Overarching structure of Chapter 6 (realist synthesis): key findings, tensions and CMOcs

1. Key finding 1: Interventions are fragmented, individual-focused and insufficiently recognise cumulative chronic stressors

- 1.1. Tension 1: The tension between a focus on individuals versus a focus on systemic issues
  - **CMO #1: A focus on individuals blames staff for systemic issues**
  - **CMO #2: Messaging from leaders/managers to look after self is at odds with the reality of work conditions**
  - **CMOc #3: the importance of granting permission to practice self-care by managers and peers**

- 1.2. Tension 2: The tension between a focus on acute episodes of trauma versus recognising and supporting chronic cumulative stressors
  - **CMOc #4: There is a need to understand the cumulative nature of chronic trauma exposure**
  - **CMOc #5: There is a need to distinguish secondary trauma arising from acute dramatic rather than chronic 'low-level' events**

2. Key finding 2: It is difficult to promote staff psychological wellness where there is a blame culture

- 2.1. Tension 3: The tension between a lack of collective accountability, which blames individual staff for errors, versus a team/system-based approach
  - **CMOc #6: Attributing cause of blame to individual staff ignores the role of the wider system**
  - **CMOc #7: There are sometimes double standards in accountability**
  - **CMOc #8: Investigation of medical errors can cause psychological ill-health in staff**
- 2.2. Tension 4: The tension between needing to raise concerns to improve conditions and patient safety versus fitness to practice processes becoming an oppressive force
  - **CMOc #9: Knowledge that the fitness to practice process is rarely supportive creates reluctance in staff to voice concerns about psychological health**
  - **CMOc #10: The investigation of medical error can result in secondary victimisation and traumatic symptoms**
- 2.3. Tension 5: The tension between encouraging staff to speak up versus the 'deaf effect' response from managers and hearers
  - **CMOc #11: Encouraging staff to raise concerns can create problems if there is no action: a 'deaf effect' response**
  - **CMOc #12 Supervision interventions (encouraging staff to voice concerns) may backfire and create burden if there is no organisational action**

3. Key finding 3: 'Serve & sacrifice': the needs of the system often override staff wellbeing at work

- 3.1. Tension 6: The tension between a professional culture that promotes a 'serve and sacrifice' ethos, which persuades staff to prioritise institutional needs, versus a culture that promotes self-care
  - **CMOc #13: A 'serve and sacrifice' professional ethos may be used to persuade compliance to institutional needs**
- 3.2. Tension 7: The tension between supporting existing staff in the context of staff shortages versus perceived coercion to fill vacant shifts beyond contracted hours
  - **CMOc #14: Staff feeling unable to say no in a felt culture of coercion**
- 3.3. Tension 8: The tension between the lived reality of staff shortages versus the wish to deliver high quality patient care, which can result in moral distress
  - **CMOc#15: Staff shortages prevent staff from giving the quality of care that patients deserve**
  - **CMOc#16: A vicious cycle of staff shortages leads to an unworkable situation for staff who remain**

- **CMOc#17: Staff shortages may lead to an over-extension of role scope**

4. Key finding 4: There are unintended personal costs of upholding and implementing values at work

- 4.1. Tension 9: The tension between the reality of healthcare delivery versus the taught theory and values, which can lead to guilt and moral and emotional distress
  - **CMOc #18: Moral distress: The theory learned through formative training may not match real-world expectations at work**
- 4.2. Tension 10: The tension between the benefits of staff empathy to patients (ensuring quality care) versus the harms of staff empathy to staff (increasing risk of vicarious trauma or unhealthy/negative coping strategies).
  - **CMOc #19: Empathic traits of staff members allows for better understanding of patient suffering and improved service provision but increases the risk of vicarious trauma**
  - **CMOc #20: Staff adopt maladaptive strategies such as controlling the environment or depersonalisation to cope with the risks of secondary trauma and as a consequence of burnout**
- 4.3. Tension 11: The tension between the excessive requirements for emotional labour inherent in healthcare practice versus the need to improve workplace psychological ill-health
  - **CMOc #21: Excessive demands on using one's emotional labour can lead to burnout**

5. Key finding 5: It is challenging to design, identify and implement interventions to work optimally for diverse staff groups with diverse and interacting stressors

- 5.1. Tension 12: The tension between making staff wellness interventions mandatory versus voluntary
  - **CMOc #22: Mandatory participation in psychological wellness interventions may stigmatise staff and be inauthentic**
  - **CMOc #23: Voluntary participation in wellness interventions provides choice but may reduce uptake**
- 5.2. Tension 13: The tension between the need for spaces to debrief with managers/leaders so they hear and can thereby offer support versus the need for peer-led spaces for debriefing
  - **CMOc #24: Psychologically safe spaces for processing work challenges can provide support and healing**
  - **CMOc #25: The importance of kindness, listening and space to be heard by mentors**
- 5.3. Tension 14: The tension between the need to act and offer support versus providing interventions that are ineffective because they are too soon, reactive and/or single timepoint
  - **CMO# 26: The importance of timing of psychological ill-health interventions.**