THE UNIVERSITY OF HULL

An Exploration of How Healthcare Professionals Working within Intensive Care Experience the Factors which Contribute to Individual and Relational Well-being at Work

being a Thesis submitted in partial fulfilment

of the requirements for the degree of Doctor of Clinical Psychology

in the University of Hull

by

Katie Hope Reading

BSc (Hons) Psychology

University of York

May 2021

Acknowledgements

First and foremost, I would like to thank all of the healthcare professionals who took part in this research. Thank you for your time, your enthusiasm and your honesty. I am even more in awe of the work that you do caring for the most seriously unwell patients. You all spoke of wanting change. I hope that you feel like your voices are captured within this piece of work and I hope that those with the with the power to invoke this change will listen to what you have said so clearly.

There are so many hard-working people working in different parts of the NHS that I want to thank for being fundamental to my research. Special thanks to Dr Jas Moorhouse for acting as my field supervisor and sharing her passion for the subject with me.

I would also like to thank my research supervisors, Dr Jo Beckett and Dr Chris Clarke, for their continued reassurance and support. You have both taught me so much and given so much of yourselves to get me to this stage. I am glad that you were the people that I was able to navigate this tricky research journey alongside. Thank you also to Dr Tim Alexander for his knowledge and speedy emails which were always so valued during times of panic.

Thank you also to my peer group. We did it together, during a world pandemic. You are all such strong and hard-working people who inspire me so much.

Finally, to my family, your continued love and encouragement has been fundamental to getting to me to the place I am now. Special thanks are deserved for my mum, for her unwavering belief in me and Matt, for being a constant support, for always encouraging me to push forwards but most importantly reminding me to take a break.

Overview

This portfolio thesis consists of three parts: a systematic literature review, an empirical paper and appendices. The thesis seeks to explore the positive experiences associated with well-being in healthcare professionals working in the intensive care unit.

Part one- Systematic Literature Review

The systematic literature review explored well-being in healthcare professionals working in the intensive care unit. A systematic review of the literature identified twelve qualitative studies which met the inclusion criteria. A thematic synthesis was conducted to bring together the studies and a Critical Appraisal Skills Programme (CASP) assessment tool was used to evaluate the quality of the studies. Three analytical themes were identified: managing challenges, finding meaning and feeling supported at work. The findings showed that well-being is multi-faceted and intensive care staff use a range of resources inside and outside of work at the individual, team and organisational level to maintain their well-being. Clinical implications and areas for further research are explored.

Part two-Empirical Paper

The empirical paper explored how healthcare professionals working in the intensive care unit experience thriving and whether this is associated with relational support at work. A qualitative Constructivist Grounded Theory (CGT) methodology was utilised to generate a theory with clinical implications for supporting staff well-being at work. Twenty participants took part in semi-structured interviews. Four superordinate categories of challenge, energy, support and access emerged to describe how intensive care staff experience thriving at work. The findings also indicate that thriving was closely related to relational support at work as individual thriving was found to contribute to more integrated multi-disciplinary team

working. The findings are discussed in the context of previous literature. Clinical implications and recommendations for future research are discussed.

Part three- Appendices

The appendices provide additional information which support the systematic literature review and empirical paper. This also includes consideration of the role of the researcher which is discussed within a reflective and epistemological statement.

Total word count: 36,805 (including tables, figures, appendices and references)

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Part One: Systematic Literature Review

Moving Away from Burnout and Towards What is Going Right: A Systematic Review and Synthesis of the Qualitative Literature Exploring Well-being in Intensive Care Staff

Katie Hope Reading[a], Dr Jo Beckett [a], Dr Chris Clarke[b] & Dr Jas Moorhouse[c]

[a]Faculty of Health Sciences, School of Health and Social Work, Aire Building, University of Hull, Hull, HU6 7RX

[b] Tees, Esk & Wear Valleys NHS Trust, Foss Park Hospital, York, YO31 8TA

[c] Hull University Teaching Hospitals NHS Trust, Anlaby Road, Hull, HU3 2JZ

*Corresponding Author Email: K.Reading-2018@hull.ac.uk

This paper is written in the format ready for submission to Journal of Interprofessional Care (see Appendix A for submission guidelines)

Word count: 8555

Abstract

Background: Most research exploring intensive care staff experiences of work has focussed on negative outcomes such as burnout. However, much can be learned about how to support staff by exploring well-being. This review aimed to explore the positive indicators, experiences and resources associated with well-being in intensive care staff.

Method: The CASP methodological quality assessment tool was used to critically evaluate the strength of the studies and their ability to answer the review questions. A thematic synthesis organised the findings from qualitative studies which met the inclusion criteria.

Findings: Twelve papers were included. Three analytical themes were identified: managing challenges, finding meaning and feeling supported. This showed that intensive care staff use a range of strategies and skills inside and outside of work to maintain their well-being; however, well-being also depends on support from colleagues and employing organisations.

Conclusions: This review indicated that well-being in intensive care staff is complex and multi-faceted. Despite a lack of research exploring the positive aspects of working in the ICU, it also highlighted how healthcare organisations can improve systems of staff support by optimising what intensive care staff say is important to their well-being at work.

Keywords: Intensive care, critical care, healthcare professionals, staff, well-being, positive, experiences, resources, strengths, thematic synthesis, systematic review.

Introduction

The Boorman (2009) Review stated that "All National Health Service (NHS) Trusts [need to] put staff health and well-being at the heart of their work" (p.12). The dominant understanding of well-being in intensive care staff has come from looking at and reviewing quantitative studies measuring factors such as burnout, compassion fatigue and moral distress (Chuang et al., 2016; Prentice et al., 2016; Van Mol et al., 2015). However, focussing only on the negative outcomes for well-being may perpetuate an image of the intensive care unit (ICU) as a place that people would not want to work, despite the many positive aspects which should be acknowledged (Galuska & Bursch, 2020). To move away from this problem-focussed view, it is important to explore more of what is perceived to already be going right in the ICU (Costa & Moss, 2018).

Positive psychology is the study of positive factors that strengthen the likelihood of an individual experiencing well-being as a desirable state (Fredrickson & Losada, 2005; Seligman & Csikszentmihalyi, 2000). A second wave positive psychology (2WPP) approach views well-being to be a dynamic relationship between positive and negative experiences, on a continuum from well-being and flourishing to ill-being (Gable & Haidt, 2005; Lomas & Ivtzan, 2016). Well-being is a multi-dimensional construct comprising affective and psychological components (Ryan & Deci, 2001; Schotanus-Dijkstra et al., 2016). Both hedonic and eudaimonic perspectives are combined within the PERMA model (Seligman, 2011) which views well-being as positive emotions, engagement, relationships, meaning and accomplishment. Galuska and Bursch (2020) demonstrated how PERMA maps onto the experiences of intensive care staff; however, these findings were based on a secondary analysis of interviews with nurses (Galuska et al., 2018) which did not report specifically on the number of intensive care staff within the sample. The PERMA model may have value in considering how intensive care staff continue to manage the demands of their work

environment, as the Job-Demands Resources Model (J-DRM) (Demerouti et al., 2001) indicates that personal resources such as optimism are also job resources which help employees to do their job even when demands are high (Bakker & Demerouti, 2017).

In a recent review, Jarden et al. (2020) explored factors strengthening the well-being of intensive care nurses and identified only four relevant studies with the broad term of 'well-being' in the title. Arguably, this may not have captured the full range of experiences that relate to the well-being of intensive care staff, given the focus on nursing, the multi-factorial nature of well-being and because experiences of well-being are contextually defined.

Jarden et al. (2018a) found that intensive care nurses rated feeling valued, respected and supported as most essential to their well-being at work and more important than being stress free. More needs to be done to learn from intensive care staff about the strengths and positive experiences which help them to cope at work even during the most challenging times (Cameron, 2008; Parsons, 2008). Understanding what constitutes well-being is important for helping healthcare organisations to increase their effectiveness as knowing where and how to direct their resources to support intensive care staff to stay well at work is important for contributing to reduced stigma, staff sickness and staff turnover (Bajoreck & Holmes, 2020; Cameron et al., 2011; Cutler et al., 2020; Pearson, 2019).

The definition of individual well-being for this review was taken from Dodge et al. (2012), "when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge" (p.230). When experiencing well-being, intensive care staff are viewed to be able to fully engage with and enjoy their job. As a result, the likelihood of feeling able to manage workplace stressors and experience positive outcomes (e.g. job satisfaction) is increased and negative outcomes (e.g. burnout) are decreased.

The following research questions were developed:

1. What indicators of well-being exist amongst intensive care staff?
2. What are the positive lived experiences and personal resources which intensive care staff use to maintain their well-being at work?

Methods

Search Strategy

A systematic search of the literature up to and including March 2021 was conducted using four electronic databases on EBSCO Host: Academic Search Premier, MEDLINE, PsycINFO and CINAHL Complete. These databases were chosen to cover multidisciplinary areas which may all have conducted research into the experiences of intensive care staff. In addition, EThOS was searched for unpublished studies from doctoral theses. To ensure that all relevant articles were included, further eligible articles were accessed by manually searching the reference lists of included articles and journals within the topic area. To prevent replication of previous work, a search for existing review articles was conducted and identified two similar but unrelated reviews (Adams et al., 2019; Jarden et al., 2020) on well-being but in intensive care nurses and without clear conceptualisations of well-being.

Search Terms

The search terms were generated by exploring the abstracts and titles of existing literature and by identifying keywords and search terms in the databases to ensure that all variations in terminology were included. Indicators of well-being were chosen by exploring the positive psychology and well-being literature (e.g. Carr, 2011; Jarden et al., 2018a; Leamy et al., 2011; Ryff, & Singer, 2008; Seligman, 2011). Although there are social components to well-being (Keyes, 1998), the chosen search terms did not include these factors owing to the review focus on individual well-being. In addition, terms which were too broad and brought up too many unrelated studies, either owing to being more quantitative terms or too medically focussed, were excluded. The search terms were then reviewed by two research supervisors who are clinical psychologists and a research librarian experienced in conducting systematic literature reviews. The final list of search terms is in Table 1.

Table 1

Search Terms

(staff OR worker* OR professional* OR practitioner* OR personnel OR doctor* OR intensivist* OR consultant* OR physician* OR nurs* OR therapist* OR allied health OR dietician OR pharmacist OR psych* OR multi-disciplin*) N5 ("intensive care" OR ICU OR "critical care" OR CCU OR "high dependency" OR HDU OR "intensive therapy" OR "intensive treatment" OR ITU OR "neonatal intensive care" OR NICU OR "p#ediatric intensive care" OR PICU)
AND
accept* OR accomplish* OR achiev* OR appreciat* OR authentic OR autonom* OR commit* OR "compassion satisfaction" OR content OR empath* OR empower* OR engage* OR enthusias* OR flourish* OR flow OR gratitude OR growth OR happy OR hope OR humour OR innovat* OR joy OR love OR mastery OR meaning OR optimis* OR passion* OR pleasur* OR positiv* OR pride OR purpose OR resilien* OR respect OR strength OR trust OR thriv* OR well#being

Owing to the large number of articles that were not relevant to the research question, only articles that featured these search terms within their titles and met the inclusion criteria were reviewed. Limiters were applied to peer reviewed, academic journals and English language only.

Inclusion and Exclusion Criteria

The inclusion and exclusion criteria alongside a rationale for each decision is provided in Table 2 and Table 3.

Table 2

Inclusion Criteria and Rationale

Inclusion Criteria	Rationale
Population: Any healthcare professional within the multi-disciplinary team working in a clinical role which involves directly caring for patients **Context**: Working in the ICU across any setting including adult/child/surgical etc	The review aimed to explore the impact on staff well-being of providing critical care treatment to patients in the ICU. Most studies have focussed on the impact on nurses but as few studies have explored the positive impact of working in the ICU, no limit was put on professional designation or type of ICU as the ICU team is diverse.
Outcome: Indicators of well-being (e.g. hope, joy) in intensive care staff as reported from a staff perspective	The review aimed to explore how individual intensive care staff relate to themselves and talk about their own personal experiences of well-being at work rather than how they evaluate the well-being of others including the team, patients or relatives. Studies were also included if they referred to both indicators of well-being and ill-being but only where well-being was the primary focus.
Language: English	As English is the only language that the researcher can understand and read.
Date Range: No limit	As this type of review has not been done before and a relatively small number of articles were identified without a limit on date.
Study Design: Qualitative	The review aimed to explore indicators, lived experiences and resources associated with well-being and detailed information about experiences are more likely to be captured in qualitative studies.
Study Type: Only full-text, primary research articles and published in an academic peer-reviewed journal	The review aimed to explore empirical studies which ask a research question, explore the topic of interest and report on a set of findings.
Unpublished Dissertations/Theses	Relevant unpublished work was available and explored as the researcher was already aware of a doctoral thesis from Allen (2017) which helped to answer the review questions.

Table 3

Exclusion Criteria and Rationale

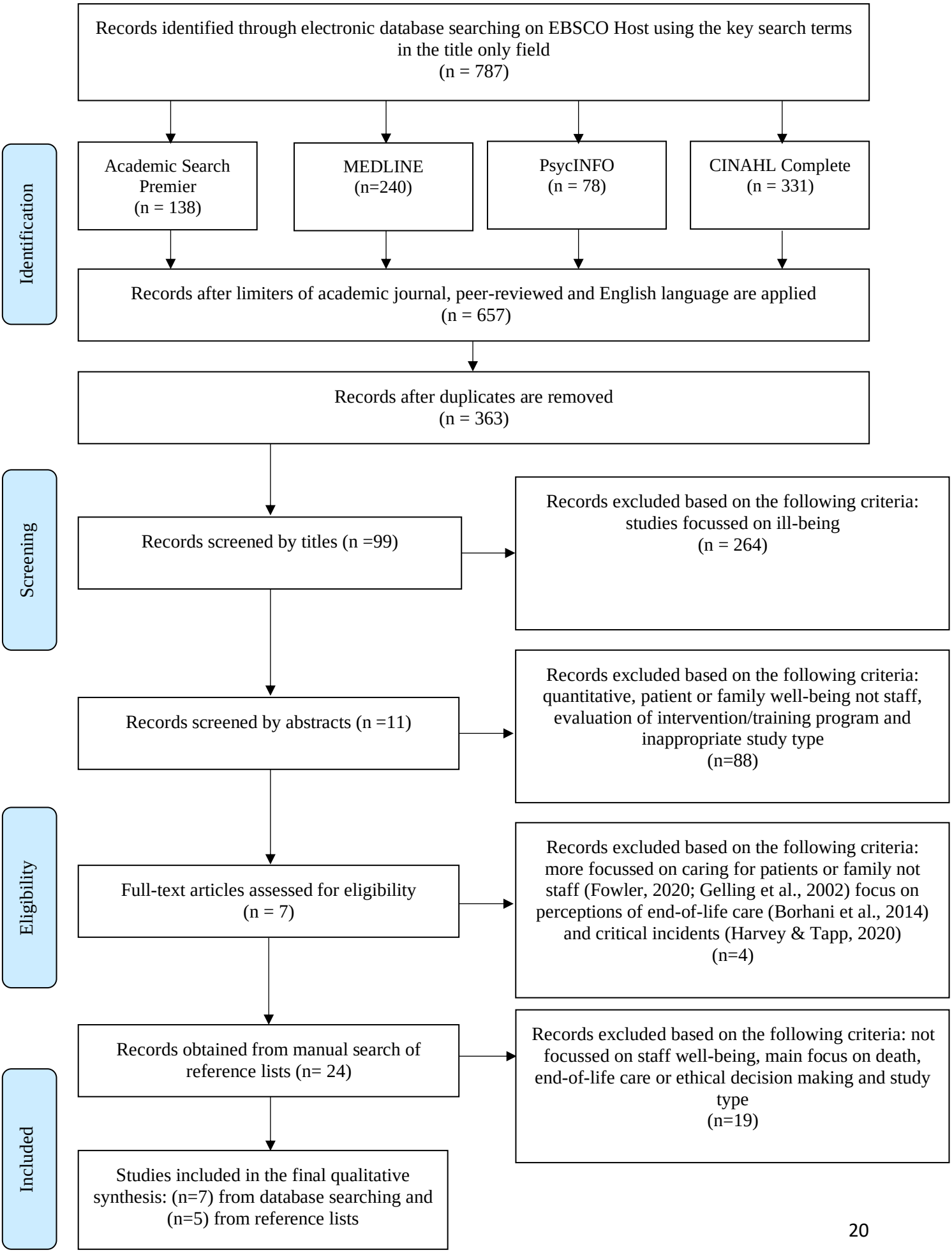
Exclusion Criteria	Rationale
Population: Staff without any clinical work experience of caring for patients **Context:** Working in departments of the hospital outside of the ICU without any regular input into the ICU	The review aimed to explore the well-being of healthcare professionals in response to the emotionally demanding clinical tasks of caring for patients and supporting families at work in the ICU. Therefore, any studies which looked at the impact on staff working in non-clinical roles or a role that does not involve working in the ICU were not included.
Outcome: Indicators of ill-being (e.g. burnout, compassion fatigue) in intensive care staff when not also accompanied by an indicator of well-being and when the main focus of the study is the well-being of patients or family members being explored from the staff perspective and not staff well-being from a staff perspective	The scope of the review was focussed on indicators of well-being not indicators of ill-being. Studies were not deemed relevant if they explored the well-being of patients, families or the team as the review focus is on individual staff well-being.
Language: Any non-English	As there was no provision for translation.
Study Design: Quantitative and Mixed	As quantitative studies are often focussed on gaining objective measurements of a phenomenon; whereas in-depth experiences can only be gained from qualitative studies which was the focus of the review.
Studies that measure the effectiveness of an intervention aimed at increasing well-being	The review aimed to explore staff experiences of well-being and not their experiences of interventions.
Study Type: Secondary research articles and articles that are not published in a peer-reviewed journal. All papers that are abstracts, literature reviews, meta-analyses, commentaries, letters, editorials, reports, conferences, grey literature, case reports.	As the review aimed to explore original, primary research articles and secondary research is beyond the scope of the review.

Article Selection

From the electronic database search, 787 articles were found (see Figure 1 for PRISMA flow diagram). After applying limiters and removing duplicates, this resulted in 363 articles. Screening of titles, abstracts and then full-text articles found seven articles which met the inclusion criteria. Combined with five articles identified from hand searching reference lists of the seven articles, this resulted in the final 12 articles which were reviewed (see Appendix B for list of excluded articles).

Figure 1

Article Selection Summary (The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram) (Moher et al., 2009)


Identification
Records identified through electronic database searching on EBSCO Host using the key search terms in the title only field
(n = 787)
Academic Search Premier
(n = 138)
MEDLINE
(n=240)
PsycINFO
(n = 78)
CINAHL Complete
(n = 331)
Records after limiters of academic journal, peer-reviewed and English language are applied
(n = 657)
Records after duplicates are removed
(n = 363)
Screening
Records screened by titles (n =99)
Records excluded based on the following criteria: studies focussed on ill-being
(n = 264)
Records screened by abstracts (n =11)
Records excluded based on the following criteria: quantitative, patient or family well-being not staff, evaluation of intervention/training program and inappropriate study type
(n=88)
Eligibility
Full-text articles assessed for eligibility
(n = 7)
Records excluded based on the following criteria: more focussed on caring for patients or family not staff (Fowler, 2020; Gelling et al., 2002) focus on perceptions of end-of-life care (Borhani et al., 2014) and critical incidents (Harvey & Tapp, 2020)
(n=4)
Records obtained from manual search of reference lists (n= 24)
Records excluded based on the following criteria: not focussed on staff well-being, main focus on death, end-of-life care or ethical decision making and study type
(n=19)
Included
Studies included in the final qualitative synthesis: (n=7) from database searching and (n=5) from reference lists

Quality Assessment

The quality of the studies included in the final review were assessed using the Critical Appraisal Skills Programme (CASP, 2018) qualitative research checklist (Appendix C). The purpose of the checklist met the review aims because it comprises ten questions each designed to critically assess the quality of qualitative studies. Following scoring (see Appendix F for guidelines), an overall quality rating score out of 10 was assigned to each paper by taking the sum of all the answers of 'yes'. Although there is no specific guidance within the CASP on how to interpret the quality, within the review an overall score of between 8-10 was regarded as 'very good quality' (Long et al., 2020). No papers were excluded based on the overall scores as all studies contributed something beneficial to the review and provided a useful insight into the quality of research that had been conducted around well-being within intensive care staff.

The CASP was chosen over other alternative checklists because it has been well-utilised for other reviews of qualitative studies in health and social care research (Dalton et al., 2017) including within intensive care (Jarden et al., 2020; Vanderspank-Wright et al., 2019). In addition, CASP is useful because it uses the same scoring system for each question and a total score can be calculated for each question.

To check rater reliability, six papers (three of the highest and three of the lowest scores) were rated by a peer reviewer, blind to the original ratings. The percentage level of agreement was 86%. Any discrepancies were discussed until there was shared agreement about the final rating. Due to the high level of agreement, the remaining sample was not peer reviewed.

Data Extraction

Relevant information was extracted from each study using a bespoke data extraction form (see Appendix D). The tool was developed through consideration of the information

that was needed to generate an overview understanding of the key features of each of the included articles and answer the review questions. The information collected included the authors(s), year of publication, research aims, indicator of well-being and definition, population and sampling, ICU setting and location, design, qualitative method of analysis and key findings in respect to the review questions.

Data Analysis and Synthesis

The findings from the included studies were analysed using thematic synthesis, which was developed by Thomas and Harden (2008). This was deemed most appropriate for answering the review question and for synthesising only qualitative studies using an inductive, interpretive approach (Dixon-Woods, 2005). Although there is some divergence across the articles in aims and how each study conceptualised well-being, the studies were mostly homogenous in their underlying concepts, sample, method of data collection and analysis. Thematic synthesis was used to identify and summarise the findings from each article, explain the links between study findings and use this new perspective to build on existing theory.

The thematic synthesis (Thomas & Harden, 2008) was conducted by first line by line reading of the 'findings/results' sections for each of the articles. Particular attention was given to the direct quotations which provided some insight into the raw data collected. Following this, the findings were re-interpreted in line with the review aims. Important parts deemed relevant to positive experiences of well-being were highlighted and all data was given initial codes which attached new meanings to the findings. Similarities and differences between the codes from each study were compared and integrated. This resulted in the most frequent codes within each study being compared to identify the most frequent codes across the included studies in the review. New codes were developed to build into descriptive

themes which were supported by direct quotations. Analytical themes were then generated to address the review questions, and this formed the basis of a theoretical understanding of well-being within intensive care staff. Initially both review questions were approached separately and then combined as a whole. Themes were adjusted until there was found to be no cross over between them and all were strongly supported by the included studies.

Results

Descriptive Overview of the Characteristics of Included Studies

The twelve included studies (see Table 4) were published between 1999-2020, with only four published before 2015 (Jahantigh et al., 2014; Mealer et al., 2012; Thornton & White, 1999; Wåhlin et al., 2010). Several countries were represented: three from Australia, two from the United States of America, two from the United Kingdom and one study each from Switzerland, Canada, New Zealand, Sweden and Iran.

All articles captured intensive care staff experiences of maintaining their well-being. However, only two studies directly investigated the concept of well-being/self-care (Jarden et al., 2018b; Siffleet et al., 2015; Wei et al., 2020). All studies explored how intensive care staff managed a challenging work environment, where burnout is a problem. One study explored the impact on ethical practice (Deflippis et al., 2020) and three studies focussed on the delivery of best care (Jahantigh et al., 2014; Jakimowicz et al., 2017; Jones et al., 2016).

The total number of participants across the articles was 384. Sample sizes ranged from seven to 171 participants. Eight papers included only intensive care nurses; one with intensivist doctors (Allen, 2017) and two with both doctors and nurses (Wåhlin et al., 2010; Wei et al., 2020). Across all studies, the number of nurses was 362 and doctors was 22.

All studies reported on participant gender which were predominately female, with 321 women and 82 men. This number is higher than the total participant number because Jones et al. (2016) reported on the overall gender split within the sample of 190 rather than on the 171 participants who provided consent to be involved. Six studies collected information about participant age and of those, five reported the age ranges, which across the articles was between 25 to 63 (Jahantigh et al., 2014; Jarden et al., 2018b; Mealer et al., 2012; Siffleet et al., 2015; Wåhlin et al., 2010). Of those studies that did report years of experience working in the ICU, the range was between one to 35 years (Deflippis et al., 2020; Jackson et al., 2018;

Jahantigh et al., 2014; Jakimowicz et al., 2017; Mealer et al., 2012; Siffleet et al., 2015; Wåhlin et al., 2010). Only four studies reported on other demographic factors (see Appendix E for further details).

The most common sampling methods used in ten studies were purposive and convenience. The other sampling methods used in order of frequency were theoretical (Allen, 2017; Deflippis et al., 2020; Siffleet et al., 2015) and snowballing (Jackson et al., 2018). Four papers used a combination of these methods (Allen, 2017; Deflippis et al., 2020; Jackson et al., 2018; Siffleet et al., 2015). Two studies did not report sampling method but were assumed to use convenience sampling (Jahantigh et al., 2014; Jones et al., 2016). Ten papers used interviews for data collection, one used open-text boxes on a questionnaire (Jarden et al., 2018b) and one used post-it notes (Jones et al., 2016).

Grounded theory was utilised as a method of data analysis by five studies, thematic analysis by three studies (Jarden et al., 2018b; Jones et al., 2016; Mealer et al., 2012) and content analysis for one study (Jahantigh et al., 2014). Two further studies used phenomenological approaches (Thornton & White, 1999; Wåhlin et al., 2010). In addition, one study used a qualitative descriptive approach which drew upon phenomenological principles (Wei et al., 2020). Seven studies used an interpretive approach and five a descriptive approach.

Table 4

Overview of Studies Included in the Review

Authors (s) and Year of Publication	Research Aims	Indicator of Well-being and Definition (if provided)	Population and Sampling	ICU Setting and Location	Design	Qualitative Method of Analysis	Key Findings	Quality Rating Score
Allen (2017)	To understand resilience in intensivists and the factors which enable them to continue managing the demands of working in the ICU	Resilience – "A dynamic process in which an individual may draw on a multidimensional characteristic in times of adversity, complexity and rapid change which allows this individual to positively adapt and thrive" (p. 48)	11 consultant intensivists Convenience and theoretical sampling	General medical adult ICU across multiple sites over four University Health Boards in Wales - UK	Open-ended, face-to-face interviews	Grounded Theory	Resilience is part personality and part learned and it depends on intensivists' ability to manage clinical and managerial responsibilities at work; whilst also protecting themselves from the emotional impact of the work and the challenges.	10
Deflippis, Curtis and Gallagher (2020)	To explore how intensive care nurses manage the challenges of working in the ICU and continue to practise in an ethical manner	Moral Resilience – "Source of inhibition for immoral actions and is necessary in order to resist negative external and internal pressures when taking a moral decision… a distinctive sense that life is meaningful" (p. 2)	16 nurses Convenience and theoretical sampling	Five ICU across multiple sites in Southern Switzerland	Face-to-face Interviews	Grounded Theory	Moral resilience involves intensive care nurses having self-awareness and confidence, as well as mutual respect and appreciation for colleagues. Both factors contribute to nurses feeling connected to themselves and others and able to manage ethical challenges at work.	10
Jackson, Vandall-Walker, Vanderspank-Wright, Wishart and Moore (2018)	To understand the process of resilience for intensive care nurses managing adversity at work in the ICU	Resilience – "The ability of an individual to adjust to adversity, maintain equilibrium, retain some sense of control over their environment and continue to move on in a positive manner" (p. 29)	11 nurses Purposive, convenience and snowball sampling	One medical-surgical ICU in one teaching hospital in Canada	Open-ended, face-to-face interviews	Grounded Theory	Workplace adversity is managed successfully through resilience/thriving or with difficulty through burnout/survival. Once aware of the problem, intensive care nurses act by protecting, processing, engaging and distancing themselves.	10

Authors (s) and Year of Publication	Research Aims	Indicator of Well-being and Definition (if provided)	Population and Sampling	ICU Setting and Location	Design	Qualitative Method of Analysis	Key Findings	Quality Rating Score
Jahantigh, Rezaee and Razaei (2014)	To explore the meaning of hope to intensive care nurses	Hope – "Wanting to realise what is possible… feeling what you want to happen… to believe a better feeling in the future… useful for having a healthy life" (p.106)	7 nurses Sampling not reported – assumed convenience	Two educational hospitals in Tehran - Iran	Semi-structured, face-to-face Interviews	Content Analysis	Hope is related to patient improvement and contributes to intensive care nurses feeling more able to perform in their role and job satisfaction.	3
Jakimowicz, Perry and Lewis (2017)	To explore factors impacting intensive care nurse's ability to provide compassion-focussed and patient-centred care	Compassion satisfaction – "An affirmative element of caring providing the 'feel good' experience of helping another during a time of suffering… may feel a sense of gratification, altruism or achievement" (p. 1601)	21 nurses Purposive sampling	Two adult ICU across two hospitals in Australia	Open-ended, face-to-face interviews	Grounded Theory	Compassion satisfaction comes from intensive care nurses feeling supported and able to meet expectations. This experience results in them feeling more engaged and energised in their work and able to provide good quality care to patients.	10
Jarden, Sandham, Siegert and Koziol-McLain (2018b)	To identify factors which intensive care describe as enhancing their workplace well-being	Well-being	65 nurses Purposive sampling	Multiple ICU sites across multiple hospitals in New Zealand	Two online free-text open-ended questions	Applied Thematic Analysis	Intensive care nurses use individual, team and organisational resources to maintain well-being at work. Getting distance from work and feeling supported and valued by colleagues and the organisation are important.	8
Jones, Winch, Strube, Mitchell and Henderson (2016)	To explore factors which enable and disable intensive care nurses to provide compassionate care	Compassion – "Being moved by another's suffering and wanting to help" (p. 3138)	171 nurses (total 190 but 19 did not consent) Sampling not reported – assumed convenience	One general-medical-surgical-trauma ICU in one hospital in South-East Queensland – Australia	Comments from sticky 'post-it' notes	Thematic Analysis	The organisation is important in providing nurses with access to supportive relationships, agreement within the team and good rapport with patients and families inside of work, as well as being able to use previous experiences and balance the demands of home life outside of work.	9

Authors (s) and Year of Publication	Research Aims	Indicator of Well-being and Definition (if provided)	Population and Sampling	ICU Setting and Location	Design	Qualitative Method of Analysis	Key Findings	Quality Rating Score
Mealer, Jones and Moss (2012)	To identify how intensive care nurses who are high in resilience manage work in the ICU compared to nurses diagnosed as having post-traumatic stress disorder (PTSD)	Resilience – "The ability to maintain healthy and stable psychological functioning despite exposure to extreme stressors" (p. 1446)	27 nurses Purposive sampling	Multiple ICU sites – medical, surgical, cardiac, cardiothoracic and paediatric in multiple hospitals in the USA	Semi-structured, open-ended, telephone interviews	Thematic Analysis	Resilience in intensive care nurses is used to manage workplace challenges and is influenced by their worldview, social network, cognitive flexibility and self-care. Resilience involves the use of positive coping mechanisms inside of work and strategies outside of work including optimism, humour, positive reframing, spirituality and distancing from work.	8
Siffleet, Williams, Rapley and Slayter (2015)	To explore how intensive care nurses maintain their emotional well-being at work and continue to work in the ICU	Emotional well-being	15 nurses Purposive and theoretical sampling	One surgical-medical-neurological-trauma and cardiothoracic ICU in one public hospital in Western Australia	Semi-structured, face-to-face interviews	Grounded Theory	Well-being contributes to satisfaction in intensive care nurses when they feel able to provide best patient care which includes working autonomously, good teamwork and using previous experiences. This alongside feeling validated and able to distance themselves from the emotional impact of the work help nurses to protect themselves from distress and motivate them to work harder.	8
Thornton and White (1999)	To explore the experience of humour in intensive care nurses and understand how they manage stress in the ICU environment	Humour – "The condition of being amused or comic… a reactive experience… unexpectedness, surprise, anticipation, incongruity or incompatibility" (p. 266)	8 nurses Convenience sampling	One ICU in one tertiary teaching hospital in the UK	Semi-structured, open-ended, face-to-face interviews	Heideggerian Phenomenological Approach	Humour at work is a way for intensive care nurses to communicate, build teamwork and relieve stress at work. The type of humour is unique to the ICU but influenced by personality and level of experience.	10

Authors (s) and Year of Publication	Research Aims	Indicator of Well-being and Definition (if provided)	Population and Sampling	ICU Setting and Location	Design	Qualitative Method of Analysis	Key Findings	Quality Rating Score
Wåhlin, Ek and Idvall (2010)	To explore how intensive care staff experience empowerment	Empowerment – "Intrinsic task motivation… to energise… four components of impact, competence, meaningfulness and choice/self-determination" (p. 263)	8 nurses and 4 doctors Purposive sampling	Two general ICU in two hospitals in Southern Sweden	Open-ended, face-to-face interviews	Empirical Phenomenological Psychological Method	Intensive care staff feel empowered by feelings that they are doing good and are confident using their knowledge/skills to care for patients, as well as maintaining good relationships with colleagues in a supportive work environment where the challenges are seen as exciting and allow for individual development.	10
Wei, Kifner, Dawes, Wei and Boyd (2020)	To understand the self-care strategies used among intensive care nurses and doctors to cope with burnout and promote well-being	Self-care – "Finding ways to replenish, recharge and invigorate oneself" (p. 52)	13 nurses and 7 doctors Convenience and purposive sampling	One paediatric ICU and one intermediate care unit in one children's hospital in the USA	Face-to-face interviews	Qualitative Descriptive Approach	Intensive care nurses and doctors maintain their well-being through the development of effective coping strategies. Feeling that the work done caring for patients is purposeful is found to be most important and contributes to staff feeling more motivated and passionate to perform their jobs.	8

Methodological Quality Assessment of Included Studies

The methodological quality of each paper was assessed using the CASP which can be found in Appendix F (see Table 3 for quality scores). Eleven studies scored between 8-10 which indicates 'very good quality' across most included studies. Of those, six were rated with a maximum score 10/10. One study was rated 3/10 (Jahantigh et al., 2014), mostly based on recruitment strategy and rigour of data analysis.

Looking at the overall quality, qualitative methodology was deemed appropriate for each study to meet their research aims which were considered to be clearly defined. Most of the studies apart from Jahantigh et al. (2014) clearly explained the data collection protocol in a way that was replicable. Data analysis was also well reported with sufficient detail, including direct quotations, and important clinical implications which could be identified. In addition, on the whole, the findings were rich in detail and clearly presented.

The most common reason for lower scores were inadequate reporting of the reflexive relationship between the participants, the data and the researcher (Jarden et al., 2018b; Mealer et al., 2012; Siffleet et al., 2015; Wei et al., 2020). Only six studies met the checklist criteria but even these studies, apart from Allen (2017), lacked a detailed discussion of both the role of the researcher and how they maintained a reflexive observer position when co-constructing a shared understanding with participants. Studies using grounded theory were best at considering reflexivity (Allen, 2017; Deflippis et al., 2020; Jackson et al., 2018; Jakimowicz et al., 2017; Siffleet et al., 2015). In addition, there was a lack of depth when reporting on ethical issues. All studies confirmed that they had obtained ethics approval but four studies which did not meet the criteria neglected to report on other factors such as informed consent and the potential impact on participants of taking part in the interviews (Jahantigh et al., 2014; Mealer et al., 2012; Siffleet et al., 2015; Wei et al., 2020).

Thematic Synthesis of Findings

Three analytical themes, nine first-order descriptive themes and seventeen second-order descriptive themes emerged from the thematic synthesis of the findings from the included studies (see Table 5). Further detail about how the themes emerged from codes is presented in Appendix G. The first order descriptive themes covered the indicators of individual well-being (i.e. the positive emotions, processes, actions, traits, resources and strengths which intensive care staff recognised as linked to their well-being) and the second order descriptive themes covered the positive lived experiences and personal resources associated with well-being (i.e. the factors intensive care staff used to maintain their well-being). Direct quotations from participants are included in italics.

Table 5

Overview of Thematic Synthesis with Representative Studies

Analytical Themes	First Order Descriptive Themes	Second Order Descriptive Themes	Representative Studies
Managing Challenges at Work	Strengths of Character (resilience)	• Ability to cope • Protection from difficult emotions	Allen (2017), Jackson et al (2018), Jakimowicz et al (2017), Thornton and White (1999), Wåhlin et al (2010), Wei et al (2020)
	Positive Outlook (hope/optimism/ acceptance)	• Reflection and reframing • Successful management of end-of-life care	Allen (2017), Deflippis et al (2020), Jahantigh et al (2014), Jakimowicz et al (2017), Jarden et al (2018b), Mealer et al (2012), Wåhlin et al (2010), Wei et al (2020)
	Getting the Job Done (confidence/ competence)	• Completing clinical tasks • Learning from previous experiences	Allen (2017), Deflippis et al (2020), Jackson et al (2018), Jakimowicz et al (2017), Jones et al (2016), Mealer et al (2012), Siffleet et al (2015), Thornton and White (1999), Wåhlin et al (2010)
	Engaging in Self-Care (joy/happiness/ satisfaction)	• Physically distancing from work • Activities outside of work	Allen (2017), Jackson et al (2018), Jakimowicz et al (2017), Jarden et al (2018b), Jones et al (2016), Mealer et al (2012), Siffleet et al (2015), Wei et al (2020)
Finding Meaning at Work	Instinctive Carer (passion/purpose/ privilege/pride)	• Guided by values • Uplifted by positive feedback	Deflippis et al (2020), Jakimowicz et al (2017), Jones et al (2016), Mealer et al (2012), Siffleet et al (2015), Wåhlin et al (2010), Wei et al (2020)
	Making a Difference (achievement/ empowerment/ rewarded)	• Contributing to patient progression • Feeling that change is possible	Allen (2017), Jackson et al (2018), Jahantigh et al (2014), Jakimowicz et al (2017), Jarden et al (2018b), Jones et al (2016), Mealer et al (2012), Siffleet et al (2015), Thornton and White (1999), Wåhlin et al (2010), Wei et al (2020)
Feeling Supported at Work	Working Together (harmony/ collaboration/ teamwork)	• Multi-disciplinary decision making	Deflippis et al (2020), Jakimowicz et al (2017), Jarden et al (2018b), Jones et al (2016), Mealer et al (2012), Siffleet et al (2015), Thornton and White (1999), Wåhlin et al (2010), Wei et al (2020)

Analytical Themes	First Order Descriptive Themes	Second Order Descriptive Themes	Representative Studies
	Shared Fun (camaraderie/ enjoyment)	• Socialising away from the bedside • Letting off steam with humour	Allen (2017), Jackson et al (2018), Jakimowicz et al (2017), Jarden et al (2018b), Jones et al (2016), Mealer et al (2012), Siffleet et al (2015), Thornton and White (1999), Wåhlin et al (2010), Wei et al (2020)
	Moving Forwards (growth)	• Opportunities for professional development • Formal resources	Allen (2017), Jackson et al (2018), Jakimowicz et al (2017), Jarden et al (2018b), Jones et al (2016), Siffleet et al (2015), Wåhlin et al (2010), Wei et al (2020)

1. Managing Challenges at Work

This analytical theme highlighted the ability of intensive care staff to manage the practical and emotional challenges within their work environment. Staff demonstrated an awareness of the demands unique within their workplace and relied on particular attributes, and the application of specific strategies at work and home to overcome challenges to their well-being. Four related sub-themes emerged of: strengths of character, positive outlook, getting the job done and engaging in self-care.

1.1 Strengths of Character

1.1.1 Ability to cope

Several intensive care staff, across different studies, related to the idea that working in the ICU involved a certain set of attributes perceived to represent resilience as a personality trait (Allen, 2017; Jackson et al., 2018; Thornton & White, 1999). These attributes were experienced as developing throughout a person's life and leading them to work within the ICU where the associated challenges are viewed as more manageable, but also interesting and exciting (Allen, 2017; Wåhlin et al., 2010). However, different definitions of resilience were provided across the studies and only Jackson et al. (2018) explicitly asked participants about

their understanding of its meaning. This calls into question whether the findings were actually about resilience, or another experience labelled as resilience.

"Resilience is the ability to handle difficult situations with poise and be able to come back to work the following day" (Jackson et al., 2018; page 33)

1.1.2 Protection from difficult emotions

The ability to disconnect from their emotions whilst at work was perceived by some intensive care staff to be protective (Allen, 2017; Jackson et al., 2018; Jakimowicz et al., 2017; Thornton & White, 1999; Wei et al., 2020). Some staff also viewed their ability to control, hide or ignore emotions at work as part of maintaining a professional identity (Allen, 2017; Jakimowicz et al., 2017; Thornton & White, 1999). However, it is unclear whether the responsibility of occupying a leadership position impacts emotional expression or management, as Allen (2017) only recruited consultants and the other studies within the sub-theme did not address the impact of seniority on well-being.

"I always distance myself from the patient becoming too close…maybe to protect myself" (Allen, 2017; page 63)

1.2 Positive Outlook

1.2.1 Reflection and reframing

Self-reflection occurred in the context of daily experiences of witnessing trauma and death at work which were positively reframed (Jarden et al., 2018b; Mealer et al., 2012; Wei et al., 2020). Being optimistic, hoping for improvements and recalling more positive memories of patient care was a common experience associated with well-being which

enabled and motivated intensive care staff to continue at work (Jahantigh et al., 2014; Mealer et al., 2012; Wei et al., 2020). However, limited information within the studies explained what this 'positive attitude' (Wei et al., 2020) involves or discussed whether it is something already present within staff or adopted in response to working in the ICU. Moreover, as only half of the studies within the review and none within this sub-theme transparently described the role of the researcher, these findings may be vulnerable to researcher bias and may reduce the robustness of the results.

"I don't get down on a lot of things. I let things fall off of me. I try to look on the bright side of everything" (Mealer et al., 2012; page 1448)

1.2.2 Successful management of end-of-life care

When hopeful fighting for life was no longer possible, accepting that death cannot be controlled was perceived by intensive care staff as enabling them to move forward from challenging end-of-life situations and focus on providing patients with a dignified death (Allen, 2017; Deflippis et al., 2020; Jahantigh et al., 2014; Jakimowicz et al., 2017; Jarden et al., 2018b; Mealer et al., 2012; Wåhlin et al., 2010, Wei et al., 2020). Holding onto spiritual beliefs helped some staff to turn these difficult situations into ones with more positive outcomes (Allen, 2017; Jahantigh et al., 2014; Mealer et al., 2012; Wei et al., 2020). Despite this, the sub-theme is partly limited in its ability to understand well-being because it is significantly represented by the study from Jahantigh et al. (2014). Whilst raising important points around the importance of a positive attitude when faced with patient death, the study quality and hence the trustworthiness of the conclusions should be questioned because the findings were not well presented and lacked detail without clear themes.

"We are doing the best we can and we are doing it with passion, but we aren't the ultimate power for anything that is going on" (Mealer et al., 2012; page 1448)

1.3 Getting the Job Done

1.3.1 Completing clinical tasks

Being able to autonomously manage the tasks of a busy workload using expert skills and knowledge to provide high quality patient care was experienced by intensive care staff as contributing to increased self-confidence (Allen, 2017; Deflippis et al., 2020; Jakimowicz et al., 2017; Siffleet et al., 2015; Wåhlin et al., 2010). Staff also perceived themselves to be more competent when they could communicate with patients and families to improve their understanding of what is happening around them in the ICU (Allen, 2017; Jakimowicz et al., 2017; Siffleet et al., 2015; Wåhlin et al., 2010). Apart from Wåhlin et al. (2010), grounded theory was the chosen method of data analysis and sample sizes were determined by reaching data saturation. Data saturation indicates that a strong understanding of the research topic may have been gained as theory is generated directly from data. However, this is a subjective process which lacks rigour with no clear guidelines and as a result, researchers run the risk of prematurely ending data collection.

"…the clinical side of things…providing the best care that you possibly can" (Allen, 2017; page 57)

1.3.2 Learning from previous experiences

Managing previously challenging situations was described by intensive care staff as important to well-being because finding solutions to problems reduced uncertainty about facing similar challenges in the future (Allen, 2017; Deflippis et al., 2020; Jackson et al.,

2018; Jakimowicz et al., 2017; Jones et al., 2016; Mealer et al., 2012; Siffleet et al., 2015; Thornton & White, 1999; Wåhlin et al., 2010). Over time, increased self-awareness and development of coping strategies were experienced as making it easier for some staff to maintain their well-being but for others, more responsibility came with more pressure (Allen, 2017; Deflippis et al., 2020; Jackson et al., 2018; Jakimowicz et al., 2017; Siffleet et al., 2015). A maximum quality rating was attributed to six studies within this sub-theme, and all were considered to be high quality. Using the CASP quality checklist, this implies that these studies can reliably answer the review questions. However, this cannot be assumed as each qualitative study can only provide an understanding of one specific context in time and therefore cannot be generalised.

"Because this is important to me…how I learn, how I feel that I'm growing in my tasks and can manage challenges better" (Wåhlin et al., 2010; page 266)

1.4 Engaging in Self-Care

1.4.1 Physically distancing from work

Intensive care staff strongly identified with the need to physically distance from work to maintain job satisfaction (Allen, 2017; Jackson et al., 2018; Jakimowicz et al., 2017; Jarden et al., 2018b; Jones et al., 2016; Mealer et al., 2012; Siffleet et al., 2015; Wei et al., 2020). Clear boundaries between work and home were ideal but not always possible (Allen, 2017; Jarden et al., 2018b; Wei et al., 2020). Flexibility in being able to take time off work through annual leave and part-time hours was experienced as necessary for managing long-term with the workload (Jackson et al., 2018; Jarden et al., 2018b). Three of the studies within this sub-theme lacked a clear description of ethical issues (Mealer et al., 2012; Siffleet et al., 2015; Wei et al., 2020), which could indicate a lack of rigour and limits confidence in

the interpretations made as it is unclear whether the participants views are their own or coerced.

"…to keep stepping away from the bedside, because that's where all the stress is for me, it's at the bedside. You need to remove yourself from the situation" (Jackson et al., 2018; page 33)

1.4.2 Activities outside of work

Connections with family, friends and activities were described by staff as helping them to rest and enjoy time away from work (Allen, 2017; Jackson et al., 2018; Jarden et al., 2018b; Jones et al., 2016; Mealer et al., 2012; Siffleet et al., 2015; Wei et al., 2020). Having interests such as exercise and journaling were viewed as important for creating separation from work stressors (Jarden et al., 2018b; Mealer et al., 2012; Wei et al., 2020). However, not all studies within the review identified outside of work factors as important to staff well-being. This may result from the variability in study aims which focussed more on workplace factors and the interview questions being asked; however, only two studies explicitly shared their interview schedules and were transparent about how data was collected (Allen, 2017; Mealer et al., 2012; Wei et al., 2020).

"…people who are good at managing stress…have very solid values around stuff outside work…which for most people is family" (Allen, 2017; page 69)

2. Finding Meaning at Work

This analytical theme considered how a desire to help other people and contribute to something worthwhile drives many staff to their chosen careers in the ICU and sustains them

even despite the challenges. Within this theme, intensive care staff strongly identified with how doing something good for someone else in a professional capacity enabled them to feel good on a personal level. Two related sub-themes emerged of: instinctive carer and making a difference.

2.1 Instinctive Carer

2.1.1 Guided by values

For many intensive care staff, caring was viewed as a privilege which fulfilled an internal purpose, and this was perceived to be an important value that guided them throughout their lives (Deflippis et al., 2020; Jakimowicz et al., 2017; Mealer et al., 2012; Wei et al., 2020). Remaining connected with their reasons for choosing to work in the ICU was considered important for helping staff to continue finding passion for their jobs (Deflippis et al., 2020; Jakimowicz et al., 2017; Wei et al., 2020). Caring for others was a prominent theme found by Wei et al. (2020), although their sample is limited because it mostly comprised females at one hospital. Furthermore, as the studies within the sub-theme differed widely in their perception and conceptualisation of well-being from self-care to resilience, it is unclear how purpose contributes and sustains staff well-being and is influenced by other factors such as gender and years of work experience.

"Caring, for me, is the heart. Doing things out of your heart adds meanings and value to what we do" (Wei et al., 2020; page 47)

2.1.2 Uplifted by positive feedback

Receiving good feedback from patients, families and colleagues in recognition of their skills and appreciation of their commitment to caring helped intensive care staff to

positively evaluate their performance in their job and experience pride (Jakimowicz et al., 2017; Jones et al., 2016; Siffleet et al., 2015; Wåhlin et al., 2010). However, the best way to deliver feedback remains unclear from the included studies. Overall, rich information for this sub-theme was gained through interviews, apart from in Jones et al. (2016) where only brief responses to the research questions were gained on post-it notes. Although this limits the richness of the data collected, the credibility of the findings is enhanced by the large sample size and because participants were asked to comment on whether the most frequent themes fit with their experiences.

"…families give you feedback and thank you, you're doing such a good job, just positive feedback" (Siffleet et al., 2015; page 308)

2.2 Making a Difference

2.2.1 Contributing to patient progression

Seeing patients improve and progress because of their determination to provide holistic care was experienced as rewarding for intensive care staff (Allen, 2017; Jahantigh et al., 2014; Jakimowicz et al., 2017; Jones et al., 2016; Mealer et al., 2012; Siffleet et al., 2015; Thornton & White, 1999; Wåhlin et al., 2010; Wei et al., 2020). Working with patients when there was low chances of recovery or unexpected changes negatively impacted well-being but often motivated staff to continue working hard for patients in the future (Jakimowicz et al., 2017; Wåhlin et al., 2010). This was similarly experienced by staff working in a range of ICU types, however; only two studies within the review recruited staff from paediatric ICU where different themes may have emerged (Mealer et al., 2012; Wei et al., 2020).

"...I know that I have been able to do everything I can for the patient that is in their best interests, and then it gets even a little bit better if it works out and they get better" (Jakimowicz et al., 2017; page 1605)

2.2.2 Feeling that change is possible

The ability to make beneficial changes to the lives of patients was perceived as important for staff to experience achievement at work (Allen, 2017; Jackson et al., 2018; Jakimowicz et al., 2017; Jarden et al., 2018b; Jones et al., 2016; Wåhlin et al., 2010). Lack of funding for resources such as staff and equipment, service pressures and slow decision making within the system often contributed to frustration when intensive care staff were aware of what needed to change but felt unable to make this happen (Allen, 2017; Jackson et al., 2018; Jakimowicz et al., 2017). Two of the included studies within the review only answered the second of the two review questions (Jarden et al., 2018b; Jones et al., 2016) as the meaning of well-being was not considered in its parts. However, all studies within the sub-theme provided sufficient detail to generate new understandings from the findings.

"I feel like I'm stuck in that situation and I can't do anything about it. I can't fix it and there's no solution to it" (Jackson et al., 2018; page 31)

3. Feeling Supported at Work

This analytical theme concerned the support that intensive care staff give and receive at work. Staff perceived their well-being to depend on how connected they felt to their team and how valued they felt by the wider organisation. Within this theme, three related sub-themes emerged of: working together, shared fun and moving forwards.

3.1 Working Together

3.1.1 Multi-disciplinary decision making

Working alongside multi-disciplinary colleagues who respect each other regardless of profession, hierarchy or seniority and worked to achieve the same goals was experienced by intensive care staff as important for making joint decisions in the interest of patients (Deflippis et al., 2020; Jakimowicz et al., 2017; Jarden et al., 2018b; Jones et al., 2016; Mealer et al., 2012; Siffleet et al., 2015; Thornton & White, 1999; Wåhlin et al., 2010; Wei et al., 2020). Even when disagreement occurred, listening non-judgementally, sharing ideas and clearly communicating treatment plans was experienced as positive for staff well-being (Deflippis et al., 2020; Jakimowicz et al., 2017; Jarden et al., 2018b; Jones et al., 2016). As most studies within the review were represented within the sub-theme, this highlights the importance of professional relationships to well-being despite the different research aims and team working terminology being excluded from the search terms.

"Working together, different professions, with the same goal in front of your eyes. And supporting each other in all directions" (Wåhlin et al., 2010; page 266)

3.2 Shared Fun

3.2.1 Socialising away from the bedside

Away from the clinical demands of work, camaraderie between colleagues was described by intensive care staff as contributing to an enjoyable work atmosphere (Allen, 2017; Jackson et al, 2018.; Jakimowicz et al., 2017; Jarden et al., 2018b; Jones et al., 2016; Siffleet et al., 2015; Thornton & White, 1999; Wåhlin et al., 2010; Wei et al., 2020). Team morale was perceived to be strengthened by knowing that colleagues understood their experience and could talk through their concerns together (Allen, 2017; Jackson et al., 2018;

Jakimowicz et al., 2017; Siffleet et al., 2015; Thornton & White, 1999; Wåhlin et al., 2010). Having time to step away from the bedside to socialise was important (Allen, 2017; Jackson et al., 2018; Jarden et al., 2018b). Although qualitative methodology was appropriate for all the studies within this sub-theme, the diversity in methodology impacts the strength of support for answering the review question. This is because it is difficult to compare the study findings when different data analysis protocols are adopted, and it cannot be guaranteed that the researchers did and found what they said they did.

"I have good friends at work, and I think just being able to talk situations through because sometimes – it's good to talk it through with people that understand" (Jakimowicz et al., 2017; page 1604)

3.2.2 Letting off steam with humour

The ability to connect with colleagues on a personal level to offer them support was perceived to involve humour, especially dark and sarcastic forms (Jackson et al., 2018; Mealer et al., 2012; Thornton & White, 1999; Wåhlin et al., 2010). Laughter was described as a team stress-reliever which made the more challenging or boring work tasks more fun (Jackson et al., 2018; Thornton & White, 1999). Despite humour frequently being identified as important, only Thornton and White (1999) provided any detail about how humour is used by staff. Furthermore, as most studies focussed on how humour contributed to stress reduction rather than well-being, this limits the transferability of the findings to answer the review questions.

"Humour is part of the team and the process of how the team works together" (Thornton & White, 1999; page 273)

3.3 Moving Forwards

3.3.1 Opportunities for professional development

Some intensive care staff perceived the ability to attend further training and conferences as important for maintaining up to date knowledge, meeting professional competencies and progressing within their careers (Jackson et al., 2018; Jakimowicz et al., 2017; Jarden et al., 2018b; Siffleet et al., 2015; Wåhlin et al., 2010). However, it is unclear whether further development is only valued by staff as a means to meet the expectations for their professional registration or more for those interested in obtaining management positions. In addition, as only nurses and a few doctors were represented within the samples, it is unclear whether professional growth is valued as highly by other MDT professionals working in the ICU.

"…adequate training and individualised plans for professional growth (that are followed through)" (Jarden et al., 2018b; page 18)

3.3.2 Formal resources

When the employing organisation provided intensive care staff with formal support, they perceived themselves to be valued employees (Allen, 2017; Jackson et al., 2018; Jakimowicz et al., 2017; Jarden et al., 2018b; Jones et al., 2016; Wei et al., 2020). Practical support involved access to food, water and breaks at work but also feeling that preferences around rotas and shifts were taken into consideration (Allen, 2017; Jackson et al., 2018). Emotional support involved encouragement from senior managers, the provision of clinical supervision and clinical psychology, as well as group support for teams, but this was generally poorly defined across the studies within this sub-theme with a lack of detail about the contribution to staff well-being (Jackson et al., 2018; Jakimowicz et al., 2017; Jarden et al., 2018b; Jones et al., 2016; Wei et al., 2020).

"…no debrief, no support from management, it's just a job now – I can't care as much as I did, I can't" (Jakimowicz et al., 2017; page 1604)

Discussion

Overview of Findings

This review aimed to explore the indicators, positive lived experiences and personal resources which enable intensive care staff to maintain their well-being at work. The majority of the research has tended to draw predominately from staff experiences of ill-being in order to consider how to support staff at work (Costa & Moss, 2018; Jarden et al., 2018a), but this misses out on a significant proportion of positive experiences. This review demonstrates how well-being involves staff using several skills and resources within themselves and others to feel positive about themselves and their work in the ICU. By considering the underlying definitions and meanings of 'well-being' within the search strategy, beyond the search term 'well*' used by Jarden et al. (2020), this review identified eleven more studies which have value in adding to the understanding of well-being in intensive care staff. Furthermore, it highlights how the qualitative literature on the topic is emerging.

Indicators of Well-Being

As described by Danna and Griffin (1999), well-being at work was found to depend on interactions between the individual, job demands and the work setting, including the team and the organisation. This review highlighted how intensive care staff draw upon a range of personal resources (Bakker & Demerouti, 2017), from hope to confidence to passion, to continue feeling engaged and motivated in their job. The first order descriptive themes fit with a eudaimonic perspective on well-being by showing that any definition of well-being should consider more than just experiencing happiness, given the clear focus on meaning and purpose (Henderson & Knight, 2012; Ruggeri et al., 2020; Ryan & Deci, 2001). For instance, the analytical theme 'finding meaning at work' demonstrated how an indicator of well-being was staff experiencing passion for caring and feeling rewarded by seeing patients improve (Ryff & Keyes, 1995; Waterman, 1993). This resonates with findings from Galuska and

Bursch (2020), as the PERMA model (Seligman, 2011) mapped strongly onto the indicators of well-being within this review (see Table 6).

Table 6

Links between Indicators of Well-being in Intensive Care Staff and the PERMA model

Positive Emotions	Engagement	Relationships	Meaning	Accomplishment
Resilience	Confidence	Harmony	Purpose	Achievement
Hope	Competence	Collaboration	Privilege	Rewarded
Optimism	Passion	Teamwork	Pride	Growth
Acceptance	Enjoyment	Camaraderie		
Joy	Empowerment			
Happiness				
Satisfaction				

The included studies had very different research aims and ways of understanding well-being. However, this highlighted the complexity of well-being which cannot be understood without fully considering its meanings and conceptual underpinnings (Dodge et al., 2012). Resilience was the most saliently reported indicator of well-being across three studies (Allen, 2017; Jackson et al., 2018; Mealer et al., 2012). Shared ideas emerged about resilience as a positive experience developing from a challenging situation and this demonstrated how well-being does not necessarily mean focussing only on what is 'positive' (Gable & Haidt, 2005; Ryff & Singer, 2008).

Positive Lived Experiences and Personal Resources Maintaining Well-Being

Despite the broad definition of well-being, similar themes, which were all strongly represented by the included studies, highlighted the many positive experiences at work which help intensive care staff to maintain their well-being. This review demonstrated that staff well-being involves the ability to use individual, team and organisational resources. It also

highlighted that well-being may be less related to the ability of staff to engage in self-care strategies outside of work, but more experiences at work often outside of personal control.

Some intensive care staff perceived that certain attributes and skills made them more suited to working in the ICU but equally the associated challenges were often experienced as getting easier over time with increased confidence. This offered support for Burgess et al. (2010) where certain traits were associated with how intensive care nurses experienced and overcame workplace stressors. Protecting themselves from the emotional challenges of caring for unwell and dying patients by maintaining some distance was found to be particularly beneficial to well-being (e.g. Henrich et al., 2017; Piquette et al., 2009).

Forming positive relationships, especially with colleagues who work alongside each other with shared goals and understandings of the work pressures, were highly valued by intensive care staff. This was perceived by staff to enable psychological safety, where it is viewed as safe to challenge existing practices and generate new learning within teams (Edmonson & Mogelof, 2006). It also highlighted the importance of organisations embedding values of compassion within teams (Fotaki, 2015; West & Bailey, 2019). Increased job satisfaction and improved patient outcomes have been identified as some of the consequences when intensive care staff feel comfortable, supported and able to make things happen together as a team (e.g. Bjurling-Sjöberg et al., 2017; Wheelan et al., 2003).

Having the support from their employing organisations was found to be necessary for intensive care staff to utilise the other resources at the individual and relational level to maintain their well-being in times of stress at work, but also during the rest of the time to remain happy and healthy. Well-being was also found to be closely linked to their ability to support patients, which Wilkin and Slevin. (2003) described within nurses as a process of advocacy and delivering holistic care in the ICU. However, for this to happen, staff needed to feel that they had both the time and the physical resources to do their job. This included being

able to leave the ward for breaks at work, as well as accessing appropriate staffing, equipment, training and emotional support. As a result, intensive care staff described feeling passionate and motivated in their jobs, rather than stressed and exhausted. This supported the definition of well-being from Dodge et al. (2012) and the J-DRM (Demerouti et al., 2001) where job resources must exceed the challenges.

Strength of the Evidence and the Review

The included studies were generally high quality and met the essential criteria for qualitative research to be replicable with clearly described data collection methods, rich findings and valuable conclusions which fit with the study aims. However, there was inconsistent reporting of the researcher's role in half of the studies and a lack of detail when describing ethical issues. In particular, Jahantigh et al. (2014) was the only study not meeting the checklist criteria for 'very good quality', which indicates that the study findings may not be valid. Despite this, several interpretations with reference to the review questions can be made from the studies with some confidence in the methodological quality of the studies and review.

The CASP checklist provided a helpful guide for determining the methodological quality of the studies. It is the most used method for assessing qualitative studies (Dalton et al., 2017) and is argued by Long et al. (2020) to be convenient for individuals new to conducting systematic reviews. However, the current review may have been improved by the development of a bespoke checklist to address some of the limitations of CASP including additional clarification questions about data analysis and the researcher's theoretical position within the research (Long et al., 2020).

As the studies within this review were mostly published in the last five years, this indicates that the findings are likely to be relevant, up to date and valuable for understanding

the review topic. However, the findings cannot be generalised to consider the well-being of the wider multi-disciplinary ICU team because qualitative studies can only capture the experiences of one group of people at one specific time point and the sample comprised mostly female nurses. In addition, as there is a lack of ethnicity across samples and only one study represented a non-Western culture (Jahantigh et al., 2014), the findings are limited to understanding well-being in Western cultures.

Charlesworth and Foëx (2016) argue that qualitative methodology is under-utilised within intensive care research. The inclusion of only qualitative studies is a strength of the review because of the depth of information that can be gained about unique staff experiences of well-being (Sinuff et al., 2007). However, one challenge of reviewing solely qualitative studies is that there is less of an agreed way of assessing quality, there are fewer tools to choose from (Katrak et al., 2004) and studies can be harder to compare without specific measures or statistics (Thomas & Harden, 2008). In addition, although there is always an influence of the researcher's own experiences on their interpretation of the data, this is arguably greater within qualitative studies as the researcher makes decisions about how data is organised into themes (Charlesworth & Foëx, 2016; Stenfors et al., 2020). Bias is introduced further by the secondary interpretations made by the lead reviewer for the purpose of this review, where the raw data is not available. The potential impact was minimised by engaging in reflective memo writing and supervision.

Finally, the review is limited by how well-being was conceptualised. The search terms were chosen after several revisions, by carefully examining the literature and discussing this with research supervisors. Despite this, the search is not exhaustive as well-being may be understood in multiple ways (Dodge et al., 2012) and choosing the terms was ultimately a subjective process under responsibility of the lead reviewer. Searching for articles in the title field only, excluding grey literature and not contacting authors to identify

any unpublished work may have impacted the review quality by introducing the potential for bias. The review is also limited by how the included studies operationalised well-being as a lack of research in certain areas limits the ideas that could be generated to answer the review questions.

Clinical Implications and Future Research

By exploring the positive experiences contributing to well-being in intensive care staff, the intention of this review was not to ignore that working in the ICU can be a highly challenging place to work but to acknowledge the other side which is often missed. The evidence base has long focussed on measuring ill-being and work-related outcomes such as absenteeism and retention (Shoorideh et al., 2015; van Dam et al., 2013). However, this approach views staff as employees first and people second, and it can be perceived as blaming of individuals who might struggle to cope with the demands. More research is needed to adopt a 2WPP approach to explore the positive by considering its merit alone and in parallel with the range of other experiences, without viewing well-being only in the context of ill-being (Gable & Haidt, 2005; Lomas et al., 2020).

Looking at ill-being and well-being may superficially appear to be flip sides of the same coin, yet there are fundamental differences and there is value in focussing more on the positive. Firstly, learning about the positive has been argued as important for creating positive change (Cameron, 2008). Secondly, it is not possible to remove all of the negative or challenging elements of working in the ICU (Alameddine et al., 2009) and so it makes sense to prioritise and optimise what staff say is going right. Finally, focussing more on the positive may encourage more people to join the profession by viewing the ICU as a “positive place to work” (Highfield, 2021, p.2).

As well-being is multi-dimensional, more high-quality research should explore indicators of well-being which may differ between professional roles, cultures and countries, as discussed by Ruggeri et al. (2020), which is likely to impact how staff want to be supported. By first going back to the basics to explore what contributes to happiness in intensive care staff may be beneficial as happiness has been linked to positive emotions and positive work outcomes (Lyubomirsky et al., 2005). Furthermore, the included studies explored very specific concepts such as resilience or empowerment but ultimately identified similar elements as important to staff, which this review broadly conceptualised as part of well-being. Despite the different labels, all studies shared a collective research objective of trying to understand how to best support intensive care staff at work. For future research exploring the various components of wellbeing, explicitly stating the relevance to the well-being literature may be helpful. This could enable people involved in supporting intensive care staff looking for this type of research in the future to quickly locate the relevant information without searching for the individual indicators as was necessary in this review.

Although intensive care staff manage their well-being through utilising skills and strategies, they need help in doing this as the biggest barriers to well-being were frequently experienced as linked to factors associated with working in chronically under-resourced and under-funded systems. Widespread financial challenges which increase pressures on staff and negatively impact the effectiveness of patient care (Robertson et al., 2017) cannot be resolved without organisations doing more to support intensive care staff (Bajoreck & Holmes, 2020; Highfield, 2019). Developing interventions which utilise the strengths and skills within the team and direct resources towards creating opportunities for these experiences is important for moving forward. Any intervention should consider the impact on the individual, team and organisation (Brand et al., 2017; Jarden et al., 2018b) and three recommendations from the findings are suggested below.

1) Celebrating staff achievements by highlighting positive feedback and thanking staff for their hard work in a challenging work environment.
2) Encouraging team working through group forums where staff can come together to develop confidence in clinical skills, reflect on the meaning of their work and offer peer emotional support.
3) Improving communal spaces where MDT staff can step away from the ward to relax and connect with colleagues.

However, these ideas should not be overshadowed by the importance of organisations supporting intensive care staff with access to resources, which are argued as critically important to retention and recruitment (Cutler et al., 2020). As a result, one key research focus should be looking at how healthcare organisations can do more to help intensive care staff to feel valued and appreciated, despite the obvious barriers to well-being which lack of funding and resources bring.

Conclusion

Overall, this review demonstrated both the complexity and importance of trying to deepen the understanding of well-being amongst intensive care staff using qualitative research. The evidence within the included studies showed how many staff have positive experiences at work in the ICU which can act as protective buffers against burnout. Well-being was maintained at work by using strategies and skills but also strongly depended on several external influences which staff have less control over, especially the support perceived and received from the organisation. Despite this, the review also highlighted the lack of research into the well-being of different healthcare professionals working in the ICU

and more qualitative research is needed to explore the strengths already present within the MDT and the resources which keep staff coming back to work in the ICU.

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Part Two: Empirical Paper

Experiences of Thriving and Relational Support in the Multi-Disciplinary Team Working in the Intensive Care Unit - A Constructivist Grounded Theory and Reflections on the Impact of COVID-19

Katie Hope Reading[a], Dr Jo Beckett [a], Dr Chris Clarke[b] & Dr Jas Moorhouse[c]

[a]Faculty of Health Sciences, School of Health and Social Work, Aire Building, University of Hull, Hull, HU6 7RX

[b] Tees, Esk & Wear Valleys NHS Trust, Foss Park Hospital, York, YO31 8TA

[c] Hull University Teaching Hospitals NHS Trust, Anlaby Road, Hull, HU3 2JZ

*Corresponding Author Email: K.Reading-2018@hull.ac.uk

This paper is written in the format ready for submission to the Journal of Occupational Health Psychology

(see Appendix H for submission guidelines)

Word count: 11,542

Abstract

Background: Protecting the well-being of intensive care staff is a priority for healthcare organisations because of the established links between burnout, staff absence and turnover. Thriving has been identified as helping intensive care staff to positively manage workplace challenges. However, little is known about what contributes to thriving and how it can be enhanced to support staff at work. As a result, this study aimed to explore whether relational support can facilitate thriving within intensive care staff at work, as well as considering the impact of COVID-19.

Methods: Twenty healthcare professionals from four NHS Trusts in the North East of England took part in semi-structured interviews. A qualitative Constructivist Grounded Theory methodology was used to guide data collection, sampling and analysis of emergent categories and generate a theory to explain the research topic.

Results: Thriving was found to be a positive experience on a continuum of individual well-being. Four superordinate themes of challenge, energy, support and access were found to facilitate thriving at work. In addition, when these four conditions were enabled, thriving was found to grow outwards from staff to the whole system including contributing to more integrated multi-disciplinary team working and improved patient outcomes.

Conclusions: The findings provided an understanding of how thriving and relational support are experienced at work in the ICU. This highlighted how thriving can emerge through relationships and emphasised the role of the organisation in enabling thriving through valuing, supporting and empowering intensive care staff.

Keywords: Intensive care, critical care, healthcare professionals, multi-disciplinary, staff, well-being, positive, thriving, relationships, support, grounded theory.

Introduction

Burnout in the Intensive Care Unit

Staff in the intensive care unit (ICU) work with incredible dedication and compassion, but this work can also be emotionally and physically challenging. As a result, there is a high risk of burnout (Chuang et al., 2016; Moss et al., 2016) which is often experienced as extreme exhaustion leading to reduced ability to perform job tasks (Maslach & Leiter, 2016). Reports from the National Health Service (NHS) show that stress from the pressure of "chronic excessive workload" (Bailey & West, 2020) is contributing to increasing rates of staff sickness and turnover (Copeland, 2019; Iliffe & Manthorpe, 2019; Survey Coordination Centre, 2020). These factors can all negatively impact on service delivery and patient care (Boorman, 2009; Sizmur & Raleigh, 2018).

The Impact of COVID-19

The COVID-19 pandemic placed further demands on intensive care staff including even greater workloads, higher rates of patient death, but also fears for the safety of themselves, their families and colleagues (González-Gil et al., 2021; Greenberg et al., 2021; Walton, et al., 2020). This once again highlighted the strains of putting further pressures on an already under-resourced ICU environment and already stretched NHS workforce. Nonetheless, as a result, an important consequence has been the growing pressure on the NHS to take responsibility and act now to support the well-being of intensive care staff (Billings, Abou Seif, et al., 2020; Wong et al., 2020).

Moving Away from Burnout and Towards the Positive

Most studies have tended to approach this issue of well-being by trying to quantitatively measure and predict levels of burnout, with the aim of reduction (Colville et

al., 2017; Embriaco et al., 2007; Feeley et al., 2021; Greenberg et al., 2021). However, this approach neglects consideration of the experiences that may already be contributing to intensive care staff being able to enjoy their work. Jarden et al. (2018a) described the existence of a negative skew within intensive care research and advocated for more research to begin "adopting [a] positive lens" (p.16). Positive psychology is the study of the strengths and experiences that are working well for people, groups and organisations (Seligman & Csikszentmihalyi, 2000; Sheldon & King, 2001). A second wave positive psychology (2WPP) approach recognises that both positive and negative experiences promote well-being (Ivtzan et al., 2015; Wong, 2019) and this is supported by the Job-Demands Resources Model (J-DRM) where job demands and resources interchangeably contribute to burnout or well-being at work (Demerouti et al., 2001).

Even outside of COVID-19, the nature of working in the ICU is likely to always be experienced as challenging at times and as a result, some intensive care staff may feel unable to cope with the job demands. However, despite the proportional lack of research, qualitative studies have consistently shown that even the most stressful aspects of the job can give rise to positive outcomes for intensive care staff (Billings, Ching, et al., 2020; Galuska & Bursch, 2020; Wåhlin et al., 2010). More research must acknowledge the whole experience of intensive care staff, including listening more to their positive experiences. This would demonstrate to healthcare organisations the ways in which they can contribute to supporting staff by enhancing what intensive care staff describe as promoting their well-being at work.

Thriving in the ICU

The concept of thriving fits well with 2WPP as it acknowledges the positive well-being outcomes which can come from experiences that may or may not be considered challenging (Burke, 2019; Spreitzer et al., 2005). Thriving at work has been defined broadly

as developing on a positive trajectory towards personal and professional growth (Burke, 2019; O'Leary, 1998; Wendt et al., 2011), with vitality and learning (Spreitzer et al., 2005).

In a grounded theory study, Jackson et al. (2018) described how intensive care nurses manage challenges at work either through burnout, survival, resilience or thriving. Thriving was identified as staff positively managing and overcoming challenges to experience love, passion and engagement for their work role. Furthermore, thriving has been found to be beneficial for organisations because individuals who feel positive towards their work environment have been identified as more likely to experience greater job commitment and satisfaction, as well as reduced absenteeism and burnout (Kleine et al., 2019; Porath et al., 2012; Spreitzer et al., 2012). Jackson et al. (2007) suggested that intensive care nurses respond to workplace challenges by leaving their jobs, staying and experiencing stress or staying and thriving.

Thriving and Relational Support

Spreitzer et al. (2005) developed a model which described how the contexts within which people work encourage thriving through the social connections formed with others. The importance of a strong support network, role models and feeling valued at work have already been emphasised as important to the well-being of intensive care staff (Highfield, 2019; Wåhlin et al., 2010). Thriving at work has also been found to be promoted by a supportive environment (Liu & Bern-Klug, 2013) and developed within relationships with colleagues and managers that are perceived as positive (Bergland & Kirkevold, 2008; Kleine et al., 2019). However, no research has yet explored whether relational support is a job resource used by intensive care staff to buffer against job demands and contribute to thriving.

Aims and Research Questions

Further exploration of thriving may help to understand how many intensive care staff continue to stay in their jobs, manage work demands and enjoy their work. The study by Jackson et al. (2018) is limited by a small sample of female nurses at one hospital and participants were not asked about their understanding of thriving. Since intensive care staff work collaboratively in multi-disciplinary teams (MDT) (Dietz et al., 2014), the current study therefore aimed to expand the understanding of thriving in a mixed sample of healthcare professionals across four NHS Trusts. A further aim was to understand whether intensive care staff use relational support as a tool to facilitate thriving and maintain their well-being at work. As the study took place during COVID-19, intensive care staff experiences of the research topic before and during the pandemic were explored and contrasted. Finally, the study aimed to use Constructivist Grounded Theory (CGT) to generate a theory to explain how relationships at work may sustain thriving, with a consideration of the clinical implications for healthcare organisations improving support for intensive care staff.

The research questions were:

1. How do healthcare professionals understand the term 'thriving' and experience it at work in the intensive care unit?
2. How do healthcare professionals experience seeking and receiving support through their relationships at work in the intensive care unit?
3. How do healthcare professionals construct 'thriving in the workplace' in the context of their experiences of different aspects of relational support at work in the intensive care unit?
4. How, if at all, have healthcare professional's perceptions of thriving and relational support at work changed because of their experiences of working in the intensive care unit during COVID-19?

Method

Design

A qualitative design was utilised to answer the research questions as this allowed an in-depth exploration of the experiences of healthcare professionals working in the ICU. Individual semi-structured interviews were used as a guide for exploring thriving and relational support. Data was analysed using the inductive principles of CGT (Charmaz, 2014). CGT was chosen because of its utility in generating categories and a theory to understand and explain the topic of interest, which is grounded in the data (Strauss & Corbin, 1990; Charmaz, 2008). Furthermore, CGT uses each interview to guide the next (Charmaz, 2014) which is useful when actively seeking a heterogenous sample and exploring similarities and differences between participants' experiences. Finally, CGT remains open to all experiences because a constructionist viewpoint considers there to be no objective truth and recognises the role of the researcher in bringing their own assumptions (Charmaz, 2008).

Recruitment and Sample

Participants were recruited through purposive, snowball and theoretical sampling between September 2020 and January 2021. In the context of COVID-19, this was six months after the first lockdown in the second wave of the pandemic in the United Kingdom (UK). Principal investigators and research teams supported recruitment by discussing the research at team meetings and distributing posters (Appendix I). An overview of the inclusion and exclusion criteria alongside the rationale are in Table 1.

Table 1

Inclusion/Exclusion Criteria and Rationale

Inclusion Criteria	Exclusion Criteria	Rationale
Over the age of 18		As participants over the age of 18 can consent to taking part in the research.
Able to complete the interview in English		As English is the only language that the researcher can understand and transcribe.
Working autonomously within clinical roles after completing all service induction protocols	Any students because they may be rotating or on temporary placements	As participants need to have spent a significant amount of time working in the ICU to be able to discuss the research topic.
Working in a clinical role as a healthcare professional	Any staff working in non-clinical roles such as administrative staff, porters, cleaners etc	As the research is interested in how being directly involved in patient care impacts the understanding of the research topic and well-being at work.
Currently working in a role which involves a minimum of one hour contact with patients in the ICU per week		As the research is interested in all multi-disciplinary staff experiences and many staff work across several wards including the ICU during the week.
Have experience of working in the ICU both before and during COVID-19	Any redeployed staff without experience of working in the ICU before COVID-19	As participants are required to reflect on how COVID-19 has impacted their perception of the research topic.

Twenty participants took part in the study, and all met the inclusion criteria. All participants were healthcare professionals who worked in ICUs in six hospitals across four NHS Foundation Teaching Trusts in Yorkshire, North East England. More detailed information about setting and location was gained through a short questionnaire (Appendix J and K). One third of individuals who expressed their interest did not take part because they could not attend the interview (n=1), did not work in the ICU before COVID-19 (n=2), did not respond to the researcher's emails (n=3) and data saturation had already been reached

(n=4). A summary of the participant demographics is provided in Table 2. 'Allied health professional' was used to group participants from speech and language therapy, physiotherapy, occupational therapy and dietetics backgrounds, who work across multiple wards including the ICU.

Table 2

Sample Demographic Information

Demographic	Number of Participants (n=)
Age	25-34 (n=7), 35-44 (n=6), 45-54 (n=6), 55-64 (n=1)
Gender	Female (n=16), Male (n=4)
Ethnicity	White British (n=16), Other (n=4)
Relationship Status and Children	Single (n=2) , In a Relationship (n=2), Engaged (n=2) , Married (n=14)/ Children (n=10)
Highest Level of Education	Bachelors (n=7), Masters (n=5), Post Graduate Diploma (n=7), Royal College Fellow (n=1)
Professional Designation	Nurse (n=5), Consultant Doctor (n=3), Allied Health Professional (AHP) (n=6) , Advanced Critical Care Practitioner (ACCP) (n=3), Pharmacist (n=3)
Time Since Qualification in Professional Designation (Years)	<5 = (n=5), 5-10 (n=2), 11-15 (n=3), 16-20 (n=2), 21-25 (n=3), 26-30 (n=4), 31-35 (n=1) Range: 4 months to 32 years and 4 months/ Mean: 24 years and 10 months
Time Since Started in ICU (Years)	<5 (n=6), 5-10 (n=6), 11-15 (n= 0), 16-20 (n=3), 21-25 (n=4), 26-30 (n=1) Range: 11 months to 27 years and 3 months/ Mean: 11 years and 4 months
Time Spent Working Per Week (Hours)	20-30 (n=2), 30-40 (n=15), >40 (n=3) Range: 24 to 60 hours/ Mean: 38 hours
Time Spent in ICU Per Week (Hours)	5-10 (n=2), 11-20 (n=6), 21-30 (n=6,) 31-40 (n=6) Range: 8 to 40 hours/ Mean: 26 hours
Overtime (Hours)	Yes (n=18), No (n=2) Range: 1 to 20 hours/ Mean: 6 hours

Demographic	Number of Participants (n=)
Employment Status	Permanent (n=20) Full time (n=18), Part time >17.5 hours (n=2)
Pay Band	Band 5 (n=1), Band 6 (n=6), Band 7 (n=6), Band 8 (n=5), Band 9 (n=2)

Ethical Considerations

Ethics approval was gained from the Faculty of Health Sciences Research Ethics Committee at the University of Hull and the Health Research Authority (Appendix L). Copies of the participant information sheets were provided, and participants had the opportunity to ask questions at any point during the study. Written or verbal consent was provided to participate in the study. All participants were aware that everything they said during the interviews was confidential and all identifiable information about the person, team or workplace would be anonymised during transcription. All participant information was stored securely and in accordance with the ethical guidelines. Furthermore, participants were provided with further information about how to access ongoing support, if needed, following the interviews. The researcher also had no pre-existing relationship with any of the participants before the interviews, apart from with one participant who was supporting data collection, and no incentives were provided for taking part.

Data Collection

Interest in the study was generated by accessing a survey (https://admin.onlinesurveys.ac.uk) through a QR code or direct link on the recruitment poster (Appendix I). Once participants agreed that they had read and understood the participant information sheet (Appendix M), they completed a demographic questionnaire

(Appendix N) which took around 5-10 minutes and asked participants about themselves and their work role.

After a period of 48 hours, participants were contacted through an initial email to thank them for their interest (Appendix O). They were also provided with a copy of the participant information sheet and an opportunity to ask any questions. A mutually convenient time and date for interviews was then agreed with participants who met the inclusion criteria. A second email communication followed to provide participants with the consent form (Appendix P). Participants who had access to the facilities to do so were asked to print, sign and scan back the consent form. Alternatively, verbal consent via audio recording was obtained on the day of the interview.

Each participant was interviewed at one time point only. All interviews took place remotely either on Microsoft Teams or over the telephone. As much as was possible to maintain confidentiality, interviews took place outside of work hours. The semi-structured interview schedule (Appendix Q) involved seven open-ended questions which asked participants about their understanding and experiences of thriving, the perceived importance of relational support at work and the impact of COVID-19. The interview schedule was developed through discussion with research supervisors to ensure consistency with CGT. In addition, principal investigators at each recruitment site who had some experience of working in the ICU provided their perspective on the terminology and appropriateness of the interview schedule for generating discussion around the research questions. An open interview style was adopted as this allowed the interviewer to guide the line of questioning to answer the research questions, whilst also enabling the participants to change the conversation flow dependent on what they considered important to share about their experiences.

Interviews were audio-recorded using an NHS encrypted laptop and then immediately transcribed. The interviews ranged in length from 46 minutes and 23 seconds to 81 minutes

and 29 seconds. Following each interview, a discussion took place about how the interview went and further information about how to access ongoing support from their employer and external local organisations was provided (Appendix R). A third email (Appendix S) was sent to thank participants for their involvement and provide them with the details of the further support available.

All participants gave their consent to be sent a monthly email from the researcher which provided them with updates on the research process. Once an initial theory had emerged through data analysis, participants were also invited to comment on how well this fit with their experiences. Follow-up feedback was provided by two participants, and this was used to adapt the emerging theory.

Researcher Roles and Position

The epistemological position taken was relativist constructivism which assumes that truth is constructed by people and the experience of reality is viewed through the lens of the individual (Willig, 2013; Young & Collin, 2004) (see Appendix W for epistemological statement). A constructivist stance also recognises the assumptions that are brought by the researcher. The researcher has their own version of the truth based on their values and experiences which may influence how they interpret what the participants say and how they construct a unifying narrative (Charmaz, 2014). As qualitative research can be easily impacted by the researcher, the chief investigator (KR) maintained an approach of reflexivity (Finlay, 2002) and considered both their position and influence on the research throughout by having monthly clinical research supervision, using memo writing notes and by keeping a reflective diary (see Appendix X for reflective statement).

The chief investigator was a trainee clinical psychologist with an interest in physical health and staff well-being. Their interest in the research was shaped by previous experience

of a short volunteering placement in an ICU at one of the sites involved in the research. Two academic research supervisors (JB and CC) and a secondary field supervisor (JM) supported in the development of the research protocol and provided feedback on the overall analysis and theory. One of the research team's assumptions was that there are many positive experiences to come out of working in the ICU environment which staff would be able to discuss, including the potential for thriving. However, they were aware that this may not have been a view shared with all of the participants in the sample and therefore invited participants to discuss any experiences that might be helpful for understanding thriving, including any more negative experiences.

Data Analysis

The first step of CGT (Charmaz, 2014) is purposive sampling to select participants for the first few interviews that would answer the research question. The chief investigator took field notes during the interviews to keep track of key ideas that emerged and reflective notes were made immediately after the interview about the process of interviewing the participant. Each transcript was first analysed using initial line-by-line coding (Willig, 2013) which involved reading each sentence, highlighting key points and then assigning meaning to the data through the identification of initial codes with related quotations (Appendix T). After more interviews, line-by-line coding continued and evolved by comparing data to look at the similarities and differences in the initial codes which became initial categories. Focussed coding was then used to identify more conceptual categories (Charmaz, 2014).

Data collection and data analysis were ongoing. The method of constant comparative analysis was used to compare new data from recent interviews to data that had been collected in earlier interviews. Similarities and differences between the initial codes were explored to identify the themes that were most significant within the data, for example those which

appeared more frequently or seemed most important. In line with theoretical sampling, each interview guided the next and new specific data was selectively collected to develop the emerging theory and explore gaps in the emerging categories (Charmaz, 2014), whilst remaining driven by the initial research question (Willig, 2013) (Appendix U). Over time, the interview schedules were added to and became more focussed to explore the emerging codes and categories in more detail. This approach enabled the chief investigator to be flexible and generate new questions throughout the data collection process to explore any new ideas which emerged from the previous interviews.

Theoretical coding involved developing a storyline to integrate the categories that had emerged from the codes during the analysis into a theory (Willig, 2013). Categories were organised under superordinate themes and sub-themes. Data collection ended when theoretical data saturation had been achieved and it became evident that no new data could be collected to provide more information about a particular category or a relationship between a category (Charmaz, 2014).

Results

The results are organised into three main sections. The first explores how intensive care staff understood and experienced thriving at work. A framework which includes a written narrative and themes, as well as a diagrammatic model is presented to explain this process. The second explores the impact of COVID-19 on staff experiences of thriving. The final part connects thriving and relational support within a unifying grounded theory. The grounded theory is presented in a written narrative and a diagrammatic model. The validity of the findings is increased as an underlying principle in CGT is the co-creation of research, the researcher engaged in reflexivity and because all sections of the results were subject to member checking.

Thriving

The framework developed to understand thriving at work in the ICU was called 'Intensive Care Staff: Navigating the Bumpy Road to Thriving'. A diagrammatic model is presented in Figure 1. To achieve thriving at work, intensive care staff identified with going on a journey, which has ups and downs. One participant explained this as a *"peak and trough kind of map" (Tessa),* whilst another illustrated this by saying *"when we go through life, we might go through like a surviving state, we might go through a stable state and then we have a thriving state" (Butterfly)*. Although the journey is not linear, navigating and moving forwards in the direction towards a positive feeling was identified as important for thriving, *"thriving means that you are progressing…it's a positive word…going in the direction that you want to go in" (Susan)*. This process of thriving was found to depend on individual, team and organisational factors. Four superordinate themes explained how thriving was achieved: challenge, energy, support and access. Fourteen sub-ordinate themes (see Table 3) are described below, alongside direct participant quotations.

Table 3

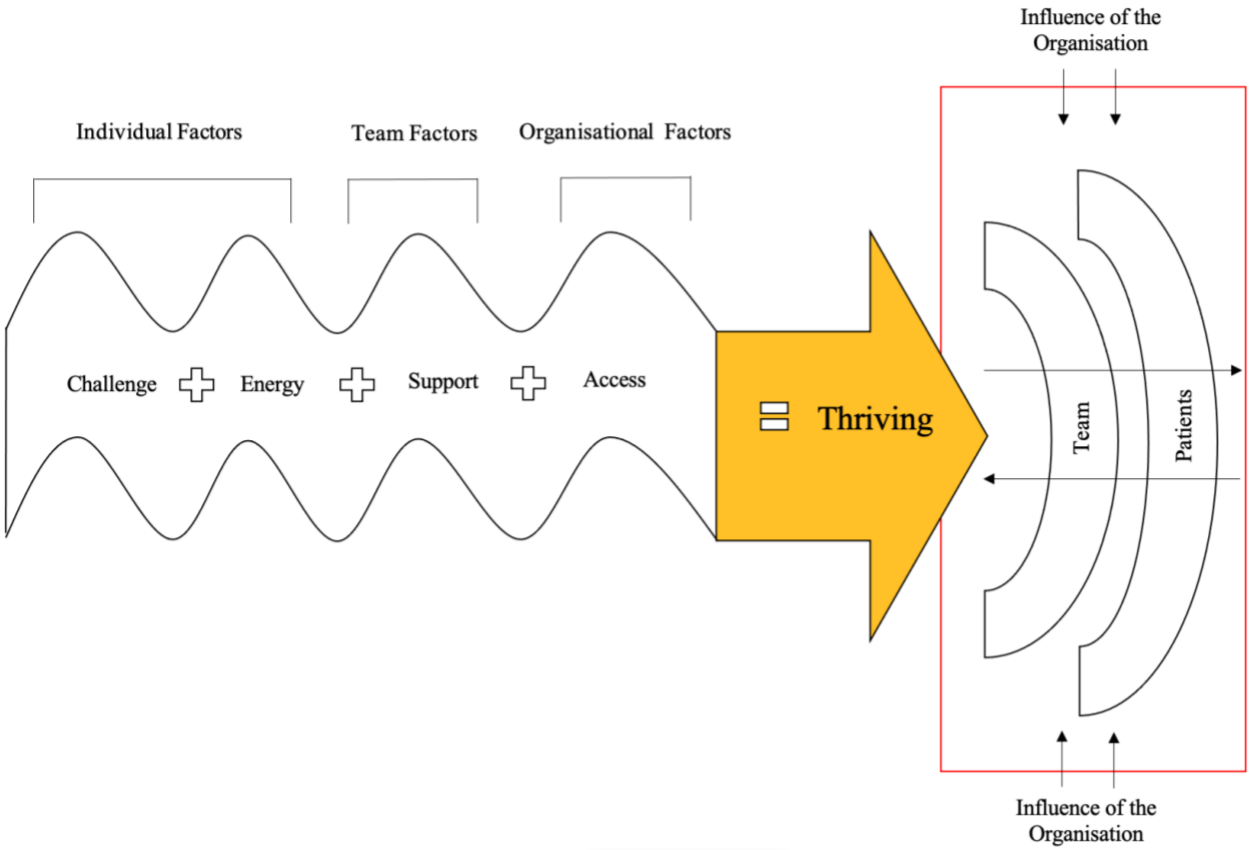
Superordinate Themes and Sub-ordinate Themes Illustrating the Thriving Framework

Individual Factors		**Team Factors**	**Organisational Factors**
Challenge	**Energy**	**Support**	**Access**
Professional Development	Able to Go the Extra Mile	A Cog in a Well-Oiled Machine	Availability of Physical Resources
Managing Emotions	Recharging During the Workday	United through Shared Experiences	Valued through Emotional Support
Being a Clinical Expert	Locating Energy Boosts Outside of Work	Lifting Each Other Up	Compassionate Culture Mindset
		Forming Support Bubbles	
		Leading by Example	

When the four conditions for individual thriving were achieved, this had a perceived positive impact on other relationships, *"I think if you thrive, and you feel that you have achieved something positive, then the whole team morale increases" (Simba)*. This process of thriving growing outwards from the individual to other members of the team and patients was named the 'Ripple Effect' (see red box in Figure 1 for model). However, for thriving to start and continue, the organisation had to be experienced as reciprocating in the process of facilitating thriving. A supportive organisation creating the right conditions for thriving was identified as important for sending ripples back to the individual, therefore sustaining thriving across time within the whole social system in the ICU.

Figure 1

A Model for Understanding How Individual Staff Experience Thriving at Work in the ICU - 'Intensive Care Staff: Navigating the Bumpy Road to Thriving' (Red box = The Ripple Effect)



Note. Large arrow demonstrates the process towards individual thriving. Smaller arrows within the red box show the direction of influence/movement within the social system within which thriving in the ICU is facilitated. These arrows go both forwards and backwards to illustrate the Ripple Effect.

1. Individual Factors

Intensive care staff identified actions they took to increase their likelihood of thriving at work. Thriving was partly determined by the person, their compatibility with the ICU environment and the use of specific strategies, leading to what one participant called going to

work with the *"bring it on aspect" (Fred)*. Thriving was often associated with a feeling of achievement noticed at the end of the day when staff were leaving work and engaging in self-reflection, *"I walk out of the building…and I have a smile on my face…sense of pride" (Susan).* The two superordinate themes were challenge and energy.

1.1 Challenge

The nature of working in ICU is that every shift brings a different challenge which can contribute to thriving. The presence of challenge was frequently described by intensive care staff as enjoyable; part of the reason why they chose their careers and something which provided them with more opportunities for learning, *"I like being in that stretched zone where you are getting challenged all the time" (Donald).*

1.1.1 Professional Development

Engaging with more challenging work emerged as something that intensive care staff felt was integral to their professional development. Most participants described recognising thriving as developing from facing challenging situations head on, *"sometimes the storm moments are the moments that will get us to thrive" (Butterfly),* even in the absence of good patient outcomes, *"we do thrive off the negatives as well…not everything goes well all the time" (Simba).* All staff spoke about the importance of learning, improving and moving forward with their career goals, with several participants identifying thriving as similar to child development, *"babies, thriving…growing and developing" (Tessa).* Thriving was also found to change throughout an individual's career as staff strived to reach the top of their respective careers. However, doing so was described as often quickly resulting in the need for change to get off the *"hamster wheel" (Minnie)* and locate new opportunities including moving to management positions. One ACCP described their thriving as stepwise, "*a stop*

and start thing, because I have maybe got to the maximum of what I can achieve and then I have moved onto another role…then I have started to thrive again" (Susan).

1.1.2 Managing Emotions

Intensive care staff also expressed how thriving involved being able to put up barriers and manage the emotional impact of caring for critically unwell patients. This was most apparent during conversations with nurses, with one participant talking about the *"bravado in intensive care nursing…more valued that you like to get stuck in…to look after poorly patients" (Ola).* Some staff described not perceiving the work environment to be stressful; whilst others identified with needing to *"build a wall" (Fred)* to separate from their emotions during work as a form of self-protection. Being too emotionally connected to patients was seen as a barrier to thriving as it could interfere with staff being able to do their jobs, *"it would not do my mental health any good if I sat and cried at work all day every day" (Sydney).* For many, resilience was closely related to thriving and described as the ability to manage stress at work most of the time when thriving, *"survival instinct…get knocked down and you stand up again" (Paddington).* Several participants also reflected on how resilience may be associated with age and experience, *"the junior nurses… they just do not have the resilience" (Lola).*

1.1.3 Being a Clinical Expert

Thriving from being a *"clinical expert" (Sydney)* was described by intensive care staff as feeling in control and able to manage both planned and emergency situations during the workday, "*working on automatic pilot" (Teresa).* More time and experience made working in the ICU feel like *"second nature" (Simba).* Confidence in their ability enabled staff to continue persevering with the challenges of ICU working, knowing exactly what to

do to help patients and being able to respond quicker in the future, *"it does not necessarily become easier, but you feel more confident and more competent" (Butterfly).* Compared to more experienced staff, junior members of the team described relying more on what one nurse called *"baby birding onto people" (Ola)* to experience thriving through learning from others until they could work more autonomously. ACCPs and consultants often spoke about being competitive with themselves and sometimes others, with one ACCP stating, *"thriving is just being the very best that I can be at all times" (Lola).* Accomplishing clinical tasks as a consequence of hard work was described as satisfying for all, with one pharmacist describing thriving as the *"buzz that you have actually done something" (Tech Head)*.

1.2 Energy

Thriving was widely described as *"feeling energised" (Paddington)* and fluctuating with changes in energy, *"it is impossible to be in thriving the whole time because that also consumes energy" (Butterfly).* Experiencing fatigue was not found to stop thriving, as long as intensive care staff could access energy sources which allow them to continue moving forwards doing their jobs, as well as looking after themselves.

1.2.1 Able to Go the Extra Mile

A passion for the job motivated many intensive care staff who, when thriving, felt able to do more for patients and their families. Most participants described thriving as feeling rewarded by having a job that is perceived to be worthwhile, *"feeling like you have got job satisfaction…delivering optimum patient quality of care" (Dolly)*. In addition, they described having the energy for *"them little extra bits that you need to do to make a difference" (Mary)* such as being involved in service development, training and research. Feeling exhausted from being overworked made it harder to thrive, as participants expressed feeling more

disconnected from their emotions and finding it harder to look beyond the immediate clinical tasks, *"exhaustion…that grinds out sympathy, kindness, caring until you can just think…how can I just get through this and get home and get to bed" (Fred).* This was illustrated by one AHP contrasting surviving and thriving, *"survival is coping…getting through doing the bare minimum, whereas thriving is doing more than that…going above and beyond" (Tessa).*

1.2.2 Recharging During the Workday

Where possible during the workday, intensive care staff spoke about needing to recharge by leaving the ICU ward environment and engaging with interactions and activities which sustained their thriving. Distance and time away, which one AHP described as *"non-clinical time off the conveyer belt" (Ruby),* was considered necessary to continue providing the same level of care to patients. Several participants also highlighted the importance of thriving coming from fulfilling their basic needs, *"thriving is like being able to go for lunch…something really basic…being able to go to the toilet" (Minnie)*. This included having frequent and long enough breaks away from the ward to re-energise by getting a coffee with a colleague or for nurses, where leaving the ward was not a luxury, being able to *"step away from your bedside to sit in a room separate to your patient" (Ola)* and access a *"tea trolley on the unit…to just stand together and chat" (Teresa)* was important. In addition, AHPs occupying dual roles spoke about balancing their caseloads with colleagues and choosing how long they spent in the ICU, *"you know you can come out of that setting and have a period away from it" (Simba).*

1.2.3 Locating Energy Boosts Outside of Work

Thriving at work was also linked to the ability of intensive care staff to locate *"the small boosts of energy" (Butterfly)* outside of work. At home, when thriving, staff felt more

able to engage in their interests including socialising with family and friends, exercise and relaxation which had the benefit of creating boundaries with work, as one AHP stated, *"you just lose yourself a little bit" (Rosalind).* Thriving was described as a good feeling which transferred between work and home and helped staff to deal with challenges at work, *"I have got energy, I want to cook…, y'know that feeling carries on and I'm in a happy mood" (Fred).*

2. Team Factors

All intensive care staff agreed that the ICU is a large team involving a core team of doctors, nurses and ACCPs, with other staff entering and exiting with their contributions. The team were experienced as contributing to thriving by providing support across the various relationships, *"I do not think any one person can give you all of the support" (Rosalind)*. Thriving was recognised when staff received positive feedback from others during the workday which helped them to feel that their hard work was being recognised, *"we all thrive from that positive feedback loop" (Tech Head)*. The superordinate theme was support.

2.1 Support

A successful team was described as being unable to thrive working in isolation, *"we achieve things better as a team…and thrive off those things rather than doing things individually" (Simba).* Everyone plays an important role and contributes to thriving by providing encouragement and support, *"It is a sort of self-sustaining glorious circle, and the colleagues make the job" (Fred).* Both practical and emotional support from the team and specific individuals were described as important.

2.1.1 A Cog in a Well-Oiled Machine

Feeling part of an integrated MDT where all staff work towards a shared goal as part of a *"cog in the team" (Vanessa)* was identified as important for thriving. Intensive care staff described how thriving developed from a sense of belonging where everyone was respected and treated as an equal, *"because I am valued, my opinions are trusted, I'm given jobs to do, I feel trusted, I feel very much part of the team" (Minnie).* Having a presence on the ward where other members of the team recognise and appreciate the specialist skills which they could bring to clinical tasks was described as important for thriving as a team. Most participants identified with the loneliness that could come from working alone providing one-to-one patient care. For intensive care staff working across multiple wards, especially AHPs, being able to work jointly alongside other professionals was described as providing the extra support that they needed to thrive in the ICU, with one AHP explaining how they benefitted from *"piggyback[ing] onto physiotherapists… become more part of a therapy team" (Rosalind).*

2.1.2 United through Shared Experiences

Intensive care staff also spoke about thriving as coming from feeling that their colleagues could fully understand their experience of caring for critically unwell patients so that support could come from anyone. One AHP described this as feeling *"psychologically safe" (Ferris)* which allowed thriving to occur from talking freely and openly with colleagues about the pressures and joys of the work. Sharing experiences with colleagues allowed intensive care staff to process events, to work through issues and learn together, and most often occurred informally on coffee breaks and *"corridor conversations" (Tech Head).* One consultant described how trusting their colleagues to listen without judgement *"turns something that could be horrific into something that's survivable and even a great place to be" (Fred).* Despite this, participants occupying management positions often described

struggling more to access support for themselves owing to the lack of *"higher support" (Dolly)* in their role and concerns around over-burdening junior staff, with nurses in particular identifying this issue, "*I would be quite choosy who I spoke to…" (Mary)*.

2.1.3 Lifting Each other Up

Intuitively knowing what colleagues needed contributed to thriving as this enabled intensive care staff to be able to respond effectively to lift each other's mood. This reciprocal process, which one AHP called *"in-group regulation" (Rosalind),* typically occurred within the same professions when one person has a bad day, and the rest of the team will be managing better and available to offer support. Staff spoke about a reliance on their colleagues to be there for them and trusted them to do what was best for them when they felt less able to care for themselves. This could involve colleagues offering to *"take something off" (Tessa)* to reduce the load of work demands or being available on the side-lines to *"keep an eye on each other" (Rosalind)*. Several participants described how their colleagues knew them so well that they felt like family, with one pharmacist stating, *"We always feel like on critical care that you are part of the family…we feed off each other and thrive off each other supporting each other" (Tech Head).*

2.1.4 Forming Support Bubbles

Thriving also depended on the ability of intensive care staff to create their own *"bubbles of support" (Ruby)* with colleagues who share similar personalities including humour. For AHPs and pharmacists occupying dual roles, multiple support bubbles in different areas were important for meeting their different needs. Several participants acknowledged how it was not possible to get along with all people but spoke about gravitating towards a small group of *"go to people…friends stroke colleagues, peers that you*

can go to" (Paddington) who had more of a *"vested interest" (Dolly)* in them as they knew them on a more personal level and sometimes outside of work. Thriving grew from spending time together in close proximity at work and having the space to develop friendships through activities such as having lunch together.

2.1.5 Leading by Example

The presence of role models leading by example helped intensive care staff to thrive, by doing things to "*create like a steady ship" (Mary).* Leading during medical emergencies, consultants spoke about the importance of remaining calm so that the whole team feel more able to cope and work together, *"I'm going to be in a leadership role and I'm going to have to show it, and usually I feel that you pull a face, and the feelings follow" (Fred).* Through a process of supporting others and feeling rewarded by seeing them develop, being a leader was described as, *"thriving from a distance" (Ferris)* and *"passing on the baton" (Susan).* For all staff, having a mentor throughout their career who encouraged them and managers who are approachable, available but also honest when they are busy and visible outside of their office were associated with thriving. Some staff also spoke about admiring managers who sought their own support. However, several participants, especially senior nurses, admitted that whilst they saw supporting others as a big part of their role, they often found it hard to take their own advice.

3. Organisational Factors

In addition, thriving was intrinsically linked to the perceived ability of the wider organisation which employed intensive care staff to take responsibility for supporting them. Thriving was experienced when staff perceived themselves to have enough resources to meet

job demands, *"when you have got heaps in staff and resource…you come home having felt like you have thrived" (Fred)*. The superordinate theme was access.

3.1 Access

Thriving was not possible with self-determination alone and was increased when the organisation gave back to intensive care staff, *"I am doing everything I can to make myself resilient…I need the resources to take the job I am handed" (Fred).* The availability and accessibility of resources was frequently viewed as a measure of how much staff felt valued as people and professionals by their employers and this contributed to challenges in thriving, *"AHPs are less important as the underfunded ones" (Tessa).*

3.1.1 Availability of Physical Resources

Having sufficient physical resources including staffing, equipment and facilities was described as necessary for thriving as it enables intensive care staff to make a positive contribution to a patient's recovery. This view was shared across professions, with one AHP stating, *"I think capacity and staffing is kind of probably one of my big things that hold my profession and myself back in terms of thriving" (Rosalind).* Exhaustion from having to regularly justify the need for resources and fight to be provided with what they needed within *"money driven" (Donald)* services was not identified as aligned with thriving. To thrive amidst what one ACCP called the "*politics of work" (Susan*), consultants spoke about celebrating the wins, *"I'm just grateful that people have turned out to work…rather than get upset that we were short of nursing staff" (Donald)* and *"we can do a lot with a little and it feels fantastic when it happens" (Fred).*

3.1.2 Valued through Emotional Support

Feeling part of an organisation that is responsive to the needs of intensive care staff through the provision of formal emotional support was identified as contributing to thriving. Several participants described the importance of feeling valued as a person, rather than just *"a slot on a spreadsheet" (Fred)*, as described by one nurse, *"I often feel like I am on a factory line where my job is just to be as efficient as possible and to go home" (Ola)*. Most staff expressed an awareness of the *"safety net" (Teresa)* of support available to them including one-to-one, groups and training. A recognition from the organisation that intensive care staff needed support in their jobs and this need should prioritised was important for enabling thriving at work. However, very few participants described having accessed this support by choice, with consultants identifying themselves as least likely. Thriving was frequently experienced when intensive care staff overcame an initial resistance to benefit from the support available and considered it to have become an important resource for looking after themselves in the future, "*once you have hooked a lot of people and they understand the benefit…I think more people would engage" (Minnie).*

3.1.3 Compassionate Culture Mindset

Thriving was also found to relate to how intensive care staff perceived themselves to be part of an organisation which prioritises staff well-being. Most participants spoke about an engrained and un-spoken stigma where emotions are perceived as weaknesses, *"ICU is one of those places where it is just accepted that we just cope" (Susan).* One nurse described a fear of being judged for taking time off work and engaging in personal therapy, "*my name is going to be mud…and people are going to talk about me behind my back" (Ola).* On the other hand, intensive care staff described thriving as those times when they felt that the organisation ethos was inclusive and encouraging of staff caring for their mental health needs.

Influence of Context – COVID-19

The socio-economic-political-cultural context is always changing and has a large influence on the functioning of healthcare organisations, specifically the NHS, which is publicly funded. The most dominant context which framed the experiences within this study was COVID-19 and its impact on intensive care staff experiences of thriving during this time was explored. In general, thriving during COVID-19 was experienced as more difficult, *"I have not been thriving through COVID, it is just survival" (Fred);* but the barriers to thriving often predated the pandemic, "*a lot of the principles that we have been dealing with in our approach to the pandemic are actually things we were also managing beforehand. So, we are under-staffed, under-resourced, weren't really being particularly acknowledged by the organisation…" (Donald).* The impact of COVID-19 on thriving is explored further using the challenge, energy, support and access format.

1. **Challenge**

COVID-19 was experienced by all participants as a greater challenge, with fear and anxiety having *"got to everybody" (Fred).* Most intensive care staff described how the same level of achievement linked to thriving was often missing because of the increased patient death rate, lack of confidence in the treatment being provided and reduced presence of patients' relatives on the ward, *"I see it as a battle that we are not going to achieve very well in…it is a fairly thankless thing" (Susan)*. After an initial period of shock, *"the rug pulled out from underneath us" (Vanessa),* all staff described finding equilibrium again where it became easier over time to do the job. For several staff, COVID-19 had a positive impact in accelerating growth through taking on new responsibilities and finding new solutions to improve services, *"a pandemic is horrific for the world, but amazing for my CV" (Minnie)*.

2. Energy

Exhaustion was a shared experience which increased as the pandemic progressed, and the initial adrenaline reduced, "*it feels like you are sprinting all the time" (Tech Head)*. Many intensive care staff spoke about how the job lost its excitement as their main priority became getting through the workday. COVID-19 took away many of the extra opportunities that previously helped staff to thrive and wearing PPE also made it more difficult to meet their basic needs, "...*you can't drink too much because then you might need a wee later on, but you would not be able to don off again" (Mary).* Thriving originated from finding different ways to re-energise during COVID-19 including gratitude for the routine of coming to work, focussing on areas where they could make a difference and looking towards the future with a re-evaluation of what is important.

3. Support

COVID-19 contributed to the pushing and pulling of relationships. Artificial teams grew from redeployed staff coming to support with the high patient demand and the loss of staff owing to shielding, sickness and burnout. In addition, some AHPs were encouraged to work remotely which contributed to feelings of isolation and also frustration from nurses who did not have this option. Despite a common experience of less connection to the hospital community, *"felt like we were going round…with the plague" (Tech Head)*, most participants felt that their team relationships in the ICU were strengthened by being *"in the same boat" (Ruby)* and having *"dragged each other through it" (Vanessa).* All MDT staff wearing the same PPE uniform and being present in one space was identified as contributing to thriving as one unified team who worked more flexibly across roles and better supported each other, as described by two AHPs, *"everybody is watching out for everybody more closely" (Lizzie)* and *"I feel like more of a team player rather than just like this extra one person" (Tessa).*

This was especially apparent for pharmacists and AHPs who described moving away from their core departments, *"critical care has held their hand out and brought us in" (Minnie).*

4. Access

An increase in access to resources and speed of decision making was reported by many intensive care staff during COVID-19, *"we have had plenty of equipment thrown our way, which would have taken years to try and get...here is a pandemic, now there is lots of money" (Donald)*. However, this did not automatically coincide with thriving as several participants described feeling no more valued by the organisation owing to experiencing the same pressures and *"terms and conditions attached" (Donald)* to resources. When thriving did occur, it was described as coming from staff feeling more able to openly discuss their feelings and access emotional support from managers more frequently expressing their gratitude and more formally, *"psychology support available, so if you look on the backs of every toilet door there are well-being numbers to ring and places to find advice" (Rosalind).*

Unifying Grounded Theory

The unifying grounded theory goes beyond the 'Navigating the Bumpy Road' (see Figure 1) framework for understanding thriving in intensive care staff to explain the relationship between thriving and relational support. This was called 'A 'Social System Facilitating' Theory of Thriving in the ICU' and a diagrammatic model is provided in Figure 2. The theory demonstrates how there are several relationships identified as important to intensive care staff which have a role in generating and maintaining thriving at work. Although COVID-19 had a significant impact on intensive care staff, similar things were described as important to their experiences of the research topic both before and during

COVID-19. As a result, the theory is transferrable across time as contexts change but the principles underlying the theory remain the same.

In summary, healthcare professionals working in the ICU were found to experience their individual well-being on a continuum from negative to positive. Thriving was perceived to exist at the far end of the positive side, whilst burnout was on the opposite end. Fluctuating along the continuum was a very normal process; however, some staff experienced themselves as moving more quickly between the two points than others. The presence of challenge and energy were important individual factors contributing to thriving.

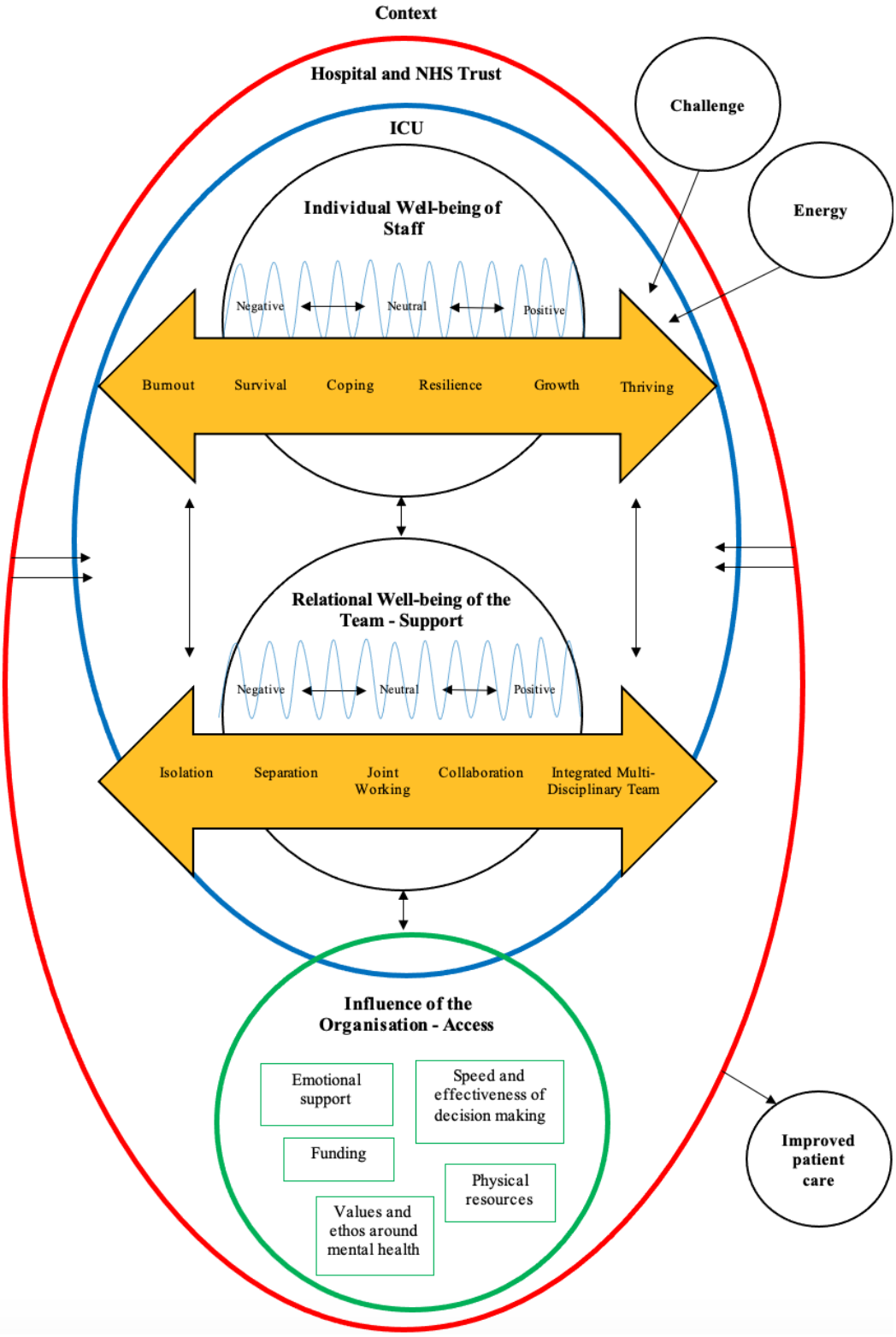
When more individual staff felt able to face in the forwards direction towards thriving, this was experienced as having a positive impact on the relational well-being of the ICU team. More thriving was perceived to contribute to a sense that the MDT were more able to work in an integrated way. As a result of feeling supported within the team through this way of working, thriving was experienced as more likely at the level of the individual and the ICU team as both felt more able to push forward together in the direction of thriving. On the other hand, when staff experienced themselves as more towards the burnout end of the continuum, this was often more associated with feelings of isolation and separation within the ICU team. Hence the individual and relational well-being of the ICU team were experienced as closely inter-linked. More detail about the specific terms linked to individual and relational well-being, which were discussed and defined by participants, is provided in Appendix V.

Looking outside of the ICU ecosystem, there are additional influences on intensive care staff. The organisation was experienced as having a significant impact on staff and team thriving, as access to resources provided a strong foundation to support the whole system. Participants' experiences were identified as driven by all these different levels of the system: staff, team, and organisation. When all levels contained within the boundaries of the hospital and the NHS Trust in which they are employed were in sync and supportive, this enabled the

full potential of thriving to be experienced. On the other hand, less support from other areas within the system might enable intensive care staff to be resilient but struggle to achieve thriving. Furthermore, there are also influences from the surrounding context, which included COVID-19 within this study. Thriving within the system from the individual to the organisation was also described as having an overall positive impact on patient care.

Figure 2

Unifying Grounded Theory Linking Thriving and Relational Support in the ICU – A 'Social System Facilitating' Theory of Thriving in the ICU



Note. The blue circle represents the ICU, inside of the red circle represents the boundaries of the hospital and NHS Trust and outside of the red circle represents the surrounding context, which in this study was COVID-19. Arrows show the direction of influence/movement within the social system within which thriving in the ICU is facilitated. For example, there are direct and indirect influences from the surrounding context down to the ICU team which contribute to individual and team thriving. Challenge and energy are represented as inputs to the system and improved patient outcomes are a potential output.

Discussion

Overview of Findings

This study aimed to develop an understanding of how thriving is experienced at work by the MDT working in the ICU and to look at whether relational support is used as a tool by staff to facilitate thriving. Thriving was explored owing to its potential utility for understanding how to better support intensive care staff at work, as Jackson et al. (2018) identified thriving as the ability to positively manage challenges at work in the ICU. Within this study, thriving at work was found to be maintained through the presence of challenge, energy, support and access to resources. In addition, more individual thriving contributed to more thriving within teams, which resulted in a more integrated MDT in the ICU, with corresponding benefits for the organisation and patients.

Thriving

Thriving was generally perceived as something which intensive care staff were unfamiliar with describing. Terms including resilience and achievement were more often identified, which is perhaps a reflection of the workplace culture of the NHS which is driven by an organisation striving to meet targets and monitor outcomes for patient care (Henshall et al., 2017). Resilience was described in the current study similarly to Jackson et al. (2018) as the ability of individual staff to manage emotions, overcome challenges and continue at work. In comparison, thriving was a conceptually distinct and different experience which all staff were able to explain despite subtly different meanings resulting from working in different roles and being at different stages of their careers.

Thriving was broadly experienced as a positive feeling which is the desirable end goal of a process which intensive care staff purposefully navigate towards by moving forwards in pursuit. More than this, thriving at work in the ICU was described as having a relational component, as well as involving staff seeking out opportunities for learning and

experiencing a passion for the job. This supports the definition from Spreitzer et al. (2005) which views thriving as important for individuals being able to identify whether they are making progress towards their goals. However, thriving is also experienced as a bumpy journey. Intensive care staff described how fluctuations in and out of thriving over time were normal as it was not possible to always maintain thriving when working in the ICU environment. Thriving was experienced as a parallel process to burnout, which fits with the 2WPP perspective whereby individual well-being exists on a continuum (Ivtzan et al., 2015; Lomas & Ivtzan, 2016) and offers support for the J-DRM (Demerouti et al., 2001) whereby work engagement and burnout are outcomes of interacting job demands and job resources (Bakker & Demerouti, 2017). The extent that intensive care staff experienced themselves as moving between points on this continuum was unique for each person but anything from neutral to positive was considered to be a good position. Additional steps were added to the original four-item continuum from Jackson et al. (2018) including growth between resilience and thriving. This was done to explain more of the complexity in well-being and staff experiences, which also included feeling fulfilled caring, learning and contributing to something perceived as meaningful.

Intensive care staff described an acute awareness of the emotional and physical challenges of working in the ICU (e.g. Chuang et al., 2016; Hamric & Blackhall, 2007). Feeling able to overcome these challenges was described as particularly integral to thriving. However, there was also more nuanced reflection about how thriving actually emerged from the embracing of challenges and developing confidence in clinical skills to feel able to meet the job demands, which Su et al. (2014) described as engagement and mastery. Wendt et al. (2011) identified thriving in work environments where emotional challenges are inherent but used as motivational processes to help others. This could be one explanation for why several intensive care staff highlighted that thriving was unrelated to happiness at work. Part of

thriving in the ICU included accepting that staff cannot be completely satisfied with every patient outcome, but they can continue to work hard and make improvements in the future.

The findings also demonstrated that not all intensive care staff who manage challenges at work will experience thriving because they also need time to rest and recharge. Intensive care staff described feeling energised by caring for patients, which supports the model from Spreitzer et al. (2005) where accomplishing work tasks and learning generate energy for thriving. However, intensive care staff also relied on replenishing their energy through interactions and activities to sustain thriving when at work. Jackson et al. (2018) suggested that actively doing something different serves the purpose of helping staff to step away from the ICU environment where the stress is often located.

Relational Support

Support available at the team and organisational levels of influence were identified as job resources for reducing the negative impact of job demands (Bakker & Demerouti, 2017; Danna & Griffin, 1999). Without positive connections at work, intensive staff described having to rely more on their own individual strategies for thriving but cannot fully achieve thriving. Thriving was experienced when intensive care staff worked as part of an integrated MDT; however, an integrated MDT also produced more thriving at an individual and team level. Support for these findings comes from Spreitzer et al. (2005) who found that work relationships are important for generating and maintaining thriving at work as thriving staff are better able to work well together and support each other.

An integrated MDT involved mutual respect and understanding, which West et al. (2020) described in nurses in terms of a core human evolutionary need for belonging. Being able to talk openly with colleagues had a particularly restorative impact which supported intensive care staff to manage the work demands. This process of trusting colleagues to listen without judgement and learn together has been called psychological safety (O'Donovan &

Mcauliffe, 2020). However, staff occupying management positions most often described struggling to seek out and find adequate support within their roles. This is in contrast to findings from Jackson et al. (2018) where more experience was associated with thriving, as it suggests that a barrier to thriving may be occupying too much responsibility when the job demands are too high. Although thriving could come from working autonomously, some AHPs and pharmacists, who often worked in smaller teams across several wards, identified with feeling less able to thrive when they were dissatisfied with feeling disconnected from ICU colleagues.

In addition, thriving was experienced as related to the extent to which intensive care staff felt valued and recognised in their roles by their employing organisation, which has been identified as a fundamental need for healthcare workers (Henshall et al., 2017; Jarden et al., 2018b). Having access to adequate staffing numbers was described as the most important resource for staff being able to do their jobs and this is frequently reported in the literature (e.g. Credland, 2020, Highfield, 2021). The 'Ripple Effect' explained how individual thriving can spread outwards and enable others within the ICU system to also thrive. However, thriving may be prevented if the culture surrounding their work is one where intensive care staff are not provided with the correct resources, the emotional impact on mental health is not acknowledged and decisions which are important to staff are dictated and imposed upon them by the organisation.

COVID-19

Despite increases in the availability of equipment and staff support, many intensive care staff explained that, in the context of the COVID-19 pandemic, survival was a better description of their experience than thriving. Survival was experienced as exhaustion, working under similar pressured work conditions but with additional demands. This shared experience is seen across the literature (e.g. Arabi et al, 2021; Billings, Ching et al., 2020;

Wong et al., 2020). However, regardless of the COVID-19 context, similar factors were found to contribute to thriving. Most importantly, intensive care staff described the strengthening of relationships with colleagues, as collectively coming together was necessary to face the pandemic (Billings, Abou Seif, et al., 2020). When staff felt supported, this also allowed room for some positive experiences including finding solutions to new problems. This fits with the idea of post-traumatic growth, described by Dowthwaite (2020), which was found in previous pandemics (Lau et al., 2006) and described by Woodford et al. (2020) to include finding opportunities amidst the challenges for experiences such as pride or purpose.

Implications

Benefits of Focussing on Thriving

Resilience as a term used in healthcare to describe the ability of staff to recover quickly and adapt well to challenging situations (Jackson et al., 2007) may be criticised for its focus on individual responsibility (Reynolds & Trethewey, 2019; Southwick et al., 2014; Traynor, 2018; van Breda., 2018). The use of this term may have inadvertently contributed to more mental health stigma among intensive care staff. Not feeling able to cope with work demands may be perceived as implying that staff are doing something wrong and likely discourages colleagues sharing their very understandable emotional reactions to a challenging work environment for fear of judgement (Billings, Abou Seif, et al., 2020; Chang et al., 2019). The research findings challenge a negative research focus in the intensive care literature (Jarden et al., 2018a) by showing that many multi-disciplinary professionals enjoy their jobs in the ICU. Furthermore, they highlight that intensive care staff are often doing everything they can to help themselves to be more resilient; however, it is impossible for them to bounce back from adversity when there is no system of support around the individual (Reynolds & Trethewey, 2019). As a result, thriving may be useful for acknowledging the

additional influence of team and organisational factors on well-being and drawing attention to factors which need to be changed within the ICU environment rather than suggesting that staff need to get better at managing those factors. However, thriving should not become another concept used to ignore systemic problems.

More Organisational Responsibility Moving Forward

Individuals are the product of systems but often have little ability to change their work context (Spreitzer et al., 2005). As a result, healthcare organisations have a responsibility for supporting staff to succeed in thriving (Arabi et al., 2021; Bryden et al., 2019; Highfield, 2019). By directly asking intensive care staff what needs to change in order for them to thrive, this research provided important insight and learning into how they want and need to be supported in the future. The findings highlighted areas where organisations can invest to make system-wide changes which are more preventative and address the root of the problem rather than reactive to managing burnout that already exists. Healthcare organisations which enable the conditions for thriving can positively impact teams through reduced absenteeism and turnover (Stevenson & Farmer, 2017; Stone et al., 2006). In addition, benefits to ICU team working may lead to improvements in patient care as the likely outputs of a thriving system (Bajoreck & Holmes, 2020; Kerlin et al., 2020; Wheelan et al., 2003). This is supported by a review from Hall et al. (2016) which identified links between higher patient safety and positive mental health factors among healthcare professionals. One potential reason for this is that rather than focussed on individual survival, supported staff may feel more able to work together with a united approach.

Moving on from COVID-19, now more than ever healthcare organisations including the NHS must take a lead in providing a foundation for improving how intensive care staff are supported to thrive at work (Berwick et al, 2019; Walton et al, 2020). For this to happen, staff need a road map for the future, which outlines how to best navigate the journey towards

thriving. Several points of change are suggested below. These points represent the most frequently generated ideas by participants and demonstrate positive steps that can be taken to encourage ripples of thriving throughout the whole MDT in the ICU.

1) ***Help staff to feel valued***

- By reducing mental health stigma. This requires a culture shift to create a work environment where it is not taboo to discuss difficult feelings and ask for help, which can only be achieved by the organisation taking action to prioritise staff well-being and encourage normalising conversations about mental health throughout the system (Arabi et al, 2021; Stevenson & Farmer, 2017).
- By recognising self-care as equally important as mandatory training, providing staff with the working conditions to rest and re-energise at work and enabling staff to step away from the ward for self-reflection or socialising. This must include having access to a consistent supply of food and water, encouraging breaks are taken, allowing staff to leave the ward at least once on their shift and ensuring that all MDT staff have a shared space to go to connect with colleagues (Billings, Abou Seif, et al., 2020; Lissoni et al., 2020; Tomlin et al., 2020).
- By showing appreciation for staff and highlighting positive feedback as a whole MDT on a regular basis. This could include during team meetings and through bulletin boards and newsletters (Highfield, 2019). Marking the end of COVID-19 with some form of reflection and celebration outside of work will be important (British Psychological Society Covid19 Staff Wellbeing Group, 2020).

2) ***Help staff to feel supported***

- By enabling all MDT staff to access formal emotional support within work which meets their individual needs. Staff should not have to access personal therapy outside of work for work-related issues. As a result, this should involve regular clinical

supervision and a dedicated clinical psychology lead (Highfield et al., 2021; Walton et al, 2020) for each ICU, as well as group forums such as reflective practice and Schwartz Rounds "Team Time" (The Point of Care Foundation, 2020) where staff can reflect on the normal emotional impact of their work (Bajoreck & Holmes, 2020).

- By providing staff with spaces to discuss clinical cases together in groups within and between professions. This may be achieved by creating safe spaces where staff can share skills and learn together (Bryden et al., 2019). Intensive care staff came through COVID-19 together and retaining this community mindset will be important.
- By providing managers with more support in their roles to care for themselves and be able to support the rest of the team (Ervin et al., 2018). This could involve providing managers with peer support schemes, enabling managers from different wards to discuss the shared pressures of leadership and encouraging self-compassion (Bailey & West, 2020).

3) Help staff to feel empowered

- By helping staff in their professional development. This could involve allowing staff time to attend training, as well as encouraging staff to seek out new challenges and opportunities to progress in their learning throughout their careers (Bryden et al., 2019; Highfield et al., 2021).
- By including staff in the decisions which impact them and ensuring that this decision making is converted into positive action for service improvement. This may be achieved by the organisation encouraging staff of all levels to participate in service development and inviting their ideas for innovation (Walton et al, 2020).
- By providing staff with the resources that they need to do their jobs. This can only be achieved through greater investment to provide staff with access to appropriate

equipment and staffing numbers (Highfield et al., 2021), which are not just taken away once COVID-19 is over.

Key Role for Clinical Psychology

Although an evolving role, clinical psychologists are widely recognised as core members of the ICU MDT (Evin et al., 2018). One of many responsibilities includes nurturing and promoting staff well-being using specialist knowledge of psychological theory and valuable leadership skills (Lissoni et al., 2020; Wade & Howell, 2019). During COVID-19, there has been an increased recognition of the mental health impact of working in the ICU, alongside an increase in the funding and provision for clinical psychologists in ICU posts (Greenberg et al., 2021). As a result, it is important that clinical psychologists listen to intensive care staff about how they prefer to be supported and use their roles to make positive changes in the workplace including by providing staff with reflective and confidential spaces, de-stigmatising mental health, reframing the semantics surrounding burnout, as well as advocating for organisational change.

Limitations and Future Research

The study met its objectives by recruiting a heterogenous sample which was deemed to be representative of the wider multi-disciplinary ICU workforce. Previous research has often focussed on nurses (Jackson et al., 2018; Jarden et al., 2018a) and has neglected to consider how team working may be affected by some staff including AHPs working across multiple wards including the ICU. More in-depth comparison between healthcare professionals and within participant demographics were not explored as this was not within the scope of the methodology utilised. However, further qualitative exploration of the impact of occupying multiple roles on the relationships and well-being of intensive care staff is needed.

The inclusion of twenty participants recruited from across six NHS hospitals was a strength because the results are more likely to reflect the experiences of intensive care staff more generally rather than being impacted by the specific team relationships and contexts at one hospital. However, several limitations with the sample can be noted. Firstly, the hospitals were all located in a small region in the North East of England which might not reflect the experiences of staff in other areas of the United Kingdom or other countries outside of the NHS. Secondly, every effort was made to recruit participants from different professional backgrounds, in line with the guidelines from Macnaughton and Webb (2019). However, this was limited by the individuals who volunteered to be involved. For instance, there was also a noticeable absence of more junior members of staff, especially doctors below consultant level. One potential reason may be that staff rotated so did not have experience of working in the ICU before and during COVID-19 or felt that their voices were less important. Thirdly, there is some lack of diversity within the participant demographics, especially in age, gender, ethnicity and employment status.

COVID-19 affected recruitment and interviewing as the researcher was unable to go to the research sites to meet the staff teams. Despite this, participants provided positive feedback around the use of remote interviewing including the ability to build rapport and greater flexibility when arranging interview times, which fits with the existing literature (Ward et al., 2015). However, COVID-19 was a constantly changing situation which affected the four NHS Trusts differently at different times and significantly impacted how participants felt on a particular day. As a result, the research can only provide a snapshot into some of the experiences during the pandemic.

Finally, the research topic of thriving may have contributed to a self-selection bias where participants who identified with the concept and had more positive experiences to share were more likely to take part. However, most participants had mixed perspectives and

reflected on both highs and lows of working in the ICU. Furthermore, as all of the participants continued to work throughout COVID-19, staff who experienced more burnout and took time off work are potentially less represented within this study. This may be important because Shevlin et al. (2021) identified that individuals with an increased fear of being infected with COVID-19 may have been particularly vulnerable to poorer mental health during COVID-19.

As managers within the study described thriving more as related to how they supported other staff, 'thriving from a distance', further research should consider what helps managers to thrive, what they need to feel supported in their roles, as well as their perception of the stigma around mental health. The final unifying grounded theory which emerged from this research to understand how thriving is facilitated through relationships at work could apply to a range of healthcare settings. However, to develop the theory further with intensive care staff, more research should explore what a thriving organisation looks like to develop the understanding of the relationship between the well-being of intensive care staff and the organisation.

Conclusion

Overall, this study highlighted how intensive care staff navigate a 'bumpy road' to achieve thriving at work. Thriving was found to be a positive experience which healthcare professionals aim to achieve by moving forwards along the well-being continuum. It was perceived to develop from working in the ICU where challenges were experienced as enjoyable, manageable and provided opportunities to grow. It also involved staff feeling energised in their work and feeling able to recharge. However, individual experiences of thriving were dependent on relational factors and were facilitated by support from both colleagues and access to resources provided by the organisation. As a result of these four

conditions being met and contributing to individual thriving, thriving within the team was also perceived to be more likely as this produced a more integrated MDT work environment. Now, more than ever, it is important that healthcare organisations take responsibility for supporting intensive care staff to stay in their jobs and work together as teams. The organisation is found to be at the start and the end of thriving and has a role in enabling thriving to grow throughout the system.

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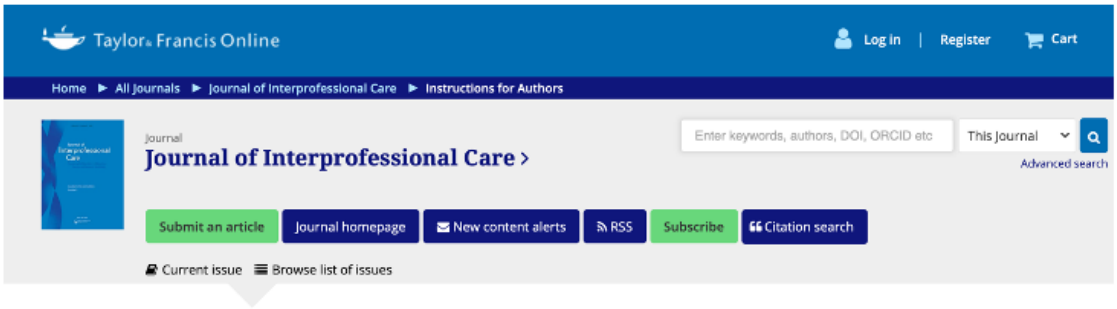
Part Three: Appendices

Appendix A. Submission Instructions for 'Journal of Interprofessional Care'



Instructions for authors

COVID-19 impact on peer review

As a result of the significant disruption that is being caused by the COVID-19 pandemic we understand that many authors and peer reviewers will be making adjustments to their professional and personal lives. As a result they may have difficulty in meeting the timelines associated with our peer review process. Please let the journal editorial office know if you need additional time. Our systems will continue to remind you of the original timelines but we intend to be flexible.

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- Guest Editorials, Normally On Invitation But Enquiries Welcomed
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- Should be written with the following elements in the following order: title page; abstract; keywords; introduction; background; method, results, discussion, conclusion; acknowledgments; declaration of interest statement; references; online supplements (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list)
- Should be no more than 7000 words, inclusive of the abstract, references, figure captions, endnotes.
- Should contain an unstructured abstract of 200 words.
- Should contain between 4 and 6 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
- The total number of words should be indicated in the appropriate space in the ScholarOne Manuscripts system during the online submission process. Authors are advised to include: an Introduction section, which introduces what the paper is about; a Background, which positions the paper in the wider, recent literature and which can include description of the intervention/education/program/ or activity where relevant; a Method section to include research design, research setting, participants and sampling, data collection, analysis, ethical considerations with ethics approval (IRB) number; a Results or Findings section, in which quantitative research includes descriptive and/or inferential statistics with effect sizes, supported by tables as appropriate, while qualitative research presents findings thematically supported by data excerpts as appropriate; a Discussion section articulating what is original about the results, what is the contribution to knowledge, what is the recommendation for interprofessional education/practice/policy/ or research and what are the study Limitations; finally a Conclusion which concisely summarizes the key finding and implications from the paper.

Short Reports, That Describe Research In Progress Or Completed, Or Innovations In The Interprofessional Field

- Should be written with the following elements in the following order: title page; abstract; keywords; introduction; background; methods; results; discussion; conclusion; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list)
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- Should contain an unstructured abstract of 200 words.
- Should contain between 4 and 6 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.
- Short Reports are submissions that describe research plans, studies in progress or recently completed, or innovative developments in the interprofessional field

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- Should be written with the following elements in the following order: title page; abstract; keywords; introduction; background; an overview of the IPEP activity; approach to implementing the activity; 10–20 key guidance issues (e.g. lessons learned); conclusion; key resources and references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list)
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- Should be written with the following elements in the following order: title page; main text introduction, discussion; conclusion; acknowledgments; declaration of interest statement; references; table(s) with caption(s) (on individual pages); figures; figure captions (as a list)
- Should be no more than 2000 words.
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Appendix B. List of Excluded Studies

Borhani, F., Hosseini, S. H., & Abbaszadeh, A. (2014). Commitment to care: a qualitative study of intensive care nurses' perspectives of end-of-life care in an Islamic context. *International Nursing Review*, *61*(1), 140-147. https://doi.org/10.1111/inr.12079

Cadge, W., & Catlin, E. A. (2006). Making Sense of Suffering and Death: How Health Care Providers' Construct Meanings in a Neonatal Intensive Care Unit. *Journal of Religion and Health*, *45*(2), 248-263. https://doi.org/10.1007/s10943-006-9012-2

Flinterud, S. I., Moi, A. L., Gjengedal, E., Grenager, L. N., Muri, A. K., & Ellingsen, S. (2019). The creation of meaning–Intensive care nurses' experiences of conducting nurse-led follow-up on intensive care units. *Intensive and Intensive Care Nursing*, *53*, 30-36. https://doi.org/10.1016/j.iccn.2019.03.009

Fowler, S. B. (2020). Critical-Care Nurses' Perceptions of Hope: Original Qualitative Research. *Dimensions of Critical Care Nursing*, *39*(2), 110-115. https://doi.org/10.1097/DCC.0000000000000405

Gelling, L., Fitzgerald, M. A., & Blight, I. (2002). Hope in the ICU: A qualitative study exploring nurses' experiences of the concept of hope. *Nursing in Critical care*, *7*(6), 271-277. http://ecite.utas.edu.au/64053

Hancock, J., Witter, T., Comber, S., Daley, P., Thompson, K., Candow, S., ... & Kits, O. (2020). Understanding burnout and moral distress to build resilience: a qualitative study of an interprofessional intensive care unit team. *Canadian Journal of Anesthesia/Journal canadien d'anesthésie*, *67*(11), 1541-1548.

https://doi.org/10.1007/s12630-020-01789-z

Harvey, G., & Tapp, D. M. (2020). Exploring the meaning of critical incident stress experienced by intensive care unit nurses. *Nursing Inquiry*, *27*(4), 1-11. https://doi.org/10.1111/nin.12365

Hinderer, K. A. (2012). Reactions to Patient Death: The Lived Experience of Intensive Care Nurses. *Dimensions of Intensive Care Nursing*, *31*(4), 252-259. https://doi.org/10.1097/DCC.0b013e318256e0f1

Hov, R., Hedelin, B., & Athlin, E. (2007). Being an intensive care nurse related to questions of withholding or withdrawing curative treatment. *Journal of Clinical Nursing*, *16*(1), 203-211. https://doi.org/10.1111/j.1365-2702.2006.01427.x

Monks, J., & Flynn, M. (2014). Care, compassion and competence in intensive care: A qualitative exploration of nurses' experience of family witnessed resuscitation. *Intensive and intensive care nursing*, *30*(6), 353-359. https://doi.org/10.1016/j.iccn.2014.04.006

Jarden, R. J., Sandham, M., Siegert, R. J., & Koziol-McLain, J. (2018). Intensive Care Nurse Conceptions of Well-being: A Prototype Analysis. *Nursing in Critical Care*, *23*(6), 324-331. https://doi.org/10.1111/nicc.12379

Jarden, R. J., Sandham, M., Siegert, R. J., & Koziol-McLain, J. (2019). Conceptual model for intensive care nurse work well-being: A qualitative secondary analysis. *Nursing in intensive care*, *25*(2), 74-83. https://doi.org/10.1111/nicc.12485

Morris, L. L., & Knafl, K. (2003). The Nature and Meaning of the Near-Death Experience for Patients and Intensive Care Nurses. *Journal of Near-Death Studies*, *21*(3), 139-167. https://doi.org/10.1023/A:1021235922301

Nazari, R., Vanaki, Z., Kermanshahi, S. M., & Hajizadeh, E. (2018). The meaning of managerial competency of ICU head nurses in Iran: A phenomenological study. *Iranian Journal of Nursing and Midwifery Research*, *23*(5), 363-370. https://doi.org/10.4103/ijnmr.IJNMR_132_17

Selph, R. B., Shiang, J., Engelberg, R., Curtis, J. R., & White, D. B. (2008). Empathy and Life Support Decisions in Intensive Care Units. *Journal of General Internal Medicine*, *23*(9), 1311-1317. https://doi.org/10.1007/s11606-008-0643-8

Söderberg, A., Gilje, F., & Norberg, A. (1999). Transforming Desolation into Consolation: the meaning of being in situations of ethical difficulty in intensive care. *Nursing Ethics*, *6*(5), 357-373. https://doi.org/10.1177/096973309900600502

Stayt, L. C. (2009). Death, empathy and self-preservation: the emotional labour of caring for families of the critically ill in adult intensive care. *Journal of Clinical Nursing*, *18*(9), 1267-1275. https://doi.org/10.1111/j.1365-2702.2008.02712.x

Vanderspank-Wright, B., Wright, D. K., & McMillan, K. (2019). Thinking about strengths in end-of-life nursing practice: the case of intensive care unit nurses. *International Journal of Palliative Nursing*, *25*(8), 378-385. https://doi.org/10.12968/ijpn.2019.25.8.378

Vivian, L., Marais, A., McLaughlin, S., Falkenstein, S., & Argent, A. (2009). Relationships, trust, decision-making and quality of care in a paediatric intensive care unit. *Intensive Care Medicine*, *35*(9), 1593-1598. https://doi.org/10.1007/s00134-009-1551-z

Wåhlin, I., Ek, A. C., & Idvall, E. (2009). Empowerment in intensive care: Patient experiences compared to next of kin and staff beliefs. *Intensive and Intensive Care Nursing*, *25*(6), 332-340. https://doi.org/10.1016/j.iccn.2009.06.003

Wassenaar, A., van den Boogaard, M., van der Hooft, T., Pickkers, P., & Schoonhoven, L. (2015). 'Providing good and comfortable care by building a bond of trust': nurses views regarding their role in patients' perception of safety in the Intensive Care Unit. *Journal of Clinical Nursing*, *24*(21-22), 3233-3244. https://doi.org/10.1111/jocn.12995

Wiencek, C. A., Ferrell, B. R., & Jackson, M. (2011). The Meaning of Our Work: Caring for the Critically Ill Patient with Cancer. *AACN Advanced Intensive Care*, *22*(4), 397-407. https://doi.org/10.4037/NCI.0b013e318232c6ef

Wilkin, K., & Slevin, E. (2004). The meaning of caring to nurses: an investigation into the nature of caring work in an intensive care unit. *Journal of Clinical Nursing*, *13*(1), 50-59. https://doi.org/10.1111/j.1365-2702.2004.00814.x

Appendix C. Methodological Quality Checklist for Qualitative Studies

CASP
Critical Appraisal Skills Programme

Paper for appraisal and reference: .....

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

CASP
Critical Appraisal Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

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6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

CASP
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8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

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Section C: Will the results help locally?

10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix D. Data Extraction Form

Author(s) and Year of Publication	
Title of Study	
Research Aims	
Indicator of Well-being and Definition	
Population and Sampling	
ICU Setting and Location	
Design	
Qualitative Method of Analysis	
Key Findings	

Appendix E. Further Participant Demographic Information

Authors (s) and Year of Publication	**Gender**	**Age**	**Professional Designation**	**Years of experience in the ICU**	**Ethnicity**	**Highest Level of Education**	**Employment Status**	**Relationship Status**	**Children**
Allen (2017)	8 male and 3 female		Intensivist Doctors	More than 1 year experience as intensivists and 10 participants had over 2 years'					
Deflippis, Curtis and Gallagher (2020)	5 male and 11 female		Nurses	Range 2-30 years					
Jackson, Vandall-Walker, Vanderspank-Wright, Wishart and Moore (2018)	11 female	20-29 = 5 30-39 = 3 40-49 = 1 50-59 = 1	Nurses	Range 4-36 as nurses and 1-24 in the ICU	White = 10	Diploma = 1 Bachelors = 8 Masters = 2	Full time = 6 Part time = 4	Single = 4 Common Law = 2 Divorced = 2 Engaged = 1 Married = 1	Children = 8
Jahantigh, Rezaee and Razaei (2014)	2 male and 5 female	Range 28-40 years	Nurses	Range 3-15 years					
Jakimowicz, Perry and Lewis (2017)	4 male and 17 female		Nurses	Range 2-15+ years					
Jarden, Sandham, Siegert and Koziol-McLain (2018b)	8 male and 57 female	Range 25-63 years	Nurses					Married = 40	

Jones, Winch, Strube, Mitchell and Henderson (2016)	171 took part but of the original 190 participants: 41 male and 149 female		Nurses	Less than 5 = 78 Over 5 = 111			
Mealer, Jones and Moss (2012)	1 male and 26 female	Range 35-59 years	Nurses	Range 4-34 years		Associates Nursing Degree = 7 Bachelors = 17 Masters/PHD = 3	Single = 6 Married = 18 Other = 3
Siffleet, Williams, Rapley and Slayter (2015)	3 male and 12 female	Range 26-50 years	Nurses	Range 3-25 years			
Thornton and White (1999)	3 male and 5 female		Nurses	More than 1 year			
Wåhlin, Ek and Idvall (2010)	5 male and 7 female	Range 27-56 years	Nurses and Doctors	Range 5-35 years			
Wei, Kifner, Dawes, Wei and Boyd (2020)	2 male and 18 female		Nurses and Doctors	Less than 10 years = 12 10-19 years = 4 20-30 years = 3 More than 30 years = 1	White = 14 Black = 2 Asian = 3 Hispanic = 1		

Appendix F: Quality Assessment Ratings for Reviewed Studies

	Checklist Item										
Article	**1 - Was there a clear statement of the aims of the research?**	**2 - Is a qualitative methodology appropriate?**	**3 - Was the research design appropriate to address the aims of the research?**	**4 - Was the recruitment strategy appropriate to the aims of the research?**	**5 - Was the data collected in a way that addressed the research issue?**	**6 - Has the relationship between research and participants been adequately considered?**	**7 - Have ethical issues been taken into consideration ?**	**8 - Was the data analysis sufficiently rigorous?**	**9 - Is there a clear statement of findings?**	**10 - How valuable is the research?**	**Overall Score**
Allen (2017)	1	1	1	1	1	1	1	1	1	1	10
Deflippis et al. (2020)	1	1	1	1	1	1	1	1	1	1	10
Jackson et al. (2018)	1	1	1	1	1	1	1	1	1	1	10
Jahantigh et al. (2014)	1	1	1	-	-	0	-	0	0	-	3
Jakimowicz et al. (2017)	1	1	1	1	1	1	1	1	1	1	10
Jarden et al. (2018b)	1	1	1	1	1	0	1	0	1	1	8
Jones et al. (2016)	1	1	1	1	1	0	1	1	1	1	9

Mealer, Jones and Moss (2012)	1	1	1	1	1	0	0	1	1	1	8
Siffleet et al. (2015)	1	1	1	1	1	0	0	1	1	1	8
Thornton and White (1999)	1	1	1	1	1	1	1	1	1	1	10
Wåhlin et al. (2010)	1	1	1	1	1	1	1	1	1	1	10
Wei et al. (2020)	1	1	1	1	1	0	0	1	1	1	8
Total	12	12	12	11	11	6	8	10	11	11	

Scoring Guidelines - To assess methodological quality of each study, each question was given one of three answers. An answer of yes was scored as '1', an answer of no was scored as '0' and an answer of 'can't tell' was scored as '-', which was considered equivalent to a score of 'no' but interpreted with caution. Following scoring, an overall quality rating score out of 10 was assigned to each paper by taking the sum of all the answers of 'yes'. A higher score was considered to indicate higher quality (Long et al., 2020).

Appendix G. Codes, Descriptive and Analytical Themes from the Thematic Synthesis

Analytical Theme	First Order Descriptive Themes	Second Order Descriptive Themes	Contributing Codes
Managing challenges at work	Strengths of character	Ability to cope	Tough/hardy personality type Culture of 'get on with it' Excitement
		Protection from difficult emotions	Self-preservation Vulnerability Professional image
	Positive outlook	Reflection and reframing	Vicarious trauma Self-awareness Looking for the good
		Successful management of end-of-life care	Maintaining dignity Fighting Spirituality Acceptance of new stages of life
	Getting the job done	Completing clinical tasks	Feeling in control Managing autonomously Sharing knowledge with others
		Learning from previous experiences	Adaptation to environment Finding solutions Responsibility

	Engaging in self-care	Physically distancing from work	Boundaries Work-life balance Shift working flexibility
		Activities outside of work	Hobbies Relaxation Connecting with family/friends
Finding meaning at work	Instinctive carer	Guided by values	Purpose Caring role
		Uplifted by positive feedback	Rapport Collaborative communication
	Making a difference	Contributing to patient progression	Advocacy role Holistic care Transitions beyond the ICU
		Feeling that change is possible	System pressures Need for necessary change Moving forwards and improving
Feeling supported at work	Working together	Multi-disciplinary decision making	Effective communication Respect of unique roles and abilities Agreement on goal/treatment plan Ability to challenge Visible role models

	Shared fun	Socialising away from the bedside	Shared understanding Talking and listening Trust Team spirit
		Letting off steam with humour	Similar personalities Laughter
	Moving forwards	Opportunities for professional development	Stuckness Career progression Learning
		Formal resources	Feeling valued and appreciated Meeting basic needs Meeting work demands Reaching out for help Accessing emotional support for individual needs Accessing emotional support for team Practical support

Appendix H. Submission Instructions for 'Journal of Occupational Health Psychology'

Journal of Occupational Health Psychology

Description

The *Journal of Occupational Health Psychology*® publishes theory, research, and public policy articles in occupational health psychology, an interdisciplinary field representing a broad range of backgrounds, interests, and specializations. Occupational health psychology concerns the application of psychology to improving the quality of work life and to protecting and promoting the safety, health, and well-being of workers.

The journal has a threefold focus, including organization of work, individual psychological attributes, and work–nonwork interface in relation to employee health, safety, or well-being.
The journal seeks scholarly articles, from both researchers and practitioners, concerning psychological factors in relationship to all aspects of occupational safety, health, and well-being.

Included in this broad domain of interest are

- articles in which work-related and nonwork-related psychological factors play a role in the etiology of occupational safety, health, and well-being
- articles examining the dynamics of occupational safety, health, and well-being
- articles concerned with the use of psychological approaches to improve occupational safety, health, and well-being

Special attention is given to articles with a prevention and a promotion emphasis. Authors should consider the financial costs and economic benefits of prevention and promotion programs they evaluate.
Manuscripts dealing with issues of contemporary relevance to the workplace, especially regarding the unique challenges of occupational safety, health, and well-being experienced by minority, cultural, or occupationally underrepresented groups, or topics at the interface of work and nonwork, are encouraged.
Each article should represent an addition to knowledge and understanding of occupational health psychology.

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Sharon Clarke, PhD
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Email

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- Theoretical/conceptual framework
- Measures of key constructs
- Research design
- Data analysis
- Interpretations and conclusions
- Writing style (clarity)
- Appropriateness of topic for *Journal of Occupational Health Psychology*
- Theoretical contribution to occupational health psychology
- Practical implications for occupational health psychology

Length of Submission

Standard manuscripts may not exceed 40 double-spaced pages (excluding figures, tables, references, and appendices). Research Note (also known as Kevin's Corner) manuscripts may not exceed 20 double-spaced pages (excluding figures, tables, references, and appendices).
Additional materials, if needed, can be placed in a supplemental materials file.

Submission letters should include a statement regarding any possible conflict of interest in conducting or reporting of the research and a statement of compliance with APA ethical standards. Authors can (but are not required to) suggest up to five reviewers who are especially qualified to review their work and who would not have a conflict of interest in serving as a reviewer.

Masked Review Policy

The journal accepts submissions in masked review format only.
Each copy of a manuscript should include a separate title page with author names and affiliations, and these should not appear anywhere else on the manuscript. Furthermore, author identification notes should be typed on the title page. Authors should make every effort to see that the manuscript itself contains no clues to their identities.
Manuscripts not in masked format will not be reviewed.
Please ensure that the final version for production includes a byline and full author note for typesetting.

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Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*).
Review APA's Journal Manuscript Preparation Guidelines before submitting your article.
Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.
Additional guidance on APA Style is available on the APA Style website.
Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.
To construct your equations with MathType or Equation Editor 3.0:

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- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.
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Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

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We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

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If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.)
If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

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All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.
Examples of basic reference formats:

Journal Article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored Book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an Edited Book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

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Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.
The minimum line weight for line art is 0.5 point for optimal printing.
For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.
When possible, please place symbol legends below the figure instead of to the side.
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APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.
Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

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The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other Information

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

Date: 17/04/20
Version: 7
IRAS ID: 273786

VOLUNTEERS NEEDED

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INSERT HOSPITAL BADGE)

For research exploring how healthcare professionals working in the intensive care unit (ICU) experience **seeking and receiving relational support at work**. Relational support at work involves any interactions with people in the ICU during the working day which provide informal or formal channels of support.

We want to give staff a voice to share their experiences and to have an opportunity to inform how they are supported at work.

Who can take part?

- Proficient English speaker
- **Any** healthcare professional currently working in the ICU and whose permanent job involves working with ICU patients on an ongoing basis
- Minimum of one hour per week contact with patients in the ICU
- Working autonomously within clinical role after completing staff induction into the service

What will happen?

- Following the QR code or link at the bottom of this page will provide you with more information about the study
- After this, you will be asked to complete a 5-10-minute questionnaire which asks questions about yourself and your job role
- If you are still interested, you can leave your contact details and the researcher will be in touch to arrange a date and time for an interview
- Interviews will last no more than one hour and will take place virtually from your home and outside of work hours through either a phone or computer

If you would like to participate or you would like more information, scan the QR code above using your phone or follow the link:

https://hull.onlinesurveys.ac.uk/relational-support-and-thriving-in-critical-care

You can also contact the researcher, Katie Reading, if you have any questions: K.Reading-2018@hull.ac.uk or 07429 675 176.

Appendix J: Questionnaire to Gather Recruitment Site Information

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Version number and date: 6 – 27/08/20 [IRAS ID: 273786]

Title of the Research: An exploration of how critical care staff experience relational support at work and whether this is related to thriving in the intensive care unit

Questionnaire about the intensive care unit

This questionnaire asks for information about the intensive care unit in order to gain more of an understanding of the environment that staff are working in. Your time to take part in this research is very much appreciated. Please provide your answers in the spaces indicated below and send the completed form to the researcher, Katie Reading, on the following email: K.Reading-2018@hull.ac.uk.

Completed by:

Name: _____

Role: _____

Date: _____

1. **Name of the hospital**

_____

2. **Name of the NHS Trust**

_____

3. **Location of the hospital (town/city and county)**

_____

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4. **The type of intensive care unit in the hospital where the research is being conducted (e.g. medical, surgical, paediatric etc). If there are multiple types, please list them all.**

5. **An estimate of the total number of staff who work in the intensive care units at this hospital**

6. **An estimate of the total number of healthcare professionals/clinical staff who work in the intensive care units at this hospital (excluding administrative staff, domestic staff, porters, students etc)**

7. **An estimate of the number of staff who work in the intensive care units at this hospital within each of the following professional designations:**

Nurses

Doctors

Advanced Critical Care Practitioners

Physiotherapists

Occupational Therapists

Speech and Language Therapists

Dieticians

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Pharmacists

Clinical Psychologists

Others

8. **An estimate of the total number of beds in the intensive care units at this hospital**

9. **The nursing staff to patient ratio within the intensive care units at this hospital**

10. **The number of clinical staff vacancies at present**

11. **Any other information that may be helpful for understanding the ICU environment**

Appendix K: Information about the Recruitment Sites

Hospital	NHS Trust	Location	Number in the Sample	Type of ICU	Estimated Total Number of Staff	Estimated Total Number of Clinical Staff	Estimated Total in each Professional Designation	Estimated Total Number of Beds	Nursing Staff to Patient Ratio	Number of Vacancies for Clinical Staff
Hull Royal Infirmary and Castle Hill Hospital	Hull University Teaching Hospitals NHS Trust – East Yorkshire	Hull	5	General ICU - medical, surgical, neurosurgical, trauma, cardiothoracic, cardiac, occasionally paediatrics	355	210	Nurse = 205 Doctor = 65 Advanced Critical Care Practitioner = 30 Allied Health Professional = 15 Pharmacist = 2 Dietician = 4	44	1:1 Level 3 and 1:2 Level 3	On 03/03/21 – nursing (3)
St James University Hospital and Leeds General Infirmary	Leeds Teaching Hospitals NHS Trust – West Yorkshire	Leeds	4	Hepatology, cardiothoracic, general surgery, medical, oncology, upper GI, renal, neurosciences, cardiac, trauma	500	475	Nurse = 350 Doctor = 70 Advanced Critical Care Practitioner = 15 Allied Health Professional = 20 Pharmacist = 8 Dietician = 4	59	1:1 Level 3 and 1:2 Level 2	On 05/01/21 – medical (4), nursing (40), SLT (1)
Northern General Hospital	Sheffield Teaching Hospitals NHS Trust - South Yorkshire	Sheffield	4	General ICU	358	340	Nurse = 285 Doctor = 40 Advanced Critical Care Practitioner = 8 Allied Health Professional = 7 Pharmacist = 5	36	1:1 Level 3 and 1:2 Level 2	On 07/04/21 – nursing (10-15%)
James Cook University Hospital	South Tees Hospitals NHS Trust – North Yorkshire	Middlesbrough	7	General ICU – medical and surgical	300	270	Nurse = 200 Doctor = 30 Advanced Critical Care Practitioner = 10	32 (COVID 50)	1:1 Level 3 and 1:2 Level 2	On 12/01/21- 10-15

	Allied Health Professional = 7 Pharmacist = 5 Dietician = 4

Appendix L. Documentation of Research Ethics Committee Approval and Health Research Authority Approval

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Appendix M: Participant Information Sheet

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Version number and date: 15 –08/07/20 [IRAS ID: 273786]

Information Sheet for Participants

You will be given a copy of this information sheet.

Title of the study: An exploration of how critical care staff experience relational support at work and whether this is related to thriving in the intensive care unit (ICU)

I would like to invite you to participate in a research study which forms part of my Clinical Psychology doctorate thesis. The study is exploring how critical care staff working within the ICU experience relational support at work and whether this is related to the experience of thriving. Relational support at work involves any interactions with people in the ICU during the working day which provide informal or formal channels of support to staff.

Before you decide whether you would like to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information sheet carefully and discuss it with others if you wish before making your decision as to whether you would like to be involved. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

A lot of research interest has been directed towards identifying how healthcare organisations can support the wellbeing of staff working in the ICU. Much of this research has focussed on reducing burnout; however, whilst this has been helpful, more research effort is needed to explore how staff experience the positive aspects of working in the ICU. Previous research has found that some staff working in the ICU use thriving to positively manage workplace stress and challenges. However, it is still unclear what factors promote thriving. One idea is that relational support at work could contribute to whether staff identify with the experience of thriving at work. Thriving at work can be defined as a positive staff response, such as experiencing passion, enjoyment, vitality and engagement in their work role which may emerge through successfully managing challenges at work and/or through feeling valued for their contribution and/or working in an environment where there are opportunities for nurturing learning and growth. To take part in this study, you do not have to identify with this definition of thriving. The research is interested in critical care staff experiences of working in the ICU whether or not this involves thriving at work, now or in the past. It is equally valuable to gain an understanding of what ICU staff consider to be barriers to thriving and how they think that thriving could be developed.

Although this research project was developed before the outbreak of COVID-19, the rationale for doing it has been further strengthened as the pandemic has shown just how important it is to ensure that all staff working in the ICU feel safe and supported in their roles. The current study will explore critical care staff experiences of thriving, workplace relationships, seeking and receiving support at work in the ICU. The questions will ask you to think back on a time before COVID-19 but there will also be opportunities to reflect on the impact of COVID-19 and to consider whether your perceptions of thriving and relational support have changed.

Why have I been invited to take part?

You are being invited to participate in this study because you are a healthcare professional working in a permanent clinical role that involves spending time in the ICU on an ongoing basis. Eligible participants must be over 18 and a proficient English speaker. You need to have completed your staff induction into the service which enables you to work autonomously in a clinical role with at least one hour of contact with patients in the ICU each week.

What will happen if I take part?

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If you choose to take part in this study, you will be asked to read the participant information sheet and complete a demographic questionnaire. This will take around 10-15 minutes. The questionnaire will ask questions about yourself including your age, gender and ethnicity. It will also ask questions about your job and role in the ICU including your professional role, employment status and number of hours spent working in the ICU each week. Completing this questionnaire will allow myself to check that you fulfil the criteria to take part in this study. Once you have completed the questionnaire, you will be asked to leave your contact details and provide consent to be contacted by myself. This will enable me to contact you to arrange a convenient date and time to meet to answer some questions about your experiences of working in the ICU. Your interest in the study is very much appreciated and every effort will be made to include all eligible participants. However, this may not be possible and so not every person who registers their interest will be selected to take part in the study. The information gained from your completion of the demographic questionnaire will influence the selection of participants for interview. It is important to a gain a sample of staff with varied characteristics so that the similarities and differences between staff experiences can be explored. If you request this, you will be contacted every month throughout the study to inform you about the progress of the study and whether you have been selected to take part in the study. You can also contact me at any time, and I can help to answer any of your questions about the study.

In light of the current COVID-19 situation, interviews will most likely take place virtually. Therefore, it is important that you have access to an electronic device, preferably a laptop or computer, so that you can use video conferencing tools such as Skype, Zoom or Microsoft Teams from your own home. For the best audio quality, it is recommended that headphones are used. It will also be possible to conduct interviews over the telephone if this suits you better. Interviews will take place at a mutually convenient time. We are aware of how busy and demanding work shifts can be in the ICU. As a result, we ask that staff attend the interviews between shifts outside of their working hours. Before the interview, you will be sent a consent form over email. On the day of the interview, you will be asked if you are happy for an audio recording to be started as we read and discuss each item of the consent form. Verbal consent will be gained relating to each item as part of the audio recording. If you are happy to proceed with the interview at this stage, you will be asked to sign the consent form. If you have the facility to do so, you will then be asked to scan and return the signed consent form to myself over email.

The interviews will be audio-recorded with your consent. Interviews will be relaxed. They will last as long as you want them to but typically between 30-60 minutes with around 10 minutes before and after for introductions and endings. A maximum of 90 minutes will be required of you on the day of the interview. You will not be expected to stay any longer than the agreed time on the day. Discussions will involve talking about your role working in the ICU including any experiences of thriving and relational support. There are no right or wrong answers and the research is only interested in your opinions, your beliefs and your experiences of working in the ICU. If you feel that the topic causes any distress, breaks can be taken at any time and the interview can also be ended at your request.

Do I have to take part?

No. Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you to make a decision about taking part. If you decide to take part, we will ask you to sign a consent form on the day of the interview and you will be given a copy of this consent form to keep. If you decide to take part in the study but later change your mind, this is also ok.

What if I change my mind about taking part?

You are free to withdraw from the study at any time before the data has been analysed without having to give a reason. Withdrawing from the study will not affect you in any way. Owing to the data analysis method being used, data analysis will happen within one week following the interview. After data analysis, withdrawal of your data will no longer be possible as the demographic questionnaire and

interview data will have been anonymised and/or committed to the final report. If you choose to withdraw from the study before this point, the data collected will be destroyed.

What are the possible risks of taking part?

In total, participating in the study will require a minimum of 60 minutes and a maximum of 110 minutes of your time which may be inconvenient for you. It is not expected that this study will cause you emotional distress. However, some people may experience upset when they talk about their experience of working in the ICU because it may bring to mind difficult memories and feelings. If this happens to you during the interview, support and reassurance will be provided. You will have the opportunity to take a break, discuss a topic more and/or end the interview. You can also withdraw from the study up until the point where the results are being analysed. A list of contacts will be given to you at the end of the interview which outline the different sources of support available to you from your workplace, the trust and external organisations, should they be needed.

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, sometimes people can find it useful to have the opportunity to reflect and talk about their experiences. We hope that the information that you give us will help us to gain a better understanding of staff experiences of relational support and thriving at work in the ICU. As a result, this may help to inform the support systems that are available to staff working in the ICU. It is now more important than ever in the time of COVID-19 to consider the changes that are needed to current staff support systems. One positive to come from the pandemic is that senior managers, leaders of healthcare organisations and governments are now more than ever reflecting on the value of their key workers, especially in the field of critical care medicine. They have all had a small glimpse at some of the challenges and triumphs of working in the ICU and whilst they are listening, it is vital that the frontline staff voices emerge strongly from within the ICU following COVID-19.

Data handling and confidentiality

GDPR stands for the 2016 General Data Protection Regulation. In the UK, we follow the GDPR rules and have a law called the Data Protection Act. All research using person identifiable data must follow UK laws and rules. Researchers must show how they protect the privacy of the people who take part in their research by ensuring that all identifiable information is kept confidential to the individual and only those in the research team who need to know. There are special rules to keep confidential patient information safe and secure. A research ethics committee checks this before the research starts. Some of the research team will need to know your name and contact details so they can contact you about your research appointments or to send you information about the study. Researchers must always make sure that as few people as possible can see this sort of information that can show who you are. In this study, your name will be removed from the research data and replaced with a code number. By doing this, the research data can then be matched up with the rest of the data relating to you by the code number. Any information that could be used to identify you will be anonymised. Researchers must make sure that they write the reports about the study in a way that no-one can work out that you took part in the study. Information collected from this study will be used for this study only and will not be used for any other purpose. Participant contact details and code numbers will be transferred to a password-protected Microsoft Excel document stored on an NHS encrypted laptop which only the researcher has access to. The information will be backed up to the secure network drives at the University of Hull and will be stored for no longer than six months after the completion of the study. The information will be deleted once the study has ended and the researcher has contacted all participants who requested feedback on the study findings.

For interested participants that are not interviewed, personal information from the demographic questionnaire on the online survey will be manually deleted immediately once no new participants need to be recruited. For participants that are interviewed, personal information from the demographic questionnaire on the online survey will be manually deleted after an interview has taken place.

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Personal information provided on the demographic questionnaire will then be anonymised using the code number assigned to you at the start of the study. The information will then be transferred to a password-protected Microsoft Excel document stored on an encrypted NHS laptop which only the researcher has access to. Information from the demographic questionnaire such as age and professional role will be combined with other anonymised participant responses in a summary table in the final research write up to provide context to the sample. The Microsoft Excel document containing the information from the demographic questionnaire will be backed up to the secure network drives at the University of Hull. This will be done by uploading the Microsoft Excel document stored on the NHS encrypted laptop to Microsoft One Drive to share with academic research supervisors. The document will be stored for no longer than six months after the completion of the study. The information will be deleted once the study has ended and the findings of the study have been written up.

Participant consent that is obtained through an audio recording will be saved as an audio file in a password-protected folder. Participant consent that is obtained through a written signature on the participant consent form will be saved as a password-protected Microsoft Word document. All files will be stored on an NHS encrypted laptop which only the researcher has access to. The files will be named according to the anonymous code number that was assigned to each participant on the consent form. The consent information will be backed up to the secure network drives at the University of Hull using Microsoft One Drive and will be stored for no longer than six months after the completion of the study before then being deleted.

To protect the security of the audio recordings, an encrypted NHS recording device will be used. Interviews will be kept strictly confidential. The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of harm. If this happens during the interview, the researcher is legally obligated to report this to appropriate authorities to ensure that you and other people are safe. It is unlikely that this will occur but should it happen, the researcher will discuss this with you at the time. During the study, all interviews will be transcribed and transferred to a password-protected Microsoft Word document stored on an NHS encrypted laptop which only the researcher has access to. After the data has been transcribed, all audio recordings will be destroyed. Anonymised transcripts of the recordings will be stored and backed up to the secure drive at the University of Hull using Microsoft One Drive. Anonymised research data transcripts will be under the responsibility of the academic research supervisors and will be stored for a period of ten years on secure drives at the University of Hull.

Data protection statement

You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR. If you want to complain about how researchers have handled your information, you should contact the research team. If you are not happy after that, you can contact the Data Protection Officer. The research team can give you details of the right Data Protection Officer. If you are not happy with their response or believe they are processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113). The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. In legal terms this means that the University process your data for research purposes as part of 'a task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form on the day of the interview. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx.

How is the project being organised and funded?

The researcher carrying out this this research is a student at the University of Hull and this research is being carried out as part of a doctorate level training program in Clinical Psychology, with the approval of Hull University Teaching Hospitals.

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What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be freely available to access on the University of Hull's on-line repository https://hydra.hull.ac.uk. Once the final report has been completed, feedback will shared with all participants who have requested it. It is hoped that feedback will be provided within nine months of your involvement in this research. Feedback will also be provided to relevant contacts at each hospital research site and with the associated NHS Trusts. However, the Trust will not be informed about which staff have taken part in the research. Participant information and any other details of individuals mentioned within the interview will be anonymised. Feedback will involve a summary of the main findings alongside some anonymised, verbatim quotes. The research may also be published in academic journals or presented at conferences. Participants will not be identifiable in the final study reports or in any conference presentations.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, who protect the interests of people who participate in research. This study has been reviewed and has been given a favourable opinion by the Faculty of Health Sciences Ethics Committee at the University of Hull. The project has also received the required Health Research Authority (HRA) approval for NHS staff research.

What should I do next?

If you are still interested in taking part in the research, please let me know by completing the consent to be contacted slip at the end of the online survey. You can also contact me if you have any further questions that you would like to be answered before registering interest in the study. If we agree an interview time, we will then meet. We will discuss informed consent and you will have the opportunity to ask any questions before we then begin the interview.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following details:

Katie Reading
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Telephone: 07429 675 176
Email address: K.Reading-2018@hull.ac.uk

What if there is a problem?

If you have concerns about any part of this study, it may be helpful to discuss these with the researcher who will do their best to answer your questions. You can contact them with the details provided above. If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisor's details below for further advice and information:

Dr Jo Beckett
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road

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Hull
HU6 7RX
Telephone: 01482 463 568
Email address: Jo.Beckett@hull.ac.uk

Dr Chris Clarke
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Telephone: 01482 464 106
Email address: C.Clarke@hull.ac.uk

Appendix N: Online Survey – Participant Demographic Questionnaire

Critical care staff experiences of relational support and thriving at work in the intensive care unit

Page 1: Introduction

I would like to invite you to participate in a research study which forms part of my Clinical Psychology doctorate thesis. The study is exploring how critical care staff working within the intensive care unit (ICU) experience relational support at work and whether this is related to the experience of thriving. Relational support at work involves any interactions with people in the ICU during the working day which provide informal or formal channels of support to staff.

If you are still interested in taking part in this study, please read the participant information sheet on the next page of the survey. Once you feel that you have understood the participant information sheet, you will be asked to complete a demographic questionnaire. The questionnaire will ask you questions about yourself and your work role. The final part of this survey will involve providing your contact details. This will allow myself as researcher to contact you to discuss meeting for an interview about the topic of interest.

If you have any questions about the survey before you continue, please contact myself, Katie Reading, as the principal investigator on: 07429 675 176 or K.Reading-2018@hull.ac.uk.

Your interest and involvement in this study is really appreciated.

Page 3: Demographic Questionnaire

By continuing with the online survey, you have stated that you have read and understood the participant information sheet. This indicates that you are aware of the purpose of the study, your involvement in the study and you give your consent for your data to be used in this research.

The next stage of the survey is to complete the demographic questionnaire. The questionnaire involves fifteen questions about yourself and your job role. This information is important to gain because it allows myself to check that you fulfil the criteria to take part in this study. In addition, it helps to guide the selection of participants for interview so that a diverse sample is obtained. It also allows for an exploration of the different factors which might influence the experience of support at work.

All questions marked with an asterix (*) are required.

Please select the category that includes your age.

- ○ Under 18
- ○ 18-24
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65 or Over

Please indicate your gender identity.

Please select exactly 1 answer(s).

- ☐ Male
- ☐ Female
- ☐ Prefer not to say

- [ ] Other

If you selected Other, please specify:

Please indicate your ethnicity.

Please indicate your relationship status. * *Required*

- ( ) Single
- ( ) In a relationship
- ( ) Engaged
- ( ) Married
- ( ) Divorced
- ( ) Other

If you selected Other, please specify:

Please indicate whether you have children. * *Required*

- [ ] Children
- [ ] No children

Please indicate your highest level of education. * *Required*

- [ ] Diploma
- [ ] Bachelor's Degree
- [ ] Master's Degree
- [ ] Doctoral Degree
- [ ] Other

If you selected Other, please specify:

Please select the category that best describes your professional designation.

Please select exactly 1 answer(s).

- [ ] Nurse
- [ ] Doctor
- [ ] Respiratory Therapist
- [ ] Physiotherapist
- [ ] Occupational Therapist
- [ ] Healthcare Assistant
- [ ] Speech and Language Therapist
- [ ] Dietician
- [ ] Clinical Psychologist
- [ ] Advanced Critical Care Practitioner
- [ ] Radiographer
- [ ] Pharmacist

☐ Other

If you selected Other, please specify:

Please indicate the specific title attached to your role if this applies, for example, consultant anaesthetist or outreach nurse. ✱ *Required*

Please indicate the length of time (in years and months) since qualification in the professional designation as indicated above. ✱ *Required*

Please indicate the length of time (in years and months) since you started to work in the intensive care unit.

Please indicate the total length of time (in hours) that you work each week.

Please indicate the total length of time (in hours) that you work in the intensive care unit each week.

Do you ever work over your typical working hours? ✱ *Required*

- [ ] Yes
- [ ] No

If so, in a typical week, how much time (in hours) do you spend working overtime? ✱ *Required*

Please select the category that best describes your current employment status.

- [ ] Full time
- [ ] Part time (less than 17.5 hours per week)
- [ ] Part time (more than 17.5 hours per week)
- [ ] Rotating
- [ ] Other

If you selected Other, please specify:

Please indicate the type of contract that you are employed under. * *Required*

- [ ] Permanent
- [ ] Temporary
- [ ] Other

If you selected Other, please specify:

Please indicate the pay banding that you are employed at. * *Required*

Please select no more than 1 answer(s).

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9

Page 4: Consent to Contact

If you are still interested in taking part in this study, please leave your contact details in the spaces provided below. Completing the demographic questionnaire and providing your contact details will provide me with your consent to contact you about the study.

All questions marked with an asterix (*) are required.

Please provide your full name. * *Required*

Please enter the name of the hospital where you work in the intensive care unit.

Please enter the name of the NHS trust that you are employed by. * *Required*

If you selected Other, please specify:

Page 5: Consent to Contact

Have you completed your induction into the service which allows you to work autonomously in your clinical role? (*Please be aware that answering no to this question will result in the termination of this survey) * *Required*

- Yes
- No

Page 6: Consent to Contact

Please enter a valid telephone number.

Please enter a valid email address.

What is your preferred method of contact?

Are there any specific times of the day that you would prefer to be contacted?

Page 7: Consent to Contact

I am incredibly thankful for your interest in this study and appreciate every person who wants to be involved. However, as the study requires a diverse sample of healthcare professionals (who vary, for example, in age, professional role and years of experience), it is not possible for everyone who registers their interest to take part in the interviews.

Do you understand that registering your interest in this study does not automatically mean that you will be contacted for an interview? (*Please be aware that answering no will result in the termination of this survey) ✱ *Required*

- ○ Yes
- ○ No

Page 8: Consent to Contact

Some people may wish to be updated on the progress of the study as it continues over the next few months. As a result, I am able to provide a short, monthly email to all those who request it. The email will provide information about the number of participants that have already been interviewed and how much longer your permission to be contacted for interviews will be needed. In addition, an email will be sent when no new participants are required to update you about the end of the study.

Do you consent to being sent monthly updates about the study over email (using the email address provided above)? ✱ *Required*

- ○ Yes
- ○ No

Page 9: Consent to Contact

It is important that you understand the purpose of the study and your involvement. Do you consent to being sent a copy of the participant information sheet and my contact details (using the email address provided above)? This will allow you to be able to get in contact at any time if you have any questions or queries about the study. ✱ *Required*

- ○ Yes
- ○ No

Page 10: Thank you

Thank you for your interest in this study exploring how critical care staff experience relational support and thriving at work in the intensive care unit.

Shortly after you submit this survey, if you have requested me to do so, you will receive an email providing you with a copy of the participant information sheet and my contact details should you have any questions about the study.

The next step will involve arranging a mutually convenient time and date for the interviews. As you will now be aware, it is unfortunately not possible for me to contact everyone who is interested in this study to arrange an interview. However, I do want to keep in touch to provide updates about the progress of the study. If you have requested updates, you will be receiving an email in the near future. You will receive this email once each month until no new participants are needed.

Thank you again for your interest in this study. If you have any questions or require more information, please contact me using the following contact details:

Katie Reading

Clinical Psychology, Aire Building,The University of Hull, Cottingham Road, Hull, HU6 7RX

Telephone: 07429 675 176/ Email address: K.Reading-2018@hull.ac.uk

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Key for selection options

19 - Please enter the name of the NHS trust that you are employed by.

Hull University Teaching Hospitals NHS Foundation Trust
Leeds Teaching Hospitals NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Other

23 - What is your preferred method of contact?

Telephone
Email

Appendix O: Email Confirmation to Participants – Pre-Interview

Email 1 – After Completion of Online Survey

UNIVERSITY OF HULL (INSERT HOSPITAL BADGE)

Dear (INSERT NAME)

Thank you for your interest in this study exploring how critical care staff experience relational support and thriving at work in the intensive care unit.

You are receiving this information because you completed an online survey for this study. In the survey, you gave me consent to send you a copy of the participant information sheet (Appendix 1 attached to this email) and my contact details using the email address that you provided.

What happens next?

The next step will involve waiting for me to get back in touch, using your preferred method of contact, to arrange a mutually convenient time and date for the interview. It is unfortunately not possible for me to contact everyone who is interested in this study. However, if you have requested updates about the progress of the study, you will receive an email from myself once each month until no new participants are needed. I am very grateful for everyone who wants to be involved in this research. I wish that I could speak to everyone but I hope that what I can do is capture some of the shared experiences of critical care staff.

All my best,

Katie Reading (Trainee Clinical psychologist and Chief Investigator)
Contact: K.Reading-2018@hull.ac.uk/ 07429 675 176)

Email 2 – Before the Interview

UNIVERSITY OF HULL

(INSERT HOSPITAL BADGE)

Dear (INSERT NAME)

Thank you for your interest in this study exploring how critical care staff experience relational support and thriving at work in the intensive care unit.

You are receiving this information because you have spoken to myself and we have agreed a suitable time and date for the interview stage of this study. Before the interview, please take some time to read the following information carefully.

- Appendix 1 – Information on how to prepare your home environment for a video interview
- Appendix 2 – Information on how to access and use MS Teams for video conferencing
- Appendix 3 – Participant consent form

What happens next?

Once you have read the attached information and feel happy to proceed, please provide a written signature and date on the consent form and scan the document back to myself via email. If you do not have the facility to do this, do not worry, we will cover the information again on the day of the interview and verbal consent can be provided as an alternative.

If you have any questions or need any further support, do not hesitate to contact myself using the contact details below. I look forward to speaking to you more about your experiences on the day of the interview.

All my best,

Katie Reading (Trainee Clinical psychologist and Chief Investigator)
Contact: K.Reading-2018@hull.ac.uk/ 07429 675 176)

UNIVERSITY OF HULL

(INSERT HOSPITAL BADGE)

Appendix 1: Preparing your home environment for a video interview

- Make sure that you sit in a space where you feel comfortable.
- Make sure that you are on your own in the room so that you feel safe to disclose experiences at work. The interviewer will also be doing the same to ensure the confidentiality of the interview.
- It is good to have a background free of distractions (a plain wall often works best).
- Wearing headphones can improve sound quality.
- Check your camera and microphone/headset are working ahead of time.

Appendix 2: How to access and use video conferencing tools

How to use Microsoft Teams:

- You do not need to download anything to join Microsoft Teams.
- The interview/meeting settings have been set to maximise the security of the interview. Please do not share access codes as this will compromise security.

- You will receive the MS Teams invite via the email address that you provided.
- It might ask you to accept the meeting but don't do anything with it (if you do accept the meeting you will find it disappears into the 'trash folder' rather than the 'index folder'.
- When it gets to around 5-10 minutes before the meeting, click the link that says 'Join Microsoft Teams Meeting'
- You will be asked to enter your name.
- You will then see a message which says that you are waiting for the meeting host. The meeting host will let you into the meeting at the right time.

- You can find out more about Microsoft Teams here https://biz30.timedoctor.com/how-to-use-microsoft-teams/
- If you experience any technical difficulties, you can call myself on: 07429 675 176.

Appendix P: Participant Consent Form

UNIVERSITY OF HULL

(INSERT HOSPITAL BADGE)

Version number and date: 7 – 18/04/20 [IRAS ID: 273786]

Consent Form

Title of study: An exploration of how critical care staff experience relational support at work and whether this is related to thriving in the intensive care unit

Name of Researcher: Katie Reading

Please initial box

1. I confirm that I have read and understand the participant information sheet (version 12 - dated 18/04/20) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary, and it is up to me to decide whether or not to take part in this study. ☐
3. I understand that I am free to withdraw at any time before data analysis has occurred without giving any reason and without any cost or my legal rights being affected. Owing to the data analysis method being used, data analysis will happen within one week following the interview. I understand that if I withdraw from the study before the interview, the demographic information that I have already given on the online survey will be destroyed. I understand that once the interviews have been linked to the demographic information from the online survey and both sets of data have been anonymised, I cannot withdraw my data. I understand that the data I have provided up to the point of withdrawal will be retained. ☐
4. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations. I understand that the research will be submitted for publication in a research journal. I understand that the research findings will be shared with my NHS Trust; however, my information will be anonymised and the Trust will not be informed about my participation in the study or any other person mentioned during the interview. ☐
5. I understand that I will be given a copy of this consent form. ☐
6. I agree to take part in the above study. ☐

Name of Participant _____ Date _____ Signature _____

Unique anonymised participant number _____

UNIVERSITY OF HULL

(INSERT HOSPITAL BADGE)

Do you want to hear about the results of the study? ☐ Yes ☐ No

Name of Person taking consent	Date	Signature

Appendix Q: Interview Schedule

Version number and date: 5 – 17/04/20 [IRAS ID: 273786]

Semi-Structured Interview Schedule

Introduction

- Introduce myself, my role and thank for taking part
- Check audio and visual are working
- Check that the participant has read the participant information sheet and understands why they are here being interviewed
  - Recap, if necessary, the purpose and acknowledge that this is not a COVID-19 study, but it feels important to bring it into the interview at the end
- Check that the participant still wants to proceed with the interview
- Gain informed consent
  - Check whether the participant has signed, scanned and emailed the consent form to myself
  - If not – start the audio recording, obtain verbal consent relating to each item and then stop the audio recording
- Ask whether there are any questions at this stage

Before – Checks

- Check that the participant is in a quiet place where they will not be interrupted and can talk openly
- Discuss what would happen if we lost internet connection - keep the audio recording going, either ask each other to repeat what we have just said or if it stops completely: first try to close and re-open the link and secondly move to using the telephone
- Check how long the participant has available for the interview, reassure that it should not last longer than an hour and we can pause/take a break at any time
- Discuss the interview process – the aim is to have a conversation and see where it leads, and I will try to say as little as possible
- Check that the participant is happy for some brief notes to be taken during
- Remind that anything discussed is confidential and any names/specific situations mentioned during will be anonymised

Before – Introduction of the Topic

- Some people love working in the intensive care unit, others can find it difficult, and others can experience something in the middle. Research has talked about the experience of thriving as being part of some staff experiences. We are currently unsure about what promotes thriving at work in the intensive care unit, but one idea is that thriving may be related to relational support at work. This is something that I would like to talk to you about today. How does that sound?
- And just a reminder here that the first few questions will ask you to think back to a time before COVID-19 but then there will be space at the end to reflect on your experiences of working during COVID-19 and to consider whether your perceptions of the research topic have changed
- Any questions before we start?
- Start the audio recording

Questions added 18/11/20
Questions added 08/12/20

Interview Questions

Thriving

- When you read the information sheet, what were your first thoughts about the word thriving?
- What does 'thriving at work in the intensive care unit' means for you as an (insert designation e.g. nurse)?
  - If the participant doesn't understand the idea of thriving – sensitise to the concept of what thriving could or could not mean and potentially provide the definition from the information sheet
- Could you tell me more about any experiences of thriving that you have had whilst working in the ICU – either direct experiences of your own thriving, thriving you may have observed in others or imagined ideas around thriving?
  - If not – move onto asking - what do you think are barriers to you experiencing thriving?
  - Prompts: Who, if anyone, was involved? When was that? How were they involved? Did you learn anything from this experience?
- What are the tools that you need in order to manage and thrive at work in the ICU?
- To what extent have you experienced thriving throughout your career working in the ICU and how has it changed over time?
- What do you think are the similarities and differences between thriving and resilience?

Relationships and Support at Work

- How important do you think relational support at work is to your job role in the ICU?
  - If the participant doesn't understand the idea of relational support – provide the definition from the information sheet
- Who would you consider to be within your team at work in the ICU?
- When there are distressing/challenging situations that happen at work in the ICU, how is this managed within the team?
- What are your experiences of being supported within the relationships that you have at work in the ICU?
  - Prompts: Where does support come from? What did the support look like? Was it accessible/readily available? Did it help? What do you look for in a person/service to offer support? Differences between giving and receiving?
- What factors do you think contribute to someone seeking support at work in the ICU?

Thriving and Support at Work

- What role, if any, does relational support at work have in enabling you to experience thriving at work in the ICU?
  - Prompts: Can you tell me more about your reasons for this?

COVID-19 Reflection

- To what extent has COVID-19 affected what you previously experienced or thought about relational support and thriving at work in the ICU?
  - Prompts: How have your perceptions changed since COVID-19? How has that perception changed over this time? What has changed to make you think this way? To what extent have you felt supported to experience thriving during COVID-19? What has been most helpful?
- Moving forward and looking towards the future, what do you think is needed for staff to experience a sense of thriving at work in the ICU?
  - Prompts: What is currently being done well? What changes are needed?

Conclusion

- We have come to the end of my questions now, is there anything else you want to discuss or share about your experiences of support or thriving at work?
- Is there anything you would like to ask me?
- End the audio recording
- Discuss how the participant found the interview – if found anything upset then ask if they have someone to talk to
- Discuss signposting to support
- Discuss next steps – I will send a summary email with my contact details and further information on accessing support if needed,
- Ask if there is a pseudonym which I can use to refer to them within the research
- Next steps – I will send an email providing with my contact details and information about how to access further support attached and if consent obtained then I will be in touch at a later date to update about the research findings

Appendix R: Sources of Support Information for Participants

UNIVERSITY OF HULL

NHS Hull University Teaching Hospitals NHS Trust

Version number and date: 5 - 18/08/20 [IRAS ID: 273786]

Sources of Support

At Work

Have a chat with your **Line Manager/Supervisor** as they can listen and help you to access appropriate support from within the service.

The **COVID-19 Staff Support 24/7 Helpline** can be accessed by telephone on: 01482 461 227.

The Chaplaincy Department provide the **Pastoral Care Service for Staff** which can be accessed 24 hours per day by email on: chaplaincy.team@hey.nhs.uk and by telephone on: 01482 675 966 for Hull Royal Infirmary or 01482 623 091 for Castle Hill Hospital.

Occupational Health services offer information and support to promote and maintain the physical and psychological health and wellbeing of employees in the workplace. Occupational health can be contacted by telephone on: 01482 675 059 for Hull Royal Infirmary or 01482 623 051 for Castle Hill Hospital.

Staff can access support from **Focus Counselling Service** via Occupational Health by telephone on: 01482 891 564.

During COVID-19, you can access personal support coaching sessions, clinical psychology sessions and psychological first aid training by email on: **staff.support@hey.nhs.uk.**

Visit Pattie to see the full range of staff support services.

External Support

Speak to your **GP** who can advise and help you to manage physical and psychological health concerns. They can also signpost to other services including community groups and psychological therapy.

Improving Access to Psychological Therapies (IAPT) provide psychological support to individuals with common mental health difficulties. IAPT run a service in Hull called **Let's Talk**. This can be accessed through an online self-referral: https://www.letstalkhull.co.uk or by telephone on: 01482 247 111. Alternatively, IAPT run a service in in East Riding called the **East Riding Emotional Wellbeing Service**. They can be by telephone on: 01482 335 451 or by email on: HNF-TR.SelfReferral@nhs.net.

Additional Contacts

If you still have concerns which have been raised by taking part in this study, you may contact the researcher at: K.Reading-2018@hull.ac.uk or by telephone on: 07429 675 176. However – note that they are unable to provide psychological advice or support and can only have a conversation about the impact of the research and signpost to other services.

If you are struggling to find the service that you require and you feel that you still need additional help with signposting to appropriate services which meet your needs, you can contact **Clinical Psychologist** Dr Jas Moorhouse on: Jaswinder.Moorhouse@hey.nhs.uk.

Sources of Support

At Work

Have a chat with your **Line Manager or Supervisor** as they can listen and help you to access appropriate support from within the service.

All staff in Adult Critical Care can access individual, confidential support with a **Clinical Psychologist** by emailing leedsth-tr.accpsychology@nhs.net or by speaking to either Dr Helen Horton or Dr Nate Shearman in person.

All staff can access **free and confidential counselling** provided by Care First, the Leeds Teaching Hospitals Trust Employee Assistant Programme (EAP). Care First has a 24/7 helpline service for staff which can be accessed by telephone on: 0800 174 319 and they can also offer short-term face to face or telephone counselling.

Occupational Health services offer information and support to promote and maintain the physical and psychological health and wellbeing of employees in the workplace. For St James' University Hospital, they can be contacted at: occupationalhealth@leedsth.nhs.uk or by telephone on: 01132 065 228.

External Support

Speak to your **GP** who can advise and help you to manage physical and psychological health concerns. They can also signpost to other services including community groups and psychological therapy.

Improving Access to Psychological Therapies (IAPT) provide psychological support to individuals with common mental health difficulties. IAPT in Leeds is called **Leeds Mental Wellbeing Service.** They offer a range of therapies and also self-help resources which can be accessed 24/7 online. They also provide face to face classes, workshops and talking therapies: either individually, in groups or online. For more information, they have a website: https://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/leeds-mental-wellbeing-service/what-we-offer/ and can be accessed either by email at: leeds.mws@nhs.net or by telephone on: 0113 843 4388.

Additional Contacts

If you still have concerns which have been raised by taking part in this study, you may contact the researcher at: K.Reading-2018@hull.ac.uk or by telephone on: 07429 675 176. However – note that they are unable to provide psychological advice or support and can only have a conversation about the impact of the research and signpost to other services.

Sources of Support

At Work

Have a chat with your **Line Manager or Supervisor** as they can listen and help you to access appropriate support from within the service.

All staff in Adult Critical Care can access psychological support with a Clinical Psychologist from the **Department of Psychological Services** at Sheffield Teaching Hospitals. They can be contacted by telephone on: 0114 226 6929. Please ask to speak to either Dr Emma Williamson or Dr Nathan Babiker, both of whom have experience supporting staff in Critical Care.

The **Staff Health and Wellbeing section of the Trust intranet** can provide you with additional sources of support including a 24-hour advice and counselling service, promoting wellbeing and resilience sessions and mindfulness sessions.

Occupational Health services offer information and support to promote and maintain the physical and psychological health and wellbeing of employees in the workplace. They can be contacted by telephone on: **0114 271 4737.**

External Support

Speak to your **GP** who can advise and help you to manage physical and psychological health concerns. They can also signpost to other services including community groups and psychological therapy.

Improving Access to Psychological Therapies (IAPT) provide psychological support to individuals with common mental health difficulties. IAPT in Sheffield have online self-help resources which can be accessed at: http://iaptsheffield.shsc.nhs.uk/how-can-i-access-self-help/. They also offer a 6-session stress management course and an online therapy programme called **Silver Cloud** which is designed to help manage stress, low mood and anxiety. For more information on the services available, IAPT can be accessed by telephone on: 0114 226 4380.

Sheffield NHS **Single Point of Access** for mental health support can be accessed by telephone on: 0114 226 3636 or by email on: SPA_AdultMentalHealth@shsc.nhs.uk.

Additional Contacts

If you still have concerns which have been raised by taking part in this study, you may contact the researcher at: K.Reading-2018@hull.ac.uk or by telephone on: 07429 675 176. However – note that they are unable to provide psychological advice or support and can only have a conversation about the impact of the research and signpost to other services.

Sources of Support

At Work

Have a chat with your **Line Manager/Supervisor** as they can listen and help you to access appropriate support from within the service.

The **Medical Psychology Service** have developed a confidential and dedicated staff support service to listen and provide information/strategies to help staff well-being during COVID-19. This service is available Monday to Friday between 10am and 4pm. They can be contacted by telephone on: 01642 854 758 or via email at: stees.psychology@nhs.net.

Extra Life @ South Tees provides information about health and wellbeing activities including trust choir and tai chi. Both groups are held in the Trinity Holistic Centre at The James Cook University Hospital.

Occupational Health services offer information and support to promote and maintain the physical and psychological health and wellbeing of employees in the workplace. They can be contacted at: occupationalhealth@stees.nhs.uk or by telephone on: 01642 282 482.

External Support

Speak to your **GP** who can advise and help you to manage physical and psychological health concerns. They can also signpost to other services including community groups and psychological therapy.

For Teesside & Surrounding Areas:

You may wish to self-refer to **"IMPACT on Teesside",** a new service designed to assess and support people with a variety of mental health concerns in the Hartlepool, Stockton, Middlesbrough, Redcar and Cleveland areas. You can access the service by telephone on: 01642 573 924.

For County Durham & Darlington:

You may wish to self-refer to **"Talking Changes".** You can access the service by telephone on: 0191 333 3300.

For North Yorkshire:

UNIVERSITY OF HULL

NHS
South Tees Hospitals
NHS Foundation Trust

You may wish to self-refer to **"North Yorkshire Increasing Access To Psychological Therapies - IAPT".** You can access the service by telephone on: 01609 768 890.

Instead of/in addition to the above for support 24 hours a day, you may wish to telephone the **Samaritans**. You can contact them by freephone: 116123 or text "SHOUT" to: 85258.

Additional Contacts

If you still have concerns which have been raised by taking part in this study, you may contact the researcher at: K.Reading-2018@hull.ac.uk or by telephone on: 07429 675 176. However – note that they are unable to provide psychological advice or support and can only have a conversation about the impact of the research and signpost to other services.

If you are struggling to find the service that you require and you feel that you still need additional help with signposting to appropriate services which meet your needs, you can contact **Clinical Psychologist** Dr Alice Webster on: alicewebster1@nhs.net.

Appendix S: Email Confirmation to Participants

Email 3 – After the Interview

UNIVERSITY OF HULL (INSERT HOSPITAL BADGE)

Dear (INSERT NAME)

Thank you for your again for taking part in this study exploring how critical care staff experience relational support and thriving at work in the intensive care unit. By sharing your experiences as part of this study, you have contributed to research which hopes to inform the support systems that are available to critical care staff.

You are receiving this information because you were interviewed for the study. Attached to this email you will find further information on how to access further support if it is needed (Appendix 1).

What happens next?

If you have requested feedback about the findings of the study, I will be in contact once the study has ended.

If you have any questions or queries at any stage, please do not hesitate to get in contact with me.

All my best,

Katie Reading (Trainee Clinical psychologist and Chief Investigator)
Contact: K.Reading-2018@hull.ac.uk/ 07429 675 176)

Appendix T. Worked Example of Initial Coding on Transcript

Following transcription of the audio recording, initial coding took place by reading the transcript line by line and attaching codes.

R = Researcher and P = Participant

R. So the first question is asking a bit more about this idea of thriving so I am wondering if you could tell me a bit about what thriving kind of means for you in the job that that you do in the intensive care unit?

P. Oh thriving, oh the good times. It's everybody working for a common purpose, you know, everybody's chosen to be there, um, you've got a team of people sort of all facing the same way with loads of different professional areas and skills coming in, doing the best for patients. Those days are just absolutely fantastic, you know, you make things happen for people… you work hard, you do the necessary for a bunch of patients and it's just, um, that's why I do what I do, it's fantastic.

R. Can you tell me a bit more about what those days kind of look like then when you are thriving?

P. So before COVID, I would get in sort of half an hour early to have a quick wander around just to have a quick eyeball of all the patients from the end of the bed. We usually look after eight patients during the day so just so I've got a little mental image of what each patient looks like, whether they are intubated, you know, whether they are seriously sick, whether they're on a down slope or an up slope, who the nurses are that day… because in ITU there is one to one nursing and that can actually really dominate the way you interact for that day. The nurse in charge is the key as well so I will sort of say hi to them, then we'll go to a handover meeting. The night resident, so the junior doctor, the day team and me will talk it through and just go round each patient quickly, so that's half an hour, and then ward round and usually I have got some sort of a rough idea of the decisions from the end-o-bed-o-grams but the main thing is teaching and communicating on a ward round and then y'know getting the fine details and making sure nothing is missed and then finally it's sort of time for a cup of tea, a break, a round up and then sort of the jobs that come out of the ward round and then all the while I will be dealing with pop up problems, emergencies which appear. The show never stops on the ITU, it is 24/7 business. There's no, it is not like when I was a medical SHO, there is no ceremonial ward round and then you start thinking about things… nothing can wait so it's all about this kind of energy to it and… attention to detail but dealing with things as they arise, possibly urgent emergencies at the same time, um… and then getting through the patients and sorting them all out.

R. How does that compare to a day where maybe you wouldn't necessarily identify with that thriving?

P. Um, you come in and there's patients scattered all over the place, there's not enough staff, there's not enough beds, you are on the back foot from minute one… you can't… there's so much happening that you can't ever get ahead of the units and catch up with what's going on, because you are just reactive rather than being, you know, two steps ahead and it's totally exhausting. So you get home having not achieved much for the patients you've had, y'know, the CT scans that need to happen, the proactive sedation holes and waking people up and

Thriving is positive – nostalgic thought?

Working united as one despite different backgrounds because of a shared goal

Shared interest and motivation to care for patients – linked to choice of career

Active process – doing something involves hard work

Influence of time – thriving is being proactive

Suggestion that thriving is not occurring during COVID?

Thriving in relationships – with patients and colleagues

Benefits of sharing in knowledge and learning from others – part of the job

Balance between accomplishing clinical tasks and taking a break to reward

Additional demands part of the nature of the role and working in the ICU

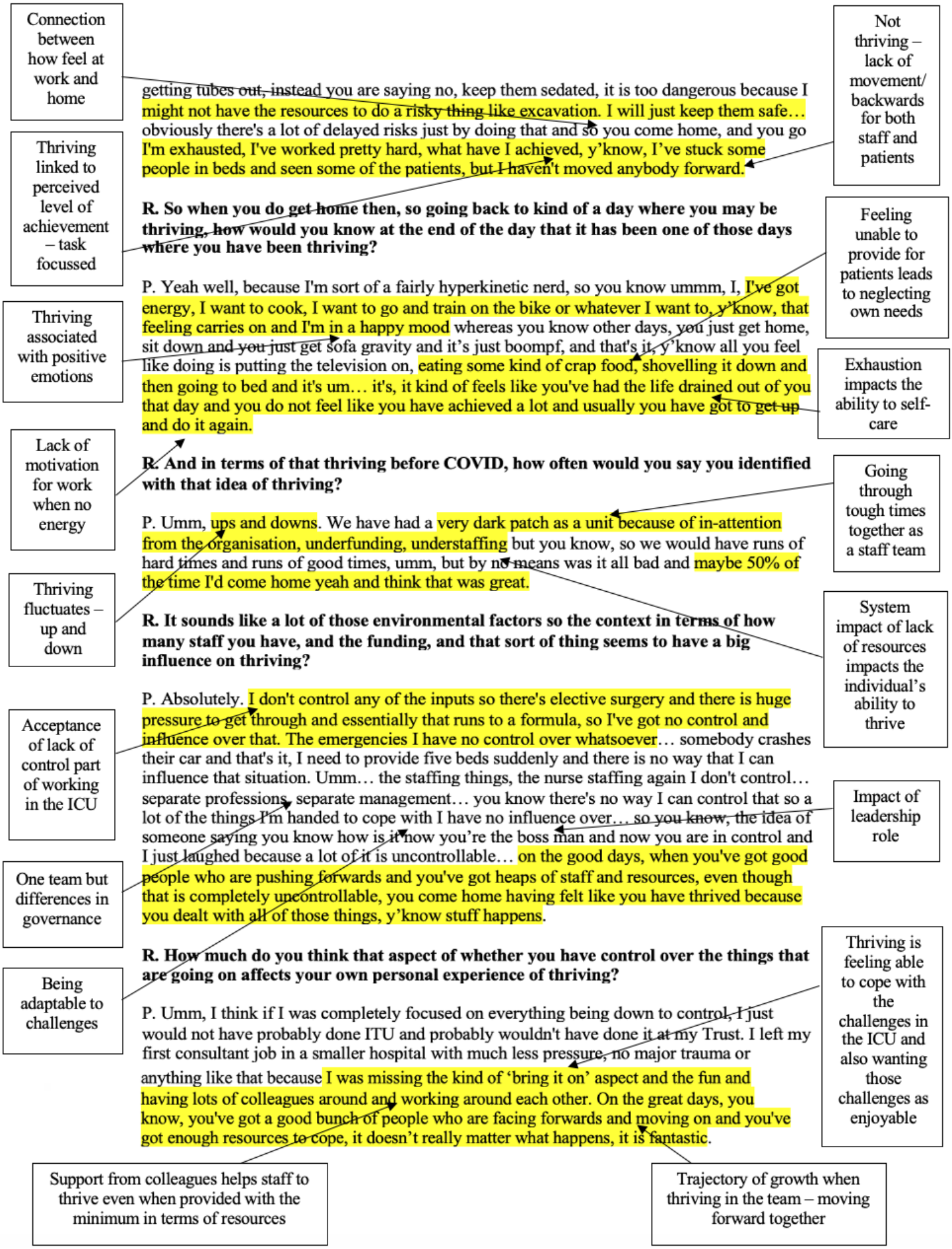
ICU dynamic environment always changing but routine important and being comfortable in knowing what to do

Thriving involves energy

Thriving linked to resources available to meet work demands?

Reflection at the end of the day helps to recognise if thriving or not

Importance of being ahead to keep up with demand



getting tubes out, instead you are saying no, keep them sedated, it is too dangerous because I might not have the resources to do a risky thing like excavation. I will just keep them safe… obviously there's a lot of delayed risks just by doing that and so you come home, and you go I'm exhausted, I've worked pretty hard, what have I achieved, y'know, I've stuck some people in beds and seen some of the patients, but I haven't moved anybody forward.

R. So when you do get home then, so going back to kind of a day where you may be thriving, how would you know at the end of the day that it has been one of those days where you have been thriving?

P. Yeah well, because I'm sort of a fairly hyperkinetic nerd, so you know ummm, I, I've got energy, I want to cook, I want to go and train on the bike or whatever I want to, y'know, that feeling carries on and I'm in a happy mood whereas you know other days, you just get home, sit down and you just get sofa gravity and it's just boompf, and that's it, y'know all you feel like doing is putting the television on, eating some kind of crap food, shovelling it down and then going to bed and it's um… it's, it kind of feels like you've had the life drained out of you that day and you do not feel like you have achieved a lot and usually you have got to get up and do it again.

R. And in terms of that thriving before COVID, how often would you say you identified with that idea of thriving?

P. Umm, ups and downs. We have had a very dark patch as a unit because of in-attention from the organisation, underfunding, understaffing but you know, so we would have runs of hard times and runs of good times, umm, but by no means was it all bad and maybe 50% of the time I'd come home yeah and think that was great.

R. It sounds like a lot of those environmental factors so the context in terms of how many staff you have, and the funding, and that sort of thing seems to have a big influence on thriving?

P. Absolutely. I don't control any of the inputs so there's elective surgery and there is huge pressure to get through and essentially that runs to a formula, so I've got no control and influence over that. The emergencies I have no control over whatsoever… somebody crashes their car and that's it, I need to provide five beds suddenly and there is no way that I can influence that situation. Umm… the staffing things, the nurse staffing again I don't control… separate professions, separate management… you know there's no way I can control that so a lot of the things I'm handed to cope with I have no influence over… so you know, the idea of someone saying you know how is it now you're the boss man and now you are in control and I just laughed because a lot of it is uncontrollable… on the good days, when you've got good people who are pushing forwards and you've got heaps of staff and resources, even though that is completely uncontrollable, you come home having felt like you have thrived because you dealt with all of those things, y'know stuff happens.

R. How much do you think that aspect of whether you have control over the things that are going on affects your own personal experience of thriving?

P. Umm, I think if I was completely focused on everything being down to control, I just would not have probably done ITU and probably wouldn't have done it at my Trust. I left my first consultant job in a smaller hospital with much less pressure, no major trauma or anything like that because I was missing the kind of 'bring it on' aspect and the fun and having lots of colleagues around and working around each other. On the great days, you know, you've got a good bunch of people who are facing forwards and moving on and you've got enough resources to cope, it doesn't really matter what happens, it is fantastic.

Appendix U: Example of Coding Process

Quote from Transcript	Initial Line by Line Coding	Focussed Coding	Theoretical Coding
"If you are working in an intensive care setting, you need to have within your personality that ability to adapt and change and that willingness to thrive because otherwise you won't be able to cope with it because of the challenges that you are faced with, such as your patient might deteriorate really fast, and you need to think and talk to doctors and nurses and to everyone that is supporting in intensive care. You need to think on your feet, but you also need to be open to accept when the time has come for that patient and that's something that is really challenging because like emotionally, yes you might try to find coping mechanisms but at the end of the day, you are a human being with emotions and feelings and it's impossible to detach yourself completely from the outcome" (Butterfly)	Considered an inherent part of the person Specific coping strategies essential Willingness to thrive – need to seek it, aim for it and allow it to happen Fast paced environment and decision making– life or death for patients Working with colleagues Need mental clarity under pressure Work constantly changing and person needs to adapt too Recognition of human side – caring for patients and themselves	Managing Emotions	Individual – Challenge
"If I think about thriving in my job, all of it, then I think mainly about being like a clinical expert so getting to the point where like you've completed all of your competencies, so you feel very comfortable looking after all patient groups. A big part of the job for me…, so I did a clinical education year, so a big part of the job for me is like supporting junior staff and educating and so I think thriving is about being a clinical expert and being able to answer any questions… like we always have this like phrase at work which is kind of like 'you're kind of ready for the next step when you get to the point where you can deal with	Staff occupying multiple roles and responsibilities Clinical job working with patients is important to staff Feeling in control and able to manage all of the tasks involved	Being a Clinical Expert	Individual – Challenge

anything that comes through the door' so say it's 3 o'clock in the morning and there's no one to help you, no matter how sick the patient is, whatever comes through the door then someone can just lock you in a room and you can completely manage that situation, as well as potentially having a junior nurse with you and having like a really difficult family to deal with at the same time, so you know just getting to the point where you're comfortable and you can deal with all of that on your own" (Sydney)	Taking on different responsibilities throughout a career and wanting to pass on knowledge and skills to junior staff Managing competing demands at one time under pressure		
"It's almost like I've come to the end of the line maybe, I'm done with this now and it's time for me to move and it's time for me to do something else. I'm very career driven, and I like learning and I feel that if I'm not constantly learning or being challenged, it's a… I feel like it's a bit of a waste actually, for me, and I'm not generalising for everybody but just for me personally, if I'm not learning and if I'm not achieving something new or I don't know, I get very itchy feet if I'm really not going somewhere. If things stop and then I start to just think same old same old every single day, I start wanting something new, hence why I did this role, this training role two years ago, over two years ago, because it was something completely new, something completely different. I knew it was going to be a big challenge and that is why I wanted to take it on because I felt a bit stale" (Susan)	Reaching goals and achievements Looking for extra challenges linked to career Benefits of learning Movement forwards Need something different to thrive as familiarity brings boredom New things are interesting	Professional Development	Individual – Challenge
"Yeah, so I think thriving…. you will have people who will kind of feel that they are thriving y'know. I enjoy the work to some extent but those ones that are really passionate about the role and you know feel supported and particularly valued in the role will put in and go that extra mile by putting in extra effort and they will work a little bit longer and they will be really involved in audits and really involved in driving the service forward and because of the kind of positive effects that will have on others and the positive effects that will have on patient care, everything kind of moves along with it" (Ferris)	Enjoying the work linked to thriving Specific extremely passionate people want to do more than the typical workload requirements Extra effort and energy from feeling motivated	Able to Go the Extra Mile	Individual – Energy

	Going the extra mile involves doing things to move the service forward Positive impacts throughout the system – staff member, team, patient and organisation		
"I think normally if I feel upset at work then I just feel like I need to be removed from the situation for a short while so to be able to go for a walk or to go on my break or do something like to be removed from it and then that normally makes me feel better" (Sydney)	Work can be challenging and make staff feel upset Physical separation is important for recovery Being able to leave the ward creates distance to process emotions Go to strategies for managing emotions at work which usually help as practiced over time	Recharging During the Workday	Individual – Energy
"I've always quite enjoyed my time off because I'm not like completely work orientated, so I've always enjoyed my time off and I've got things that I like doing that obviously work well to just reset my brain and try and just get a bit of normality and I think you have to, I think I've learned that through working in intensive care" (Paddington)	Time outside of work is valued Able to achieve some work-life balance is important Doing things that are enjoyable – hobbies and interests that make feel good and have been useful over time Leaving what helps to manage the work stress – having a go to tool kit for coping at home Intense work can be all consuming	Locating Energy Boosts Outside of Work	Individual – Energy

	Need to step outside of the ICU environment which is seen as not normal		
"Oh thriving, oh the good times. It's everybody working for a common purpose you know everybody's chosen to be there, um you've got a team of people sort of all facing the same way with loads of different professional areas and skills coming in, doing the best for patients. Those days are just absolutely fantastic you know you make things happen for people, you work hard you know you do the necessary for a bunch of patients and it's just, ugh that's why I do what I do, it's fantastic" (Fred)	Thriving is a good feeling Everyone sharing the good feeling Sharing a goal which everyone agrees to, is aware of and is working towards Large skill mix in the ICU Main priority is patient care Doing the best that can be done Making progress – achieving things Reason for choice of career	A Cog in a Well-Oiled Machine	Team – Support
"I spoke with one of my sisters, bless her, she gave me massive moral support during the first wave but because her experiences were different, it's not that she didn't understand what I was going through and of course, she was there for me, but it's different because unless you go through it, it's very hard to really understand what the other person is actually feeling and she was trying her best to cheer me up and to support me but it got to a point that I just had to say 'okay like thank you very much and like I'll catch up tomorrow' because I felt that it wasn't helping and it's not her fault at all, it was just because her view of the situation is based on her own personal experience which is completely opposite from my own personal experience so yeah, I think that's the big point, always find people that understand where you are because they will be the people that will be able to first, help you look at things	Connection to family outside of work is a different kind of relationship Needing more to support than someone being physically there Recognition of family member doing their best to understand but having difficulty without experience of working in the ICU More depth of understanding important	United through Shared Experiences	Team – Support

from a different perspective and second, that will be able to actually listen to what you're saying and will be open to your worries" (Butterfly)	Acknowledging everyone has different experiences even of the same experience Different needs require different people and needs are different across time People who understand the work environment are the first people you go to for support about work as they are validating and can actively work through problems with you rather than just listen		
"I mean, fortunately, we've all been a little bit, um, on a different roller coaster so on the days that some people are really flat, other people are quite cheerful and kind of help pick those people up and then it tends to switch so not everyone is being down and in the dumps all at the same time and I think it's about that kind of in-group regulation of just keeping an eye on each other, but then also you know if there was a situation that I didn't feel happy about, I would then feel comfortable to just kind of catch one of the other girls and just say 'can I have a chat with you about that' and then it's just whether we go grab a coffee and have a chat and sit down to talk about it, or if it's not appropriate then it's kind of about making the time and getting those opportunities because I think if you don't make the time, you just burn yourself out really " (Rosalind)	Everyone is on their different journeys – ups and downs Mood within the team fluctuates often Not everyone in the team is feeling low or happy all the time and that is normal Seeing someone feeling down leads to the team coming around them to offer support Look out for each other by being a physical presence around them If disagreements happen then try to work through them together Having time to speak together is important for managing problems	Lifting Each Other Up	Team – Support

“Umm, I think for me personally, I do have one really close friend at work so she'll come into my office and she will know straight away by how I am set, how I am feeling and she will close my door and she will go, just vent and I think just her knowing that I need to vent something without opening my mouth and saying something inappropriate is important” (Lola)	Friendships form at work Intuitively knowing what is wrong Close peers know what you need and help you to get it Providing a safe space to talk about things that are frustrating	Forming Support Bubbles	Team – Support
“When they are in there and they have a leader or team members who are very passionate about the role, it almost rubs off on that individual and therefore you kind of set an example of what is expected in that role and what is expected within the team and therefore you kind of bring them along with you as opposed to somebody who's quite negative, umm just does the job and you know that's fine and things, that again has a similar effect on individuals that are coming through as these will be… we quite often get students and new graduates who are inexperienced in hospitals and things and if they are kind of well led and somebody is thriving as a leader and thriving as an individual as part of the team and they are supporting that individual as well they will kind of bring them with them, umm, and they will again start to thrive because they are in an environment where you know you feel valued” (Ferris)	Staff enjoy their jobs when leaders show that they enjoy their jobs as there is a transfer of good feelings Leaders need to act as role models to set a good example Everyone holds expectations which need to be made clear Leaders who are negative can make staff feel negative People thrive from seeing other people thriving Less experienced staff look up to senior staff to help them to thrive	Leading by Example	Team – Support
“Things like, umm…. funding and you know, just the general lack of money that there is in the NHS and the general lack of resources can try and put barriers in the way from the achievements that you have on shift	Money has a big impact To provide resources, the NHS needs money	Availability of Physical Resources	Organisation - Access

but actually I have found that working as a team and involving other people that have maybe have a bit more power to put resources in place and things like that, make things known, can sort of help you to overcome those barriers if you like so I'm one for making sure that I speak up about things" (Susan)	Lack of resources negatively impact the sense of achievement as staff cannot make things happen as they want to Having power can contribute to change Importance of having conversations about the barriers which get in the way		
"Sorry if this is politics but Boris Johnson is all worried about protecting the NHS but I think what Boris Johnson is forgetting is that the NHS is nothing without its people so he should be more worried about supporting his people and keeping his people so his doctors, his nurses, his allied health professionals, his admins… the skeleton of the NHS happy because it doesn't matter if he empties the hospitals because if he doesn't have the staff motivated to treat the patients, you won't get anywhere so I would say that for people, for us to carry on to moving forward, definitely that and of course I know that there are a lot of, quite a few resources available within my trust and I can imagine them being within the other Trusts too to support the mental health of the staff and to help staff cope better but… a big part of it is the feeling valued and feeling appreciated and it's, so… a big part of it is being supported and a big part of it is feeling valued and feeling appreciated for the job you are performing" (Butterfly)	Politics of the country impacting work in the ICU Staff viewed as a resource in healthcare – the backbone of the organisation Need motivated staff to move forward healthcare innovation and change Mental health support beneficial for staff Feeling valued and appreciated is a higher importance than being provided with things	Valued through Emotional Support	Organisation - Access
"The other thing is that there's a culture throughout the organisation that doesn't tolerate explosive bullying aggressive behaviours, so people just don't do it because they know that they just won't get away with it." (Fred)	The organisation has specific values and principles for employees Views must be shared by all staff not just intensive care staff	Compassionate Culture	Organisation - Access

	If bad behaviour is not accepted by everyone then it doesn't happen No bullying creates a positive work atmosphere for staff		

Appendix V: Further Explanation of Terms Linked to Individual and Relational Well-Being

(Definitions taken from participant interviews)

	Individual Well-being		Relational Well-being	
		Definition		**Definition**
Negative	**Burnout**	• Constant exhaustion – feeling that there is nothing left to give • Time off work • Withdrawal • Usual coping strategies ineffective	**Isolation**	• Dissatisfied in a team of one • Sat across multiple departments with no sense of belonging • Feeling alone in decision making
	Survival	• Physical fatigue • Emotional shut off • Struggling to meet basic self-care needs including sleep and nutrition	**Separation**	• Distanced from others • Tension
Neutral	**Coping**	• Doing their best • Getting tasks done • Leaving work at work	**Joint Working**	• Sharing the workload • Utilising each other's strengths
	Resilience	• Keep going most of the time • Managing emotions • Meeting competencies		
	Growth	• Adapting to challenges • Doing extra things • Seeking out new opportunities	**Collaboration**	• Belonging • Working through issues Learning together
Positive	**Thriving**	• Feeling engaged at work • Enjoying the challenges • Energy to push forward • Feeling supported and valued	**Integrated MDT**	• Facing forwards together • Mutual respect • Shared decision making • Intuitive reciprocal support

Appendix W: Epistemological Statement

It is important for all researchers to reflect on their positioning within their research as they bring their own assumptions about the data based on their own experiences (Charmaz, 2014). One way that the researcher influences the research is through the ontological and epistemological position that they assume (Ritchie et al., 2013). This statement aims to explore the development of the ontological and epistemological positions which underpin this thesis and to consider how the positions taken by the researcher influenced the grounded theory which emerged from the data.

Ontology is concerned with the meaning and nature of reality (Ritchie et al., 2013). The two dominant perspectives are realist and relativist (Willig, 2013). The former considers that there is a truth which exists and is measurable (Ritchie et al., 2013), whilst the latter views all experiences to be subjective as there are multiple context-dependent ways of understanding a single experience (Willig, 2013). Epistemology is the study of knowledge and how we acquire and know what we do about reality (Willig, 2013). Positivism is the view that there is only one way to understand reality which is objective, and this typically aligns with a more scientific approach (Willig, 2013). On the other hand, constructivism is the opposite in assuming that meaning is always constructed and so reality is viewed through the lens of the individual which is framed through their thoughts, perceptions and experiences (Ritchie et al., 2013; Young & Collin, 2004).

A relativist ontology fits with a constructivist epistemology (Guba & Lincoln, 1994) and this position was adopted within this research. This approach considers there to be no objective truth which can be experienced and identified through research enquiry (Guba & Lincoln, 1994; Young & Collin, 2004). This is because research is a constructed reality (Ritchie et al., 2013), which is also influenced by the researcher co-constructing the research

through their interpretation of each participant's explanation of their experience (Taghipour, 2014).

Methodology is the approach taken in order to acquire knowledge and understand something about reality (Willig, 2013). Constructivist Grounded Theory (CGT) was the chosen qualitative methodology which influenced how data collection and data analysis were framed (Willig, 2013). CGT was considered to be most appropriate because it uses inductive principles of generating a theory which is grounded in the data about how a particular experience is understood (Ritchie et al., 2013). CGT was chosen over Interpretative Phenomenological Analysis (IPA) because IPA aims to gain a detailed insight into an individual's lived experience (Smith et al., 2009; Willig, 2013), whilst CGT has more utility for contrasting similarities and differences between participant experiences to develop a theory for understanding those experiences (Charmaz, 2014). The use of theoretical sampling and the constant comparative method within CGT also enabled the exploration of gaps within the data through new interviews and adapting the interview schedule as the interviews progressed (Charmaz, 2014; Hood, 2007).

The following choices about ontology, epistemology and methodology, which make up the research paradigm, were made as they were considered most helpful for answering the research questions. The research explored the experiences of healthcare professionals working in the intensive care unit (ICU), specifically the experiences of thriving and relational support. To do so, qualitative methodology was regarded as important for gaining a more in-depth insight into the personal experiences of staff which cannot be gained using statistical analysis but also to add to the lack of qualitative research within the field of intensive care (Charlesworth & Foëx, 2016). It was important to remain open to all participant experiences, whether more positive or negative. As a result, semi-structured interviews were used as the chosen data collection method as this allowed flexibility during

the interviews to explore different directions that were important for the participants and their understanding of the research topic. Furthermore, thriving is a relatively new concept and there is currently no unifying model for understanding thriving within the ICU literature. The epistemological and ontological positions were adopted because whilst an external reality might exist about working in the ICU, it is recognised that there are multiple interpretations of the research topic which might be affected by a range of personal and professional influences. This includes the researcher's own underlying values and beliefs. As a result, the emergent theory, which is co-constructed between researcher and participants, can only be one of many context dependent versions of what is happening which is known through how each individual views this and assigns meaning to their experiences (Willig, 2013).

In addition to the empirical paper, thematic synthesis was the methodology utilised within the systematic literature review. A critical realist ontology and epistemology may be viewed as underpinning thematic synthesis (Barnett-Page & Thomas, 2009). Critical realism considers reality to be neither objective nor subjective but recognises that there is more to understand beyond what we know about reality based on our constructions of reality (Fletcher, 2017). Therefore, behind every observable experience is an underlying, unobservable structure and the experience cannot be understood through the human lens alone without knowledge of the underlying mechanisms which have generated the event (Fletcher, 2017). This fits with thematic synthesis because subjective experiences are brought together for re-interpretation and quality assessment tools are used to objectively measure the quality of the papers. However, thematic synthesis is also compatible with the relativist constructivist approach adopted within this thesis because all of the papers reviewed are qualitative and this approach underpins the guiding values and principles of the researcher who understands that the findings cannot be generalised as there are multiple truths which are context dependent.

It is the researcher's responsibility to engage in a reflexive process with relation to the research (Finlay, 2002). A constructivist stance considers the assumptions brought by the researcher who has their own version of the truth (Charmaz, 2014). The main assumption brought to the research was that there are many positive experiences of working in the ICU which could be explored with participants. This assumption was based on some very limited previous insight into what it is like to work in an ICU. This included a brief volunteering role in an acute hospital setting, a placement experience as a trainee clinical psychologist in a staff support role during COVID-19 and information learned through reading relevant literature and witnessing the media coverage during COVID-19. As a result, it was important to engage in reflective writing and supervision to consider the outsider perspective that was being brought to the research. This was important for considering the approach taken to both data collection and data analysis.

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Appendix X: Reflective Statement

Background to Portfolio Thesis

Development of Ideas

When I initially thought about ideas for this thesis, I was drawn to the role of psychology within physical health settings. I had recently been working as a therapeutic care volunteer which involved listening, interacting and engaging patients in activities aimed at improving quality of life whilst at hospital. This experience demonstrated to me the interconnection of mental and physical health, as well as the incredible strength of both staff and patients. Then when I started the doctorate, my partner also qualified as a doctor. I often found myself reflecting on the differences in the support that we had at similarly critical points in our careers. This made me think about how healthcare professionals are supported at work, as well as how experiences may differ between professions.

At the research fair, I was immediately drawn to the topic proposed by Dr Jas Moorhouse exploring burnout and resilience with staff in the intensive care unit (ICU). My very limited experience of working in the ICU came from my therapeutic care volunteer role. I remember feeling shocked and sad after my first visit, witnessing often unconscious patients surrounded by beeping machines. However, my perceptions significantly changed over time as I saw how there were opportunities for positive staff experiences coming from a really emotionally and physically challenging work environment.

The Research Question

In my scoping search, terms such as burnout and moral distress within intensive care nurses jumped out of my laptop screen. I could not help but feel that something was missing about what keeps intensive care staff coming to work. Dr Emma Wolverson first encouraged me to read about second wave positive psychology (2WPP) which then led me to explore

resilience in the ICU when Dr Chris Clarke became my research supervisor. When Dr Jo Beckett joined the research team, she suggested that I think more critically about resilience in healthcare and a pivotal paper by Jackson et al. (2018) introduced me to the idea of thriving which I chose to explore further as my research question.

When COVID-19 started to impact the United Kingdom in March 2020 and the media spotlight focussed on the ICU, I felt overwhelmed and wondered whether it was appropriate for me to research thriving during this time of change, fear and exhaustion for staff. A conversation with Dr Nathan Babiker encouraged me to ask myself why I would ignore the elephant in the room. This turned my worry into excitement, and I felt motivated that I could continue to explore thriving and acknowledge the impact of COVID-19 through the inclusion of an additional research question. My perspective was that, in line with 2WPP, intensive care staff could still thrive amidst the additional challenges of COVID-19, and they deserved to be given a voice through research whilst the world was listening. Research can become all-encompassing, and I learned that seeking different perspectives is really important.

Conducting the Empirical Research

Ethics Process

Trying to predict the impact of COVID-19 on the research was difficult as everything was so unknown. Several feasibility adjustments and back-up plans were put in place to try and prepare for all eventualities. This included changing from face-to-face interviews to using the telephone or Microsoft Teams, as well as submitting an amendment to use Twitter for recruitment. I also tried to remain a few steps ahead of deadlines and submit ethics earlier than was suggested. Knowing myself and how I like to be organised was important for learning about who I am as a new researcher. I found that having a clear idea of the tasks that I needed to complete in what time frame was important for keeping me on track, as well as

breaking down bigger tasks into smaller parts so that I could feel the sense of accomplishment from ticking things off on my to do list.

The whole ethics process took about seven months and was relatively easy until I had to apply for capacity and capability approvals. I stand behind my decision to recruit from four NHS Trusts as I think that it really adds to my research but holding in mind the different procedures and protocols at each site was really challenging. It was also hard maintaining momentum during this process when we were in lockdown. I had imagined pressing the submit button on ethics and feeling like a weight had been lifted. However, a lot of the time I felt that I was navigating the whole process quite blindly trying to jump through the hoops and worried about my progress. I managed this by reassuring myself that NHS ethics was completely new to me. I also took advantage of the times when I was not constantly replying to emails to engage in webinars and discussions in ICU forums, which helped when it came to writing my introduction and discussion sections. One thing that I should have done more is ask for help from people with more experience of research and ethics submissions.

Recruitment

I was passionate about building connections with multiple hospitals and with the help from Jas, this was something that I achieved quite early on. Unfortunately, after a couple of face-to-face meetings, all communication moved to over email and Microsoft Teams as COVID-19 restricted travel. As a result, I had to rely more heavily on key contacts to support recruitment. I was blown away by the support that I received but I had to learn to give up some control to others, whilst also making sure that things got done on time. I often found myself getting into personal battles between sending more emails to follow up on actions that had been agreed, whilst also feeling guilty, holding back a little and recognising the pressure that they were under. I felt that everyone understandably had bigger priorities than research

during COVID-19, but Jo really encouraged me to keep going as research was my priority as chief investigator. Approaching any research in the future, I will definitely ask directly for people's phone numbers because a lot of time can be wasted waiting for email responses.

I eventually got the green light to move forward in September 2020 and initially recruitment was slow. One challenge that I experienced was that I could see people accessing the online survey but not completing it. I found myself refreshing the survey at every opportunity and wondering whether I had been approachable enough. However, I knew that I was doing my best and noticed that my worry was just a reflection of my passion for the research. Setting up email alerts which informed me when someone completed the online survey helped to create boundaries between myself and the research. To increase recruitment, I also started to ask research contacts for email templates which introduced myself and my research interest to be distributed within their teams. This change from predominately using posters was successful as it allowed myself as the researcher to connect more with potential participants despite the physical distance created by COVID-19. It also helped me to target specific groups such as pharmacists who spend less time in the physical ward environment. Participants who had been interviewed also started to offer to support recruitment. Confidentiality was managed by encouraging participants not to mention to colleagues that they had been interviewed and limiting the demographic information within the write-up.

Data Collection

My first interview was with a speech and language therapist who shared their experience of growth during COVID-19. Hearing about this gave me the boost I needed to continue to push forward with renewed energy for recruitment. For my first experience of research interviews, I was proud that I was able to strike an open and conversational tone. I did try the approach of saying as little as possible to limit the researcher's influence on the

interviews, but I found this quite difficult as there was so much that I wanted to explore. My interview style is something that I would like to develop through future research.

I was initially worried about developing rapport during remote interviews. However, I was regularly humbled when participants spoke about how it felt like I was sat in the room with them, they felt put at ease and enjoyed the opportunity to reflect. As intensive care staff were so busy, one of the most important things that I could do for them in return was to be flexible with my time. I also think that rapport was achieved by developing the relationships with participants outside of the interviews. This involved communication over email, speaking about my passion for the research at the end of the interviews and keeping in touch through a monthly email to provide updates on the research progress. I would definitely consider using Microsoft Teams again for future research because it increased accessibility.

Data Analysis

Juggling all of the steps in data analysis was demanding, especially as someone new to qualitative research. I often worried that I was not doing 'proper grounded theory'. I managed this by creating a flow chart which explained the process involved but Chris also reminded me that everyone has a different approach and doing my own version is good.

The benefit of ongoing data collection and analysis was that I felt really immersed in the data to develop themes. I noticed how participants spoke about thriving as a journey of growth and exhaustion during COVID-19. This resonated with myself completing the doctorate and working in the NHS through COVID-19, which gave me an interesting perspective of being on the outside but also on the inside trying to understand the experiences of intensive care staff. There were so many things that I wanted to discuss in the research, but I was restricted by the word limits of my chosen journals. One thing that helped was to view COVID-19 as a context that influenced the findings. Jo and Chris also reminded me that I

needed to ensure that my results told the story of my research in a way that best answered the research questions. I found that drawing diagrams was an essential part of my research approach as this enabled me to visualise the interactions and processes taking place.

Systematic Literature Review

Choosing a topic for the review came quite naturally and linked with the empirical. Following my initial shock at the lack of research, I was interested to see how much research had actually explored the more positive experiences associated with well-being in the ICU. The hardest part of the review process was deciding what indicators of well-being to include within the search terms to ensure that my search was comprehensive but did not bring up too many unrelated studies. In addition, I struggled with working on the review alongside my empirical research. As this process took a long time, I had to keep running the searches to make sure that no new articles were published. My ability to multi-task definitely improved and I learned the importance of building research teams for any future research. I also panicked when initially realising the similarities between the findings of the empirical and review. Thankfully my partner reassured me that this surely made sense because similar experiences are likely to contribute to both thriving and well-being and the findings just further emphasise the importance of the clinical implications.

Final Reflections

Reflecting on this research process, I can now understand why people say that research is a rollercoaster of emotions. At times I have felt really disconnected from the research and overwhelmed by the task ahead of me. However, thinking about where I started from to now seeing my ideas having come to life makes me feel proud. For myself, what started as a small seed of interest in staff well-being has now grown into something that I want to pursue as a career. Positive psychology has also impacted my values and approach to

clinical work. It has also helped me during COVID-19 whilst writing my thesis, by encouraging me to look towards my own strengths and resources during a challenging time.

Thinking about all of the people who have helped me along the way will forever make me smile. Without the kindness and willingness of others to help, I would not have been able to succeed in meeting my research goals. I am most proud that I was able to involve participants in the research beyond just taking part in the interviews. For me, this made the research feel really meaningful and provided me with energy to keep going. I hope that participants felt valued and can see their contribution to the research through the direct quotations and the unifying theory. The importance of the co-creation of research will be something that I will always hold in mind when I approach any future research.

I am also glad that I took a different approach by highlighting some of the positive experiences associated with ICU work. When I first met Jas to discuss the research, she spoke of the lack of clinical psychology support in the ICU. It is strange now thinking that we are coming out of a global pandemic which has drawn the attention of everyone to the well-being of intensive care staff. I hope that my research comes at a useful time to highlight the continued need to invest in intensive care staff beyond COVID-19 and I am keen to continue to use my voice to amplify their voices through research dissemination and publication. I plan to discuss the research at each of the hospitals where participants were recruited through a presentation where anyone interested can attend. I also hope to speak to some of the senior management team including board executives to ensure that they are also aware of the findings. In addition, I plan to publish the research findings.

The research also helped me to notice when I was actually not thriving myself and this allowed me to think about what I needed to change to thrive. Throughout the research process, I found myself becoming less self-critical and allowing myself to really enjoy it when I realised that everyone approaches research differently. Accepting the process which

inevitably involves delays and using those down times to keep busy with other tasks and prioritise my own self-care was an important learning experience. Intensive care staff taught me that moving forward in a positive direction, no matter the pace, is good and that is what I did.

References

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