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ORIGINAL ARTICLE

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Family caregivers' perceived level of collaboration with hospital nurses: A cross-sectional study

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Abstract

Aim: To describe the extent of perceived collaboration between family caregivers of older persons and hospital nurses.

Background: Collaboration between hospital nurses and family caregivers is of increasing importance in older patient's care. Research lacks a specific focus on family caregiver's collaboration with nurses.

Method: Using a cross-sectional design, 302 caregivers of older patients (≥70 years) completed the 20-item Family Collaboration Scale with the subscales: trust in nursing care, accessible nurse and influence on decisions. Data were analysed with descriptive statistics and bivariate correlations.

Results: Family caregivers rated their level of trust in nurses and nurses' accessibility higher than the level of their influence on decisions. Family caregivers who had more contact with nurses perceived higher levels of influence on decisions ($p \leq .001$) and overall collaboration ($p \leq .001$).

Conclusion: Family caregivers' collaboration with nurses can be improved, especially in recognizing and exploiting family caregivers as partner in the care for older hospitalized persons and regarding their level of influence on decisions.

Implications for Nursing Management: Insight into family caregivers' collaboration with nurses will help nurse managers to jointly develop policy with nurses on how to organise more family caregivers' involvement in the standard care for older persons.

KEYWORDS

collaboration, family caregivers-nurses, hospitalization, partnership

1 | INTRODUCTION

The care for older home-dwelling persons by family members is intensifying due to the ageing population, and, relatedly, a growing number of older persons experiencing chronic conditions (WHO, 2015). As a result, a growing number of family members are becoming informal partners of health care professionals, such as nurses (Broese van Groenou & De Boer, 2016). Older persons are often hospitalized as a result of chronic illness or for diagnosis, and hospital admissions are generally becoming shorter. Consequently, they may not achieve a stable health status before their discharge from the hospital, making the care provided by family caregivers more complex and burdensome (Reinhard et al., 2012). Patient and Family Centred Care (PFCC) acknowledges that families are crucial to the health and well-being of older persons and advocates for quality and safety within the health care system (Conway et al., 2006). PFCC as well as the World Health Organization recognizes that family members are essential partners of the caregiving team (WHO, 2013). Therefore, it is important that family caregivers can decide how to participate in decision making and how to collaborate with hospital nurses in the delivery of care (Wittenberg et al., 2018). The quality and continuity of care for older adults who are temporarily admitted to the hospital improves when hospital nurses involve family caregivers in caregiving and decision-making (Bridges et al., 2010; Neumann et al., 2018; Park et al., 2018). Involvement of older persons' caregivers during the hospitalization reduces potential complications (Li, 2005) and reduces the length of stay (Park et al., 2018) and the risk of hospital readmission (Park et al., 2018; Rodakowski et al., 2017). Also, the physical and psychological conditions of both the patient (Weinberg et al., 2007) and the caregivers themselves improve when family caregivers are involved (Hartmann et al., 2010; Neumann et al., 2018). Most encouraging interventions to advance involvement and constructive relationships between health care professionals and family caregivers entail clear communication, building and negotiating relationships with professionals, and effective collaboration strategies (Bélanger et al., 2016; Haesler et al., 2010; Park et al., 2018).

Previous studies primarily report on experiences of family caregivers' involvement in the care for hospitalized older persons based on qualitative studies. These studies indicated that family caregivers find their ability to influence decisions seriously reduced when an older person is admitted to the hospital (Lowson et al., 2013; Nyborg et al., 2017). These caregivers did not always feel acknowledged as competent care partner by professionals (Aasbø et al., 2017; Lindhardt et al., 2006) and experienced an insufficient exchange of information and knowledge about disease related aspects, care and support (Bove et al., 2016; Røthing et al., 2015). Although qualitative studies give in-depth insight into the content and experience of caregiving and collaboration, they do not provide insight into the extent to which collaboration between family caregivers and hospital nurses is present in nursing practice. By quantitatively measuring family caregivers' perceived collaboration, more insight can be obtained into the various aspects of collaboration in order to formulate specific areas for improvement.

Collaboration can be defined as a caring partnership in which caregivers are regularly informed and involved in decision-making processes (Haesler et al., 2010). Such a collaborative relationship is characterized by trust and respect as well as open communication that subsequently enable a negotiation of the roles between nurses and family caregivers at any particular point in time (MacKean et al., 2005). Relationships between families and health care professionals (e.g. nurses) develop sequentially in three phases: involvement, collaboration and empowerment (Elizur, 1996). A collaborative relationship necessitates a more active role of nurses and requires a more mutual character than involvement and empowerment (Elizur, 1996). In this study, collaboration was defined as nurses responsible for the daily nursing care pro-actively initiate contact with family caregivers of older patients and actively involve these caregivers in a process of information exchange and shared decision-making as partners in care.

Lindhardt Nyberg and Rahm Hallberg (2008a) developed a theoretical framework of collaboration between family caregivers and hospital nurses. The framework consisted of five domains: 'contact and information', 'attributes for collaboration', 'promoters and barriers' and 'outcomes of collaboration' (Lindhardt Nyberg, & Rahm Hallberg, 2008a). A 56-item Family Collaboration Scale (FCS) was developed based on this framework, which has a broad scope and measures aspects other than only collaboration. To measure collaboration only, the FCS previously was revised to a 20-item scale using Lindhardt theoretical framework of collaboration and evaluated using face and content validity methods (Hagedoorn et al., 2019). In the current study, we aim to describe to what extent family caregivers of older persons perceive collaboration with hospital nurses.

2 | METHODS

2.1 | Design and participants

This study has a cross-sectional descriptive design. To identify family caregivers of older persons ≥70 years who were admitted to the hospital for at least 2 days, a convenience sample was employed. To measure collaboration, the family caregivers had to have been in contact with nurses during hospitalization and involved in discharge follow-up agreements. Excluded were family caregivers of patients who were admitted for a day, living in a care facility, had cognitive impairment or were too ill to be approached for the study. Patients themselves identified their family caregiver as a person who was important for their support at home. Assuming that five to ten respondents for each of the 20 items of the FCS are needed, a sample size >150 is desired (Streiner et al., 2015).

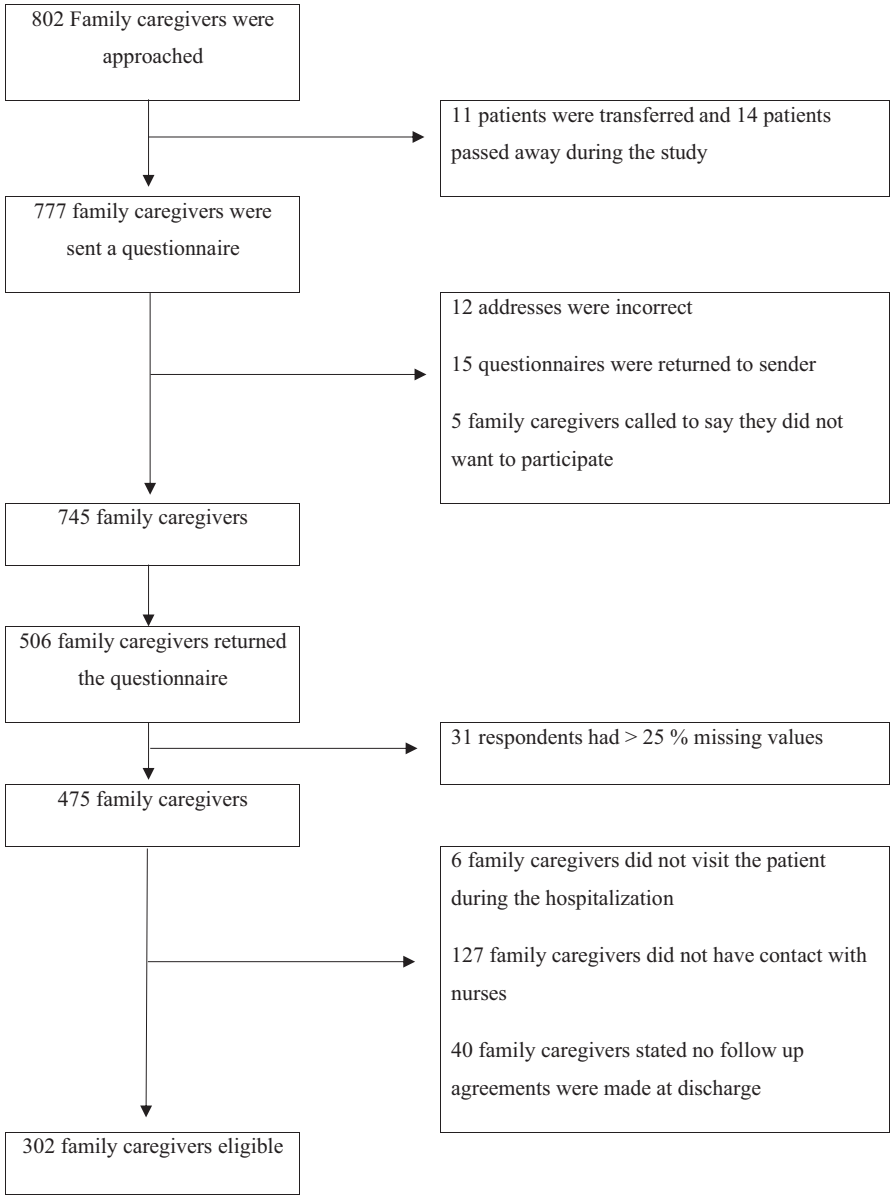

FIGURE 1 Flowchart of eligible respondents

2.2 | Measurements

The validated 20-item FCS was used to measure collaboration, consisting of three subscales: *Trust in nursing care*, *Accessible nurse* and *Influence on decisions* (Hagedoorn et al., 2019). A higher score on the self-report Likert (1–5) type statements represents a higher level of collaboration. Response alternatives were *totally disagree – totally agree* or *never-always*. Internal reliability was good, with ordinal alphas of 0.81, 0.87 and 0.88, respectively, on the subscales, and a Cronbach's alpha of 0.89 for the total FCS (Hagedoorn et al., 2019).

Data on family caregiver characteristics included age, gender, marital status, relationship to the patient, living together with the patient, professional background in health care, highest level of education, and type and frequency of support offered to the patient at home. These variables were part of the original FCS and, therefore, were included.

2.3 | Data collection

This study was ruled not to be under regulation of the Medical Research Involving Human Subjects Act (Reference METc2015/620). Ethical committees of the hospitals each granted permission for the study. Data were collected in October–December of 2016 and April–June of 2017 as part of an earlier study to psychometrically evaluate the FCS. Charge nurses received written and oral information about the aim of the study prior to the start.

Patients were screened by charge nurses and approached and informed by data collectors with written information. Patients were asked to provide names and addresses of their primary caregivers. Eligible family caregivers were sent a survey and a return envelope to their home address by post after discharge of the patient out of the hospital. One reminder was sent to non-responders 2 weeks later. Written consent was granted by patients as

TABLE 1 Characteristics of family caregivers

	Mean (*SD*)
Age (year)	64.8 (13)
Gender	**%**
Female	71
Male	29
Marital status	
Married/living together	90
Single/divorced/widowed	10
Relationship to patient	
Partner	50
Daughter/son	39
Other*	11
Living with patient	
Yes	50
No	50
Highest level of education	
Primary/lower vocational education	24
Secondary education: lower general/upper vocational/upper general	52
Bachelor/master education	24
Professional background in health care	
Yes	23
No	77
Frequency of support at home	
Every day	44
4–6 times a week	11
2–3 times a week	23
Once a week or less	22
Duration of support at home	
More than 1 year	62
4–6 months	9
3 months or shorter	7
Since discharge of relative out of hospital	22
Frequency of hospital visits	
Every day	83
A few times a week	15
Once a week	1
Less than once a week	1
Frequency of contact with nurses during hospitalization	
More than 10 times	10
5–10 times	23
1–4 times	67

* Niece/nephew (9), Daughter/Son in law (8), Brother/Sister (3), Friend (3), Grandchild (2), Neighbour (2), Family caregiver (2), Sister in law (1) and Stepdaughter (1).

well as their family caregivers and both were informed that their participation was voluntarily, and that data would be processed anonymously.

2.4 | Data analysis

Descriptive statistics were used to report mean item scores and standard deviations. Correlations between family caregivers' characteristics and the total and subscales sum scores of the FCS were explored using a bivariate analysis with simple bootstrapping for the correlation coefficient since the data are not normally distributed. Correlations with a correlation coefficient of ≥0.30 are considered to be influential (Field, 2014). Ordinal and ratio variables were analysed with Spearman's correlation, and nominal variables were measured with Cramer's *V*. SPSS version 24.0 (IBM Corp., 2016) was used for data analyses.

3 | RESULTS

Of the 506 family caregivers who responded (63%), 302 were eligible based on the inclusion criteria, as outlined in Figure 1. Family caregivers' characteristics presented in Table 1 show that most of them were female (71%), and the majority was married or living together with their partner (90%). Nearly all of the caregivers were either a partner (50%) or a child (39%) of the patient; 50% were living with the patient; and 62% provided support for more than 1 year. Most caregivers (83%) visited the patient every day during hospitalization or a few times (15%) per week, and 67% had contact with nurses one to four times during the hospitalization.

The mean scores of the subscales and total FCS are presented in Table 2, with a higher score representing a higher level of collaboration. Overall, family caregivers perceived their influence on decisions at the lowest mean score of 59, and the score was highest on the items of the subscale of trust in nursing care and accessible nurse with a mean score of 75 and 74 out of 100, respectively.

In Table 3, response percentages and mean score of family caregivers' perceived level of collaboration are presented per item. Items of the subscale trust in nursing care demonstrate that most family caregivers (95%) perceived nurses to be respectful towards patients (4.5), 86% perceived nurses to be competent (4.4), and 88% had trust in the necessary nursing care (4.4). Almost three quarters (73%) of the caregivers felt that they were properly informed about the patients' illness with a mean score of 3.9 (Item 3). Items of the subscale *accessible nurse* also show mean scores of approximately 4, indicating that family caregivers perceived most nurses (89%) to be willing to help, and 76% stated that nurses had taken the time to talk with them. Items of the subscale *influence on decisions* show that almost one third of the family caregivers (72%) felt properly informed about plans for the patient's discharge, and most (81%) were satisfied with follow-up agreements with mean scores between 3.6 and 4.2. Items concerning nurses actually inquiring about family caregivers' knowledge of the patient and using that knowledge show lower mean scores (2.6) compared to other item mean scores of this subscale. In total, 19% of the family caregivers could influence decision made regarding patient care, which was rated with the lowest mean score of 2.2.

TABLE 2 Scale scores of the Family Collaboration Scale and subscales

Subscale	Mean (*SD*) 100-point range
Trust in nursing care	75.4 (15.7)
Accessible nurse	73.5 (17.4)
Influence on decisions	58.8 (21.5)
Total Family Collaboration Scale	67.4 (15.6)

Correlations between caregivers' characteristics and the total and subscales of the FCS are presented in Table 4. A positive correlation was ascertained between caregivers who live with the patient and their level of trust in nursing care and the level of influence on decisions. A positive relationship was also found between family caregivers' frequency of contact with nurses and their level of influence on decisions as well as overall collaboration.

4 | DISCUSSION

The extent of perceived collaboration between family caregivers of older persons and hospital nurses was measured with the subscales trust in nursing care, accessible nurse and influence on decisions of the FCS. The results of this study show that overall family caregivers perceived nurses as trustworthy, competent and accessible, which was also found in other studies (Lindhardt et al., 2008b, 2018). These are necessary aspects in order to establish collaboration (Haesler et al., 2010; MacKean et al., 2005; Wittenberg et al., 2018). Family caregivers who live with the patient rate a higher level of trust in nursing care and influence on decisions than those who do not live with the patient, which was also found

TABLE 3 Percentages of responses and mean scores of family caregivers' collaboration

Item #/Subscales	Percentage of responses[a] 1–2	3	4–5	Mean (*SD*)
Subscale Trust in nursing care				
1. Nurses struck me as quite competent	4	10	86	4.4 (0.85)
2. I trusted that my family member received all the necessary care during their stay	5	7	88	4.4 (0.87)
3. I felt properly informed about my family member's illness	14	13	73	3.9 (1.2)
4. Nurses treated patients with respect	1	4	95	4.5 (0.63)
5. In any contact you had with the nursing staff, how often did you yourself initiate this?[b]	38	41	21	2.8 (1.2)
Subscale Perceived accessible nurse				
6. It was easy to contact a nurse that was familiar with my family member	7	24	69	3.9 (0.96)
7. The nursing staff were happy to help whenever I sought them out	3	8	89	4.3 (0.76)
8. The nursing staff had the time to speak to me	5	19	76	4.1 (0.89)
9. I felt comfortable in expressing my feelings	9	21	70	3.9 (1.0)
10. I felt comfortable in expressing any criticism	19	28	53	3.4 (1.1)
11. Nurses were understanding towards my situation as a family member of the patient	8	16	76	4.0 (0.98)
Subscale Perceived influence on decisions				
12. The nursing staff inquired about my knowledge of my family member's situation	47	31	22	2.6 (1.2)
13. The nursing staff used my knowledge of my family member to their advantage	44	36	20	2.6 (1.2)
14. I was able to influence decisions that were made with regard to the care provided to my family member (*eating*, *drinking*, *mobilizing*, *lifestyle*)	61	20	19	2.2 (1.3)
15. I was satisfied with the influence I was allowed to exercise	14	21	65	3.7 (1.2)
16. I was properly informed about the plans for my family member after he/she was discharged from the hospital	17	11	72	3.8 (1.4)
17. I was involved in making plans for my family member when he/she discharged from the hospital	28	18	54	3.4 (1.5)
18. I was happy with the follow-up agreements that were made once my family member was discharged from the hospital	10	9	81	4.2 (1.1)
19. I feel that my family member was discharged from the hospital at the proper time	13	10	77	4.1 (1.2)
20. I have received sufficient information with regards to how I can best help my family member	25	12	63	3.6 (1.5)

[a]1–2: never /totally disagree; 4–5: always/totally agree.

[b]Item was reversed.

TABLE 4 Correlations between family caregiver characteristics and total and subscales FCS

Scale and subscales	Total FCS	Trust in nursing care	Accessible nurse	Influence on decisions
Characteristics	**Coefficient**	**Coefficient**	**Coefficient**	**Coefficient**
Age[a]	0.065	0.229**	−0.019	0.030
Gender[b](0 = female)	0.448	0.267	0.241	0.321
Marital status (0 = married)	0.404	0.162	0.256	0.432
Relationship to patient[b] (0 = partner)	0.443	0.369*	0.293	0.379
Living with patient[b] (0 = yes)	0.463	0.406**	0.292	0.399*
Highest level of education[a]	−0.087	−0.274**	0.032	−0.053
Professional background in health care[b] (0 = yes)	0.472	0.291	0.302	0.324
Frequency of support at home[a]	0.064	0.133*	0.020	0.023
Duration of support at home[a]	−0.054	−0.134*	−0.055	−0.001
Frequency of hospital visits[a]	−0.009	0.055	−0.026	−0.020
Frequency of contact with nurses during hospitalization[a]	0.366**	0.062	0.283**	0.398**
Duration of patient hospital admission[a]	0.001	−0.127*	0.054	0.017

[a]Ordinal and ratio variables were analysed with Spearman's correlation.

[b]Nominal variables were analysed with Cramer's V.

*$p \leq .05$.

**$p \leq .001$.

in a study on family caregivers of intensive care patients (Epstein & Wolfe, 2016). Results also show that a majority of caregivers felt properly informed about the patients' illness during hospitalization, another core concept of PFCC (Conway et al., 2006). A review of literature shows that family caregivers of older persons experiencing chronic diseases are in need of basic disease information that is proactive, understandable and tailored to caregivers' individual needs (Washington et al., 2011).

In one fifth of the family caregivers, nurses inquired about the carer's knowledge of the patient's situation and in the same number nurses utilized the caregiver's knowledge to their advantage. This shows that nurses may not see family caregivers as competent partners in care (Aasbø et al., 2017; Bélanger et al., 2016). In addition, only one fifth of the family caregivers indicated that they had influence on decisions about the patient's care activities, such as eating, drinking, mobilizing and lifestyle. Family caregivers generally know best what the patient's habits and lifestyle preferences are in regard to eating, drinking and activities of daily life. Other studies also found that caregivers experienced limited influence on decisions regarding care activities after an older home-dwelling adult was admitted to the hospital (Bragstad et al., 2014; Bridges et al., 2010; Lindhardt et al., 2006; Lowson et al., 2013; Popejoy, 2011). Acknowledgment and a greater appreciation of family caregivers' role can facilitate collaboration (Wittenberg et al., 2018). It is remarkable that two thirds of the caregivers rate their actual level of influence on decisions as low, while the same number was satisfied with the overall influence they had. Family caregivers may be satisfied with their influence on decisions because they expect to have less influence when their relative is admitted to the hospital (Lindhardt et al., 2006; Lowson et al., 2013) for they consider the hospital as a nurses' domain (Li, 2004), and, therefore, adapt themselves to the hospital system (Allen, 2000; Walker & Dewar, 2001).

In this study, only 21% of the nurses initiated contact with caregivers themselves during the hospitalization. It might be that nurses mostly consider patients as their main concern (Ekstedt et al., 2014; Mackie et al., 2018) or do not consider family caregivers as informal partners in the care of older persons (Bélanger et al., 2016; Lindhardt et al., 2008; MacKean et al., 2005). This could also explain why 23% of the family caregivers who responded to the survey were not eligible, and, primarily, because they had no contact with nurses during the hospitalization other than a greeting and a goodbye.

In Western societies, there is increasing emphasis on older persons' self-care in order to stay at home longer, and, consequently, an increasing dependency on their family caregivers. In line with the theory of PFCC, family caregivers need to participate in decision-making and collaborate with hospital nurses in the delivery of care for older persons (Coyne et al., 2011). A first step towards collaboration is that nurses pro-actively initiate contact with family caregivers and assess and negotiate their respective roles as partners in care (MacKean et al., 2005; Røthing et al., 2015). Since 83% of family caregivers in this study visited the patient every day, there appears to be ample opportunities for nurses to meet with them during the hospitalization. When nurses acknowledge and utilize these carers' expertise in negotiating patients' care plans care can be more tailored to the patients' preferences, and subsequently, the quality and continuity of care for the elderly can be better monitored. Other components of collaboration concern nurses who actively involve family caregivers in processes of information sharing and shared decision-making (Elizur, 1996; Haesler

et al., 2010). By involving family caregivers as part of the regular nursing process, collaboration with all family caregivers can be formalized from admission to discharge (Haesler et al., 2010; Ris et al., 2018).

To implement these practices, first there needs to be a clear strategy on how to include family caregivers in regular nursing care (Ris et al., 2018), because a lack of policy may also be a reason why nurses do not routinely involve caregivers in discussions (Moyle et al., 2011). For a successful implementation, it is important for nurse managers and policymakers to support nurses' own initiatives (Hansson et al., 2017), and to formulate policies together with them (Scerri et al., 2015). Finally, adequate resources as well as organisational and managerial support are required in more patient and family focused care (Coyne et al., 2011; MacKean et al., 2005; Walker & Dewar, 2001).

4.1 | Limitations of the study

A strength of this study is that the sample of family caregivers was obtained from five general hospitals, even though it concerned a single country study. Collaboration in this study was measured with the validated 20-item FCS showing good psychometric properties for this study population. Several study limitations can be identified. First, the cross-sectional design limits the ability to interpret causality between the different variables, which could be hypothesized in experimental research. Second, the convenience sample that was obtained may have resulted in a limited number of eligible patients and selection bias may have occurred because some patients and family caregivers did not want to participate in a study in general. A number of steps were taken to ensure that the most appropriate patients and their most significant family caregivers were included. As a result, 23% of family caregivers who responded to the survey were not eligible, and therefore, an important group of family caregivers may have been missed from whom no insight was gained in their collaboration needs with nurses. Next, family caregivers' prior experiences with hospital admissions can be a barrier of collaboration (Lindhardt Nyberg et al., 2008a) and, therefore, may have affected their responses and the validity of the study results. Because the survey was based on self-reporting statements, it may have provoked subjective and socially desirable responses.

5 | CONCLUSION

This study highlights specific areas of collaboration between family caregivers and nurses that can be improved. Although it is positive that most family caregivers perceive nurses as trustworthy and accessibility, and that most were satisfied with the influence they were able to exercise, involvement of caregivers in decisions regarding the patients' daily care needs to be improved. Family caregivers play an import role in managing older persons' chronic conditions and self-care abilities at home. Nurses need to utilize family caregivers' knowledge when preparing care plans in order to maintain continuity of care when an older person is temporarily hospitalized. PFCC theories advocate to engage patient and their informal caregivers as partners in care to guaranty the quality and continuity of care. By doing so as part of the regular nursing care, all family caregivers get the opportunity to be involved as informal care partners. This is especially important in countries where nurses are also responsible for the coordination of care during the hospitalization of these older patients. Further research should focus on the effects of collaboration between family caregivers and nurses as part of the regular care in intervention studies.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

This study contributes to the knowledge about collaboration between family caregivers of home-dwelling older persons and hospital nurses. The extent to which family caregivers perceive collaboration with hospital nurses suggests that family caregivers adhere to the hospital system and therefore seem to be satisfied with the influence they can exercise. It is therefore important that nurses pro-actively initiate contact with family caregivers of older persons to find out how they want to be involved in the patients' decision-making and care planning. Hospital policy and nursing position statements underline the importance of patient' and family caregiver' involvement in nursing care without addressing how such policy should be implemented. The results of this study can facilitate nurse managers to jointly develop policy with nurses on how to organise collaboration with family caregivers as part of the standard nursing care in order to improve the quality and continuity of care for older home-dwelling persons who are temporarily hospitalized.

CONFLICT OF INTEREST

The authors have no conflicts of interests to disclose.

ETHICAL APPROVAL

The Medical Ethics Review Committee of the University Medical Center Groningen approved this study (Reference METc 2015/620).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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REFERENCES

Aasbø, G., Rugkåsa, J., Solbrække, K. N., & Werner, A. (2017). Negotiating the care-giving role: Family members' experience during critical exacerbation of COPD in Norway. *Health and Social Care in the Community*, *25*(2), 612–620. https://doi.org/10.1111/hsc.12350

Allen, D. (2000). Negotiating the role of expert carers on an adult hospital ward. *Sociology of Health and Illness*, *22*(2), 149–171. https://doi.org/10.1111/1467-9566.00197

Bélanger, L., Bourbonnais, A., Bernier, R., & Benoit, M. (2016). Communication between nurses and family caregivers of hospitalised older persons: A literature review. *Journal of Clinical Nursing*, *26*, 609–619. https://doi.org/10.1111/jocn.13516

Bove, D. G., Zakrisson, A.-B., Midtgaard, J., Lomborg, K., & Overgaard, D. (2016). Undefined and unpredictable responsibility: A focus group study of the experiences of informal caregiver spouses of patients with severe COPD. *Journal of Clinical Nursing*, *24*, 483–493. https://doi.org/10.1111/jocn.13076

Bragstad, L., Kirkevold, M., & Foss, C. (2014). The indispensable intermediaries: A qualitative study of informal caregivers' struggle to achieve influence at and after hospital discharge. *BMC Health Services Research*, *14*, 331. https://doi.org/10.1186/1472-6963-14-331

Bridges, J., Flatley, M., & Meyer, J. (2010). Older people's and relatives' experiences in acute care settings: Systematic review and synthesis of qualitative studies. *International Journal of Nursing Studies*, *47*(1), 89–107. https://doi.org/10.1016/j.ijnurstu.2009.09.009

Broese van Groenou, M. I., & De Boer, A. (2016). Providing informal care in a changing society. *European Journal of Ageing*, *13*, 271–279. https://doi.org/10.1007/s10433-016-0370-7

Conway, J., Johnson, B., Edgman-Levitan, S., Schlucter, J., Ford, D., & Sodomka, P. (2006). *Partnering with patients and families to design a patient- and family-centered health care system: A roadmap for the future: A work in progress*. Institute for Family-Centered Care. Retrieved October 26 2016 from https://www.ipfcc.org/resources/Roadmap.pdf

Coyne, I., O'Neill, C., Murphy, M., Costello, T., & O'Shea, R. (2011). What does family-centred care mean to nurses and how do they think it could be enhanced in practice. *Journal of Advanced Nursing*, *67*(12), 2561–2573. https://doi.org/10.1111/j.1365-2648.2011.05768.x

Ekstedt, M., Stenberg, U., Olsson, M., & Ruland, C. M. (2014). Health care professionals perspectives of the experiences of family caregivers during in-patient cancer care. *Journal of Family Nursing*, *20*(4), 462–486. https://doi.org/10.1177/1074840714556179

Elizur, Y. (1996). Involvement, collaboration, and empowerment: A model for consultation with human-service agencies and the development of family-oriented care. *Family Process Journal*, *35*, 191–210. https://doi.org/10.1111/j.1545-5300.1996.00191.x|

Epstein, E. G., & Wolfe, K. (2016). A preliminary evaluation of trust and shared decision making among intensive care patients' family members. *Applied Nursing Research*, *32*, 286–288. https://doi.org/10.1016/j.apnr.2016.08.011

Field, A. (2014). *Discovering statistics using IBM SPSS statistics* (4th ed.). Sage.

Haesler, E., Bauer, M., & Nay, R. (2010). Recent evidence on the development and maintenance of constructive staff–family relationships in the care of older people – A report on a systematic review update. *International Journal of Evidence-based Healthcare*, *8*(2), 45–74. https://doi.org/10.1111/j.1744-1609.2010.00165.x

Hagedoorn, E. I., Paans, W., Jaarsma, T., Keers, J. C., van der Schans, C. P., Luttik, M. L. A., & Krijnen, W. P. (2019). Psychometric evaluation of a revised Family Collaboration Scale. *Geriatric Nursing*, *40*(5), 463–472. https://doi.org/10.1016/j.gerinurse.2019.02.003

Hansson, A., Svensson, A., Hedman Ahlstrom, B., Larsson, L. G., Forsman, B., & Alsén, P. (2017). Flawed communications: Health professionals' experience of collaboration in the care of frail elderly patients. *Scandinavian Journal of Public Health*, *46*(7), 680–689. https://doi.org/10.1177/1403494817716001

Hartmann, M., Bäzner, E., Wild, B., Eisler, I., & Herzog, W. (2010). Effects of interventions involving the family in the treatment of adult patients with chronic physical diseases: A meta-analysis. *Psychotherapy and Psychosomatics*, *79*(3), 136–148. https://doi.org/10.1159/000286958

IBM Corp. (2016). *IBM SPSS Statistics version 24.0*. Armonk, NY, USA.

Li, H. (2004). Hospitalized elders and family caregivers: A typology of family worry. *Journal of Clinical Nursing*, *14*(1), 3–8. https://doi.org/10.1111/j.1365-2702.2004.01013.x

Li, H. (2005). Identifying family care process themes in caring for their hospitalized elders. *Applied Nursing Research*, *18*(2), 97–101. https://doi.org/10.1016/j.apnr.2004.06.015

Lindhardt, T., Bolmsjo, I., & Hallberg, I. (2006). Standing guard-being a relative to a hospitalised, elderly person. *Journal of Aging Studies*, *20*(2), 133–149. https://doi.org/10.1016/j.jaging.2005.06.001

Lindhardt, T., Nyberg, P., & Rahm Hallberg, I. (2008a). Relatives' view on collaboration with nurses in acute wards: Development and testing of a new measure. *International Journal of Nursing Studies*, *45*(9), 1329–1343. https://doi.org/10.1016/j.ijnurstu.2007.10.006

Lindhardt, T., Nyberg, P., & Rahm Hallberg, I. (2008b). Collaboration between relatives of elderly patients and nurses and its relation to satisfaction with the hospital care trajectory. *Scandinavian Journal of Caring Sciences*, *22*(4), 507–519. https://doi.org/10.1111/j.1471-6712.2007.00558.x

Lindhardt, T., Rahm Hallberg, I., & Poulsen, I. (2008). Nurses' experience of collaboration with relatives of frail elderly patients in acute hospital wards: A qualitative study. *International Journal of Nursing Studies*, *45*(5), 668–681. https://doi.org/10.1016/j.ijnurstu.2007.01.010

Lindhardt, T., Sivertsen, D., Smith, L., Klausen, T., & Andersen, O. (2018). Collaboration between relatives of older patients and nurses in acute medical wards: Confirmatory factor analysis of the revised family collaboration scale. *Journal of Nursing Measurement*, *26*(2), 311–340. https://doi.org/10.1891/1061-3749.26.2.311

Lowson, E., Hanratty, B., Holmes, L., Addington-Hall, J., Grande, G., Payne, S., & Seymour, J. (2013). From 'conductor' to 'second fiddle': Older adult care recipients' perspectives on transitions in family caring at hospital admission. *International Journal of Nursing Studies*, *50*(9), 1197–1205. https://doi.org/10.1016/j.ijnurstu.2012.02.005

MacKean, G. L., Thurston, W. E., & Scott, C. M. (2005). Bridging the divide between families and health professionals' perspectives on family-centred care. *Health Expectations*, *8*, 74–85. https://doi.org/10.1111/j.1369-7625.2005.00319.x

Mackie, B. R., Marshall, A., & Mitchell, M. (2018). Acute care nurses' views on family participation and collaboration in fundamental care. *Journal of Clinical Nursing*, *27*, 2346–2359. https://doi.org/10.1111/jocn.14185

Moyle, W., Borbasi, S., Wallis, M., Olorenshaw, R., & Gracia, N. (2011). Acute care management of older people with dementia: A qualitative perspective. *Journal of Clinical Nursing*, *20*(3–4), 420–428. https://doi.org/10.1111/j.1365-2702.2010.03521.x

Neumann, D., Lamprecht, J., Robinski, M., Mau, W., & Girndt, M. (2018). Social relationships and their impact on health-related outcomes in peritoneal versus haemodialysis patients: A prospective cohort study. *Nephrology Dialysis Transplantation*, *33*(7), 1235–1244. https://doi.org/10.1093/ndt/gfx361

Nyborg, I., Danbolt, L. J., & Kirkevold, M. (2017). Few opportunities to influence decisions regarding the care and treatment of an older hospitalized family member: A qualitative study among family members. *BMC Health Services Research*, *17*, 619. https://doi.org/10.1186/s12913-017-2563-y

Park, M., Giap, T.-T.-T., Lee, M., Jeong, H., Jeong, M., & Go, Y. (2018). Patient- and family-centered care interventions for improving the quality of health care: A review of systematic reviews. *International Journal of Nursing Studies*, *87*, 69–83. https://doi.org/10.1016/j.ijnurstu.2018.07.006

Popejoy, L. L. (2011). Complexity of family caregiving and discharge planning. *Journal of Family Nursing*, *17*(1), 61–81. https://doi.org/10.1177/1074840710394855

Reinhard, S. C., Levine, C., & Samis, S. (2012). *Home alone: Family caregivers providing complex chronic care*. AARP Public Policy Institute. Retrieved

May 4 2019 from https://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/home-alone-family-caregivers-providing-complex-chronic-care-rev-AARP-ppi-health.pdf

Ris, I., Schnepp, W., & Mahrer Imhof, R. (2018). An integrative review on family caregivers' involvement in care of home-dwelling elderly. *Health and Social Care in the Community*, *27*(3), 95–111. https://doi.org/10.1111/hsc.12663

Rodakowski, J., Rocco, P. B., Ortiz, M., Folb, B., Schulz, R., Morton, S. C., Leathers, S. C., Hu, L. U., & James, A. E. (2017). Caregiver integration during discharge planning for older adults to reduce resource use: A metaanalysis. *Journal of American Geriatrics Society*, *65*(8), 1748–1755. https://doi.org/10.1111/jgs.14873

Røthing, M., Malterud, K., & Frich, J. C. (2015). Family caregivers' views on coordination of care in Huntington's disease: A qualitative study. *Scandinavian Journal of Caring Sciences*, *29*, 803–809. https://doi.org/10.1111/scs.12212

Scerri, A., Innes, A., & Scerri, C. (2015). Discovering what works well: Exploring quality dementia care in hospital wards using appreciative inquiry approach. *Journal of Clinical Nursing*, *24*(24), 1916–1925. https://doi.org/10.1111/jocn.12822

Streiner, D. L., Norman, G. R., & Cairney, J. (2015). *Health Measurement Scales a practical guide to their development and use* (5th ed.). Oxford University Press.

Walker, E., & Dewar, B. (2001). How do we facilitate carers' involvement in decision making? *Journal of Advanced Nursing*, *34*(3), 329–337. https://doi.org/10.1046/j.1365-2648.2001.01762.x

Washington, K. T., Meadows, S. E., Elliott, S. G., & Koopman, R. J. (2011). Information needs of informal caregivers of older adults with chronic health conditions. *Patient Education and Counseling*, *83*(1), 37–44, https://doi.org/10.1016/j.pec.2010.04.017

Weinberg, D. B., Lusenhop, W. R., Hoffer Gittell, J., & Kautz, C. M. (2007). Coordination between formal providers and informal caregivers. *Health Care Management Review*, *32*(2), 140–149. https://doi.org/10.1097/01.HMR.0000267790.24933.4c

WHO (2013). *Patients for patients safety: Partnerships for safer health care*. : World Health Organization. Retrieved November 11, 2020, from https://www.who.int/patientsafety/patients_for_patient/PFPS_brochure_2013.pdf

WHO (2015). *World report on ageing and health*. World Health Organization. Retrieved November 2 2020 from http://www.who.int/ageing/publications/world-report-2015/en/

Wittenberg, Y., Kwekkeboom, R., Staaks, J., Verhoeff, A., & de Boer, A. (2018). Informal caregivers' views on the division of responsibilities between themselves and professionals: A scoping review. *Health and Social Care in the Community*, *26*, 460–473. https://doi.org/10.1111/hsc.12529

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ORIGINAL ARTICLE

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Sources of satisfaction, dissatisfaction and well-being for UK advanced practice nurses: A qualitative study

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Abstract

Aims: To examine and explore organisational and role conditions that promote or inhibit job satisfaction and workplace well-being for advanced practice nurses.

Background: The advanced practice role is common across the world. Research shows it is well regarded by patients and improves patient outcomes, but there is little evidence about what the role is like for nurses.

Methods: A subsample of an existing cohort of advanced practice nurses were invited for interview. Twenty-two nurses were interviewed over the phone. Interviews transcripts were analysed using thematic analysis.

Results: Four themes were derived from the data; 'the advanced nurse role and professional identity', 'feeling exposed', 'support for the advancement of the role' and 'demonstrating impact'.

Conclusion: Nurses report considerable dissatisfaction with role identity and concerns relating to isolation on a daily basis, and these negatively affect well-being. However, they also identified significant satisfaction with the role, particularly when well supported and able to recognize the unique contribution that they made to the lives of patients and to their organisations.

Implications for nursing management: Clear role definitions, provision of high-quality clinical supervision and addressing issues of isolation are likely to improve the job satisfaction of advanced practice nurses.

KEYWORDS

advanced practice nursing, nurse practitioner, nurse's role, satisfaction, well-being

1 | BACKGROUND

Advanced Practice Nurses (APNs) are now established across the globe (International Council of Nurses, 2008; Schober et al., 2020). Positive outcomes emanating from APN care has been demonstrated in the specific fields of: primary care (Collins, 2019), ambulatory care (Martin-Misener et al., 2015), transitional care (Donald et al., 2015) and gerontological nursing (Morilla-Herrera et al., 2016).

However, a range of challenges of an organisational, relational and inter-professional nature has hampered the development of the APN role, including role ambiguity (King et al., 2017), role overload and challenges in clinical autonomy (Woo et al., 2019). Barriers related to effective leadership include a lack of understanding of role, poor interdisciplinary working, pressure on resources and overload, and structural impediments to strategic posts. Facilitators include the provision of good organisational support, mentorship and

frameworks of support (such as clinical supervision) as well as peer support (Elliott, 2017).

The importance of the organisational embeddedness and clarity of role is further reflected in existing evidence concerning levels of job satisfaction for APNs. Role ambiguity and a lack of intra-practice collegiality have been identified as specific forms of dissatisfaction amongst senior practitioners in the USA (Faris et al., 2010). There are correlations between intention to stay in post with job satisfaction, role perception and role ambiguity (Brom et al., 2016). A systematic review identified extrinsic factors, such as autonomy and meaningful work, as important factors in determining levels of job satisfaction amongst APNs (Han et al., 2018). O'Keeffe et al. (2015) identified poor intra-practice collegiality and limited support for role development as the least satisfying aspects of being an APN. Qualitative papers have sought to explore these issues still further. Jangland et al. (2016) point to 'not being accepted' within an organisation as a source of dissatisfaction. On the other hand, Jangland et al. (2016) highlight patient outcomes as determinant of satisfaction. Workplace well-being is known to be related to workplace satisfaction (Kim et al., 2019). There is a close relationship between satisfaction, work place well-being and intention to leave (De Milt et al., 2011). Similarly, the relationship between job satisfaction and stress for APNs has been noted (Brom et al., 2016). Jangland et al. (2016) note a threat to well-being emerging from '*being caught between two roles*'. We sought to explore organisational and role conditions that promote or inhibit job satisfaction and workplace well-being for APNs.

2 | METHODS

The study utilized a qualitative approach, centred on a thematic analysis. This approach enabled an in-depth exploration of the relational, organisational, professional and contextual factors influencing work-related satisfaction for APNs from their perspective. This allowed us to explore the responses made by participants through close examination of social experiences, meaning and psycho-social processes, enabling explanatory insight (Denzin & Lincoln, 2005).

2.1 | Sampling and recruitment

We sampled purposively from the Advanced-Level Nursing Practice Cohort Study (Wood et al., 2020) (total number 143) on the basis of cohort participant responses to job satisfaction and well-being items in the core questionnaire. We chose the range of 15–20 participants after consideration of the factors that contribute to the number of participants required to achieve 'meaning saturation' (Hennink et al., 2017). Participants in the cohort study had consented to be approached via email to consider participation in 'new' studies relating to advanced nursing practice. The email contained a link to an information sheet and consent form, completion of which initiated further contact to arrange a telephone interview.

2.2 | Data collection

We carried out semi-structured telephone interviews with participants. The interview schedule consisted of several open-ended questions to encourage participants to talk about stress and well-being in the workplace, as well as allowing an exploration of organisational conditions. The questions were designed to explore issues that had arisen from analysis of the cohort's first survey questionnaire. See Appendix S1 for the 'Topic Guide'.

Interviews were conducted in summer 2019, at a time convenient to the participant. They were digitally recorded for transcription and lasted between 20 and 35 min. Interviews were conducted by two of the co-authors [EW and TR]. Field notes were not made during the interviews, but researchers reflected on the interviews afterwards and recorded their thoughts for discussion. Transcripts were not sent to the participant. Participants were offered a complimentary gift voucher after the interview. We adhered to the COnsolidated criteria for REporting Qualitative research (COREQ) reporting standards (Tong et al., 2007).

2.3 | Data analysis

Data were analysed using an approach informed by thematic analysis (Braun & Clarke, 2014). This approach has six stages: familiarization, generating initial codes, searching for themes, reviewing themes, confirming themes and reporting. The data were coded and categorized primarily by one researcher (TR), and a subsample was then analysed independently by two others (EW and RK). All authors assisted in finalizing the themes. All researchers used Quirkos (www.quirkos.com) v2.1 software to manage the data.

2.4 | Ethical considerations

This research was reviewed by the Institutional ethics committee and given approval on September 3rd 2018 (reference number 022736). Informed consent was gained from all participants. This research was carried out in accordance with the principles of the Helsinki Declaration.

3 | FINDINGS

Of the 29 cohort members approached, 22 agreed to be interviewed of whom three were male. Twelve worked in primary care settings, eight in secondary care settings and two across both settings. Most had advanced practitioner in their job title (e.g. advanced nurse

practitioner, advanced clinical practitioner), but other advanced roles were also named including nurse practitioner, community matron, specialized clinical educator and professional lead. They had been working at an advanced practice level for between three and 15 years, often across multiple settings.

Four super-ordinate themes were derived from the data: 'the APN role and professional identity', 'feeling exposed', 'support for the advancement of the APN role' and 'demonstrating impact'. Each of the four themes are comprised of a number of subordinate themes and are presented below. The four themes cannot be understood in isolation from one another. Each theme relates to our primary concerns about the conditions, which might inhibit or promote role satisfaction, dissatisfaction and overall workplace well-being.

4 | THE APN ROLE AND PROFESSIONAL IDENTITY

There is a well-established understanding that nursing has a strong professional identity and there exists a robust sense of belonging within the profession. Role definition is key to this process, but there is also evidence that hierarchical and organisational positioning influenced how participants were perceived by others. Role confusion furthered the process of dislocation from a stable professional identity and is identified here as a source of dissatisfaction.

4.1 | Professional and work related identity

Participants spoke about the identity of APNs and reflected on how nurses had transitioned from traditional roles, into those perceived as previously located within the medical field. This shift challenged the social and professional identity of some participants leading to a sense of loss of identity, resulting in a sense of liminality and isolation. The participant below had recently changed title from nurse to Advanced Clinical Practitioner:

> We fall under the medical team, didn't want us to work as a nurse, so I found that quite difficult. They didn't want us to think of ourselves as nurses anymore, but also, the senior nurses in the department didn't really want that much to do with us because we'd left the nursing workforce, as they saw it. So you kind of feel like you're in the middle of nowhere.
>
> (APN 12)

For some, there remained a robust link with the nursing profession, remarking upon a feeling that they will '*always be a nurse*' (APN16). Professional isolation, however, often stemmed from changes in daily routines and practices. Often, newly formed daily routines were at odds with those that they had undertaken in the past, creating discontinuity with established ways of working, professional networks and patterns of work presence.

4.2 | Role confusion

Participants repeatedly commented that fellow professionals were often unsure of the nature of their role. The notion of pushing boundaries of competence is noted below, but alongside this, participants also noted an inefficiency about this failure to clearly identify roles and responsibilities.

> I find it quite frustrating because I know like other places have had this role for a very long time, so it seems like a lot of the time it does seem like we're probably reinventing the wheel, we're probably coming up against the same problems that everywhere has, and if there was a sort of wider structure to it, like nationwide, it would be helpful if you could just step into that.
>
> (APN 05)

Role flexibility was recognized as something that may contribute to improved patient outcomes. However, as one participant pointed out, flexibility may have limits and where role confusion and overlap were such that lines of responsibility have become unclear, inefficiencies may occur:

> I'm very comfortable with blurred role boundaries, as in flexing them in individual situations. But I think when they become blurred to the point where nobody's quite sure who's responsible for doing what, that is unhelpful.
>
> (APN 20)

These comments reflect the discomfort and ultimate dissatisfaction with one's working environment. Participants presented a range of consequences to the lack of clear national standards and regulation. It offered the benefits of role flexibility and innovation, but it also contributed to the challenges related to widespread ambiguity.

5 | FEELING EXPOSED

APNs talked of the clinical risk associated with their expanded scope of practice and, in the absence of a national framework, the personal accountability for regulating their own practice. This theme is primarily concerned with the transition to new roles.

5.1 | Accountability for autonomous practice

The emerging APN role was viewed as considerably altered and laden with additional responsibilities and practices. Participants spoke of a newly expanded range of patient concerns, others noted the transition to areas of clinical practice with considerable risk attached:

> I think we've taken on a lot of the risk that medical colleagues have traditionally taken on. And I think for a lot of nurses, that's a major issue.
>
> (APN 01)

APNs at times felt under pressure from the weight of this clinical responsibility and accountability, recognizing the risk associated with practising autonomously in their expanded roles. Threats to well-being are clear. The exposure as an individual and the absence of a regulatory framework, weighed down on some, especially when new in post:

> But I think there is a significant amount of stress clinically. You know, if I give them the wrong antibiotic or don't admit them when they need admitting, or anything of that ilk, clinically there could be somebody that is very sick, or indeed, dead because of my action or inaction.
>
> (APN 17)

In light of this, APNs were acutely aware of their responsibility to remain within scope of their own practice competences. Participants reported instances where, by virtue of the APN status, fellow professionals were encouraging them to work beyond their competencies.

5.2 | Team expectations

Exposure to the strain of managing one's own clinical practice, within the context of an absence of a regulatory framework, was exacerbated by the presumption of others about the APN role. Workplace well-being and the sense of satisfaction derived from practice were at times threatened. The participant below has a joint clinical and educational post, relinquishing her full-time nursing role:

> I found it very difficult and I did know it was increasing my stress levels because of the expectation that was still put upon me by the team at the time.
>
> (APN 06)

There is a further organisational context to these manifestations of burden in the form of a perceived failure, of regulatory bodies to provide a framework for collective responsibility. For example, in addition to the pressures of self-regulation, some APNs were uncertain that their professional body (the Nursing and Midwifery Council (NMC)) underpinned their role with the necessary regulatory framework:

> I wonder if actually the NMC know exactly what I do and how they would feel, and who would have our back, I suppose, and that's what's stressful, I think.
>
> (APN 05)

APNs recognize that their role involves high levels of uncertainty and lack of support and this threatens work place well-being and role satisfaction. This, alongside self-regulation and a lack of standardized training, leads some to experience stress and perhaps a self-imposed reduced scope of practice to minimize the risk associated with more challenging consultations.

6 | IMPORTANCE OF SUPPORT FOR THE ADVANCEMENT OF THE APN ROLE

Support for the APN role was recognized as a key mechanism in enabling productive, safe and efficient clinical practice. Those sources of support were, however, variable in quality and diverse in source. Physical location, the presence or absence of robust policies and resources to provide support were identified as important factors in the availability of support, particularly in relation to clinical supervision.

6.1 | Clinical supervision

Participants in the study reported that they received good clinical supervision, although it was observed that community-based APNs were at risk of not being supported in this way. Good clinical supervision contributed to positive well-being. Once again, differences between employing organisations were highlighted. In some areas, this was mandatory, in others an optional extra to be sought in one's own time. This further 'individualization' of clinical supervision practices placed further burden and responsibility on participants.

> I sought out and I receive clinical supervision. It's one of those things. There is a policy in our Trust, it's not mandatory, it's up to people to seek it out.
>
> (APN 20)

6.2 | Other sources of support

A supportive network of fellow professionals was a key element of peer support within the APN role and participants valued these professional connections. Participants spoke about peer support as a key condition upon which effective advanced practice was based, the existence of which allowed participants to '*work at the level I do (APN11). Geographical isolation, however, brought challenges to the maintenance of*

such networks, especially in primary care and rural areas. However, even in large, busy urban surgeries isolation still occurred:

> *The one thing I do find, the one thing that doesn't help, is the fact you feel quite isolated, because you're in a room on your own and you may not see anybody all day apart from your patients.*
>
> *(APN 09)'*

Participants also spoke of other sources of support from within the team, acting as informal clinical supervision, prompting a sense of satisfaction with one's role. Some had been especially proactive in setting up ways to give and receive support. This was often more common in primary care as a response to the physical and professional isolation experienced in that environment:

> I've actually set up in our area a Nurse Practitioner Forum. And part of it is just for that, speaking to peers, bouncing things off, having that contact, even just knowing what training courses are out there. Just so we can support one another. And I use social media a lot for that. There's a lot of advanced practice groups on Facebook and closed groups that are used for that.
>
> (APN 01)

Social media and face-to-face forums were essential to consolidating the professional identity of APNs and for sharing knowledge and training opportunities. It is interesting to note, however, the perceived need to orchestrate such opportunities in response to isolation and an absence of organisational forms of support.

7 | DEMONSTRATING IMPACT

The final super-ordinate theme addresses the ways in which participants described an awareness of the impact of the role of APN, enhancing work satisfaction. Impact can be identified at three levels: the personal, the interpersonal and the organisational.

7.1 | Bridging in the work environment

Decision-making in the arena of patient care is identified as a territory where relationships have been mediated via complex interactions between nurses and medical colleagues. The changing role of nurses, via advanced roles, has contributed to this complexity. The position of nurses in decision-making situations, and the subsequent impact, can be attributed here to APN status, via the notion of 'bridging' between that of the Registered Nurse and medical professional:

> Simple things like that, having the clinical presence to actually say to relatively senior doctors, no we're not going to do that, we don't need to, she's fine… and then afterwards being able to actually explain why that decision was made and why I overruled it and said, no we're not going to do anything until she can at least help us and then we'll look at it. So, that kind of bridging between nursing and medicine is actually quite an ideal role for the [APN].
>
> (APN 06)

The participant is recalling an encounter where 'overruling' was identified as a moment when the status of advanced practice was crucial to this process of gaining professional autonomy, in part through having access to comprehensive knowledge about the patient. Furthermore, the participant notes that the role allows for 'bridging' between the disciplines, contributing to impact on patient outcomes.

The second example of the changing power within working relationships is identified via the negotiation of role. APN impact was viewed as being enhanced when the idea that the role was an adjunct to medicine was challenged. In such circumstances, APNs preferred to identify a clear nursing skillset and identity:

> Well actually, no we are not taking doctors' job roles, we are lead nurses. We are nurses who are working to a higher level, but also there to support other nurses and lead with other nurses. We are not taking any doctors' job role at all.
>
> (APN 18)

7.2 | Essence of advance practice nursing

The second subordinate theme identified within the theme of the impact of APN is concerned with what participants began to view as the essence of advanced practice nursing. This idea is concerned again with challenging the notion of substitution. It is reflected in these data and suggests that being an APN draws centrally upon one's biography as a nurse, utilizing tacit knowledge, yet enabling and facilitating the confident execution of advanced competencies. Despite noting her isolation from others at times within her work, the participant below highlights moments of significant satisfaction in her role as an APN. For her, the use of existing nursing knowledge, practice and skills are central to her work as it is applied in a new context, yielding high impact on patient outcomes:

> I think when I'm actually sat with my patient in front of me, yes, I can listen to a chest, yes, I can do diagnostics. Yes, I can refer this; I can come up with the clinical diagnosis. But how I get to that, I use my nursing knowledge and my nursing skill and all these years of experience to be able to communicate effectively and to be able to read the language of my patient.
>
> (APN 09)

The provision of continuity of care for patients was also established as a key feature of the APN role. This continuity is transferred into the role of the APN, whilst also demonstrating the advanced competencies already described, as APN participants also referred to being able to respond to a '*complete episode of care*' (APN 09) for patients.

7.3 | 'Strategic influence'

Finally, impact can be evidenced through reports of influence at an organisational level. Participants described how organisations had now come to know the value of APNs, recognizing that '*they've come to rely upon us*' (APN 05) *In addition, participants were also able to identify the APN as an influencing force. This, in part, was noted as a product of the APN role in both having credibility as leaders and maintaining relationships with patients. This boundary spanning position allows APNs to observe the delivery of care at a diverse range of levels. The participant below notes how this affects organisational direction:*

> *And sometimes as nurses you can see patterns emerging more so than medics sometimes because you've got that closer contact with the patient. Maybe it's because I'm in primary care and community settings.*
>
> *(APN 21).*

This part of the advanced role reflects the leadership responsibilities inherent within APN roles. This unique positioning allows APNs to identify the challenges being faced by patients, instigate and pursue analysis of those challenges and provide strategies for improvement and development.

8 | DISCUSSION

This exploration into the organisational and role conditions that promote or inhibit job satisfaction and workplace well-being for APNs has highlighted four key themes: 'the APN role and professional identity', 'feeling exposed', 'support for the advancement of the APN role' and 'demonstrating impact'. Each theme relates to our primary concerns about the condition that may inhibit or facilitate role satisfaction, dissatisfaction and overall workplace well-being. We encountered APNs in a range of circumstances, some benefiting from a wealth of experience and others capitalizing on formal and informal support. The data note that some APN participants here were experiencing the burden of the elevated expectation of colleagues, whilst others were struggling to maintain work satisfaction as a result of confused role definition and altered workplace identity.

A failure to feel accepted by one's medical and nursing colleagues, leaving a sense of liminality for some participants, is important. This feature of APN experience has been previously identified in Nurse Practitioners in Sweden (Jangland et al., 2016). The absence of intra-practice collegiality as a specific form of dissatisfaction amongst a group of senior practitioners in the USA (Faris et al., 2010). The nature of intra-practice relationships (particularly with medical colleagues) has been reported as a major source of dissatisfaction (Jones, 2005; O'Keeffe et al., 2015). Our data concur with this evidence, suggesting that isolation from one's established nursing networks may account for dissatisfaction amongst APNs, diminishing workplace well-being and that newly transitioned APNs are more likely to indicate work-related stress (Brom et al., 2016).

A feature of these data relates to role definition and clarity, which is recognized as being absent at times. This is not new, and not peculiar to the UK. The Swedish study by Jangland et al. (2016) highlighted a feeling of being 'between two roles', neither nurse nor medic. Positive role perception correlates with high levels of job satisfaction among APNs (Brom et al., 2016). APNs who have little autonomy in their roles are more likely to leave their posts (De Milt et al., 2011). Jones (2005) recognized role ambiguity, role overload and challenges in clinical autonomy as key factors hampering the development of the APN. External role ambiguity is noted here as a source of dissatisfaction, particularly within the wider health care workforce. Perhaps more salient in terms of workplace burden, the absence of protected status and a regulatory framework was identified here as 'exposing' individuals who found themselves in roles of significant clinical responsibility.

Confusion about role and the adverse ways in which APNs are regarded is not universal. We identified APNs who demonstrated significant satisfaction, particularly regarding the impact their work was making on the lives of patients. A review of the advanced nursing role in relation to outcomes reported significant evidence in the fields of long-term conditions and older people (Case y et al., 2017). Participants noted that maintaining continuity with patients led to enhanced outcomes, as is the case for ambulatory care (Martin-Misener et al., 2015), transitional care (Donald et al., 2015) and gerontological nursing (Morilla-Herrera et al., 2016). The particular mechanisms that contribute to improved outcomes are not always articulated. Jangland et al. (2016), however, point to the preservation of a core set of nursing competencies, alongside the elevation to APN as important in facilitating improved outcomes. Nurse presence and greater knowledge of care environments are reported as contributing factors in improved outcomes (Woo et al., 2017). It is noted here that increased status within the multi-disciplinary team, resulted in APNs advocating on behalf of patients in a more effective way. Evidence would suggest that the APN role brings with it a range of features that might explain improved outcomes, including those already noted, as well as enhanced collaboration, opportunities for patient advocacy, leadership, expert clinical judgement and care management (Sastre-Fullana et al., 2014).

9 | LIMITATIONS

The sample within this study is relatively homogeneous. All were aged 40 years or over and identified as White British. Despite our best efforts, there are only three male participants within the study.

10 | CONCLUSIONS

There remains considerable dissatisfaction among APNs with role identity, concerns relating to isolation and frustration at the absence of a national regulatory framework. Nonetheless, we also identified significant satisfaction with the role, particularly when APNs were well supported and able to recognize the unique contribution that they made to the lives of patients and to their organisations. Support and satisfaction subsequently enhances APN well-being.

11 | IMPLICATIONS FOR NURSE MANAGEMENT

This study has highlighted a number of areas of dissatisfaction among APNs, with potential impact on nurse retention. We recommend managers seek to reduce isolation, particularly for primary care APNs, promote role clarity (through clear and consistent job descriptions) and generate opportunities for inter-professional development. APNs should be supported, through clinical supervision (with a suitably qualified supervisor), to enable them to flourish within clear role boundaries. Health care providers should seek to utilize the skills and experiences of APNs in order to maximize impact.

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CONFLICT OF INTEREST

The authors have no conflicts to declare.

AUTHOR CONTRIBUTIONS

EW drafted the protocol and the paper, collected and analysed the data. TR collected data, contributed to the protocol and paper and analysed the data. RK, SR, MS, AT and TR contributed to the analysis and protocol development. All authors read and approved the final manuscript.

ETHICAL APPROVAL

This research was reviewed by the Institutional ethics committee and given approval on 3 September 2018 (ref number 022736). Informed consent was gained from all participants. This research was carried out in accordance with the principles of the Helsinki Declaration.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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REFERENCES

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *International Journal of Qualitative Studies on Health and Well-Being*, *9*(1), 26152. https://doi.org/10.3402/qhw.v9.26152

Brom, H. M., Melnyk, B. M., Szalacha, L. A., & Graham, M. (2016). Nurse practitioners' role perception, stress, satisfaction, and intent to stay at a Midwestern academic medical center. *Journal of the American Association of Nurse Practitioners*, *28*(5), 269–276. https://doi.org/10.1002/2327-6924.12278

Casey, M., O'Connor, L., Cashin, A., Smith, R., O'Brien, D., Nicholson, E., O'Leary, D., Fealy, G., McNamara, M., Glasgow, M. E., Stokes, D., & Egan, C. (2017). An overview of the outcomes and impact of specialist and advanced nursing and midwifery practice, on quality of care, cost and access to services: A narrative review. *Nurse Education Today*, *56*, 35–40. https://doi.org/10.1016/j.nedt.2017.06.004

Collins, D. (2019). Assessing the effectiveness of advanced nurse practitioners undertaking home visits in an out of hours urgent primary care service in England. *Journal of Nursing Management*, *27*(2), 450–458. https://doi.org/10.1111/jonm.12680

De Milt, D. G., Fitzpatrick, J. J., & McNulty, S. R. (2011). Nurse practitioners' job satisfaction and intent to leave current positions, the nursing profession, and the nurse practitioner role as a direct care provider. *Journal of the American Academy of Nurse Practitioners*, *23*(1), 42–50. https://doi.org/10.1111/j.1745-7599.2010.00570.x

Denzin, N., & Lincoln, Y. (2005). *The Sage handbook of qualitative research* (3rd ed.). Sage Publications.

Donald, F., Kilpatrick, K., Reid, K., Carter, N., Bryant-Lukosius, D., Martin-Misener, R., Kaasalainen, S., Harbman, P., Marshall, D., & DiCenso, A. (2015). Hospital to community transitional care by nurse practitioners: A systematic review of cost-effectiveness. *International Journal of Nursing Studies*, *52*(1), 436–451. https://doi.org/10.1016/J.IJNURSTU.2014.07.011

Elliott, N. (2017). Building leadership capacity in advanced nurse practitioners - The role of organisational management. *Journal of Nursing Management*, *25*(1), 77–81. https://doi.org/10.1111/jonm.12444

Faris, J. A., Douglas, M. K., Maples, D. C., Berg, L. R., & Thrailkill, A. (2010). Job satisfaction of advanced practice nurses in the Veterans Health Administration. *Journal of the American Academy of Nurse Practitioners*, *22*(1), 35–44. https://doi.org/10.1111/j.1745-7599.2009.00468.x

Han, R. M., Carter, P., & Champion, J. D. (2018). Relationships among factors affecting advanced practice registered nurses' job satisfaction and intent to leave. *Journal of the American Association of Nurse Practitioners*, *30*(2), 101–113. https://doi.org/10.1097/JXX.0000000000000006

Hennink, M. M., Kaiser, B. N., & Marconi, V. C. (2017). Code saturation versus meaning saturation: How many interviews are enough? *Qualitative Health Research*, *27*(4), 591–608. https://doi.org/10.1177/1049732316665344

International Council of Nurses (2008). *The scope of practice, standards and competencies of the advanced practice nurse*.

Jangland, E., Yngman Uhlin, P., & Arakelian, E. (2016). Between two roles – Experiences of newly trained nurse practitioners in surgical care in Sweden: A qualitative study using repeated interviews. *Nurse Education in Practice*, *21*, 93–99. https://doi.org/10.1016/j.nepr.2016.10.005

Jones, M. L. (2005). Role development and effective practice in specialist and advanced practice roles in acute hospital settings: Systematic review and meta-synthesis. *Journal of Advanced Nursing*, *49*(2), 191–209. https://doi.org/10.1111/j.1365-2648.2004.03279.x

Kim, S. R., Park, O. L., Kim, H. Y., & Kim, J. Y. (2019). Factors influencing well-being in clinical nurses: A path analysis using a multi-mediation model. *Journal of Clinical Nursing*, *28*(23–24), 4549–4559. https://doi.org/10.1111/jocn.15045

King, R., Tod, A., & Sanders, T. (2017). Development and regulation of advanced nurse practitioners in the UK and internationally. *Nursing Standard*, *32*(14), 43–50. https://doi.org/10.7748/ns.2017.e10858

Martin-Misener, R., Harbman, P., Donald, F., Reid, K., Kilpatrick, K., Carter, N., Bryant-Lukosius, D., Kaasalainen, S., Marshall, D. A., Charbonneau-Smith, R., & DiCenso, A. (2015). Cost-effectiveness of nurse practitioners in primary and specialised ambulatory care: Systematic review. *British Medical Journal Open*, *5*(6), e007167. https://doi.org/10.1136/bmjopen-2014-007167

Morilla-Herrera, J. C., Garcia-Mayor, S., Martín-Santos, F. J., Kaknani Uttumchandani, S., Leon Campos, Á., Caro Bautista, J., & Morales-Asencio, J. M. (2016). A systematic review of the effectiveness and roles of advanced practice nursing in older people. *International Journal of Nursing Studies*, *53*, 290–307. https://doi.org/10.1016/J.IJNURSTU.2015.10.010

O'Keeffe, A. P., Corry, M., & Moser, D. K. (2015). Measuring job satisfaction of advanced nurse practitioners and advanced midwife practitioners in the Republic of Ireland: A survey. *Journal of Nursing Management*, *23*(1), 107–117. https://doi.org/10.1111/jonm.12096

Sastre-Fullana, P., De Pedro-Gómez, J. E., Bennasar-Veny, M., Serrano-Gallardo, P., & Morales-Asencio, J. M. (2014). Competency frameworks for advanced practice nursing: A literature review. *International Nursing Review*, *61*(4), 534–542. https://doi.org/10.1111/inr.12132

Schober, M., Lehwaldt, D., Rogers, M., Steinke, M., Turale, S., Pulcini, J., Roussel, J., & Stewart, D. (2020). *Guidelines on advanced practice nursing 2020*. International Council of Nurses.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Woo, B. F. Y., Lee, J. X. Y., & Tam, W. W. S. (2017). The impact of the advanced practice nursing role on quality of care, clinical outcomes, patient satisfaction, and cost in the emergency and critical care settings: A systematic review. *Human Resources for Health*, *15*(1), 1–22. https://doi.org/10.1186/s12960-017-0237-9

Woo, B. F. Y., Zhou, W., Lim, T. W., & Tam, W. W. S. (2019). Practice patterns and role perception of advanced practice nurses: A nationwide cross-sectional study. *Journal of Nursing Management*, *27*(5), 992–1004. https://doi.org/10.1111/jonm.12759

Wood, E., King, R., Robertson, S., Allmark, P., Senek, M., Tod, A., & Ryan, T. (2020). Advanced practice nurses' experiences and well-being: Baseline demographics from a cohort study. *Journal of Nursing Management*, *28*(4), 959–967. https://doi.org/10.1111/JONM.13030

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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EDITORIAL

WILEY

Managing holistic nursing practice: The need for spiritual care competence in health care practice

Over the past 30 years, greater attention has been paid to individual, psychological, societal, sociocultural, political, economic and environmental factors that contribute to health and well-being (McEwen & Wills, 2014). This reorientation of health care required a shift from a disease orientated model, towards a greater consideration of the individual, and their psychosocial make up, and supporting or addressing key broader influential issues related to health. The consequential rise in consideration of the need for a person-centred approach to health and health care grew in popularity as greater understandings of the contributions that individual lifestyle to health were made.

The nursing profession has long embraced this person-centred holistic approach to health care, and this philosophy is enshrined within its scientific foundations (McEwen & Wills, 2014). Early attempts at establishing nursing as a scientific discipline began in the United States in the 1960s, focused on determining and understanding not only the person, but equally defining health, environment, nursing and the specific nurse's role through conceptual statements (McEwen & Wills, 2014). Gradually over time, several nursing theories emerged that described what nursing is, shaped nurses' thinking and what nurses do to articulate the unique contribution that nurses make from each nursing disciplinary perspective. The holistic nursing movement that followed was underpinned by a systematic approach to care, offering guidance to nurses on how to assess the individual person and family, plan, implement and evaluate nursing care, with consideration of environmental and other associated factors that might affect health (McEwen & Wills, 2014).

Nursing theories and models initially promoted and espoused holistic care. However, these are not always understood or respected in contemporary nursing practice (McCormack, 2020a) or a good fit for the busy health care environment (Chapman, 2018). However, their legacy remains, as does interest in the core values that these theories espoused (McCormack, 2020a). Resultingly, there is a clear and growing emphasis on person-centred care approaches (McCormack, 2020b), the fundamentals of care (International Learning Collaborate, 2021; Kitson, 2018), compassionate care (Chapman, 2018) and a reemphasis (Pajnkihar et al., 2017) on caring science (Watson, 2012, 2019). Some of this is in response to the lapses in care that received attention at a very high level in the United Kingdom for example (Francis, 2013; Royal College of Nursing [RCN], 2012) and has led to an overarching concern with reinvigorating the nursing profession with skills of compassion (Gallagher, 2013, 2014). However, this reorientation and reemphasis on the core values of nursing has not necessarily highlighted the need to provide spiritual support to patients by addressing their spiritual needs in health care practice. Spirituality as an aspect of the person was clearly recognized by many of the early nurse theorists (McEwen & Wills, 2014; Ramezani et al., 2014) and requires consideration in health care (McSherry et al., 2020). Authors have linked this requirement for compassion, dignity and respect to the core concepts of spiritualty (McSherry et al., 2020), and as such, the absence of clear attention to this element of nursing within emerging frameworks is of concern. Indeed gaps in support for spiritual needs were recently evidenced by a study that explored online resources and supports for spiritual care for hospitalized patients during the COVID-19 pandemic (Papadopoulos et al., 2021). Lack of education and preparedness to provide spiritual support emerged as a clear finding from this study. Indeed, picking up on the findings of this study, the Nursing Times reported that 'emotional and spiritual care [were] "hugely lacking" during pandemic' (Ford, 2021). There are obviously some examples of good practice. The Polish Association for Spiritual Care in Medicine (PTODM), for example, from mid-2020 developed a project entitled 'stay with me—social and spiritual support for patients hospitalized due to COVID-19'. The aim of this project was to enable patients with COVID-19, especially those who are dependent, with a serious or life-threatening condition, to have virtual contact with their relatives. Under the first part of the project, entitled 'talk to me', hospitals participating in the programme received smartphones with a package of free calls and data transmission. In the second part of the project, entitled 'raise me on the spirit', the association provided support for personal protective equipment (PPE) for health care chaplains (PTODM, 2021).

Despite such examples, there is evidence that while we have had more than three decades of calls for a more considered approach to caring for and about the patients in health care that takes account of the person's perspective and situation, anecdotal evidence suggests that the hospital experience can sometimes be quite the opposite. In fact, many patients experience dehumanization (Głębocka, 2019). Although patients are largely satisfied with care received, and find it dignified (Quality Care Commission, 2020), advocacy groups are replete with descriptions of an indifferent approach adopted by health care professionals and poor communication, possibly as a result of care erosion (de Vries & Timmins, 2015, 2016). This impresses upon patients that they were unimportant, insignificant and therefore not considered as individuals. Within this context, spiritual needs can get forgotten

(Radford, 2008). Paradoxically, nursing's focus is directed towards valuing people, and while lapses in care and thoughtlessness may be attributed to many systemic factors (de Vries & Timmins, 2015, 2016; McSherry et al., 2018) including stress (Głębocka, 2019), patients and their families are greatly affected by this.

The omission of spiritual support, particularly at the end of life, described as 'poor' in one study (Ó Coimín et al., 2017), can have long-lasting effects on families (Office of the Ombudsman, 2014; Parliamentary and Health Service Ombudsman, 2014). Nurses are often unclear about what spirituality means to a patient and whether as professionals they should begin to assess and question patients about their spirituality and at what point (Harrad et al., 2019). In some health care organizations, straightforward religious affiliation questions are asked (Timmins et al., 2017), although these are inconsistently applied, and often little all else is done. Asking the patient about his or her spirituality, religion, worldviews, health beliefs related to spirituality and health that might affect their interaction, acceptance and concordance with health interventions and treatment is infrequent. Moreover, these issues are often considered as too intimate or even taboo, therefore omitted (Pawlikowski & Dobrowolska, 2016). Spiritual care intervention involves the nurse responding firstly with compassion (Giske et al., 2021). The nurse also needs to consider the patient's beliefs and values and offer relevant care to create a stronger connection between the patient and nurse (Giske et al., 2021). Spiritual care can also involve the provision of or access to religious supports (Giske et al., 2021) and health care chaplaincy services. Patients may have spiritual and religious beliefs that when unattended in the hospital/health care setting, can cause loss, spiritual distress (Martins et al., 2021) and or disenfranchised grief further contributing to experiences of dehumanization. Patients who use spirituality and religion as distinct resources and coping mechanisms (Ross & Austin, 2015) may not be encouraged to use them within health care settings (Radford, 2008); in fact, they may be discouraged.

Encouragingly, there are international guidelines (Whelan, 2019) and now more recently clear European guidelines (Education and Compassionate Care [EPICC], 2021; McSherry et al., 2021; van Leeuwen et al., 2021) because of three decades of ongoing work by this team (McSherry et al., 2020) to support the provision of spiritual care to patients. However, the application of guidelines for spiritual care up until now has been inconsistent and lacking clear direction at both a national and local level (Timmins et al., 2017). This means that spiritual care provision, as a component of holistic nursing care, is inconsistent at best and absent at worst. Additionally, there are limited national nursing standards for spiritual care. In Poland, for example, although single institutions may have guidelines, national guidelines do not exist (Dobrowolska, 2018). Similarly, within the Republic of Ireland, current national requirements and standards (Timmins & Whelan, 2018) provide little specific direction in relation to spiritual care provision.

The standardized European spiritual care competencies that have been recently developed for nurses and midwives (EPICC, 2021; van Leeuwen et al., 2021) may serve to address these deficits. These competencies stem from a 3-year funded project that require nurses firstly to express *intrapersonal spirituality* (develop an awareness of the importance of spirituality on health and well-being). *Interpersonal spirituality* is also required (engaging with a person's spirituality and acknowledging individual, spiritual, cultural world views and practices) (EPICC, 2021). These require nurses to be competent in *spiritual care assessment* and planning to assess patients' spiritual needs and provide *spiritual care interventions and evaluation* (responding to spiritual needs and providing resources within a caring, compassionate relationship) (EPICC, 2021; van Leeuwen et al., 2021). While these four competencies are new for the nursing profession, it is anticipated that they will be integrated across health care settings in Europe to strengthen and guide spiritual care support. However, support to do this is needed at university level to include this standard to nursing education and equip new nurses with professional knowledge, skills and attitudes in the scope of spiritual care (EPICC, 2021). At the same time, support is needed from nurse managers and nurses in practice settings to support these competencies to guide nurses in health care hospital settings to understand how best to provide spiritual care to patients and their families. The work of this EPICC (2021) group has spearheaded new understandings of spirituality for nurses internationally by clearly outlining four distinct required competencies. Another helpful resource that nurse managers can suggest is the brief screening tool developed by Ross and McSherry (2018). This offers two questions: a model termed '2Q-SAM' that elicits expression of patients' spiritual needs in a straightforward manner, by using the two questions: *What's most important to you now?* and *How can we help?*

Another positive and important step in improving nurses' understanding of spirituality and spiritual care provision is the recent initiation of the Erasmus Plus Project 'From Cure to Care, Digital Education and Spiritual Assistance in Healthcare' (2021), in which the authors are closely involved. This aims to provide education for nurses in spiritual care. This Erasmus Plus Project builds on the EPICC (2021) project by developing an E-Learning programme to support religious–spiritual competencies within a multicultural perspective and ultimately hopes to address national and international gaps in nurses' knowledge and skills and improve their confidence in support patients' spiritual needs. It is hoped that this emergent body of knowledge, competencies and specific tools related to spiritual care provision begin to provide the guidance and support that urgently needed across health care settings internationally.

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REFERENCES

Chapman, H. (2018). Nursing theories 3: Nursing models. *Nursing Times*, *114*(1), 34.

de Vries, J., & Timmins, F. (2015). Care erosion in hospitals: Problems in reflective nursing practice and the role of cognitive dissonance. *Nurse Education Today*, *38*, 5–8. https://doi.org/10.1016/j.nedt.2015.12.007

de Vries, J., & Timmins, F. (2016). Teaching psychology to nursing students—A discussion of the potential contribution of psychology towards building resilience to lapses in compassionate caring. *Nurse Education in Practice*, *26*, 27–32. https://doi.org/10.1016/j.nepr.2017.06.004

Dobrowolska, B. (2018) Enhancing nurses and midwives competence in providing spiritual care through innovative education and compassionate care: Implementation of (draft) spiritual care education standard. EPICC Teaching & Learning Event 2 (EPICC Erasmus Plus Project Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care 2016–2019). Zwolle, 24–28 September 2018.

Education and Compassionate Care. Enhancing nurses and midwives' competence in providing spiritual care through innovation, (2021) http://blogs.staffs.ac.uk/epicc/

Ford, M. (2021) Emotional and spiritual care 'hugely lacking' during pandemic, finds nurse-led study. *Nursing Times*. Available at: https://www.nursingtimes.net/news/research-and-innovation/emotional-and-spiritual-care-hugely-lacking-during-pandemic-finds-nurse-led-study-11-10-2021/. Accessed 9 December 2021.

Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Stationery Office. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf. Accessed 9 December 2021.

From Cure to Care, Digital Education and Spiritual Assistance in Healthcare. (2021) KA226, Strategic Partnerships for Higher Education—Digital Education Readiness, from Erasmus+ programme. Available at: http://research.unir.net/blog/project-from-cure-to-care-digital-education-and-spiritual-assistance-in-hospital-healthcare/. Accessed 31 October, 2021.

Gallagher, A. (2013). Values for contemporary nursing practice: Waving or drowning? *Nursing Ethics*, *20*(6), 615–616. https://doi.org/10.1177/0969733013496362

Gallagher, A. (2014). Ethics education: Do we need compassion boot camps? *Nursing Ethics*, *21*(6), 635–636. https://doi.org/10.1177/0969733014543880

Giske, T., Damsma-Bakker, A., Calderia, S., González Romero, G. M., de Abreu, W. C., & Timmins, F. (2021). Spiritual care, intervention and evaluation. In W. McSherry, A. Boughey, & J. Attard (Eds.), *Enhancing nurses' and midwives' competence in providing spiritual care: Through innovative education and compassionate care*. Springer Nature. https://doi.org/10.1007/978-3-030-65888-5_8

Głębocka, A. (2019). Stress and dehumanizing behaviors of medical staff toward patients. *Advances in Experimental Medicine and Biology*, *1133*, 97–104. https://doi.org/10.1007/5584_2018_308

Harrad, R., Cosentino, C., Keasley, R., & Sulla, F. (2019). Spiritual care in nursing: An overview of the measures used to assess spiritual care provision and related factors amongst nurses. *Acta Bio-Medica: Atenei Parmensis*, *90*(4-S), 44–55. https://doi.org/10.23750/abm.v90i4-S.8300

International Learning Collaborate. (2021) The fundamentals of care. Available at: https://intlearningcollab.org/mission/the-fundamentals-of-care/. Accessed 22 May 2021.

Kitson, A. L. (2018). The fundamentals of care framework as a point-of-care nursing theory. *Journal of Clinical Nursing*, *27*(11–12), 2175–2176.

Martins, H., Caldeira, S., Vieira, M., Campos de Carvalho, E., & Flanagan, J. (2021). Spiritual distress in patients with cancer initiating chemotherapy: A cross-sectional study. *Journal of Nursing Scholarship*, *53*(5), 578–584. https://doi.org/10.1111/jnu.12670

McCormack, B. (2020a). What is the value of nursing knowledge in a time of crisis? *Journal of Clinical Nursing*, *29*(17–18), 3120–3121. https://doi.org/10.1111/jocn.15323

McCormack, B. (2020b). The person-centred nursing and person-centred practice frameworks: From conceptual development to programmatic impact. *Nursing Standard*, *35*(10), 86–89. https://doi.org/10.7748/ns.35.10.86.s40

McEwen, M., & Wills, E. M. (2014). *Theoretical basis for nursing*. Wolters Kluwer Health|Lippincott Williams & Wilkins.

McSherry, R., Timmins, F., de Vries, J. M. A., & McSherry, W. (2018). A reflective qualitative appreciative inquiry approach to restoring compassionate care deficits at one United Kingdom health care site. *Journal of Nursing Management*, *26*(8), 1108–1123. https://doi.org/10.1111/jonm.12630

McSherry, W., Boughey, A., & Attard, J. (2021). *Enhancing nurses' and midwives' competence in providing spiritual care*. Springer. https://doi.org/10.1007/978-3-030-65888-5

McSherry W, Ross L, Attard J, van Leeuwen R, Giske T, Kleiven T, Boughey A, & the EPICC Network. Preparing undergraduate nurses and midwives for spiritual care: Some developments in European education over the last decade. *Journal for the Study of Spirituality* 2020;*10*(1):55–71, DOI: https://doi.org/10.1080/20440243.2020.1726053

Ó Coimín, D., Korn, B., Prizeman, G., Donnelly, S., Hynes, G., Curran, M., & Codd, M. (2017). *Survey of bereaved relatives: VOICES MaJam*. Mater Misericordiae University Hospital and St. James's Hospital.

Office of the Ombudsman. (2014). *A good death: A reflection on ombudsman complaints about end of life care in Irish hospitals*. Office of the Ombudsman.

Pajnkihar, M., Štiglic, G., & Vrbnjak, D. (2017). The concept of Watson's carative factors in nursing and their (dis)harmony with patient satisfaction. *PeerJ*, *5*, e2940. https://doi.org/10.7717/peerj.2940

Papadopoulos, I., Lazzarino, R., Wright, S., Ellis Logan, P., & Koulouglioti, C. (2021). Spiritual support during COVID-19 in England: A scoping study of online sources. *Journal of Religion and Health*, *60*(4), 2209–2230. https://doi.org/10.1007/s10943-021-01254-1

Parliamentary and Health Service Ombudsman. (2014). *Dying with dignity. Investigations by the Parliamentary and Health Service Ombudsman into complaints about end of life care*. Parliamentary and Health Service Ombudsman.

Pawlikowski, J., & Dobrowolska, B. (2016). Familiarity and understanding of patients' religiosity and faith influence the level of comfort nurses and care workers feel when providing care. Commentary on: Skomakerstuen Ødbehr L, Kvigne K, Hauge S, et al. A qualitative study of nurses' attitudes towards and accommodations of patients' expressions of religiosity and faith in dementia care. J Adv Nurs 2015;71:359–69. *Evidence-Based Nursing*, *19*(2), 63.

Polish Association for Spiritual Care in Medicine. (2021). Project "stay with me". Available online: https://ptodm.org.pl/badz-przy-mnie. Accessed 12 December 2021

Quality Care Commission. (2020) Adult inpatient survey 2020. Available at: https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey-2020. Accessed 9 December 2021.

Radford, K. (2008). Health, faith and equality. Prepared for the Health Research Board through building partnerships for healthier society research award. Health Research Board/Irish School of Ecumenics, Trinity College Dublin.

Ramezani, M., Ahmadi, F., Mohammadi, E., & Kazemnajad, A. (2014). Spiritual care in nursing: A concept analysis. *International Nursing Review*, *61*, 211–219. https://doi.org/10.1111/inr.12099

Ross, L., & Austin, J. (2015). Spiritual needs and spiritual support preferences of people with end-stage heart failure and their carers: Implications for nurse managers. *Journal of Nursing Management*, *23*(1), 87–95. https://doi.org/10.1111/jonm.12087

Ross, L., McSherry, W.. 2018 Two questions that ensure person centred spiritual care: Nursing Standard; [cited 6 December 2021]. Available from: https://journals.rcni.com/nursing-standard/feature/the-power-of-two-simple-questions-ns.33.9.78.s22/abs

Royal College of Nursing. (2012) *Quality with compassion: the future of nursing education. Report of the Willis Commission on Nursing Education, 2012*. Royal College of Nursing. Available at: https://www.macmillan.org.uk/documents/newsletter/willis-commission-report-macmail-dec2012.pdf. Accessed 9 December 2021.

Timmins, F., Caldeira, S., Murphy, M., Pujol, N., Sheaf, G., Weathers, E., Whelan, J., & Flanagan, B. (2017). An exploration of current approaches to and facilities for spiritual care provision in the Republic of Ireland. *The Journal of Pastoral Care & Counseling: JPCC*, *71*(2), 122–131. https://doi.org/10.1177/1542305017708158

Timmins, F. & Whelan, J. (2018) Enhancing nurses and midwives competence in providing spiritual care through innovative education and compassionate care: Implementation of (draft) spiritual care education standard. EPICC Teaching & Learning Event 2 (EPICC Erasmus Plus Project Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care 2016–2019). Valetta Campus, University of Malta, 24–28 September 2018.

van Leeuwen, R., Attard, J., Ross, L., Boughey, A., Giske, T., Kleiven, T., & McSherry, W. (2021 Feb). The development of a consensus-based spiritual care education standard for undergraduate nursing and midwifery students: An educational mixed methods study. *Journal of Advanced Nursing*, *77*(2), 973–986. https://doi.org/10.1111/jan.14613

Watson, J. (2012). *Human caring science a theory of nursing* (2nd ed.). Jones & Bartlett Learning.

Watson, J. (2019) Watson Caring Science. Retrieved from: https://www.watsoncaringscience.org. Accessed 9 December 2021.

Whelan, J. (2019) Teaching and learning about spirituality in healthcare practice settings. In Timmins F, Caldeira S. *Spirituality in healthcare: Perspectives for innovative practice*. Springer Nature. 165–192, DOI: https://doi.org/10.1007/978-3-030-04420-6_11

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ORIGINAL ARTICLE

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Aggressive incidents in home care services and organizational support: A cross-sectional survey in Switzerland

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Abstract

Aims: To explore the available organizational structures addressing aggressive incidents towards home care services staff.

Background: Organizational structures how professional caregivers deal with care recipients' aggressive incidents.

Methods: An explorative cross-sectional survey using the Violence Experienced by Staff (German version revised) and the Impact of Patient Aggression on Carers Scale was conducted. Data from 852 health care professionals in the German-speaking part of Switzerland were collected between July and October 2019. Multiple logistic regression models were used to investigate associations. The STROBE-Checklist was used as the reporting guideline.

Results: Organizational support and management support in home care services were generally rated high and found to cause a significant decrease in negative feelings. Some self-rated skills regarding aggression management were linked to a decrease in perceived burden after aggressive incidents, whereas others increased the perceived burden.

Conclusion: Organizational structures including official procedures for affected professional caregivers should be established in home care services. This should contain efficient reporting systems and aggression management training for the specific setting.

Implications for Nursing Management: The study highlights the importance of organizational support regarding aggressive incidents in the home care setting as well as of aggression management training.

KEYWORDS
home care, survey methodology, community health, gerontology, violence

1 | BACKGROUND

Care recipients behaving aggressively with professional caregivers is a common phenomenon in the health care setting (Paschali et al., 2018; Yu et al., 2019). Investigations in the home care settings show that aggressive behaviour against professional caregivers occur often in the home care setting as well (Hanson et al., 2015; Schablon et al., 2018). Schnelli, Ott, et al. (2021) found that 14.8% of clients availing home care services display verbally or physically aggressive behaviour towards caregivers and that such behaviours were linked to cognitive impairment. Home care services have gained importance due to demographic changes worldwide (Genet et al., 2012). However, home care services face specific challenges such as increasing demand for care for people with dementia (Genet et al., 2012). Care for persons with dementia is often rewarded by aggressive behaviour against professional caregivers (Paschali et al., 2018; Schnelli, Mayer, et al., 2021; Yu et al., 2019). However, there is a lack of research regarding this phenomenon in the professional home care setting. Therefore, this study's research interest was directed towards aggressive behaviours in the home care setting.

The consequences of aggressive behaviour against professional caregivers include stress and burden, often resignation from the job, and post-traumatic stress (Paschali et al., 2018; Schnelli, Mayer, et al., 2021). Consequences of aggressive behaviour on behalf of the clients cause disturbances in the professional relationship and provoke increased fixations or assault from professional caregivers (Heckemann et al., 2017). Research could show ways to reduce such consequences after aggressive incidents. An important aspect that influences the perceived burden in the context of aggressive behaviour is team culture and support from the management (Heckemann et al., 2020). A positive team culture means the opportunity to discuss aggressive incidents in the team during informal conversations (Heckemann et al., 2020). Health professionals often seek support from their team members after surviving aggressive incidents (Edward et al., 2014; Heckemann et al., 2020).

Although support from colleagues is helpful, receiving support from the management was identified as being crucial as well (Schnelli et al., 2019). Support from the management includes an active role of the team leader. This means encouraging the team members to complete reporting forms, talking to affected professionals, and offering further measures such as case reviews or psychological support according to the affected person's needs. Additionally, management support includes promoting the employer's attitude to protect the staff and not take aggressive incidents as a "normal part of the job" (Heckemann et al., 2020; Schnelli et al., 2019). Poor support from management results in non-reporting of aggressive behaviour, even if a reporting system is available (Edward et al., 2014). Further reasons for non-reporting include the fear of being seen as oversensitive or existing horizontal violence such as harassment from team colleagues (Edward et al., 2014). Reporting systems allow analysing aggressive incidents systematically and, thus, implementing changes on an organizational level to prevent them in the future. Hence, it is necessary to address the reservations and barriers to reporting. Aggression management training leads to increased confidence, improved attitude and skills, and knowledge of risk factors of aggressive behaviour (Heckemann et al., 2015).

In Switzerland, aggression management training is part of nursing education. Further standardized aggression management trainings for health care organizations are available for inpatient settings (OdASanté, 2017). These trainings include following contents: defence techniques, verbal de-escalation techniques and information about the development of aggressive behaviour (Netzwerk für Aggressionsmanagement im Gesundheits- und Sozialwesen [NAGS], 2015).

Research from inpatient settings such as hospitals, long-term care institutions or psychiatry departments show that organizational support positively affects the consequences of aggressive incidents as well as their prevention (Edward et al., 2014; Heckemann et al., 2015). Organizational support includes the general attitude in the organization towards prevention and defusion of aggressive incidents, which has a supportive effect. This is reflected in, for example, the available reporting systems, and whether the staff is obligated to report incidents, and the official responses to reported incidents. Responses include established case reviews and free availability/offer of psychological support after aggressive incidents to professional caregivers (Schnelli et al., 2019). Regarding reporting systems, it is important that professional caregivers are able to report the incident anonymously if they wish and do not have to fear negative consequences of their report (Schnelli et al., 2019). Further, availability of concepts around prevention and dealing with aggressive behaviour, frequent aggression management trainings and refresher trainings and the opportunity to call safety staff or police for instrumental support in challenging situations are aspects of organizational support that help professional caregivers to deal with aggressive incidents (Heckemann et al., 2020; Schnelli et al., 2019).

Organizational support, team support, management support and aggression management training are crucial factors that prevent negative feelings after aggressive incidents in inpatient settings. There is insufficient corresponding research for home care services despite their unique organizational structure and the fact that aggressive incidents occur in the professional home care as well and are set to increase in the future with an increasing number of persons with dementia seeking home care, a clear gap that motivated this study. Based on insights from research in inpatient settings, the study aimed to gain knowledge of the existing organizational structures around aggression management in home care services. The following research questions guided the study:

- What organizational and management support structures are in place in home care services to support professional caregivers in dealing with their client's aggressive behaviour?
- How do these structures perceive the negative feelings experienced by professional caregivers after aggressive incidents?
- What are the training conditions for the professional caregivers in home care services and how far do they affect the negative feelings in the caregiver after aggressive incidents?

2 | METHODS

Due to the lack of existing research on organizational structures in home care services regarding aggression management and training, an explorative cross-sectional design was chosen. The Strengthening the Reporting of Observational Studies in Epidemiology Checklist (STROBE) for cross-sectional studies was chosen as the reporting guideline (von Elm et al., 2007).

2.1 | Sample/participants

The participants were adult (older than 18 years) professional caregivers working in home care services in the German-speaking part of Switzerland. Professional caregivers working in home care services of all educational levels were included: registered nurses, health specialists (a 3-year apprenticeship with a focus on basic care that ends with a diploma, but a health specialist does not have the competencies of a nurse), nursing assistants (a marginal education of 17 days' theoretical content and a 2-week practice session that ends with a certificate) and house aides (same education as nursing assistants, but with a focus on working to support households). Persons with different education (e.g. social workers) or similar education (those who work as nursing assistants) were also included, and so were persons working in direct contact with clients during nursing assignments. A total of 24 home care organizations participated in the study.

In line with the exploratory approach of the project, a convenience sampling strategy was applied. The home care service associations of non-profit organizations as well as those of the for-profit organizations in the German-speaking part of Switzerland were asked to spread the news of the study through their network. Further, the study proposal was presented in meetings of the operational managers and spread through the professional network of the research team. Interested organizations contacted the main author for further information. The contact person, either an operational manager or a nursing expert, received instructions to provide an envelope containing a prepaid and addressed answer envelope, the hard copy of the survey and an information sheet to the employees of the home care service and to inform them in a team meeting regarding the participation of the organization in the study. They were instructed not to put pressure on employees regarding participation. The following inclusion criteria were used: age over 18 years, working in direct contact with clients and working in a participating home care service.

2.2 | Data collection

Data were obtained using the Survey of Violence Experienced by Staff (German version revised) (SOVES-G-R) (Hahn et al., 2011; McKenna, 2004), which contains the Impact of Patient Aggression on Carers Scale (IMPACS) (Needham et al., 2005). Data were collected between July and October 2019. A total of 1923 hard-copy questionnaires were provided to the contact persons of the organizations. This number was the total of adult employees working in direct contact with the clients in the participating home care service organizations, that is, the number of potential participants. The contact persons delivered the questionnaires to the participants, who were assured of anonymity and voluntary participation by the project team information sheet. This sheet, as well as the hard copy of the questionnaire, mentioned that by completing and returning the questionnaire, the participants provided their consent. The participants were instructed not to provide any identifying personal information in the questionnaire. The questionnaires were marked with a specific code for each organization.

The information sheet also stated that the participants had 2 months to answer the survey. After a month, the research team sent a reminder to the contact persons of the organizations, along with the number of the returned questionnaires. The contact persons reminded the potential participants to complete the questionnaire using the usual information sources of the specific organization (mail, meeting or information sheet). The data from the questionnaire hard copies were transferred into an SPSS file using a codebook. To ensure the correctness of the data, a double-entry check was made on 10% of the data set: The error rate was 0.2%.

2.3 | Instruments

We used the SOVES-G-R (Hahn et al., 2011; McKenna, 2004), which includes socio-demographic data as well as the IMPACS (Needham et al., 2005). It is the appropriate instrument for this investigation because it contains questions regarding organizational support, team support, management support, aggression management training and burden after aggressive incidents.

SOVES contains 65 questions across eight sections. Originally developed by McKenna (2004) and tested for content validity by the European Violence in Psychiatry Group (McKenna, 2004), SOVES was translated into German and validated by Hahn et al. (2011). This survey was also used in a long-term care facility in Switzerland (Zeller et al., 2012). To meet specific issues of the home care setting, we adapted SOVES-G-R regarding wording, influencing and triggering factors (Section D) and specific measures (Section E). Face validity was tested with a nurse, a health specialist and a nursing assistant working in home care services. Marginal changes were made based on the feedback received. In this manuscript, a total of 34 questions from Sections A and F–H were included.

General information on the participants were assessed with SOVES-G-R Section A, such as socio-demographic data, with one yes/no question and eight objective-type questions. The consequences of aggressive incidents were assessed with Section F of SOVES-G-R, which also includes IMPACS, an instrument to measure negative feelings after experiencing aggressive behaviour. Section F explores the consequences of aggressive incidents and consists of two yes/no questions (regarding fear and sick leave), one

subjective-type question to describe what factors lead to fear, one objective-type question with four choice options regarding the form of sick leave after an aggressive incident, three questions with an exit option (e.g. no threat experienced) and a 5-point Likert scale with each to assess the experience of burden (1 = *not upsetting* to 5 = upsetting) and a multiple-choice question to assess the support needed. Needham et al. (2005) had conducted IMPACS psychometric testing with satisfying results (Cronbach's alpha = 06.–0.78). It consists of 10 items on 5-point Likert scales (1 = *never* to 5 = *always*) with higher scores representing more negative feelings (Needham et al., 2005).

Organizational support, team support and management support were explored with the SOVES-G-R Section G, which assesses organizational support as well as documentation and reporting of aggression events with five statements regarding staff and management support on a 5-point Likert scale (1 = *completely agree* to 5 = *completely disagree*), two yes/no questions and two objective-type questions on documentation, official procedures and reporting systems.

Aggression management training was explored with Section H that assesses training in aggression management and consists of 10 statements regarding skills measured on a 4-point Likert scale (1 = *very good* to 4 = *not good*), one yes/no question and one objective-type question.

The SOVES-G-R sections not included in this study are described briefly: Section B assesses the form of aggression experienced during work time; Section C assesses the frequency, perpetrator and form of aggression experienced within the last 12 months; Section D assesses the aggressive incidents experienced within the last 7 working days; and Section E assesses which measures were taken quickly and from a long-term perspective after an aggressive incident. At the end of the survey is a free text field named 'personal remarks and amendments' for additional comments.

2.4 | Ethical considerations

The study was reviewed and approved by the responsible ethics committee (Project ID: 2019-00502 EKOS: 19/041).

2.5 | Data analysis

Variables were analysed using descriptive statistics (frequencies). After an explorative analysis of the data set, multiple regression models were calculated for assessing relationships between organizational support (self-rated skills) and perceived burden or negative feelings after an aggressive incident. Associations between self-rated skills and received aggression management training were investigated using logistic regression. Assumptions were checked, and outliers (cases with standardized absolute residuals greater than three) were eliminated. We conducted the statistical analysis using IBM SPSS Statistics (Version 25). A level of significance of 0.05 was assumed.

3 | RESULTS

From the 1923 questionnaires sent out, 874 were returned, or a response rate of 45.4%. We excluded 22 (2.5%) questionnaires from analysis either because the cover pages were missing ($n = 1$), less than 50% of the questionnaire was answered ($n = 13$) or socio-demographic data were not provided ($n = 8$). The final sample of 852 questionnaires (44.3%) was used for data analysis.

3.1 | Description of the organizations and participants

A total of 24 home care service organizations with employees ranging from 23 to 319 participated in our study. Table 1 illustrates the socio-demographic data of the participants. The mean response rate was 55.6%, ranging from 4.0% to 92.0%. The two organizations that did not allow filling the questionnaire during working hours had a response rate of under 30.0%. Whereas a majority of the participating organizations had under 50 employees ($n = 12$), eight organizations had 51–150 employees, and the rest ($n = 4$) had more than 150 employees. Four of the participating organizations were located in rural, five in urban and 15 in suburban areas. Two organizations were for-profit organizations, and the rest, non-profit.

3.2 | Organizational structures

A third (33.3%, $n = 284$; missing: $n = 18$; 2.1%) of professional caregivers reported that an official procedure for employees affected by aggressive behaviour was in place at the home care service they worked for. Meanwhile, 17.1% ($n = 146$) reported no official procedure, and 47.4% ($n = 404$) reported that they were not aware of any available official procedure. The documentation of aggressive behaviour was mostly done in the written nursing report (88.3%, $n = 708$, missing: $n = 5$; 0.6%,). About 5% ($n = 43$) of the participants reported a protocol being followed in their organization to document aggressive behaviour, and 22.1% ($n = 188$) reported the availability of an official reporting system. Of the latter, 179 persons answered the question on reporting aggressive incidents: 46.9% ($n = 84$) reported all or nearly all of the incidents, whereas 53.1% ($n = 95$) reported half or less of the aggressive incidents.

A total of 61.5% ($n = 524$) of the professional caregivers stated that support was available at the workplace in general, whereas 61.4% ($n = 523$) reported that specific management team support was available. Nearly half of the participants (49.9%, $n = 425$) said that support from team colleagues was available, 27% ($n = 230$) said employees were reluctant to discuss aggressive behaviour at the workplace, and 12.8% ($n = 109$) said it was difficult to receive support at the workplace in general. Table 2 illustrates the correlation of the items regarding organizational support and the IMPACS items (negative feelings after aggressive incidents). Significant associations

TABLE 1 Socio-demographic characteristics of the participants

Socio-demographic characteristics		Total ($n = 852$)		
		n	(%)	Missing
Sex	Female	818	96.0	$n = 2$; 0.2%
Age (years)	18–29	121	14.2	
	30–45	250	29.3	
	>45	479	56.2	$n = 2$; 0.2%
Education	Nurse	397	46.6	
	Psychiatric nurse	20	2.3	
	Health specialist	210	24.6	
	Nursing assistant	131	15.4	
	House aid and others	80	9.4	$n = 14$; 1.6%
Working experience (years)	0–4	83	9.7	
	5–9	145	17.0	
	10–15	175	20.5	
	>15	442	51.9	$n = 7$; 0.8%
Level of employment	<50%	300	35.2	
	50%–79%	225	26.6	
	80%–100%	320	37.6	$n = 7$; 0.8%
Time of direct contact with care recipient (in relation to total work time)	<30%	91	10.7	
	30%–60%	288	33.8	
	>60%	461	54.1	$n = 12$; 1.4%

Source: Schnelli, Mayer, et al. (2021).

between the items 'support of the management is available', 'support of team colleagues is available', 'difficulty of receiving support at the workplace', 'employees are reluctant to discuss aggressive behaviour at the workplace' and 'support is available at the workplace' with IMPACS items were found. The IMPACS item 'I have a guilty conscience regarding the patient' resulted in no significant correlation with the items regarding organizational support. None of the five aspects of organizational support after aggressive incidents remained in the ANOVA model with 'I have a guilty conscience regarding the patient', and therefore, this item is not illustrated in Table 2.

3.3 | Aggression management training

Our survey found that 48.7% ($n = 415$; missing: 1.3%, $n = 11$) participants received aggression management training during their professional education or their work time as a professional caregiver. None of the house aides or the nursing assistants had received aggression management training. Therefore, the results regarding aggression management training do not involve these persons. Aggression management training was rated as unimportant, slightly important or moderately important by 26.2% ($n = 220$, missing: 1.6%, $n = 14$) and as important or very important by 72.5% ($n = 618$) of the participants. The self-rated skills regarding aggression management strategies are illustrated in Table 3. The skills 'knowledge on physical defence techniques', 'ability to confront patients with their aggressive behaviour' and 'ability to address the needs of persons who show aggressive behaviour' were rated the lowest.

A logistic regression model to find out if self-rated skills are associated with received aggression management training was built. The results of the logistic regression are illustrated in Table 4. Those with better knowledge of physical defence techniques ($p = .000$) as well as the ability to perceive their behaviour in dealing with aggressive patients ($p = .013$) were significantly more likely to have had training and were the only remaining items in the model. There was no significant association between the rating of the skills and aggression management training received in most items.

The analysis found that some skills influence the perception of the burden, especially after verbally aggressive events (Table 5). However, some of the higher rated self-perceived skills engraved the perceived burden after verbally aggressive incidents. Only the self-perceived skills 'ability to seek conversation with the patient with aggressive behaviour' ($B = -.287$, $p = .047$, F_{model}: 3.191 corr. $R^2 = 0.013$, df: (2; 344), $p_{model} = .042$, $n = 347$) and 'ability to set boundaries' ($B = .301$, $p = 0.32$, F_{model}: 3.191 corr. $R^2 = 0.013$, df: (2; 344), $p_{model} = .042$, $n = 347$) had a significant influence on such burden after physically aggressive incidents; there were none for experiencing threats.

TABLE 2 ANOVA: Organizational support and IMPACS

		Support available at the workplace	Support from the management is available	Support from team colleagues is available	Employees are reluctant to discuss aggressive behaviour in the workplace	It is difficult to receive support at the workplace	p_{model}	df	Adj. R^2	*F*	*n*
I have feelings of anger towards the institution I work in	B[a]		−.169	.109		.106		1			
	p		.001	.009		.001	.000	426	.171	23.220	432
I experience a disturbance in the relationship with the patient	B[a]	−.281				-.094		1			
	p	.000				.058	.000	436	.037	9.334	439
I avoid contact with the aggressive patient	B[a]	−.299						1			
	p	.000					.000	431	.071	33.888	433
I feel sorry for the patient	B[a]				−.131			2			
	p				.001		.000	433	.034	8.600	436
I feel insecure at work	B[a]	−.213						1			
	p	.000					.000	427	.041	19.455	430
I feel that I have to deal with society's problems	B[a]		−.234		.101			2			
	p		.000		.023		.000	434	.048	12.029	437
I feel insecure in working with the patient	B[a]				−.115	.134		1			
	p				.003	.001	.000	435	.030	7.758	439
I have feelings of being a failure	B[a]	−.116						1			
	p	.019					.012	429	.012	6.352	432
I feel ashamed of my work	B[a]	−.046						1			
	p	.013					.013	418	.012	6.292	421

[a]Regression coefficient (IMPACS: 1 = *never*, 5 = always; organizational support: 1 = *totally disagree*, 5 = *totally agree*).

TABLE 3 Self-rating of skills in aggression management

Organizational support (*total n = 852*)	Good or very good		Not good or bad		Missing
	n	%	*n*	%	
Ability to seek conversation with the patient with aggressive behaviour	653	76.6	167	19.6	*n* = 32, 3.8%
Ability to protect oneself against physical assaults	643	75.5	177	20.8	*n* = 32, 3.8%
Ability to set boundaries	632	74.2	187	21.9	*n* = 33, 3.9%
Ability to demonstrate that aggressive behaviour will not be tolerated	618	72.5	200	23.5	*n* = 34, 4.0%
Ability to address the needs of aggressive patients	595	69.8	223	26.2	*n* = 34, 4.0%
Ability to show appreciation towards the aggressive person	625	73.4	183	21.5	*n* = 44, 5.2%
Ability to confront aggressive patients about their behaviour	464	54.5	350	41.1	*n* = 38, 4.5%
Knowledge on physical defence techniques	350	41.1	476	55.9	*n* = 26, 3.1%
Ability to perceive one's behaviour in dealing with aggressive patients	708	83.1	109	13.3	*n* = 35, 4.1%
Ability to show understanding of the situation of the aggressive patient	675	79.2	135	15.8	*n* = 42, 4.9%

TABLE 4 Association of aggression management training and self-rated skills

	B[a]	Wald	*p*	Exp(B)	Confidence interval (95%)
Associated self-rated skills to received training					
Knowledge of physical defence techniques	−0.655	25.545	.000	.519	0.419–0.644
Ability to perceive one's behaviour in dealing with aggressive patients	−0.387	7.742	.013	.679	0.500–0.921

Note: Backward stepwise according to likelihood ($n = 707$; Hosmer–Lemeshow test: $p = 0.164$, Nagelkerkes $R^{2:}$ 0.101, classification of prediction: 61.4%; $X^2(2) = 55.584$, $p = .000$, 1 = *very good*, 2 = *good*, 3 = *not good*, 4 = *bad*).
[a]Regression coefficient.

4 | DISCUSSION

To our knowledge, this is the first investigation that surveyed organizational, management and team support and aggression management training conditions and their effect on the negative consequences of aggressive incidents in home care services. It found that availability of organizational support and aggression management conditions reduced negative feelings or burden after aggressive incidents.

Regarding organizational support, there was a lack of availability of reporting systems or internal concepts to prevent or deal with aggressive incidents, in line with the insights received from inpatient settings (Heckemann et al., 2020). A third of the participants reported an established official procedure to deal with aggressive incidents, and 22.1% said there was an official reporting system available, yet the reporting rate in the latter case was poor at under 50%. This conforms to the current literature, confirming that reporting of aggressive incidents is low (Edward et al., 2014). Reasons for non-reporting in inpatient settings are high administrative burden and a lack of time, the fear of stigma after reporting an incident or of no reaction on reporting (Edward et al., 2014; Schnelli et al., 2019). Based on our data, it remains unclear why the reporting rate in the home care setting is poor, and further research on that topic is suggested. As our survey found a poor reporting rate of aggressive incidents, one can suggest that reporting systems are not well established. The importance of measures to aid the implementation of reporting systems has been emphasized by studies in the acute hospital setting (Hahn et al., 2012; Schnelli et al., 2019). In home care settings, the implementation of a reporting system is possibly more challenging because professional caregivers are not physically present in the organization, and therefore, the personal information on the reporting systems is difficult (Genet et al., 2012).

Another aspect regarding organizational support found in the survey was that the general attitude of an organization that makes the employees feel they receive support if they need it leads to reduced negative feelings after aggressive incidents: Availability of support in the workplace is strongly linked to fewer feelings of 'disturbance of the relationship', 'avoidance of contact with the aggressive patient', 'insecurity at work', 'being a failure' and 'shame', whereas difficulties in receiving support at the workplace provoke feelings of 'anger' or 'insecurity' when working with the patient.

In line with research from inpatient settings, the survey identified the support of the management as crucial in the prevention of

TABLE 5 ANOVA abilities and perceived burden after verbally aggressive incidents

Self-rated skills		Burden after verbally aggressive incidents
Ability to seek conversation with the patient with aggressive behaviour	B[a]	*Not in the model*
	p	
Ability to protect oneself against physical assaults	B[a]	.160[b]
	p	.091
Ability to set boundaries	B[a]	*Not in the model*
	p	
Ability to demonstrate that aggressive behaviour will not be tolerated	B[a]	.234[b]
	p	.015
Ability to address the needs of aggressive patients	B[a]	.271[b]
	p	.009
Ability to behave appreciatively towards the aggressive person	B[a]	.211[b]
	p	.042
Ability to confront aggressive patients about their behaviour	B[a]	−.265[b]
	p	.004
Knowledge of physical defence techniques	B[a]	−.194[b]
	p	.010
Ability to perceive own behaviour in dealing with aggressive patients	B[a]	
	p	
Ability to show understanding for the situation of the aggressive patient	B[a]	.165
	p	.077

Note: (adj. $R^2 = 0.108$, F_{model}: 7.471, $df_{model} = (7; 369)$, $p_{model} = .000$, n = 377).

[a]Regression coefficient (self-rated skills: 1 = *very good*, 2 = *good*, 3 = *not so good*, 4 = bad).

[b]Due to the direction of the scales, the signs are to be interpreted as follows: Negative implies higher burden; positive implies lower burden.

negative feelings after aggressive incidents (Heckemann et al., 2020). Availability of support from the management significantly reduces 'anger' and the feeling 'to deal with society's problems' after aggressive incidents. Feelings such as 'anger', 'disturbance of the relationship', 'insecurity' or 'shame' as a perceived consequence of aggressive behaviour might influence the interaction between the professional caregiver and the care recipient, worsening the aggressive behaviour (Richter, 2012). These insights substantiate that organizational and management support is crucial in the primary as well as secondary prevention of aggressive behaviour against professional caregivers. This is also in line with theoretical approaches on person-centred care. McCormack and McCance's (2016) person-centred care model establishes that the care environment, such as the workplace, is a crucial aspect of successful caregiving. They state that shared decision-making, effective staff relationships and supportive organizational systems are necessary to provide person-centred care. An organization aiming at person-centred care delivery, therefore, should establish a positive safety culture and provide organizational support. Another aspect of the care environment in a person-centred care model is the presence of effective staff relationships (McCormack & McCance, 2016), which might be influenced on the interpersonal exchange after aggressive incidents and therefore requires the availability of team support. In this study, we investigated the 'reluctance to discuss aggressive incidents', which yielded ambivalent results. On the one hand, this reluctance seemed to reduce feelings of compassion and insecurity in working with the patient, whereas on the other hand increasing the feeling of having to deal with society's problems. Interestingly, 'receiving support from team colleagues' is strongly associated with an increased feeling of 'anger' after aggressive incidents. This result hints that unguided discussions between team colleagues might increase negative feelings against the care recipient. In the light the results of Schnelli, Ott et al. (2021), which disclose that staff with lower education is mostly used in the case of clients with aggressive behaviour, these insights highlight the need for guided reflexive processes. Guided reflexive processes such as case reviews might help reframe the aggressive incidents experienced. Based on these results, an extension of conducting case reviews is indicated in home care services. A lack of professional guided interpersonal discussion of aggressive incidents might decrease the chances of questioning one's actions when working with the patient, decreasing the quality of care.

Questioning one's actions can also be part of aggression management training. Aggression management training was also part of the survey and the results of this study are in line with results from inpatient settings (Heckemann et al., 2015): Less than half of the participants (48.7%) had received aggression management training during their education or work time. However, self-rated skills regarding aggression management were high, but the skills need to be reviewed closely because it is important to include any potential discrepancy between self-rated skills and potentially lower actual skills. The review of self-rated skills and actual skills is an important aspect in intervention development to address aggression management in home care. Increased self-rated skills of 'perceive their behaviour in dealing with aggressive incidents' and 'knowledge of physical defence techniques' were significantly associated with the group that received aggression management training. These results are partly in line with Heckemann et al. (2015), highlighting the positive effect of aggression management training on confidence, attitude, skills and knowledge. However, as Heckemann et al. (2015) state, aggressive management training might not lead to decreased aggressive incidents, but to reduced perceived burden after experiencing aggressive incidents and to increased team resources to deal with the incidents. Our study found that the most sought skills were not positively associated with the group who received aggression management training. This indicates that aggression management training is not sustainable. However, most of the survey participants (72.5%) marked training as important or very important, highlighting its benefits. Aggression management training must be refreshed at regular intervals to ensure sustainability, a practice not being followed by home care services.

It was also found that increased self-rated skills in aggression management might reduce the perceived burden after aggressive incidents, whereas other increased self-rated skills enhance the

perceived burden significantly. The skills 'addressing the needs of the patient', 'acting appreciatively', 'demonstrating that aggressive behaviour is not tolerated' and 'to set boundaries' are associated with decreased perception of burden after aggressive incidents. The finding underlines the importance of knowing one's boundaries and communicating them. The skills 'acting appreciatively' and 'addressing the needs of the patient' during aggressive behaviour indicate a person-centred nursing attitude that might improve well-being during and after aggressive incidents. A constructive way to deal with the situation by 'acting appreciatively' or 'addressing the needs of the patient' might lead to a positive end to the situation, reducing the burden. Aggression management training and nursing education must specifically address these skills in the future. The skills 'confronting aggressive patients with their behaviour' and 'knowledge of physical defence techniques' increased the perceived burden and seem to be of a more confrontative nature. These skills do not address specific situations and, when used, lead to more burden after aggressive incidents. The safety of a physically present team in the background is not assured in the home care setting, indicating that these strategies increase burden instead of decreasing it. Such aspects in the development of future aggression management training must be addressed, with a focus on specific conditions in home care settings. The conditions in home care services should be improved to provide person-centred and need-oriented care while supporting the employees.

4.1 | Limitations

We conducted an explorative cross-sectional survey using a convenience sample that is not representative. Our sample is comparable to the entirety of professional home caregivers in Switzerland, although registered nurses were over-represented (Bundesamt für Statistik, 2020). This indicates that better-educated nurses are more likely to consider the topic relevant because they have more resources gained from their nursing practice. The survey studies which structures for organizational support in the organizations are available; however, the results focus on the German-speaking part of Switzerland, making the transferability of the results possible with caution. Our results are partly in line with research in the field of aggression management and its lack around home care settings. This study with an exploratory approach gains basic insights on the topic; however, further research is necessary to strengthen these insights.

5 | CONCLUSION

Home care services in the German-speaking part of Switzerland have established organizational support structures. However, reporting systems or official procedures are present in very few organizations, and the reporting rate is only under 50%. Therefore, home care organizations should implement such structures urgently and carefully. Organizational and management support can lead to reduced negative feelings after aggressive incidents, underlining the importance of a positive safety culture and promoting guided interpersonal exchange between professional caregivers. Aggression management training should be further established in nursing education, with refreshers tailored to specific situations in home care settings. Aggression management training should especially focus on constructively learning from aggressive behaviour. Further research on organizational structures in home care services with a focus on aggression management and the implementation of aggression management concepts is necessary to improve the situation for professional caregivers and the care recipient regarding the occurrence and consequences of aggressive behaviour.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Leadership in home care services must have a positive safety culture, and regular and specific aggression management training on the agenda. Additionally, the implementation of further measures like reporting systems or regular case reviews is necessary. To implement such measures, specific strategies that address the nature of home care services should be developed. The specific nature of home care services means that staff is not regularly in the spatial structures of the organization and staff exchange is reduced. This makes it challenging to ensure the flow of information regarding client situations or even implementation of innovations.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICS STATEMENT

The study was reviewed and approved by the Ethics Committee Eastern Switzerland, Project ID: 2019-00502 EKOS: 19/041.

AUTHOR CONTRIBUTIONS

Study design: AS, AZ, HM and SO; data collection: AS; data analysis: AS and SO; manuscript preparation: AS, AZ, SO and HM.

DATA AVAILABILITY STATEMENT

Data available only on request due to privacy restrictions.

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REFERENCES

Bundesamt für Statistik. (2020). Hilfe und pflege zu hause. https://www.bfs.admin.ch/bfs/de/home/statistiken/gesundheit/gesundheitswesen/hilfe-pflege-hause.html

Edward, K., Ousey, K., Warelow, P., & Lui, S. (2014). Nursing and aggression in the workplace: A systematic review. *British Journal of Nursing (Mark Allen Publishing)*, *23*(12), 653–659. https://doi.org/10.12968/bjon.2014.23.12.653

Genet, N., Boerma, W., Kroneman, M., Hutchinson, A., & Saltman, R. (2012). *Home care across Europe: Current structure and future challenges*. Observatory Studies Series. World Health Organization.

Hahn, S., Hantikainen, V., Needham, I., Kok, G., Dassen, T., & Halfens, R. J. G. (2012). Patient and visitor violence in the general hospital, occurrence, staff interventions and consequences: A cross-sectional survey. *Journal of Advanced Nursing*, *68*(12), 2685–2699. https://doi.org/10.1111/j.1365-2648.2012.05967.x

Hahn, S., Müller, M., Needham, I., Dassen, T., Kok, G., & Halfens, R. J. (2011). Measuring patient and visitor violence in general hospitals: Feasibility of the SOVES-G-R, internal consistency and construct validity of the POAS-S and the POIS. *Journal of Clinical Nursing*, *20*(17–18), 2519–2530. https://doi.org/10.1111/j.1365-2702.2011.03768.x

Hanson, G. C., Perrin, N. A., Moss, H., Laharnar, N., & Glass, N. (2015). Workplace violence against homecare workers and its relationship with workers health outcomes: A cross-sectional study. *BMC Public Health*, *15*, S11. https://doi.org/10.1186/s12889-014-1340-7

Heckemann, B., Peter, K. A., Halfens, R. J., Schols, J. M., Kok, G., & Hahn, S. (2017). Nurse managers: Determinants and behaviours in relation to patient and visitor aggression in general hospitals. A qualitative study. *Journal of Advanced Nursing*, *73*(12), 3050–3060. https://doi.org/10.1111/jan.13366

Heckemann, B., Siegrist-Dreier, S., Thilo, F. J. S., & Hahn, S. (2020). Team efficacy and leadership in managing aggressive situations in the general hospital setting: A qualitative descriptive analysis of focus groups with ward managers. *Journal of Clinical Nursing*, *29*(5–6), 974–986. https://doi.org/10.1111/jocn.15169

Heckemann, B., Zeller, A., Hahn, S., Dassen, T., Schols, J. M. G. A., & Halfens, R. J. G. (2015). The effect of aggression management training programmes for nursing staff and students working in an acute hospital setting. A narrative review of current literature. *Nurse Education Today*, *35*(1), 212–219. https://doi.org/10.1016/j.nedt.2014.08.003

McCormack, B., & McCance, T. (2016). *Person-centred practice in nursing and health care: Theory and practice*. Wiley-Blackwell.

McKenna, K. (2004). Study of work-related violence. Committee on Workplace Violence. North Eastern Health Board, Ireland (pp. 1–121).

Needham, I., Abderhalden, C., Halfens, R. J. G., Dassen, T., Haug, H.-J., & Fischer, J. E. (2005). The impact of patient aggression on carers scale: Instrument derivation and psychometric testing. *Scandinavian Journal of Caring Sciences*, *19*(3), 296–300. https://doi.org/10.1111/j.1471-6712.2005.00344.x

Netzwerk für Aggressionsmanagement im Gesundheits- und Sozialwesen. (2015). Basiskurs Aggressionsmanagement. https://nags.ch/wp-content/uploads/2020/11/Basiskurs-Beschreibung-04_2015.pdf

OdASanté. (2017) Bildungsplan FaGe. https://www.odasante.ch/fileadmin/odasante.ch/docs/Grundbildung/FaGe/FaGe_BiPla.pdf

Paschali, M., Kamp, D., Reichmann, C., Jaenner, M., Lange-Asschenfeldt, C., & Supprian, T. (2018). A systematic evaluation of impulsive-aggressive behaviour in psychogeriatric inpatients using the staff observation aggression scale-revision (SOAS-R). *International Psychogeriatrics*, *30*(1), S61–S68. https://doi.org/10.1017/S1041610217001600

Richter, D. (2012). Theorien und modelle für aggression und hewalt gegen mitarbeiter im gesundheitswesen. In G. Walter, J. Nau, & N. Oud (Eds.), *Pflegepraxis Psychiatrische Pflege. Aggression und Aggressionsmanagement: Praxishandbuch für Gesundheits- und Sozialberufe* (1st ed.) (pp. 72–88). Huber.

Schablon, A., Wendeler, D., Kozak, A., Nienhaus, A., & Steinke, S. (2018). Prevalence and consequences of aggression and violence towards nursing and care staff in Germany-A survey. *International Journal of Environmental Research and Public Health*, *15*(6). https://doi.org/10.3390/ijerph15061274

Schnelli, A., Fringer, A., & Zeller, A. (2019). Gewalt im akutspital - Einschätzung des nachsorgebedarfs. *Pflegewissenschaft*, *7*(8), 332–341.

Schnelli, A., Mayer, H., Ott, S., & Zeller, A. (2021). Experience of aggressive behaviour of health professionals in home care services and the role of persons with dementia. *Nursing Open (Advance Online Publication)*. https://doi.org/10.1002/nop2.689

Schnelli, A., Ott, S., Mayer, H., & Zeller, A. (2021). Factors associated with aggressive behaviour in persons with cognitive impairments using home care services: A retrospective cross-sectional study. *Nursing Open*, *8*(3), 1345–1359. https://doi.org/10.1002/nop2.751

von Elm, E., Altman, D. G., Egger, M., Pocock, S. J., Gøtzsche, P. C., & Vandenbroucke, J. P. (2007). The strengthening the reporting of observational studies in epidemiology (STROBE) statement: Guidelines for reporting observational studies. *Annals of Internal Medicine*, *147*(8), 573–577. https://doi.org/10.7326/0003-4819-147-8-200710160-00010

Yu, R., Topiwala, A., Jacoby, R., & Fazel, S. (2019). Aggressive behaviours in Alzheimer disease and mild cognitive impairment: Systematic review and meta-analysis. *The American Journal of Geriatric Psychiatry*, *27*(3), S290–S300. https://doi.org/10.1016/j.jagp.2018.10.008

Zeller, A., Dassen, T., Kok, G., Needham, I., & Halfens, R. J. G. (2012). Factors associated with resident aggression toward caregivers in nursing homes. *Journal of Nursing Scholarship: An Official Publication of Sigma Theta Tau International Honor Society of Nursing*, *44*(3), 249–257. https://doi.org/10.1111/j.1547-5069.2012.01459.x

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REVIEW ARTICLE

WILEY

Identifying the evidence base of interventions supporting mental health nurses to cope with stressful working environments: A scoping review

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Abstract

Aim: To scope the evidence on interventions used to help mental health nurses cope with stressful working environments.

Background: Nursing managers may implement interventions to support mental health nurses cope in their role. However, the evidence supporting these interventions has not been recently reviewed.

Methods: A scoping review was conducted which entailed searching and selecting potential studies, undertaking data extraction and synthesis.

Results: Eighteen studies published since 2000 were identified. They employed different designs, ten used quasi-experimental methods. Interventions involving active learning appeared beneficial, for example stress reduction courses and mindfulness. However, small sample sizes, short follow-up periods and variation in outcome measures make it difficult to identify the optimum interventions. No studies have considered cost-effectiveness.

Conclusion: There is some evidence that mental health nurses benefit from interventions to help them cope with stressful working environments. However, higher quality research is needed to establish the effectiveness and cost-effectiveness of different interventions.

Implications for Nursing Management: Managers should provide opportunities and encourage mental health nurses to engage in active learning interventions, for example mindfulness to help them cope with stressful working environments. Nurses also want managers to address organisational issues; however, no research on these types of interventions was identified.

KEYWORDS

burnout, coping, nurses, stress, well-being

1 | INTRODUCTION

Mental health nurses face stressful working environments because of their role in delivering support to people experiencing mental health issues. The role can entail significant emotional labour (Edward et al., 2017), aggression from service users (Jalil et al., 2017) and demanding workloads (Yanchus et al., 2017). This can result in workplace stress (Lanctôt & Guay, 2014), reduced well-being (Edward et al., 2017) and burnout (Morse et al., 2012). Furthermore, it can negatively impact on the quality of care delivered to service users (Roche et al., 2011) and result in increased absenteeism and decreased workplace retention (Lamont et al., 2017).

In response, nurse managers are implementing interventions to support mental health nurses to cope with working in stressful environments (Wood et al., 2019). Interventions include mindfulness practice (Munn, 2018a), resilience training (Foster, Shochet, et al., 2018) and communication skills courses (Traynor, 2017). We define coping as mental health nurses themselves or organisations adopting methods to support people working in mental health services (which are considered stressful environments), so coping is a process rather than a dichotomous variable of someone either coping or not coping (Carson & Kuipers, 1998). Often interventions focus on addressing a specific psychological construct including burnout, resilience or well-being but are comparable in terms of seeking to support mental health nurses to cope with stressful working environments (King & Rothstein, 2010). Furthermore, research has found that relevant psychological constructs are inter-related, so interventions which reduce burnout can also result in people experiencing improvements in their levels of stress and resilience (Lee et al., 2019).

Research has evaluated the impact of interventions supporting mental health nurses. These were reviewed by Edwards and Burnard (2003), who identified that interventions including stress management courses, relaxation sessions and training in psychosocial skills appeared effective. A more recent meta-analysis by Dreison et al. (2018) considered burnout interventions for mental health professionals and had similar findings. Foster et al. (2019) undertook a review focused on resilience and identified that resilience training programmes appear beneficial. Despite these two reviews being conducted a decade after Edwards and Burnard (2003), they all reported similar weaknesses with the evidence base. These included studies having small samples, short follow-up periods and studies using different outcome measures, making comparisons difficult. Whilst these three reviews are useful, they have limitations. Edwards and Burnard's (2003) review was conducted almost twenty years ago; Dreison et al. (2018) do not specifically focus on mental health nurses and Foster et al. (2019) only consider resilience interventions. Consequently, there is a need to understand the breath of literature that evaluates interventions to support mental health nurses to cope with stressful working environments, irrespective of the specific psychological construct that they are aimed at. This will help nurse managers understand the evidence on interventions that they may be implementing whilst also identifying priorities for future research.

1.1 | Aim of the review

The aim of the review is to scope the literature to identify the nature of evidence evaluating interventions supporting mental health nurses to cope with stressful working environments.

2 | METHODS

A scoping review was conducted because we wanted to explore the nature of evidence as well as considering what future research is needed (Armstrong et al., 2011; Grant & Booth, 2009). Scoping reviews can be undertaken iteratively, developing the parameters of the review as literature is identified. We conducted the review in 2020, drawing upon established guidance (Arksey & O'Malley, 2005; Colquhoun et al., 2014) and reporting standards (Tricco et al., 2018) (Appendix S1).

2.1 | Stage 1—Identifying the research questions

The research questions were to scope the nature of evidence on interventions that may help mental health nurses cope with stressful working environments and to identify areas of future research.

2.2 | Stage 2–Identifying the relevant studies

We iteratively refined the inclusion and exclusion criteria after performing the search. Initially, we were unsure about the extent of research on mental health nurses. Consequently, a search process was designed that also identified literature related to any type of nurse or mental health professional, for example psychologists. This gave us the potential to consider the relevance of studies focused on similar occupational groups if there was a lack of literature on mental health nurses.

Database searches were undertaken in MEDLINE, EMBASE, PsycINFO and CINAHL. Search terms were related to workplace, potential interventions, for example yoga, psychological constructs such as stress and staffing terms including team and staff (Appendix S2 provides an example of the search). The search sought to identify the breadth of literature rather than be exhaustive (Grant & Booth, 2009). Consequently, the search strategy did not undergo the extent of refinement that would be undertaken for a systematic review (Morris et al., 2016). We also conducted reference checking of identified reviews for relevant primary studies. A lack of researcher resource prevented us from utilizing other search techniques.

As the search identified a number of studies involving mental health nurses, we amended the inclusion criteria to focus on them. Other inclusion criteria were studies including information on an intervention's impact, be published between 2000 and June 2020 and be in English.

2.3 | Stage 3—Study selection

AF screened all the titles and abstracts, undertaking full-text review on potentially relevant studies. EW and MC provided support including giving a second opinion about some studies' eligibility. We did not have the resources to have two researchers undertake study selection. The results were reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart (Moher et al., 2009).

2.4 | Stage 4—Charting the data

AF undertook data extraction using a standardized form to chart the data. We considered study design, population, sample size, setting, conduct, findings and reported limitations. We also extracted information on the interventions including content and delivery method. We reflected on the quality of studies because it has implications for future research. However, systematic quality appraisal using a specific criteria was not undertaken because it was a scoping rather than systematic review (Munn et al., 2018b).

2.5 | Stage 5—Collating, summarizing and reporting the results

Narrative synthesis was used to collate the extracted data (Barnett-Page & Thomas, 2009).

3 | RESULTS

3.1 | Selection of studies

The search yielded 8,682 records (Figure 1). Initially, 166 duplicates were removed. Following title/abstract review, 8,439 records were excluded. Key reasons for exclusion were studies (a) focused on service users/informal carers or the general public, (b) measuring prevalence or causes of stress-related constructs and (c) staff development. There was a high rate of exclusion because the search was not restricted to studies about mental health nurses (as explained previously). Seventy-seven studies underwent full-text review, 59 were excluded, mainly because the studies were about other types of mental health professionals ($n = 41$). Eighteen studies were included in the review.

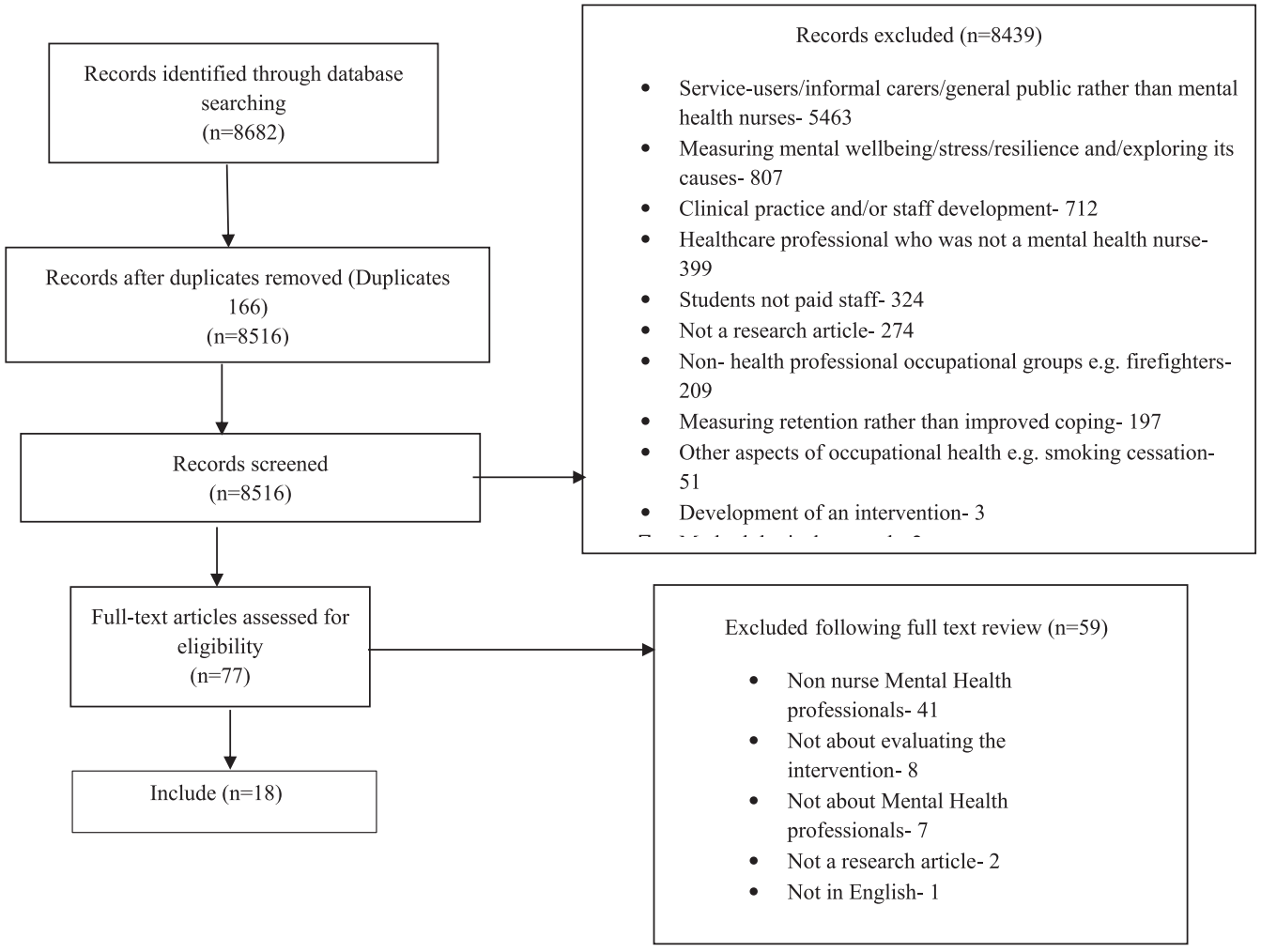

FIGURE 1 PRISMA Statement

3.2 | Description of studies

The 18 studies utilized a variety of study designs (Table 1). Five studies used a quasi-experimental design with intervention and control groups (Alenezi et al., 2019; Ewers et al., 2002; Ghazavi et al., 2010; Hsieh et al., 2020; Nhiwatiwa, 2003). Five studies involved a quasi-experimental design with no control group (Abdelaziz et al., 2020; Edwards, 2015; Flarity et al., 2016; Foster, Shochet, et al., 2018; Sailaxmi & Lalitha, 2015). Safarzei et al. (2016) and Yang et al. (2018) utilized a randomized controlled trial (RCT) design whilst Bernburg et al. (2019) conducted a pilot RCT. Henshall et al. (2020) and Rush (2018) undertook mixed methods. Foster Cuzzillo and Furness (2018) and Olofsson (2005) used qualitative methods including interviews. Finally, Lakeman and Glasgow (2009) conducted action research, involving nurses in designing and evaluating the intervention. The quantitative studies largely focused on impact whilst the qualitative and mixed methods explored both the impact and feasibility of interventions. Foster, Shochet, et al. (2018) and Foster, Cuzzillo, et al. (2018) evaluated the same intervention using different study designs. The majority of studies were published since 2015 ($n = 13$). The studies were based in 12 different countries including the United Kingdom, China and Australia.

The studies were focused on different psychological constructs. The prominent construct was stress (e.g. Yang et al., 2018; Rush, 2018; Sailaxmi & Lalitha, 2015; Ghazavi et al., 2010; Bernburg et al., 2019). Other constructs included resilience, burnout and assertiveness. Regardless of a study's specific focus, the interventions being evaluated appeared similar, for example providing mental health nurses with opportunities to practise relaxation techniques (detailed in Section 3.3).

The quantitative studies were of variable quality. The majority had small sample sizes and short follow-up periods. For example, Edwards (2015) and Flarity et al. (2016) had 10 or less participants. Most of the studies did not consider the long-term impact of interventions, with only Bernburg et al. (2019) measuring outcomes for longer than six months. An additional challenge in comparing findings was that studies used different primary outcome measures including the Maslach Burnout Inventory (Alenezi et al., 2019; Edwards, 2015; Ewers et al., 2002) the Nursing Stress Scale (Yang et al., 2018) and measures designed for the study (Ghazavi et al., 2010; Henshall et al., 2020).

The majority of studies were based in adult inpatient wards and a small number focused on mental health nurses working in specialist services including forensics (Henshall et al., 2020) and dementia care (Edwards, 2015). A small number of studies targeted the interventions at people with higher levels of stress (Yang et al., 2018) or those who had experienced workplace violence (Hsieh et al., 2020; Nhiwatiwa, 2003). Some studies reported recruitment issues because nurses felt stigmatized for accessing support, worrying that nurse managers and colleagues would think that they cannot cope with their role (Henshall et al., 2020).

3.3 | The interventions

All of the studies focused on interventions aimed at individual nurses. The majority of studies evaluated active learning interventions, for example assertiveness training and mindfulness, where nurses had the opportunity to practise coping strategies. Nine studies evaluated group-based courses where participants shared their concerns, learnt about specific mental health constructs, received peer support, developed coping strategies and practised relaxation techniques (Abdelaziz et al., 2020; Alenezi et al., 2019; Bernburg et al., 2019; Flarity et al., 2016; Foster, Cuzzillo, et al., 2018; Foster, Shochet, et al., 2018; Henshall et al., 2020; Safarzei et al., 2016; Sailaxmi & Lalitha, 2015). Four studies focused specifically on relaxation techniques including mindfulness (Edwards, 2015; Hsieh et al., 2020; Rush, 2018; Yang et al., 2018). Two studies evaluated supervision-based interventions (Lakeman & Glasgow, 2009; Olofsson, 2005). Ewers et al. (2002) and Ghazavi et al. (2010) focused on enhancing communication skills. Different to the other studies, Nhiwatiwa (2003) evaluated an information booklet on coping with trauma. None of the identified studies considered organisational- or management-level interventions such as decreasing caseloads, with Foster, Cuzzillo, et al. (2018)) and Henshall et al. (2020) reporting that this was a research gap.

The studies evaluated interventions that were heterogeneous in their length and nature of delivery (Table 1). Variation in length ranged from six all day workshops (Henshall et al., 2020) to a two-hour reflection group (Olofsson, 2005). Fourteen studies focused on in-person group-based interventions whereas others evaluated online interventions (Rush, 2018). One reason for online delivery was that nurses did not always have time to be released from their duties to attend training (Lakeman & Glasgow, 2009). Hsieh et al. (2020) reported no difference in outcomes between in person and online delivery.

3.4 | Identified impact

The identified studies generally reported that mental health nurses appeared to benefit from receiving support, with all of the interventions besides the booklet (Nhiwatiwa, 2003) having a positive impact (Table 1). Benefits included improvements in resilience (Foster, Shochet, et al., 2018), assertiveness (Abdelaziz et al. (2020) and reductions in stress (Yang et al., 2018). One of the larger studies: Alenezi et al. (2019) identified that mental health nurses receiving a burnout prevention group programme experienced a statistically significant reduction in their burnout compared to the control group at 1-month post-intervention ($p = <.001$) and 6 months post-intervention ($p = .04$) (measured by the Maslach Burnout Inventory). Bernburg et al. (2019) also identified that participants experienced a statistically significant improvement in their stress levels when engaging in a mental well-being group at 3 months ($p = <.001$), 6 months ($p = <.001$) and 12 months post-intervention ($p = .01$) (measured by

the Perceived Stress Scale). The only intervention which did not appear beneficial was the booklet, the intervention group experienced a worse outcome than the control group ($p = .03$) (measured using the Impact of Events Scale) (Nhiwatiwa, 2003). Undertaking a meta-analysis would be useful to understand the relative effectiveness of different interventions.

There appears a need for studies which consider the longer-term impact of interventions. This is because there was some evidence that the benefits of an intervention decreased over time. For example, Alenezi et al. (2019) reported that burnout amongst the intervention group increased between 1 month post-intervention: 63.15 (*SD*: 9.85) to 66.15 (*SD*: 17.23) at 6 months post-intervention (measured by the Maslach Burnout Inventory). Furthermore, future studies may want to consider the effect of providing follow-up intervention sessions because Foster, Cuzzillo, et al. (2018)) identified that participants felt they needed additional sessions. None of the identified studies considered whether the interventions were cost-effective. For example, whether the costs of delivering the intervention and covering staff to attend training were offset by reduced absenteeism.

4 | DISCUSSION

The aim of the review was to scope the evidence on interventions used to support mental health nurses cope with stressful working environments. Eighteen studies were identified which used different methods to evaluate a range of interventions including stress management courses and mindfulness practice. The studies indicated interventions involving active learning appeared beneficial. However, many of the quantitative studies had small sample sizes, short follow-up periods and did not consider cost-effectiveness. These factors indicate that whilst nurse managers may want to implement interventions, there is a need for further research to identify the most effective interventions.

Active learning interventions appeared to result in improvement in burnout, resilience and stress. The need to involve active learning reflects the findings of Edwards and Burnard's (2003) review. Furthermore, other reviews of different occupational groups have also identified the importance of active learning (Askey-Jones, 2018; Dreison et al., 2018; Hamilton-West et al., 2018; Richardson & Rothstein, 2008). However, it is unknown which specific interventions are most effective or the optimum delivery models, for example whether the same benefits are derived from 2 or 8 sessions. Consequently, there is a need to undertake a meta-analysis so that recommendations can be made to nurse managers on the relative value of different interventions. At present, the identified studies focus on interventions aimed at supporting individual nurses rather than organisational changes such as reduced caseloads. Nurse managers may want to consider the impact of organisational approaches because mental health nurses feel these approaches are important (Itzhaki et al., 2015). Supporting this rationale is evidence that organisational approaches such as different shift patterns are effective for general nurses (Barrientos-Trigo et al., 2018).

Some studies targeted mental health nurses who had higher levels of stress or who had been assaulted at work whereas other studies were aimed at any mental health nurses. Further research is needed to establish which approach has the greatest impact. This is because Dreison et al. (2018) identified that interventions may have greater impact when targeted at mental health professionals experiencing higher levels of burnout. However, Johnson et al. (2018) propose that all mental health nurses need support because the role generally involves high levels of stress and burnout because of the working environment. Furthermore, the studies were generally based on inpatient settings and nurse managers should consider how relevant the findings are for community-based mental health nurses, who may experience specific stressors, for example lone working (Edwards et al., 2001). Issues were identified that mental health nurses were concerned that accessing support attracted stigma. This is consistent with Knaak et al. (2017) in respect of health care professionals generally. Consequently, future studies need to consider the acceptability alongside the effectiveness of interventions.

We identified similar issues with the evidence base as Edwards and Burnard (2003) including small sample sizes and short follow-up periods. This indicates that the quality of evidence has not evolved and there is a need for further quantitative studies that utilize larger sample sizes and collect outcome measures for longer than 6 months. The latter is important because nurse managers want interventions which provide longer-term benefits (Wood et al., 2019).

The variety of outcome measures used by studies including researchers developing measures specifically for their study makes it difficult to compare the findings of studies. This challenge was also identified in Edwards and Burnard (2003) and Dreison et al. (2018). Consequently, it is recommended that a Core Outcome Set is developed for future studies to utilize (Prinsen et al., 2014). None of the identified studies considered cost-effectiveness. This absence of cost-effectiveness has also been identified in relation to other occupational groups (Pieper et al., 2019), indicating that further research is needed.

A key strength of the review is that it explores recent research on supporting mental health nurses; this is salient because a number of studies have recently been published which had not been synthesized. However, there were six key limitations. First, the search strategy could have been developed further for example, including terms associated with symptoms of mental health illnesses, for example depressive symptoms. Second, there was not the capacity to utilize additional search methods including exploring grey literature, creating publication bias. Third, only including studies published in English may have excluded potentially relevant studies. Fourth, whilst we applied a date limitation to focus on more recent publications, this could have excluded relevant papers. Fifth, limited staff resource meant it was not possible to undertake double selection of the studies. Finally, as it was a scoping review, formal quality assessment of identified studies was not undertaken. However, future

Author (Year)	Country	Setting	Information about the intervention	Type of study	Methods	Sample	Findings[a]
Abdelaziz et al. (2020)	Egypt	Mental health hospital	**Assertiveness training** Intervention was for 1.5–2 hr and consisted of 2–3 sessions a week for 7 weeks delivered in groups of 9. Content included: • Exploring different elements of assertiveness. • Developing coping mechanisms. • Improving communication skills.	Quasi-experimental—all received the intervention	Participants completed measures at baseline and post-intervention. Outcomes measured: • Assertiveness • Well-being	Newly qualified mental health nurses Sample size = 36	Participants experienced an improvement in assertiveness. Baseline: 45.78 (*SD*: 11.12) Post-intervention: 53.75 (*SD*: 8.05) *t* test: 4.204, $p = .001$ (measured by the Rathus Assertiveness Scale)
Alenezi et al. (2019)	Saudi Arabia	Inpatient units	**Burnout prevention training** Intervention entailed 2 × 6 hr programme delivered at the hospital (12 hr) in groups of 20–25 mental health nurses. Content included: • What is burnout and its symptoms. • Developing coping skills, for example social support and communication skills.	Quasi-experimental including randomization at hospital level	Participants completed outcome measures at baseline and 1 and 6 months post-intervention. Outcomes measured: • Burnout	Sample size = 296 Intervention group = 154 Control group = 142	Participants who received the intervention experienced an improvement in burnout. Baseline: Intervention group: 71.13 (*SD*: 1.18) Control group: 66.28 (*SD*: 11.36) 1 month post-intervention: Intervention group: 63.15 (*SD*: 9.85) Control group: 67.93 (*SD*:11.32) $p = <0.001$ 6 months post-intervention: Intervention group: 66.15 (*SD*: 17.23) Control group: 69.99 (*SD*: 11.48) $p = .04$ (Measured by the Maslach Burnout Inventory)
Bernburg et al. (2019)	Germany	Mental health hospital	**Mental Well-being group** Intervention entailed 12 × 1.5–2-hr group sessions of 10–12 mental health nurses, facilitated by a psychologist. Content included • Learning skills in cognitive behaviour therapy and solution focused therapy. • Developing relaxation techniques. • Enhancing communication skills. • Exploring ways of coping with the organisational culture.	Pilot RCT	Participants completed outcome measures at baseline and 1, 6 and 12 months post-intervention. Outcomes measured: • Job stress	Sample size = 86 Intervention group = 44 Control group = 42	Participants who received the intervention experienced a reduction in stress. Baseline: Intervention group: 3.34 (*SD*: 0.49) Control group: 3.49 (*SD*: 0.5) 3 months post-intervention: Intervention group: 2.86 (*SD*: 0.51 Control group: 3.45 (*SD*: 0.52) $p = <0.001$ 6-month intervention: Intervention group: 2.90 (*SD*: 0.59) Control group: 3.39 (*SD*: 0.58) $p = <0.001$ 12 months post-intervention: Intervention group: 3.05 (*SD*: 0.51) Control group: 3.32 (*SD*: 0.47) $p = .01$ (Measured by the Perceived Job Stress Scale)

Author (Year)	Country	Setting	Information about the intervention	Type of study	Methods	Sample	Findings[a]
Edwards (2015)	United States of America	Inpatient unit for people with dementia	**Mindfulness training** Intervention entailed mental health nurses attending 2 × 2 hr group training sessions on mindfulness facilitated by a mental health nurse. Additionally, participants were asked to practise mindfulness for 15–20 min a day for 5 days per week for 2 weeks. Intervention content: • Understanding of stress and its causes. • Learning about mindfulness and its potential benefits. • Developing skills in utilizing mindfulness.	Quasi-experimental—all received the intervention.	Participants completed outcome measures at baseline and post-intervention. Outcomes measured: • Burnout	Sample size = 10	Participants experienced a reduction in burnout. Baseline = 31.3 Post-intervention = 9 *t* test = 6.208 (p = <0.05) (Measured by the Maslach Burnout Scale)
Ewers et al. (2002)	United Kingdom	Forensic services	**Psychosocial intervention training** Intervention consisted of 20 sessions delivered at the hospital by an expert in psychosocial interventions. Content included • Improving understanding of schizophrenia and developing coping strategies for when supporting people with schizophrenia.	Quasi-experimental including randomization	Participants completed outcome measures at baseline and post-intervention. Outcomes measured: • Knowledge of schizophrenia • Burnout	Sample size = 20 Intervention group = 10 Control group = 10	Participants who received the intervention experienced an improvement in emotional exhaustion. Baseline: Intervention group: 13.52 Control group: 18.82 Post-intervention: Intervention group: 10.51 Control group: 18.91 p = .04 (Measured by the Emotional Exhaustion scale of the Maslach Burnout Inventory).
Flarity et al. (2016)	United States of America	Forensic services	**Preventing compassion fatigue workshop** Intervention entailed a 4-hr interactive group workshop delivered by a specialist trainer. Content included: • Learning about compassion fatigue and it symptoms. • Opportunity to develop and practise coping skills to manage compassion fatigue.	Quasi-experimental—all received the intervention	Participants completed measures at baseline and post-intervention. Outcomes measured: • Burnout • Compassion satisfaction	Sample size = 7	Participants experienced an improvement in compassion satisfaction. Baseline: 36.6 Post-intervention: 43.7 p = <0.001 (Measured by the ProQOL)

Author (Year)	Country	Setting	Information about the intervention	Type of study	Methods	Sample	Findings[a]
Foster, Shochet, et al. (2018)[b]	Australia	Inpatient Units	**Resilience training** Intervention entailed 2-day workshops, 3 weeks apart. Booster emails between the sessions & for 3 months afterwards. Content included: • What is resilience and causes of reduced resilience. • How to increase resilience. • Developing and practice coping methods to develop resilience.	Quasi-experimental—all received the intervention.	Participants completed outcome measures at baseline and 3 months post-intervention. Outcomes measured: • Mental health—stress, anxiety and depression • Well-being • Satisfaction with life • Satisfaction with work • Self-efficacy • Resilience	Sample size = 24	Participants experienced decreased stress. Baseline: 12.3 (*SD*: 8.8) 3 months post-intervention: 9.6 (*SD*: 6.8) $p = .02$ (Measured by DASS-21-Stress Component)
Foster, Cuzzillo, et al. (2018)[b]	Australia	Inpatient units	**Resilience training** Intervention entailed 2-day workshops, 3 weeks apart. Booster emails between the sessions & for 3 months afterwards. Content included: • What is resilience and causes of reduced resilience. • How to increase resilience. • Developing and practise coping methods to develop resilience.	Qualitative study	Participants were mental health nurses and facilitators. Data collection included focus groups and interviews. Thematic analysis was used to analyse the data.	Sample size = 29	Participants reported increased knowledge on resilience and how to cope better with work especially with managing traumatic events, for example assault from patients. Participants felt they could also apply the learning to their personal lives. Participants found the group format useful—they learnt from each other and gained peer support. Participants felt receiving support deterred them from leaving their roles. Participants felt follow-up sessions were needed to help them to sustain improvements. Participants felt organisational issues also need to be addressed.
Ghazavi et al. (2010)	Iran	Inpatient units	**Reducing occupational stress by improving communication skills.** 2 × weekly group sessions over 3 weeks. Intervention content: • Developing and trying out communication skills.	Quasi-experimental including randomization	Participants completed outcome measures at baseline, post-interventions and 1 month post-intervention. Outcomes measured: • Stress	Sample size = 45 Intervention group = 23 Control group = 22	Participants who received the intervention experienced a reduction in stress. Baseline: Intervention group: 63.3 Control group: 63.2 Post-intervention: Intervention group: 54.9 Control group: 63.9 $p = .04$ 1 month post-intervention Intervention group: 54.8 Control group: 64.3 $p = .03$ (Measured by a study developed measure)

Author (Year)	Country	Setting	Information about the intervention	Type of study	Methods	Sample	Findings[a]
Henshall et al. (2020)	United Kingdom	Forensic unit	**Resilience training** Interventions entailed 6 full day workshops over 12 weeks. Additionally, participants were provided with mentoring from senior mental health nurses. Intervention content included: • Resilience, spirituality and self-care including developing coping strategies	Mixed methods—Questionnaire and interviews	Semi-structured interviews with mental health nurses and mentors after the intervention was delivered. Participants completed outcome measures at baseline and post-intervention. Outcomes measured: • Resilience	Questionnaire = 26 Mental health nurse interviews = 12 Mentor interviews = 12	Participants experienced an improvement in resilience. Baseline: 3.42 (*SD*: 0.70) Post-intervention: 4.12 (*SD*: 0.60) (t49 = 3.80, p = <0.001, 95% CI = 0.32, 1.07). (Measured by study developed resilience measure) Intervention provided mental health nurses the opportunity to learn more about resilience and to develop coping skills. Participants felt they benefitted from peer support including developing networks. Participants felt the intervention could be useful for any mental health nurses, irrespective of their specific role. Participants were concerned that attending the intervention would attract stigma.
Hsieh et al. (2020)	Taiwan	Inpatient units	**Breathing/relaxation intervention** 2-hr resilience workshop for all participants (the control). This was followed by either: 1 hr weekly sessions for 6 weeks of self-guided training. Or Relaxation sessions delivered by smartphone rather than in person.	Quasi-experimental including randomization	Participants completed measures at baseline and post-intervention. Outcomes measured: • Resilience • Occupational stress • Depressive symptoms	Mental health nurses who had experienced workplace violence in the last 12 months. Sample size = 135 Biofeedback training intervention group = 49 Smart phone intervention group = 47 Control group = 39	Participants who received an intervention experienced an improvement in resilience but there was no difference between those who received the intervention in person or via smartphone. Baseline: Biofeedback training group: 153.98 (*SD*: 26.58) Smartphone delivered training group: 143.13 (*SD*: 26.29) Control group: 151.9 (*SD*:24.56) Post-intervention: Biofeedback training group: 164.15 (*SD*: 23.16) Smartphone delivering training group: 158.77 (*SD*: 19.20) Control group: 153.67 (*SD*: 23.75) Difference between control & two interventions groups was: p = <0.05 No difference between the different models of delivery p = .36 (Measured by the Resilience Scale)

Author (Year)	Country	Setting	Information about the intervention	Type of study	Methods	Sample	Findings[a]
Lakeman and Glasgow (2009)	Trinidad and Tobago	Inpatient Units	**Supervision/reflection groups** The participants co-designed the intervention. Intervention involved a 1-day training session on clinical supervision. People then received 1.5–2 hr of fortnightly supervision for approximately 4 months in groups of 5 mental health nurses. Content included: • Clinical supervision including opportunities to reflect on practice, share learning and develop ways of coping with the role.	Action research project	Mental health nurses met monthly to design then evaluate the intervention through focus groups. Focus groups analysed using thematic analysis.	Sample size = 10	Mental health nurses chose to develop a peer-led supervision intervention. Participants found the support helpful in terms of reflection on their practice and developing ways of coping in their roles. Participants found it difficult to find time to attend the intervention.
Nhiwatiwa (2003)	United Kingdom	Privately funded inpatient units	**Information booklet** Booklet contains information about trauma and potential coping techniques.	Quasi-experimental including randomization	Participants completed measures at baseline and post-intervention. Outcomes measured: • Distress	Mental health nurses who had experienced an assault by a patient in the last month. Sample size = 40 Intervention group = 20 Control group = 20	Participants who received the intervention experienced less improvement than the control group. Baseline: Intervention group: 8.40 (*SD*: 13.22) Control group: 12.62 (*SD*:14.48) Post-intervention: Intervention group: 10.40 (*SD*: 16.79) Control group: 6.62 (*SD*: 8.66) $Z = -2.18$, two-tailed, $p = .03$) (Measured by the Impact of Events Scale)
Olofsson (2005)	Sweden	Inpatient units—one elderly & one adult.	**Supervision/reflection groups** One off reflective group for 1.5–2 hr following a coercive incident. Delivered in groups of 2–4 at the hospital and facilitated by a supervisor. Content included: • Supervision focused on the coercive event and developing coping mechanisms for future events.	Qualitative interviews	Undertook interviews with mental health nurses participating in the intervention.	Mental health nurses involved in a coercive incident, for example restraint. Sample size = 23	Participants valued receiving peer support. Receiving clinical supervision helped mental health nurses manage their role. Participants found it difficult to attend the intervention because of getting cover for their role. Participants felt it was important that the intervention was facilitated by someone skilled. Not all mental health nurses felt they needed support.
Rush (2018)	United States of America	Inpatient units	**Mindfulness training** Interventions entailed 4 × 30 min weekly online modules. Content included: • Learning about mindfulness. • Developing skills in mindfulness and incorporating it into work and personal lives.	Mixed methods—focus group and questionnaire after the intervention.	Focus groups with mental health nurses. Participants completed outcome measures after receiving the intervention. Outcomes measured: • Stress	Questionnaire = 16 Focus group = 2	87.5% of participants reported that they found the mindfulness programme helpful and acceptable. Participants reported that the resources were accessible and they were able to use mindfulness to manage workplace stress.

Author (Year)	Country	Setting	Information about the intervention	Type of study	Methods	Sample	Findings[a]
Safarzei et al. (2016)	Iran	Inpatient units	**Stress management intervention** Intervention entailed 2 × 4 hr stress inoculation workshops a week apart. Participants also received a fortnightly phone call with a researcher during and after the intervention to check in. Content included: • Developing an understanding of stress and causes. • Exploring ways of managing stress including relaxation techniques and time management. • Developing coping mechanisms.	RCT (waitlist control)	Participants completed outcome measures at baseline, post-interventions and 1 month post-intervention. Outcomes measured: • Work–life quality	Sample size = 60 Intervention group = 30 Control group = 30	Participants who received the intervention experienced an improvement in their work life quality. Baseline: Intervention group: 80 (*SD*: 13.8) Control group: 83.4 (*SD*: 11.4) Post-intervention: Intervention group: 86.7 (*SD*: 18.1) Control group: 83.3 (*SD*: 11.0) 1 month post-intervention: Intervention group: 88.3 (*SD*: 17.6) Control group: 82.7 (*SD*: 10.9) $p = <0.001$ (Measured by Dargahi's work life quality questionnaire)
Sailaxmi and Lalitha (2015)	India	Inpatient units	**Stress management intervention** Interventions entailed 2 × 1 hr session a week for 9 weeks delivered in groups of 10 mental health nurses. Content included: • Exploring what is stress and its causes. • Developing coping techniques. • Learning relaxation and assertiveness methods.	Quasi-experimental—all received the intervention.	Participants completed outcome measures at baseline, post-intervention and 4 weeks post-intervention Outcomes measured: • Stress	Mental health nurses who had at least a years' experience. Sample size = 53	Participants experienced a reduction in stress. Baseline: 57.45 (*SD*: 16.42) Post-intervention: 41.06 (*SD*: 16.51) $p = <0.001$ 4 weeks post-intervention: 26.43 (12.82) $p = <0.001$ (Measured by the DCL stress scale)
Yang et al. (2018)	China	Mental health settings	**Mindfulness training** Sessions over 8 weeks that could be done at home or at work. Content included: • Learning about stress • Developing and practising mindfulness.	RCT	Participants completed outcome measures at baseline and post-intervention. Outcomes measured: • Stress • Anxiety • Depression	Mental health nurses experiencing higher levels of stress. Sample size = 100 Intervention group = 50 Control group = 50	Participants who received the intervention experienced a reduction in stress. Baseline: Intervention group: 83.9 (*SD*: 8.3) Control group: 84.8 (*SD*: 8.1) Post-intervention: Intervention group: 68.2 (*SD*: 9.1) Control group: 83.1 (*SD*: 8.4) $p = <0.001$ (Measured by the Nursing Stress Scale)

[a] The reporting of statistical tests is limited by what the authors included in their paper.[b] These two studies were evaluating the same intervention.

reviews should do this, so that nurse managers can understand the nature of evidence underpinning potential interventions.

5 | CONCLUSION

There have been a number of studies identifying interventions which can support mental health nurses develop their coping mechanisms. Further primary research along with meta-analyses is needed to establish the most effective interventions including the optimum delivery models, the cost-effectiveness of interventions and whether they have longer-term benefits.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Emerging evidence indicates that managers should encourage and provide opportunities for mental health nurses to engage in interventions which support nurses develop techniques to help them cope with stressful working environments. However, to date it is not possible to make recommendations on which interventions are most beneficial, the optimum delivery models, whether nurses sustain improvements, the cost-effectiveness of providing support and whether some nurses should be prioritized for support. Furthermore, there is a gap in the literature evaluating organisational- and management-level interventions. Given the limitations of the current evidence base, nurse managers are encouraged to evaluate any interventions that they deliver.

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CONFLICT OF INTEREST

All of the authors declare that we have no conflicts of interests.

ETHICAL APPROVAL

Ethical approval was not required for this paper.

DATA AVAILABILITY STATEMENT

As it is a review all the data is drawn from articles available in the public domain.

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REFERENCES

Abdelaziz, E., Diab, I., Ouda, M., Elsharkawy, N., & Abdelkader, F. (2020). The effectiveness of assertiveness training program on psychological wellbeing and work engagement among novice psychiatric nurses. *Nursing Forum*, *55*, 309–319. https://doi.org/10.1111/nuf.12430

Alenezi, A., McAndrew, S., & Fallon, P. (2019). Burning out physical and emotional fatigue: Evaluating the effects of a programme aimed at reducing burnout among mental health nurses. *International Journal of Mental Health Nursing*, *28*, 1042–1052. https://doi.org/10.1111/inm.12608

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*, 19–32. https://doi.org/10.1080/1364557032000119616

Armstrong, R., Hall, B. J., Doyle, J., & Waters, E. (2011). Cochrane Update. 'Scoping the scope' of a cochrane review. *Journal of Public Health*, *33*, 147–150. https://doi.org/10.1093/pubmed/fdr015

Askey-Jones, R. (2018). Mindfulness-based cognitive therapy: An efficacy study for mental health care staff. *Journal of Psychiatric and Mental Health Nursing*, *25*, 380–389. https://doi.org/10.1111/jpm.12472

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: A critical review. *BMC Medical Research Methodology*, *9*, 59. https://doi.org/10.1186/1471-2288-9-59

Barrientos-Trigo, S., Vega-Vázquez, L., De Diego-Cordero, R., Badanta-Romero, B., & Porcel-Gálvez, A. M. (2018). Interventions to improve working conditions of nursing staff in acute care hospitals: Scoping review. *Journal of Nursing Management*, *26*, 94–107. https://doi.org/10.1111/jonm.12538

Bernburg, M., Groneberg, D. A., & Mache, S. (2019). Mental health promotion intervention for nurses working in German psychiatric hospital departments: A pilot study. *Issues in Mental Health Nursing*, *40*, 706–711. https://doi.org/10.1080/01612840.2019.1565878

Carson, J., & Kuipers, E. (1998). Stress management interventions. In S. Hardy, J. Carson, & B. Thomas (Eds.), *Occupational stress: Personal and professional approaches*. Stanley Thornes.

Colquhoun, H., Levac, D., O'Brien, K., Straus, S., Tricco, A., Perrier, L., Kastner, M., & Moher, D. (2014). Scoping reviews: Time for clarity in definition, methods, and reporting. *Journal of Clinical Epidemiology*, *67*(12), 1291–1294. https://doi.org/10.1016/j.jclinepi.2014.03.013

Dreison, K., Luther, L., Bonfils, K., Sliter, M., McGrew, J., & Salyers, M. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. *Journal of Occupational Health Psychology*, *23*(1), 18–30. https://doi.org/10.1037/ocp0000047

Edward, K., Hercelinskyj, G., & Giandinoto, J. (2017). Emotional labour in mental health nursing: An integrative systematic review. *International Journal of Mental Health Nursing*, *26*, 215–225. https://doi.org/10.1111/inm.12330

Edwards, D., & Burnard, P. (2003). A systematic review of stress and stress management interventions for mental health nurses. *Journal of Advanced Nursing*, *42*(2), 169–200. https://doi.org/10.1046/j.1365-2648.2003.02600.x

Edwards, D., Burnard, P., Coyle, D., Fothergill, A., & Hannigan, B. (2001). A stepwise multivariate analysis of factors that contribute to stress for mental health nurses working in the community. *Journal of Advanced Nursing*, *36*, 805–813. https://doi.org/10.1046/j.1365-2648.2001.02035.x

Edwards, L. W. B. (2015). A mindfulness and health promotion program to decrease the perception of stress and burnout in psychiatric mental health nurses who provide direct patient care to individuals in mental health units with a diagnosis of Alzheimer's type dementia. *Doctoral Projects*, *7*.

Ewers, P., Bradshaw, T., McGovern, J., & Ewers, B. (2002). Does training in psychosocial interventions reduce burnout rates in forensic nurses? *Journal of Advanced Nursing*, *37*, 470–476. https://doi.org/10.1046/j.1365-2648.2002.02115.x

Flarity, K., Nash, K., Jones, W., & Steinbruner, D. (2016). Intervening to improve compassion fatigue resiliency in forensic nurses. *Advanced Emergency Nursing Journal*, *38*, 147–156. https://doi.org/10.1097/TME.0000000000000101

Foster, K., Cuzzillo, C., & Furness, T. (2018). Strengthening mental health nurses' resilience through a workplace resilience programme: A qualitative inquiry. *Journal of Psychiatric and Mental Health Nursing*, *25*(5–6), 338–348. https://doi.org/10.1111/jpm.12467

Foster, K., Roche, M., Delgado, C., Cuzzillo, C., Giandinoto, J., & Furness, T. (2019). Resilience and mental health nursing: An integrative review of international literature. *International Journal of Mental Health Nursing*, *28*(1), 71–85. https://doi.org/10.1111/inm.12548

Foster, K., Shochet, I., Wurfl, A., Roche, M., Maybery, D., Shakespeare-Finch, J., & Furness, T. (2018). On PAR: A feasibility study of the Promoting Adult Resilience programme with mental health nurses. *International Journal of Mental Health Nursing*, *27*, 1470–1480. https://doi.org/10.1111/inm.12447

Ghazavi, Z., Lohrasbi, F., & Mehrabi, T. (2010). Effect of communication skill training using group psychoeducation method on the stress level of psychiatry ward nurses. *Iranian Journal of Nursing and Midwifery Research*, *15*, 395–400.

Grant, M. J., & Booth, A. (2009). A typology of reviews: An analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal*, *26*, 91–108. https://doi.org/10.1111/j.1471-1842.2009.00848.x

Hamilton-West, K., Pellatt-Higgins, T., & Pillai, N. (2018). Does a modified mindfulness-based cognitive therapy (MBCT) course have the potential to reduce stress and burnout in NHS GPs? Feasibility study. *Primary Health Care Research & Development*, *19*, 591–597. https://doi.org/10.1017/S1463423618000129

Henshall, C., Davey, Z., & Jackson, D. (2020). The implementation and evaluation of a resilience enhancement programme for nurses working in the forensic setting. *International Journal of Mental Health Nursing*, *29*, 508–520. https://doi.org/10.1111/inm.12689

Hsieh, H.-F., Huang, I.-C., Liu, Y., Chen, W.-L., Lee, Y.-W., & Hsu, H.-T. (2020). The effects of biofeedback training and smartphone-delivered biofeedback training on resilience, occupational stress, and depressive symptoms among abused psychiatric nurses. *International Journal of Environmental Research and Public Health*, *17*, 2905. https://doi.org/10.3390/ijerph17082905

Itzhaki, M., Peles-Bortz, A., Kostistky, H., Barnoy, D., Filshtinsky, V., & Bluvstein, I. (2015). Exposure of mental health nurses to violence associated with job stress, life satisfaction, staff resilience, and post-traumatic growth. *International Journal of Mental Health Nursing*, *24*, 403–412. https://doi.org/10.1111/inm.12151

Jalil, R., Huber, J. W., Sixsmith, J., & Dickens, G. L. (2017). Mental health nurses' emotions, exposure to patient aggression, attitudes to and use of coercive measures: Cross sectional questionnaire survey. *International Journal of Nursing Studies*, *75*, 130–138. https://doi.org/10.1016/j.ijnurstu.2017.07.018

Johnson, J., Hall, L., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications, and recommendations for future interventions. *International Journal of Mental Health Nursing*, *27*(1), 20–32. https://doi.org/10.1111/inm.12416

King, G., & Rothstein, M. (2010). Resilience and leadership: The self-management of failure. In M. Rothstein, & R. Burke (Eds.), *Self-management and leadership development* (pp. 361–394). Edward Elgar Publishing Limited.

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum*, *30*, 111–116. https://doi.org/10.1177/0840470416679413

Lakeman, R., & Glasgow, C. (2009). Introducing peer-group clinical supervision: An action research project. *International Journal of Mental Health Nursing*, *18*, 204–210. https://doi.org/10.1111/j.1447-0349.2009.00602.x

Lamont, S., Brunero, S., Perry, L., Duffield, C., Sibbritt, D., Gallagher, R., & Nicholls, R. (2017). 'Mental health day' sickness absence amongst nurses and midwives: Workplace, workforce, psychosocial and health characteristics. *Journal of Advanced Nursing*, *73*, 1172–1181. https://doi.org/10.1111/jan.13212

Lanctôt, N., & Guay, S. (2014). The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences. *Aggression and Violent Behavior*, *19*, 492–501. https://doi.org/10.1016/j.avb.2014.07.010

Lee, Y., Lee, J., Kim, J., Shin, I., Yoon, J., & Kim, S. (2019). A comparative study of burnout, stress, and resilience among emotional workers. *Psychiatry Investigation*, *19*(9), 686–694. https://doi.org/10.30773/pi.2019.07.10

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D., PRISMA Group (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Med*, *6*(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

Morris, M., Boruff, J., & Gore, G. (2016). Scoping reviews: Establishing the role of the librarian. *Journal of the Medical Library Association: JMLA*, *104*(4), 346–354. https://doi.org/10.3163/1536-5050.104.4.020

Morse, G., Salyers, M., Rollins, A., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health*, *39*(5), 341–352. https://doi.org/10.1007/s10488-011-0352-1

Munn, F. (2018a). Trusts use mindfulness to boost staff resilience. *Nursing Standard*, *32*(24), 9–9. https://doi.org/10.7748/ns.32.24.9.s6

Munn, Z., Peters, M. D. J., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018b). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology*, *18*, 143. https://doi.org/10.1186/s12874-018-0611-x

Nhiwatiwa, F. (2003). The effects of single session education in reducing symptoms of distress following patient assault in nurses working in medium secure settings. *Journal of Psychiatric and Mental Health Nursing*, *10*, 561–568. https://doi.org/10.1046/j.1365-2850.2003.00661.x

Olofsson, B. (2005). Opening up: Psychiatric nurses' experiences of participating in reflection groups focusing on the use of coercion. *Journal of Psychiatric and Mental Health Nursing*, *12*, 259–267. https://doi.org/10.1111/j.1365-2850.2005.00827.x

Pieper, C., Schröer, S., & Eilerts, A. (2019). Evidence of workplace interventions-A systematic review of systematic reviews. *International Journal of Environmental Research and Public Health*, *16*(19), 3553. https://doi.org/10.3390/ijerph16193553

Prinsen, C., Vohra, S., Rose, M., King-Jones, S., Ishaque, S., Bhaloo, Z., Adams, D., & Terwee, C. (2014). Core Outcome Measures in Effectiveness Trials (COMET) initiative: Protocol for an international Delphi study to achieve consensus on how to select outcome measurement instruments for outcomes included in a 'core outcome set'. *Trials*, *15*, 247. https://doi.org/10.1186/1745-6215-15-247

Richardson, K., & Rothstein, H. (2008). Effects of occupational stress management intervention programs: A meta-analysis. *Journal of Occupational Health Psychology*, *13*, 69–93. https://doi.org/10.1037/1076-8998.13.1.69

Roche, M., Duffield, C., & White, E. (2011). Factors in the practice environment of nurses working in inpatient mental health: A partial least squares path modeling approach. *International Journal of Nursing Studies*, *48*, 1475–1486. https://doi.org/10.1016/j.ijnurstu.2011.07.001

Rush, K. (2018). *Paving the path to mindfulness: Implementation of a program to reduce stress and burnout in inpatient psychiatric nurses*. University of North Carolina at Chapel Hill Graduate School.

Safarzei, E., Darban, F., & Mazloum, S. (2016). Effect of stress on the nurses' work life quality in psychiatric ward. *IIOAB Journal*, *7*, 16–21.

Sailaxmi, G., & Lalitha, K. (2015). Impact of a stress management program on stress perception of nurses working with psychiatric patients. *Asian Journal of Psychiatry*, *14*, 42–45. https://doi.org/10.1016/j.ajp.2015.01.002

Traynor, M. (2017). *Critical resilience for nurses: An evidence-based guide to survival and change in the modern NHS*. Routledge.

Tricco, A., Lillie, E., Zarin, W., O'Brien, K., Colquhoun, H., Levac, D., Moher, D., Peters, M., Horsley, T., Weeks, L., Hempel, S., Akl, E., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M., Garritty, C., … Straus, S. (2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of Internal Medicine*, *169*, 467–473. https://doi.org/10.7326/M18-0850

Wood, E., Mason, A., French, S., & Weich, S. (2019). *Building resilience in mental health wards working on adult acute inpatient wards*. HSRUK 2019 Manchester.

Yanchus, N., Periard, D., & Osatuke, K. (2017). Further examination of predictors of turnover intention among mental health professionals. *Journal of Psychiatric and Mental Health Nursing*, *24*, 41–56. https://doi.org/10.1111/jpm.12354

Yang, J., Tang, S., & Zhou, W. (2018). Effect of mindfulness-based stress reduction therapy on work stress and mental health of psychiatric nurses. *Psychiatria Danubina*, *30*, 189–196. https://doi.org/10.24869/psyd.2018.189

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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ORIGINAL ARTICLE

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Initial testing of the use of the Safer Nursing Care Tool in a Canadian acute care context

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Abstract

Aim: Initial testing of England's Safer Nursing Care Tool for adult in-patient acute care wards in a university-affiliated Canadian hospital.

Background: Safe-nursing staffing decisions have significant impacts on patients' safety and quality of care. The Safer Nursing Care Tool was developed in England to provide managers with a validated formula for making appropriate nursing staffing decisions. The tool has been widely used and studied in the UK but has yet to be tested in a Canadian context.

Method: Ten high service quality acute care wards from a university-affiliated Canadian hospital tested the use of the Safer Nursing Care Tool. Service quality, patients' dependency/acuity and staff activity data were benchmarked against information collected in 726 comparable UK wards.

Results: Higher bed occupancy and patient dependency/acuity mix were found in the 10 Canadian wards compared to their UK counterparts. Overall staff activity was comparable between UK and Canadian wards.

Conclusion: The Safer Nursing Care Tool can be applied in this Canadian hospital, and further testing in other hospitals and specialties is required.

Implication for Nursing Management: The Safer Nursing Care Tool is a valid staffing tool to use that, when combined with professional judgement, can help managers to properly establish nursing staff in acute care wards.

KEYWORDS

patient dependency/acuity, safe-nursing staffing, Safer Nursing Care Tool

1 | BACKGROUND

Having the appropriate number of nursing staff in each acute care ward is essential for quality of care and patient safety (Aiken et al., 2014; Griffiths et al., 2016; Griffiths et al., 2018; Hurst, 2005; Kane et al., 2007). However, making a nursing staffing decision is influenced by efficiency and quality of care but also by costs. Indeed, nurses represent the largest group of health care providers, thus a

significant part of a hospital's budget (Kavanagh et al., 2012). Minimum patient-to-nurse ratios have been found to improve the quality of care in Australia and in the United States of America (e.g., Osborne, 2014; Unison, 2015). Individual patient needs play a major role in making appropriate decisions about safe-nursing care and staffing requirements. The National Institute for Health and Care Excellence (NICE, 2014a) highlighted that staffing decisions should be made at a ward level as no staff-to-patient ratio can be applied to all wards equally. Thus, recommended or legislated patient-to-nurse ratios should be used as a general guideline and other workforce planning tools and strategies should be employed (NHS, 2013a). Many tools have been developed to aid the safe-nursing staffing decision-making process, but most tools have not yet been supported by robust evidence-based research (Griffiths et al., 2020). However, the Safer Nursing Care Tool (SNCT) is widely used in England and has been tested in validation studies in United Kingdom (UK) countries (Shelford Group, 2014).

2 | SAFER NURSING CARE TOOL (SNCT)

The SNCT has been developed in England to help the National Health Service (NHS) hospital managers make evidence-based staffing decisions by assessing patient dependency and/or acuity and staff activity (Shelford Group, 2014). The tool was first published in 2006 in conjunction with the Association of United Kingdom University Hospitals. The original SNCT development included over 1,000 acute and rehabilitation wards. The most recent nursing database, which is continuously updated, and from which the SCNT staffing multipliers were developed, includes 1,928 high-quality acute care wards spanning up to 34 clinical specialities. The database stores 2,274,990 timed nursing interventions delivered to 1,255,041 patients allocated to distinct dependency/acuity categories (Hurst, 2020). The SNCT is currently used in about 80% of English NHS' acute care hospitals (Ball et al., 2019) and is the only safe-nursing staffing tool endorsed by the NICE (2014a).

The SNCT is a patient classification system; five levels of care with each level representing patients incrementally reliant on nurses for care and daily activities. According to the Shelford Group (2014), SNCT levels of care are described as follows:

- Level 0: patients with low dependency/acuity who require hospitalization but whose needs are met by normal ward care.
- Level 1a: patients who are acutely ill and who require interventions or who are at a greater risk of deterioration.
- Level 1b: patients who are dependent on nurses for most, if not all, of their daily living activities but whose condition is stable.
- Level 2: deteriorating/single organ compromised patients requiring specialist experienced nursing staff to manage their care within clearly identified, designated beds OR may require transfer to a dedicated Level 2 facility/unit.
- Level 3: patients with complete reliance on nursing care and needing advanced respiratory support or therapeutic support of multiple organs.

Each level of care (0, 1a, 1b, 2, 3) is characterized by clinical descriptors such as the level of dependence of a patient (i.e., required assistance for activity of daily living) and the intensity of the care and clinical surveillance required for the level of acuity of a patient (e.g., frequency of vital sign monitoring post procedure, early warning sign, oxygen requirement). Some other elements are present in the descriptors as well, such as the required supervision for patients presenting a risk of elopement, falls, self-injury and the required time for discharge planning and to support a family. Each time that one of the several elements of the clinical descriptor is found the patient falls into that specific level of dependency and acuity. When elements are found in more than one dependency and acuity level, the highest level is always selected.

Therefore, the SNCT can estimate how many nursing staff are required to provide safe and quality nursing care. The nursing staff include nurses and support workers such as health care assistants. Each dependency/acuity level has a workload multiplier, which represents the nursing staff (expressed in whole time equivalent) required per category. The workload multipliers and the number of patients in each level are used to estimate the total number of whole time equivalent required on a given unit or service. The multipliers have been validated on over 40,000 observations of patient care episodes (NICE, 2014b). Multipliers account for annual or study leave as well as sickness and compassionate leave with at least a 22% uplift (Shelford Group, 2014). The five multipliers have the advantage of providing nursing decision-makers with software supported, simple evidence-based staffing formula derived from data drawn from several hundred high-quality best practice wards.

A recent study by Fanneran et al. (2015) suggested that nursing decision-makers found the SNCT is simple to use and less time-consuming than other workload measures. This study further found that the SNCT is perceived as a valuable resource for making nursing staffing decisions when used in combination with one's professional judgement. However, the same study suggested that the SNCT fails to capture all nursing activities despite non-participant observations including 15 direct care activities; five indirect care; eight associated work (i.e., administrative and clerical work); and four non-productive activities (e.g., coffee breaks). Efforts have been deployed to use and adapt the SNCT to different nursing specialities such as palliative care, hospice wards (Roberts & Hurst, 2013) and community nursing (Kirby & Hurst, 2014). Using the SNCT in different nursing specialities and environment will lead to additional specialty-specific multipliers aligned to care level descriptors and to a better understanding of each speciality/environment workload realities and staffing needs.

3 | THE PRESENT PROJECT

The SNCT has been widely adopted in England, but little is known about the tool's usability in other countries. Thus, we aimed to perform an initial testing of England's SNCT care level descriptors and staffing multipliers in a large university-affiliated Canadian hospital as part of a quality improvement (QI) project. We selected the SNCT because it is currently the only evidence-based staffing evaluation tool

that is based on quality and safety standards. Furthermore, the SNCT has a database from almost two thousand (and growing) best practice wards throughout the UK's NHS health network. Finally and following appropriate training, the SNCT was also selected for this project as it is simple to use, taking about 30 min for a 32-bed unit and requiring only simple daily assessments (i.e., patient dependency/acuity).

4 | METHOD

4.1 | Design

A prospective descriptive design was used for this QI project.

4.2 | Setting and sample

The acute care clinical specialities from both the Canadian and the UK hospitals as well as the patient populations and data collection methods were matched to ensure comparability.

4.2.1 | Canadian hospital

This QI project was conducted in a large university-affiliated Canadian hospital from a major metropolitan city between January 2016 and September 2016. Originally, 12 acute care wards were selected to participate in the QI project but two failed to reach the 70% service quality watermark (Hurst, 2020) and were then excluded. The clinical specialities of the 10 included wards were general and internal medicine, neurology, oncology and the surgical specialities included orthopaedic, colorectal, gynaecology, ENT (ear, nose, throat) and general surgery.

4.2.2 | United Kingdom hospitals

UK acute care wards were matched to Canadian wards according to clinical specialties. A total of 726 UK speciality wards from the acute nursing database similar to the 10 acute care ward's clinical specialities from the Canadian hospital were selected and comprised the UK sample. UK data were collected by independent observers from participating hospitals who undergo standardized training. The same procedure (described below) was used in the Canadian hospital.

4.3 | Procedure

Service quality, patient dependency/acuity and staff activity data from the target Canadian hospital were benchmarked against information collected in the same way in 726 UK wards drawn from the same clinical specialities using identical procedures to ensure that the UK and Canadian patient samples and data collection methods were similar.

4.4 | Measures

4.4.1 | Service quality

To ensure that the data gathered are only from best practice wards, service quality was first assessed. Only wards with acceptable service quality scores were retained (as in the UK database) to generate optimum SNCT staffing multipliers. Five service quality categories (157 items) were assessed both in the UK and in the Canadian hospitals:

- **Category 1:** Patient assessment: its timing and completion (14 items);
- **Category 2:** Care planning: its nature and value (12 items);
- **Category 3:** Nature, timing and implementing interventions suggested in the care plan (80 items);
- **Category 4:** Evaluation of nursing care (11 items); and
- **Category 5:** Ward and management-oriented questions (40 items).

Categories 1–4 applied to each patient, while Category 5 applied to the ward (i.e., not patient related).

The 157 items were developed in the UK context and were reviewed for clarity and relevance to the Canadian context. Clarity (yes/no) and relevance (4-level descriptive scale, i.e., very irrelevant, irrelevant, relevant, very relevant) of items were evaluated by 24 advanced practice nurses (i.e., CNS and nurse educators) and nurse managers. Out of the 157 items, 123 items were evaluated as clear by 80% of the nurses. From the 34 items considered unclear by at least 20% of the nurses, six were in the patient assessment category, four in the care planning category, 13 in the implementation category, one in the evaluation category, and 10 in the ward management category. Most aspects were fixed by adapting terms (e.g., type of assessment, catheter, facilities) to align with the Canadian culture and the Canadian English language (e.g., bed side rail instead of cotsides). Only 12 items were rated as either very irrelevant or irrelevant by at least 20% the nurses. Six of these items were in the implementation category, and six other items were in the ward management category. Overall, 20 items were modified to adapt the language and three were removed according to Canadian standards. For instance, in the implementation category, the patient's name is not displayed on bed in Canada and was removed, and the male patient is not shaved every day but rather done based on patient's preference and was modified accordingly. Also, in the ward management category, electrical equipment is not unplugged when not in use because it has to be plugged in to be charged; therefore, this item was modified. Modifications and adaptation of items were discussed with the UK team to ensure that the meaning of items was preserved.

Service quality categories 1–4 were applied to one third of the patients in each dependency/acuity group (i.e., questions were answered up to 10 times in one ward) for data to reflect ward patient dependency and acuity. Category 5 questions were submitted once in each ward. Consequently, each ward's full audit represents a sizable sample.

4.5 | Safer Nursing Care Tool

Data from the present study were collected by 21 independent observers. Observers did not collect data in their own wards. All were advanced practice nurses, either clinical nurse specialists (CNS) or nurse educators. The qualified independent observers were trained by the research team and the English SNCT academic and clinical leaders. All 21 observers were paired for inter-rater reliability checks of all items of the service quality audits and of the staff activity scoring over three afternoon shifts. Percentages of agreement had to range from 95%–100% between two raters for the results to be considered reliable. For the staff scoring activity, a minimum of two assessments with rater pairs achieving perfect agreement had to be reached before each rater could pursue assessments individually. This ensured reliable data in this QI project.

The original English version of SNCT tool was translated into French Canadian inspired by Sousa and Rojjanasrirat's (2011) four-step back-translation procedure. First, two French-speaking health care professionals independently translated the tool from English to French Canadian. Second, a committee comprising three persons including the two health care professionals who translated the tool and the academic researcher with expertise in health measurement development, adaptation and validation compared the French Canadian versions to the original English version. Disagreements between the two French Canadian versions were resolved until a preliminary French Canadian version was unanimously accepted by the committee. The third step was independently translating the preliminary French Canadian version back into English by two English-speaking individuals who had no prior knowledge of the tool. One was an experienced nurse familiar with health care terminology, and the other was not a health care professional and was familiar with colloquial phrases and idiomatic expressions in English. Finally, the two English versions obtained at step 3 were compared to the original English version by a six-person committee including the two persons who translated the tool into English, one of the two persons who first translated the tool into French Canadian, two health care professionals not yet involved in the tool's translation and the academic researcher. Again, disagreements were discussed and resolved through discussions which resulted in a final French Canadian version. The original English SNCT tool authors were also consulted in order to ensure proper translation.

4.5.1 | Patient dependency/acuity

Patients were assessed over six shifts from the Thursday night shift to the Saturday afternoon shift, thus covering two day shifts, two evening shifts and two night shifts. Weekday and weekend were included to ensure representativeness. Each unit was assessed on a different week by up to four observers. The dependency-rating scale used by the qualified independent observers is available upon request to the author (Hurst, 2020). As a result, patients were placed into four categories ranging from low (Dep. 1) to high (Dep. 4) dependency/acuity. The four categories represent patients of increasing reliance on nurses for daily needs.

4.5.2 | Staff activity

Hurst's (2008) data collection procedure for recording staff activity was followed. Nurses in selected wards were observed over six shifts (covering 24 hr, Monday to Sunday). Staff activity data were collected alongside patient dependency information by hand using hard copies of the tool. Qualified independent observers located all ward staff every 10 min and recorded their primary activity as:

- Direct or face-to-face care;
- Indirect care (activities not at the bedside such as a writing a report);
- Non-nursing/associated work (e.g., non-patient paperwork, routine cleaning); and
- Personal time (unproductive periods such as meal breaks).

4.6 | Analyses

Service quality, bed occupancy, patients' dependency/acuity and staff activity are summarized using descriptive statistics for UK and Canadian acute care wards, and 95% confidence intervals for UK wards. Percentages were obtained for service quality data including the five quality categories. Averages were calculated for number of occupied beds (bed occupancy), number of patients in each dependency/acuity category, staff activity counts and related time (i.e., care hours per activity and care hours per dependency/acuity category). A workload index was also calculated using bed occupancy, patient dependency/acuity mix and staff activity data.

4.6.1 | Data accuracy

The main threat to the SNCT system as a workload-based staffing method is inaccurate patient assessment by ward nurses or staff activity recording inconsistencies by independent (non-participant) observers. The workload-quality method's strength, however, is an implicit data collection accuracy and consistency check, which are difficult to falsify. Direct care ratios are the average time (in hours) of face-to-face care per patient per day in each dependency/acuity category, which were calculated for UK and Canadian wards. We argue that if ward nurses failed to assess patient dependency/acuity accurately, or if non-participant observers wrongly assigned nursing interventions using ward nurse patient classification, then the observed incrementally rising care times from least to most dependent patients would falter.

4.6.2 | SNCT multiplier creation process

Best practice wards in the master database (n = 1,927) are used for several purposes other than SNCT multiplier creation (such as national benchmarking). Consequently, patient and staff activity data are recorded and stored in the main databases using a universal patient classification system (Dep. 1 to Dep. 4) first used for database purposes in 1985. Creating the first SNCT multipliers, in 2006, therefore, meant that dependency/acuity categories had to be recalibrated as SNCT care levels. The process was lengthy and detailed. That is, NHS patients were dual scored, that is assigned a Dep. 1 to Dep. 4 score and a SNCT care level score so that each patient had two dependency/acuity scores. The cross-tabulation in Table 1 summarizes dual scores from almost 48,000 NHS inpatients (taken from the database at the time the Canadian project was underway).

We know from staff activity analysis in best practice wards precisely how much care (as whole time equivalents per patient) Dep. 1 to Dep. 4 patients require. Total patients falling in each Dep. 1 to Dep. 4 category are multiplied by the relevant FTE (full time equivalent) to give the ward's staffing establishment. It is then a process of apportioning dependency Dep. 1 to Dep. 4 FTEs to SNCT care levels: For an illustration, check Table 2.

5 | RESULTS

5.1 | Section 1: Service quality

Service quality scores for all UK wards as well as the 12 wards from the Canadian hospital are described in Table 3. Two Canadian wards had service quality below 70% and were then excluded to avoid extrapolating from suboptimal wards. Results suggested that the overall service quality at the Canadian wards was lower than what was found in the UK wards for three service quality categories: assessment, planning and implementation.

5.2 | Section 2: Data accuracy

Direct care ratios for all 726 UK wards and the 10 wards from the Canadian hospital per patient's dependency/acuity category are presented in Table 4. In the UK wards, the highest dependency/acuity patients (Dep. 4, direct care ratio = 14.9) received almost five times more hands-on care time from ward nursing staff than Dep. 1 patients (direct care ratios = 3.1). In the Canadian hospital, the highest dependency/acuity patients (Dep. 4, direct care ratio = 10.4) received two times more hands-on care time from ward nursing staff than Dep. 1 patients (direct care ratios = 4.9). Thus, findings suggested that more care hours per patient day in the lowest (Dep. 1) dependency/acuity category and less care hours per patient day in the highest dependency/acuity category (Dep. 4) were observed in the Canadian wards compared to their UK counterparts.

5.3 | Section 3: Occupancy and dependency

The average bed occupancy and the patient dependency/acuity for the 10 Canadian hospital wards and their comparable 726 UK wards are described in Table 5. The UK data include 479,160 patient dependency/acuity assessments, while the data from the Canadian hospital include 1,170 patient dependency/acuity assessments. The 10 Canadian wards had a higher bed occupancy rate (30.6) than the UK wards (22, 95% CI: 21–23). Furthermore, the Canadian wards had a patient dependency/acuity mix that generated a heavier workload than their UK counterparts. Specifically, proportionally more patients from the Canadian wards fell into the higher dependency/acuity categories, a difference that was observed for all four dependency/acuity categories. For instance, 3.3 patients per day on average were classified as highly dependent/acute (Dep. 4) in the Canadian wards, while 2.2 (95% CI: 1.2–2.3) patients per day were classified in Dep. 4 in the 726 UK wards.

5.4 | Section 4: Staff activity

In the UK, ward nursing staff activity was observed for a total of 20,772 hr in 776 wards comparable to those selected in Canada resulting in 704,950 recorded ward activities. In the Canadian hospital, ward nursing staff was observed for 480 hr in 10 wards resulting in 26,869 recorded ward activities. Total observations and percentage of time spent in each care category in the UK as well as in the Canadian hospital are described in Table 6. Findings showed that

TABLE 1 Cross-tabulation of dependency level and SCNT care level

Dep. level * SNCT cross-tabulation

	SNCT care level					
Dep. level	0	1a	1b	2	3	Total patients
1	22%	0%	0%	0%	NA	4,388
2	66%	70%	21%	21%	NA	23,888
3	12%	30%	58%	54%	NA	15,684
4	0%	0%	21%	25%	NA	3,978
Total patients	19,740	10,085	13,937	4,176	NA	47,938

TABLE 2 Dependency category, FTE per patient and proportion falling in SNCT Level 0

Dep. category	FTE per patient	Proportion falling into Level 0 (%)
1	0.72	22
2	1.01	66
3	1.56	12
4	2.39	0

Note: Example from this cross-tabulation, a SNCT Level 0 patient, therefore, requires: (a) 22% of Dep.1 FTE, (b) 66% of a Dep.2 FTE, (c) 12% of a Dep.3 FTE, (d) 0% of a Dep.4 FTE, which equates to 1.01 FTEs per patient. The process is repeated to generate SNCT Level 1a to Level 2 multipliers. The Level 3 multiplier, on the other hand, is based on one-to-one patient care and does not require the dual score calculation process. The Dep. conversion to SNCT described here is an illustration. The latest SNCT multipliers are proprietary, copyright, protected by intellectual property and only released to licensed users who sign a non-disclosure agreement. For that reason, SNCT multipliers cannot be published in this article.

TABLE 3 Service quality (%) in UK and Canadian acute care wards

	726 UK wards	95% CI	10 Canadian wards
Overall	78%	77–80	74%
Assessment	69%	68–73	59%
Planning	59%	57–62	56%
Implementation	87%	86–90	78%
Evaluation	68%	67–72	67%
Environment	83%	82–86	82%

Note: 95% CI, confidence interval.

TABLE 4 Direct care ratios in UK and Canadian acute care wards

Wards	*N*	Dep. 1	Dep. 2	Dep. 3	Dep. 4
UK	726	3.1	5.0	8.9	14.9
Canadian	10	4.9	5.8	8.8	10.4

Note: Dep. 1, independent; Dep. 2, low-medium; Dep. 3, medium-high; Dep. 4, dependent.

nearly half of all staff activity was spent in direct patient care (44.8% in UK and 42.1% in Canadian wards). The direct care percentage was higher in the UK than in the Canadian hospital, but it should be noted that the Canadian hospital direct care percentage fell outside the UK's 95% confidence interval lower bound by only 0.3% representing a difference of only three recorded direct care activities per 1,000 observations. The percentage of time spent in indirect care was higher in the Canadian than in the UK wards. Similarly, the percentage of time spent in associated care was lower in the Canadian than in the UK wards. Finally, a higher percentage of time was spent in personal time in the Canadian than in the UK wards related to nurses' contract in Québec. However, personal time should be ruled out of the SNCT comparability decision-making process because the Canadian hospital's break time allowance policy differs to the UK's.

6 | DISCUSSION

In a context of increasing nurse shortage in North America (e.g., Han et al., 2015) and in Europe (e.g., Collins, 2019; Thomas, 2020), and given the significant impact understaffing has on patients care and safety (e.g., Aiken et al., 2014; Griffiths et al., 2016; Griffiths et al., 2018; Hurst, 2005; Kane et al., 2007), it is essential for acute care hospitals to use their nursing resources appropriately. It is believed that the SNCT, a safe-nursing staffing tool, provides managers with the appropriate guidance for making sound staffing decisions. Contrary to policies where staffing decisions are based on patient-to-nurse ratios, the SNCT is more sensitive to the true dynamics of individual wards as it is based on workload and patients' dependency on nursing staff. The SNCT is now widely used in England (Ball et al., 2019), and ample data exist from the English NHS hospital network; however, it has never been trialled in a Canadian context. Thus, the goal of this QI project was to determine whether the SNCT care level descriptors and staffing multipliers established in the UK can be applied in a Canadian hospital.

Overall results supported the use of the England's SNCT multipliers for making safe-nursing staffing decision in the Canadian hospital. Specifically, findings suggested that the direct care ratios and staff activity in the Canadian wards were comparable to their UK counterparts. Some differences were nonetheless detected. The overall service quality was found to be significantly lower in the Canadian hospital even though it reached the pre-determined 70% quality watermark (overall score of 74%). The 726 UK wards' 95% confidence interval indicates that 95% of the best practice UK wards have an overall service quality score between 77% and 80%. It thus appears that the use of the SNCT tool is beneficial to the Canadian hospital because lower quality scores are related to rising workload and understaffing. Another difference was found to be related to bed occupancy and dependency/acuity mix in the 10 Canadian wards that were greater/more dependent/acute than their UK counterparts, which may explain the lower service quality score described above.

7 | IMPLICATION FOR NURSING MANAGEMENT

The implications for nursing management in Canada are extensive as the findings supported that the SNCT tool and its associated staffing multipliers, derived from very large samples of UK acute care wards, can be applied in a Canadian health care context. The SNCT is a validated, easy-to-use tool that is recommended to be administered only twice per year (Shelford Group, 2014), which makes it a safe-nursing staffing tool of no significant burden on managers.

TABLE 5 Bed occupancy and patient dependency/acuity in UK and Canadian acute care wards

	Average bed occupancy	Dep. 1	Dep. 2	Dep. 3	Dep. 4	Assessments	Workload Index
726 UK wards	22	3.3	9.7	6.8	2.2	479,160	2.24
95% CI	21–23	2.03–3.4	8.4–10	6–7	1.2–2.3		2.23–2.49
10 Canadian wards	30.6	0.8	12.3	14.2	3.3	1,170	2.54

Note: Dep. 1, independent patients; Dep. 2, low-medium; Dep. 3, medium-high; Dep. 4, dependent; 95% CI, confidence interval.

TABLE 6 Main staff activity in UK and Canadian acute care wards

	726 UK wards			10 Canadian wards	
Source	Observations	Time spent (%)	95% CI	Observations	Time spent (%)
Direct care	315,936	44.8	42.4–46.1	11,317	42.1
Indirect care	168,804	23.9	23.8–34.1	8,445	31.4
Associated work	123,823	17.6	9–13.7	2,517	9.4
Personal	96,387	13.7	6.5–8.3	4,590	17.1

Note: 95% CI, confidence interval.

Interestingly, the Shelford Group (2014) recommends assessing patients' dependency and acuity specifically in January and in June which would, over time, track seasonal trends in safe-nursing staffing requirements.

As highlighted by several authors (e.g., Griffiths et al., 2020; Mitchell et al., 2017), the SNCT as well as any safe-staffing tool must be used in combination with professional judgement of the person making the assessments and the final staffing decision. This is also ascertained by the Shelford Group who highlights the importance of combining multiple methods such as using the SNCT in combination with qualitative data and professional judgement to make the most appropriate staffing decisions (NHS, 2013b). Thus, the SNCT is a valid and valuable workforce planning tool that, when combined with professional judgement, can be of significant use to nursing management.

8 | LIMITATIONS

The major limitation of this project is that the SNCT was tested in a single Canadian hospital. Findings are appropriate for this particular urban health care organisation from a large urban area, but SNCT testing in other Canadian hospitals from different areas is necessary. Another limitation pertains to including only 10 acute care wards from the Canadian hospital. The inclusion of other speciality wards would be relevant. Comparing nursing culture in Canadian and English hospitals using other variables would strengthen the arguments that SNCT has validity in other Canadian hospitals. Furthermore, it is recommended that the SNCT patient rating system is used for a 20-day minimum to accurately estimate the total nurses that should be employed in each ward (Shelford Group, 2014) and a recent independent review suggested a minimum of 40 days sample (Griffiths et al., 2020). In this QI project, assessments were collected on only six shifts per ward. However, the goal was to determine whether the observed bed occupancy, direct care ratios, patient dependency/acuity and staff activity were comparable to the UK's where nearly 480,000 patient dependency assessments were conducted and 20,772 hr of staff activities was recorded. Finally, the SNCT tool was tested for use with registered nurses in a primary care model in this QI project. Further validation testing would be necessary in a different care model including both registered nurses and licensed practical nurses work owing to their different scope of practice.

9 | CONCLUSION

In summary, this QI project described the SNCT's first use in a Canadian hospital. Findings showed a higher bed occupancy and higher dependency/acuity mix in the Canadian wards compared to their UK counterparts. Although less time appeared to be spent in direct care in the Canadian wards, overall staff activity was similar to what was observed in the UK wards. Thus, findings suggest that the Canadian direct care ratios, the workload index and staff activity are comparable to their UK counterparts. Consequently, the SNCT care level descriptors and staffing multipliers can be applied in this Canadian hospital and potentially at a large scale in Canada.

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CONFLICT OF INTEREST

All authors have no conflict of interest to report.

ETHICAL APPROVAL

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DATA AVAILABILITY STATEMENT

Author elects to not share data.

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REFERENCES

Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., Diomidous, M., Kinnunen, J., Kózka, M., Lesaffre, E., McHugh, M. D., Moreno-Casbas, M. T., Rafferty, A. M., Schwendimann, R., Scott, P. A., Tishelman, C., van Achterberg, T., & Sermeus, W. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *The Lancet*, *383*(9931), 1824–1830. https://doi.org/10.1016/S0140-6736(13)62631-8

Ball, J., Barker, H., Griffiths, P., Jones, J., Lawless, J. A., Burton, C., & Rycroft-Malone, J. (2019). Implementation, impact and costs of policies for safe staffing in acute NHS trusts. *University of Southampton*. https://doi.org/10.5258/SOTON/P0012

Collins, A. (2019). NHSE/I workforce plan reveals reliance on unregistered nurses. *Health Service Journal*. Retrieved from https://www.hsj.co.uk/workforce/exclusive-leaked-nhse/i-workforce-plan-reveals-reliance-on-nursing-associates/7026480.article

Fanneran, T., Brimblecombe, N., Bradley, E., & Gregory, S. (2015). Using workload measurement tools in diverse care contexts: The experience of staff in mental health and learning disability inpatient settings. *Journal of Psychiatric and Mental Health Nursing*, *22*(10), 764–772. https://doi.org/10.1111/jpm.12263

Griffiths, P., Ball, J., Drennan, J., Dall'Ora, C., Jones, J., Maruotti, A., Pope, C., Recio-Saucedo, A., & Simon, M. (2016). Nurse staffing and patient outcomes: Strengths and limitations of the evidence to inform policy and practice. A review and discussion paper based on evidence reviewed for the National Institute for Health and Care Excellence Safe Staffing guideline development. *International Journal of Nursing Studies*, *63*, 213–225. https://doi.org/10.1016/j.ijnurstu.2016.03.012

Griffiths, P., Recio-Saucedo, A., Dall'Ora, C., Briggs, J., Maruotti, A., Meredith, P., Smith, G. B., Ball, J., & the Missed Care Study Group (2018). The association between nurse staffing and omissions in nursing care: A systematic review. *Journal of Advanced Nursing*, *74*(7), 1474–1487. https://doi.org/10.1111/jan.13564

Griffiths, P., Saville, C., Ball, J., Culliford, D., Pattison, N., & Monks, T. (2020). Performance of the Safer Nursing Care Tool to measure nurse staffing requirements in acute hospitals: A multi-centre observational study. *British Medical Journal Open*, *10*(5), e035828. https://doi.org/10.1136/bmjopen-2019-035828

Han, K., Trinkoff, A. M., & Gurses, A. P. (2015). Work-related factors, job satisfaction and intent to leave the current job among United States nurses. *Journal of Clinical Nursing*, *24*(21–22), 3224–3232. https://doi.org/10.1111/jocn.12987

Hurst, K. (2005). Relationships between patient dependency, nursing workload and quality. *International Journal of Nursing Studies*, *42*(1), 75–84. https://doi.org/10.1016/j.ijnurstu.2004.05.011

Hurst, K. (2008). UK ward design: Patient dependency, nursing workload, staffing and quality—An observational study. *International Journal of Nursing Studies*, *45*(3), 370–381. https://doi.org/10.1016/j.ijnurstu.2006.09.007

Hurst, K. (2020). *The UK nursing database and nursing quality audit*. Retrieved from keithhurst.research@yahoo.co.uk

Kane, R. L., Shamliyan, T. A., Mueller, C., Duval, S., & Wilt, T. J. (2007). The association of registered nurse staffing levels and patient outcomes: Systematic review and meta-analysis. *Medical Care*, *45*(12), 1195–1204. https://doi.org/10.1097/MLR.0b013e3181468ca3

Kavanagh, K. T., Cimiotti, J. P., Abusalem, S., & Coty, M.-B. (2012). Moving healthcare quality forward with nursing-sensitive value-based purchasing. *Journal of Nursing Scholarship*, *44*(4), 385–395. https://doi.org/10.1111/j.1547-5069.2012.01469.x

Kirby, E., & Hurst, K. (2014). Using a complex audit tool to measure workload, staffing and quality in district nursing. *British Journal of Community Nursing*, *19*(5), 219–223. https://doi.org/10.12968/bjcn.2014.19.5.219

Mitchell, G., Cousins, C., Burrows, R., & Cousins, G. (2017). A review of safe-staffing models and their applicability to care homes. *Journal of Nursing Management*, *25*(2), 157–162. https://doi.org/10.1111/jonm.12450

National Institute for Health and Care Excellence (2014a). *Safe staffing for nursing in adult inpatient wards in acute hospitals*. NICE. Retrieved from https://www.nice.org.uk/guidance/sg1

National Institute for Health and Care Excellence (2014b). *Endorsed resource - The Safer Nursing Care Tool (SNCT)*. NICE. Retrieved from https://www.nice.org.uk/guidance/sg1/resources/endorsed-resource-the-safer-nursing-care-tool-snct-11943902

NHS Education for Scotland (2013a). *Nursing and midwifery workload and workforce planning. Learning toolkit* (2nd ed.). The Scottish Government. Retrieved from https://test1.nes.digital/media/248268/nursing_midwifery_workforce_toolkit.pdf

NHS Foundation Trust (2013b). *Adult ward nursing establishment review using the Safer Nursing Care Tool*. National Health Service.

Osborne, K. (2014). Australian staffing ratios have led to safer care and motivated nurses. *Nursing Standard*, *28*(39), 7. https://doi.org/10.7748/ns.28.39.7.s2

Roberts, D., & Hurst, K. (2013). Evaluating palliative care ward staffing using bed occupancy, patient dependency, staff activity, service quality and cost data. *Palliative Medicine*, *27*(2), 123–130. https://doi.org/10.1177/0269216312447593

Shelford Group (2014). *Safer Nursing Care Tool: Implementation resource pack*. Shelford Group.

Sousa, V. D., & Rojjanasrirat, W. (2011). Translation, adaptation and validation of instruments or scales for use in cross-cultural health care research: A clear and user-friendly guideline. *Journal of Evaluation in Clinical Practice*, *17*(2), 268–274. https://doi.org/10.1111/j.1365-2753.2010.01434.x

Thomas, R. (2020). NHS on course to miss major workforce target. *Health Service Journal*. Retrieved from https://www.hsj.co.uk/workforce/nhs-on-course-to-miss-major-workforce-target/7028131.article

Unison (2015). *Staffing levels survey 2015: Red alert: Unsafe staffing levels rising*. Unison. Retrieved from https://www.unison.org.uk/content/uploads/2015/04/TowebRed-Alert-Unsafe-Staffing-Levels-Rising1.pdf

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ORIGINAL ARTICLE

WILEY

Preceptorship as part of the recruitment and retention strategy for nurses? A qualitative interview study

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Abstract

Aim: To explore aspects that are important for the integration of preceptorship and processes for recruitment and retention of nurses.

Background: The shortage of nurses is a global concern that has a major impact on health care systems around the world. However, earlier research has not considered whether preceptorship of nursing students can be an integral part of recruitment and retention of nurses.

Method: A descriptive design with a qualitative approach was used. Semi-structured interviews were conducted with ten preceptors and six ward managers in different health care specialties in Sweden.

Results: Three aspects were found central for integrating preceptorship with recruitment and retention: perceptions of preceptorship, the organisation of preceptorship and the way preceptorship operates in relation to recruitment and retention strategies.

Conclusion: The findings suggest that preceptorship and recruitment strategies could both benefit from being integrated.

Implications for Nursing Management: It is central for nursing managers to develop organisational practices that enable the integration of preceptorship with recruitment and retention of nurses. This could increase the quality of both preceptorship and the work environment in general.

KEYWORDS

nurse, preceptorship, recruitment, retention, ward manager

1 | INTRODUCTION

A shortage of nurses is a global concern with a major impact on health care systems around the world (Blomberg & Stier, 2016; Coomber & Barriball, 2007; Duffield et al., 2014; Hong et al., 2012; Lu et al., 2019). Suggestions for solving this problem are multifaceted and linked to areas both inside and outside the health care sector (Blomberg & Stier, 2016; Lu et al., 2019). For instance, some studies suggest that health care organisations should provide nurses with continuous education, that nurses need to take some responsibility for change and that politicians must ensure a sufficient number of nurses in the future (Price & Reichert, 2017). Others emphasize the importance of improving nurses' working conditions, through higher wages, more flexible hours, less stress and a more satisfying workplace (Hong et al., 2012; Karatuna et al., 2020; Lu et al., 2019; Putra et al., 2020). A shortage of nurses is partly because many students drop out of nursing education (Bakker et al., 2019; UKÄ, 2017), and some newly qualified nurses also leave the profession (Brook et al., 2019; Rudman et al., 2010). However, few studies on nursing shortages have examined the preceptorship of nursing students as a process for recruitment and retention of nurses.

1.1 | Background

1.1.1 | Preceptorship in nursing

Preceptorship is a process embedded in nursing as a profession for decades (Chicca, 2020). Preceptors have been described as role models, with a responsibility to motivate students to develop their clinical skills and appreciate the value of nursing practice (Omansky, 2010). Preceptorship has also been consistently recognized as a strategy to maximize the benefits of clinical education by assisting in the achievement of skills and knowledge, and enhancing confidence and professional socialization (Happel, 2009; Hilli et al., 2014).

Preceptorship facilitates the integration of nursing students into clinical settings by pairing them with preceptors. The preceptors are usually experienced staff members who can support and educate the nursing students by providing a clinical orientation into specialized health care settings over a specific period of time (Ke et al., 2017; Oermann et al., 2017; Quek & Shorey, 2018). Activities during preceptorships include goal setting, competency validation and feedback on progress (Omer et al., 2016). Preceptors therefore help nursing students to assimilate into a nursing environment and culture.

Several studies have highlighted the importance of different organisational aspects for meaningful and positive preceptorships. For instance, a supportive work environment where colleagues acknowledge each other as preceptors strengthens the preceptorship experience (Kalischuk et al., 2013; Panzavecchia & Pearce, 2014). Support from clinical teachers at universities, especially through provision of feedback and contributions to the assessment of students, is also valuable for preceptors (Ward & McComb, 2017). Preceptors face organisational challenges such as no real reduction in their clinical work to reflect the time required for preceptorship, and little preparation (Dodge et al., 2014; Tracey & McGowan, 2015). Experienced nurses may be unwilling to become preceptors of nursing students because they perceive themselves as ill prepared or unsupported by their peers, and lack confidence (Sorrentino, 2013; Warren & Denham, 2010). Ward managers also seem to find it difficult to allocate time for nurses who want to act as preceptors, which increases the workload for preceptors' colleagues (Panzavecchia & Pearce, 2014).

1.1.2 | Preceptorship and recruitment

Ward managers are responsible for ensuring the quality of care by recruiting, retaining and developing ward staff (Drennan et al., 2016). To date, preceptorship and recruitment have largely been regarded as separate processes in health care organisations. A recent review (Irwin et al., 2018) found that team preceptorship has a greater impact than an individual preceptor on students' confidence and competence. This suggests that preceptorship needs to be considered as an organisational rather than an individual matter.

This study argues that preceptorship of nursing students is relevant for recruitment and retention of nurses for at least two reasons: (a) It is a practice where the organisation meets and has the opportunity to attract potential employees; and (b) it is a process related to development and retention of employees because it is often described as a highly positive experience, where preceptors have the opportunity to see students develop, and can convey the importance of their profession and strengthen nursing knowledge while updating and increasing their own knowledge base (Chicca, 2020; Foley et al., 2012).

The shortage of nurses and the dropout rate among nursing students (Bakker et al., 2019; UKÄ, 2017) means it is important to take measures to retain nursing students in the health care system. One way of doing this could be by integrating preceptorship of nursing students as an explicit part of future recruitment. The aim of this study was to explore aspects that are important for the integration of preceptorship and processes for recruitment and retention of nurses.

2 | METHODS

Precepting of nursing students traditionally involves one student nurse being precepted by one registered nurse. In Sweden, as well as internationally, the increasing number of student nurses has led to a pressing need for additional preceptors and clinical placements (Stenberg & Carlson, 2015). In the health care setting, the ward manager is usually the one responsible for allocation of students to preceptors. Undergraduate nursing students enrolled in a 3-year bachelor programme have clinical practice during the 2nd semester (10 weeks), 4th semester (12 weeks) and the 6th and final semester (14 weeks).

2.1 | Design and sample

We used a descriptive design with a qualitative approach. To explore what aspects are important for the integration of preceptorship and recruitment and retention of nurses, we conducted semi-structured interviews with ten preceptors and six ward managers from different health care specialties (see Table 1). The participants were all nurses and were recruited by the central HR Department of the organisation responsible for all public health care in one of the regions in Sweden. Criteria for sample selection for the preceptors were registered nurses with experience from preceptorship, and criteria for sample selection for the ward managers were those with a current position as manager.

2.2 | Data collection

The interviews were conducted between 8 April and 30 June 2019. All but one took place at the participants' workplaces, and the remaining interview took place at the researchers' workplace. They ranged between 40 and 90 min in duration. The interviews were based on a guide focusing on the content of the process of being a preceptor, incentives and challenges, roles and responsibilities, and the development of the role. The interviews were recorded, with informed consent, and were later transcribed verbatim.

2.3 | Ethics

Before the study began, the participants provided oral and written informed consent to participate. They were informed about the research and its purpose, that they had the right to withdraw at any stage and that the data collected would be treated as confidential.

2.4 | Data analysis

Qualitative content analysis was guided by Graneheim and Lundman (2004). The focus of the analysis was to identify expectations, perceptions and approaches that could enable or hinder integration of the preceptorship process with the recruitment and retention strategy. The verbatim interview transcriptions were read thoroughly, and meaning units based on the study aim were extracted and labelled with codes. Codes were sorted into six subthemes, which were abstracted into three main themes (see Table 2). Collection and analysis of data was a sequential and simultaneous process and continued until data could add no new information to the emerging themes, and so-called saturation was met (Glaser & Strauss, 1967).

3 | RESULTS

3.1 | Perceptions of preceptorship

3.1.1 | Professional perspectives

Preceptorship has a long history in nursing and is therefore regarded by many as a natural part of the profession. All nurses are expected to be able to provide this type of guidance, and it is considered to be part of the role. However, not everybody is considered suitable as preceptor, this can be due to the lack of interest in the role, or because they have a complicated or 'heavy' situation in their private life. This means that the nurses who are most interested in preceptorship are most likely to do it.

> All the nurses are supposed to provide preceptorship, it is part of the job. However, there are nurses that say no to it and they get away with it as there is a risk that preceptorship will not be successful with an unmotivated preceptor. So, it is often the most dedicated nurses that become preceptors.
>
> (Preceptor)

Nurses perceived preceptorship as rewarding for several reasons: it is fun, students bring new knowledge, and it provides an opportunity to reflect upon their own knowledge and work as a nurse. The nurses maintained that they were intrinsically motivated to become preceptors, and did not do it for external rewards. The role of being a preceptor was viewed positively and was seen as closely linked to nurses' professional identity.

> The students ask a lot of questions so one has to be alert as a preceptor; they make us aware of things that we normally do not reflect upon.
>
> (Preceptor)

TABLE 1 Description of the interviewees

	Role/title	Health care speciality
1	Ward manager	Palliative care
2	Preceptor	Emergency care
3	Ward manager	Primary care
4	Preceptor	Forensic psychiatry care
5	Preceptor	Surgical ward
6	Preceptor	Primary care
7	Ward manager	Neurology
8	Preceptor/clinical teacher	Emergency care
9	Preceptor	Neonatal care
10	Preceptor	Emergency care
11	Preceptor	Gastroenterology
12	Preceptor	Psychiatric care
13	Ward manager	Emergency care
14	Preceptor	Psychiatric care
15	Ward manager	Intensive care
16	Ward manager	Oncology

3.1.2 | Organisational perspectives

The interviewees discussed different aspects of preceptorship and its organisational prerequisites. First, they noted that wards are obliged to provide preceptorship for nursing students, and it is not negotiable. This applies even though nurses may perceive preceptorship as demanding.

> Preceptorship can unfortunately be perceived as demanding and taxing, but it is part of our role. We have to admit students.
>
> (Ward Manager)

Nurses pointed out that providing preceptorship meant extra work on top of their everyday tasks. It became especially taxing if it was not well organised and planned. However, some of the ward managers were keen to point out that they did not tolerate any discussion of 'students as burden' among nurses and that it was important that all students were treated with respect.

> I wouldn't like to call preceptorship a burden, but it means extra work … And from an organizational

TABLE 2 Main themes and subthemes identified in the interviews

Main themes	Subthemes
Perceptions of preceptorship	- Professional perspectives - Organisational perspectives
Organising preceptorship	- Responsibilities and functions - Planning and communication
Preceptorship in relation to recruitment and retainment of nurses	- Marketing of the profession - Marketing of the workplace

> point of view – if one is not prepared or informed beforehand, it does not work very well.
>
> (Preceptor)

Some of the managers were not directly involved in providing preceptorship but highlighted that preceptors have significant responsibility. They are viewed as ambassadors for the ward, which is liable for the quality of preceptorship, so that patient safety can be guaranteed.

> Preceptorship includes a great responsibility – being a preceptor is like being an ambassador for the organization.
>
> (Ward Manager)

3.2 | Organising preceptorship

3.2.1 | Responsibilities and functions

The managers usually make decisions about the number of students and, in some cases, the allocation of students to preceptors. However, they may appoint one person to take overall responsibility for students and their education.

> I have two people who are responsible for the students. They handle this very well. I do not go in and interfere. The only thing I do in relation to students is that I am in charge of the allocation of preceptors. And it's a lot about making sure that's fair… my decision is respected … there are never any protests.
>
> (Ward Manager)

During the process of preceptorship, the clinical teachers and other preceptors play an important role in inspiring and motivating preceptors, which compensates for any lack of structure and planning.

> I try to show that I see them and reward them in my own way. They usually get a summer gift and a Christmas present, and I invite them to lunch. At the meetings, I see them, and I acknowledge them…. but the manager must also reward them and acknowledge them for their qualities.
>
> (Clinical teacher)

In addition to appointing preceptors, the ward managers are involved in preceptorship in any situations of conflicts, when there is a need to change preceptor or when a student is not meeting their objectives.

> This does not happen often, but we have had students where it has not worked out very well…. I have a dialogue with the clinical teacher, where she and I jointly make a plan for how to deal with the situation….and sometimes there has been a change of preceptors… then I get involved in that dialogue.
>
> (Ward Manager)

It is not always clear to managers and preceptors how preceptorship is organised. A common feature is that the preceptors take a lot of individual responsibility and, when faced with uncertainty or lack of planning, find a way to deal with the situation. The preceptors' main focuses are the students and making sure that they meet the course objectives. Preceptors themselves therefore compensate for the lack of planning by their flexibility, loyalty and engagement. This is linked to their sense of responsibility as ambassadors for the profession.

3.2.2 | Planning and communication

Responsibility for preceptorship is closely related to aspects of planning and communication. In some hospital units, there is a plan for preceptorship, which is clearly communicated to the preceptors and more widely.

> We are very eager to include the students in our team…. we talk to the students in the same way as we talk to each other… they are welcome to attend our internal lectures and they can participate in workplace meetings etc.
>
> (Ward Manager)

The ward managers had different ways of planning preceptorships. Some ensured clear organisation with responsibility for the process; that is, they create a team with crucial actors or delegate the responsibility to a colleague. In other cases, the managers deal with these issues themselves. Some of the managers are involved in the process of preceptorship and have an ongoing dialogue with the appointed preceptors, while others do not prioritize work on preceptorship, usually because of lack of time and resources. In

some cases, planning is more ad hoc, and in a few cases, preceptors had neither been asked nor informed about the arrival of a student:

> Sometimes it happens, that when I come into work, there is my name plus someone else's name on the board.... that means that I will be someone's preceptor that day.
>
> (Preceptor)

The majority of the preceptors felt that they did not have enough time to prepare for the student. It is up to individual nurses to find the time, and this can sometimes be frustrating.

3.3 | Preceptorship in relation to recruitment and retention of nurses

3.3.1 | Marketing of the profession

There was a consensus among both ward managers and preceptors that preceptors are role models and ambassadors for the profession. Preceptors need to show how the work is performed, including what it means to work to ethical standards, and make sure that students have a comprehensive picture of the profession as a whole.

> I think it's a bit of a boost to my ego too, that I help to educate the next generation of nurses... and hopefully give them what I didn't get... and that this could actually be a future colleague....I want to do a good job so that they want to work here and have me as a colleague.
>
> (Preceptor)

Several of the preceptors enjoyed the work with the students and considered preceptorship as an opportunity for learning and development. It was seen as a crucial part of the job, and nurses believed that it was important to do it properly.

3.3.2 | Marketing of the workplace

Recruitment and retention of nurses is formally the responsibility of managers. During the analysis of our data, it became clear that some managers see preceptorship as a natural part of the recruitment process, while others perceive and work with these two processes separately. This was also visible among some of the preceptors, who viewed the process as a way to recruit future colleagues.

> When they have been here for a few days, they think that this is the best (work) place...and can definitely imagine working here.
>
> (Preceptor)

It can also be seen as an opportunity to 'test' new colleagues and in some way 'take control' of the somewhat turbulent and challenging recruitment situation. If students have a positive experience of the preceptorship and the workplace, they can play an important role in promoting the workplace.

> I think that students are an important part of marketing our workplace and our type of care, because it is quite specific... but I also see students as a very important part of being able to recruit new nurses... even if you do not recruit that particular nurse... if they have a good experience of clinical practice, you will still get external marketing and external advertising.
>
> (Ward Manager)

Managers who viewed preceptorship as connected to recruitment thought it was important for all employees to have a professional approach to students. This applies both to preceptors and to the other employees at the workplace. In some cases, the preceptors experienced this as a dilemma because they felt it was important to show a full picture of the workplace, with both positive and negative aspects.

4 | DISCUSSION

Both in research and in the organisation of health care, preceptorship and strategies for recruitment and retention of nurses have traditionally been handled as two separate processes. Preceptorship is viewed as part of the nursing profession (Chicca, 2020), and recruitment is regarded as managers' responsibility (Drennan et al., 2016). However, the global shortage of nurses means that it might be beneficial for recruitment and retention of nurses if these two processes were integrated. The aim of this study was therefore to explore aspects that are important for the integration of preceptorship of nursing students and recruitment and retention of nurses.

Previous studies on preceptorship have identified different factors, such as the image of the individual preceptor as a role model for the prospective nurse (Omansky, 2010) and the preceptor being responsible for the student's clinical learning and socialization in the profession (Happel, 2009; Hilli et al., 2014). Several studies have highlighted the importance of different organisational aspects for meaningful and positive preceptorship (Kalischuk et al., 2013; Panzavecchia & Pearce, 2014). Others show that preceptors face organisational challenges such as no real reduction in their clinical work to reflect their additional responsibilities and no adequate preparation (Dodge et al., 2014; Tracey & McGowan, 2015). These aspects were also mentioned in our study. However, when we apply a more holistic approach and look at preceptorship in the light of recruitment and retention processes, the results can be understood from a different perspective. We identified three overarching themes: perceptions of preceptorship, organising preceptorship and preceptorship in relation to recruitment and retention of nurses.

The first theme, *perceptions of preceptorship*, illustrates how integration can be hindered by viewing preceptorship as a professional rather than an organisational issue. Providing preceptorship is an obligation for individual nurses and is expected to be carried out without complaint, even though it is additional to nurses' everyday duties. Preceptorship is mainly viewed positively by preceptors because working with students provides an opportunity for development and learning. Some of the managers emphasized the importance of the quality of preceptorship and how it adds value to the whole organisation including patient safety. Managers, together with preceptors and other colleagues, are responsible for the values and norms that shape the conditions for preceptorship and the success of the process from the recruitment point of view.

Within the second theme, *organising preceptorship*, a crucial factor for integration emerged as a well-defined organisation with clear functions and responsibilities for preceptorship. Integration also requires a continuous dialogue between the key functions (i.e. managers, clinical teachers and preceptors) and planning using a long-term perspective. It is also important to make sure that providing preceptorship is perceived as a joint effort and a shared responsibility by everyone in the workplace.

The third theme, *the role of preceptorship in the work with recruitment and retention*, implies that it is better for integration if students are welcomed into the workplace as a whole. It is also helpful if students are viewed as possible (future) colleagues, and preceptorship is seen as an opportunity for feedback. To support integration, preceptors also need to see themselves as ambassadors for both the profession and the workplace.

We suggest that the integration of preceptorship and recruitment is not a question for either individual ward managers or individual preceptors. Instead, it needs to involve the whole organisation and be considered as a collective responsibility. Managers who perceive preceptorship as part of their responsibility to lead and organise also seem to establish the necessary conditions for this. They appear to view the provision of preceptorship as an important part of the work environment and a collective responsibility. Integrating the processes of preceptorship and recruitment should therefore have a positive impact not only on both areas, but also indirectly on the work environment and the organisational culture.

One of the limitations in this study is that participants were recruited by the HR department of the organisation. They may therefore be more engaged and more positive about preceptorship than 'the average' ward manager or preceptor. As a qualitative study, the results can also only be generalized at the theoretical level (Crotty, 1998). However, the study offers insights that could be tested in other nursing contexts.

5 | CONCLUSIONS

In the literature, organisational support has mainly been seen as contributing better conditions for preceptors and preceptorship. Examining both managers' and supervisors' views on preceptorship in relation to recruitment suggests that the relationship can work both ways. In other words, preceptorship can make a positive contribution to both the work environment and future recruitment.

We therefore suggest that both preceptorship and recruitment strategies could benefit from being integrated, particularly because this should result in a more holistic perspective. Students need to be seen by ward staff as future colleagues. This implies the need for better organisational prerequisites for the preceptors, so that they can fully engage in the process of working with students. Preceptorship should also be viewed as a collective and organisational responsibility, rather than the responsibility of individual preceptors. Creating a work environment that is welcoming for students might therefore require changes in leadership, organisational culture and structure.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

The global shortage of nurses means that it is essential for nursing managers to develop organisational practices that enable the integration of preceptorship with recruitment and retention of nurses. This might also increase the quality of preceptorship and the work environment in general. Managing preceptorship as an organisational and collective responsibility rather than an individual concern could also contribute to a more sustainable recruitment strategy.

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CONFLICT OF INTEREST

The research has been conducted independently by the authors. The funding organisation, a public organisation responsible for the health care in one of the regions in Sweden, assisted in the recruitment of the participants, but the funders had no role in the design of the study; in the collection, analyses or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

DATA AVAILABILITY STATEMENT

Author elects to not share data.

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REFERENCES

Bakker, E. J., Verhaegh, K. J., Kox, J. H., van der Beek, A. J., Boot, C. R., Roelofs, P. D., & Francke, A. L. (2019). Late dropout from nursing education: An interview study of nursing students' experiences and reasons. *Nurse Education in Practice*, *39*, 17–25. https://doi.org/10.1016/j.nepr.2019.07.005

Blomberg, H., & Stier, J. (2016). Metaphorical expressions used in Swedish news media narratives to portray the shortage of nurses

and their working conditions. *Journal of Advanced Nursing*, *72*(2), 382–395. https://doi.org/10.1111/jan.12839

Brook, J., Aitken, L., Webb, R., MacLaren, J., & Salmon, D. (2019). Characteristics of successful interventions to reduce turnover and increase retention of early career nurses: A systematic review. *International Journal of Nursing Studies*, *91*, 47–59. https://doi.org/10.1016/j.ijnurstu.2018.11.003

Chicca, J. (2020). Should we use preceptorships in undergraduate nursing education? *Nursing Forum*, *55*, 480–484.

Coomber, B., & Barriball, K. L. (2007). Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: A review of the research literature. *International Journal of Nursing Studies*, *44*(2), 297–314. https://doi.org/10.1016/j.ijnurstu.2006.02.004

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.

Dodge, T., Mazerolle, S. M., & Bowman, T. G. (2014). Challenges faced by preceptors serving in dual roles as health care providers and clinical educators. *Athletic Training Education Journal*, *9*, 29–35. https://doi.org/10.4085/090129

Drennan, V. M., Halter, M., Gale, J., & Harris, R. (2016). Retaining nurses in metropolitan areas: Insights from senior nurse and human resource managers. *Journal of Nursing Management*, *24*(8), 1041–1048. https://doi.org/10.1111/jonm.12402

Duffield, C. M., Roche, M. A., Homer, C., Buchan, J., & Dimitrelis, S. (2014). A comparative review of nurse turnover rates and costs across countries. *Journal of Advanced Nursing*, *70*(12), 2703–2712. https://doi.org/10.1111/jan.12483

Foley, V., Myrick, F., & Yonge, O. (2012). Generational clashpoints in nursing preceptorship. *Journal of Nursing Education*, *51*(10), 556–562. https://doi.org/10.3928/01484834-20120820-04

Glaser, B. G., Strauss, A. L., & Strutzel, E. (1967). *The discovery of grounded theory strategies for qualitative research*. Aldine.

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Happel, B. (2009). A model of preceptorship in nursing: Reflecting the complex functions of the role. *Nursing Education Perspectives*, *30*(6), 372–376.

Hilli, Y., Melender, H. L., Salmu, M., & Jonsén, E. (2014). Being a preceptor—A Nordic qualitative study. *Nurse Education Today*, *34*(12), 1420–1424. https://doi.org/10.1016/j.nedt.2014.04.013

Hong, L., Barriball, L. K., Zhang, X., & While, A. E. (2012). Job satisfaction among hospital nurses revisited: A systematic review. *International Journal of Nursing Studies*, *49*, 1017–1038. https://doi.org/10.1016/j.ijnurstu.2011.11.009

Irwin, C., Bliss, J., & Poole, K. (2018). Does preceptorship improve confidence and competence in newly qualified nurses: A systematic literature review. *Nurse Education Today*, *60*, 35–46. https://doi.org/10.1016/j.nedt.2017.09.011

Kalischuk, R. G., Vandenberg, H., & Awosoga, O. (2013). Nursing preceptors speak out: An empirical study. *Journal of Professional Nursing*, *29*, 30–38. https://doi.org/10.1016/j.profnurs.2012.04.008

Karatuna, I., Jönsson, S., & Muhonen, T. (2020). Workplace bullying in the nursing profession: A cross-cultural scoping review. *International Journal of Nursing Studies*, *111*, 103628. https://doi.org/10.1016/j.ijnurstu.2020.103628

Ke, Y. T., Kuo, C. C., & Hung, C. H. (2017). The effects of nursing preceptorship on new nurses' competence, professional socialization, job satisfaction and retention: A systematic review. *Journal of Advanced Nursing*, *73*(10), 2296–2305. https://doi.org/10.1111/jan.13317

Lu, H., Zhao, Y., & While, A. (2019). Job satisfaction among hospital nurses: A literature review. *International Journal of Nursing Studies*, *94*, 21–31. https://doi.org/10.1016/j.ijnurstu.2019.01.011

Oermann, M. H., Shellenbarger, T., & Gaberson, K. B. (Eds.) (2017). *Clinical teaching strategies in nursing*. Springer.

Omansky, G. L. (2010). Staff nurses' experiences as preceptors and mentors: An integrative review. *Journal of Nursing Management*, *18*(6), 697–703. https://doi.org/10.1111/j.1365-2834.2010.01145.x

Omer, T. A., Suliman, W. A., & Moola, S. (2016). Roles and responsibilities of nurse preceptors: Perception of preceptors and preceptees. *Nurse Education in Practice*, *16*(1), 54–59. https://doi.org/10.1016/j.nepr.2015.07.005

Panzavecchia, L., & Pearce, R. (2014). Are preceptors adequately prepared for their role in supporting newly qualified staff? *Nurse Education Today*, *34*, 1119–1124. https://doi.org/10.1016/j.nedt.2014.03.001

Price, S., & Reichert, C. (2017). The importance of continuing professional development to career satisfaction and patient care: Meeting the needs of novice to mid-to late-career nurses throughout their career span. *Administrative Sciences*, *7*(2), 17. https://doi.org/10.3390/admsci7020017

Putra, A. P., Kusnanto, K., & Yuwono, S. R. (2020). Effects of job satisfaction and organizational commitment on nurse retention: A systematic review. *Indonesian Nursing Journal of Education and Clinic (INJEC)*, *5*(2), 197–205. https://doi.org/10.24990/injec.v5i2.319

Quek, G. J., & Shorey, S. (2018). Perceptions, experiences, and needs of nursing preceptors and their preceptees on preceptorship: An integrative review. *Journal of Professional Nursing*, *34*(5), 417–428. https://doi.org/10.1016/j.profnurs.2018.05.003

Rudman, A., Omne-Pontén, M., Wallin, L., & Gustavsson, P. J. (2010). Monitoring the newly qualified nurses in Sweden: The Longitudinal Analysis of Nursing Education (LANE) study. *Human Resources for Health*, *8*(1), 10. https://doi.org/10.1186/1478-4491-8-10

Sorrentino, P. (2013). Preceptor: Blueprint for successful orientation outcomes. *Journal of Emergency Nursing*, *39*(5), e83–e90. https://doi.org/10.1016/j.jen.2012.05.029

Stenberg, M., & Carlson, E. (2015). Swedish student nurses' perception of peer learning as an educational model during clinical practice in a hospital setting—An evaluation study. *BMC Nursing*, *14*(1), 48. https://doi.org/10.1186/s12912-015-0098-2

Tracey, J. M., & McGowan, I. W. (2015). Preceptors' views on their role in supporting newly qualified nurses. *British Journal of Nursing*, *24*(20), 998–1001. https://doi.org/10.12968/bjon.2015.24.20.998

UKÄ (2017). *Report 2017:17 E (summary of Swedish full report 2017:17) Early higher education drop-out rates in Sweden. Analyses of throughput rates of ten large study programmes*. Swedish Higher Education Authority.

Ward, A., & McComb, S. (2017). Precepting: A literature review. *Journal of Professional Nursing*, *33*(5), 314–325. https://doi.org/10.1016/j.profnurs.2017.07.007

Warren, A. L., & Denham, S. A. (2010). Relationships between formalized preceptor orientation and student outcomes. *Teaching and Learning in Nursing*, *5*(1), 4–11. https://doi.org/10.1016/j.teln.2009.02.003

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