A Pilot Evaluation of the Professional Nurse Advocate (PNA) Programme in Adult Critical Care: A mixed-methods approach.

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Introduction

Context of Service Evaluation

This service evaluation project (SEP) was commissioned by Dr Nate Shearman, Senior Clinical Psychologist for the Staff Psychological Support service within Leeds Teaching Hospitals NHS Trust (LTHT). This project aimed to evaluate the utility, acceptability, and impact of a Professional Nurse Advocate (PNA) scheme, newly launched amongst nurses within the adult critical care service.

Burnout Amongst Critical Care Nurses

Critical care is the provision of specialist care to acutely ill or injured patients within intensive and high dependency care units, across the hospital setting (NHS England, 2019). Nurses in this field are highly trained and work as part of a multi-disciplinary team (MDT) to offer holistic support to families and carers as well as nursing acutely unwell patients.

The highly intensive nature of critical care has many resultant challenges, and elevated rates of burnout are consistently reported within the literature for nurses working in this setting. Burnout amongst nursing staff has been described to include emotional exhaustion, depersonalisation or detachment, and a reduced sense of personal and social accomplishment (Alharbi et al., 2016; Bakker et al., 2005; Epp, 2012; Friganovic et al., 2019). A feature of burnout more specifically noted in caring roles is Compassion Fatigue, reflecting the emotional, physical, and spiritual exhaustion which can occur as a result of chronic exposure to others' suffering (Alharbi et al., 2019; Figley, 1995). This aspect of burnout is particularly relevant to critical care nurses, given the high dependency of the patients for which they provide care (Duarte & Pinto-Gouveia, 2017). Within the UK, an estimated 20,000 nurses work in adult intensive care units and large-scale data from this sample, suggests that around 42% are at high risk of burnout (Vincent et al., 2019). Notably, this group is the highest at risk when compared with other healthcare roles within the critical care MDT.

Factors increasing the vulnerability to burnout amongst critical care nurses have been reported to include high patient acuity, stress of providing end-of-life care, high levels of emotional exhaustion, and chronic occupational stressors (Bakker et al., 2005; Epp, 2012;

Poncet et al., 2007). These same challenges, alongside limited opportunities for professional development, and the implications of shift-working have also been linked to the high staff turnover observed in intensive care units within the UK (Cartledge, 2001). Whilst there is consistent evidence of a correlation between burnout and low job satisfaction in nursing, the intricacies of this association remain poorly understood (Friganovic et al., 2019).

Another possible contributor to high rates of compassion fatigue observed amongst critical care staff may be the phenomenon of 'burnout contagion' amongst colleagues (Bakker et al., 2005). This observation suggests that the psychological wellbeing of staff may have implications for critical care units on a systemic level, rather than just on an individual basis. The wider impact of burnout is also reflected in evidence of reduced quality of care amongst nurse teams who are struggling with high rates of emotional exhaustion; associations have been found with negative patient outcomes, increased frequency of medical errors and patient safety incidents (Friganovic et al., 2019).

In addition, the high rates of burnout amongst this staff group may impact recruitment and retention. This may contribute to a vicious cycle of understaffed critical care teams, leading to further burnout amongst remaining staff, elevated staff absences or departures, and continuing staffing pressures. This has been a chronic problem within critical care services for decades, and not only impacts the health and wellbeing of nursing staff, but subsequently the provision of patient care (Friganovic et al., 2019; Poncet et al., 2007). It is therefore imperative for critical care services to take action to reduce burnout amongst nurses, at a systemic level, to protect both its staff and patients. Recognition of this need has paved the way for the development of a PNA Programme within critical care teams, intended to support the personal and professional development of nursing staff, and begin to address the extensive burnout rates observed within this group.

Impact of COVID-19 Pandemic

Extensive burnout rates amongst nurses in adult critical care is not a new phenomenon. Already a significant body of research acknowledges this issue and the need for intervention to reduce burnout amongst this staff group, well before the onset of the COVID-19 pandemic. This has had a dramatic impact on all aspects of the healthcare system, arguably most significantly on services such as critical care teams who were often responsible for caring for the most acutely unwell patients during this time.

Research exploring the impact of the pandemic, both in the UK and America indicated increased risk of depression, anxiety, and PTSD amongst critical care nurses (Guttormson et al., 2022; Hall et al., 2022; Montgomery et al., 2021). More acutely elevated burnout was associated with; a sense of feeling unsupported, working in a constantly changing environment and an awareness of personal risk. Further challenges emerged in response to the adapted working conditions, including additional occupational stressors such as shortages to personal protective equipment (PPE), having to train less experienced staff whilst working, and working with less familiar colleagues following staff re-deployment. In line with pre-pandemic data suggesting nurses are the most at-risk group within the wider critical care team (Vincent et al., 2019), recent evidence suggests that nurses were disproportionately impacted amongst the critical care MDT. Nurses were observed to have the highest increase in burnout during the pandemic, and younger, less experienced nurses were identified at greatest risk of suffering burnout and other mental health difficulties (Guttormson et al., 2022; Hall et al., 2022; Moll et al., 2022).

The PNA Programme

In response to the crisis of burnout amongst critical care nurses, exacerbated by the COVID-19 pandemic, Ruth May, Chief Nursing Officer for England, announced in March 2021 the roll out of a new PNA Programme. This programme proposed to deliver training and restorative clinical supervision (RCS) to nursing staff in support of their personal and professional development. RCS aims to support staff wellbeing and is intended to provide further support and skills for the development and implementation of quality improvement initiatives (May, 2021; Critical Care Networks, 2022). RCS is delivered by a trained PNA; a qualified practicing nurse who has completed a Level 7 (postgraduate master's level) PNA Accredited programme.

The PNA Programme has been developed from the Advocating for Education and Quality Improvement (A-EQUIP) Model (See Appendix A), initially based on Proctor's (1987) Clinical Supervision Model. The A-EQUIP Model comprises of four primary functions: (i) normative, relating to monitoring, evaluation, and quality control of the work, (ii) restorative, relating to personal development and building resilience, (iii) personal action for quality improvement, and (iv) education development, relating to the professional development of knowledge and skills (NHS England, 2017; 2021). This model provides a framework for the delivery of RCS,

one of the core tenets of the A-EQUIP model. Evidence suggests this safe, supervisory space enables the development of personal and professional resilience and empowers staff to identify and implement actions to improve quality of care (Dunkley-Bent, 2017; MacDonald, 2019). A systematic review of UK and international literature indicates that supervision amongst nursing teams not only improves quality of care delivered, but also benefits staff in terms of developing peer support relationships, stress relief, increased professional accountability, knowledge, and skills (Ernawati et al., 2022). This review also notes overall improvements to job satisfaction, and reduced risk of burnout amongst those who routinely attend RCS.

The PNA programme has been previously introduced in the midwifery sector in 2017 and is now embedded as part of routine clinical practice (NHS England, 2017). In April 2021, the PNA Programme was launched in the nursing sector with a target to have at least one PNA per clinical team, and 1 in 20 nurses trained in the PNA role by 2025 (NHS England, 2021). There is a paucity of research into the implementation, impact, and efficacy of the PNA programme in nursing, and as such, operational guidelines and service implementation strategies are being developed with a 'bottom-up' approach.

Implementing the PNA Programme in LTHT

Within LTHT, the roll out of the PNA programme within adult critical care has been done in consultation with the Trust's Staff Psychological Support service and qualified PNAs. Given the limited PNA resource, RCS was offered in a group format across adult critical care teams. Nurses new-in-post to a Band 6 role during the pandemic were identified in need of further support, as they had received fewer mentoring, preceptorship, and shadowing opportunities during their transition into the role, given the pressures of the pandemic. PNAs were also offered their own RCS groups, of the same format and based on the A-EQUIP model, facilitated by a clinical psychologist (SEP commissioner).

Aims

This SEP aimed to explore markers of burnout amongst nursing staff working within adult critical care, and to evaluate the impact and acceptability of RCS groups as part of the newly launched PNA programme within adult critical care. It was intended to investigate the impact and acceptability of RCS groups by exploring the supervisory relationship between facilitators and participants, and the perceived impact of RCS groups for participants on their

clinical skills, confidence, and stress levels. This research aimed to capture experiences of both the band 6 nurses (attending RCS groups facilitated by a PNA) and PNAs (attending RCS groups facilitated by a clinical psychologist).

Method

Design

A two-phase mixed methods design was selected to address the aims of this service evaluation. Phase I implemented a quantitative design to gather larger-scale, standardised data whereby participants were asked to anonymously complete an online survey following attendance at an RCS group. Phase II used a qualitative design to provide more in-depth information on individuals' experiences using semi-structured interviews. Other designs were considered, such as a purely quantitative approach, however given that implementation of the PNA programme was taking place in a novel setting, a mixed methods design was selected to provide richer and more comprehensive data (O'Cathain et al., 2007). Whilst it is recognised that validity and reliability are stronger features of quantitative designs, the qualitative component provides meaning and context to this information and offers more depth surrounding participants experiences (Jogulu & Pansiri, 2011). The design and method of analysis reflect the flexible idealist ontological position of the researcher. Given the nature and aims of this service evaluation, a pragmatist epistemological position has been held throughout, with the intention of considering how the data gathered can be usefully reported in relation to development of the service.

Participants

All clinicians participating in the PNA programme in adult critical care (n=42) were invited to take part in both phases of this research. This included all PNAs (n=5) and Band 6 nurses (n=37).

Measures

Participants were invited to complete an online survey providing feedback on their experiences of RCS groups (Appendix B) either facilitated by PNAs (for Band 6 nurses) or facilitated by a clinical psychologist (for PNAs). This consisted of three measures:

(a) The Leeds Alliance in Supervision Scale (LASS; Wainwright, 2010). This is a 3-item measure, scored on a 10-point Likert scale, used to assess supervisory alliance.

(b) The Professional Quality of Life (PROQOL; Fifth Edition; Stamm, 2009). This 30-item questionnaire explores three domains; (i) Compassion Satisfaction (CS), the pleasure derived from work, (ii) Burnout (BO), associated with feelings of hopelessness and ineffectiveness at work, and (iii) Secondary Traumatic Stress (STS), an element of compassion fatigue in response to work-related vicarious traumatisation. This measure is scored on a 5-point Likert scale with 10 questions relating comprising each of the three domains and a total score for each calculated out of 50.

(c) The Impact of Group Supervision (IGS), a novel four-item questionnaire developed by the researcher to explore the impact of RCS on; clinical skill development, confidence, work related stress, and whether RCS had been perceived as a good use of time. This is scored on a 5-point Likert scale.

Procedure & Data Collection

Quantitative data for Phase I was collected between January 2022 – June 2022. Clinicians involved with the PNA programme were contacted by the commissioner via email, on behalf of the researcher, providing them with the participant information sheet (PIS; Appendix C) and inviting them to participate in the project. PNAs and the commissioner were also asked to provide verbal reminders for survey completion during each RCS session.

Participants who had attended RCS sessions in December 2021 were asked to complete the online survey retrospectively.

Phase II of the project was carried out between May 2022 – July 2022. Once again, all clinicians in the PNA programme were contacted via email inviting them to take participate in semi-structured interviews. Clinicians were directed to an online Microsoft (MS) Form (Appendix D) which requested confirmation that they had read and understood the PIS and consented to be contacted to arrange participation in an online interview.

Clinicians who volunteered to participate in interviews were then contacted directly via email to arrange a 60-minute online interview, carried out over MS Teams (See Appendix E for interview schedule). Although there is often a preference for in-person interviews,

research suggests attending online can be a viable alternative with several practical benefits (Lo Iacono et al., 2016).

At the start of the interview, participants were advised that this would be recorded and asked to confirm their consent to participate. Interviews were recorded using the process in-built to the MS Teams programme, and then stored securely on the University of Leeds OneDrive.

Ethical Considerations

Ethical approval was sought from the University of Leeds School of Medicine Research Ethics Committee (reference: DClinREC 21-001) and granted on 18th January 2022. After consultation with the NHS Trust Research & Innovation department, it was agreed that no further ethical approval was required.

All clinicians invited to take part in the project were provided with the PIS via email prior to participation. It was explicitly stated that participation in the project was entirely voluntary, and that confidentiality would be maintained throughout. Submitting the anonymous online surveys was taken as implicit consent for data to be used and it was stated on the survey that once submitted it was not possible to withdraw data.

All recorded interview data was stored securely online and destroyed once analysis had taken place. All data reported in this report has been coded and anonymised accordingly to protect participants confidentiality.

It was not anticipated that participants would find interviews distressing, however it was acknowledged that reflecting on experiences of restorative supervision may raise sensitive or difficult content and therefore individuals were reminded that they were able to take breaks or terminate interviews at any point, without having to give an explanation. In addition, the PIS provided clinicians with information on staff wellbeing services offered by the trust, if required.

A potential risk or drawback identified in participation of this project was the time taken to attend an interview may place additional strain on an already busy workforce, and as such interviews were arranged flexibly in collaboration with each participant.

Data Analysis

Quantitative data obtained from online surveys in Phase I were collated, analysed, and descriptive results have been reported below.

Qualitative data collected in Phase II has been analysed using rapid qualitative analysis, outlined below in Table 1 (Hamilton, 2013). This has been identified as a reliable and time-saving alternative approach to thematic analysis (Taylor et al., 2018). Rapid qualitative analysis was selected for this research project for its flexibility and in line with the pragmatic epistemological position of the researcher.

Table 1
A Summary of The Steps of Rapid Qualitative Analysis as set out by Hamilton (2013)

Step	Process
1	Create a neutral domain name corresponding to each interview question
2	Create a summary template
3	Test summary template for usability, relevance, etc.
4	After consistency and utility is established, summarise recordings/transcripts
5	Transfer summaries into a matrix to identify themes across data sets

Credibility

During analysis, emerging themes were discussed with the project commissioner and an independent credibility check of the themes was carried out by another psychologist in clinical training, not affiliated with the project.

Researcher Reflexivity

Within qualitative research there is always some contribution from the researcher to the research. As such, self-reflexivity is imperative to maintain an awareness of how the researcher's stance may influence the research and interpretation of data (Tracy, 2019). The researcher has no affiliation to adult critical care services. However, there are previously held beliefs and assumptions about the role and utility of RCS, and it has been important to hold these in mind when collecting, analysing, and reporting the data, to ensure any risk of researcher bias is minimised.

Results

Phase I: Sample

Newly appointed Band 6 nurses (n = 37) were invited to attend RCS as part of the PNA

programme. Nurses were organised into five supervisory groups, based on the unit in which they worked, with group size ranging from 12 to 5 nurses. Groups met online, on alternate months, for 90 minutes. A total of 16 groups took place between December 2021 – June 2022. Had all invited nurses attended each of their respective RCS groups, there would have been a total of 134 attendances. In practice, just over half attended (n = 68, 51%) with a mean attendance rate of 60% per group.

Of the total attendees (n = 68), 34% completed feedback via the online survey (n = 23).

All PNAs (n=5) were invited to attend their own RCS group. This was held online, on alternate months, for 90 minutes with a mean attendance rate of 88% for groups taking place between October 2021 – June 2022. Of the instances of PNA attendance at the RCS groups during this period (n = 16), 69% completed feedback via the online survey (n = 11).

Phase I: Descriptive Results

Table 2 contains descriptive data gathered from analysis of online surveys completed by both groups; Band 6 nurses and PNAs. This has been broken down by measure and domain within each measure.

It appears that both groups report overall positive experiences of attending RCS groups. PNAs report consistently positive responses towards RCS, with high average scores for supervisory alliance and the impact of RCS. Nurses' scores reflect a strong positive supervisory alliance, however only modest improvements in confidence and clinical skills are reported. A greater range of scores can be observed amongst the nurses, which may reflect the larger sample size of this group.

As with experiences of RCS, PNAs scored consistently across all domains of professional quality of life, indicating lower risk of burnout, secondary traumatic stress, and an increased sense of pleasure derived from work (compassion satisfaction). Nurses scored within the healthy ranges for compassion satisfaction and risk of secondary traumatic stress, however there was some evidence of increased risk of burnout amongst this group.

Table 2

Descriptive results from online surveys completed by Band 6 Nurses and PNAs

Band 6 Nurses	***Mean***	***Highest Score***	***Lowest Score***	***Range***
LASS 1: Approach	8.3	10	5	5
LASS 2: Relationship	8.26	10	1	9
LASS 3: Needs	7.13	10	1	9
LASS Total	23.7	30	11	19
PROQOL: CS	34.87	46	19	27
PROQOL: BO	28.83	42	18	24
PROQOL: STS	26.3	38	16	22
PROQOL Total	90	111	75	36
IGS 1: Clinical Skills	3.17	5	2	3
IGS 2: Confidence	3.3	5	2	3
IGS 3: Stress	3.3	5	2	3
IGS 4: Use of Time	3.61	5	2	3
IGS Total	13.39	20	8	12

PNAs	***Mean***	***Highest Score***	***Lowest Score***	***Range***
LASS 1: Approach	9.64	10	7	3
LASS 2: Relationship	10	10	10	0
LASS 3: Needs	10	10	10	0
LASS Total	29.64	30	27	3
PROQOL: CS	40.36	47	32	15
PROQOL: BO	19.64	26	15	11
PROQOL: STS	15.64	20	13	7
PROQOL Total	75.64	86	70	16
IGS 1: Clinical Skills	4.27	5	3	2
IGS 2: Confidence	4.55	5	4	1
IGS 3: Stress	4.45	5	3	2
IGS 4: Use of Time	4.73	5	4	1
IGS Total	18	20	14	6

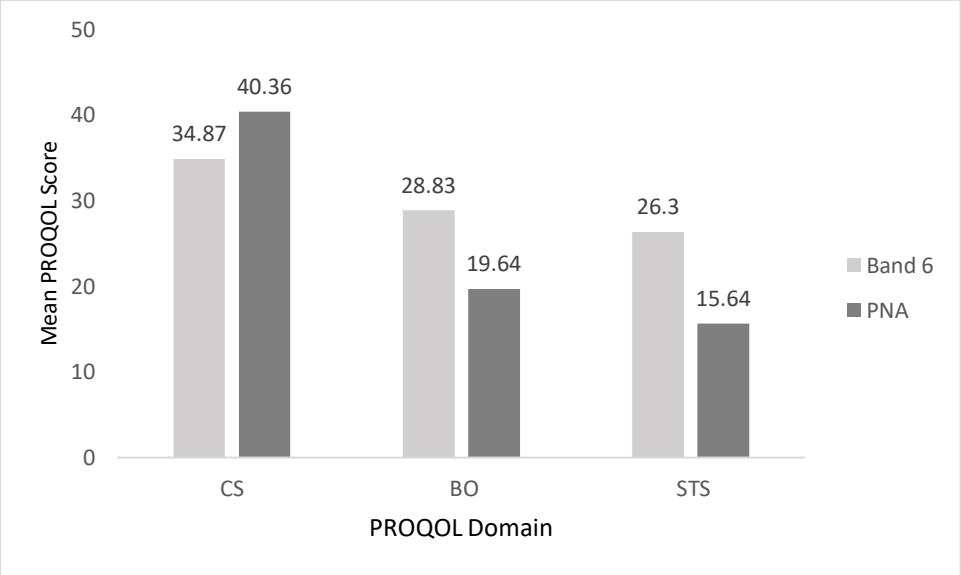
Markers of Burnout. PNAs indicated a healthy professional quality of life in all domains whilst the nurses reported lower mean scores for each domain of the PROQOL measure, indicating reduced professional quality of life (see Figure 2). For the first domain, Compassion Satisfaction (CS), scores below 23 indicate reduced pleasure derived from work (Stamm, 2010). Both nurses and PNA responses are above this cut off and PNA responses appear indicative of greater professional satisfaction.

The second domain of the PROQOL refers to clinician's Burnout (BO) levels, with lower scores reflecting reduced risk of experiencing burnout. Scores below 23 are indicative of a

positive sense of professional efficacy, and scores above 41 suggestive of possible concern (Stamm, 2010). PNA scores reflected a lower risk of burnout amongst this group, with more positive feelings towards professional efficacy. Whilst nurses' scores did not indicate major concerns (i.e., not above 41 points), they were on average above the 23-point score. This is evidence of a reduced sense of professional efficacy and indicates nurses may be at slightly elevated risk of burnout.

The final domain within the PROQOL relates to experiences of Secondary Traumatic Stress (STS). For this domain, lower scores indicate reduced risk of STS, with scores above 43 identifying this as an area of concern. As with previous domains, both groups scored on average below the range of concern.

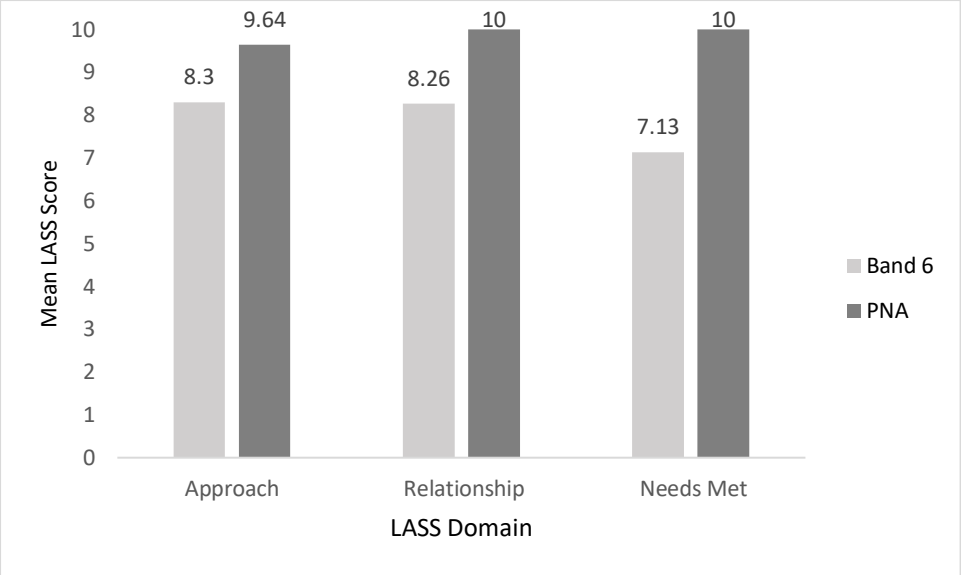
Figure 1
Mean scores for PROQOL measure



Impact and Acceptability of RCS Groups: Supervisory Relationship. On the LASS measure, both PNAs and nurses indicated a positive supervisory alliance (see Figure 1). PNAs scored highly on this measure overall (mean = 29.64), as did nurses (mean = 23.7), with higher scores reflecting more positive experiences of RCS. This positive response to RCS Supervisory alliance can be observed in each of the three domains of the LASS, with supervisory approach, supervisory relationship, and helpfulness of the RCS in meeting supervisees needs all being scored highly.

Figure 2

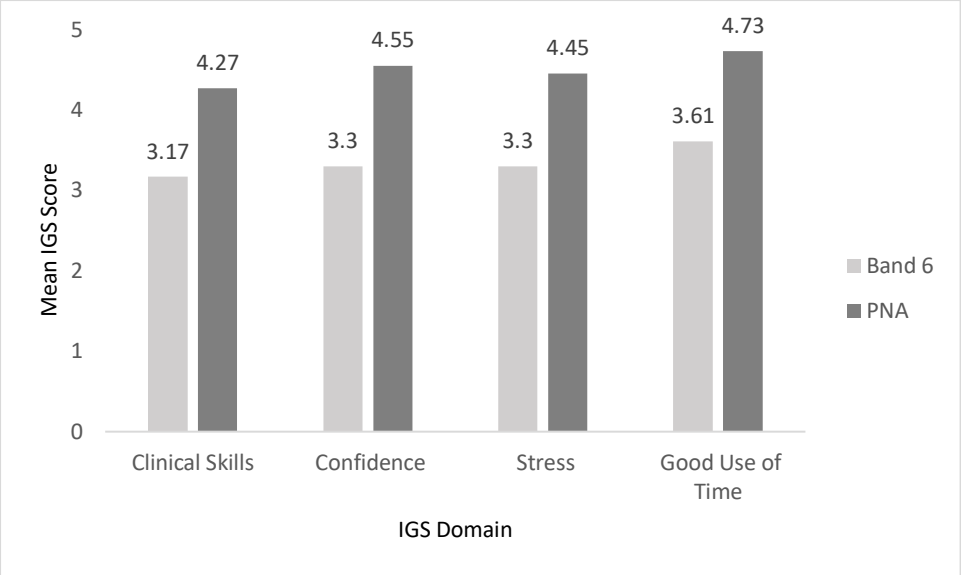
Mean scores for the Leeds Alliance in Supervision Scale (LASS), reported by domain



Impact and Acceptability of RCS Groups: Clinical Skills, Confidence and Stress Levels. The final measure comprising the online survey was the Impact of Group Supervision (IGS). The PNAs reported high average scores on each domain, indicating a positive response to RCS groups in terms of clinical skill & confidence development, as well as perceiving RCS as useful for managing stress. The nurses reported a consistent, but only modest positive response to RCS in each of the four domains (see Figure 3). The majority of nurses responded 'neutral' when asked if RCS improved clinical skills (57%), or confidence (43%). However, 39% stated they 'agree' or 'strongly agree' that RCS helped to manage stress and 52% reported they 'agree' or 'strongly agree' RCS was a good use of time.

Figure 3

Mean scores for the Impact of Group Supervision (IGS) measure, reported by domain



Phase II: Sample

All Band 6 Nurses and PNAs involved in the programme (n = 42) were invited to participate in semi-structured interviews. The final sample for Phase II consisted of three participants, all employed in the PNA role.

Phase II: Themes & Sub-Themes

Five superordinate themes emerged from qualitative analysis, with multiple sub-themes for each, as highlighted in bold in the text below. Themes, sub-themes, and supporting quotes are captured in Table 3 (pp 16).

Superordinate Theme One: Impact and Motivation for PNAs. This theme explores factors which contributed to participants' decision to sign up to the PNA programme, and the subsequent impact of this role. Participants spoke of observing friends and colleagues work through extremely traumatic conditions during the COVID-19 pandemic and expressed an **intrinsic motivation to help** and support colleagues where possible. They also spoke about feeling driven by the opportunity to contribute to **shaping the PNA programme** in adult critical care. Another influential factor reported was the opportunity for professional and **personal growth**, including completion of a Masters' level course, developing a greater sense of empathy for colleagues, building confidence with supervisory skills, and making a positive impact for staff.

Superordinate Theme Two: Barriers for PNA Programme. This theme captures some of the challenges identified by participants in establishing the PNA programme. Participants expressed thoughts that the PNA programme could have been better launched, publicised, and promoted by the Trust. There was a sense that the PNA role and expectations of the programme were not clearly communicated, and **insufficient promotion of the programme** has led to difficulties engaging Band 6 nurses and fears that the invitation to attend RCS is perceived as criticism of clinicians' work. It was noted that **meeting online** may act as a barrier, and some valuable interpersonal interactions are lost in online meetings. Finally, participants reported feeling unprepared in the delivery of RCS and expressed feeling that the more practical skills were not adequately developed during the training course, with inconsistencies and **variation between PNA training courses**.

Superordinate Theme Three: Facilitators for PNA-led RCS Groups. This theme summarises the elements of the PNA programme which participants identified as successful and valued during RCS groups. Participants described the **A-EQUIP model as a useful underpinning** for groups, ensuring that the focus remains centred around proactive change, addressing challenges, and quality improvement, rather than being used solely as a space to offload complaints. It was expressed that the **duration and frequency of meetings** worked well, and that an informal, **flexible, and collaborative approach** developed over time which helped groups to flow naturally, and provided staff a space to feel heard, supported, and valued. It was also hoped that encouraging staff to reflect on clinical practice offered development opportunities and built confidence in their existing knowledge and skills.

Superordinate Theme Four: Value of PNA RCS. This theme reflects the value participants placed on attending their own PNA RCS groups where they were offered support, guidance, and a space to reflect on experiences of facilitating RCS groups for nurses. Participants identified that PNA RCS served to **supplement the training course**, provide examples of good practice, model useful questions, and practical skill development in the delivery of RCS. Groups were described as a supportive environment, which were well-led and offered opportunity to share ideas, identify and anticipate challenges, and improve confidence. Participants recognised the range of **personal and professional development** benefits of this group including opportunities to network, develop peer

support relationships, and broaden perspectives beyond their own unit. This support was perceived by participants as evidence of the Trust investing in and **validating the PNA role**.

Superordinate Theme Five: Hopes for the Future Development of PNA Programme. This theme describes participants' hopes for the continuing growth of the PNA programme. The importance of continued promotion of the PNA programme was acknowledged, on the condition it remains useful in supporting nurses' professional development, and serves to **improve staff wellbeing, and retention**. Participants expressed hope that attending RCS becomes **embedded into routine practice**, without any stigma or fear of criticism. Continued support for PNAs in the form of their own psychologist-led RCS groups was viewed as essential. Ideas were shared around the PNA programme becoming a **self-maintaining support system**, with hopes that current attendees are inspired to train as PNAs and facilitate future RCS groups.

Table 3
Key Themes from Analysis

Superordinate Themes	Subthemes	Example Quotations
Impact & Motivation for PNAs	Intrinsic motivation to help	*As a manager it was something that I felt passionate that I wanted to be equipped to be able to support my staff effectively.* *I felt it would have been morally wrong of me to sit back and not do anything…I would not have been the kind of friend, or leader, or nurse that I want to be if I hadn't done it.*
	Shaping the PNA Programme	*I feel privileged to be [a PNA] I think it's a really important role that we've been given the opportunity to develop.*
	Personal Growth	*It's been quite humbling in a way, [hearing] about the different experiences that staff have been through and I think it's helped me grow and have more understanding and be more empathetic to the staff that we're supervising.*
Barriers for PNA Programme	Insufficient promotion of programme	*It has been really hard to implement it when we've kind of had no one senior in the Trust or even in NHS England to help us develop and shout about this course.*
	Meeting online	*It makes it more difficult in a sense, because you don't get the same flow when you're meeting in a group on teams that you would if you were in a room…it's more stilted isn't it.*

	Variation between PNA training courses	*There was no parity in the courses across the country.*
Facilitators for PNA-led RCS Groups	Flexible and collaborative approach	*Sometimes it's just evolved as conversation's gone on, so I think it's nice to not have that rigidity of 'this is what we're going to do'.*
	Duration and frequency of meetings	*I'm always worried that the conversation will dry up and an hour and a half sounds an awful long time, but once you get going and start probing, the conversation does start to flow…so I think the length of time is right.*
	AEQUIP Model as a useful underpinning	*Sometimes I'm conscious that supervision sessions can become a little bit of a moaning session, where it's really important to try and keep it focused…it's about how to move forward and being constructive and I think the AEQUIP model brings that really well into the restorative clinical supervision element.*
Value of PNA RCS	Supplement the training course	*We weren't actually taught on the course that I did how to deliver any supervision, it was all very theoretical, erm so I didn't really feel prepared for doing the sessions.*
	Validating the PNA role	*I think it gives some validity to what I do, as with everything with nursing, I think nursing has these great ideas that we must do this, and then it's thrown out and you're left to get on with it, and there's never any clear direction. And I think the group has given that clear direction, the group has guided the journey.*
	Personal and professional development	*When we first started, it was incredibly daunting, and I certainly wouldn't have the audacity to say I'm the finished article, but I feel more confident than I did and it's been lovely to have a group of people that you can go to and talk to.* *It's been really useful to have that safe space to explore things we've found difficult.* *The group has given me the confidence to think I might actually be able to do this role*
Hopes for the Future Development of PNA Programme	Improve staff wellbeing and retention	*The whole point of the Professional Nurse Advocate is to reduce stress and improve wellbeing, and we do know that we've got a massive turnover of critical care staff nationally, and hopefully this might be a reason for some people to stay, and retain staff, and also recruit staff as well.*
	Embedded in routine practice	*I hope that it does just become part of normal practice.*
	Self-maintaining support system	*[Supervisees] might then feel motivated to put themselves through the training and then be able to offer that to the Band 5s so that as a whole team everybody can feel supported, feel that they've got*

		somebody to go to, and that can help them take themselves forward and achieve their best selves

Discussion

Summary of Key Findings

This evaluation of a newly launched PNA programme within adult critical care intended to explore markers of burnout amongst nursing staff in this setting and evaluate impact and acceptability of RCS groups as the programme was being developed and implemented in a novel setting.

The results indicate that positive experiences of RCS were reported by both Band 6 nurses and PNAs. Across the board, PNAs reflected more positive experiences of RCS groups, with consistently higher supervisory alliance reported. In line with previous research exploring the impact of RCS (Dunkley-Bent, 2017; MacDonald, 2019), this group expressed finding RCS more useful in building clinical skills, confidence, and regarded this a better use of time when compared to the Band 6 nurses. Further exploration of the differences observed in these groups' experiences would be useful to understand how to increase the efficacy of RCS in practice, particularly for the Band 6 nurses who may face differing professional pressures. Future research may wish to consider the factors which influence utility of RCS.

Professional quality of life appears generally more positive for PNAs when compared to nurses. Whilst nurses displayed healthy levels of pleasure derived from work and appeared at lower risk of vicarious trauma, their risk of burnout was slightly elevated. This is unsurprising given the wealth of research identifying critical care nurses to be at increased risk of burnout, given the numerous challenges of their role (Duarte & Pinto-Gouveia, 2017; Vincent et al., 2019). Whilst it is not possible to infer causality for differences observed in professional quality of life between nurses and PNAs from this data, it is interesting to observe that PNAs reported more positive professional quality of life and appeared to find RCS more useful. This corroborates previous research recognising an association between improved job satisfaction, reduced risk of burnout and regular attendance at RCS (Ernawati et al., 2022).

PNAs appeared passionate about their role, describing an intrinsic motivation to participate in the programme, driven to support their teams and shape the development of the PNA programme. The A-EQUIP model was recognised as a useful framework in which to ground RCS and ensure the space remained supportive yet productive, maintaining focus on professional development. It was acknowledged that barriers to the PNA programme included lack of clarity and promotion of the PNA role, which may have influenced nurses' expectations about the aims and structure of RCS groups. Finally, PNAs identified their own RCS groups with a clinical psychologist as highly valuable to bridge gaps from their respective training courses, build skills and confidence in delivering RCS, and establish peer support relationships.

Strengths & Limitations

A strength of this project is the use of a mixed-methods design, enabling breadth and depth in the collection, analysis, and reporting of the data. In addition, the implementation of credibility checks with both the commissioner and an independent trainee have enhanced the quality of the analysis.

One obvious limitation to this project is the absence of any qualitative data from the nurses attending PNA-led RCS groups. As such, the rich, detailed information captured during semi-structured interviews is limited in applicability and can only be considered in the context of the experience of the PNA's. Whilst this preserves some homogeneity in the sample for the benefit of analysis, capturing perspectives of the nurses in greater depth remains a significant gap in this research. Without hearing from them directly, it's not possible to draw conclusions about why none of the nurses in this sample chose to participate in interviews. However, as recognised in much of the literature, critical care nursing is a highly intensive, fast-paced environment with limited opportunities to take time for professional development (Cartledge, 2001). One possible hypothesis may be that it would have been likely that any nurses taking part in interviews would have had to do so whilst off-shift and this may have presented an additional barrier to participation.

Another limitation to the data collected is the use of anonymity in the completion of online surveys. Whilst this was an intentional feature of the questionnaire design, to encourage a more honest reflection of participants' experiences of RCS, this resulted in a significant flaw

in the design of this research. As participants' responses were anonymous, it was not possible to match up questionnaires which may have been completed at differing time points, by the same participant. The consequence of this was such that it was not viable to carry out a pre-post analysis and therefore it has not been possible to evaluate any change in responses over time. Had this been possible, it would have been valuable to compare LASS and IGS scores over time to explore any potential changes in supervisory alliance and perceived utility of RCS groups as these became embedded in routine clinical practice. In addition, the opportunity to compare PROQOL scores over time may have also been useful in further evaluating the impact of RCS groups on measures of burnout and professional quality of life. In light of the limitations identified from this project, recommendations have been made below for future research.

Conclusions & Recommendations

Overall, it appears that both Band 6 nurses and PNAs find benefit in attending RCS, with greater utility and benefit reported by the PNAs than Band 6 nurses. There have been some initial barriers in implementing this programme from the perspective of PNAs, such as the variability to PNA training courses, a requirement for greater promotion across the service, and adapting to the interpersonal challenges of meeting online. However, PNAs recognise the utility of grounding RCS in the A-EQUIP framework and remain hopeful that current supervisees will be empowered and inspired to take up future PNA roles.

Based on the findings from this project, several recommendations are made below (Table 4).

Table 4

Recommendations based on the outcomes of the SEP

Recommendations for continued development of the PNA Programme within Adult Critical Care
• Successful implementation and growth of the PNA programme requires input at all levels, with greater organisational awareness, promotion, and more regular service-wide discussion of the PNA role and the rationale underpinning RCS. • Nurses invited to attend RCS may benefit from the development and dissemination of clear guidelines on the rationale, format, expectations, and preparation tips for RCS. • In the interest of embedding RCS into routine clinical practice in adult critical care, it may be useful to expand this offer to all practicing and training nurses, with a view that this may normalise attendance at RCS and reduce the stigma or perceived criticism felt by some nurses invited to attend. This may be more practically feasible as the PNA programme grows over time, as per guidance outlined by Ruth May and NHS England (2021). • PNAs appear to value continued consultation with Psychology to consolidate learning from the PNA training course and develop skills and confidence in delivering RCS. This appears a valued resource in the personal and professional development of PNAs and facilitates reflection on the impact, challenges, and successes of the PNA role.
Recommendations for further research
• Further research will be valuable in exploring the nurses' experiences of attending PNA-led RCS groups, as it was not possible to capture this in as much depth for this project. • Future research may also wish to explore any impact of the RCS groups over time. This could include evaluating any development in supervisory alliance, perceived utility, and whether any changes are observed in PROQOL scores over time, or in other quality improvement measures such as staff sickness rates.

Dissemination

The findings from this project were presented at an annual SEP conference, as part of the University of Leeds Doctorate in Clinical Psychology Programme (Appendix F), at an LTHT Staff Mental Wellbeing Group Meeting, and PNA team meeting. The final report will be shared with the commissioner and relevant services within LTHT.

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Appendices

Appendix A: Professional Nurse Advocate: The A-EQUIP Model

Appendix B: Measures Used in Online Survey

Appendix C: Participant Information Sheet

Appendix D: Online Consent Form to be Contacted for Interviews

Appendix E: Semi-Structured Interview Schedule

Appendix F: Research Poster for University of Leeds Doctorate in Clinical Psychology Programme SEP Conference

Appendix A

Professional Nurse Advocate: The A-EQUIP Model

The A-EQUIP model works for nurses in four ways:

- advocating for the patient, the nurse and healthcare staff
- providing clinical supervision using a restorative approach
- enabling nurses to undertake personal action for quality improvement
- promoting the education and development of nurses.

The A-EQUIP model stems from the three functions of clinical supervision in Brigid Proctor's 1987 clinical supervision model that is commonly used in health services:[1]

- **normative** – managerial aspects concerning practice, learning and core mandatory training
- **formative** – educational aspects: developing knowledge and skills in professional development and self-reflection
- **restorative** – supportive aspects, including personal development, improving stress management and mitigating burnout.

Bowles and Young (1999) stated "nurses greatly benefit from clinical supervision from each of the[se] three functions" and that the model provides a framework for using clinical supervision "to change and critically examine nursing practice".[2]

NHS England added a fourth function: personal action and quality improvement.[3] Subsequent to this addition, a new taskforce was convened in England with sponsorship from the Chief Nursing Officer for England to further develop the A-EQUIP model for use in professional nursing leadership and clinical supervision, and for use by PNAs.

The A-EQUIP model is flexible and can be implemented according to organisational requirements to support collaboration between nurses and healthcare colleagues when delivering RCS sessions.

Taken from:
NHS England (2021). *Professional Nurse Advocate A-EQUIP Model: A Model of Clinical Supervision for Nurses*. Retrieved October 22, 2022, from https://www.england.nhs.uk/wp-content/uploads/2021/12/B0799-national-professional-nurse-advocate-implementation-guide-with-links.pdf

Appendix B

Measures Used in Online Survey

<u>Leeds Alliance in Supervision Scale (LASS)</u>

Instructions: Please choose a number to indicate how you feel about your supervision session

(Approach)

1	2	3	4	5	6	7	8	9	10
This supervision session was not focused									This supervision session was focused

(Relationship)

1	2	3	4	5	6	7	8	9	10
My supervisor and I did not understand each other in this session									My Supervisor and I understood each other in this session

(Meeting My Needs)

1	2	3	4	5	6	7	8	9	10
This supervision session was not helpful to me									This supervision session was helpful to me

Professional Quality of Life Scale (PROQOL – B6N)

When you care for people, you have direct contact with their lives. As you may have found, your compassion for those you care for can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a nurse. Consider each of the following questions about you and your current work situation as a Band 6 Nurse. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1 = Never 2 = Rarely 3 = Sometimes 4 = Often 5 = Very Often

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I care for.
___ 3. I get satisfaction from being able to care for people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I care for.
___ 7. I find it difficult to separate my personal life from my life as a Nurse.
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I care for
___ 9. I think that I might have been affected by the traumatic stress of those I care for.
___ 10. I feel trapped by my job as a Nurse.
___ 11. Because of my Nursing, I have felt "on edge" about various things.
___ 12. I like my work as a Nurse.
___ 13. I feel depressed because of the traumatic experiences of the people I care for.
___ 14. I feel as though I am experiencing the trauma of someone I have cared for.
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with the nursing techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a Nurse.
___ 20. I have happy thoughts and feelings about those I care for and how I could help them.
___ 21. I feel overwhelmed because of my workload seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I care for.
___ 24. I am proud of what I can do to help.
___ 25. As a result of my nursing, I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a Nurse.
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

Impact of Group Supervision for Band 6 Nurses (IGS – B6N)

Instructions: Please select the response which best reflects your experience of the supervision session

This supervision session has been helpful for building my clinical skills in my role as a Band 6 Nurse

Strongly Disagree Disagree Neutral Agree Strongly Agree

This supervision session has increased my confidence as a Band 6 Nurse

Strongly Disagree Disagree Neutral Agree Strongly Agree

This supervision session has been useful in managing my work-related stress as a Band 6 Nurse

Strongly Disagree Disagree Neutral Agree Strongly Agree

This supervision session has been a good use of my work time

Strongly Disagree Disagree Neutral Agree Strongly Agree

Appendix C

Participant Information Sheet

Participant Information Sheet Version 2: An Evaluation of the Professional Nurse Advocate (PNA) Pilot project in Adult Critical Care

Dear member of staff,

My name is Marina Beckwith and I am currently studying for a doctoral degree in Clinical Psychology at the University of Leeds. I am conducting a service evaluation project alongside Dr Nate Shearman aiming to evaluate the Professional Nurse Advocate (PNA) programme.

I am inviting all staff members who have attended the Supervision Groups to get involved in this project. This information sheet gives you some information about the evaluation to see if you would be willing to take part. Taking part is completely voluntary.
Ethical approval has been given by the Doctorate in Clinical Psychology Research Ethics Committee at the University of Leeds (DClinREC ref number: 21-001)

What is the purpose of the project?
The aim of the project is to evaluate the PNA programme which was established to facilitate supervision for nursing staff working within the Adult Critical Care Unit, by trained nursing staff. We would like to know more about whether the PNA supervision groups were useful and any impact of this additional support for staff. This evaluation would also enable us to consider if and how this programme could be continued in future.

What will I be asked to do?
There are two parts to this research project.
If you decide to take part in the first part of the evaluation, each time you attend supervision you will be asked to complete a set of questionnaires about the supervision session you have just attended. These questionnaires will take approximately 5-10minutes to complete.

The second part of this evaluation will involve attending an online interview. You will be contacted via email asking for volunteers to take part in an online interview. If you decide to take part in the interview stage of the evaluation, I will be in contact with you to discuss the details of the interview with you and confirm you are happy to go ahead with this. We will then arrange a suitable time for the online interview, which will last up to 60 minutes, during which you will be asked about your experience of attending the PNA supervision sessions. This will be audio recorded.

Do I have to take part?
Each time you are asked to complete the post-supervision measures it is up to you to decide whether you wish to take part. By completing the online questionnaires, you are consenting to your information being used for the evaluation project, once you submit your responses, you will be unable to withdraw this data as it will be anonymised.

If you agree to take part in the interview stage of this evaluation, you will be asked to read and complete a separate interview consent form. Even after you have consented you can choose not to answer specific questions or to withdraw from the study up until one-week post interview by contacting the researchers. You do not have to give a reason to withdraw your data.

Data collection and storage
All the information you provide in the study will be confidential. Dr Nate Shearman will not be informed about which members of staff have taken part or responded. I will be the only member of the research team who has access to any identifiable data and only anonymous research material will only be accessible to members of the research team (Dr Nate Shearman, Staff Support for Adult Critical Care, Dr Ciara Masterson, Academic

Supervisor, University of Leeds). The research team will be supported with analysing anonymous data in the form of Survey responses by Hana Javed, (Undergraduate Student, University of Leeds). Anonymised data from the study will also be stored securely on the Trust and University's shared drive and kept anonymous (identified only by a number) and confidential.
Recordings will be used only for analysis and will be deleted after the analysis has been completed. The transcripts will be anonymised and only identifiable by an identification number. The data will be stored on a private university computer drive and will be deleted either 2 years after publication or 3 years after data collection, whichever is longer. Extracts of quotes may be used when writing up the project and for publication, however, all information with remain anonymous and confidential. The results will be disseminated through several means, and likely be published. As a participant, you will not be identified in any report or publication. Given the importance of the evaluation data, the findings from the project may be used for additional research. The University guidelines on the use of personal data will be adhered to. More information on the University guidelines can be found here: https://dataprotection.leeds.ac.uk/research-participant-privacy-notice/

I have some more questions; how can I contact you?
I am happy to answer any further questions you may have. You can contact me or my supervisors using the contact information below.

Thank you for taking the time to read this information.

If you are happy to take part, please complete and return the enclosed consent form via email to ummbec@leeds@ac.uk

Marina Beckwith: ummbec@leeds.ac.uk
Clinical Psychology Training Programme, Institute of Health Sciences, Level 10, Worsley Building, University of Leeds, Clarendon Way, Leeds, LS2 9NL.

Supervisors:
Dr Ciara Masterson: c.masterson@leeds.ac.uk
Clinical Psychology Training Programme, Institute of Health Sciences, Level 10, Worsley Building, University of Leeds, Clarendon Way, Leeds, LS2 9NL.

Dr Nate Shearman: nathan.shearman@nhs.net
Department of Clinical & Health Psychology, The Leeds Teaching Hospitals NHS Trust, Fielding House, St James' University Hospital, Beckett Street, Leeds, LS9 7TF.

Further support
The interviews will involve asking you to reflect on the impact of the Supervision Groups on your personal lives and work lives and so there is a small chance that this may cause you distress. If you feel you need any further support, please find the following contacts of support:
· Your GP
· Your manager/supervisor
· Occupational Health Services, Leeds Teaching Hospitals NHS Trust
· More information on Trust support services is available on the staff intranet
· The staff counselling service for the Trust - Care First, Employee Assistance Programme (EAP) - they offer confidential telephone counselling. To access, call 0800 174319 or visit the Staff Support Website for more information on psychological support available for staff:
https://www.leedsth.nhs.uk/staffhealthandwellbeingsupportnetwork/psychology-staff-support/

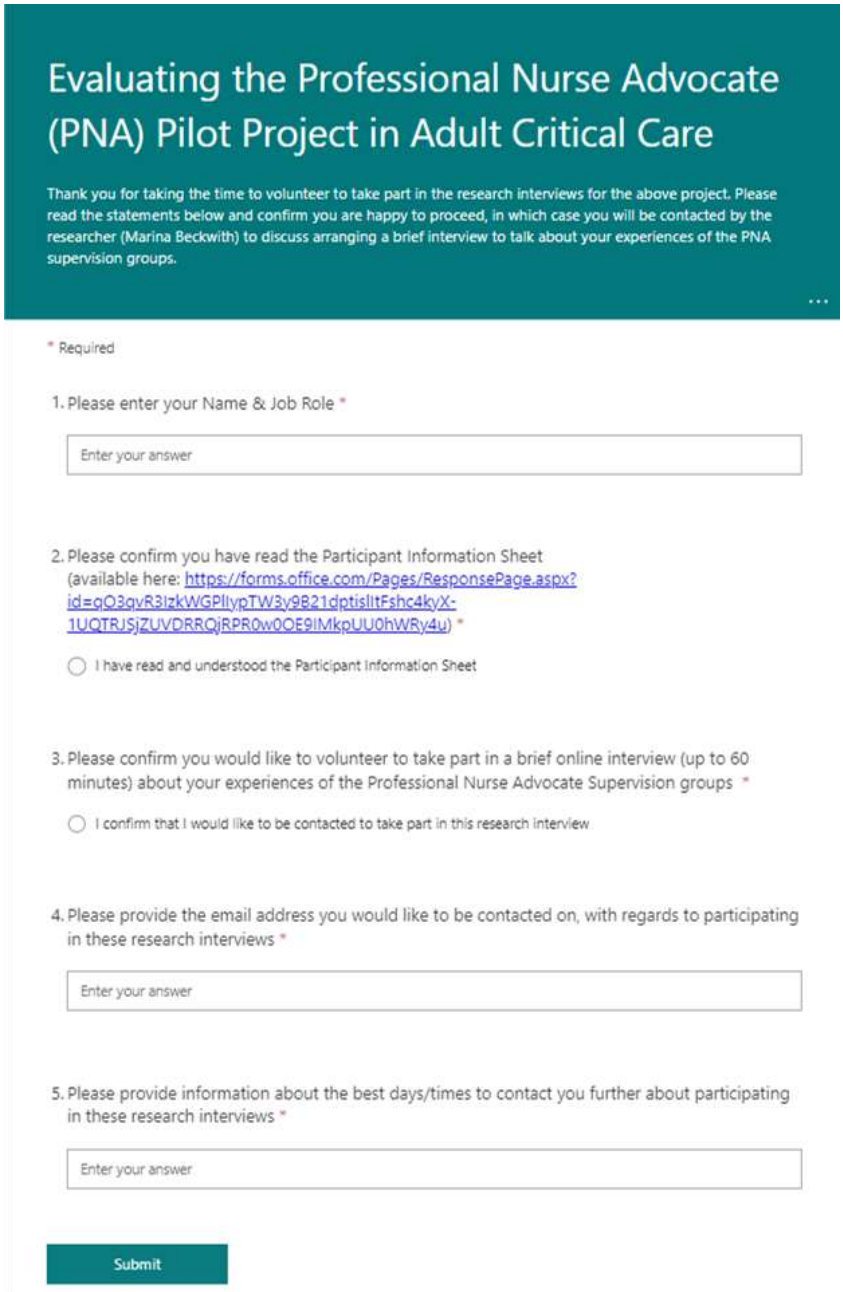
Yours sincerely,

Marina Beckwith
Psychologist in Clinical Training

Dr Nate Shearman
Senior Clinical Psychologist

Appendix D

Online Consent Form to be Contacted for Interviews



Evaluating the Professional Nurse Advocate (PNA) Pilot Project in Adult Critical Care

Thank you for taking the time to volunteer to take part in the research interviews for the above project. Please read the statements below and confirm you are happy to proceed, in which case you will be contacted by the researcher (Marina Beckwith) to discuss arranging a brief interview to talk about your experiences of the PNA supervision groups.

* Required

1. Please enter your Name & Job Role *

Enter your answer

2. Please confirm you have read the Participant Information Sheet (available here: https://forms.office.com/Pages/ResponsePage.aspx?id=qO3qvR3IzkWGPIlypTW3y9B21dptisIltFshc4kyX-1UQTRJSjZUVDRRQjRPR0w0QE9IMkpUU0hWRy4u) *

○ I have read and understood the Participant Information Sheet

3. Please confirm you would like to volunteer to take part in a brief online interview (up to 60 minutes) about your experiences of the Professional Nurse Advocate Supervision groups *

○ I confirm that I would like to be contacted to take part in this research interview

4. Please provide the email address you would like to be contacted on, with regards to participating in these research interviews *

Enter your answer

5. Please provide information about the best days/times to contact you further about participating in these research interviews *

Enter your answer

Submit

Appendix E

Semi-Structured Interview Schedule

1. **Opening**

A. (**Introduction/Establish rapport**) My name is ***Marina Beckwith*** and I am training at the University of Leeds and employed by Leeds Teaching Hospitals trust as a trainee Clinical Psychologist, and today I am here to interview you for a service evaluation project that you have consented to take part in. I am going to turn the recording on now. Are you ready? (*wait for response and turn on recording if participant is ready*) Can I just confirm for the recording that you have consented to take part in this interview? (*wait for response*)
B. (**Identification for withdrawal purposes**) The ID number for this recording is (*state ID number given and recorded on consent form*)
C. (**Purpose**) The purpose of this interview is to explore your experiences of participating in a supervision group facilitated by Professional Nurse Advocates, as part of your work in Adult Critical Care.
D. (**Motivation**) We hope to use this information to develop the structure, content and further implementation of these groups.
E. (**Time line**) The interview should last no more than one hour. If you wish to end the interview at any point then you are free to do so. Please let me know. You can choose not to answer a question. You can also take pauses of silence if you need time to think too. If I ask a follow up question and you have nothing more to say on that part of the interview then please say.
F. (**Online only**) If for some reason we experience technological issues then we will monitor to see if these subside, but if they persist or we lose connection then I will hang up and try to re-establish a connection. If re-establishing a connection is not possible then I will e-mail you to re-schedule. Just to explain that I am also in a room by myself, to protect your confidentiality.
G. (**Clarify**) Does that all sound okay? Are we okay to begin? Can I start by just confirming your role within the team?

1. **Practicalities**
    a. How many of the Supervision Groups have you attended?
    b. What do you think about the timings of when you meet, the location of where you meet and how long you meet for?
    c. Who has attended the group?
    d. Tell me a bit about the facilitation of the group. What are your views on how the group is facilitated?

2. **Understanding**
    a. What do you think the purpose of your supervision group is?
    b. What was it like when you first heard about this group and you could be a member of it?
    c. How much choice did you think you had about whether to attend or not?
    d. Is there anything else you would like to say about your views on the purpose of the group or your understanding of it?

3. **Meaning**
    a. What does it mean to you to be a part of this group?

   b. How much have your views on this group changed over time?
   c. What do you think this group means to the Band 6s who attend?
   d. How much do you talk about the group outside of the group?
   e. What do you hope will happen to this group in the future?
   f. Is there anything else that you would like to share about what this group means to you?

4. **Impact**
   a. What has the impact of this group been?
   b. How is the group impact measured?
   c. What do you think the impact of the group over time might be for you?
   d. What do you think the impact of the group over time might be for Band 6s?

5. **Ending**

A. We are nearing the end of this interview.
   a. Are there any questions you would like to go back to?
   b. Is there anything to do with your experience of these Groups that we have not covered that you would like to share?
B. We are now at the end of the interview. I am now going to turn the audio recorder off and we will move onto the debriefing process.

Appendix F

Research Poster for University of Leeds Doctorate in Clinical Psychology Programme SEP Conference