What are the experiences of Acute Liaison Psychiatry Service nurses attending a reflective practice group?

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Introduction

Background of the service

The Acute Liaison Psychiatry Service (ALPS) is a team of 15 mental health nurses and two senior nurses based at St James’s Hospital. The team works 24 hours a day, seven days a week covering referrals from the Emergency Department. Their fast-paced work consists of conducting assessments of individuals in high risk situations, often following severe self-harm or an attempt to end their own life. The team face unique pressures of having multiple interfaces, liaising with gatekeepers to different services, and little or no continuity with patients once they are discharged. Specialist psychiatric input into Emergency Departments is recommended as good practice in the UK (AMRC, 2008), and is being implemented in other countries, such as Australia (Webster & Harrison, 2004) and the United States (ACEP, 2014). Liaison psychiatry nurses working in the Emergency Department may be at risk of occupational stress and burn-out due to exposure to individuals experiencing high levels of distress in the context of pressure for a quick turnaround (a waiting time target of 4 hours is dictated nationally for UK Emergency Departments).

Burnout in mental health nurses

Maslach and Jackson (1981) define burnout as the experience of emotional exhaustion (draining of one’s emotional resources), depersonalization (development of negative, callous and cynical attitudes towards patients) and reduced personal accomplishment (tendency to judge one’s work-related behaviour and performance in a negative manner). Previous research suggests that nurses working on mental health wards
show significantly higher levels of emotional exhaustion and depersonalisation than nurses working on physical health wards (Johnson et al., 2017a; Sahraian et al., 2008). Specific types of mental health work may have a particularly high impact on burnout; for example, working with individuals who have attempted suicide or self-harmed evokes a range of difficult emotions (Hagen et al., 2017). Furthermore, mental health nurses who work with acutely unwell inpatients report higher emotional exhaustion than norms for all mental health workers (Jenkins and Elliott, 2004). Research also suggests that nurses working in Emergency Departments report elevated burnout (Potter, 2006).

Whilst no research has investigated the level of burnout in ALPS nurses, it could be expected that they may be at high risk of occupational stress and burnout as they work with individuals who are acutely mentally unwell, often suffering from suicide related crises within the Emergency Department.

**Staff wellbeing**

The RCP (2015) emphasises the importance of prioritising staff wellbeing to reduce stress and burnout. Not only is this important for nurses themselves, but over 80% of NHS staff believe that their state of health and wellbeing affects patient care (Boorman, 2009). Poor staff wellbeing and burnout is linked to poor patient safety (Hall et al., 2016; Welp & Manser, 2016) and good staff wellbeing and engagement are linked to improved patient safety and satisfaction (Maben et al., 2012; West & Dawson, 2012). Additionally, staff wellbeing and engagement has an economic impact through productivity and absence rates (CIPD, 2012) and burnout is linked to staff turnover intentions (Spence Laschinger et al., 2009).
A recent review suggested that burnout interventions are effective for mental healthcare staff, but that effect sizes are small (Dreison et al., 2016), and more research is needed to understand how their impact can be increased.

**Reflective practice with nurses**

Whilst supervision may be one route to reducing burnout in mental health nurses (Hyrkäs, 2005), Buus & Gonge (2009) conducted a systematic review and suggested research on the effectiveness of supervision for psychiatric nurses is inconclusive. These studies have usually focused on the impact of task-focused supervision, rather than reflective supervision.

The New Ways of Working document (Lavender & Hope, 2007) encourages psychologists to maximise their impact by integrating into teams and offering specialist skills including Reflective Practice (RP). Learning by reflecting on experiences is considered a key practice for personal and professional development of nurses and it integrates and builds on knowledge and skills (Jasper, 2003).

Whilst no research has investigated the usefulness of RP in ALPS nurses, studies on nurses who work in other areas suggest it may be beneficial. For example, McVey and Jones (2012) carried out a thematic analysis on interviews with nurses who work in oncology, renal and neurology services about their experiences of RP groups. The key findings were that the nurses valued the groups as a place they could compare their practice and discuss stressful and emotional issues. Buus et al. (2011) conducted interviews with psychiatric nurses on their experiences of clinical supervision groups with a central component of reflection. Nurses reported the groups to be beneficial and
their only forum for reflection that could solve the most difficult situations. Some of the benefits came from personal insight through reflection, insight offered by others, and emotional relief from a problem being acknowledged. They emphasised the importance of an external facilitator and highlighted shift work and high workload as a hindrance to participation. Olofsson (2005) interviewed psychiatric nurses on their experiences of a reflection group. The nurses reported benefits of the group as having time for reflection, confirmation of thoughts and feelings, gaining new perspectives, an increased sense of collaboration with co-workers and relating more effectively with patients. They emphasised the importance of prioritising the group, scheduling time for the group and having a clear common aim. Therefore, whilst no research has been conducted into the effectiveness or usefulness of reflective practice groups with ALPS nurses, previous research on similar groups suggests there may be a range of benefits to taking part.

**The commissioning of this project**

The current group is an unstructured psychologist facilitated RP group. It began in May 2016 and is run twice a month by two alternating psychologists who are external to the ALPS team and work for another NHS Trust. The size of the group is usually 3 nurses, but can be 4 or 5. Other clinical supervision that the ALPS team receive include a twice weekly group case discussion provided by a Consultant Psychiatrist, bimonthly clinical supervision with a supervisor of their own choice and ad-hoc supervision for complex cases provided by a Section 12 approved Psychiatric doctor. Management supervision is provided every four to six weeks by the ALPS clinical team manager.

This evaluation was commissioned by one of the RP group facilitators to explore
the experiences of the nurses attending the RP group. The commissioner was interested to see if the RP group is a worthwhile use of psychology resources, and wanted to gather data to justify either continuing or discontinuing the groups.

**Research question**

What are the experiences of ALPS nurses attending a reflective practice group?

**Methodology**

**Design**

This evaluation used a mixed methods design. Data on demographic information, length of service and number of groups attended was collected and participants completed pre and post questionnaires regarding burnout and self-care.

A semi-structured interview collected information on the experiences of what the nurses perceived to be helpful about the group and suggestions for improvements. Interviews were conducted and analysed in line with Thematic Analysis (TA; Braun & Clarke, 2006). Other qualitative methods that aim to capture participants’ experiences were considered, but TA was chosen as it is recommended for novice qualitative researchers and is used in health services research. Themes can be data driven in a ‘bottom up’ way (inductive analysis), or can be theory driven in a ‘top down’ way (deductive analysis). As our research question was aimed at participants’ experiences of the group, and not whether their experiences fit a theory, this analysis was conducted in an inductive way.

Nevertheless, in line with TA, it is necessary for researchers to make their assumptions explicit (Braun & Clarke, 2006). Whilst I attempted to remain neutral, my
biases may have drawn me towards wanting to portray the group in a favourable light as this would be helpful for the psychologists running the group. I am also aware that my biases may have tempted me to overlook controversial topics or conflicts as these may have been uncomfortable to feed back to the team. However, I hope that by holding my biases in mind and ‘bracketing’ them whilst I conducted the research enabled me to lessen their influence on the findings.

Participants

All the ALPS nurses were invited to take part, giving a potential pool of 17 participants. Four people chose not to take part in the evaluation (one due to a recent bereavement, one due to not attending any of the groups due to shift work, and two due to workload).

Procedure

Nurses were sent the information sheet (appendix 1) attached to a recruitment email (appendix 2) by their manager. Each interested nurse was allocated approximately 45 minutes within a shift to meet with the interviewer in a private office at St James’s Hospital. The interviewer talked through the information sheet and gave the opportunity to ask questions. If the nurse agreed to take part they then filled in the consent form (appendix 3) and the demographic form (appendix 4) and post questionnaires (appendix 5). Participants had filled in the pre questionnaires when they attended their first group session. The interview was then conducted (appendix 6) and was audio recorded. Participants were given a debrief sheet (appendix 7) and thanked for their time.
Measures used

Maslach Burnout Inventory (MBI; Maslach, Jackson, & Leiter, 1996). This 22-item scale measures three dimensions related to the construct of burnout. Emotional Exhaustion (EE, range 0-54) and Depersonalisation (DP, range 0-30), which increase as the level of burnout increases, and Personal Accomplishment (PA, range 0-48), which decreases as burnout increases.

Self-Compassion Scale (SCS; Neff, 2003). This is a 26-item scale where participants are asked how often they agree with the statements about how they typically act towards themselves at difficult times. The items are grouped into self-kindness, common humanity, mindfulness, isolation, self-judgement, and over-identified; with the latter three scales being reversed scored.

Analysis

Data on demographics is presented in the Participants section of the Results. The pre and post questionnaire data was analysed using Microsoft Excel to produce descriptive statistics. These are presented in the Descriptive Statistics section of the Results below. Due to the small sample size, inferential statistics were not possible as there would not have been enough power for the calculations.

Interview data was analysed using TA as described in Braun and Clarke (2006). The audio recordings were transcribed after each interview and checked for accuracy. Initial codes were generated for each interview and data was collated that was relevant to each code. Codes were organised into potential themes and a thematic map was created.
Two interview transcripts were independently double coded by the supervisor. Themes were reviewed for their inclusiveness and comprehensiveness by checking back against the data and refined to give clearer definitions of each theme, resulting in four themes. These are explained and illustrated with quotes in the Qualitative Analysis section of the Results.

Ethical considerations

This study was approved by the School of Psychology Ethics Committee at the University of Leeds, UK (ref no:16-0328, date approved: 18 Nov 2016) and by the Research and Development department at the relevant NHS Trust. Participants gave voluntary, informed consent to take part. Participants were made aware that they could stop the interview at any time and that their responses were confidential with only the interviewer having access to the audio recording. They were made aware that the rest of the research team, who might recognise their voice, would only have access to the data once transcribed and any identifiable information omitted.

Results

Participant demographics

Twelve mental health nurses and one senior nurse were interviewed (9 females and 4 males). Participants were aged 29-54 (mean=40.3, SD=8.4). Length of time working in the ALPS team ranged from 10 months to five years (mean=31 months, SD=16). Participants had attended between 1 and 6 of the reflective practice groups
(mean=3.2, SD=1.5). Nine complete sets of pre and post questionnaires were collected due to some missing pre data.

**Descriptive Statistics**

Results suggested a general trend in a positive direction. Table 1 shows the mean pre and post scores for the SCS and the MBI.

The mean total scores on the SCS increased slightly from 3.13 to 3.48, with each of the item areas showing a very small increase in self-compassion scores. The mean scores for the EE and DP MBI subscales decreased slightly from 19.11 to 16.78 and 6 to 4.56 respectively, indicating a small decrease in burnout. The mean scores for the PA subscale increased from 34.67 to 35.56, indicating a small increase in personal achievement.

**Table 1. Mean pre and post scores for SCS and MBI**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Subscale</th>
<th>Mean pre score (SD)</th>
<th>Mean post score (SD)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCS</td>
<td>Total</td>
<td>3.13 (0.78)</td>
<td>3.48 (0.71)</td>
<td>0.35</td>
</tr>
<tr>
<td></td>
<td>Self-kindness</td>
<td>2.73 (0.92)</td>
<td>3.18 (1)</td>
<td>0.44</td>
</tr>
<tr>
<td></td>
<td>Self-judgment (reversed)</td>
<td>3.07 (0.86)</td>
<td>3.44 (0.75)</td>
<td>0.38</td>
</tr>
<tr>
<td></td>
<td>Common humanity</td>
<td>3.42 (0.80)</td>
<td>3.53 (0.85)</td>
<td>0.11</td>
</tr>
<tr>
<td></td>
<td>Isolation (reversed)</td>
<td>3.39 (0.93)</td>
<td>3.97 (0.76)</td>
<td>0.58</td>
</tr>
<tr>
<td></td>
<td>Mindfulness</td>
<td>3.17 (0.88)</td>
<td>3.69 (0.78)</td>
<td>0.53</td>
</tr>
<tr>
<td></td>
<td>Over identified (reversed)</td>
<td>3.03 (1.23)</td>
<td>3.14 (0.94)</td>
<td>0.11</td>
</tr>
<tr>
<td>MBI</td>
<td>Emotional Exhaustion</td>
<td>19.11 (4.37)</td>
<td>16.78 (7.90)</td>
<td>-2.33</td>
</tr>
<tr>
<td></td>
<td>Depersonalisation</td>
<td>6.00 (3.91)</td>
<td>4.56 (3.94)</td>
<td>-1.44</td>
</tr>
<tr>
<td></td>
<td>Personal Accomplishment</td>
<td>34.67 (4.66)</td>
<td>35.56 (6.39)</td>
<td>0.89</td>
</tr>
</tbody>
</table>

Based on normative data for mental health workers (n=730) from the MBI manual (Maslach, 1996), each subscale has been categorised into low, average and high burnout.
ranges (EE Low <13, Average 14–20, High >21; DP Low <4, Average 5–7, High >8; PA Low >34, Average 33–29, High <28). For the EE and DP scales on the MBI, the pre and post mean scores fell within the ‘average burnout’ range. For the PA scale, both mean pre and post scores fell into the ‘low burnout’ range. Data on the number and percentage of individual participants scoring within each range is displayed in table 2.

Table 2. Number and percentage of participants scoring within the low, average and high ranges for all three subscales of the MBI at baseline and post RP group.

<table>
<thead>
<tr>
<th></th>
<th>Emotional Exhaustion</th>
<th>Depersonalisation</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Average</td>
<td>7</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>High</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Qualitative analysis

The thematic analysis resulted in four main themes: ‘Sharing and learning’, ‘Grounding and perspective’, ‘Space’ and ‘Relationships’. These are presented in a thematic map in figure 1 and are explained and illustrated below.
Figure 1. Thematic map

Theme 1. Sharing and learning

Participants spoke about sharing experiences that they had in common, and said that this made them feel less alone. Participants discussed how sharing experiences helped them and others to feel better and reported finding it helpful to know that other people found the same things difficult.

Participants discussed a cathartic process from sharing and unloading their experiences. They discussed the stressful nature of their work and the type of clients that they see who have self-harmed or attempted suicide. They felt that the group provided a platform to offload their frustration and anger and that without it, there might have been more sickness absence. They described feeling clearer minded, listened to and lighter after the group.
As well as sharing experiences, participants talked about using the group as a place to facilitate learning from each other. Participants valued getting others’ opinions on a topic, or asking what they would have done in a similar situation. There was a sense of learning new information or ideas to help move forward.

Table 3. Illustrative quotations for theme 1

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Illustrative example quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing experiences in common</td>
<td>10 “When you listen to other people’s issues that they bring you understand you’re not the only one or that other people are experiencing the same sort of problems that you are and that you’re not alone in the matter”</td>
</tr>
<tr>
<td></td>
<td>3 “By sharing your experiences it might make someone else feel better or might make you feel better.”</td>
</tr>
<tr>
<td>Cathartic process</td>
<td>7 “Get them out and get them off your chest. There’s a lot of stress within the team, from the nature of the job, our role is to see people who have self-harmed or attempted suicide so were dealing with all these negative emotions day in day out and this is a place where we can air these thoughts which is useful. It can be cathartic.”</td>
</tr>
<tr>
<td></td>
<td>9 “If the group didn’t exist there wouldn’t be that platform and people would be going off sick because of stress because there is no platform to offload frustration and anger. We do see difficult clients, we have near misses and we need to talk about those things.”</td>
</tr>
<tr>
<td>Learning from each other</td>
<td>1 “You get other people’s opinions. More chance of being able to work through things and find some sort of solutions or way of dealing with issues.”</td>
</tr>
<tr>
<td></td>
<td>7 “People have had similar situations and they’ve done things I wouldn’t have thought of. So, it’s good that it brings this information to the surface.”</td>
</tr>
<tr>
<td></td>
<td>13 “Its enlightening to hear other people’s perspective on it which can help with either confirming your own views about it or give you the opportunity to think about it in a different way from someone else’s perspective.”</td>
</tr>
</tbody>
</table>

Theme 2. Grounding and perspective

Participants talked about the group as a place to take a step back from being on automatic pilot, which they said gave them perspective on what they do and the difficulty and risk involved. Discussing their work with someone external from the team was
reported to be helpful, as the process of explaining their day to day work reminded them of what they do and the value in their work. They reported the psychologist being well placed as someone who was external but could understand.

Many participants spoke about the group as a useful place to explore and reflect on how the work impacts on them. This was discussed in the contexts of looking after themselves and ensuring they do not become desensitised to clients’ crises.

However, three participants questioned whether the group was necessary for these discussions as they thought these happen elsewhere. They reported that they already reflected enough in other supervisions and informally in the office. Nevertheless, two of these participants felt that their colleagues might be benefiting from the group and did not want to suggest it ended.

Around half of the participants talked about how the group provided a platform which is different and is appreciated. People talked about feeling more listened to and less judged than in other supervisions and appreciating the privacy and confidentiality of the group.

Some participants talked about mirroring the reflective process of the group in their work. They commented on taking time to reflect and valuing reflective practice as part of their work. One participant talked about how the infrequency of the group made it difficult to continue the reflective practice outside of the group.

Table 4. Illustrative quotations for theme 2

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Illustrative example quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuing your work</td>
<td>3 “You do tend to run on automatic pilot and you don’t really think about what you’re doing then you actually say to someone else and you think is that what we really do? And it validates what you’re doing and you see it in quite a different light when you explain it to somebody.”</td>
</tr>
</tbody>
</table>
9 “We have near misses and we need to talk about those things, we need to be able to say oh gosh I nearly got killed.”

11 “A lot of people don’t understand what it’s like working in the NHS do they. It’s good to have someone listening who… Even though the psychologists don’t work in our job, they’re more likely to understand it a bit better than your partner or your friend.”

2 “Yeah in our area of work it’s easy to lose that degree of sensitivity that you need when you’re seeing case after case of people in crisis situations. It’s good to reflect on how that’s affecting you. Otherwise there’s a danger of becoming desensitised or not registering somebody’s crisis as you would want your own crisis to be treated.”

10 “We’re nurses, we’re machines, were expected to deal with tough difficult things but some of the cases we see are going to impact on us and cause us upset.”

We already reflect enough
4 “For me individually I feel that I get enough from daily contact with my colleagues and the supervision that I get. But obviously some people might find it really helpful and I wouldn’t want to stop them having that opportunity if they do find it beneficial I wouldn’t want them to not have that.”

This group is different
10 “In honesty, it’s a really good group, I appreciate it, I appreciate all the supervisions we have available in the team, but this one more so than others because it’s private and it feels it’s in the right environment and it feels a safe place to let off our loads, it’s not like we’re going to be judged or anything and its confidential.”

11 “I just think that we all benefit from it. It’s an hour to get things out and someone to listen. At other times, there’s always someone who’s got an answer or fighting against what you’re saying. It’s nice to be listened to really.”

Mirroring of the group process outside of the group
1 “It’s made me think a lot in the group and afterwards which I think is always a good thing.”

2 “It reminds me I should take stock when I’ve assessed somebody I need to give myself that bit of time to reflect on the assessment and we try to encourage each other to do that.”

13 “For me personally I come away thinking that was good while it lasted.”
Theme 3. Space

Participants talked about the group being a private and confidential ‘safe space’ which encouraged openness in the discussions in the group. There were comments on the group being framed in a different way to other supervisions; in the reflective practice group reflection was encouraged and it was safe to ask for help or to say that you were unsure of what you were doing. This allowed people to accept input from others without feeling threatened.

Participants commented on the role of psychologists in creating the safe space. They said they created a comfortable and relaxed atmosphere, and that having someone external made the space safe as they did not know personal issues and team dynamics.

Some of the participants had attended the group with managers present and said that it changed the group as people were afraid of being judged or told how to think or act. There were also concerns that managers may follow up conversations outside of the group which they preferred to keep private. Participants valued the group as time away from management where they could voice their concerns and reflections, and said that this helped to create the safe space. Two participants suggested that management might benefit from having their own RP group.

As well as a safe space, participants talked about the benefits of the group being a structured space. Participants appreciated input from the psychologists in keeping the conversation on track. They talked about their skills in reflecting and asking questions that helped to clarify. Most of the participants valued the open space where anything could be brought. Two participants expressed their views that they would have liked the
psychologists to give more structure, but then reflected on how this might shut down conversations, put barriers up or be excluding. One participant voiced that they thought a much more structured educational group might be more helpful than RP.

Ten participants talked about practical aspects of the group that allowed it to be a protected space that was different to other supervisions. Participants talked about the group having protected time in a different location where they are undisturbed for an hour. They spoke about how they did not have to carry their bleep or worry about the phone ringing or Emergency Department staff knocking on the door and posting referrals under the door. This protected space took the pressure off and allowed the group members to open up more.

The topic of shift work was brought up by six of the participants as a barrier to regular attendance.

A theme that emerged from three participants was of the group being an awkward space. They talked about waiting in silence until someone talked and how it could be difficult to get started. One participant noted that there were more awkward pauses at the beginning and that the group managed to overcome these as the confidence of group members increased. Another participant suggested the awkward pauses were helped by attending with group members who had attended more regularly and when the psychologist was more interactive, summarising and offering direction and opinions.

Some participants noted that it might have been better if more people could have attended as the small numbers can be quite limiting and people might have been more comfortable talking in a bigger group.
Two participants noted that they preferred to talk to their colleagues than in the group.

Table 5. Illustrative quotations for theme 3

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Illustrative example quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe space</td>
<td>7 “I think people probably are more relaxed and more open.... In the group, it’s framed in a different way. It’s reflecting on what you’ve done... I think it allows for people to accept others input without feeling as though people are targeting their practice.”</td>
</tr>
<tr>
<td></td>
<td>13 “Being run externally and the privacy and confidentiality and boundaries and rules that make me feel it’s ok to be there and to have an openness with the proviso of who is in the group. You always chose whether you say something.”</td>
</tr>
<tr>
<td></td>
<td>3 “Having somebody outside of the team to facilitate who can be quite objective so they don’t know people’s personal issues and team dynamics and stuff so it’s about dealing with what we take to the group. It makes it quite safe as well because of that.”</td>
</tr>
<tr>
<td></td>
<td>Safe space away from managers</td>
</tr>
<tr>
<td></td>
<td>9 “I think the times when the two managers are allowed to come in, it changes, it alters it, because there’s a manager there you feel like you’re being judged... Yeah you don’t know whether they will take things further or outside.”</td>
</tr>
<tr>
<td></td>
<td>7 “It allows us, the ALPS team, to voice our concerns and gripes with regards to whatever, without having management there. There’s a difference between what’s said when it’s just the ALPS practitioners compared to when there’s management there as well. It’s quite noticeable... you feel as though management aren’t coming in and listening to your conversations that they might pull you up about at a later point.”</td>
</tr>
<tr>
<td></td>
<td>10 “I think the group is great and we get a lot out of the group and it’s a space to go away and reflect with people who aren’t management in a neutral role.... where you’re not judged, or told how you should be thinking of acting.”</td>
</tr>
<tr>
<td></td>
<td>9 “If managers are there you watch what you say so it’s preferable if they could have their own manager forum.”</td>
</tr>
<tr>
<td>Structured space</td>
<td>7 “Within the office there can be friction at times. But in the group, it’s tolerated more and that’s because there is someone there directing”</td>
</tr>
<tr>
<td></td>
<td>12 “The facilitator was more interactive, summarising and feeding back and offering some kind of directions and opinions which was quite helpful to offer maybe an alternative view of what was going on or scenarios or explanations.”</td>
</tr>
<tr>
<td></td>
<td>13 “Just their ability to reframe and ask questions that cause you to rethink and...”</td>
</tr>
</tbody>
</table>
clarify what you want to say which can be very useful.”

8 “I’m not sure if the idea at the minute is just to give us a free floor to talk about anything because from my very limited experience that what it seems like…. I don’t know maybe they could say this week were going to talk about cases or about this but then that doesn’t give people an open forum to discuss what’s bothering them…. anytime you try to impose structure on something you’re going to exclude something else, aren’t you?”

Protected space

I “It’s about having the space and time to discuss things because you don’t always get that in the office or in A&E, you don’t get to explore things in any depth… I think just having that time really to sit and discuss things without the external pressure that you usually have when you’re at work or in the office in terms of time and knowing there’s other things to do”

6 “That hour is protected time for us that we very rarely get anywhere else. It gives us the opportunity to reflect as individuals and as a team. It’s very positive I enjoy that time out.”

10 “In our other supervision, A&E will come in, the door is closed but they’ll still come in. the phones are still ringing. It’s not a free space because you might end up picking up the phone or dealing with the incident in A&E. whereas this is our space and it’s not a disturbed space.”

12 “It’s been difficult in terms of people doing long shifts so not everybody is on the day when there is the RP group so some people haven’t been to many or any and others have managed to attend them quite regularly.”

Awkward space

5 “Sometimes getting people started can be quite hard. I think we all try to take something to the group but then when were there it’s like that starting point of getting someone to talk.”

11 “Right at the beginning, when it first started there were some slight awkward silences but that’s gone now. We’ve all got a bit more confident in saying things and how we feel. So that happened at first but not now. I think one of two of us just spoke up and then once one does it the others just follow suit.”

4 I don’t think I want to sit in a circle in a group in a room and start talking about the emotional side of things. I’d rather do that with my colleagues like we already do. You can talk about how things impact on you and I guess it’s to the degree maybe.

3 “I suppose it would be nice if more of the team could attend but that’s idealistic really because there’s not a time when more of the team are available because we cover 7 days. So, it’s probably the best it can be really.”
**Theme 4. Relationships**

Some participants reported that the group gave them a place to have conversations with colleagues that they would not otherwise have had, due to having the space and time and due to being able to approach topics sensitively in a non-threatening environment. They also spoke about how it gave them a place to find out more about colleagues that they did not interact with as much and to see some colleagues in a different light.

Some participants spoke about noticing a change in how they are around their colleagues. They commented on being more thoughtful in how they engage with others and on being more relaxed around colleagues than in the past.

Some participants reported a realisation of how supportive the team was and how the group provided a space that enabled them to come together as a team. Participants talked about the group as a place to provide support to each other. This was talked about from the perspective of providing support to someone else and being the recipient of support from others.

There were some frustrations expressed about the people who participants attended the group with. Some participants found it difficult when people in the group did not contribute. Whereas others found it difficult when other participants were vocal and dominant in the discussions. Some participants talked about having to attend with individuals they did not get along with or would find intimidating to express their views in front of.

Participants reported a conflict in how different group members preferred to use the group. Some people found it helpful to air and vent issues that were affecting the team. Other participants spoke about how they found it difficult when other people in the
group want to use the group to vent and said they preferred to use the group for reflection. However, there seemed to be a difference between venting about environmental factors that could not be changed and cathartic airing thoughts and feelings about clinical issues, with the latter being more acceptable to the group.

Also under the theme of relationships, people spoke about their relationship with themselves. Some people noticed that they had become more self-aware, others commented on being less self-critical and more kind towards themselves. They commented on their confidence and self-esteem increasing through self-affirming experiences in the group, such as colleagues agreeing with them, trusting them or making positive comments about them.

Table 6. illustrative quotations for theme 4

<table>
<thead>
<tr>
<th>Subtheme</th>
<th>Illustrative example quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive interpersonal processes</td>
<td>10 “What I think it has changed is being able to have the confidence to discuss sensitive issues.”</td>
</tr>
<tr>
<td></td>
<td>13 “I think that it’s helped me to consider what I do and how I engage with people. It has been a useful experience because sometimes things sit and if you don’t voice them or you’re not as open with them you’re not aware.”</td>
</tr>
<tr>
<td></td>
<td>3 “Taking support from the group and offering support to other people. That’s the only real space we have to do that so it feels meaningful.”</td>
</tr>
<tr>
<td>Conflicts and frustrations</td>
<td>10 “One thing that is a bug bear of mine is when people come and don’t really engage in it and not really caring. It really frustrates me because they let it down for everyone else, they’re happy to just sit there, you think you might as well be back in the office taking bleeps if you don’t want to be involved in it.”</td>
</tr>
<tr>
<td></td>
<td>5 “Some colleagues are more opinionated than others which is fine. But sometimes it can be a bit controlled by their opinions though, so you end up taking more of a back seat.”</td>
</tr>
<tr>
<td></td>
<td>6 “What I find difficult is when there’s someone who I don’t particularly get along with. I get on with everybody on the surface but I think sometimes I’d rather not be in the group with those people. I don’t always agree with what they’re saying or they might get on my nerves a bit. Its human isn’t it.”</td>
</tr>
</tbody>
</table>
|                                       | 9 “To ventilate my feelings about issues concerning my team. Changes taking
place. People’s different practice ways. Where we might disagree. Work related stress. Volume of work. I bring all that to the group to discuss and to offload about my concerns about when I feel strongly about things.”

5 “They vent. I always like to talk more about your work, how you feel, the pressures of the job. I think sometimes it can get stuck on environmental factors rather than the actual work that’s being done or the stress of the job and the emotional aspect of the job. I thought it would be to explore more of that.”

With self

3 “It helps you do look at things from a more human factor and that we’re all different and we’re all doing our job and trying to do the best we can. I think it’s maybe taken the heat out of myself, I’ve become less self-critical and more confident in the job because at one point I think I’d lost that a bit.”

13 “Hearing people agree with what I’m saying or make positive comments about me or say things that require trust with me being there is self-affirming and makes me feel comfortable about what I do and about my role in the team. So, my self-esteem and self-worth within the service has definitely increased and that’s one of the ways it shows itself.”

Discussion and conclusions

Summary of qualitative results

Participants said the group was a safe space which felt protected and structured, although some participants said that it felt awkward in the beginning. They spoke about how the group encouraged reflection of how work impacts on them, and that it gave them perspective on what they do in their day-to-day work. They felt it increased their sense of valuing their skills and helped them to recognise the difference they make to their patients. The group provided a platform to share experiences in common, express emotions and to learn from each other. The group also impacted on their relationships with each other and allowed them to support each other; enabling conversations to be conducted in a sensitive and non-threatening space that they otherwise would not have had. Some people reported frustrations related to attending the group with people who either did not contribute or dominated the conversation and people reported conflicts on
how the group is used. Discussions in the group enabled some participants to become kinder towards themselves and increased their confidence and self-esteem.

Although the participants identified a range of benefits from taking part, some of their preferences differed. Some participants talked about valuing the open space whereas others preferred more structured facilitation from the psychologists. Three participants felt that the group was not necessary as the issues discussed were also spoken about in team meetings and other supervisions, whereas others felt there was something fundamentally different about the group, stating that it was the only undisturbed, confidential time they had. Some participants talked about valuing the time to get things off their chest and ‘vent’, whereas others said that they did not see the point in going over issues that could not be changed and said they would have preferred to spend the time reflecting.

**Qualitative results in the context of wider literature**

The results are consistent with previous research on RP groups (McVey & Jones, 2012), which suggested that nurses valued the groups as a place they could compare their practice and discuss stressful and emotional issues. In line with findings from Buus et al. (2011), the groups provide a platform for gaining insight from others and expressing emotions. They also found that having an external facilitator and prioritising the group led it to be beneficial and shift work was a barrier. Consistent with Edwards et al. (2005), participants commented on the benefits of the group taking place away from their usual work place and in line with Olofsson (2005), nurses spoke about the importance of having their thoughts and feelings confirmed rather than questioned.
The current study also extends the literature as it provides the first evidence that RP groups may be beneficial for Acute Liaison Psychiatry nurses, who are at particularly high risk of occupational stress and burnout.

Summary of descriptive statistics

The results are useful for giving a profile of the team. The baseline MBI scores for the current sample of ALPS nurses are fairly consistent with the norm reference group of mental health workers provided in the manual. Whilst the mean scores fell into the moderate burnout range for both EE and DP, the scores for PA fell into the low range. This indicates that even though the nurses are feeling moderately emotionally exhausted and reporting moderate negative feelings towards their clients, they are not dissatisfied with their accomplishments on the job.

Although the sample size is too small to conduct inferential statistics, means for both the SCS and the MBI questionnaires moved in a positive direction indicating slightly more self-compassion and slightly less burnout. It is possible that the RP group contributed to this small effect. Although, it is also possible that the changes could be due to a number of other external factors that would not be captured by this evaluation, such as positive personal life events, a change in workload or better resourcing.

Descriptive statistics in the context of wider literature

Whilst the SCS does not have a manual with norms, other research can be used as a benchmark for comparison. The baseline total mean score of 3.13 is comparable to
results found in other studies. For example, Duarte, Pinto-Gouveia and Cruz (2016) found a total mean score of 3.22 in a sample of nurses.

There currently is no published profile of MBI data for ALPS nurses. Comparing the baseline MBI scores with data on 57 qualified nurses working on acute mental health wards (Jenkins and Elliott, 2004), the percentage of ALPS nurses scoring in the high burnout range was lower for EE (22%, compared to 52%) and PA (0%, compared to 14%), and higher for DP (44.4%, compared to 35.1%). This could suggest that the unique role of nurses in the ALPS team leads them to feel accomplishment in their work but the short time they spend with each patient and seeing ‘revolving door’ patients may result in pessimistic attitudes towards the client group. However, caution is needed when interpreting this as the post intervention profile for the ALPS nurses gives different results (EE=33%, PA=11% and DP=11%) suggesting a great reduction in DP. Whilst this may be due to the RP group intervention, it is more likely attributable to other extraneous variables and unreliability of the measure. Using the MBI cut offs may be questionable, as detailed in the limitations section.

**Practical implications for the service**

Both the qualitative and descriptive data suggest that the RP group is a useful and valued part of the ALPS team supervision. It is recommended that the group continues to run, but with some small changes and discussions to attempt to resolve some of the frustrations and conflicts that are occurring.

One recommendation is that the managers of the team do not attended these groups, but instead allow the band 6 nurses to have their own space to reflect freely.
Revisiting the group aims might help to give clarity on whether the group can be used as a space to vent about issues that cannot be changed and whether more structure would be helpful. It may be useful for the group to have a discussion around getting the most out of the group when a participant is not contributing, or is dominating the conversation.

Dissemination

The findings were fed back to the ALPS team meeting on the 27/09/2017 (see appendix 8 for handout). They reported finding the results interesting, although nothing surprised them. They commented that there are so many different people in the team that it would be difficult to run a group that fits with everyone’s preferences and needs. The findings have been feedback to the commissioner who has decided that the groups are a good use of psychology input and will continue to run them. Additionally, the findings have been presented at the DClinPsy SEP conference on 27/10/2017 and will be submitted to a peer reviewed journal.

Limitations

Not all team members took part in this evaluation. Although taking part is optional in line with ethical approval, it may be that those who chose not to take part may have different views on the group that were not captured.

Participants had attended between 1 and 6 of the reflective practice groups, which means that some of the participants were basing their experience on a single attendance. In the interviews, a couple of participants did comment on how their experience might not be representative of the groups in general. We had not set exclusion criteria as we
aimed to capture as much of the team as possible. However, the participants may have felt that they could contribute more and the data might have had higher validity if we had set a minimum number of groups to have attended in order to take part in the evaluation.

The MBI cut offs are taken from the MBI manual and as such a limitation is that the norms are based on an American sample. There may be cross cultural differences in burnout scores (e.g. Schaufeli & Van Dierendonck, 1995). Additionally, the MBI norms are based on the lower, medium and upper thirds of the score frequency distribution, rather than any clinical criteria. Consequently, it is questionable how useful these cuts offs are.

Finally, whilst the sample size is adequate for qualitative analysis, it is very small for the questionnaire data and therefore inferential statistics have not been possible.
References


McVey, J., & Jones, T. (2012). Assessing the value of facilitated reflective practice groups: Clinical supervision offers staff a safe space in which to talk about work and compare their practice with that of people in similar roles. Joanne McVey and Theresa Jones describe the findings of an evaluative study. *Cancer Nursing Practice, 11*(8), 32-37.


PARTICIPANT INFORMATION SHEET

What are the experiences of nurses attending a reflective practice group?

You are being invited to take part in a research study. Taking part in this study is completely voluntary. Please take time to read the following information carefully. Talk to others about the study if you wish, and if you would like to ask any questions please contact a member of the research team (listed below). You will be given a copy of this information sheet and signed consent form for you to keep if you chose to take part.

**What is the purpose of the study?**
The current study aims to explore the experiences of nurses taking part in a reflective practice group. We would like to know what works well, what doesn’t work so well, and how these kinds of groups could be improved.

**Why have I been chosen?**
We would like to hear from nurses who have attended the reflective practice group.

**What will happen if I take part?**
We will ask you to participate in a one to one interview, lasting around 30 minutes which will ask questions regarding your experience of attending the group. We will also ask you to fill in a series of short questionnaires (similar to the one you will have filled in when you started the group). These questionnaires will take around 10 minutes to complete. With your permission, we would also like to be able to use the information in the questionnaire you filled in when you started the group, to see if there have been any changes over time.

**Do I have to take part?**
It is up to you whether to take part. If you decide to take part, you will be asked to sign a consent form. You may choose not to respond to any of the individual questions asked to you in the questionnaire or interview and you may withdraw from the questionnaire or interview after it has started. You do not have to give a reason for withdrawing or not responding to any question. After the questionnaire and interview has finished, you can withdraw your data from the study up to two weeks after you have completed it, by contacting a member of the research team. However, you will not be able to withdraw your data after this time as it will have been anonymised and your data will not be able to be identified.

**What will happen to the information I provide?**
All the information you provide in the study will be confidential. Any identifiable information such as your name or contact details will be stored separately to your questionnaire and interview data. The interview will be audio recorded but any names,
locations or dates will be altered when the interview is written down. All data will be stored on password protected computers and transferred by encrypted USB pen drives, and will only be accessible to members of the research team. Audio recordings will not be accessible by psychologists who run the group and could identify your voice. Any identifiable information will be kept for no more than 2 years and then deleted. The anonymised questionnaire and interview data which cannot be linked to you will be securely stored for up to ten years and will then be deleted. This study will be written up to be published in a peer reviewed journal and to be presented at conferences. You will not be able to be identified from any material published.

**Who has reviewed the study?**
This study has been reviewed by the University of Leeds, School of Psychology Research Ethics Committee (Approval date: 18 Nov 2016, Approval number: 16-0328).

**What if there is a problem?**
The study researchers will be available to resolve any minor problems (contact details below).
Dr Judith Johnson: j.johnson@leeds.ac.uk 0113 343051
Lucy O’Neill: ps07lo@leeds.ac.uk

If you are unhappy about any aspect of the way you have been approached or treated during the course of this study, and you do not want to discuss this with the researchers, you can contact the School of Psychology Research Ethics Committee: psyc-ethics@leeds.ac.uk.
Appendix 2. Recruitment email

Dear Team,

As part of the support offered to the Emergency Department, the Clinical and Health Psychology Department offer a twice monthly Reflective Practice group to the Acute Liaison Psychiatry Service.

We would like to explore the experiences of nurses taking part in this group, finding out what works well, what doesn't work and identifying ways that group supervision can be improved. This is important both to our own service and to other groups like ours.

I am a Psychologist in Clinical Training at the University of Leeds. I have been asked to interview the group members and analyse the themes that arise from these interviews. I hope to conduct these interviews in January 2017. Interviews will take around 30 minutes and will include a short questionnaire.

If you would like to take part, please contact me on the e-mail address below.

All the information that you provide will be anonymised and every effort will be made to ensure that individuals cannot be identified (for more information please see the attached participant information sheet). Psychologists who run the group, and therefore may recognise your voice, will not have access to the audio recordings to protect your anonymity.

The research has received ethical approval from the University of Leeds School of Psychology Research Ethics Committee (Approval date: 18 Nov 2016, Approval number: 16-0328).

If you have any questions, please feel free to contact me on ps07lo@leeds.ac.uk.

Lucy O’Neill 
Trainee Clinical Psychologist

Institute of Health Sciences
University of Leeds
School of Medicine
Level 10 Worsley Building
Clarendon Way
Leeds
LS2 9NL

Supervised by Dr Judith Johnson: j.johnson@leeds.ac.uk 0113 3430510
Ethics approval number: 16-0328, Ethics approval date: 18 Nov 2016
Appendix 3. Consent form

**Title:** What are the experiences of nurses attending a reflective practice group?

**Name of researchers:** Dr Judith Johnson (supervisor), Lucy O’Neill

**Please initial the box to show you have understood and agree:**

1. I confirm that I have read and understood the information sheet for the above study.
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
3. I understand that my participation is voluntary and that I am free to discontinue and withdraw my data at any time during the study, without giving a reason.
4. I understand that some questions will ask about my personal experience of taking part in the group and that I do not have to respond to any question if I wish, without giving reason.
5. I understand that I will not be able to withdraw my data after 2 weeks from taking part as it will have been anonymised and will not be identifiable to be able to delete it.
6. I consent for the interview to be audio recorded and understand that this recording will not be accessed by people who may recognise my voice.
7. Once the data is transcribed and anonymised I understand that all members of the research team will have access to it.
8. I agree to the use of my questionnaire responses and understand that in the final report it will not be possible to recognise my responses.
9. I agree for my initial questionnaire responses when I started the group to be used as part of this study
10. I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records
11. I agree to take part in the study.

**Name of Participant:** ______________________
**Date:** ______________________
**Signature:** ______________________

**Name of Researcher:** ______________________
**Date:** ______________________
**Signature:** ______________________
Contact details of researchers: Dr Judith Johnson: j.johnson@leeds.ac.uk 0113 3430510
Lucy O’Neill: ps071o@leeds.ac.uk   Ethics approval number: 16-0328, Ethics approval date: 18 Nov 2016
Appendix 4. Demographic questionnaire

1. Age ______ years ____ months

2. Gender ____________________________

3. Preferred pseudonym _________________

4. Occupation and banding (e.g., band 5 nurse) ________________________

5. Employment status (e.g., full time, part time, bank, agency) 
________________________________

6. Length of time spent working in adult liaison psychiatry team ______ years  ____ months

7. Length of time attending the group _____ years ____ months

8. Number of group sessions attended ____________________
Appendix 5. Pre and Post Questionnaires
Maslach Burnout Inventory

Removed from online version of report for copyright reasons.
## Self-Compassion Scale

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

<table>
<thead>
<tr>
<th>Almost never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Almost always</th>
</tr>
</thead>
</table>

____1. I’m disapproving and judgmental about my own flaws and inadequacies.
____2. When I’m feeling down I tend to obsess and fixate on everything that’s wrong.
____3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
____4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
____5. I try to be loving towards myself when I’m feeling emotional pain.
____6. When I fail at something important to me I become consumed by feelings of inadequacy.
____7. When I’m down and out, I remind myself that there are lots of other people in the world feeling like I am.
____8. When times are really difficult, I tend to be tough on myself.
____9. When something upsets me I try to keep my emotions in balance.
____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
____11. I’m intolerant and impatient towards those aspects of my personality I don't like.
____12. When I’m going through a very hard time, I give myself the caring and tenderness I need.
____13. When I’m feeling down, I tend to feel like most other people are probably happier than I am.
____14. When something painful happens I try to take a balanced view of the situation.
____15. I try to see my failings as part of the human condition.
____16. When I see aspects of myself that I don’t like, I get down on myself.
____17. When I fail at something important to me I try to keep things in perspective.
____18. When I’m really struggling, I tend to feel like other people must be having an easier time of it.
____19. I’m kind to myself when I’m experiencing suffering.
____20. When something upsets me I get carried away with my feelings.
____21. I can be a bit cold-hearted towards myself when I’m experiencing suffering.
____22. When I’m feeling down I try to approach my feelings with curiosity and openness.
____23. I’m tolerant of my own flaws and inadequacies.
____24. When something painful happens I tend to blow the incident out of proportion.
____25. When I fail at something that’s important to me, I tend to feel alone in my failure.
____26. I try to be understanding and patient towards those aspects of my personality I don't like.
Appendix 6. Semi-structured interview schedule

- How do you find the group?
- What do you mostly use it for?
- Do you take an active role in the group or do you prefer to listen to others?

- Is there anything about the group that you think is particularly useful? Can you tell me about it?
- Can you give me an example of how attending the group has changed something in your work?
- Has the group helped you to think differently about clinical issues? Can you give me an example?
- Do you think you have changed anything about how you are at work since attending the group? E.g. how you are with yourself or how you are with patients.

- Is there anything about the group that you have found difficult or unhelpful?
- Can you give me any examples of times in the group that have been hard for you?
- What was unhelpful about it?

- Do you have any suggestions of improvements that could be made to the group?
- Is there anything you’d like to be done differently?
- If you could change anything what would you change? Why?

- Is there anything else that you would like to add about your experience of being in the group?
Appendix 7. Debrief sheet

We hope that taking part in this study has not caused you any distress. However, if the questions asked in the study have raised any issues for you, which you would like to discuss with a person not involved with the research, there are sources of support and organisations that are available to you. Please find listed below:

- Human Resources department – for help with queries about Trust HR policy or procedure E: ltht.humanresources@nhs.net, T: 01132066468
- Information on the Trust’s harassment and bullying policy can be found in the Dignity at Work policy and guidance which can be found via the Human Resources page on the intranet
- Information on and self-referral forms for the Trust’s Staff Counselling service can be found on the Intranet via the Health and Wellbeing page, or the department can be contacted on 01132065897
- For doctors of all grades or experience, contact the independent, confidential helpline staffed by volunteer doctors T: 0844 395 3010 or visit the web site: www.dsn.org.uk
- Workplace Health and Wellbeing intranet site - for more information about other support services available to staff

Useful web sites
- Bully Online: www.bullyonline.org/action/action.htm
- The Dignity At Work Partnership www.dignityatwork.org
- Health & Safety Executive: www.hse.gov.uk/stress/furtheradvice/bullyingindividuals.htm
- Samaritans: www.samaritans.org/how-we-can-help-you
- Stonewall: www.stonewall.org.uk/employer/harassment-workplace
Appendix 8. Feedback sheet

Feedback summary: What are the experiences of ALPS nurses attending a reflective practice group?

- Twelve band 6 nurses and one band 7 nurse were interviewed
- Nine females and four males
- Participants were aged 29-54 (mean=40.3, SD=8.4)
- Length of time working in the ALPS team ranged from 10 months to five years (mean= 31 months, SD=16)
- Participants had attended between 1 and 6 of the reflective practice groups (mean=3.2, SD=1.5)

Thematic map:

If you have any questions, please feel free to contact me on ps07lo@leeds.ac.uk.

Lucy O'Neill, Trainee Clinical Psychologist: Institute of Health Sciences, University of Leeds, School of Medicine, Level 10 Worsley Building, Clarendon Way, Leeds, LS2 9NL

Supervised by Dr Judith Johnson: j.johnson@leeds.ac.uk 0113 3430510
Ethics approval number: 16-0328, Ethics approval date: 18 Nov 2016