I shouldn't have been there and that's what I find completely and utterly frustrating that at the end of the day it's my fault (19) I should not have been there and that's what I find really difficult, again they were covering their backs (20). I was in the wrong place so I couldn't have sued – not that I was going to but it's the fact that I should have been further up the bed.	14: CLINICAL DEMANDS – self sacrifice 15: CLINICAL DEMANDS - going the extra mile 16:EMOTIONAL DEMANDS – patients' and families' expectations 17:EMOTIONAL DEMANDS – patients' and families' expectations 18:EMOTIONAL DEMANDS – being taken for granted 19:MANAGERS' SUPPORT – don't feel supported 20:MANAGERS' SUPPORT – self - protection
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Triangulation Sheet		Code name
A. Barainger		18/20.
S	What do other people think?	
5	I think stress is caused by the pressure of everything that's what is expected, it's not just looking after the patients which is our main aim (1) , it's what is expected of us to do in our own time really. E-learning will take you two hours to do on the computer and this will take you another two hours so it's not just the work here it's everything else that comes with it these days.	1: Clinical: High Standards best patient care. ✓
3	That's rights because you couldn't take those two hours out of your shift to come along and do an e-learning programme because there isn't the staff to cover so you do it at home and then you have to take the time back and then you don't get your time back and that's quite stressful because as soon as you've done one there are more on the notice board (2) , I think there are four up now all taking between 1 and 4 hour to do.	2: Training- Too many mandatory training courses ✓
S	So it feels pressured to keep up what you are professionally required to do.	3: New NHS - high demands either " " ✓
5	It's not professionally required to do, its what the NSH require us to do, it's not the professional bodies (3) . or Higher Management - Decisions made remote from unit	5: Training - too many mandatory courses ✓ 6: Manager's Support - self protection. ✓
4	It's like manual handling (4) you do it constantly and I know things change, but everyone is expected to go on it every year (5) it's just to cover backs (6) isn't it.	7: Training - too many mandatory courses ✓ 8: Manager's Support - self protection. ✓
3	We've got 14 mandatory courses for the year (7) and like you said most of them are to cover their backs (8) so if you hurt your back, "oh you've done manual handling", so you can't sue the Trust, you've done the training now how to use the equipment - and that's what it comes down to.	9: Manager's support - don't feel supported. ✓
6	When you do this mandatory stuff where's the time for other professional development on	

Appendix 26: Transcript of Phase 3

1 **Transcript of the Coaching Sessions**

2

3

4 **Question 3: What have you found most useful of the coaching session?**

5

6 **Hospice 1**

7 Being able to identify thinking patterns.

8 Prioritize areas of my life that need more work or attention.

9 Being able to discuss situations openly within the group and

10 Realizing that you are not the only one who feels stress.

11 Distorted thinking patterns and coping statements.

12 Realizing my own approach to my stresses was inconsistent.

13 Explorations of distorted thinking and how to turn this around.

14

15 **Hospice 2**

16 Helped me to focus on challenging disturbed thinking patterns.

17 Understanding thought patterns more deeply and how to challenge them.

18 Reflecting on stresses in life and how to cope.

19 That I am not the only one feeling stressed.

20 Learning to challenge my own thoughts.

21 Reminder to keep things in perspective.

22

23 **Support Staff**

24 Being able to talk/share a situation.

25 Listening to views on how to deal with stress.

26 The concept of Cigar Model. Very thought provoking.

27 Very helpful to help understand what is happening when stress levels begin to rise and

28 especially how it can help cope.

29 The ability to look closely at myself and how to handle situations.

30 Identifying improvements with coping strategies.

31

32 **Community Nurse Specialists**

33 To realize that I am in control of my thoughts and reactions and I can accept and move on.

34 Distorted thinking patterns and beginning to recognize them in myself

35 Becoming more aware of sources of stress and identifying methods of reducing it.

36 Learning about coping strategies

37

38

39

40

41

42

43

44

45

46 **Question 4: What have you found least useful of the coaching session?**
 47
 48 **Hospice 1**
 49 List of self-nurturing activities, although it was amusing to read them
 50 Not enough time! Would have like to have gone into some areas in more depth, such as
 51 coping strategies.
 52 Self-nurturing activities
 53 Time constraints
 54 Handout of slides used would be good to consolidate further reflection/work.
 55
 56 **Hospice 2**
 57 Nothing- all useful
 58 Nothing
 59 Nothing
 60 I found it all useful
 61 Nil – all useful
 62
 63
 64 **Support Staff**
 65 Tentative about sharing personal info. Ok about sharing work-related issues.
 66 Every part was useful and on a par.
 67 Nothing- all very positive
 68 -
 69
 70 **Community Nurse Specialists**
 71 Nothing
 72 Work-life balance, because I have changed it!
 73 -
 74 Nothing
 75
 76
 77
 78
 79
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 81
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 85
 86
 87
 88
 89
 90

91 **Question 5: How able do you now feel to challenge negative self-appraisal?**
 92 **(please explain)**
 93
 94
 95 **Hospice 1**
 96 A bit more confidently, although I am still finding my feet in other areas at work.
 97 More able than before. I feel that I have begun to realize that it is unrealistic and bad for
 98 me.
 99 I sort of know what to do already but having it clarified helped. But Whether I put it into
 100 practice or not is a difficult one. Depends on situation and mood.
 101 I will use the stress coaching literature and apply it to future stressful situations
 102 I do it all the time!
 103
 104
 105 **Hospice 2**
 106 (1 not readable)
 107 I feel more aware of negative thinking and therefore will recognize it and be able to
 108 challenge.
 109 Listen to my thought, than put them to one side
 110 I feel like I will be able to manage better because I before realized I was doing it.
 111 More awareness of impact of negative self-thoughts that worsen a situation
 112
 113
 114 **Support Staff**
 115 Not sure –hope I will use the tools and daily if necessary- to improve my reactions
 116 Session has given me an insight into why I think as I do using the “personality types”. I will
 117 question my thoughts and challenge them. It will help me put things in perspective and find
 118 ways to resolve a situation rather than procrastinate!
 119 Most able. I will Endeavour to be more positive in my thinking which will hopefully make me
 120 a stronger person.
 121 Look at the positives in my life. To build on my confidence, that I will be strong and will
 122 cope. To read more about coping strategies.
 123
 124 **Community Nurse Specialists**
 125 I will work through whether the negativity is actual or perceived and remember to
 126 concentrate on good/positive parts.
 127 I feel more able – equipped with being able to recognize distorted thinking – is at least a
 128 start.
 129 I now feel more able to challenge negative self-appraisal by being more aware of sub-
 130 personality groups and thought processes.
 131 I feel more aware of negative thinking + therefore will recognize it and be able to challenge
 132 I feel like I have seen the map and need to go away, ponder it in detail and walk it out,
 133 before it will make real sense to me.
 134
 135
 136
 137

138 **Question 6: How confident do you feel you will implement your personal**
139 **stress-coaching plan? (please explain)**
140
141

142 **Cynthia Spencer Hospice**

143 I know that by implementing the plan, I will gain a lot more confidence in that area and
144 others also.

145 Fairly confident – I think it will take time to get out of the habit of being too hard on myself,
146 but feel I have a basis to build upon.

147 I feel fairly confident, but depends on situation, people around me and my mood. Of course
148 there is a risk my plan may go pear shaped. Then it will be difficult to try again.

149 Very confident that I can positively turn around a stressful situation.

150 I try to keep my stress levels low. I generally say what is bugging me – probablyothers by
151 this. Only to think just before opening my mouth, but don't always succeed.

152

153

154 **Cransley Hospice**

155 Feel quite able to use a plan as such –now reassured that I am doing pretty ok.

156 I am keen to try this in everyday life and am aware of my needs in work-life balance.

157 Take time to recognize that I am stress and letting myself pass through it.

158 I think I will although I find my current strategies work.

159 Fairly confident

160

161

162 **Support Staff**

163 I need to use the plan to avoid causing myself problems, so fairly confident.

164 Understanding a little better what is happening during a stressful situation will now enable
165 me to devise a strategy to use. I feel very confident that I will be able to use the stress
166 coaching plan.

167 Very confident. I feel I will be able to look at any situation, work or at home, and put what I
168 have learnt into action.

169 I need to gain more confidence, to challenge my fears and worries. To strive towards putting
170 a positive action in place. To set aside more "me" time and to invest in more exercise for a
171 natural mood lift.

172

173

174 **Community Nurse Specialists**

175 I feel confident that I will endeavor to implement my more positive thought processes
176 immediately.

177 I am not sure how well I will be able to implement things –(....) when easier to slip into old
178 patterns.

179 Quite confident. I will use clear model in future.

180 I will use the coping strategy statements.

181

182

183

184

185 **Question 7: Would you be interested in attending future sessions?**
186 **If so, which topics would you like to be addressed?**
187
188

189 **Hospice 1**

190 Yes

191 Yes, coping strategies

192 Yes

193 Yes, always interested in any psychology topics

194 Yes

195 Yes, because it's interesting but would not want to take the place of somebody who would
196 really want to attend.

197

198

199 **Hospice 2**

200 Yes, need to be longer and in more detail

201 Yes

202 Yes, the same session. I found it very interesting.

203 Yes, I would like to know more about thinking patterns –reasons why we talk negatively.

204 Yes

205

206

207 **Support Staff**

208 Possible. Understanding how to not let situations have such an effect on me personally, and
209 dealing with emotions.

210 Yes. What topic are on offer?

211 Yes, - family dynamics

212 Yes, definitely. Strengths, weaknesses, stress management.

213

214

215 **Community Nurse Specialists**

216 Yes. Changing some extreme emotions attached to stress, re. anger/crying.

217 Yes. Anger in "hospice" setting.

218 Yes. Further challenging negative thought patterns!

219 Maybe more on cognitive behavioural.

220

221

222

223

224

225

226

227

228

229

230

231 **Question 8: Any other comments?**

232

233 **Hospice 1**

234 Really enjoyed it. Thank you.

235 -

236 -

237 Great teaching session – and one that I can use and continue to use. Thanks Addy

238 Thank you for an interesting session.

239

240

241

242 **Hospice 2**

243 -

244 Very useful...

245 -

246 Very useful!

247 -

248

249

250

251 **Support Staff**

252 We all dealt with situations differently – having reassurance that anger can be good and not
253 feeling it is wrong.

254 A very interesting, thought provoking, practical (not to “airy fairy”) helpful session. I would
255 consider it an “investment” of time as I have come out with something I can do to help
256 myself.

257 A very interesting session. (I wish this had been available in my very early days here at work)
258 Thoroughly enjoyed the session, very thought provoking – over too soon.

259

260

261 **Community Nurse Specialists**

262 Good session. Great to reflect and have time to work through stress coaching.

263 -

264 Very useful, thank you.

265 -

266

Appendix 27: Stress Coaching Workshop Structure

Stress-Coaching Workshop

Aims and objectives of the workshop

1. Understanding the nature of stress and how it affects working in the hospice service
2. Identifying current stress management strategies: cognitive and lifestyle
3. Identifying new/additional stress management strategies: cognitive and lifestyle
4. Developing a personal stress management plan

Format of the workshop

The workshop will follow the CIGAR coaching model (Centre for Coaching, 2007), which I chose as it suits the framework of Cognitive Behavioural Coaching (CBC). The CIGAR acronym stands for: **C**urrent Reality, **I**deal Outcome, **G**aps, **A**ction and **R**evue. In CBC it is important to start with a thorough assessment of the current reality as this will give a base-line understanding of where the client is at in terms of cognitions and behaviour, and will highlight the areas that need to be worked on.

1. Current Reality

Presentation 1: The concept of Stress

- Review of the concept of stress; stress theories
- Impact on of cognitive distortions on mood
- Work –Home life balance (handout 1), Exercise worksheet 1
- Switching off
- Self-care strategies (handout 2)

Group Discussion

- Identifying sources of work stress and nature of their stress in the hospice
- Identifying current coping strategies
- Fill in worksheet question 1

Presentation 2: Sub-personalities

- Bourne's sub-personalities and the associated distorted thinking patterns and how it triggers stress.

Individual Exercise + Group Discussion

- Identify your own most prominent sub-personality (handout 3)

2. Ideal Outcome

Group Discussion + Individual Exercise

- Identify how you would like to feel/think/behave in relation to stressful situations (related to most prominent sub-personality).
- Fill in worksheet question 2

3. Gaps

Presentation 3: Self-talk and distorted thinking

- How to challenge negative self-talk (handout 4 and 5)
 - * Reframing
 - * Objective scrutiny
 - * Challenging overgeneralizations etc.

Group Discussion + Individual Exercise

- What would you need to learn to do differently (in relation to most prominent sub-personality)
- Fill in worksheet question 3

4. Action

Group Practise

- Dispute negative self-appraisal with positive, rational, self-supportive statements.

Developing a Personal Stress Management Plan (handout 6 and 7)

- What to include in new strategy to stress management
- What to exclude from current strategy to stress management
- I can improve my home-work life balance by:

- My worst cognitive distortions are/were:
- I can change these to:
- Some of the best ways for me to switch off are:
- I can include the following self-care strategies:

5. Reflection

- Reflecting on the process so far and making changes if necessary
- Filling in the evaluation form

Appendix 28: Stress Management Plan

Personal Stress Management Plan

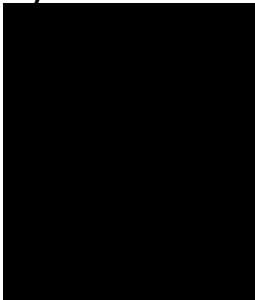
For:

A) Things to do: I want to include in my new strategy to stress management:



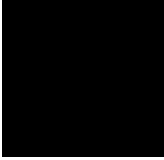
I want to exclude from my old/current stress management strategy:

B) Mind Matters: My worst cognitive distortions are/were:

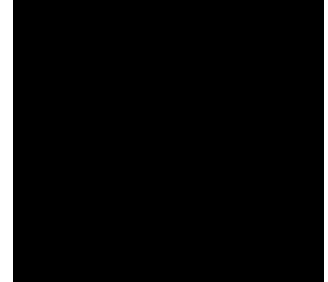


I can change these to:

C) Mood Matters: I can manage the intensity of my emotions by:

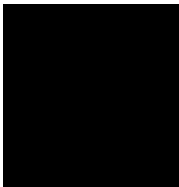
A solid black rectangular box used to redact information.

D) Home-work life balance: I can improve the balance between home and work life by:

A solid black rectangular box used to redact information.

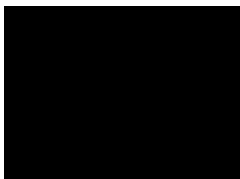
E) Switching Off

Some of the best ways for me to switch off are:

A solid black rectangular box used to redact information.

F) Self-Care

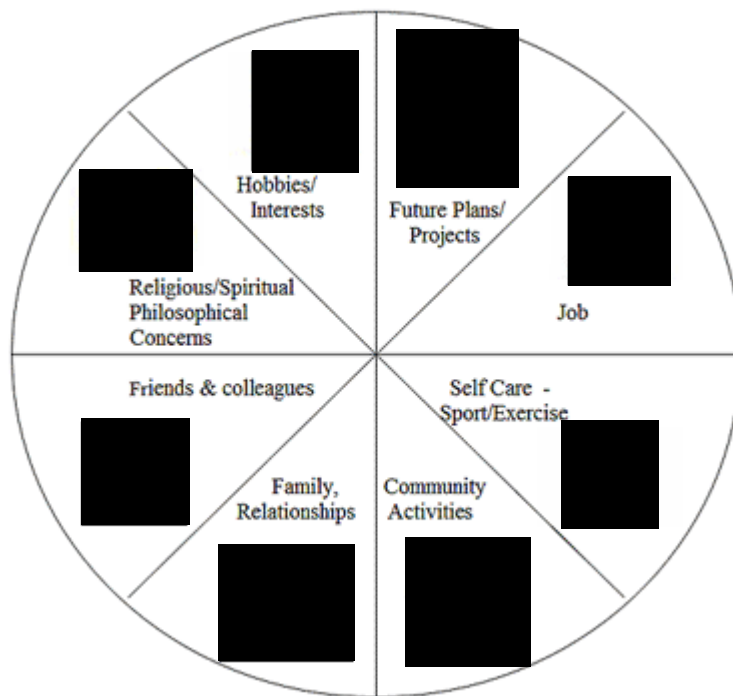
I want to include the following self-care strategies in my life (specify daily/weekly etc) :

A solid black rectangular box used to redact information.

Appendix 29: Stress Management Worksheet

Stress Management Worksheet

1. How is your Work-Life Balance ?



The areas where I could do with some improvement are:

- 1.
- 2.
- 3.

I could do this by:

2. Current Reality

Current sources of stress are:

I normally deal with these stresses by (doing, thinking behaving):

3. Ideal Outcome

Instead of how I normally deal with stressful situations, I would like to (do, think, behave):

4. Gaps

What do you need to add or take away from the situation?

What would you need to learn to do differently?

What are your main cognitive distortions?

5. Action

What action do you need to take?

Change the negative self-talk to a more accurate and/or positive statement

Are there any self-care strategies you would like to include?

Appendix 30: Handouts of Stress Coaching Session

Handout 1: Work-Life Balance

10 top tips for juggling your work-life balance

- Take up time management. Set out the goals you want to achieve that week and stick to them.
- Don't try to emulate what other people do. Find the right balance for you and your family.
- Make time for yourself. Working women – and men – often feel so guilty about not giving enough time to their children that they never allow themselves time to relax, exercise or have fun.
- Forget guilt. It's a waste of time. There will always be more you could have done at work and at home. Employers and families have insatiable appetites and you'll never be able to satisfy all of them.
- Make sure you have good support networks. When times are easier offer help to your friends, then when you are under pressure you won't feel bad about asking them to help you.
- Make quality time for you and your partner too. It is vital that you can support each other.
- Try to keep a sense of proportion. It is not really the end of the world if you run five minutes late, or occasionally have to ask for more time to finish a report.
- If you're not happy, don't wait too long so that things escalate. Start making small changes to your life straight away.
- Accept that you'll never find a lasting solution to the work-life dilemma. Children's needs change, parents age and need more support, and your own desires change too. Be prepared to be flexible and change the way you work in the future.
- A sense of humour helps. You can minimise the stress you cause yourself – and others – by laughing at the smaller irritations that are sent to try us.

Handout 2: Self-Nurturing Activities

1. Take a warm bath
2. Have breakfast in bed
3. Take a sauna
4. Get a massage
5. Buy yourself a rose
6. Go to the pet store and play with the animals
7. Walk on a scenic path in the park
8. Visit a zoo
9. Have a manicure or pedicure
10. Stop and smell some flowers
11. Wake up early and watch the sunrise
12. Watch the sunset
13. Relax with a good book and/or soothing music
14. Rent a funny video
15. Play your favourite music and dance to it by yourself
16. Go to bed early
17. Sleep outside under the stars
18. Cook a special dinner just for yourself and eat by candlelight
19. Go for a walk
20. Call a good friend (or several)
21. Go out to a good restaurant
22. Go to the beach
23. Take a scenic drive
24. Meditate
25. Buy some new clothes
26. Browse in a book or record store
27. Exercise
28. Buy yourself a cuddly stuffed animal
29. Ask someone special to spend some time with you
30. Go see a good film or show
31. Go to the park and feed the ducks
32. Visit an interesting place
33. Write out an ideal scenario concerning a goal and then visualize it.
34. Write a letter to an old friend
35. Bake something special
36. Go window shopping
37. Buy a meditation tape
38. Write down your accomplishments in a special diary
39. Use some perfume

Handout 3: Sub-personalities and types of negative Self-Talk

Not all negative self-talk is the same. Human beings are not only diverse but complex, with multifaceted personalities. These facets are sometimes referred to as "sub-personalities." Our different sub-personalities each play their own distinct role and possess their own voice in the complex workings of consciousness, memory, and dreams. Below are four of the more common sub-personality types that tend to be prominent in people who are prone to stress and anxiety: the Worrier, the Critic, the Victim, and the Perfectionist. Since the strength of these inner voices varies for different people, you might find it useful to rank them from strongest to weakest in yourself.

Bourne, 1995: Retrieved from <http://pages.prodigy.net/bderoes/bourne.html>

1. The Worrier (promotes anxiety)

Characteristics:

Usually this is the strongest sub-personality in people who are prone to anxiety. The Worrier creates anxiety by imagining the worst-case scenario. It scares you with fantasies of disaster or catastrophe when you imagine confronting something you fear. The Worrier promotes your fears that what is happening is dangerous or embarrassing. In short, the Worrier's dominant tendencies include 1) anticipating the worst, 2) overestimating the odds of something bad or embarrassing happening, and 3) creating grandiose images of potential failure or catastrophe. The Worrier is always vigilant, watching with uneasy apprehension for any small symptoms or signs of trouble.

Favourite Expression:

By far the favourite expression of the Worrier is "What if..."

Examples:

Some typical dialogue from the Worrier might include: "What if I panic and lose complete control of myself?" "What if I make a mistake?" "What if I just can't get it all finished?" or "What if I upset the family member.."

2. The Critic (promotes low self- esteem)

Characteristics:

The Critic is that part of you which is constantly judging and evaluating your behaviour (and in this sense may seem more "apart" from you than the other sub-personalities). It tends to point out your flaws and limitations whenever possible. It jumps on any mistake you make to remind you that you're a failure. The Critic generates anxiety and stress by putting you down for not being able to handle your emotions, for not being good enough, for being unable to perform at your best, or for having to be dependent on someone else. It also likes to compare you with others, and usually sees them coming out favourably. It tends to ignore your positive qualities and emphasizes your weaknesses and inadequacies. The Critic may be personified in your own dialogue as the voice of your mother or father, a dreaded teacher, or anyone who wounded you in the past with their criticism.

Favorite Expression:

What a disappointment you are!" "That was stupid!"

Examples:

Typical of the Critic's self-talk are statements such as the following: "You stupid..." (the Critic relishes negative labels). "Can't you ever get it right?" "Why are you always this way?" "Look at how capable _____ is," or "You could have done better."

3. The Victim (promotes depression)

Characteristics:

The Victim is that part of you which feels helpless or hopeless. It generates stress and anxiety by telling you that you're not making any progress, that you will never be able to change (things), or that the road is too long and steep for you to have a real chance. The Victim also plays a major role in creating depression. The Victim believes that there is something inherently wrong with you: you are in some ways deprived, defective, or unworthy. The Victim always perceives insurmountable obstacles between you and your goals. Characteristically, it bemoans, complains, and regrets things as they are at present. It believes that nothing will ever change.

Favourite Expression:

"I can't." "I'll never be able to."

Examples:

The Victim will say such things as: "I'll never be able to do that, so what's the point in even trying?" "I feel physically drained today - why bother doing anything?" "Maybe I could have done it if I'd had more initiative ten years ago - but it's too late now."

4. The Perfectionist (promotes chronic stress and burnout)

Characteristics:

The Perfectionist is a close cousin of the Critic, but its concern is less to put you down than to push and goad you to do better. It generates stress and anxiety by constantly telling you that your efforts aren't good enough, that you *should* be working harder, that you *should* always have everything under control, *should* always be competent, *should* always be pleasing etc. The Perfectionist is the hard-driving part of you that wants to be best and is intolerant of mistakes or setbacks. It has a tendency to try to convince you that your self-worth is dependent on *externals* such as vocational achievement, money and status, acceptance by others, being loved, or your consistent ability to be pleasing and nice to others regardless of what they do. The Perfectionist isn't convinced by any notions of your inherent self-worth, but instead pushes you into stress, exhaustion, and burnout in pursuit of its goals. It likes to ignore warning signals from your body.

Favourite Expressions:

"I should." "I have to." "I must."

Examples: The Perfectionist may provide such instructions as "I should always be on top of things." "I should always be considerate and unselfish," "I should always be pleasant and nice".

Handout 4: Some Basic Points About Self-Talk

Self-talk is usually automatic and subtle

You often do not notice it or the effect it has on your moods and feelings. You react without noticing what you told yourself right before you reacted. Often it's only when you relax, take a step back, and really examine what you've been telling yourself that you can see the connection between self-talk and your feelings. What is important is that *you can learn to slow down and take note of your negative internal monologue.*

Self-talk often *appears in telegraphic form.*

One short word or image contains a whole series of thoughts, memories, or associations. For example, you feel your heart starting to beat faster and say to yourself, "Oh no!" Implicit within that momentary "Oh no!" is a whole series of associations concerning fears or stress, memories of previous stressful situations, and thoughts about how to escape the current situation. Identifying self-talk may require unravelling several distinct thoughts from a single word or image.

Stress self-talk is typically *irrational but almost always sounds like the truth.*

What-if thinking may lead you to expect the worst possible outcome in a given situation, one that is highly unlikely to occur. Yet because the association takes place so quickly, it goes unchallenged and unquestioned. It's hard to evaluate the validity of a belief you're scarcely aware of - you just accept it as is.

Negative self-talk is a series of bad habits.

You aren't born with a predisposition to negative self-talk: you *learn* to think that way. Just as you can replace unhealthy *behavioural* habits such as smoking or drinking excess coffee, with more positive, health-promoting behaviour, so can replace unhealthy thinking with more positive, supportive *mental* habits. Bear in mind that the acquisition of positive mental habits takes the same persistence and practice required for learning new behaviours.

Handout 5: Distorted Thinking Patterns

All-or-nothing thinking: Seeing events in extreme terms that allows for no shades of grey or middle ground.

Magnification/minimization: Exaggerating the negative and reducing the positive.

Personalization: Holding yourself to blame for events you are not responsible for.

Emotional reasoning: You believe something is true because you feel it strongly.

Mind Reading: Thinking you know the thoughts of others without normal means of communication.

Labelling: You attach a global and negative label to yourself based on specific behaviours.

Discounting the positive: Any positive experiences or qualities are disregarded.

Shoulds and Musts: These are usually about rigid rules of living that you impose on yourself, others and/or life.

Mental Filters: Focussing exclusively on one negative aspect of a situation and thereby judging the whole situation by it.

Fortune telling: Believing you can predict the future in a consistently accurate way.

Overgeneralization: Drawing sweeping conclusions based on a single event or insufficient information.

Catastrophizing: Always assuming the worst and, if it occurs, your inability to cope with it.

Handout 6: Challenging Negative Thinking

Examples of negative thinking:

- Thought/Feelings of inadequacy
- Worries that your performance in your job will not be good enough
- An anxiety that things outside your control will undermine your efforts
- Worries about other people's reactions to your work

Starting with these, you might challenge these negative thoughts:

- **Feelings of inadequacy:** Have you trained and educated yourself as well as you reasonably should to do the job? Do you have the experience and resources you need to do it? Have you planned, prepared and rehearsed appropriately? If you have done all of these, are you setting yourself unattainably high standards for doing the job?
- **Worries about performance:** Do you have the training that a reasonable person would think is needed to do a good job? Have you planned appropriately? Do you have the information and resources you need? Have you cleared the time you need and cued up your support team appropriately? Have you prepared appropriately? If you have not, then you need to do these things quickly. If you have, then you are well positioned to give the best performance that you can.
- **Problems with issues outside your control:** Have you conducted appropriate contingency planning? Have you thought through and managed all likely risks and contingencies appropriately? If so, you will be well prepared to handle potential problems.
- **Worry about other people's reactions:** If you have put in good preparation, and you do the best you can, then that is all that you need to know. If you perform as well as you reasonably can, then fair people are likely to respond well. If people are not fair, then this is something outside your control. Often, the best thing to do is to rise above unfair comments.

When you challenge negative thoughts rationally, you should be able to see quickly whether the thoughts are wrong or whether they have some substance to them. Where there is some substance, take appropriate action. In these cases, negative thinking has been an early warning system showing where you need to direct your attention.

Continuing the examples above, positive affirmations might be:

- **Feelings of inadequacy:** “I am well trained for this? I have the experience, the tools and the resources I need. I have thought through and prepared for all possible issues. I can do a superb job.”
- **Worries about performance:** “I have researched and planned well for this, and I thoroughly understand the problem. I have the time, resources and help I need. I am well prepared to do an excellent job.”
- **Problems issues outside your control:** “We have thought through everything that might reasonably happen and have planned how we can handle all likely contingencies. Everyone is ready to help where necessary. We are very well placed to react flexibly and effectively to unusual events.”
- **Worry about other people’s reaction:** “I am well-prepared and am doing the best I can. Fair people will respect this. I will rise above any unfair criticism in a mature and professional way.”

As well as allowing you to structure useful affirmations, part of Positive Thinking is to look at opportunities that the situation might offer to you. In the examples above, successfully overcoming the situations causing the original negative thinking will open up opportunities. You will acquire new skills, you will be seen as someone who can handle difficult challenges, and you may open up new career opportunities.

Handout 7: Coping Statements

- This feeling isn't comfortable or pleasant, but I can accept it.
- I can be stressed and still deal with this situation.
- I can handle these symptoms or sensations.
- This isn't an emergency. It's okay to think slowly about what I need to do.
- This isn't the worst thing that could happen.
- I'm going to go with this and wait for my stress to decrease.
- This is an opportunity for me to learn to cope with my fears and worries.
- I'll just let my body do its thing. This will pass.
- I'll ride this through – I don't need to let this get to me.
- I deserve to feel okay right now.
- I can take all the time I need in order to let go and relax.
- There's no need to push myself. I can take a small a step forward as I choose.
- I've survived this before and I'll survive this time too.
- I can do my coping strategies and allow this to pass.
- I can just go with the flow and trust that I will handle it.
- These are just thoughts, not reality.
- I don't need these thoughts – I can choose to think differently.
- So what
- Don't worry – be happy

Handout 8: Positive Coping Strategies for Stress

Physical and Lifestyle Strategies

1. Abdominal breathing and relaxation
2. Low-stress diet
3. Regular exercise
4. Relaxation days / mental health days
5. Mini-breaks (5 to 10 minute periods to relax during the day)
6. Pacing yourself
7. Sleep routine
8. Choosing a “nontoxic” environment

Emotional Strategies

1. Social support
2. Self-nurturing
3. Good communication
4. Assertiveness
5. Recreational activities (“playtime”)
6. Emotional release
7. Sense of humour (ability to see things in perspective)

Cognitive Strategies

1. Constructive thinking (ability to counter negative thinking)
2. Distraction
3. Acceptance
4. Tolerance of ambiguity (ability to see shades of gray)

Philosophical / Spiritual Strategies

1. Consistent goals or purposes to work towards
2. Positive philosophy of life
3. Religious / spiritual life and commitment

Section C: Professional practice

A one-to-one stress coaching intervention:

A Cognitive- Behavioural Case study

A) Introduction and the start of Coaching Relationship

Introduction

In this case study I will present my work with a coachee who expressed her wish to work on stress management issues. The study therefore describes the process of a coaching psychology intervention within a health coaching context. As coaching psychology is a relatively new specialty within psychological theory and practice, I will endeavour to provide a thorough explanation of the theory underpinning my choices of intervention throughout this study. I will also highlight some of the differences between therapy and coaching and explain my rationale for choosing this particular client within this context. I will highlight some of the difficulties faced within the coaching process and reflect on my own learning processes in relation to the theory and practice of coaching. Furthermore, I will reflect on my own learning processes in relation to making the transition from being a clinical psychologist to becoming a coaching psychologist.

Theoretical orientation

The term coaching has become very popular over recent years. This popularization has highlighted the need for a clear definition of the term as well as clarification of its purpose and application. As coaching is applied within a wide variety of contexts it is proving difficult to find a clear concise definition. The Association for Coaching (AC) - the UK's main professional association for coaches - gives different definitions for specific coaching areas (Please see Appendix A for the AC definitions).

This case falls under the heading “Speciality/Niche Coaching” as coaching psychology provides expert psychological knowledge and skills which are being used within the specialist area of Health Coaching. Coaching psychology can be understood as the systematic application of behavioural science to the enhancement of life experience, work performance and well-being for individuals, groups and organizations who do not have clinically significant mental health issues or abnormal levels of distress (Grant, 2006). Psychological coaching borrows from the techniques used within the psychological therapies and transforms these techniques to fit the coaching contexts. Examples of psychological coaching are Cognitive-behavioural coaching (CBC), Multimodal coaching, Rational Emotive Behaviour Coaching and coaching using Neuro-linguistic Programming (NLP).

The psychological coaching framework for this case is CBC. CBC has been adapted from the methodological framework of cognitive behavioural therapy (Neenan & Palmer, 2001; Neenan & Dryden, 2002), which was originally developed by Beck (1976) and Ellis (1994). Beck realised that the link between thoughts and feelings was very important. He invented the term 'automatic thoughts' that might “pop up” in the mind. Beck found that if a person was feeling upset in some way, the thoughts were usually negative and neither realistic nor helpful. Cognitive behavioural approaches focus on challenging and re-evaluating these limiting automatic thought processes and to experiment with alternatives in order to obtain more realistic and helpful viewpoints and behaviours (Neenan & Palmer, 2001).

Consistent with this approach, CBC aims to help the coachee to become aware of the relationship between thoughts, mood and behaviour through a process of discovery, and thereby challenging and changing their self-defeating behaviour, thinking, attitudes and beliefs (Centre for Coaching, website). CBC does not offer quick fixes but emphasizes the need for sustained effort and commitment to achieve the desired goals (Neenan & Dryden, 2002). CBC is characterized by being a time-limited approach with the main focus on the here and now.

Results from initial research into the effectiveness of cognitive behavioural techniques in the field of coaching are promising (Grant, 2001; Libri & Kemp, 2006; Green, Oades, & Grant, 2006; Grbcic and Palmer, 2006). Grbcic and Palmer (2006) found in a randomised controlled trial that stress was significantly reduced amongst middle managers after using a cognitive-behavioural self-coaching manual. This evidence informed my decision to use CBC as my main model of working for this case.

Distinguishing between Coaching and Psychotherapy

Coaching and psychotherapy are similar in some respects: both approaches use knowledge of human behaviour to motivate behavioural or emotional change using interactive counselling techniques. However, there are major differences in the process and focus of the sessions and the level of professional responsibility (Starr, 2003 p11, p39). One of the main differences between coaching and psychotherapy is that coaching aims to enhance performance or one's life experience rather than primarily treating dysfunctionality (Grant, 2001). Psychotherapy, on the other hand, is a health care service focusing on identifying and treating diagnosable psychological disorders. In coaching the coachee sets the agenda for the sessions and each session is geared towards achieving a specific goal. Each session goal in turn is geared towards achieving an overall goal which is identified early on in the coaching contract. In this way, coaching is about enhancing individuals' abilities to self-regulate and move systematically towards goal attainment (Grant, 2001). In coaching it is assumed that the coachee is capable and best placed to find their own solutions. Coaching therefore characterized by a Socratic questioning style, which promotes insight and better rational decision making (Neenan & Palmer, 2001). Through the use of Socratic questioning the coachee is encouraged to identify their own, individually suited, strategies and solutions.

A further difference between coaching and psychotherapy is that coaching often occurs within an organizational context. This means that the manager has been involved in the arrangement of the coaching contract or is at least aware of the

coaching taking place. Subsequently, confidentiality issues may be more complicated than those most frequently encountered in psychotherapy. Skill is being required from the coach to ensure that the individual coaching goals are in line with the organizational coaching goals.

Biographical details of the Coachee

The coachee, who I have named Emma to protect confidentiality, is a 40 year old Occupational therapist, working in Palliative Care. At the start of the sessions she had been working full time in Palliative Care for eight years and generally enjoyed her work as a senior member of the therapy team. Emma was a single mother of two teenage daughters, of which one had recently left the family home to go to University. She had divorced her husband six years prior, after having suffered physical and emotional abuse from him. Although she still lived on her own, she had started a new relationship one year ago. Emma presented as a warm and sociable person who clearly played a central role within her family circle. In addition to dealing with a hectic work- and family life, Emma had recently re-started her MSc course. She had temporarily abandoned this course one year ago due to the stress this was causing her. At that time she had suffered symptoms of extreme stress, including panic attacks and insomnia which had had a negative effect on her work- and home life. At the start of the coaching Emma perceived her stress levels as being constantly high, however, since stopping the MSc. course she had not experienced any further pathological symptoms of stress.

Context of the work and referral

The work described in this study was conducted within a NHS Palliative Care Service and the sessions took place in a Hospice setting. As a Consultant Clinical Psychologist working for this Palliative Care Service, my role is divided between providing direct psychological input to patients and their carers, and providing Consultation, Clinical Supervision, Training and Staff Support to the team members. For the purpose of this assignment, and within the context of Staff Support, I asked my manager for permission to offer coaching to a small number of colleagues. My manager agreed that this would be an intervention which would not

only benefit my studies but could also potentially be very useful to individual members of the team as well as the service as a whole. I then designed a leaflet which I handed out to a small section of the service (Occupational Therapists, Physiotherapists and Lymphoedema Team) to avoid being flooded with requests and having to disappoint people due to time constraints. I selected these teams because they were relatively small and functioned as independent units. In the leaflet I explained that I was going to do a case study on coaching psychology and would be interested to hear from anybody who would like to receive some coaching on a specific work-life topic. I recruited three members of the team who were willing to participate. After having had an initial consultation with all candidates, exploring their suitability for the purpose of this project and explaining the contract details to them, they all agreed to participate.

Emma's case was chosen for this study as it gave me the most opportunity to reflect on my work and to learn to make the transition from being a Clinical Psychologist to a Coaching Psychologist.

Initial Consultation and coaching contract

Prior to the start of the sessions I had arranged to meet with Emma to explore her current understanding of coaching, her expectations of the sessions and to discuss the coaching contract. As Emma had very little prior knowledge of the coaching process I explained the concept and process to her. I used the remaining part of the session to explain the coaching contract: we would have up to six sessions to work on a specified goal. I explained to her that I might want to use her case as a case study and would ask her to sign a consent form (See Appendix B) prior to the start of the first session, stating that she had given her consent for the sessions to be used as training material, for the sessions to be audio recorded and for the case-study to be published. Emma then agreed to participate. At the end of the meeting I asked Emma to start thinking about a work-life issue which she would like to bring to the first coaching session. As Emma mentioned that her issue would be around stress, I also asked her to fill in the short version of the DASS (Depression, Anxiety and Stress Scale) (Lovibond & Lovibond, 1995). The

DASS21 is a 21-item, self-report questionnaire designed to measure the negative emotional states of depression, anxiety and stress in the non-clinical population. I intended to use this assessment tool for obtaining a baseline measurement of current distress, and repeat it at the end of the sessions to obtain an objective measure of coaching benefit and goal achievement.

The first session and presenting problem

At the start of the first session Emma walked in looking rushed and anxious and presented as a person who was experiencing high levels of stress. Despite this observation, Emma reported that she had not filled in the DASS-21 form as she felt the questions did not relate to her experience. Observation of her non-verbal “hectic” presentation made me think there were other reasons why she might not have filled in the form, like lack of time or the inability to self-reflect, but as I could not be totally sure about the reasons at this point in time, I accepted her explanation. Emma’s inability to fill in the base-line assessment form disrupted my plan of action, and in the spur of the moment I decided to measure the (to be identified) goal(s) in an alternative way by measuring behavioural and/or cognitive changes.

I continued by giving an explanation of my intended format of the sessions. There are several coaching models which could be used to structure the sessions. The GROW model (Whitmore, 1992) is probably one of the most widely used models, GROW being an acronym of: **G**oal, **R**eality, **O**ptions, **W**hat next or **W**ay forward or **W**rap up. Although this is a very popular model, I chose a different model for this case, which is known as the CIGAR model (Centre for Coaching, 2007). This acronym stands for: **C**urrent Reality, **I**deal Outcome, **G**aps, **A**ction and **R**eview. The main reason why I selected this model was that it starts with the exploration of the current reality of the coachee which suits the CBC model. In CBC it is important to start with a thorough assessment of the current reality as this will give a base-line understanding of where the client is at it terms of cognitions and behaviour, and will highlight the areas that need to be worked on. A further advantage of starting with the current reality is that this will provide the opportunity

to build rapport with the coachee early on in the relationship (Leimon, Moscovici & McMahon, 2005, p29). Research suggests that a good coaching relationship is needed for the coaching to be beneficial (Gyllensten & Palmer, 2007). An additional reason for starting with assessing the current reality is that it gives the opportunity to check out the level of motivation to change (Prochaska & DiClemente, 1992).

Emma had identified that her most pressing topic was to change the way she had managed her stress for quite a few years. She mentioned that when she gets stressed, she falls into the habit of eating excessively to find immediate relief from that stress. In the next paragraphs I will illustrate the use of the CIGAR model as applied to session one.

Current situation:

According to Whitmore (2003), the most important criterion for examining the Current situation or the Reality, is objectivity. He states that objectivity is subject to major distortions caused by the opinions, judgements, expectations and prejudices, concerns, hopes and fears, which both the coach and the coachee must bypass. To do this a high level of detachment is needed and he suggests that the coach should encourage the coachee to use descriptive terminology rather than evaluative terminology.

Adhering as closely as I could to the above suggestions, I facilitated a process of exploration about the binge behaviour and its relationship to perceived stress. We explored aspects like: when the bingeing would occur, what would trigger it, how often it would happen, where it would happen and when it first started. Emma explained that she had **used food** for many years to manage her stress and shared with me some of the family stresses she has dealt with, including a divorce and bringing up two children as a single mum. She mentioned that any stress could trigger a binge now so binges happened on a very regular basis. When asked how often she would have these binges during the week or day, she said that it really depended on the amount of stress experienced, but that she felt stressed a lot and

therefore had binges nearly every day. Socratic questioning helped Emma to identify that the urge would come up when she felt out of control. We explored memories of previous attempts where she had either successfully or unsuccessfully tried to manage the stress differently (both answers would be useful to identify road blocks and previous successful strategies). She mentioned that she had managed her stress differently during a period of her life when she felt that life's circumstances had helped her to be in the right frame of mind. The technique she had used was to distract herself for five minutes and then re-assess the need for food. Emma pointed out that being in the "right frame of mind" had been significant to this and that she did not feel that way at this point in time.

Ideal Outcome

During this part of the session it became clear that Emma found it difficult to imagine what her ideal outcome would be. She knew that she wanted to manage her stress differently, but could not specify alternative actions in any detail. Due to her inability to engage with a desired goal, I realised that Emma was not quite ready to effectively embrace change. I picked up from her non-verbal behaviour that she was quite frustrated with herself about this. Keeping an eye on body language is important in coaching as this will help with the choice of questions (Whitmore, 2003, p50). A key aspect of psychological health coaching is to motivate the coachee towards readiness to change (Health Coaching Australia, 2007). I therefore felt it would be useful to explain the Stages of Change (SoC) model to her so that she could monitor her change progress. The SoC model was originally developed by Prochaska and DiClemente (1982) who described behavioural change as a dynamic process. They identified five stages in this process (Ogden, 2004, p22):

- 1) Pre-contemplation: not intending to make any changes yet
- 2) Contemplation: considering a change
- 3) Preparation: preparing for change and making small changes
- 4) Action: actively engaging in a new behaviour
- 5) Maintenance and Relapse Prevention: sustaining the change over time

The SoC model shows that change in behaviour occurs gradually and that relapses are almost inevitable and become part of the process of working toward life-long change.

Coaching often includes presenting the coachee with a Model of Change (Centre for Coaching, 2007). The reason for this is that there are many factors that influence the effectiveness of the process of change and having knowledge of the change process can help the coachee stay motivated and focussed. This might be particularly helpful when the Coachee feels ambivalent about the changes as it often brings losses as well as gains. It might also be helpful when a coachee is investing tremendous effort and energy into the process of change but is seeing only minimal gains. Viewing change as a process may also remind the coachee that we need to be flexible towards our goals, as they may change or might need to be adjusted whilst entering further into the “change cycle”. As Emma had been critical towards her own lack of motivation, I felt that normalizing her emotions in accordance with the Stages of Change model would help defuse some of her own stigmatization. Despite my attempts to coach Emma into a positive experience of success, she continued to describe her thoughts in negative terms. She also mentioned that she always had this heavy feeling in the back of her mind that did not want to go away and that this heavy feeling related directly to her binge behaviour. At this point I was particularly keen not to digress into a therapeutic type intervention as by doing so, the boundaries between the coaching relationship and a therapeutic relationship would be blurred. I explained to her that we did not necessarily needed to go into the deep feelings surrounding her coping strategies and that it possibly would be most useful to her to keep focusing on her goal and identify the steps to achieve this. As identifying a clear goal was proving difficult for Emma I changed my question focus and asked her what the benefits would be for her if she did find alternative ways of dealing with her stress. She mentioned that she would lose weight, that her health would improve and that she would feel less stressed because she would not have the problem anymore. She also mentioned that her confidence would grow once she had learned to manage her stress without reaching for food. These benefits however did not provide us with a clear

defined goal. To ensure that we would have a measurable outcome to the sessions I asked Emma how she would know that our work had been successful. Emma felt that if she could get the binge habit down to only once a week she would be successful. The measurable overall goal therefore was to reduce the binge episodes to maximum once a week. At this point no measurable sub-goals could be identified.

We agreed that there would be several steps in between her current situation and her desired overall goal, and I suggested that the first step would involve moving from the “Contemplative” stage to the “Preparation” stage. The preparation stage would include getting in “the right frame of mind”.

Gaps

Emma mentioned that “getting in the right frame of mind “seemed to be a huge thing to do. To my question of how it feels to be in the right frame of mind, Emma answered that she would feel positive and up for the challenge. The identified gap at this point therefore was that she needed to get into the right frame of mind in order to obtain the skills and/or ability to manage her stress in a way that would give her quick release and/or enjoyment, other than binge-eating. Emma also recognised that there was a need to change aspects of her life to reduce the overall stress in the first place.

Action

In the final stages of the session, Emma mentioned that the process of thinking and talking about her situation was helping her to start to feel empowered; a feeling of “I can do it”. She started saying things like “It is *how* I am going to manage my stress I suppose”, and “perhaps I *will* have to deal with the stress in a different way”. These statements showed me that Emma now started to be ready to move to the Action stage of the SoC model. To check this out, I asked her how she would rate her motivation on a scale from 0 to 5, and her answer was 4. According to the SoC model she now was well and truly into the Preparation stage and was ready to

explore Action options. We discussed different actions she could start to take and Emma felt that she could start by delaying the behaviour for 5 minutes again, as this had been a successful management technique during the time she had been able to manage her stress more effectively. She also felt that she needed to start talking to her partner and children about the changes she was aiming to make, which included prioritizing some time for herself instead of focusing primarily on everybody else's needs. Emma felt that for years she had been limitlessly giving and giving to everyone around her, denying herself any time for self-caring. Emma expressed some thoughts of guilt about her need for self-caring, but felt that despite this, it was time for a change.

Evaluation

During the evaluation part of the session we summed up the progress that Emma had started to make and Emma left the session saying that she felt better already, feeling less stressed and more positive.

Initial formulation of coaching needs

Reflecting on this first session I felt that we had been able to establish good initial rapport and progress had been made as Emma had become ready to move from her pre-contemplative state to a state where she started to take some action. However, it puzzled me that we had not been able to achieve a more detailed vision of an end goal. Goal setting is one of the main steps within a coaching strategy and can in itself be a strong motivational power (Latham & Locke, 1991). My initial formulation was that Emma felt overwhelmed by all her home and work commitments and that she had not developed the skills to manage her time effectively nor to use self-care strategies to be able to maintain an emotional equilibrium. She seemed to allow feelings of stress to build up to a high level, until it would overwhelm her and then she would seek a quick fix in food binges. Emma also seemed to have developed a mental habit of focusing on the negatives in life which stopped her from being able and comfortable with exploring positive change. In line with the CBC model, I identified the following coaching needs:

- To learn to identify her negative thought processes in relation to her bingeing habit and stress
- To learn to develop more neutral or accurate thought processes in relation to her binge behaviour and stress
- To learn to challenge negative thought processes once she has identified them
- To learn to set positive goals with the help of the above mentioned processes
- To identify strategies to achieve those goals for the current coaching issue as well as for future issues (through learning how to self-coach)

B) The development of the Coaching Relationship

The coaching plan

Good coaching is always client-lead (Whitmore, 2003, p70) so, in contrast to a therapeutic intervention no firm coaching plan would be established. It is important that the coachee owns the process rather than the goals being imposed or assumed by the coach, as this would create an unproductive and dependent relationship (Leimon, Moscovici, & McMahon, 2005, p39-40). However, the coach helps the coachee to keep focusing on the overall goal and it is useful within this process for the coach to be aware of areas which might need further investigation through appropriate questioning. The exploration of the “current situation” had brought to the fore two main areas to focus on during the following sessions. Emma seemed to be struggling with episodes of acute stress overload for which she used bingeing as her only stress reduction strategy, and also experienced a chronic sense of being emotionally overwhelmed. Although it felt important to work on both levels of stress to ensure long-term benefits from the coaching, my plan for the next session was to give Emma a choice on where to focus on first. Whitmore (2003, p38) argues that giving people choice stimulates the coachee to take full responsibility for the coaching process which is crucial to achieving positive

outcomes. My assumption was that Emma was at this stage most concerned about directly addressing the binge behaviour. My second assumption was that the acute stress overload would reduce once she had developed strategies to maintain an overall sense of emotional equilibrium. There were at least three domains in Emma's life that were feeding into her experience of chronic emotional overload: emotional overload at work, emotional overload at home, and emotional overload in relation to study demands. I felt it would be useful to separate these three areas and address each one during individual coaching sessions as and when appropriate, and to make sure that a clear stress management strategy would emerge for each domain. Within each session I would integrate the CBC model to ensure that we obtained a better understanding of Emma's belief systems and automatic negative thought patterns in relation to her binge behaviour and perception of overall stress. This insight would then be used to help Emma to transform the negative thought processes into neutral or positive ones which would feed into the new stress management plans.

The coaching process and main techniques used

All sessions were conducted in a similar format as the first session, using the CIGAR model as its basic framework. The initial focus of the sessions was on the management of the binge behaviour in response to acute stress overload. To draw out all the aspects related to this behaviour, I decided to use the SPACE model as this model would give a good visual representation of all the aspects of her experience. SPACE is a psychological model which is used within cognitive behavioural coaching (Edgerton & Palmer, 2005). The SPACE model provides for a bio-psycho-social perspective in which SPACE stands for: Social context, Physiology, Action, Cognition and Emotion. The components of this model are used in a more graphical way than the more commonly used ABCDE model in cognitive behavioural approaches (ABSDE stands for: Activating events, Beliefs, Consequences, Disputing beliefs and Effects). Please see Appendix C for the graphical representation of Emma's SPACE model in relation to her binge behaviour. The SPACE model is developed with the coachee by first drawing out the aspects of the issue "as it is" (in black). The second stage is to identify which

aspects are most important by underlining them (ideally with a different colour pen), and the third stage is to add (again in different colour pen, blue) alternatives for the important aspects.

As we went through this process Emma developed a deeper awareness of the depth of her issues which is an important development within the coaching process (Whitmore, 2003, p33, p69). She now was able to identify some behavioural alternatives (See Appendix C, blue), which became Emma's intermediate goals: going to the gym/sauna once per week, using nurturing activities like reading and being assertive towards people who were demanding her time. The above exploration also brought to the fore some important cognitions. One of the main cognitions was "I am just a silly person". She said that she had been put down for so long by other people that she had started to do it to herself via a critical internal voice. It also became clear that the belief "I need to please everybody" was central to her binge behaviour and overall stress. We then spent some time looking at the pros and cons of pleasing everybody and Emma concluded: "Everyone takes my time. I can't sustain it. I don't want to be doing it and that makes me binge...I go back to my "stupid feeling".

From the information gathered in the first two sessions I was able to update my initial formulation into a CBC formulation which included more specific cognitions and beliefs (Please see Appendix D for the updated formulation). In the following session Emma mentioned that she had started to change her belief about having to please everybody into a belief around "I deserve it". We talked through the CBC formulation diagram and identified where changes had been made already. A new adapted diagram was formulated which now included positive beliefs and cognitions (See Appendix E).

As we evaluated the process, Emma realized that some real progress had been made within her belief systems. However, the individual stress management strategies for the different domains still needed to be identified. We constructed another SPACE diagram on the topic of studying and worked on the core belief of

“I am stupid”. We looked at evidence to support “being stupid” and evidence that supported that she could achieve her study goal. She came to the conclusion that it was likely that she would be able to complete the course as she had managed to get a degree already in the past. Now she had changed her belief from “I am stupid” to “I can do it” and she was ready to make a concrete plan on how to work through the assignments without accumulating a lot of stress.

The main obstacle within Emma’s progress occurred in session four. An unexpected conflict at work had caused Emma to feel very stressed again and she displayed one of the more common thinking mistakes identified in CBC as “all or nothing thinking”. This thinking pattern causes people to view events in extreme terms without allowing shades of grey (Neenan & Dryden, 2002. P5). Emma presented very disillusioned with her progress and felt that *everything* had been lost. Through careful analysis of the situation and looking at the evidence that supports or rejects the thinking mistake, CBC allows the coachee to formulate a more realistic view of the situation. In this case, the evidence that all had been lost was disputed as Emma reported that she had not fallen into binge behaviour despite her obvious experience of stress and distress. I also reminded her that in the SoC model some set-backs were expected within the cycle of change. Emma was now ready to re-evaluate the situation at work and through the use of Socratic questioning was able to design a strategy to come to terms with- and resolve the work conflict.

At the start of session five Emma reported feeling back on track again. The stress at work had been resolved and her life overall felt less stressful. Emma reported that she had continued with being assertive about her own needs within her family circle and had added more self-care interventions to her strategy by going on bike rides and relaxing in the sauna afterwards. In addition to this she had created a private space for herself in her home, by transforming one of the bedrooms into her own “sanctuary”. She said that she had not had the urge to binge once even though there had been “binge food” in the house. A start was made with designing

concrete plans to manage the different stress domains in her life with particular focus on managing her MSc course demands.

We started session six with evaluating the coaching progress. Emma had stayed on target with the study, continued to use self-care techniques and assertiveness skills to deal with stressors, was feeling calm and in control at work and in her home life, and had not fallen into binge behaviour since the start of the sessions. Emma however again fell in the trap of the CBC thinking mistakes: “discounting the positives” (Neenan & Dryden, 2002. P6). She was tempted to attribute her success to changes in circumstances rather than her own hard work. Socratic questioning again helped to remind her that she had been really stressed in the past under similar circumstances, which helped her to accept the credit she deserved. We completed the stress-prevention strategies for future challenges and concrete plans were drawn up for all three stress domains. I committed to writing our conclusions up in a Stress Prevention Plan (See Appendix F). The final part of the session was spent on discussing the CBC steps (Neenan & Dryden, 2002, p34: See Appendix G) for problems solving and how she could use these steps for managing future challenges without incurring stress overload.

Difficulties in the work and making use of supervision

My training in clinical psychology and work experience in this field has given me some advantages in relation to building rapport and using the CBC model. However, this advantage can easily be turned into a disadvantage as it would be all too easy to fall into a therapeutic type of relationship rather than staying in a coaching relationship. Emma’s coaching issue was closely related to mental health which further emphasized the need to maintain clear boundaries between coaching and therapy. On occasions this differentiation was in danger of being blurred and early on in the coaching relationship I sought supervision to clarify the appropriate coaching approach to deal with the presented emotional issues. If the sessions would have been within a therapeutic context, I would most likely have spent much more time on the history and development of the binge behaviour and also would have explored the meaning of these symptoms in more detail. However, my clinical

knowledge and experience allowed me to recognize that Emma's presentation was a coping strategy rather than a presentation that fitted a clinical diagnosis, and supervision helped me to stay focused in the here and now and to facilitate a process of self discovery in relation to achieving specific goals, without pathologizing a coping style which would otherwise have been classified as a symptom of deeper psychological disturbance.

A further challenge presented itself when Emma showed to have difficulties with identifying clear goals as this is one of the pillars of good coaching practice. At this point in the relationship I started to question my own skills and the quality of my questioning. It was not until I realized that learning to think positively about the future and to set positive goals was in itself a goal which needed to be addressed within the coaching process, for Emma to be able to set these goals. This skill could only be developed at a later stage within the process, once Emma had learnt to understand her negative thought processes. It helped me reflect on the coaching process and the need for flexibility, even if it means compromising on one of the main aspects of the coaching process.

Finally, the presented coaching issue turned out to be quite complex with many aspects that were feeding into the experience of feeling emotionally overwhelmed. The complexity of the case initially evoked a response in me, similar to the feelings experienced by the coachee, of feeling overwhelmed with the "chaotic circumstances" that this coachee was presenting. The challenge of facilitating a process of change within a brief coaching contract seemed rather ambitious. It challenged me to set aside my background in clinical psychology and trust that the coaching process would be sufficient and effective to deal with these potentially deeper issues. Reading up on this (Jenkins & Palmer, 2003) as well as making use of my supervision helped me to clarify my thought processes and to ensure that I did not respond with my clinical psychology hat on, or to respond with an overly complex mixture of techniques to facilitate this change.

Changes in the coaching process over time

Although I had developed a basic coaching plan, it became clear that a flexible approach to session content was needed. During the course of the sessions several major changes happened within Emma's life which needed attention straight away. The content of coaching therefore turned out to be much more "ad hoc" than I had originally anticipated. However, using acutely stressful situations proved to be beneficial in that it gave opportunity to deal with current stress issues in the here and now, without losing track of the overall goal.

C) The conclusion of the Coaching Relationship

Ending the coaching relationship and evaluation of the work

Despite the complexities that this case presented, the ending of the coaching relationship after just six sessions felt appropriate and timely. Although further work could have been identified, the ultimate goal of CBC is to enable the coachee to utilize the newly learnt coaching skills for self-coaching (Neenan & Palmer, 2001). Emma left the last session feeling very optimistic about her ability to maintain an emotional equilibrium and to handle future challenges by using the tools she had learnt within the sessions. Despite some hic-ups and challenges along the way, the coaching process had been successful in terms of goal achievement for the coachee and learning objectives of the coach.

Arrangements for follow-up

As maintaining the gains made in coaching requires consistent work and commitment (Neenan & Dryden, 2002, p156), we agreed that it would be useful to book a follow-up session to enable us to evaluate the sustainability of the progress made. The follow-up session was held ten weeks after the last coaching session and during this session Emma had maintained her progress and continued to manage her life's challenges without resorting to binge behaviour.

What I have learnt about the practice and theory of coaching

This case has given me the opportunity to explore in theory- and experience in practice- the difference between coaching and therapy. I have become more aware of the pitfalls in relation to this, but have also become aware of the immense potential for coaching within contexts that could otherwise be classified as borderline mental ill-health. The case has shown me that an enormous amount can be achieved within a surprisingly short space of time, without having to revert to labelling coping strategies as symptoms. Furthermore, the coaching process has proven to be very empowering to the coachee which is satisfying for the coachee and the coach alike.

What I have learnt from the case about myself

Although I have been keen to make the transition from clinical to coaching psychologist, this transition has not always been easy. This case has given me the opportunity to really think- and practice- hard on this. My preferred model of working within the clinical context is person centred and solution focused, which allows for a less structured approach than CBC. Additionally, over the years my clinical approach has evolved to a much more eclectic style, to suit each individual client's needs. Working with the CBC model therefore challenged me to work much more structured than I was used to and to stay within a model which is not my first choice of working. However, looking back on the process I have enjoyed this challenge and feel richer for having experienced it. I have witnessed immediate benefit for the coachee and the work environment which encourages me to pursue further application of this within my work context. What is more, I have learnt that I thoroughly enjoy the coaching process and feel excited about developing my skills further within the coaching psychology specialty.

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Appendices

Appendix A

Coaching definitions as specified by the Association for Coaching:

Personal/Life Coaching

"A collaborative solution-focused, results-orientated and systematic process in which the coach facilitates the enhancement of work performance, life experience, self-directed learning and personal growth of the coachee."

Executive Coaching

"As for personal coaching, but it is specifically focused at senior management level where there is an expectation for the coach to feel as comfortable exploring business related topics, as personal development topics with the client in order to improve their personal performance."

Corporate/Business Coaching

"As for personal coaching, but the specific remit of a corporate coach is to focus on supporting an employee, either as an individual, as part of a team and/or organisation to achieve improved business performance and operational effectiveness"

Specialty/Niche Coaching

"As for personal coaching, but the coach is expert in addressing one particular aspect of a person's life e.g. stress, career, or the coach is focused on enhancing a particular section of the population e.g. doctors, youths."

Group Coaching

"As for personal coaching, but the coach is working with a number or individuals either to achieve a common goal within the group, or create an environment where individuals can co-coach each other."

Appendix B

Consent Form one-to-one Coaching

Doctorate in Coaching Psychology at City University

Individual Coaching Sessions

I understand that Addy Hackett is a student at City University and that the coaching sessions I receive from her are audio recorded for the purpose of her continued professional development in partial fulfilment of her Doctorate in Coaching Psychology.

I understand that these recordings may be used to write up a case study and, if so, that a section of one of the recordings will be submitted to the university supervisor as an example of the coaching process.

I understand that the case study may be submitted for publication and that all identifiable information will be taken out of it prior to publication. I will be asked to read the draft article to ensure that I am happy with the content of the case study prior to publication.

I understand that all the materials obtained from the sessions will be kept confidential and anonymous at all times.

I give my consent for these sessions to be used as training material
and to be written up as a case-study

Yes / No

I give consent for these sessions to be audio recorded

Yes / No

I give consent for the case-study to be published

Yes / No

Name

Signed

Date

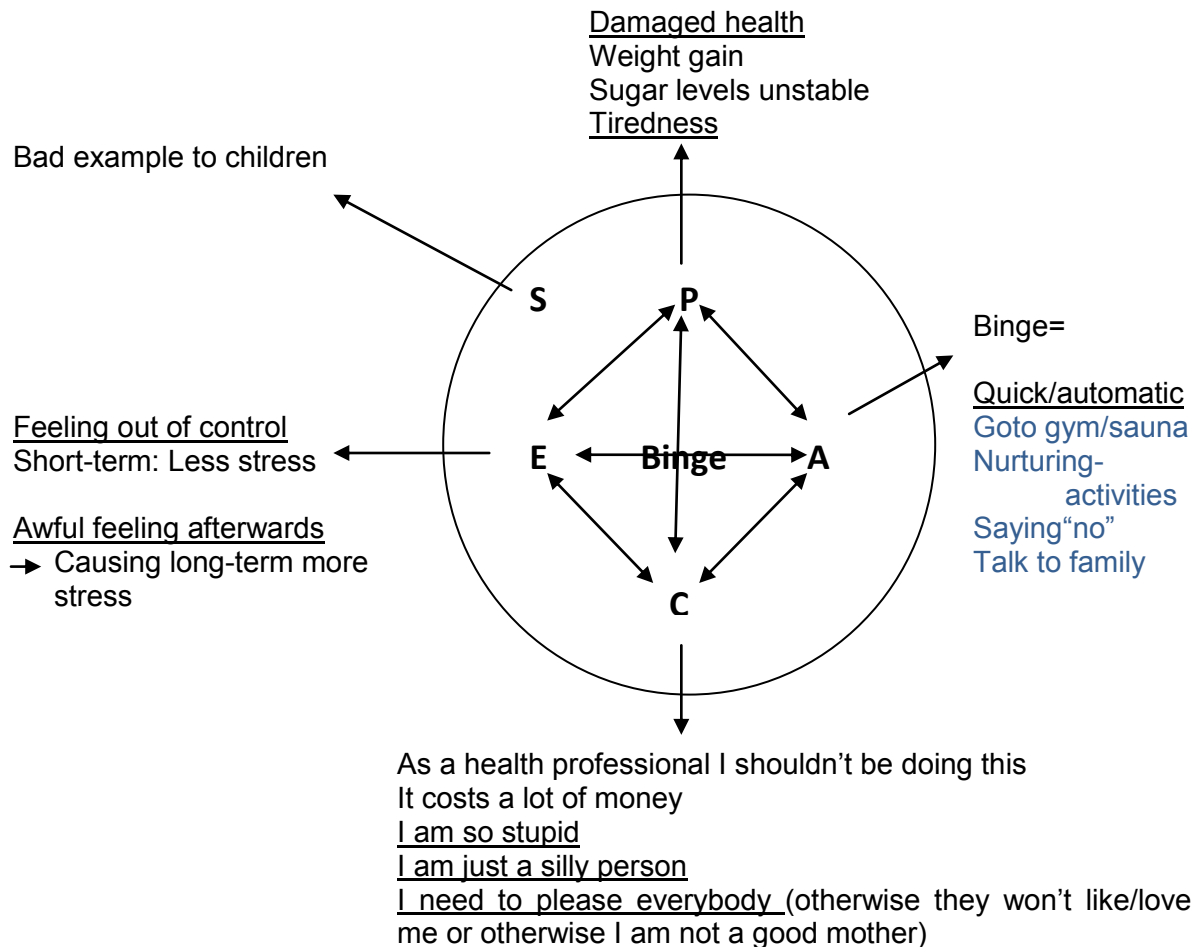
Addy Hackett

Signed.....

Date

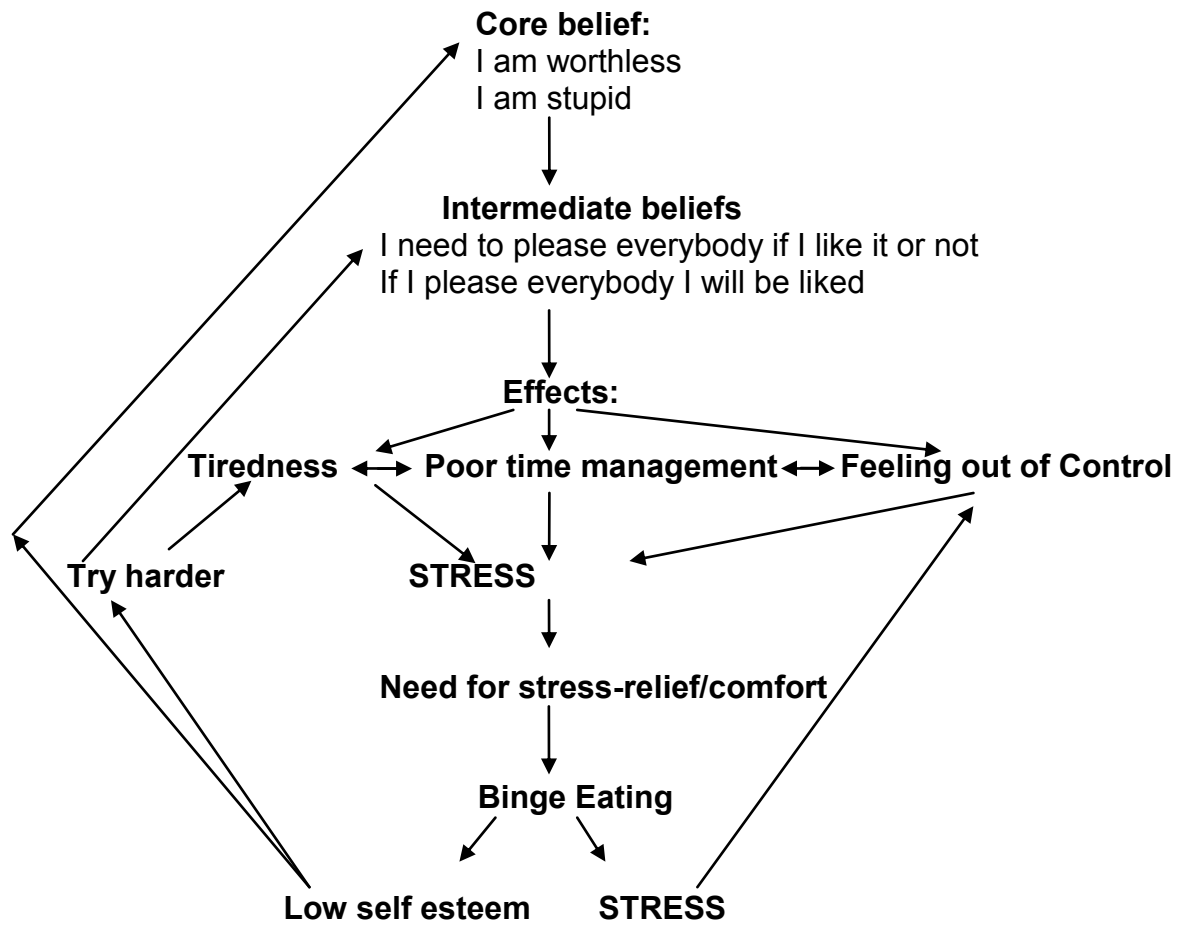
APPENDIX C

Emma's SPACE model Relating to binge behaviour



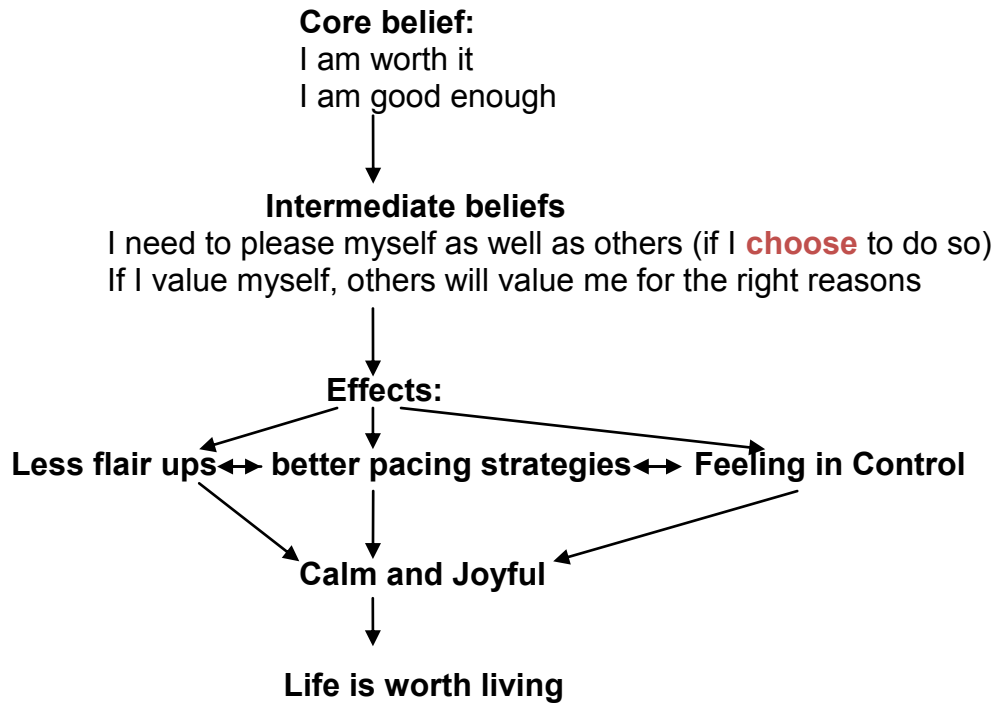
APPENDIX D

Updated CBC formulation



APPENDIX E

Positive Cognition formulation



APPENDIX F

Emma's stress prevention plan

Preventing Stress at Work:

- **Not overload myself:** Limit the number of patients to max 2 on Mondays and max 4 on other days.
- **Take a lunch break:** Plan in the morning when it will be a good time to take a break that day.
- **Delegate some work as/when appropriate.**

Preventing Stress relating to Study:

- **For each module, make a written time schedule.** This needs to happen on the first college day of each module. It needs to be specified in clear steps to be achieved on certain days and needs to be realistic within the available time.
- **Sticking to the time schedule!**
- **Remind myself that I can do it.** Remind myself of previous achievements

Preventing/Managing Stress at home:

- **Continue to value my own emotional needs and don't allow myself to be used.**
- **Continue to create time for myself on Sundays:** Going to the gym/steam room, cycling etc.
- **Continue to create time for reading:** this ideally would happen on a daily basis.
- **Continue to create space in the house that is a quiet space for me to retreat to when needing to de-stress.**

APPENDIC G

CBC coaching steps

Steps	Questions/Actions
1. Problem identification	What is the concern?
2. Goal selection	What do I want?
3. Generation of alternatives	What can I do?
4. Consideration of consequences	What might happen?
5. Decision making	What is my decision?
6. Implementation	Now do it!
7. Evaluation	Did it work?

Section D: Critical Literature Review

Which Stress Management Programmes are most effective for Nursing Staff and Student Nurses?

Introduction

The Health and Safety Executive (HSE, 2001) has identified “Healthcare” as one of the five priority sectors where work related stress is most reported as being a major cause of absence. Evidence suggests that work stress is a precipitating factor of diagnosable depression and anxiety in previously healthy young workers (Melchior, Philipsen & Abu-Saad, 2007). Approximately 1.3 million people work in the National Health Service (NHS) and the National Audit Office found stress related illness to be the second highest cause of sickness absence in the NHS accounting for 30% of lost time. Among nurses the prevalence of stress is about three times the national average (Pascoe, 2005). The Annual NHS staff survey run by the Healthcare Commission (the independent inspection body for both the NHS and independent healthcare) reports that work-related stress has fallen from 39 per cent in 2003, to 35% in 2005 to 33% in 2006. The Commission also reports improvements in safety by illustrating a fall in the percentage of staff saying they saw errors, incidents or “near misses” with potential to harm patients, down from 49 per cent in 2003 to 38 per cent in 2006. The above figures show a positive trend in the reported stress by NHS staff, however, they also show that one in three employees still report feeling stressed in relation to their NHS work. The above figures highlight the need for effective stress management programmes in the NHS.

The Nursing and Midwifery Council (NMC) maintains the register of qualified nurses, midwives and health visitors for the UK. The NMC register is updated on a daily basis and contains over 600,000 records. The NMC estimated that, as of the

end of March, 2004, roughly 632,000 (or 96%) of the 660,215 registrants resided in the UK, of whom roughly 509,000 were in England, 64,000 in Scotland, 32,000 in Wales and 22,000 in Northern Ireland (Batata, 2005). As a large percentage of NHS staff are nurses, this staff group has been chosen to assess the evidence of effectiveness of stress management interventions. The aim of the review is to identify the most effective strategies and, in this way, to contribute to the development of appropriate and effective programmes which are fit for purpose and meet the needs of the current NHS organization as well as its individual staff members.

Rationale for including this review in the Thesis

Over the years, many different approaches have been put forward and researched in order to aid the management of stress in the nursing profession. The research section of this Thesis (Section B) explores stress in palliative care, as well as the effectiveness of a coaching intervention to help this staff group manage their perceived stress. The coaching model presented in the research section has not been researched within the nursing profession before and aims to add to the existing knowledge. The coaching approach to stress management offers a modern, cutting-edge intervention which could be applied holistically, on an individual and organizational level alike. To be able to develop effective coaching strategies, it is important to learn from and integrate previous research evidence of effective stress management strategies as applied within the NHS organization. The knowledge obtained from this review therefore links directly to section B of this Thesis as it underpins the development of effective coaching interventions within the NHS of the future.

Workplace stress management

A full definition of stress is given in section B of this Thesis (please see chapter 1.2.1). Stress in the workplace is often referred to as “occupational stress”, and refers to the strain experienced as a result of the demands presented by an

organisational setting. Work-related stress has been defined from a range of perspectives of which the transactional perspective is widely accepted. The transactional model conceptualizes stress as an outcome of ongoing situational transactions. It views stress as “too much or too little arousal resulting in harm to mind and body” (Schafer, 1992, p14), with demands only becoming distressing and potentially harmful when they are perceived as such.

Ivancevich, Matteson, Freedman and Philips (1990) defined workplace stress management interventions as “any activity program or opportunity initiated by an organization which focuses on reducing the presence of work related stressors or on assisting individuals to minimize the negative outcomes of exposure to these stressors. Stress management programmes vary widely with respect to objectives, type of intervention, structure and target group. Occupational stress management programmes in particular are subject to great variation as the programmes can focus on individual employees as well as organisational aspects. Organisational stress management programmes can therefore be grouped into different categories. Newman and Beehr (1979) identified 12 categories based on the types of adaptive response or participants (person, organization, outsider), the primary target (person, organization) and the type of response (preventative, curative). DeFrank and Cooper (1987) simplified this classification by distinguishing interventions as well as outcomes of stress management programmes on three levels: Individual, individual-organisational interface, and organizational. Murphy (1988) also highlighted three levels of intervention, namely a primary level (stressor reduction), a secondary level (stress management) and a tertiary level (Employee Assistance Programmes).

In this review the classification of DeFrank and Cooper’s (1987) has been used to classify the existing literature on stress management for this staff group. However, only the first two categories have been used: Stress management strategies targeting individuals and stress management strategies targeting the individual-organisational interface. The third category has been left out of this review as it would tap into the operational management strategies of the NHS which fall

outside the remit of this Thesis. The first category, stress management strategies for individuals, is split into two further categories: 1) Single-method interventions for individuals, 2) Multi-method interventions for individuals.

Method and boundaries of the review

Due to the changing philosophy of the NHS it was decided to limit this review to articles published within the last 20 years. This review therefore includes articles published between 1988 and June 2008. The review was conducted using the following data bases: Cochrane Library, CINAHL, Medline, PsychINFO, British Nursing Index (BNI), Royal College of Nursing (RCN). A visual inspection of the reference lists of the retrieved articles was also used. Key words used were: Nursing, Nurses, Student Nurses, Stress, Stress Management, Stress Reduction, Anxiety, work-related distress, work-site, burnout prevention. Included in the review are articles which clearly describe at least one stress management intervention and the research design used was mainly quantitative using pre-experimental, quasi experimental or randomized controlled designs. Further inclusion criteria were that the studies used qualified nurses and/or student nurses as participants and that the participants worked in hospital settings within the physical health arena. Although the work tasks and responsibilities differ between student nurses and qualified nurses, it was felt appropriate to include research on students as they make up a significant proportion of the nursing force. An additional consideration in this was that the challenges faced by student nurses would overlap with those experienced by qualified nurses, and challenges would continue to present themselves throughout the nursing career.

In total 30 studies published within the identified time-span were sourced, and 29 were retrieved. One study by Forbes (1992) could not be retrieved and it is unclear if this study would have met all the criteria. In total 16 studies met the additional criteria as set above. These 16 studies will be discussed below according to the category they fall into. Within these categories, the listings are presented alphabetically.

Review of the literature

1a. Stress Management Strategies for Individuals: Single-Method Interventions.

Relaxation Training

King, J.V. (1988)

King studied the effects of relaxation training which included a guided imagery script (RGI) to test the effects on reducing state anxiety as measured by the State-Trait Anxiety Inventory (STAI: Spielberger, Gorsuch & Lushene, 1983). The RGI script was administered three times, at two week intervals between the sessions. The research used an experimental pre-test/post-test design for one group only. No control group was used. In total 33 graduate nursing students participated. The findings show that short-term state anxiety was reduced using this method, but no changes were measured for trait anxiety. The main limitation of the study was of course that there was no control group. Additional limitations were the fact that the STAI measurements were repeated six times which could have caused the figures to be skewed, as well as the fact that the research was using volunteers as its participants.

Stanton, H.E. (1988)

This study investigated the benefits of deep relaxation and visualization techniques to manage stress. The study used an experimental design with control group. The measure used was the Stress Profile (Kiev & Kohn, 1979) and measures were taken before and after the course of sessions, and one follow-up 9 months later. The nurses were matched on their Stress Profile and one member of each pair was allocated at random to either the experimental or the non-treatment control group. Once the experimental intervention had been completed the control group experienced the same treatment sessions as the experimental group. The programme existed of four sessions, the first session lasting 50 minutes to include the teaching of the technique as well as a practical aspect, the following three

sessions lasting 20 minutes to practise the technique only. The results show that stress was significantly lower both immediately after treatment as well as at nine-month follow-up. Although the results of this study are very promising, there are some limitations that need to be considered. The main limitation of this study is that it uses a measure that does not seem to be widely used or validated. It may therefore not accurately reflect the nurses' perception of stress. An additional limitation is that the participants were self-selected and sought help in coping more effectively with the pressures they experienced in their work environment.

Assertiveness training

Lee & Crockett (1994)

This study examined the effectiveness of assertiveness training for improving perceived stress and assertiveness amongst nurses in Taiwan. The study used a two-group experimental design with pre and post tests and a follow-up. One group received assertiveness training and the other group became the control group. In total 60 nurses volunteered to participate in the six 2-hour workshops. The measures used were the Rathus Assertiveness Schedule (Rathus, 1973) and the Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983). The treatment group scored significantly lower on reported stress and significantly higher on assertiveness than the control group, indicating that assertiveness training has a positive effect on stress for this nursing group. However, the generalisability of this study is limited as cultural characteristics could have influenced the outcome as well as the fact that the sample group was self-selected.

Yamagishi, Kobayashi, Kobayashi, Nagami, Shimazu, & Kageyama (2007)

The purpose of this study was to examine the effects of a web-based assertion training programme on assertion knowledge, attitude and behaviour, job stress and depression. The programme lasted 70 minutes spread over three weeks. In total 25 Japanese nurses volunteered to complete the course. Three measurements were taken, one pre- and post measure and one follow-up measure one month after finishing the course. The measures used were the Assertive Mind Scale

(AMS, Ito 1998), the Assertion Check List (ACL, Hiraki, 1993) the Job Stress Brief Questionnaire (Nishikido, Kageyama & Koboyashi, 2000), the Brief Job Stress Questionnaire (Shimomitsu, Yokoyama & Ohno, 1998) and a demographic questionnaire. The results show that Assertion Knowledge and Voluntary Behaviour of the ACL significantly increased at post-training. This increase was maintained at follow-up. The mental job stress variable had decreased after 1 month but did not show to be significant. The research did not show any significant changes towards job-stress. There are several limitations to this study, as the participants were volunteers from one hospital, and no control group was used. Although the results show benefits for increased assertion following this course, no evidence was produced to suggest it was a useful programme to reduce stress amongst the nursing group.

Imagery

Speck, B.J. (1990)

This study examined the effect of guided imagery upon anxiety as experienced by nursing students learning to perform their first injections. Although this intervention targets only one specific area which can cause stress amongst nursing students, the author argues that nursing students are faced with many highly stress evoking situations and the proven benefits of the imagery techniques could therefore be generalised to other areas of the nursing profession. The study uses a quasi-experimental design with pre and post test measures and control group. The State-Trait Anxiety Inventory (Spielberger, Gorsuch, Lushene, Vagg & Jacobs, 1983) was used to obtain self-reported anxiety data and the Biodot Stress Dots were used to measure physiological stress. Further measures were “students’ performance time” and “performance Score”. The experimental group received instruction on guided imagery through the use of an audio cassette tape plus 3 hours of supervised practise. It is not clear from the article if the control group also received the 3 hours of supervised practise. The control group existed of ten subjects and the experimental group existed of 16 subjects split into two groups. There were no significant differences between the experimental and control groups

on age, number of children, hours of employment and the baseline measures of the STAI.. However, the groups differed in marital status, gender and number of semester hours. Using analyse of covariance, the results showed significantly lower self-reported anxiety for the experimental groups. No significant differences were found on the other measures. However, the fact that the groups differed on some important factors may reduce the generalisability of this study as well as the fact that the study used only a small number of participants who also were not randomly assigned to the experimental and control groups. A final limitation of the study is that, apart from the STAI, the measures lacked validity.

Educational

Razavi, Delvaux, Machal (1993)

Razavi *et al.* conducted a randomised controlled study investigating the effects of a psychological training programme (PTP) on attitudes, communication skills and occupational stress in oncology. In total 72 nurses took part in this study, which existed of 8 weekly sessions, each lasting for 3 hours. Participants were self selected and were assigned to groups of 12. Six members within each group were assigned to the experimental or the control groups. The sessions used a teaching approach. Issues were discussed related to patient care, health care professional' problems and family care. The sessions included role-play on patient related issues like pain control, collusion and euthanasia requests. The assessment of this study is rather complex, using ratings from independent assessors through semi-directive interviews, a Semantic Differential Questionnaire (SDQ, Silberfarb & Levine, 1980) as well as the Nursing Stress Scale (Gray-Toft & Anderson, 1980).The results show a significant training effect on the total attitudes scores, including attitudes about self, attitudes toward illness and death, and occupational attitudes. A significant result also came up for the nursing stress sub-scale: stress related to inadequate preparation. After a two month follow-up the positive effects of the training had been reversed.

The outcome of this research is very difficult to evaluate as the treatment formula lacks clarity and the aim of the study was not clearly defined. An additional difficulty is that the actual stress levels are not reported.

1b. Stress Management Strategies for Individuals: Multi-Method Interventions

Foley & Stone (1988)

This is a pilot study using a repeated-measures design with control group, to assess the effectiveness of stress inoculation with nursing students. Thirty-six student nurses participated in a programme existing of four 1 hour sessions which included teaching on stress, identification of the relationship between thoughts and feelings and their relationship to stress, progressive muscle relaxation and imagery. Eight measures were used including the State-Trait Anxiety Scale, The Cognitive Need Scale (Cacioppo et al, 1984), a self-efficacy Measure (Bandura, 1977) and The Revised Ways of Coping Checklist (Folkman & Lazarus, 1983). The results show a positive trend in the treatment group but this was not statistically significant. However, the treatment groups showed a significant increase in positive coping strategies. The study has some major limitations as the power was compromised due to the small sample size and the large number of measures. Also, the control group was not included in the follow-up measurements.

Godbey and Courage (1994)

This study is different from most of the other studies as it used an individualized stress-management programme for nursing students who had identified their own stress. The design is quasi-experimental using pre-test/post-test measures and follow-up, including a control group. The programme existed of a 6 weekly counselling sessions facilitating adaptive coping strategies related to nutrition, exercise, progressive relaxation, cognitive control and time management. The

measures used were: the Hudson's Inventory of Self-Esteem, the Generalized Contentment Scale (Hudson, 1982) and the State-Trait Anxiety Inventory (Spielberger *et al.* 1983). The results show significant increases in self-esteem and decreases in depression and anxiety. A major limitation of this study is that the sample group was very small, as there were only 7 participants in the experimental group and 12 in the control group which limits the interpretation of these results due to lack of power. Additionally no attention has been paid to confounding variables related to the individual attention participants received during the counselling sessions.

Heaman, D. (1995)

Heaman examined the effectiveness of a 5-week stress management programme for 40 first year nursing students. The study uses a quasi-experimental pre-and post-test design with control group. The participants were randomly assigned to two experimental and two control groups. Five students withdrew from the programme due to scheduling problems and other commitments. The intervention consisted of five 90 minute training sessions spread over 5 weeks. The content of these sessions included didactic information, cognitive modification techniques and Stroebe's Quieting Response (QR) (Stroebe, 1978) including the use of diaries and an audio cassette, and augmentation with biofeedback techniques for self-relaxation. The control groups did not receive any treatment. The measure used for this study was the State-Trait Inventory (Spielberger *et al.* 1983.) The results show a significant reduction of state anxiety for the experimental groups, while this remained relatively unchanged for the control groups. There were no significant changes found for trait anxiety. Overall, this is a well executed research, although the numbers of participants are too low to draw definite conclusions. Limited attention is given to confounding variables.

Johansson, N (1991)

The aim of this study was to evaluate the effectiveness of a stress management programme using education, relaxation training aided by biofeedback, and cognitive restructuring. The programme consisted of six 50-minute sessions held

twice per week for three weeks. The study used an experimental pre-test/post-test design with control group. The participants were 424 sophomores nursing students and 34 senior students. The measures used were the State-Trait Inventory (Spielberger *et al.* 1983) and the IPAR Depression Scale (Krug & Laughlin, 1976). The results show significant differences in anxiety and depression between the experimental and control group, with reduced levels for the experimental group. The results also show that the sophomores and seniors were equally responsive to the stress management programme. This study has limitations for generalization as the participants were not representative for the whole nursing profession as they were students in a baccalaureate nursing programme in a small, private, sectarian liberal arts college.

Michie & Ridout (1990)

This study evaluates a two day course of stress management for nursing staff combining teaching, discussion, cognitive coping strategies, physical relaxation and role-play. The study used a pre-test/post-test design with follow-up, and the measures used were the State-Trait Anxiety inventory (Spielberger *et al.*, 1983) and a measure of job satisfaction. In total 16 nurses participated. The results show that the state and trait anxiety were significantly reduced while the level of job satisfaction was increased. No follow up measures are available as there were too few respondents who returned the forms after 1 month.

There are several limitations to this study. First, it does not give much information about the participants and no control group was used to rule out confounding variables. Second, the job satisfaction measure was not specified and it is unclear if the tool used has been validated. Third, the course used a wide variety of topics and methods of teaching with no clear measurements used to assess their usefulness. This makes it difficult to identify which aspects of the course are most effective in stress management. Fourth, the group of participants is very small and further studies would be needed to validate the results. Overall, the presentation of the research methods has been rather poor, which makes the evaluation of this course very difficult.

Russler, M.F. (1991)

In his study, Russler investigates the effectiveness of a multidimensional stress management training consisting of a 16-hour workshop spread over two days. The training programme incorporated cognitive, behavioural and physiological approaches to stress management. In total 57 baccalaureate nursing students took part with 19 subjects randomly allocated to an experimental, placebo or waiting control group. The design of the study was experimental, using pre-test/post-test measurements for the three groups. The experimental group received teaching, guided relaxation, refuting irrational beliefs and assertiveness skills. The placebo control group was structured around self-awareness and no direct attempt was made to change an individual's appraisal and coping skills. The content included teaching on basic stress concepts, self-writing, identification of stressors, values clarification and social support. The measures used were the State-Trait Anxiety Inventory (Spielberger *et al.*, 1983), the Reported Emotions Survey (Folkman & Lazarus, 1985a), the Ways of coping (Folkman & Lazarus, 1985b) and the Coopersmith Self Esteem Inventory (Coopersmith, 1981). A repeated measures analysis of variance demonstrated no significant differences between the groups across time, indicated that this programme did not have a positive effect on perceived stress. A major problem with this study is the multiple-treatment interference which might have obscured the effective components of this study. Too many confounding variables makes the (non)effectiveness difficult to evaluate.

Stephens, B.L. (1992)

This study examines the effectiveness of audio-taped imagery in reducing anxiety amongst student nurses in relation to test taking. The study uses a quasi-experimental pre-test/ post-test design with control group. A total of 159 participants were recruited and randomly assigned to treatment group 1 (using imagery only), treatment group 2 (using imagery plus 5 minutes of progressive relaxation), and a control group. The imagery technique used was an audio-tape which was developed by the author and lasted 15 minutes. Participants in group 1 were asked to listen to this tape every day for five consecutive days, followed by 3 times per week for three weeks. Participants in group 2 received the same

treatments but the tape for this group included 5 minutes of progressive relaxation, presented before the imagery. The control group received no tape. The measure used was the State-Trait Anxiety Inventory (Spielberger, *et al.*, 1983) and an evaluation questionnaire with open questions. Only subjects who reported listening to the tapes five or more times were included in the analysis. Based on the results of the evaluation questionnaire, the experimental groups were reduced to 31 subjects each and the control group to 38 subjects. The results show that state anxiety scores of the experimental groups were significantly lower for the control group. No differences were found between the two experimental groups. Subjects in the experimental groups also reported an increased sense of well-being, improved ability to sleep, greater energy, and improved self-confidence. This study does not comment on the levels of trait anxiety and does not report on longer term benefits, as no follow-up measures were done. It also reports that the control group differed significantly from the experimental groups which makes the interpretation of the results dubious. The study uses relatively small numbers of participants and would need to be replicated to validate the results. The paper does not report on the specific imagery techniques used, it just states that it was designed by the author. This makes it impossible to replicate this study.

Tsai & Crockett (1993)

Tsai and Crockett studied the effectiveness of relaxation training, using a cognitive-behavioural model and combination of meditation and imagery. The design used a pre-test/post-test model with a control group. The measures used were the Nurse Stress Checklist (Benoliel, McCorkle, Georgiadou, Denton & Spitzer, 1990) and the Chinese General Health Questionnaire (Cheng, Wu, Chong & Williams, 1990). In total, 137 subjects were selected randomly from three teaching hospitals in Taiwan, 134 nurses participated in the end. From each hospital, twenty-three subjects were allocated to the experimental group and 23 in the control group. The training consisted of three 90-minute sessions, held in week one, two and five. The sessions included a presentation on sources of stress at work, relaxation as a coping method, and the process of relaxation. The control group had the same sequence of sessions with a presentation on theory analysis in nursing. The results

show that the relaxation used in this study decrease the nurses' self-reported work stress and increased the self-reported psycho-physiological health. It is not clear from the paper if the groups were similar at the start of the treatment. The measurements of the control group decreased from week 1 to week 2 and then kept stable between week 2 and 5. Contamination, placebo effect or other factors might have contributed to this.

2. Stress Management Strategies targeting the Individual-Organisational Interface

Jones & Johnson, 2000

This is a well executed study using a randomized controlled design with pre and post test and follow-up. The intervention consisted of six 2 hour sessions, each incorporating 15 minutes presentation on the practice of specific coping skills like self-monitoring, the use of problem solving strategies to change the situations, the use of cognitive techniques of situational re-appraisal, the development of time and self-management skills to improve personal effectiveness, and the use of experiential learning. Each session also incorporated the learning of different aspects of a rapid relaxation technique. The participants were helped to formulate their own stress management plans. In addition, strategies described as having an interface/organisational focus were included, using the participants experience as a focus and using group work to reduce work-family stress. The measures used were the General Health Questionnaire (Goldberg, 1978), the State-Trait Anxiety Inventory (Spielberger *et al.*, 1983), The Beck Depression Inventory (Beck, 1978), The Derogatis Stress Profile (Derogatis, 1980), The Beck and Srivastava Stress Inventory (Beck & Srivastava, 1991), and The Ways of coping Questionnaire (Coyne, Aldwin & Lazarus, 1981). Additional data was collected through Objective Performance Measures like sickness and absence and measures of course work and examination performance. The results show that the intervention had a significant impact on affective well-being and anxiety. The intervention produced

changes in coping with an increase in rational task-orientated coping and adaptive changes in “relaxation potential” scores seen post-intervention for experimental group participants were maintained to follow-up. The intervention group also reported a reduction in situational, course-related sources of stress as well as adaptive changes in “domestic” and “vocational satisfaction” which demonstrated an impact of the overall programme at an interface level. However, no detectable effects on organisational outcomes of sickness, absence, and academic performance were found. The study identified some threats to internal validity. For instance other variables like social support, and the positive experience of being able to “escape” from difficult clinical situations” for a little while could have influenced the positive outcome of the study. Another difficulty is that the intervention did not have a clearly defined organisational element within it. To understand the impact outcomes such as sickness absence, an investigation and intervention on organisational level may be needed.

Proctor, Stratton-Powell & Tarrier (1998)

This research assesses the impact of a training program for care staff in nursing and residential homes for the elderly on staff stress. Although the paper states that the research method is a randomized controlled trial, the allocation to the groups was actually not random. The research used 12 homes of which six received training and the other six became the control groups who did not receive training. There were two elements to the training schedule which lasted 6 months. First, a series of seven, hour-long seminars were provided by a multi-disciplinary team which covered topics related to the care of the residents on topics where staff perceived to have lack of knowledge. The second part of the training focused on helping staff to become skilled in behavioural management of residents by developing individual care programmes. The measures used were the Occupational Stress Indicator (Cooper, Sloane & Williams, 1988) and the General Health Questionnaire (Goldberg & Hillier, 1978). This research did not work with specific stress management strategies, but rather focussed on managing environmental factors and receiving appropriate knowledge for the job. The results are interesting as the stress levels for both the treatment and the control groups

went up after the intervention, which was attributed to the organisational and managerial changes which occurred in some of the homes. The results for the treatment group however came out slightly more favourable than the control group which could indicate that the programme slowed down the rising stress levels. However, these findings were not significant.

Summary of findings

In category 1a, stress management strategies for individuals using single-method interventions, four different intervention options were investigated: relaxation training, assertiveness training, imagery training and an educational programme. Two studies (King, 1988; Stanton, 1988) investigated relaxation training as its primary method, but included visualization techniques to aid the relaxation. The studies reported reduced state anxiety and reduced stress respectively but both had limitations. King (1988) had not used a control group, and the measure used by Stanton (1988) had not been validated effectively. Both studies used volunteers.

The effectiveness of assertiveness training on stress was researched by Lee and Crockett (1993) and Yamagishi *et al.* (2007). These two studies differed from each other as the first study was done using six 2-hour face to face sessions whilst the second study used web-based assertion training. Both studies showed improved assertiveness, but only the study by Lee & Crockett (1993) reported reduced stress. The design of the latter study was more thorough as they had used a control group and a larger sample size. The studies were conducted in Taiwan and Japan respectively, and thus might reduce generalizability to western societies. One study by Speck (1990) aimed at using Imagery to reduce anxiety for student nurses. Although a small part of this course involved relaxation, this research was grouped separately from the relaxation intervention as the aim was not primarily relaxation, but to use imagery to “practice and rehearse” specific, anxiety provoking tasks. The results showed significantly reduced anxiety however, there were some major limitations to this study, including lack of randomisation and small number of participants. The benefits of an educational programme on stress was researched

in only one study (Razavi *et al.*, 1993). Although the study was well designed, it did not directly teach on the concept of stress but rather taught on job specific issues amongst oncology nurses. Stress related to inadequate preparation improved significantly as well as the training effect on the total attitudes scores. However, these positive effects were not maintained at two month follow-up.

In category 1b, stress management strategies for individuals using multi-method interventions, eight studies were found. All of these studies included an element of teaching, some relaxation training and cognitive behavioural modification. The format and length of the intervention varied widely between the studies, with some using two whole day workshops and others spreading the teaching over several weeks. The studies used a wide variety of tools to measure the outcomes but except from the study by Tsai and Crockett (1993), all studies used the State-Trait Anxiety Inventory (Spielberger *et al.*, 1983) as one of their measures. This at least provides some consistency to help with interpreting and the comparison of the results. Most of the studies indicate that a multi-method approach can be effective in the management of stress. However, two of the studies (Foley & Stone, 1988; Russler, 1991) do not support this benefit. Reasons why the Foley and Stone (1988) research did not support these findings may be found in the fact that they used a large number of measures with a relative small number of participants, which may have compromised the power of the analysis. Only a small number of the studies report on both state and trait values on the STAI. The benefits on state anxiety have been most prominent although Michie and Ridout (1990) report significantly reduced anxiety on the trait scales as well. All studies present with a number of limitations, but despite these limitations the overall trend shows that multi-method interventions can be effective for the management of stress.

Category 2 covers studies on stress management strategies which target the individual-organisational interface. Two studies were found that fitted in this category. The Study by Jones & Johnson (2000) showed a significant impact on affective well-being and anxiety. The intervention group also reported a reduction in situational, course-related sources of stress as well as adaptive changes in

“domestic” and “vocational satisfaction” which demonstrated an impact of the overall programme at an interface level. One of the difficulties with this study was that the intervention did not have a clearly defined organisational element within it. The study by Proctor et al. (1998) aimed to improve knowledge on aspects of care, as well as develop individual care programmes for the residents. This study did not show to improve stress. Organizational changes during the time of the research may have influenced these results.

Conclusions

The above reviewed studies highlight the breadth of interventions and strategies used to facilitate the management of stress. The studies not only used a variety of interventions and combination of interventions, they also differed in terms of format (individual vs group), time-span and intensity. Overall, the research into each specific stress management intervention is very limited and the use of different research methods and target groups makes it difficult to compare these studies. The lack of replication between the studies therefore limits the ability to conclusively demonstrate which stress management technique or strategy is most effective for the nursing profession. Apart from the diversity in research methodology, most of the reviewed studies showed to have a number of methodological limitations. Particularly the fact that most studies used only small numbers of participants and these were mostly volunteers, was highlighted as one of the more common limitations within this field of research.

Taking the above differences and difficulties into account, it is fair to conclude that a positive trend can be observed within some of the stress management approaches reviewed in this paper. Amongst the single-method approaches for individual stress management, relaxation training as well as imagery to master challenging situations both showed to be effective in reducing stress. In addition, it can cautiously be concluded that the multi-method approach used in the reviewed studies also showed to be effective. However, most of the research in this category did not clarify which of the aspects or combination of aspects were most effective.

As relaxation techniques were used in most of these studies, it could be argued that this intervention has contributed to most of the benefits experienced through these programmes. However, the process of relaxation in itself is not a simple one, and can be viewed as a mixture of techniques which include components of visualization as well as cognitive re-structuring. Therefore the benefits achieved by relaxation sessions could be ascribed to more than just the physical and emotional letting go of tension. Tsai and Crockett (1993) argue the benefits of cognitive aspects of relaxation by stating that relaxation training is feasible to provide the nurse with sufficient knowledge and skills to help him or her re-appraise the stressful situation and to become more receptive. Receptivity can lead to being more able to tolerate and accept experiences that may be uncertain, unfamiliar or paradoxical (Smith, 1990). In this way, relaxation can be viewed as a multi-level interactive process with a cognitive component, which fits in with the theory of stress, appraisal, and coping as postulated by Lazarus and Folkman (1984). In addition to the cognitive processes involved in relaxation, imagery is also often used to create the relaxation response and to process stress-evoking responses. Although imagery can be used to facilitate the process of relaxation, it can also be practised outside and beyond the relaxation process. The fact that imagery and relaxation tap into different cognitive processes is highlighted by Brown (1974, p143), who stated that “the release of the body’s tension during relaxation stimulates a dream-like trance in which many mental images are released”. In this state, thoughts are free flowing and intentionally undirected. This is in contrast to imagery as practiced without relaxation, where the individual directs the images towards performing a goal-directed activity (Dossey, 1988). The above information shows that the processes involved in stress management strategies and the different aspects involved in these processes are integrate and complex. This makes the drawing of definite conclusions about the effectiveness of these aspects, individually or in combination rather difficult.

Finally, the review highlighted a lack of studies which have investigated the interface between the individual and the organisation in the field of nursing and the NHS.

Future research

The above review has identified the lack of replication between the different studies and the need to understand the contribution of the individual aspects used in multi-method approaches to stress management. Randomized replication studies with larger sample sizes would therefore enhance our current understanding of effective stress management strategies. Additionally, in order to incorporate current knowledge on stress management interventions into a holistic stress coaching strategy, it is important to examine the role of other health variables like diet, exercise and work-life balance in relation to the management of stress. Furthermore, the development of a stress coaching strategy would also benefit from further investigations into the individual-organisational interface for nursing staff working within the NHS.

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