'Just because I love nursing doesn't mean it loves me back' -The experiences of providing patient care on acute medical nurses' personal health perceptions: An interpretive phenomenological analysis

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Contents

Abstract

Aim

To explore the lived experiences of nurses working in AAU when caring for acutely ill patients and to examine how AAU nurses make sense of their experiences in terms of their own health and well-being.

Methodology and design

This qualitative study took place in a large regional hospital in the North-East of England. Interpretative Phenomenological Analysis (IPA) was the chosen methodology. IPA is an approach, epistemological position and a way of doing research and this influenced the research design. Participant voice was a priority throughout this research and a heavy emphasis was placed on ensuring this was represented.

The study used purposive sampling to recruit a small homogenous sample of 6 experienced AAU nurses. One-to-one semi-structured interviews were conducted to gather rich data relating to participants' experiences of caring in AAU and how this impacted upon their personal health perceptions.

Findings

The key findings of this study fit into three super-ordinate themes; I feel like I'm drowning, I don't want to end up like that, repeat offenders. Drowning as a metaphor, was used by participants to describe the emotional and physical burden of their work. Participants described not wanting to become their patients and rationalised these

feeling in terms of the futility of aging and the acceptance they would develop conditions commonly seen in their patients.
An unexpected finding was the description of patients as 'repeat offenders', this pejorative term was used to describe self-inflicted regular attenders. They were viewed as a waste of time and a reason for nurses to become burnt out.

Recommendations

The 'I feel like I'm drowning' and 'I don't want to end up like that' themes suggest a

need for further research to examine the impact of stress, anxiety and altered health-beliefs of nurses arising from their belief that they will develop the illnesses of their patients. The 'repeat offender' findings suggest a need to explore nurses' perceptions in greater detail and to attempt to identify strategies to manage the burnout associated with this patient group.

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Prologue

I am Chris Elliott, I grew up in the North East of England but left the area when I joined the British Army as a student nurse in 2005. I have spent the last 18 years as a serving member of the Queen Alexandra's Royal Army Nursing Corps and have worked across a range of settings both operationally and in peace-time. My career so far has seen me wroking in the Middle-East, treating Ebola patients in West Africa, working in the extreme cold of a Norwegian Winter as well as a multitude of clinical roles during secondments to the NHS.

Working alongside the NHS as an Army Nurse has allowed me gain exposure in several roles. Firstly, as a staff nurse then as ward manager and more recently as a clinical skills tutor. I have held a number of short-term roles such as, Accident and Emergency, charge nurse in Burns and Plastics and Infection Prevention and Control Support team lead during the Covid-19 crisis but, I am currently working as a charge nurse in an Acute Assessment Unit (AAU).

The way healthcare is delivered and managed has always been of interest to me but, my experience of working in an Ebola treatment facility in Sierra Leone changed how I view healthcare and nursing completely. I deployed as a member of an Ebola treatment team but was quickly given the extra task of assisting with teaching and training local nationals who had been recruited into a very basic form of nurse training. These people were living and working in absolute poverty whilst working with one of the most dangerous diseases on the planet and, yet, unlike many of my colleagues in the NHS and Army, they were incredibly happy to be doing their job and exhibited the most positive attitude towards nursing I have ever encountered. This led me to become curious about the lived experiences of nurses within the UK healthcare system where I had seen so many burn out and leave the profession.

Throughout my career I have spoken to many nurses and overheard even more conversations between nurses, many of which centred around their fears, experiences and desire to change roles or leave nursing altogether. This research project was borne out of my curiosity and desire to explore the lived experiences of fellow AAU nurses in terms of their own health and well-being as it appeared to be influenced by providing patient care.

Chapter 1 – Introduction and background

1.1 Background and rationale

This project was borne out of an observation in my own practice. Over several years I observed nurses become increasingly stressed, anxious for their own health and eventually burnt-out with many leaving the profession prematurely.

Work-place stress has a significant impact on nurses and can arise from time pressures, emotional labour and personal anxiety (Heinen et al, 2012). The personal costs of work-place stress should not be understated and have been shown to cause nurses to experience burnout which in turn creates a reduction in their ability to care (Francis, 2013; Peters, 2018). To reduce nurse burnout and work-stress we must better understand and manage emotional labour (EL), health anxiety and its contributing factors. Smith, (2008) demonstrated that burnt-out nurses are less willing to offer compassion and may become emotionally detached from patients and more likely to suffer from stress or health anxieties which has been linked to nurses leaving the profession.

Nurse retention is a significant issue across the UK health sector with thirty eight percent of nurses considering leaving (Scott, 1996; Heinen et al, 2012; Marufu et al, 2021). The NHS employs over 377,000 nurses (NHS Confederation, 2016) therefore a large-scale exodus could create a significant human capital and experience deficit (Jones and Gates, 2007). A systematic review by Marufu et al (2021) suggests poor nurse retention could lead to an important public health issue.

CGI (2015) reported that nurse retention has become a critical issue and state that up to thirty percent of nurse absenteeism can be linked to work-place stress, CGI (2015) estimate the annual cost of this absenteeism to be £400,000,000 however, the range of bands, seniority and specialities making up this estimate is unclear.
To reverse retention issues, work must be undertaken to understand how nurses make sense of their experiences, to facilitate the subsequent design and implementation of strategies to manage or mitigate against negative factors.

The phenomenon of interest is AAU nurses' lived experience in terms of their own health and well-being. Considering the retention crisis caused me to wonder if nurses' health and well-being was affected by their work. My own experiences of working within the clinical environment supports this case within the AAU environment. However, we cannot understand these complexities without exploring the lived experience (Smith et al, 2021).

1.2 Research questions

- What are the lived experiences of nurses working in an Acute Assessment Unit?
- How do these experiences affect their own health perceptions?

1.3 Project aim and purpose

This project aims

- To explore the lived experience of nurses working in an Acute Assessment Unit when caring for acutely ill patients.
- To examine how AAU nurses make sense of their experience in terms of their own health and wellbeing

It is hoped that achieving these aims will illuminate the personal health fears and stresses faced by AAU nurses and offer insight and understanding into why these arise and how they are managed and mitigated.

1.4 What is an Acute Assessment Unit?

Acute Assessment Units (AAU) are becoming commonplace in most large hospitals, sometimes called Emergency Assessment Units or Clinical Decisions Units they are a front of house department which accept direct admissions from Emergency Ambulances and General Practice surgeries. Patients typically present in the acute phase of illness and attend for stabilisation, urgent intervention and onward referral to downstream or specialist wards.

1.5 Considering the anecdotal evidence

To gain a greater awareness and understanding of health anxiety and perceptions amongst nurses I examined some online nursing forums. Many nurses posting claimed that working in the acute environment impacted upon their own health and well-being. There were many comments relating to health, death anxiety, work-place stress, and hypochondria. Many forum members also commented on becoming fixated on a particular illness with which they associated. Considering the anecdotal evidence helped shape the aim of this study, inform the literature review, and confirm my suspicions that nurses do suffer for their work.

Table 1 shows some of the quotes from online forum users and offers some idea of the self-reported experiences of these nurses.

Table 1 – Quotes from online forums

Personal experiences of health anxiety and hypochondria	*I'm bad for being a hypochondriac. So far I have had; dementia, lupus, MI, gall stones and renal failure.* *I used to be a horrid hypochondriac, though I believe the proper term is health anxiety. I really thought I had everything until I quit nursing.* *We all go through this, I certainly did. Every disease I encountered I was sure I had.* *I know I'm a hypochondriac, I keep it to myself because I know it's a response to stress.*
The experience of health anxiety and hypochondria in others	*One nurse I work with always has a problem of the month. One month she'll think she's diabetic, the next if CHF.* *I've seen nurses hooking themselves up to monitors, worrying about the smallest things.* *Since nursing school, we've been self-diagnosing* *I thought I was the only crazed nurse out there with these feelings* *I'm so glad to know there are others out there like me*
Cause and prevalence	*I do believe it comes from the stress of seeing sickness every day.* *You can't compare societal depression to what we face as nurses. The stresses placed on us daily is not moderate or healthy. It is more sever, unhealthy that comes home with is. Even the experienced, skilful nurses are apt to show signs of depression.* *You will find the mass majority of nurses suffer from anxiety and depression*

1.6 Overview of thesis

This chapter has outlined the historical and contemporary context of nursing in the Acute Assessment Unit (AAU). The stress, anxiety and retention issues facing these nurses serve as rationale for the study. Chapter two presents a literature review focused on issues likely to influence the experience of AAU nurses. Chapter three outlines the study design, methodology and methods as well a rationale for their selection. Chapter four presents the individual idiographic analyses and cross-case analysis with themes identified for further examination and discussion. Chapter five presents a return to the literature which became necessary due to an unexpected finding not covered in the earlier literature review. Chapter six offers a discussion of the findings and themes and finally, chapter 7 presents my conclusions and recommendations.

Chapter 2 – Literature review

2.1 Literature review

AAU patients are typically admitted in an acute phase of their illness and there is often a high degree of clinical uncertainty surrounding their prognosis. The previous section demonstrated that feelings of health anxiety can increase over time, a limitation of the anecdotal evidence was the inability to determine if this is the prevailing discourse or whether it is skewed by those compelled to comment in forums. I therefore conducted a review of the empirical evidence to further inform the research.

This review retains a degree of speculation. Smith et al (2009) state that, researchers cannot know what will influence participant experience and therefore can only speculate on what might be behind the phenomena of interest. The evidence discussed was used to guide and inform the design of subsequent interview schedules but were not used to influence or steer participant responses. Chapter five re-examines the literature based upon participant disclosures and findings post-analysis, essentially offering a targeted and less speculative review as suggested by Smith et al (2021).

2.2 Search strategy

Owing to the interpretative nature of enquiry and the fact that researchers cannot know what participants will disclose, literature reviewing in IPA is typically speculative (Smith et al, 2021). Researchers commonly use their knowledge of the subject or phenomena and findings of similar studies to identify search terms. Search terms for this study were based on common themes found in online forums, the researcher's own practice and experience of the phenomena of interest. To source relevant and useful literature the following inclusion and exclusion criteria was applied:

Papers published in English from 1975 were included in the initial search. This was done to facilitate a contemporary and historical overview and to allow me to be more aware of the changes to nurse education over time and the changed profession resulting from project 2000, all included papers were peer reviewed and include references to acute care nurses and exposure to patients with acute or chronic illnesses.

All papers were critically appraised using the appropriate Joanna Briggs Institute (JBI)

critical appraisal tools (Lockwood et al, 2015) to ensure quality and scientific rigour.

The following databases were searched:

Table.2

SEARCHED DATABASES:
CINAHL
British Nursing Index
Medline
Embase
Psychinfo
Google Scholar

The below table shows the selected search terms;

Table.3

Search terms	
Lived experience	Fear of death/dying
Illness	Health anxiety
Health perception	Compassion fatigue
Nurse	Acute medicine
AAU/Acute Assessment Unit	Care giving
Exposure	Stress
Medically unexplained physical symptoms	Illness anxiety disorder
Somatic symptoms	Psychotherapy
Emotional labour	Secondary traumatic stress
Moral distress	Moral Injury
Work-pressure / Work-place stress	Health-behaviour
Burnout	Quality of life

Key words and terms were combined as per the protocols for each database, individual search results were then combined to increase relevance.

Secondary searches were carried out using reference lists from selected articles (back-chaining), which identified several further sources. In addition, historical and seminal

works were sought out by hand searching to gain insight into the historical background of the phenomena of interest.

2.3 Results

The PRISMA diagram below illustrates the process of screening, rejecting and selecting papers for inclusion in the study.

Figure. 1
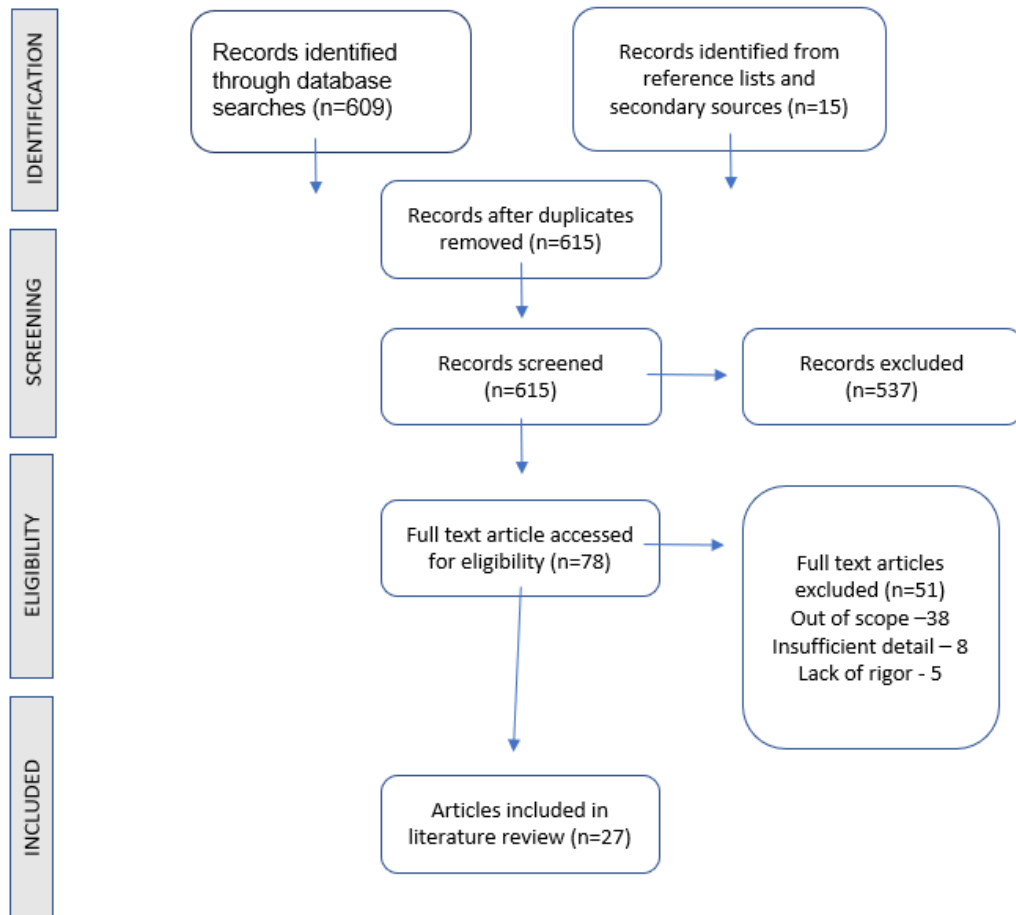
2.4 Reviewing the literature:

Hippocrates claimed that medicine and caring was an art which was a source of pain for those who possessed and practised it (Kleisiaris et al, 2014). He identified causes for this including, witnessing the pain and suffering of others, unpleasant or traumatic sights and handling human by-products. These themes are still found in today's nursing literature and form the foundations of the discussion in this chapter.

2.5 Professional quality of life

There is an increasing shortage of qualified nurses (Craigie et al, 2016), it has been suggested by Drury et al (2009) that this is attributable to decreased recruitment and retention however, there is growing argument that high stress environments and workplace pressures play a pivotal role in nurse retention (Bakker, 2011; Craigie et al, 2016). Stamm (2010) undertook qualitative research examining the various facets of caring roles and coined the phrase professional quality of life which is broadly accepted as nurses' perception of emotional well-being, job satisfaction and work engagement. These factors have been shown to be linked to retention (Bakker, 2011; Hobfoll, 2011; Sabo, 2011).

The notion of a measurable professional quality of life amongst healthcare workers is widely attributed to Figely and Stamm (1996) who first researched what they described as several work-place related factors impacting upon quality of life. Stamm (2010) developed this, designing specific and validated tools for measuring professional quality of life in healthcare professionals (ProQol). The work of Stamm (2010) was used as a basis for further research and the ProQol tool remains in-use due to its proven effectiveness. Craigie et al (2016) used ProQol scales to examine trait negative effects and compassion satisfaction on compassion fatigue, their findings suggested compassion fatigue, emotional labour and burnout amongst acute care nurses is largely affected by the levels of compassion satisfaction and professional quality of life they possess. The use of widely accepted and validated tools adds credibility to the work of Craigie et al (2016). Heritage et al (2018) proposed several updates to the ProQual tools to account for new technology and practice developments however, they did reaffirm the robust nature of the original tool.

Compassion fatigue (CF) has been discussed widely and appears intrinsically linked to nurses' satisfaction, retention, and work-related stress and/or anxiety (Kelly et al; 2015; Bibi et al, 2018). Despite this there is a paucity of evidence specifically related to the effects of compassion satisfaction on health beliefs of nursing staff although, Kelly et al (2018) conducted in depth narrative analysis of nurses across a range of experience levels and reported increased likelihood of burnout arising from compassion fatigue amongst more experienced nurses. Hall (2004) also reported compassion satisfaction as a predictor of burnout amongst acute care nurses.

Compassion satisfaction has been linked to absenteeism, reduced retention, and decreased quality of care (Aiken et al, 2013; Hooper et al, 2010; Li et al, 2013). Professional quality of life research commonly refers to compassion fatigue/satisfaction and secondary traumatic stress. As such it is important to consider these in terms of their contribution to nurses' perceptions of health and well-being.

Stamm (2010) defined compassion satisfaction as the positivity one has towards their professional practice, it is the satisfaction gained through knowing one's actions have aided someone who has suffered, conversely; compassion fatigue (CF) is the negative experiences of caring arising from caring and working in stressful and emotionally challenging environments (Craigie et al, 2016). Stamm (2010) concluded that CF is a two-dimensional concept comprising secondary traumatic stress (STS) and burnout.

STS has been described as the effect experienced by care workers who have witnessed the aftermath of life changing or traumatic events and can occur in the absence of any personal physical trauma (Boyle, 2011). Figely (1995) and more latterly Boyle (2011) undertook analysis of the experiences of those who regularly witness trauma reporting that symptoms are like those experienced by the trauma victim themselves, symptoms may include anxiety, nightmares, flashbacks, disturbed sleep, physical and psychological disturbances, and avoidance behaviours.

2.6 Compassion, Morality and Burnout

Burnout was described by Maslach et al (2001) and Stamm (2010) as work-related stress leading to emotional dissonance, depersonalisation, and withdrawal. All of which lead to an ineffective carer (Maslach et al, 2001). Burnout is a broad concept with many contributing factors and as such, it is difficult to identify why a particular nurse should become burnt-out. That said, an appreciation of the concept does help us to understand and appreciate the experiences and sense-making of nurses.

Yam (2004) called nursing a profession, a vocation and a calling but, this could create an expectation of nurses (Watts et al, 2022). Nurses are present at all stages of life (Herbert et al, 2011) and are entrusted with providing compassionate care to patients at their most vulnerable. NMC (2015) reiterates the requirement for a patient centred

approach, however, the emotional tolls of nursing can be detrimental (Boyle, 2011). A phenomenon exists whereby nurses develop decreasing devotion to their duties and patients (Heinen et al, 2012; Gillman et al, 2015). Yoder (2010) and Coetzee and Klopper (2010) describe this as compassion fatigue, similarly; Spinetta et al (2000) and Maslach (2003) described nurses who lose their motivation to care as, burnt-out.

Yam's (2004) description of the vocational nature of nursing is commonly espoused in the media and academic literature alike, however, it is also necessary to consider how nurses view themselves in the professional context. Maslach (2003) considered experiences against a framework focussing on the inter-personal relationships between professional and patient and found nurses continued to work despite high degrees of burnout. Graham et al (2005) gathered nurses' narratives further identifying circumstances where nurses reported suffering alongside their patients.

Burnout and compassion fatigue are responses to repetitive unmanaged physical or emotional stresses manifesting as a diminishing desire to nurse (Maslach, 2003; Boyle, 2011). Heinen et al (2012) examined nurses' attitudes across a range of settings using a combination of semi-structured interviews and questionnaires and found 10 to 38 percent of participants planned to cease nursing, due to the physical and emotional burdens of caring and workplace stress.

Scott, (1996) and Heinen et al, (2012) conducted in-depth interrogation of participant feedback and experiences as part of cross-sectional observational studies, findings from both show nurses become increasingly frustrated with the personal investment they must make in terms of emotional work, physical labour and self-degradation. Several participants claimed to be working themselves sick. The fact that this was reported in separate studies, 16 years apart suggests the issue prevails and offers an insight into nurses' perceptions of their own health. The congruence of themes across both studies and time between them gives me confidence that their findings are both relevant and robust.

NHS confederation (2016) declared there to be 377,191 nurses employed by the National Health Service (NHS). Jones and Gates (2007) suggested large numbers leaving the profession create a human capital deficit. Despite this warning, almost 14,000 nurses left the profession in 2021 compared to just over 11,000 in 2020

(Nursing notes, 2021). These figures demonstrate increasing numbers of nurses leaving but do not show the reasons for each departure. Retention is a local and national issue, CGI (2015) identified thirty percent of nurses' absence as attributable to work-place stress. Over thirty nine percent of nurses claim to suffer work induced stress. CGI (2015) argued retention has reached critical levels and work is required to establish what drives nurses' disillusionment. Testament to the scale of the problem, NHS Business Services Authority (2008) produced policy for incentivising retention within understaffed areas.

Fineman (1993) observed that all organisations are emotional arenas and nursing demands an additional level of emotional involvement. Within acute settings nurses encounter severe illnesses often evoking emotional responses. James (1989) identified a need to process the feelings of others, suggesting a crucial component was regulating one's own emotions. Huynh et al (2008) developed this argument claiming, emotional labour (EL) relates to how nurses regulate external expressions despite inward emotions, qualitative enquiries led them to claim EL ensues where dissonance arises between inward emotions and what is expected by patients.

Dissonance invites increasing levels of EL (Mann, 2005) and whilst Msiska et al (2014) concede EL is intrinsically linked to nursing practice, Bolton (2001 and 2008) and Smith (2008) suggest nurses have personal tolerance levels for EL which if exceeded lead to compassion fatigue/burnout.

This project refers to acute assessment units tasked with providing unscheduled and urgent assessment and intervention to acutely ill patients. It is accepted that AAU nurses face high levels of emotional distress and EL (Mann, 2005; Smith, 2008). High volumes of nurses reporting reduced well-being and considering leaving the profession presents challenges for healthcare providers (NHS confederation, 2016).

Sinha et al (2009) and Feldman et al (1999) suggest people facing difficult, stressful situations often adopt behaviours such as smoking, drinking and overeating as coping mechanisms (Sinha et al, 2009; Feldman et al, 1999) it is possible that nurses do this and there may be a link between coping mechanism and altered health perceptions.

Gillman et al (2015) believed burnout resulted from multiple factors but failed to

recognise altered personal health beliefs as a contributor. Many nurses consider themselves stressed or working themselves sick (CGI, 2015) and as suggested by Heinen et al, (2012) this leads to burnout and drives them towards leaving nursing. It is a shortcoming of Gillman et al's work that personal health was not considered however, considering their findings against the wider context suggests there may be a link.

Literature suggests commonalities between burnout and EL; firstly, the competence of the nurse does not appear to impact upon propensity to burnout whereas personality and resilience does (Westerman et al, 2014; Epp, 2012; Sinclair et al, 2017) however, Kelly et al (2018) claims burnout occurs more in experienced nurses. It is notable that experience and competence are not necessarily linked, experience is easily quantified yet competence would appear more subjective and difficult to measure which is perhaps why Kelly et al (2018) made no reference to competence as a predicator of burnout. Westerman et al (2014) conducted a systematic review of burnout interventions, similarly a meta-narrative review by Sinclair et al (2017) examined burnout in critical care nurses, both reported that competence and experience is not a predictor of burnout, instead stating capacity for resilience to be a determinant factor. This contradicts Kelly et al (2018) however, all demonstrated strong evidence for the part resilience has to play in burnout.

Sinclair et al (2017) found those who suffer compassion fatigue appear to share personality traits indicative of reduced resilience which suggests susceptibility to compassion fatigue is something individuals may be predisposed to, this reinforces the argument made by Westerman et al (2014) in that experience and competence are not an inherent part of an individual's psyche. It is notable that these authors did not consider organisational factors which could impact upon resilience. The way in which departments are managed, the organisational culture and the clinical speciality might all have a part to play and according to Hooper et al (2010) and Jenkins and Warren (2012) the level of emotional dissonance experienced by nurses becomes heightened in proportion with the increasing level of patient acuity.

Brady (2015) and Nia et al (2016) report the need for organisations to recognise the stress faced by clinicians regularly exposed to death and severe illness arguing that these experiences are linked to negative feelings, emotional dissonance, and burnout. Sliter et al (2014) conducted a multi-time point cross-sectional study which found death

anxiety otherwise known as thanatophobia arose from continued exposure to severely ill patients, leading nurses to consider their own mortality. Unlike other studies such as those of Brady, (2015) or Nia et al (2016) Sliter et al (2014) found acute and chronic responses to the stress of caring for acute patients. It was reported that nurses initially experience emotional dissonance which they counter through deep engagement with providing treatment, however this subsides giving rise to fear and chronic-stress, increased absenteeism and decreased engagement as they contemplate their mortality. One study is not sufficient to confirm this idea, however, it is conceivable that as resilience levels are reached burnout/stress/anxiety all increase and mortality salience may be part of this.

Sliter et al (2014) focussed on acute care nurses and fire fighters using small, homogenous samples to extract rich idiographic data. Findings suggest both groups experienced increased cues for death/mortality salience. However, in fire fighters exposure to death was often less frequent but of greater disturbance compared to nurses who experienced death more frequently but in less traumatic circumstances. The study failed to adequately quantify what was deemed traumatic and how levels of trauma could be discerned, however, it is evident that the authors deemed unexpected, violent, or 'messy' deaths as more traumatic. Both groups were found to have high levels of stress and burnout however, in the nursing cohort there were more chronic elements and nurses were found to be more aware of their own mortality and health. This is one of the few papers which identifies progression of emotional stress and anxiety from acute to chronic and reinforces the idea that nurses' personal health beliefs are changed because of their on-going exposure to patients.

Peters et al (2013) argued that nurses are comfortable with death and dying and that this causes them little stress, instead claiming that it is dealing with families and friends of patients that causes anxiety and stress. The argument that nurses are comfortable with death and that stress does not ensue is unsupported in wider literature however, the findings of Peters et al (2013) result from a study of expected deaths in the palliative sector. Peters et al did acknowledge that in emergency settings, nurses report significantly lower abilities to deal with dying. Sliter et al (2014), examined emergency workers and nurses' perceptions of trauma and unexpected death concluding that those who were less prepared for death and trauma experienced heightened anxiety and negative effects, thus reinforcing the opinion that higher acuity patients leads to

heightened stress amongst nurses.

Workplace and emotional stress including death anxiety have been linked to compassion fatigue, burnout and absenteeism (Roche-Fahy and Dowling, 2009; Kelly et al, 2015) all of which are contributors to health anxiety (Kelly et al, 2015). Epp (2012) demonstrated nurses working with high acuity patients experienced greater stress requiring managerial support. Epp (2012) suggested peer support mechanisms as a method for reducing workplace stress however, she failed to test the efficacy of this intervention. Westerman et al (2014) conducted a systematic review concluding that personal interventions have short-term effects on EL and burnout, and that organisational change is required to achieve long term mitigation, recommendations include staff support, stress counselling and rotation out of acute settings for short but regular periods. Westerman et al (2014) argued that supporting staff through emotional situations can offer a mechanism for decompression which may reduce their experience of health anxiety.

Jones and Johnson (2012) refute the need for organisational support and in a cohort study of 171 nurses found that following serious adverse patient incidents, negative emotions were experienced by 95% of nurses although they do not offer descriptions of these emotions, nor did they state duration or impact. Following managerial intervention most reported continued negative effects for the remainder of their shift, of those not receiving managerial intervention a greater number reported subsidence of negative emotion. It is unclear how generalisable this is as participants were drawn from one healthcare provider rather than a cross section. It is conceivable that participants had a poor relationship with their managers or that the organisational culture included an us and them view of management. These findings have not been replicated in other research which generally recognises the need for managerial or organisational support. Kinnman and Leggetter (2016) for example, refer to the development of emotional resilience built from a combination of personal experience and managerial support.

The literature generally agrees there must be a strategy for reducing numbers of nurses leaving the profession through EL and stress resulting from patient interactions (Jones and Gates, 2007; Jones and Johnston, 2012). There is a clear need to improve understanding of the phenomena in the context of acute assessment nurses as this is an

under-researched area. Greater exploration of the narrative may offer deeper understanding of nurse's experience and could uncover a hidden narrative surrounding the usefulness of management strategies to alleviate the altered health perceptions and stress experienced by this group of nurses.

It appears the discussion around these concepts has moved on and terms including, moral distress and moral injury have entered the vocabulary, there appears to be an overlap between these terms and in the interests of attempting to understand the part each plays they are examined separately.

Moral distress was described by Jameton (1984) who defined it as a situation where one is aware of the right thing to do but organisational constraints make it impossible. Fourie (2017) proposed broadening the definition to incorporate morally challenging situations not necessarily linked to nurses feeling constrained. Fourie (2017) suggested that Jameton's definition applied to circumstances in which constraints such as physician's decisions or institutional rules impinged upon a nurse's ability to take their perceived course of correct action. In contrast, Fourie claimed a broad definition should recognise situations arising from unconstrained conditions resulting from morally challenging or troubling situations which call upon an individual to act contrarily to their personal code of ethics or morality.

By broadening the definition, Fourie (2017) made the concept more applicable to the wider experience of nurses thus increasing the attention it received, this came at a time when NHS staff were reporting deteriorating morale and engagement, with many citing work-pressure and short staffing as causes (NHS, 2017). The undermining of health professionals' well-being through workplace and emotional distress can have negative implications for both patient and organisation (Finley, 2016). McArthy and Gastmans (2015) suggested nurses in departments with higher acuity or greater clinical uncertainty could be at greater risk of moral distress due to increased psychological and physical burdens of their role, this echoes previous burnout research (Maslach, 2003) suggesting some overlap of terms. Austin (2016) added, nurses in these settings would be increasingly bound by constraints due to the increased numbers of physicians. Moral distress and injury have been linked to reduced staff retention and increased absence (NHS, 2017), when considering intervention strategies, Oliver (2018) claimed resilience training should be targeted at managing the risk of carrying difficult

emotional burdens and not to equip nurses for the poor staffing and associated unsafe conditions.

There have been several suggestions on how moral distress could be managed including, introducing Schwartz rounds (NIHR, 2014) and collegiate and managerial support groups which encourage open and honest conversations to identify and mitigate the effects of emotional burdens (Phillipou et al, 2015). Furthering the argument for resilience training and mitigation strategies, Lizarondo (2020) conducted an RCT and related moral distress to the inability of nurses to act in accordance with their personal morality claiming that this experience often induced low self-esteem, frustration and helplessness noting that physical symptoms such as headache and palpitations may also occur. Saedi et al (2019) and Dacar (2019) independently reported that once nurses began experiencing these symptoms they may begin to turn away or avoid patients with whom they associate moral distress. Lizarondo (2020) suggested where employers fail to mitigate the impact of moral distress, nurses will experience moral injury leading to negative impacts on the organisation and patient care due to absenteeism or burnout, this was found to be more prevalent during the Covid-19 pandemic (Watts et al, 2022).

Catrolovni et al (2021) described moral injury as deep emotional wounds unique to those who witness intense human suffering. Moral injury was discussed by Shay (1995) who examined the experiences of American veterans of the Vietnam conflict. The concept is gaining acceptance as part of the healthcare nomenclature (Talbot and Dean, 2018; Kopacz et al, 2019) and its definition has broadened to include more personal perspectives of caring for patients. Litz et al (2009) redefined moral injury suggesting it involves the perpetration, failure to prevent or witnessing of events which conflict with one's deeply held moral or ethical beliefs. Unlike previous definitions, Litz et al (2009) considers not only actions but inactions, arguing that constraints can compel nurses to act or not act in a manner in keeping with their personal morality.

It has also been suggested that the impact of moral injury accumulates over time, undermining the care-giving process and leading to dehumanisation of patients (Tenbrunsel and Messick, 2004; Cartolovni et al, 2021). Walsh et al (2015) examined nurses' experiences of caring and described this as a slippery slope. It appears behavioural indicators of burnout, emotional labour and moral injury are closely related; however, a distinction of moral injury is that it is intrinsically linked to the

experience of deep anguish (Dean and Talbot, 2019). Burnout and moral injury have been shown to overlap in terms of their manifestation leading Kopacz et al (2019) to recommend moral injury be brought into the burnout discourse. Progression from burnout to moral distress and latterly, moral injury has been described as a cascade in which unchecked and unmanaged negative experiences can lead nurses to become less willing or able to perform their duties (Gustavsson et al, 2020).

Like burnout and emotional labour, there appears to be an element of cognitive dissonance involved in the experiences of moral distress and injury in so far as nurses feel compelled to act in certain ways (Kopacz et al, 2019), this leads to violations of their moral code and can produce profound emotional reactions resulting in long-term consequences (Molendijk, 2018). The insult to one's morality gives rise to moral injury leading to temporary distress and cognitive dissonance. The implication of which is that nurses' moral identity is challenged or eroded which has been shown to result in long-term anxiety and social withdrawal (Gibbons et al, 2013). Moral injury/distress has been shown to detrimentally affect nurses' professional and personal lives leading nurses to become desensitized to morally questionable situations (Molendijk, 2018; Morley et al, 2020).

2.7 Secondary Traumatic Stress (STS) and Mutual Suffering

STS is not the result of the way nurses are compelled to act; it arises from the things they witness. Those working with the acutely unwell are at increased risk of suffering emotional disturbance resulting from their prolonged patient contact and their empathetic relationships with patients in an acute or end stage of suffering, distress, illness or disease (Potter et al, 2010). Nurses do not suffer the same physical or pathological insults as their patients however, they are affected by their continued exposure to suffering. In a qualitative study of nurses' experiences of trauma, Baird and Kracen, (2006) demonstrated a deeply traumatic impact on nurses which can influence their ability to continue nursing.

STS, also referred to as Vicarious Trauma is defined by Zerach (2013) as the experience of trauma in absence of personal injury. Figley (2002) suggested, STS is an empathetic response and is the manifestation of emotional stress from witnessing patients' traumatic experiences or the uncertainty of their prognosis. Baird and Kracen,

(2006) concur, suggesting it results from continued exposure to emotionally traumatic, physical events in others. Empathy is a central component of nursing (NMC, 2015) and so it is conceivable that nurses are predisposed to STS.

Graham et al (2005) suggested nurses with prolonged exposure to patients develop entangled relationships which sometimes caused nurses to experience detrimental emotions influencing their own perceived health and well-being, they reported experiencing anxiety and health fears. It is possible that this entanglement might involve an 'osmotic' effect and transference of emotion, both consciously, and unconsciously could impact upon how nurses perceive their health and well-being. STS may occur instantly, later, or progressively, however, when it does there is always a cost to the carer (Figely, 2002; Figley and Roop, 2006; Craigie et al, 2016). This is supported in the wider literature with Henderson (2001) and Dowling (2008) reinforcing the notion that decisions to emotionally engage with patients exposes nurses to professional and personal, emotional costs.

STS has been shown to create suffering for nurses witnessing traumatic events however, the idea of suffering alongside patients can be seen in wider practice. According to Graham et al (2005), caring for the dying and for patients whose prognosis may be uncertain can cause significant discomfort. This gives rise to the concept of mutual suffering. Graham et al (2005) sought to understand nurses' lived experience of mutual suffering when caring for the acutely ill or dying and suggested that mutual suffering is a uniquely personal experience resulting from being placed in a situation in which disintegrated, or emotionally challenging care must be delivered. Detailed analysis of participant responses led Graham et al (2005) to report nurses experiencing feelings of guilt, impotence and anger at these situations.

Mutual suffering is both an acute and chronic response and a triggering event where the nurse experiences a range of negative emotions. These can lead to an acute sense of suffering, latterly, or following continued regular negative experiences, chronic elements of mutual suffering, such as health anxiety, fear for one's own health and an increased propensity to burnout take hold. According to Graham et al (2005) in the acute phase nurses push against the negative feelings but later create new ways of thinking or behaving, participants in Graham et al's study declared an acceptance that as we give care, we also give a little of ourselves. Clemens (1993) also concluded that

caring for the acutely ill can have a profound impact upon the personal well-being of carers. Graham et al (2005) reported that a sense of failure is a permanent feature of nursing going on to describe reports of guilt, low self-esteem and anxiety about uncertainty which all contribute to the experience of chronic mutual suffering.

Wilson (1999) and Sen (1998) describe paradoxical experiences in which the carer is torn away from a patient or loved one whilst simultaneously united with and bonded to others who have shared similar experiences. Sen (1998) recognised the anxiety this separation caused carers but did not examine the nature of newly created bonds whereas Wilson (1999) reported these form an important part of the coping mechanisms of nurses.

Mutual suffering is a negative experience in which carers experience a detachment from patients ultimately leading to a degradation in care delivery (Graham et al, 2005; Clemens, 1993) however, Maeve (1998) reflected on how nurses were able to draw upon the dilemmas of their patients' lives and suffering to amend their own lives for the better. Maeve (1998, p1138) describes this process as 'weaving a fabric of moral meaning' reporting that where this was achieved, a sense of positive outcome could arise which might reduce the negative effects of mutual suffering leading to a degree of re-engagement. This was not found in the wider literature and may have been a process unique to the environment in which Maeve's study was conducted. These views should be considered with interest but may not be a true representation of how nurses experience mutual suffering.

The earliest study discussing detachment and re-engagement appears to be Kralik et al, (1997) who claimed the engagement between nurse and patient is a significant determinant of quality and standards of care. Much like the later studies conducted by Sen (1998), Wilson, (1999) and Graham et al, (2005); Kralik et al (1997) concluded that when engagement suffered so do did patient and carer alike, for patients the standard of care was compromised and for nurses there was a sense of failure, frustration and trauma.

This section described a number of work induced stresses affecting nursing staff. As nurses are exposed to the trauma and suffering of others, they face increased risks of experiencing compassion fatigue and burnout and it is possible that these might be

linked to STS and mutual suffering.

2.8 Fear of dying, health anxiety and clinical uncertainty

Nurses have reported feelings of anxiety and fear surrounding their own mortality when there are circumstances of clinical uncertainty. Several terms have been used to describe these feelings; health anxiety, thanatophobia and death anxiety, to name but a few. These concepts are not distinct from MD as treatment decisions form a big part of that literature (Mak et al, 2103; Walker and Deacon, 2016). The moral distress of caring when not appropriate was discussed by Tan et al (2006) who suggested caring for the dying in the acute setting can induce fears for ones' own death, anxiety about personal health and other negative experiences. This theme discusses these in the context of the academic literature. It should be noted that due to the similarities between death anxiety, fear of death and the dying patient, thanatophobia is considered in its broadest sense to incorporate each of these sub-categories.

Thanatophobia is the anxiety brought about by death and dying (Clark et al, 2015), it is a fear of death typically experienced by physicians, nurses and healthcare workers (Thompson, 1993). Thompson (2003) hypothesised that nurses' attitudes and experiences of thanatophobia are closely related to their branch of nursing, concluding that work settings play a far more significant role in changing nurses' attitudes toward death and dying than their personal experience.

Thompson (2003) discussed the notion of curative expectations, which is the idea that healthcare in the acute setting is less focussed on allowing death to occur as a natural process of living and more on death prevention. The concept of curative healthcare is prevalent throughout the related literature (Chaikin et al, 2000; Merrill et al, 2000, Oliveira et al, 2016; Bibi et al, 2016), however, whilst there is research focussed on nurses' perspectives on the shift from curative to palliative care provision within palliative services (Thompson et al, 2006; Clark and Ross 2005) there is considerably less research seeking to understand the experiences of nurses dealing with the dying within the acute care setting. Studies such as Tan et al (2006), Mak et al (2013) and Walker and Deacon (2016) did focus on the acute setting with a specific focus on unexpected death and bereavement. They concur that where this occurs there is often a negative impact on the carer in the form of STS, mortality salience and moral distress.

Oliveira et al (2016) sought to understand the lived experience of nurses providing end of life care in an acute medical unit concluding that thanatophobia exists amongst acute care nurses and develops for several reasons including, the physical drain of caring, the emotional impact of seeing uncertain or unexpected dying and clinical uncertainty. Oliveira et al (2016) suggests uncertainty of what is expected to be offered to patients and their families often arises because of a drive to cure all patients within acute settings. Where this becomes impossible there is a difficult transitional period where the medical team continue to attempt a cure despite nurses accepting this is not possible. Oliveira et al (2016) mirrors the moral distress and injury literature suggesting that in such circumstances tensions arise leading to personal and emotional anxiety for nursing staff which can present as emotional/moral distress or injury.

Studies conducted in intensive care settings reported congruent findings with Fridh, Forsberg and Bergborn (2009) and Yang and McIlfatrick (2001) concluding stress and personal anxiety amongst nurses increases when there is clinical uncertainty. Oliveira et al (2016) discussed the idea of witnessing suffering. Participants described battling and struggling with anxiety and emotional turmoil which developed from uncertain patient outcomes, a futile curative focus, and the expectation that they should continue delivering a care plan which they believed to be contributing to patient suffering. Oliveira et al (2016) undertook a phenomenological study, interviewing ten nurses from acute medical departments and concluded that this contributed to STS, thanatophobia and workplace stress amongst nurses who did not wish to find themselves in a similar position to their patients later in life. These findings are useful as they offer insight into similar clinical settings to that which my research will be undertaken.

Popoff (1975) first described nurses' thanatophobia finding that death anxiety and fear of death was linked to clinical futility and failure. Merrill et at (1994, 1998 and 2000) and Chaikin et al (2000) support this but add ongoing and sustained exposure to the dying patient serves as a reminder of the inevitability of death. Lester (1985) argued nurses' thanatophobia and death anxiety decreased with experience however, this is refuted by Thompson (1985) and Bibi et al (2018) who found increased exposure to death in curative settings lead to increased death anxiety and thanatophobia. An earlier study by Stoller (1980) also found fear of death increased with exposure amongst nurses, unlike in physicians where death anxiety reduced as experience increased.

These findings are mirrored in online nursing forums.

The idea of uncertainty outcomes as a catalyst for stress, health anxiety and increased thanatophobia is a common theme, as far back as the 1960s, there was evidence of nurses feeling responsible for patient outcomes, especially patient deaths (Glasser and Strauss, 1965; Folta, 1965). Many nurses develop feelings of helplessness and frustration resulting from the uncertainty they experience in their role (Quint, 1965). For some, the requirement to provide care to the dying in an environment in which curative outcomes were expected left them unable to engage due to personal mortality salience and a fear of dying (Quint and Strauss, 1964). Death anxiety and fear of clinical uncertainty remains a driver for nurses' thanatophobia and health anxiety in contemporary practice (Oliveira et al, 2016; Craigie et al, 2016).

According to Chaikin et al (2000) healthcare workers are often drawn to caring roles as a means of mastering thanatophobia through the process of gathering the knowledge and perceived power to cure patients, control disease and save lives. Deutsch and Fishman (1963) noted when faced with dying patients, some physicians distanced themselves entirely for fears about their own mortality. Olin (1972) and Chaikin et al (2000) offered explanation for this withdrawal suggesting claimed the dying patient is often seen as a physician's failure and one which reminds them of the surety of their own death. The physician's role means they often move from ward to ward as they attend to patients, for AAU nurses however, the role necessitates staying in one setting for the duration of their shift and as such they do not have the ability to remove themselves from dying patients. Inability to self-extract from these difficult situations may impact upon nurses' experiences of caring and health anxiety (Chaikin et al, 2000).

Glaser and Strauss (1965) suggested that the difficulty associated with caring for the terminally ill in acute and curative settings leads health workers to distance themselves in an attempt at self-preservation, Chaikin et al, (2000) and Merrill et al (2000) expand this idea reporting nurses will spend more time with patients who can be cured to thwart feelings of uselessness and helplessness often associated with dying patients.

Merrill et al (1996) compared personality traits of physicians and medical and nursing students and found medical students scored significantly higher on the thanatophobia scale than nursing students suggesting that this was due to differences in role, as

medical students focused more on a biomedical model and nurses on more emotional and holistic approaches. It should be noted that Merrill et al (1996) did not take into account emotional burden, STS or health anxiety and focussed solely on levels of death anxiety. There has been no similar study in recent years during which time nurses have begun to take on more of the roles traditionally associated with junior doctors, it would be useful to repeat the study considering this shift. Merrill et al (1994) validated a scale to measure intolerance to clinical uncertainty reporting increased levels of uncertainty are strongly linked to increased thanatophobia across all participant groups, it is likely in areas such as AAU where clinical uncertainty is prevalent that there is likely to be increased fear of death and dying amongst all healthcare staff.

The difficulties experienced by nurses involved in the provision of uncertain care and incurable illness requires further research. A general finding is that whilst there is awareness and acceptance of the existence of a problem in palliative care settings there has not yet been enough research to seek what and how this anxiety may be combated, especially in acute settings. Studies referenced in this section describe the anxiety surrounding caring for the dying and fear of one's own death as a form of mutual suffering however, as shown earlier mutual suffering involves more than these elements alone.

2.10 Environmental stresses and coping strategies

Work environments can and will influence how we work, how we experience our work and how we feel about our work.

Oliveira et al (2016) suggests the high intensity of many nursing roles leads to increased workplace stress. For some, the lack of time to provide quality care has been cited as a key contributor to stress and anxiety (Oliveira et al, 2016; Chang et al, 2005). This is supported by Utrainen and Kyngas (2009) who found nurses derived great satisfaction from being able to forge good therapeutic relationships resulting from shared time and caring interventions. For others, stress arises from the inability to cure, the fear of one's own death, the emotional toll of nursing or a personal disposition to health anxiety however, for many there are coping strategies which can mitigate the impact of environmental stress. Communication and the use of supportive networks

appear to be an under-researched but regularly reported element of stress/anxiety management for nurses (Oliveira et al, 2016).

Studies have demonstrated that nurses cope better following distressing situations when they are able to access informal collegiate support (Badger, 2005, Halcomb et al, 2004; Jones and Fitzgerald 1998). Badger, (2005) and Halcomb et al (2004) reported that these informal networks were far more effective than formal or managerial support, this idea was discussed by Haavardsholm and Naden (2009) who identified the importance of professional networks of co-workers who offer confidence and security for nurses. They identified that trusting collegiate relationships led to feelings of value and support and a sense of shared experience and suffering, crucially, Haavardsholm and Naden (2009) identified that when nurses felt they are sharing their burden, they are less likely to suffer with workplace stress and health anxiety. Zeydi et al (2022) conducted a systematic review of MD intervention effectiveness and found strategies such as ethical education, resilience training and moral empowerment programmes to be promising interventions but not as yet widely employed. Zeydi et al (2022) concluded that there was insufficient evidence to implicitly show the value of these.

Utrainen and Kyngas (2009) acknowledged that inter-professional relationships played an important role in nursing care and professional quality of life however, it was once again identified that time constraints often impinge on perceived quality of care and on the time available for nurses to have informal debriefing and supportive discussions. Utrainen and Kyngas (2009), recommended that nursing management in the acute environment must recognise the value of cultivating and nurturing supportive relationships amongst nursing staff. Adams and Bond (2000) also made this case and reported a need to maintain cohesion through an emphasis on retaining a core of motivated and experienced staff.

Nursing has been likened to battling a complex web (Oliveira et al, 2016), a web fraught with difficult personal, emotional, ethical and physical barriers which nurses must overcome to remain effective. Oliveira et al (2016) conducted interviews with ten nurses across two hospital medical units and listed several factors including the complexity of caring for acutely unwell patients, dealing with uncertainty, bearing witness to suffering and trying to create calm in a hectic and demanding environment. Participants offered insight into each of these areas through a semi-structured interview

approach in which they were asked to explain their experiences of nursing in the acute setting. A key theme, 'finding a way through the web' was identified and offers a number of insights which help make sense of how nurses cope in demanding circumstances, Oliveira et al (2016) argued that nurses learn through personal experience and mentorship, participants in the study suggested mentorship and learning from experienced colleagues was vital to their ability to cope with and reduce anxiety and fear of death. Oliveira et al's study had a sample size of only 10 nurses and yielded some detailed data and valuable findings however, the small homogenous sample limited the wider generalisability of their findings, however, other studies have echoed these findings (Chaikin et al, 2000; Bibi et al, 2018). Thompson (2003), however, refuted Oliveira et al's assertion and claimed increased experience and exposure led nurses to develop a greater sense of personal anxiety and thanatophobia.

Thompson (2003) did concede that greater experience brings a degree of desensitisation; Kelly et al (2015) echo the argument for desensitisation but add that with increased experience comes a decrease in compassion satisfaction which only serves to make experienced nurses more likely to endure the role, often at the detriment of patient care as they become depersonalised and uncaring. There is insufficient evidence specific to the acute assessment unit to determine which of these arguments is most compelling however both have merit.

Merrill et al (2000) found that increased exposure to dying led to workplace and emotional stress amongst nurses. This finding is common across the literature and transcends most clinical areas (Bibi et al, 2018; Thompson, 2003; Kelly et al, 2015).

The idea of collegiate and supportive networks has been described previously however, for some this does not serve to reduce or remove the anxieties experienced in the course of their duties and for these nurses there is a reduced sense of satisfaction and devotion to duty with many claiming that they are undervalued and not appreciated for their sacrifices (Kelly et al, 2015). Lefton (2012) and Perry (2008) demonstrated the impact that meaningful recognition can have upon nurses' resilience. These studies acknowledge nurses' feelings of honour, pride and re-invigoration associated with receiving meaningful recognition and praise for their efforts.

More recently Hunsaker et al (2015) and Kelly et al (2015) have shown that

recognising nurses' contribution in a meaningful way not only improves resilience but has a positive impact upon compassion satisfaction and professional quality of life, each of which improve the likely hood of reduced burnout, anxiety, thanatophobia and departure from the profession. Hunsaker et al (2015) added that managerial support and recognition (as well as that from patients/relatives) is an important factor in improved compassion satisfaction within the acute medical unit, although, again, there is a paucity of research in this area.

2.11 Chapter summary

This literature review examined several key areas including secondary traumatic stress, burnout and the impact of clinical uncertainty. There is a congruence in the literature appearing to suggest that nursing, especially within the acute setting, is fraught with factors which might impact upon how nurses perceive their own health and well-being. It has been shown that nurses experience heightened health anxiety because of their work and that this can often be attributed to witnessing the suffering of others as well as out of a sense of moral distress/injury possibly resulting from heightened emotional labour. It is clear from the literature review that nursing impacts upon nurses' well-being however, the evidence failed to address how AAU nurses make sense of their experiences.

Chapter 3 – Methodology and methods

3.1 Chapter overview

The aims of this research were to explore the lived experiences of nurses working in an Acute Assessment Unit when caring for acutely ill patients. And, to examine how AAU nurses make sense of their experiences in terms of their own health and well-being.

This chapter will discuss the theoretical, philosophical and epistemological underpinnings of the IPA methodology and will outline why it has been selected for this research project.

3.2 The emerging methodology

To address the research aims it was important to recognise all experience as individual and to take an idiographic approach to participants. Experience cannot easily be quantified, nor can personal meaning be appropriately examined using a statistical approach. The richness of experience requires immersion and interpretation therefore this research is naturally aligned to the qualitative/interpretative paradigm. Paying attention to context meant that participants would need to work within the same environment and be exposed to similar patients. AAU has limited numbers of potential participants and the idea of small homogenous samples yielding rich idiographic data (Smith, 2009) led me to identify IPA as the methodology for this study.

3.3 Why not another approach?

Examination of the existing literature and my initial visit to the study setting (AAU) led to the conclusion that the study must include a means of exploring and focussing not only on the experiences and perceptions of individuals but also that there must be scope to combine these accounts. This would allow the analysis and interpretation of a collective experience, therefore the selected methodological approach needed to facilitate this. Many epistemological approaches exist and influence research for a variety of reasons, other approaches I considered included thematic analysis, narrative analysis and grounded theory.

Grounded theory was discounted as the potential sample size could not guarantee saturation of data (Urquhart, 2013). Narrative analysis was excluded as it fails to consider body language and non-verbal communication (Andrews et al, 2013). I ultimately felt the idiographic nature of IPA was more suited to my study.

3.4 Finding an epistemology that fits

There are a multitude of phenomenological approaches or perspectives of which IPA is just one. However, having examined these it became increasingly clear that the epistemological foundations and methodological approaches of IPA were well suited to exploring and understanding Acute Assessment Unit (AAU) nurses' lived experience in terms of their own health and well-being.

At the heart of IPA is its concern with the lived experience of individual participants (Eatough et al, 2008). According to Smith (1996), IPA is multi-faceted attending to the phenomenological element which involves exploration of personal experiences but also the interpretative element in which researchers attempt to enter and explain participants' lived world. Smith (1996) recognises that there is no direct approach to understanding participants' personal experiences and accepts that the researcher's preconceptions will impact upon the final interpretation. This is relevant as I am a senior nurse within a similar clinical setting to that hosting this study, this means my previous experiences and understanding of participants' roles may impact. My experience is the lens through which I see the world. I cannot see the world without it and thus my interpretations will be affected. IPA embraces and acknowledges this impact rather than ignoring or trying to remove it (Smith et al, 2009 and 2021).

Thorne et al (2004) has described methodological slurring in which the boundaries between recognised qualitative methods begin to overlap and warns that this is most likely to occur when there is not a clearly defined epistemological position. There are vagaries within many qualitative approaches, in fact Madill et al (2000) argues that numerous epistemological perspectives exist within single methodologies. It would therefore be inappropriate to simply declare this study to be an IPA study without offering sufficient insight into each of its epistemological foundations. There have been calls for researchers to ensure provision of a "solid grounding of methods and their

theoretical underpinnings" (Yardley, 2008, p259) as well as to demonstrate a suitable fit between the methodology and the stated research question and its aims.

What follows is an explanation of the key philosophical and epistemological components of IPA.

3.5 IPA – Understanding the theoretical and philosophical elements

IPA is a qualitative research approach committed to the examination of how people make sense of their life experiences (Smith et al, 2009; 2021). The methodology is primarily concerned with gaining detailed understanding of the lived experiences of participants (Smith and Nizza, 2021), it is experiential and inductive in its approach giving voice to the experiences of participants. A key premise of IPA is that experience is explored in its own context, I am interested in how participants make sense of their daily experiences at the point where they begin to take on increased significance. IPA methodology allows the researcher to gain increased understanding through asking carefully considered questions of participants who, by nature, are experts of their own experience (Smith, 2011; Smith et al, 2021). IPA recognises that our experiences, communication, interpretation and perspective are connected and framed within a specific context (Smith, 2011).

Smith et al (2009) claims when we are engaged with significant experiences we begin to reflect, attempting to make sense of what has happened to us. A central component of IPA research is the attempt to critically engage with participant reflections to interpret how a specific person in a specific context makes sense of a given phenomenon. Smith (2011) further adds these experiences share a common significance to the individual who will spend considerable time contemplating and reflecting as they attempt to make sense of what they have encountered.

Hermeneutics is the study of interpretation and IPA recognises individuals will attempt to interpret their own experiences however, as outlined by Smith et al (2009 and 2021) researchers can only base interpretations on what participants are willing to disclose. Smith et al (2021) suggests researchers must be skilled in delving beneath the surface of accounts, from this perspective researchers must attempt to make sense of the participant's understanding. This is known as the double hermeneutic (Smith and Osborn, 2003) and encapsulates the duality of researchers as both observer and part of

the interpretative process. IPA recognises the existential as well as personal meaning that participants attach to experiences and as such the role of the researcher is to remain sensitive whilst attempting to makes sense of what the experience means to the individual participant (Smith, 2004). IPA researchers are engaged in analysing and interpreting the interpretations and understanding of participant experience (Smith and Osborn, 2003). The researcher must remain cognisant of their own values, beliefs, experiences, and knowledge with particular focus on how this might impact upon the analysis and interpretation. This acceptance of the researcher's part in the sense-making process compelled me to the methodology.

3.6 Epistemology

Harper and Thomson (2012) describe epistemology as the philosophical theory of how knowledge is attained and assessed as reliable. According to Smith et al (2009) to understand the world in which we live we must understand experience. IPA considers people as "embedded and immersed in a world of objects and relationships, language, culture, projects and concerns" (Smith et al, 2009, p.21).

Larkin and Thompson (2012) summarise the epistemological position of IPA identifying the need to understand experience within the context of an individual's own world, a focus on specifics is necessary and participants' experience is accessed through the researcher's lens therefore researchers must remain reflexive towards their own suppositions. Smith et al (2021) reminds us of the need to ensure interpretation remains grounded in participant data and not in the researchers experience or perception, as a novice researcher this will present a challenge. I will ensure findings are grounded through immersion in the data and presentation of an auditable trail to support my interpretation.

IPA recognises that reality is individual and that one cannot simply access the reality of another. Instead, there is an intersubjectivity where participants and researchers become engaged. Finlay (2006) suggests that this merging of realities allows the researcher to access and interpret participants' experiences. I accounted for the potential blurring of realities by discussing my interpretations and ideas with supervisors and by maintaining a reflexive diary.

As a senior nurse working in an AAU, I have a close knowledge of participants' field of work as well as my own lived experience. It is important to reflect upon this in the context of analysis to attempt to attain balance between "near" and "far" experience (Smith, 2011, p10) to ensure analysis is grounded in participant experiences. This means being aware of my presuppositions and assumptions and trying to separate these from what participants describe whilst acknowledging how my experience will impact upon interpretation. I achieved this through acknowledging my world view and position within the research and by maintaining a reflective diary which helped separate my own ideas from those which were truly grounded in the data.

IPA facilitates an understanding of how a given person, in a given circumstance or situation makes sense of a given experience. The researcher's role is to remain reflective and reflexive in their analysis accepting there is a degree of intersubjectivity which must be recognised whilst ensuring findings remain grounded in the participant interpretations and interview data. IPA has its origins in hermeneutics, phenomenology and ideography, each of which have their own uniqueness and philosophical origins.

3.7 Phenomenology

Phenomenology is the study of subjective being (Nebauer et al, 2019), at its heart is the principle that experience must be examined in the context in which it occurs. This fits well with my research which examines nurses' experiences as they occur within the AAU setting. Finlay (2011) suggests phenomenology requires us to slow down and dwell within the phenomena being observed, the immersive and iterative processes of idiographic and cross-case analysis of IPA allow for this.

Husserl has been dubbed the father of phenomenology, he stated *"go back to the things themselves"* (cited by Smith et al, 2009, p.12) by which he was referring to the essential qualities of an experience and human consciousness. Husserl argued that if one could capture the essence of what it is to experience a phenomenon then this could transcend individual understanding and offer insight into a wider population. The challenge was to find a way of doing so which considered the need for sufficient depth, understanding and rigour. Husserl was focussed on the particular, exploring what it meant to feel and be. He argued for a need to step outside of our everyday experience (Welton, 1999) instead adopting a phenomenological attitude in which we cease to look

at things from the outside and rather focus inwardly on the object of our experience. Husserl called this reduction, and it was his reaction to the limitations of the more traditional quantitative approaches to research which he felt could not account for human emotion and the essence of experience (Danziner and Dzinas, 1997). Husserl promoted the notion of separating one's own experience and knowledge from that being observed through a process he called bracketing however, more contemporary interpretative writers have argued that this is not entirely possible, instead suggesting that phenomenological interpretation has room for the researcher's interpretative lens as long as it is acknowledged (Finlay, 2011; Smith et al, 2021). The idea that we cannot entirely separate ourselves from the data is at the heart of IPA and the double hermeneutic (Smith, 2009). This acceptance of the researcher's influence and interpretative lens was a compelling argument for its selection for this study as I believe it to be impossible to perform interpretative analysis without becoming a part of it.

Husserl's reduction approach has been challenged for its lack of pragmatism (Ashworth, 1996) and the inability of the researcher to entirely separate their own assumptions and prior knowledge from what participants disclose (Giorgi, 2009) however, there is common agreement that this should at least be attempted in so far as is possible, this is a central concept of the double hermeneutic of IPA (Smith et al, 2004). The phenomenological component of IPA promotes a natural curiosity and a willingness to be surprised by unexpected or unusual occurrences (Dahlberg, 2008). This curiosity and phenomenological attitude is prevalent in IPA research which according to Smith et al (2009) employs an enlivened approach to bracketing whereby a cyclical, reflexive and hermeneutic acknowledgement of prior understanding is reached but where the openness and curiosity of the researcher's attitude causes them to be fully engaged in the participant's world thus making bracketing less necessary (Smith et al, 2009). Heidegger argued the requirement for an interpretative stance claiming we are inextricably linked to that which we study and as such a fundamental part of any interpretation (Herrigan-Kelly et al, 2016).

Heidegger suggested that interpretation can be a close approximation of the participant's true lived experience so long as we pay close attention to the language used and non-verbal cues. Word choice plays a key role in the expression of understanding and interpretation (Smith et al, 2009; 2021) and IPA facilitates in-depth

interviewing of participants offering me the opportunity to play close attention to linguistic cues and descriptions offered by participants again, strengthening my belief that IPA is the best fit for my research.

Heidegger's belief that we can only view things from our own position was expanded upon by Merleau-Ponty who whilst agreeing with the phenomenological attitude proposed by Husserl also asserted the need to acknowledge the role our own experience and knowledge plays in shaping the analysis, as such Merleau-Ponty professed that any qualitative research is by design subjective and interpretative (Smith et al, 2009) as we cannot truly understand another person's experience. Merleau-Ponty believed that researchers should acknowledge their own place in the world and the influences this may have on the research, for me, as a senior nurse within an AAU I have what may be very similar professional knowledge and lived experiences as the study participants and I must remain cognisant of how this may impact upon my interpretation of the data. Smith et al (2004) describes an acceptance of the researcher's experience and impact on analysis and interpretation, in an effort to recognise my inability to entirely separate myself from the data, I was eager to identify a methodology which not only accepted the lens/experiences of the researcher but also embraced it, IPA does exactly this (Smith, 2011).

3.8 Hermeneutics

Hermeneutics is the theory of interpretation and is integral in IPA (Smith et al, 2021). Heidegger was prominent in hermeneutics, proposing meaning and therefore interpretation could come from sources aside from just the participants voice, he believed accounts of participants contained surface as well as hidden meanings which are uncovered throughout any interpretation. Schleirmacher also concluded there was more to participant accounts than the verbal response, suggesting grammatical nuances and flow of language played a role in facilitating interpretations (cited by Smith and Nizza, 2021).

Gadamer, like Heidegger, believed interpretation to be a fluid, dynamic process in which researchers apply their own knowledge and understanding to the data and remains aware of their projections throughout the reading and analysis stage. Gadamer professed that interpretation is always influenced by context and temporality. Finlay,

(2011) clarifies this proposition declaring that contextual interpretation will yield more thorough understanding of experiences, and that its subjectivity is influenced by the researcher's experience and the cultural and temporal-spatial lens through which it is viewed. Finlay (2011) makes clear that meeting of researcher and participant produces the contextual backdrop for subsequent interpretation.

I acknowledge that the findings of my study will be influenced by my own understanding of caring for the acutely unwell, the interaction and rapport between myself and participants and by the current climate within the AAU environment. Once more, the IPA allows for and embraces this (Smith et al, 2021) making it a natural fit for my research. Perhaps one of the most important considerations is the Hermeneutic Circle, it is primarily concerned with the interrelatedness between the part and the whole (Smith et al, 2009). Put simply to understand the whole we must examine its parts, likewise, to identify the role of a particular part we must observe the whole. By moving in and out of the cycle at different points we can gain greater perspective and richer interpretation. For example, a singular word could have multiple meanings however, by examining the complete sentence we gain greater context but perhaps still misinterpret the meaning, expand further to the entire paragraph and the meaning becomes apparent. Therefore, a single utterance or word can offer significant analytical leverage (Smith et al, 2009).

Hermeneutics forms an important aspect of IPA and of our intellectual history (Smith et al 2009). IPA is a phenomenological and interpretative approach and the contributions of the philosophers described in this section have helped enrich our approach to interpreting what we are told. Many of these philosophers mention the importance of context and specific times, cultures and influences. The next section picks up on the importance of the particular and discusses the third pillar of IPA; ideography.

3.9 Idiography

Idiography is concerned with the particular (Smith et al, 2009). IPA can be described as idiographic due to focussing on the fine details of contextualised analysis of a given phenomenon (Eatough and Smith, 2006), IPA concerns itself with the experiences and sense-making of a specific group or individual in a specific circumstance. Idiography resonates with the concepts of hermeneutics and phenomenology in which there is a

prioritisation of the perspectives and experiences of the individual rather than the general population, this favouring of the specific over the general makes IPA an idiographic approach.

The importance of an idiographic approach for my study cannot be understated, I am focussed on the sense-making of a small group of nurses working in the same environment, sharing common experiences and therefore rich and specific detail is crucial if I am to produce a robust and detailed interpretation. Smith et al (2021) supports the need for an idiographic component when conducting studies using small and homogenous populations. The idiographic nature of IPA allows for an exploration of the detailed lived experiences of the participants which I hope will adequately reflect their experiences.

According to Smith, (2004) the idiographic approach can have theoretical transferability as through an exploration of detailed and specific areas we can gain some understanding about the general, whilst not specifically what my study seeks to achieve, this may prove an additional beneficial element for subsequent research.

3.10 IPA as a means of exploring lived experiences

IPA incorporates the phenomenological approach described by Heidegger, yet Langdridge (2007) and Smith et al (2011) claim IPA requires us to focus on intentionality (conscious experience) and intersubjectivity between individual and environment. Smith (1996) made connections between phenomenological interests of IPA and cognition, although it appears this is more of an outward consciousness based on lived experience than the traditional inward consciousness described in psychology literature. Smith et al (2011) describe the concepts of meaning and meaning making which echo the description of cognitive conceptualisation offered by Bruner (1990). In accordance with Bruner (1990), IPA acknowledges that participants are the experts in experiencing the phenomena under investigation. This requires researchers to adopt an interested and holistic approach to gathering data if they are to successfully identify and explore the experiences of participants.

"Collectivity that allows the possibility of mutual understanding" (Smith, 2007, P.5) is present in each of us and we all have a receptivity to other people, this is reflective of

my own belief that we create our world according to our experiences and interactions with others. For me IPA is particularly attractive as instead of viewing researcher involvement in the interpretation as a source of bias, it embraces the researcher's knowledge, conceptions and interpretations as valuable and inseparable from the research process (Shaw, 2011).

3.11 Holistic explorations of participants' experience

The interpretative elements of IPA place value on the totality of participants (Smith, 2008), this means recognising the idiographic and individuality of each participant and as such fits with the aims of this study. The research is situated in a specific context and interested in a specific population, but it is the entirety of their experience of caring for the acutely unwell and its impact on their perceived well-being that is crucial to understanding and interpreting the phenomena under investigation as such the holistic approach encouraged within IPA literature is entirely appropriate to this study. Smith (2008) tells us that the interpretative stance of IPA allows an insider perspective, in which researchers attempt to appreciate participants' sense-making of their lived experience through listening to their accounts but also to gain an outsider perspective in which the researcher seeks to make sense through asking probing questions about the experience of the phenomenon.

3.12 Individual experiences

Individual experience is at the heart of this research and this central focus has led to the exclusion of several possible alternatives to IPA. Smith (2009) explains, IPA incorporates richness and diversity of individual accounts thus it maintains an idiographic focus.

IPA is well aligned to the aim of this study, especially as it recognises the existence of a gap between the objects and individual perceptions and experiences of that object (Smith, 2008). From this perspective IPA does not seek to make objective statements, it remains focussed on the specificity of individual experiences. This idiographic stance ensures that IPA regards individual accounts and interpretations as equally valid and important contributions to the researcher's emerging interpretation of participant experiences. IPA is concerned with the analysis of individual subjective accounts

(Brocki and Wearden, 2006) which are used by researchers to interpret the experience of the phenomenon under investigation, as such both individual case analysis and cross case analysis are important steps in IPA data analysis.

Interpretation within IPA operates under the assumptions of the double hermeneutic which recognises meaning making at several levels, IPA can be said to recognise that experiences hold different meanings for different people (Smith et al, 2009), an important consideration leading to my choice of IPA was the studies' intended focus on the individuality of experiences and how nurses are personally affected by their involvement with patients.

The exploration of individual experience is also concerned with the recognition of the context of the study, and this is pertinent to this study where the well-being perceptions of individual nurses are explored within the shared context of the AAU. There have been large numbers of IPA studies in health which investigate phenomena shared by a group but experienced on a personal level, Reid et al (2005) highlights the efficacy of IPA in facilitating this kind of exploration.

Smith and Eatough (2006) argued that despite the central facet of IPA being the experience of participants, there must be recognition of the historical, social and cultural factors effecting context and wider group experiences. It is interesting given the wealth of literature identifying the importance of context within IPA that Larkin et al (2006) criticise the methodology as overlooking the role of context. Larkin et al (2006) claim that the inexperienced researcher is at risk of misrepresenting the idiographic elements of IPA in such a way as to infer that the participant can be separated from the context. The separation of participant from context within IPA is a misnomer and if we trace the approach back to its philosophical underpinnings then we are reminded of Heidegger's argument that experiences and interpretations are situationally and context specific and that knowledge and understanding is locally produced according to socio-cultural factors. This argument renders research participants a "person-in-context" (Madill et al, 2009. P.9). It is this focus on individuals in context which afford the flexibility and interpretive range associated with high quality IPA studies.

3.13 Shared experience and the emergence of a collective framework

IPA is characterised by its epistemological diversity evident from the emphasis on both hermeneutics and phenomenology. Analysis of data need not look for an either/or answer and can remain focused on both the idiographic and generic aspects of the data. Smith and Eatough (2006) recommend that high quality IPA studies allow themselves to fluctuate between the identification of the generic themes within the analysis and the identification and interpretation of specific elements of participant narratives. Smith et al (2011) and Eatough et al (2008) suggest that the presentation of results from IPA studies should represent the specifics of participant accounts and should be embedded within a collective framework which represents the phenomena under investigation.

Within an IPA methodology a representation of any analysis which examines both generic and individual elements of the experiences of the phenomena under investigation are, according to Smith et al (2011) and Hefferon and Rodriguez (2011), idiographic as the account is produced as a result of working from the individual accounts through to wider and more general claims. This is different from other qualitative methods which collate large scale data sets to make nomothetic claims (Smith, 1999).

This study involves a small population of registered nurses all working within the same clinical area, caring for similar patients and sharing a co-constructed social world. Whilst there are many other AAU departments nationally, each will have their own unique process, organisational-cultures and shared values separating them from each other. This research does not seek to make widely generalisable claims about the well-being of AAU nurses nationally, but rather seeks to explore the experiences of those nurses working in a given AAU. IPA is decisively inward looking with the aim of understanding a given group's experience of a certain phenomenon in a specific context (Smith and Osborn, 2008) with findings being compared to other studies later. This approach is significantly different from other methodologies such as grounded theory which instead seeks to broaden its sample to make findings increasingly applicable to wider settings.

3.14 Research Methods

The coming sections outline the methods of this study.

3.15 Rationale for interviews

The approach to data collection is fundamental in any research project and, the chosen method must be appropriate to the methodology. In IPA studies there is a requirement for rich idiographic data which records not only a narrative but linguistic elements and body language (Smith et al, 2004). Smith (2008) recommends several options including the use of semi-structured interviews as they allow researchers to guide the discussion/interview without leading participant responses. Given my research aim, I could have asked one nurse to complete a diary about their own health and well-being over time and whilst this would be an appropriate approach, I felt interviewing a sample of participants allowed me to achieve greater insight into the experience of nursing in AAU and the socio-cultural issues at play.

An interview schedule was designed including several general questions to guide discussion, the schedule allowed flexibility for probing and detailed questioning where necessary as recommended by Smith (2008). The schedule was tested prior to use in participant interviews, test subjects were willing volunteers from among my peer group. The interview schedule was found to be appropriate and flexible enough to allow participants to recount their experiences.

Semi-structured interviewing is in the main a collaborative endeavour which views participants as the experts in their own experience (Brocki and Wearden, 2006). I had to remain cautious of a perceived power imbalance given my senior status within the Trust, this had potential to limit the openness and collaborative nature of the interviews. I addressed this by wearing civilian clothing to interviews and introducing myself as a research student and not as a hospital trust employee. There is an epistemological assumption suggesting what a person says is always, in part, a reflection of their experiences (Smith and Osborn, 2003) and therefore interviews are further identified as a useful means to explore participant perceptions.

 Smith (2008) reports that precontemplation of possible participant responses allows

the researcher to respond more appropriately to participant answers and listen more attentively throughout the interview modifying questions as necessary to probe areas of interest as they arise. Smith (2008) goes on to describe the requirement to balance attempts to elicit in-depth responses against the potential bias which could ensue if participant responses became led by the researcher's questions. As a novice researcher this was a potential pitfall, however, practicing interviews with peers and developing a well-planned interview schedule allowed me to develop my technique and approach prior to participant interviews. This meant interviews remained focused but allowed the emergence of unexpected areas.

3.16 Interview content

Participants interviews focused on several key areas centred around their nursing careers and clinical experience, personal perceptions and view of well-being, where they saw themselves in future and how they thought nursing impacted upon them. Having considered the recommendations of Smith (2008) this appeared to be the most appropriate, chronological and logical order in which to approach the interviews. The interview schedule is at appendix 1.

Questions were designed to unearth participant's stories of what it is to provide care to the acutely unwell within AAU and what it gives or takes from the individual participant. The focus on participant stories affected the approach to question design, Holloway (2001) proposed that qualitative interview questions should encourage story telling rather than the provision of explanations therefore, why/how questions were not used in the main question set although there was the option to use these where probing was required. After consideration of Willig (2001), who believed that meaning and experience are intertwined, I decided to prioritise the idea of participant led interviewing. This approach meant responding to participants disclosures and facilitating their story telling using additional questions, pauses and responding appropriately to non-verbal ques. I applied this approach to maintain a sensitivity to context and IPA methodology. Allowing participants to affect the flow of the interview, pace of questions and attending to their comfort levels allowed me to secure rich data.

I considered asking participants about any underlying health issues as this could have offered additional insight into how perceptions of well-being are affected. After

consideration (and in keeping within ethical approval) I decided that this could place participants in a vulnerable position, increasing the potential for discomfort which Edwards (2005) suggests might cause them to limit disclosures or to withdraw from the study.

Questions were designed based on my own presuppositions and from nurses' accounts in online forums. According to Fade (2004) it is useful to have some pre-identified themes for discussion when conducting semi-structured interviews, and, as recommended by Fade (2004) the emphasis must remain focused on adopting an inductive and idiographic approach in which the researcher avoids leading participants into predetermined areas of interest.

The purpose of the interviews was to collaboratively uncover participant experiences. In preparation for this I discussed interview strategy and techniques with my supervisors and senior researchers within my organisation. My role was primarily to guide discussions and ensure participants were comfortable and felt like they were in a safe space. Brief light-hearted chat and the offer of drinks and a private comfortable space were offered before the commencement of each interview.

3.17 Sampling and recruitment

The study sample was recruited from a single AAU department and was purposive in nature. Posters outlining my study were displayed in the AAU staff room and ward office and participant information sheets were left in the handover room and nurses' station so potential participants could read these at their leisure. I attended the AAU staff room one week later in plain clothes to avoid participants realising my senior status. I used this visit to speak to available nurses about the aims and methods of my study and to offer them the opportunity to ask any questions they had in relation to the study. I repeated this process one week later to speak to any staff that had not been available at my first visit, on both occasions I asked any potential volunteers to contact me via email or telephone to arrange a further discussion and issuing of consent forms. After two weeks I attended AAU once more wearing plain clothes and held a brief discussion with each volunteer and reiterated their volunteer status and right to withdraw. They were provided with consent forms at this point and asked to consider their participation for a few days prior to being consented. I returned three days later to

collect consent forms.

Six volunteers came forward, all of whom met the inclusion criteria and as such all were interviewed in the study.

Sampling within IPA studies involves the recruitment of small, usually homogenous samples meaning the participant group are "closely defined" (Smith, 2008, p.56) and for whom the research question will be of particular significance. Hence, IPA tends to be less focused on random or representative samples instead, recruiting and sampling is largely based on the phenomenon of interest (Smith et al, 2011).

According to Smith and Eatough (2006) IPA and ethnographic researchers often attempt to investigate a specific context, culture or phenomena instead of investigating wider society/culture. As such the resultant findings are less generalisable but do offer specific and valuable insight into specific groups. This approach is clearly founded in the context-based epistemology of IPA whereby the emphasis is on context specific findings and in the ontological vision which sees knowledge as dependent on situation, circumstance and locality (Madill, 2009).

Within quantitative methodologies and in many qualitative approaches there has traditionally been an assumed connection between the number of participants and the overall quality of findings (Reid et al, 2005). Smith (1999) and Smith and Eatough (2006) argued the IPA approach being focussed on lived-experience, context and process need not recruit such large samples, instead, it is argued that a small homogenous sample ranging between six and eight (Smith and Eatough, 2006) or three to seven (Smith et al, 2011) is sufficient especially in post-graduate research projects. Brocki and Wearden (2006) advocate a less is more approach and suggest larger samples should be reserved for focus groups or comparison studies. It is widely argued (Brocki and Wearden, 2006, Smith, 2006, Hefferon and Rodrigues, 2011) that larger samples contradict IPA's commitment to idiography and often become too broad, loosing focus on specific phenomena and context.

3.18 Participation

All participants were volunteers who met the inclusion criteria and were happy to take part in the study. I met each volunteer in person to allow them the opportunity to

discuss the research, they were left with information and a consent form which was collected not less than 48 hours later. The below table shows participant demographics:

Table.4

Participant No.	Pseudonym	Age	Sex	Qualified	AAU Years
1	Amy	34	F	2015	3
2	Sara	28	F	2014	3
3	Rob	26	M	2014	3.5
4	Lee	30	M	2011	6
5	Beth	51	F	2002	1.5
6	Eve	25	F	2014	3.5

3.19 Ethical approval

This research was approved by the Cardiff University School of Healthcare Ethics Committee and sponsored by Cardiff University. The project was approved by the hosting NHS trust's Research and Development Department. The project was discussed with the AAU manager who gave permission for the research to be conducted within her department. Cardiff University Ethics Committee approval is at appendix 2 and the host NHS trust Research and Development approvals can be found at appendix 3.

3.20 Inclusion and exclusion

Participants were purposively recruited following the process outlined at 3.17 based on their employment in AAU. The sample was relatively homogenous in the sense that all participants were registered nurses working within the same AAU and caring for acutely unwell patients on a regular basis.

The inclusion/exclusion criteria were simple but allowed for an appropriate sample to be recruited. Anyone off work due to ill-health or maternity were not invited to participate, student nurses and non-registered auxiliary nurses and healthcare assistants were also excluded.

All participants met the following inclusion criteria:

1. Registered nurse
2. Employed in AAU
3. Personal lived experience of caring for the acutely unwell
4. Aged over 21 (minimum age at which a nurse can qualify)
5. A good degree of spoken English to ensure quality of interview data.

3.21 Informed consent

Having shown an interest in taking part in the study, potential participants were provided with a personal copy of the participant information sheet (Appendix 4) and given a period of no less than 48 hours to consider their decision. All participants were offered the opportunity to ask questions and care was taken to ensure they had a thorough understanding of the research and their role within it. Participants were reminded of their right to withdraw at any point and that they were under no obligation to take part. Those in agreement were asked to give written consent on the form at appendix 5.

3.22 Confidentiality

Cardiff University data guidelines and the NHS Code of Confidentiality (DoH, 2003) were adhered to throughout this project. Participants were allocated pseudonyms to protect their identity. All personal identifying data was stored separately from the anonymised data and was only accessible to the researcher. All hard-copy data was stored in a locked box within a locked office and digital data was stored on an encrypted device when in transit and on password protected folders on my personal computer.

3.23 Participant's well-being

During the initial design of the study, I realised there was a potential risk to participant's well-being, this risk took the form of emotional distress arising from their disclosures and recounting of difficult experiences. This risk was highlighted on the participant information sheet and all participants reminded of their right to pause or terminate the interview at any time. Occupational health services within the host site and the staff confidential counselling service were available to support any participant

requiring their help.

The participant information sheet also highlighted the potential need to breach confidentiality should a safeguarding issue be uncovered, again participants were reminded of this and agreed when signing the consent form. At the beginning of each interview participants were reminded of the risks of poor practice being disclosed and the possibility of me needing to report any danger to patients. Time was also allocated at the end of each interview to ensure participants were not distressed and were content with the manner their interview had been conducted.

3.24 Researcher's well-being

This research was conducted within an NHS hospital in Northern England and participants were all Registered Nurses and employees of that trust. Cardiff University lone working practices and Trust policy were always adhered to. Interviews took place in non-clinical offices within AAU and my whereabouts was communicated to my manager prior to each interview, I also carried a mobile phone which remained on silent. A reflective journal and regular supervision were used to assist me to process my thoughts and feelings, especially those regarding difficult clinical interactions or highly emotive subjects. This process served as a means of decompressing and was useful in maintaining my well-being.

3.25 Data analysis

The coming sections attend to how data was analysed.

3.26 Levels of interpretation

Hefferon and Rodriguez (2011) caution against IPA becoming an easy choice for those who incorrectly view it as a simplistic thematic analysis. Larkin et al (2011) goes on to warn of the tendency to offer reflection based on participant accounts rather than focusing on interpreting meaning within the data. Smith et al (2011) claims successful IPA studies move beyond simple reflection or thematic analysis and offer contextual interpretation and critical examination of the participant story in a given context.

Smith et al (2011) suggests that interpretation in IPA requires a deep and thorough immersion in the data. To achieve this after each interview I listened to the audio recordings no less than five times, firstly making notes on areas of interest, then noting linguistic detail such as pauses, hesitancy, repetition etc before moving on to detailed transcription. Transcription was done alone in my office with the audio played through a speaker, I found this helped me to become immersed in participant accounts.

Transcripts were read several times, on initial reading I made general notes on things such as areas of interest, possible themes and language use. This progressed to line-by-line coding and analysis to identify individual emerging themes. Following individual participant analysis, all transcripts and notes were considered as a collective and cross case analysis conducted, several superordinate themes were identified for subsequent interpretation.

3.27 Individual idiographic analysis

This process involved repetitive reading of transcriptions and listening to audio recording of interviews, printed copies were annotated with initial thoughts and ideas. The transcripts were highlighted in several colours each represented a facet of analysis, for example, green represented directed quotes used to illustrate possible emerging themes whereas yellow represented areas of interest. An example of an annotated transcript is at appendix 6.

Transcripts were then printed and cut up to give individual comments and statements which were laid out on a large area of floor. For each participant these segments were then clustered according to their interrelatedness, for example, statements pertaining to the stress of working in AAU would be grouped together to form a cluster. Following this, clusters were grouped to form individual participant themes. What resulted was a table of emergent themes for each participant, an example of this can be found at appendix 7. The titles of these emergent themes for each participant were then written on A4 papers and colour coded according to participant. These were cut out up and grouped into clusters, these clusters of participant themes were used to identify the superordinate themes discussed in the cross-case analysis. A photograph of this process can be found at appendix 8.

Chapter 4 provides a written account of each participant's analysis.

3.28 Cross-case analysis

Cross-case analysis involved the examination of each individual participant analysis and the grouping of themes into master themes. This process involved printing each analysis and cutting out quotes to support each emerging master theme. Having completed this process a table of master themes and their corresponding themes and sub-themes was produced (this can be found in chapter 4).

3.29 The researcher's role

IPA offers an active role for researchers (Smith et al, 2004 and Smith, 2011). Ely et al (1997) argue that themes are housed in the data and can be found simply by looking, this is countered by Smith et al (2011) who suggests that if themes are to be found anywhere then they are found in the mind of researchers as we read and consider our data.

This position is linked to the interpretive aspects of IPA and support the notion that researcher and data are linked in such a manner that the researcher identifies themes through their own interpretation of the participant's interpretation of their experiences. This can only be achieved by the researcher becoming a "person in context" (Larkin et al, 2006. P.106) much in the same way the participant is.

Smith (2008) discusses the requirement for researchers to remain immersed in and engaged with the data to allow for the identification of meaning analysis must be a balance between phenomenological insider and outsider positions, a balance between the interpretations of both individual participant accounts and the cumulative interpretation made by the researcher. I was aware of my presuppositions and whenever a theme was identified I repeatedly returned to the data to check the themes I was identifying were grounded in the participant experience and not my own.

3.30 Transcription

I transcribed participant interviews within 24 hours of recording. Transcription times

varied from 4 to 7 hours depending upon the length of the recorded interview. Transcripts were double line spaced and contained 3cm margins to allow for initial coding and notes. This process allowed me to become immersed in the data and as such the participant's world, according to Smith, (2009) this forms a significant part of the interpretative process and whilst laborious has proved valuable in helping me interpret data and to identify, challenge and reflect upon my own pre-suppositions about possible themes.

3.31 Ensuring quality

I have used Yardley's (2000) framework for ensuring quality as recommended by Smith (2011). The below sections are titled according to that framework and present an explanation of the commitment to quality in this study.

3.31.1 Sensitivity to context

Yardley (2008) claims good IPA studies demonstrate sensitivity to context. My choice of IPA demonstrates an early appreciation of the need to remain sensitive to context as the need for this study to focus on the particular and idiographic was a key influence on my decision making. This sensitivity continued through the design and execution of the research. Smith et al (2021) suggests studies are only as good as the data collected from interview, I ensured that in each interview I attempted to relax participants by ensuring a calm space for conducting interview, demonstrating empathy by pausing and allowing breaks when participants became upset and being alert to interactional difficulties especially those arising during emotive questions.

Sensitivity to context continued through the analysis phase where I remained immersed in the data through a process of repeatedly returning to it to ensure the participants voice remained prominent. The analysis chapter includes many verbatim quotes from participants demonstrating commitment to projecting their voice and allowing readers to become immersed in the context of the study. This sensitivity continues into the discussion chapter where relevant empirical evidence is used to support the claims, I make arising from the analysis of participant experience.

3.31.2 Commitment to rigour

To enhance rigour several procedures were implemented. The sample was selected carefully based on participants' relation to the research question and interviews were not time limited. This allowed participants to speak freely, without pressure allowing me to gather rich idiographic data required for analysis (Smith et al, 2009). Data was analysed using an iterative approach which involved listening to recorded interviews several times, transcription was done by myself to improve my immersion in the data, reading and re-reading of transcripts was performed alongside note making and reflexive commentary as recommended by Smith (2004). As a novice researcher I found it difficult to ensure the participant voice was not overshadowed by my own, supervision and consistently returning to the data eventually allowed me to overcome this issue.

The researcher clearly has an influence upon the overall conduct of the study but crucially they play a key role in recording individual participant accounts which must be interpreted. As a senior AAU nurse, I have had experience of caring for similar patients to my participants and have worked in comparable environments, this could impact upon how I interact with the data and as such I attempted to always remain sensitive to not allowing my own experiences and ideas to overshadow participant voices, this was done by noting my presuppositions in my reflexive diary and returning to these and to the interview data whenever a new idea or potential theme was discovered. According to Yardley (2008) reflexivity is the consideration of the researcher's influence or potential influence at each stage of the research and it is suggested that transparency and as such validity, can be enhanced where the researcher remains committed to the reflexive process throughout. Throughout this study I maintained a reflective diary as well as a reflexive approach to each stage of the study.

3.31.3 Transparency and coherence

Transparency and coherence relate to the quality and accessibility of the research write up (Yardley, 2008; Smith et al, 2011). I have remained cognisant of the requirement to present details, practicalities and procedures in a clear and structured manner throughout, for example this chapter outlines how sampling and interviewing was conducted. Readers should be able to follow the progression and development of the study from inception through to conclusion and I feel that after several iterations of this thesis this has been achieved. The philosophical underpinnings of the IPA methodology

are hopefully evident and allow the reader to feel as if they are making sense of my attempts to understand participants' sense making. My commitment to transparency and coherence was complete but, only readers can determine my success or failure.

3.31.4 Impact and Importance

Yardley (2008) claims that the true test of validity is whether the study tells readers something interesting or important. Smith et al (2011) suggest this is true of IPA studies and I invite readers to draw their own conclusion on this matter.

Chapter 4 – Data Analysis

The first part of this chapter attends to individual participant idiographic analysis.

4.1 Amy

Amy was the first participant interviewed; she was married with two young children. She grew up in the area but left to go to university in Southern England. On qualifying in 2015, she returned home and had been working in her local hospital since. She was a band 5 staff nurse aged 34, she had worked in AAU for 3 years; prior to this she spent a short while on another AAU at a different site within the same organisation. The interview lasted 49 minutes and was held in a meeting room within the host site.

Amy was confident, articulate and appeared to be considering her answers. Analysis of Amy's transcript revealed several themes. The below table shows how Amy's themes eventually became part of the study's main themes.

Table 5 showing development of themes from Amy's interview

Sub themes from Amy's interview	Fit with cross-case superordinate themes
In it together	I feel like I'm drowning
Coping mechanisms	
Nature of AAU	
Stress self-doubt and anxiety	
Fear of becoming a patient	I don't want to end up like that
Exposure anxiety	

Nature of AAU

"*it's acute innit. The sharp edge of nursing I suppose.*" She considers AAU to be the forefront of secondary healthcare, her description suggests a cutting-edge environment. Amy described her role as varied and unpredictable professing that "*anything can come through that door*". She understood AAU to be busy and fast-paced in which variety and acute patient presentations are expected, she also recognised the learning and development opportunities that this environment offers: "*you get the opportunity to develop and practice your skills in that acute environment*" this has led Amy to believe that a competent AAU nurse can work effectively in many other clinical arenas.

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"*and if you can work in that challenging environment where patients become sick really quickly then you can probably work in most areas*".

Amy was a relatively junior nurse and her preconceptions of AAU led her to believe that working within this area had kudos attached to it, she attributed this to the acuity of patients presenting for treatment.

"*Because it's acute and in my naivety as a nurse I thought to work in an acute area has kudos attached to it*"

As she spoke Amy took a sharp intake of breath and grimaced. She later told me of the stress and anxiety that her work has caused, but not before describing AAU as;

"*A bit like A and E only harder. I guess like because you've got more patients but of the same level of illness. Straight from ambulance, GPs, you've got more of them and more paperwork but less doctors around you to help you. It's tough.*"

She believed the increased patient flow, reduced medical staff and higher administrative burden are the components which make AAU a harder working environment than Accident and Emergency (A&E). Amy had not worked in A&E, so this statement is based on her own ideas of A&E work as compared with her own work in AAU. These factors which drive her belief that AAU attracts kudos are what she went on to describe as a source of stress.

Tasks, time, and stress

"*I admit the patients so that involves doing their observations, blood and putting in cannulas. Erm, writing up the front sheet and making sure the doctor reviews them*"

Describing her typical day, Amy listed several tasks and duties, she made sense of her role in terms of the things she is able or unable to achieve during the shift, she spoke of these tasks on several occasions when describing her daily routine and there is a notable absence of references to her patients as more than a vessel through which tasks and duties are discharged.

"*I erm give out medication and carry out any treatment that has been asked for by the doctor. I give out meals at mealtimes assist with washes, fill out care plans and discharge patients home or to other wards, change bed, do washes.*"

Amy described feeling like she had failed at times when she was unable not meet her targets, although it was unclear whether she meant she had failed herself or her patients. It was apparent that she perceives pressure to perform tasks in a timely fashion;

"there's an expectation that certain duties should be done in a certain time frame and when they're not you feel like you've failed."

This suggested Amy recognised that she is unable to perform all the tasks presented to her and she created metaphorical lists which she attempted to work through, often unsuccessfully.

"Like just lists and lists in your head you, you just, well you just can't do it."

She recognised that she cannot perform all her duties, and this became a source of stress. It seems significant that she changed to second person when discussing this inability to complete duties. The change suggested an attempt to distance herself from her failures

"you try to do too much, try to be faster but then you make more mistakes and it just gets more and more stressful."

Continuing in second person Amy described a sequence of events where she attempts to perform task faster to accomplish that she believes are expected of her, this increased tempo inevitably leads to mistakes which add an extra dimension to the experience of task related stress she experienced. This sense of failure meant she became acutely aware of her experiences of stress, so much so that *"You get worried sick"*. This powerful statement suggested her experiences of stress have gone beyond what might be perceived as healthy and has entered the realms of harmful and disruptive.

"The stress of the job makes me stressed, it causes stress"

Amy recognised the challenges of her role and stress it caused, it is noteworthy that she spoke of stress being the cause of her stress, this tautology is interesting and possibly linked to Amy's experiences of stress in herself and others. It raised questions about how she perceived stress and its causes. She had experienced physical exhaustion resulting from her continued attempts to perform her duties at the rate she believed to be expected for success; *"It can be quite stressful. It's a challenge, you don't stop for 12 hours, its knackering."*

The impact of stress left Amy feeling overwhelmed, she described feeling sick when thinking about her working day and has become so overwhelmed by the stress she feels as if she is drowning;

"I actually feel sick when I think about my day, like I'm drowning. I'm drowning in the stress, the horrible things I see, the fear and worry and just wish I could you know? I wish I could just float away into something else"

The sense of drowning and desire to float away are important features of Amy's sense-making. She used these metaphors to express her wish to escape from her work. Amy

used these and similar metaphors several times throughout the interview and rationalised her metaphor saying;

"because sometimes on an AAU you can feel like you're just keeping your head above water. A good day is a day you don't drown."

Once-more there is a return to second person possibly indicative of another attempt to separate herself from difficult experiences or feelings. She does not say I am drowning despite meaning exactly that, she struggled to process her stress and in saying *"just keeping your head above water"* she recognised she is struggling to cope and demonstrated this further when explaining that a good day is one *"when you leave and feel you've managed to handle the shift"*.

When asked to explain a bad or stressful day, Amy replied:

"A bad day is; when you've been involved or a drug error or you've sent a patient home without keys and you're struggling to get hold of a taxi to take the keys and someone has just put another patient in the bed the patient has left that you need to admit but you can't, and they might be really ill but you can't see them because you're phoning everyone trying to sort the bloody keys."

Amy made numerous references to the things and tasks that happen around patients not to patients themselves. She seemed concerned with the administrative burden or minor tasks that impede her ability to complete duties. She went on to say; "*I will take between 4 patients on a good day and 6 on a bad day.*" She referred to a bad day as one where she is responsible for a greater number of patients, it is reasonable to assume based on her previous statement that higher patient numbers incur more tasks. Patient acuity does not seem to feature in her approximation of whether a day is good or bad. Listing only the number of patients as the determinant factor of a good or bad day suggested that 4 very ill patients would still be a better day than 6 well patients.

Amy's experiences of work-related stress have begun to impact on her personal life, and she has begun ruminating on her experiences; *"I think you just play it in your head, over and over on the drive home."* She is aware of this and has begun questioning her motivation and desire to continue in AAU.

"because of the pressure and demands and the stress I wonder if it's all worth it, you're putting yourself on the line every time you walk into this ward"

She spoke again in second person, this time about a sense of putting herself on the line, she explained this as the feeling of making herself sick for benefit of others;

"When the stress piles up and I start to feel fed up or like I'm making myself sick for

other people then yeah."

Amy made sense of her experiences of accumulating stress through the metaphor of drowning. She recognised physical and mental tolls it has on her which has led her to question her motivations and reach a point where she believed she has become sick for the benefit of others.

Self-doubt and Anxiety

Amy described circumstances where she suffered a sense of anxiety and self-doubt regarding her clinical performance. This appeared linked to stress but is a separate theme in that she understands and interprets her experiences of each differently. The above section described Amy's experience of stress as a sense of drowning and was linked intrinsically with task completion. Her experience of anxiety and self-doubt, however, are linked more to errors and inability to perform to the expected standard.

"Yeah, you think about, you feel, well, you want to be a nurse don't you? You know you want to be on top of things and do things right for your patients but sometimes AAU doesn't facilitate that in the sense that so much going on that sometimes things get missed"

Above, Amy again adopted second person, as if distancing herself from the statement. She spoke of a continued desire to nurse and to do it well. In going on to tell me that AAU does not always facilitate this she inferred that she is unable to always provide the standard of care she would like. The choice of second person may be indicative of her discomfort with this situation. Unlike her descriptions of work-related stress which related to the volume of tasks, in this instance Amy describes circumstances where things can be missed. She described a culture in which this is accepted;
"I think a culture on AAU where it's ok for things to not get done, you know?"

The impact of this inability to perform her duties according to her own standards has led to emotional experiences, she described being unable to provide optimum care to a terminally ill patient;
"I sat in the car in the car park and just cried and cried as I told them the whole event, from beginning to end because I was heartbroken and felt I had let the woman, and her husband down"

Her description gave a sense of the impact this experience had on her. Amy felt she had

failed her patient, and this caused her upset, both at the time and as she recounted the story during the interview. She is evidently passionate about her role and experienced anxiety when unable to perform her duties. This upset may have been related to her own expectations and standards rather her actual performance.

This and other experiences of not performing or completing her duties to a high standard have led her to question her performance and experience self-doubt;

"it does make you feel that you need to do better".

The above statement suggests Amy's experiences are not only impacting her in terms of stress and anxiety (the need to do better) but also upon her sense of self (the need to be better).

The impact of self-doubt has led Amy to experience anxiety which she likens to an illness; *"You get worried sick."* Once more Amy uses the second person describing these feelings. It was apparent from her shifting in her chair and avoiding eye-contact that she was uncomfortable; however, this body language and linguistic distancing accentuates the potency of her experiences. In contrasting the anxiety arising from self-doubt against her experiences of task-induced stress Amy claimed;

"I would say my professional work probably affects my mental well-being far more than my physical well-being".

This section considered Amy's sense of self-doubt and experiences of anxiety which have arisen from her work on AAU, she described a feeling of needing to do and be more and feelings of failure when she was unable to complete tasks.

'Cancer is everywhere'

Cancer featured prominently in Amy's narrative, she made reference to cancer, cancer patients and her fears of developing the disease at frequent intervals throughout the interview. Amy said; *"cancer is everywhere"* and this was certainly true of her interview.

"I have no intention of taking an overdose or doing heroin, I'm quite young and do plenty of exercise and I eat quite well so the chances of me having a heart attack are quite slim. I don't have any long-term conditions, so probably the most likely thing to my mind is cancer, it's more of a possibility for me I suppose than a lot of other things I come across day to day."

Amy appeared to rationalise her perception of the risks of developing cancer, ruling out other causes of illness suggesting that she maintains a healthy lifestyle and is unlikely to take an overdose. She hints at her health status saying she does not suffer from any long-term conditions. For these reasons she has come to believe that cancer is the illness most likely to affect her, she appeared considered and thoughtful as she made these statements. She apparently rationalised her conclusion based on her health beliefs and exposure to other illnesses and patient groups.

When discussing patients and diseases, Amy skipped over her experiences of other illnesses and instead choosing to recount in greater detail her recollections of dealing with cancer patients and their relatives.

"most patients who come in there in and out aren't they, you know? Paracetamol overdoses treat and they leave or heroin addicts who come and go or a heart attack they get moved on quickly too. But cancer it sticks around. It's closer to you than you think I suppose, you just never know what's coming."

The above passage is indicative of Amy's experience and anxiety, when describing other patient groups, she uses words such *"they"* and *"who"* suggesting the patient experiences the illness while she experiences the patient whereas with cancer patients she made no reference to patients instead employing the word *"it"* describing the disease rather than the patient. This appeared to gives the disease a significance and independence from the patients, Amy has personified cancer in her descriptions of *"it"* as something which sticks around *'lurking around the corner.'*

She referred to cancer as being close and unpredictable. She appeared to make sense of her experiences by comparing the ages of sufferers to that of herself and those closer to her age are given greater significance in her experience.

"I think probably for me my most memorable patients are, a lady with non-Hodgkin's lymphoma who came in with horrendous pain and what struck me was that she was probably only in her early 40s (.) and again there was a man in his 50s with pancreatic cancer who is absolutely my most memorable patient"

She described being struck by the ages of these patients and described them being her most memorable. Her choice of words was particularly pertinent, she used *"my"* when describing these patients as if taking ownership of them and their experiences of the disease and mutual suffering, the pain of the patient has become her own, she told me; *"you always feel for those patients"* and *"they always deserve more from you"*. Again,

Amy reverted to second person when making these statements, this perhaps reflects her anxiety about cancer, here we see her attempting to distance herself from the fact that it is her who feels for these patients and that she feels they deserve more from her. It is unclear why she feels they deserve more but it seems evident that Amy is worried about developing cancer herself and sees it as an ever-present threat to her health;

"to me because of the increased exposure regularly it makes you feel cancer is everywhere, it's all around me, following like."

Amy explained the idea of cancer following her in terms of regular exposure to those suffering with it. She compared patients to her family and friends and drew parallels which have cause her to become convinced that cancer is inevitably going to impact her or her loved ones;

"these people are my mother's age, brother's age, my age and I always think about that; if these people have it then it is going to happen isn't it, someone close to me is going to get it surely."

She believed her role in AAU increases her contact with cancer, and compares her private and professional life explaining that she sees far more cancer at work;

"it makes me, well I think somebody who didn't work in nursing would well outside of my professional life for example; I know of one, two, three, four, four people who have had cancer in my private life. In my professional life in the years to date I couldn't count how many (...) a lot, too many, a significantly higher number than four"

Amy has become increasingly concerned about cancer as her exposure to it has increased, she described a constant fear of her or her family developing *"these horrible things I see"*. She has become so concerned about cancer that she has altered her health behaviour and lives with the assumption that *"cancer will get me; I never miss a smear test"*. Amy believed cancer to be an inevitability for her and has become very aware of the presence of cancer and cancer patients in her work. This has led to hyper-vigilance regarding her own health. She explained this by once-more personifying cancer, describing it as shouting and reminding her of its presence. She appears to attribute this hyper-vigilance and anxiety to her job;

"If you had just seen four, it would be rare something you know exists but is hidden, being a nurse lets it out, makes it visible shouting and reminding you it is there, and you can get it just like that at the next turn of a corner"

The above quote further exemplified Amy's personification of cancer and the fear she experienced. Cancer scared her when she first encountered it and this fear has never left her, *"when you first come across cancer, it's scary. It still scares me now."*

Amy's experiences of caring for cancer patients has shaped the way she thinks to the

point that she fears encountering these patients;

"it' scary to see these things every day. I don't want to end up like them."

"I often feel I'm working myself sick, but all nurses are worried about what they see, we all worry about getting some disease or another, it's like part of the job you know"

The fear and anxiety caused by continued exposure to cancer led Amy to believe her work was impacting negatively upon her health, she described working herself sick as if this is a choice that she makes yet she dismissed this powerful statement suggesting all nurses are fearful and that it is part of the job. It is linguistically significant that she described fear/experience in first person before making a broader statement claiming a shared experience of fear, in the closing words of the sentence she questioned me (*"you know?"*) as if seeking reassurance that her fears were widely shared.

Amy made multiple references to collective fear and health anxiety throughout the interview, she expressed a belief that nurses in areas outside of AAU also experience these negative cognitions, and claimed the issue goes beyond fears of cancer and involves nurses worrying about stress, pressure and health issues;

"I think wherever you go now there are pressures and nurses are struggling and worried about getting sick or stressed, for me it's cancer but we all worry about what we see. It's daft but, you know?"

Amy returned to her fears of cancer which for her is evidently very real and yet, she attempted to dismiss it as *"daft"* and immediately goes on to seek reassurance for her feelings. Her anxiety is evident throughout the interview and was a dominant element of her narrative and sense making, it was interesting to hear Amy say;

"I mean, don't get me wrong, I don't spend all day wandering around thinking oooh cancer, it just sits in the background but every now and again I get to thinking on it and worrying."

This was significant because, against the backdrop of continuous references to cancer, cancer patients and her fears it was a striking statement, it seemed in direct contrast to her declaration that cancer would *"get"* her. Here Amy claimed she does not continuously worry about cancer and that it is a background thought which occasionally rises to prominence. This is at odds with her numerous statements about her *"constant worry"* and the anxiety this has created. This could be Amy's attempt to downplay and minimise her fear of cancer, she described her fears as *"daft"* which might suggest she considered her fear irrational, her body language and tone as she said

this was dismissive but, the statement was clearly at odds with the rest of her interview. Interestingly, very soon after talking of cancer as a background thought she went on to give yet another example of how this disease has shaped her thinking and health behaviours;

"my son had a little lump in his neck and because of the things I know, you can't help wondering if it's leukaemia or if it was this or that and everybody can think that or Google stuff and come up with anything, but I often think people who aren't in this profession probably worry less, I do wonder that, but I don't know the answer"

Amy questioned whether non-nurses experience the same fears as her hypothesising that those working outside of healthcare worry less about their health as they do not encounter the sick and dying continuously. She conceded not to know the answer, but was curious about the health anxieties and experiences of the wider population.

"I do wonder how people who aren't nurses and don't work in this kind of environment you know, how often it crosses their mind and do they worry"

The fear Amy experienced led to hyper-vigilance, stress, anxiety and fear of herself or her family developing cancer. Her considerations of whether non-nurses experience similar fears and her supposition that they do not led her to consider leaving AAU in the hope that she can answer the question, *"Would these things be in my mind less?"*.

Cancer is such a source of anxiety for Amy that she personified it, describing it as a threat which was waiting to get her. She is scared and has started considering if different employment might allow her fear to subside.

In it together – coping and support

Amy has shown herself to be experiencing work related stress, time pressures, self-doubt, and fears for her health, in the above section Amy disclosed her thoughts about a life outside of AAU, this section focuses on Amy's support network and reasons for staying in her current role. When asked what made her stay, Amy described a sense of camaraderie and mutual support and togetherness. She described a clinical incident in which she made a serious medication error;

"I made a drug error, quite a serious one, and the sister came to support and, and assist me, the first priority was to make sure the patient was ok obviously but then she was quick to make sure I was ok. She offered to explain to the patient's family on my behalf"

In the above statement Amy spoke of the sister making sure she was okay, Amy felt valued, and this supportive approach was important to her continuance in AAU. She described the above incident further saying;

"supported me through the process, no element of discipline. It was about making it right never any judgment from her and when others have done errors its always the same you know, we just try to help make sure it doesn't happen again so (...) if you needed help or you didn't know something you can go to any of the other nurses. There is never that, well attitude you can sometimes get in nursing when it's like; what, you don't know that. There is never any of that here. It's always ... yeah, no problem,"

Amy described non-judgemental and unconditional support and described a culture of shared learning in which help, and support is *"always"* available. She commented on the absence of an *"attitude",* her tone was indicative of negativity, she grimaced and took a sharp intake of breath as she made this comment. She did not expand on this negative attitude but what is important is that she felt this did not exist in AAU. Referring to the fast pace of AAU and the fact that mistakes are common-place, she once-more spoke of shared experience, learning, understanding and support offered to those making the mistake;

"people support each other when things like that do happen, they share their experience or show you how to do things, and they understand that things get missed and we... well, we support each other"

This statement was interesting as she began in third person as if suggesting she is separate from the mistakes being made and then changed to first person plural when talking of the support on offer. Amy feels like she is part of something which she perceives to be a positive and important element of her working experience and sense making and yet still tried to separate herself from the negatives of AAU.

"the job can be hard, we really support each other, you know we're all in this shit together, so we keep each other sane I suppose."

Amy described a togetherness born from the *"shit"* of the job. She found comfort in the shared sense making and mutual support that being part of AAU brought. Amy Spoke of the team keeping each other sane and suggested that this supportive, reassuring presence is the primary reason she stays in AAU;

"If it wasn't for the team I would be gone, we support each other"

She explained this in terms of shared experience and the opportunity to decompress, Amy used the term *"offloading"* to describe the process of collegiate discussions and

sharing experiences and reflecting. This was important for Amy allowing her to let go of the stress and anxiety she experienced. She described sharing the stress and talking about fears within a group, she found reassurance here which reminded her she is just like her colleagues. Amy believed they were all *"in it together"* and this makes her feel like she is normal despite her stress, cancer fears and other anxieties:

"what makes it easier is speaking to other nurses, knowing it's not just me, we all have our fears or worries but we reflect together. I don't mean in a formal way like, but just offloading, letting it go, talking to a colleague or nurse friends over a coffee you know just letting it all out and telling each other that you're being daft, and you aren't harbouring a tumour or something."

This mutual support was vital to Amy, who believed;

"We have to help each other through, if we didn't, we'd all be broken."

Her word choice here indicates the value she places on being part of the team and the cathartic benefits this brings. The use of first-person plural is indicative of shared experiences and values whilst the assertion *"we have to"* clarifies the perceived requirement for AAU nurses to offer and receive this support. The suggestion that in the absence of this support nurses would break is a powerful statement which offers insight into Amy's sense making which has been shaped and influenced by her work in AAU.

4.2 Sara

Sara was a 28-year-old band 5 staff nurse. She spent her first-year post-registration on a surgical ward, she was offered a move into AAU as part of a rotation programme and had been there for three years when interviewed. She described AAU as *"a natural fit"* and presented herself as knowledgeable and passionate, she appeared nervous which was apparent from her repeated use of *"erm"* and her withdrawn body language, however, she was articulate and descriptive in her responses.

The table below shows Sara's themes as they relate to the study's main themes.

Table 6 showing development of themes from Sara's interview

Sub themes from Sara's interview	Fit with cross-case superordinate themes
In it together	I feel like I'm drowning
Coping mechanisms	
Nature of AAU	
Don't drown	
Stress self-doubt and anxiety	
Fear of becoming a patient	I don't want to end up like that
Exposure anxiety	

Sara was passionate about her role but recognised that she was under a lot of stress due to working in what she described as an acute and fast paced environment. She spoke of the resilience required to *"survive"* in AAU and reported a need for well-developed professional knowledge and skill to be able to recognise deteriorating patients. She made clear that whilst a source of pressure, it is one on which she thrives.

"I wouldn't want to work anywhere else. I think if you can survive in AAU then you can survive anywhere as a nurse, the stress that it causes, the pressure on you to make sure that you identify any patient that is deteriorating and just that autonomous practice where you can put things in place to stop them going downhill is just so important for me."

Nature of AAU

The above quote introduced several factors effecting Sara's interaction with and understanding of her existence within AAU. Before examining Sara's themes, it is important to understand how she perceived AAU and her role. When asked what makes a good AAU nurse Sara replied;

"time management is critical, you've got to be able to manage between four and six patients that aren't OK, they come into AAU in an acute situation and it's managing their needs, making sure the assessments are done quickly, making sure the interventions are done in a timely fashion so that the treatment isn't delayed such as antibiotics, repeat bloods and erm referrals to appropriate teams are done quickly."

The criticality of time management is repeated throughout Sara's narrative, she spoke of this in terms of getting things done, completing tasks on time and the stresses of working in AAU. Sara was task focused, placing an emphasis on completing tasks in a timely fashion, she believed completing her duties quickly meant she was delivering quality care.

She spoke of the unpredictable nature of AAU.

"You come across different medications all the time and see conditions that you've never seen before and are expected to know how to erm, well, just what to do."

For Sara this was a positive and negative. She claimed to thrive on the variety and challenge that AAU has to offer but, equally recognised that this unpredictability can be a source of stress and anxiety.

"You are getting tested every day."

Sara felt she was not only being tested by her patients and colleagues but against her own standards too. The testing she experienced from patients and colleagues is more superficial and she managed this by always appearing to know her role and displaying outward confidence.

"You don't always know what to do but you have to appear to".

More complex, was the self-imposed testing and judgement;

"A bad day is when you leave and all you can think about is what you have left or missed for that patient, like not being able to deliver the fundamentals. A patient has been so poorly that 4 other patients have sadly not even had just the basics off you. You haven't been able to give them individualised care or even just take 5 minutes to sit with them and it's that bit where you imagine if it was your family member you wouldn't want them to be treated like that and you do go away a bit guilty a bit thinking I let people down."

Guilt and self-doubt featured throughout Sara's narrative and appeared to be caused by things beyond her control;

"It's frustration, guilt, it can be caused by so many things we don't control"

This appeared linked to things like patient movement, management, and other organisational factors. A second, and more upsetting cause of guilt and frustration were those factors she believed to be in her control such as; time management, task completion and execution of her duties. An inability to meet her self-imposed expectations were a great cause of guilt to Sara.

"You just become so frustrated that you can't do everything your role entails"

Sara expressed guilt as frustration and recognised that this led to feelings of self-doubt. She actively questioned her clinical practice and explained that this is a constant background process which increased her experience of stress.

"What did I miss, or did my practice directly relate to that incident?"

Feelings of guilt and self-doubt were a constant feature of Sara's work and caused a lot of stress and anxiety, this has become a chronic issue causing her to question her motives for nursing.

"You question why you even became a nurse".

Sara moves between first and second person when describing her experiences and feelings. When recalling specific examples, she readily used first-person taking ownership of her immediate feelings of guilt, for example, she stated, *"what did I miss"* However, when talking about this issue more widely or in the context of self-doubt she reverted to *"you".* This was interesting from a linguistic perspective as it appeared, she is attempting to distance herself from her feelings of self-doubt, especially those relating to her choice of profession. She stated she is proud to be an AAU nurse and stated it is a natural fit for her, therefore, to acknowledge she finds herself questioning her motivation to nurse must be very difficult to accept and perhaps she is subconsciously switching to the second person as a means of separating or denying these feelings of self-doubt.

Drowning, self-doubt and anxiety

This sense of self-doubt and guilt merges with Amy's experiences of stress and continued throughout her narrative becoming part of what she described as a sense of drowning and a need to stay afloat. Interestingly, Sara stated;

"Oh I wouldn't want to work anywhere else. I think if you can survive in AAU then you can survive anywhere as a nurse, the stress that it causes, the pressure on you to make sure that you identify any patient that is deteriorating and just that autonomous practice where you can put things in place to stop them going downhill is just so important for me."

Sara appeared proud making this declaration, as if being recognised or praised for her ability to fix patients. She spoke clearly and confidently in her declaration that she would not want to work anywhere else. This was powerful and poignant given that she went on to describe the fear, anxiety, reduced personal well-being and stress she encounters almost daily. Her determination and desire to continue nursing appeared greater than her desire to leave, this seemed at odds with much of her the narrative.

Sara spoke about surviving in AAU, this terminology conjured images of a dangerous

environment where one could be injured/killed and it seemed this is how Sara view AAU, she talked of stresses, time pressures and illnesses she encounters as if they are the dangers. Her survival is linked to her ability to cope with stress, perform tasks in a timely manner and exhibit a degree of skill in her clinical practice, her statement about not wanting to work anywhere else suggests she enjoys her work and considers AAU as a *"natural fit"* for her although this was not always the case.

"I was a bit naïve going into medicine, not much exposure as a student so I think that set me up for a lot of stress even more because I didn't have much insight. It was not what I was expecting."

Sara moved to AAU after one year of post-registration experience with little prior knowledge of acute medicine, she had become used to the routine of surgical nursing and admitted the lack of routine and variety of patients common to AAU presented challenges and stress. She had assumed she would find it a straightforward transition however;

"I was wrong, really wrong. AAU is really stressful and initially it was hard to stay afloat".

Sara again used the staying afloat metaphor to help explain her early experiences of AAU. It was comforting to hear Sara telling me that she can *"survive anywhere"* and despite the challenges she faced, she still enjoyed her current role. As the interview progressed however, she began to talk increasingly of the difficulties she faced eventually telling me of a sense of drowning in the stress, lack of time and sheer volume of tasks she is expected to complete. It seemed Sara wanted to believe that she is able to cope in AAU but is actually struggling to *"stay afloat"*. When asked what it means to be drowning, she stated:

"I guess I mean like I'm slowly sinking in the stress of lists, tasks, jobs from doctors, demands from the boss all the stuff about nursing that isn't really about caring for real people it's just crap we have to do so the trust don't get sued."

The language used to describe drowning suggests a gradual process arising from continual build-up of the *"crap we have to do"*. She talked about it being a slow sinking. Perhaps more telling is that the first mention of staying afloat comes on page 4 of the transcript, this is followed by a further five pages of description of stress, frustration, and lack of time to *"care"* before she finally recognised, she was drowning.

Not long after making this declaration she goes on to describe feelings of wanting to leave AAU. Sara recognised, *"You need to be able to cope with a lot of pressure and stress to work in AAU",* and it seemed for Sara the majority of this stress came from a lack of time and self-induced pressure to complete tasks quickly;

"I sometimes miss that [time to care] *in AAU and that for me is the worst part of the job. We miss these opportunities because of forms, bed pressures. Everyone, as well we are just too stressed to do it. There's no time anymore."*

Time and stress seem intrinsic in Sara's sense-making, and she felt stress was endemic in AAU. Above, she used *"we"* by this she meant the collective nursing team, she recognised increased personal stress but also observed it in her colleagues. Sara previously described her ability to survive anywhere because of her AAU experience. Unfortunately, this, according to Sara was not true of some of her colleagues who ultimately are redeployed to less acute areas.

"a lot of them on AAU they'll move them if they can't survive AAU, they move them to other what they class easier areas, so they won't have to cope with the stress again."

It is apparent that an ability to deal with stress is a necessary attribute of a successful AAU nurse. Sara described stress in many ways; frustration, time pressure, management issues, drowning and bad days to list a few. It was clear stress was gradually increasing and taking a toll on her wellbeing. She disclosed this early in the interview telling me;

"You're just frustrated, you hope the next day isn't going to be as bad as that again cos you just can't have those days one after another it's just starts to wear you down."

This statement offered a great deal of insight into Sara's experiences, she reverted to the third person as if distancing herself from her experiences. She described being worn down by the accumulation of bad days *"one after another"* and a feeling of hope, that the next day might not be as bad, this may be genuine hope but seems coupled with a sense of anxiety and fear which she described as frustration. This was reiterated when she stated;

"it's just like, there's so much going on, to think about that it just drives you mad. It can be really worrying and stressful"

In stating it drives you mad, Sara appeared to be recognising the toll her work is taking on her mental health, she experienced anxiety in her work which has increasingly

become the focus of her experiences;

"you focus on the bad, in the bad days you're right in the middle of it drowning so, erm you think about the bad more. Only when you really question why you keep doing it do the good things come out"

Once again, she adopted second person but described the drowning victim as *"right in the middle of it"*, she was evidently describing herself and a sense of being encircled by worry, stress, and anxiety. Her use of this term is suggestive that she does not see a clear exit from her worries. Without prompting she told me she really must question why she continues to be able to identify any good things about her role. There was a clear path beginning to emerge, at the outset of the interview she was positive describing a sense of not wanting to work anywhere else and AAU being a natural fit but, as the interview progressed and she unpacked her feelings she begun to suggest she is slowly sinking, drowning in the stress of her duties. The statement that she must think hard to identify positives is evidential of her decline.

Sara was acutely aware of the stress and negative mental health impacts her work was having on her. She described an alternative existence away from the negative experiences of AAU;

"without the stress that the Acute Assessment Unit gives you, you could do more, be happier, give more time and spend more time with individuals"

She also considered that she could experience a greater sense of well-being away from AAU

"just elsewhere in nursing, somewhere that doesn't cause me so much pain and suffering."

Again, she moved between first- and second-person narrative, this was common when describing difficult or what she perceived embarrassing feelings. She commonly switched between I and you in what can be interpreted as an attempt to distance herself from those concepts which cause her anxiety.

Fear of becoming a patient

Beside the stress already described, Sara was experiencing stress and anxiety about her own health due to witnessing the ill-health of others although her sense making of this is not as simple as first described. Within AAU there was high volumes of Chronic Obstructive Pulmonary Disorder (COPD) patients so many in fact that Sarah referred to

these as *"same old, same old"*, yet she described the disease as *"horrendous", "awful"* and even *"terrifying"*. The terminology surrounding her description of COPD is interesting, she used powerful adjectives to describe COPD giving the impression that it is something to be feared, yet she described sufferers as *"same old"* suggesting a commonality of repetitive presentation. It is curious how a disease so worrisome could also have its victims be described as almost mundane. It would have been beneficial to explore this further however, it was only after listening to the recording several days after the interview that this became apparent. Sara was scared of this disease and the impact it has on its sufferers.

"you see that patient in the tripod position gasping for air, panicking, you're giving them oxygen, nebs, you're giving them every line of treatment you have and especially with respiratory type patients you can see the fear in their eyes and they are scared, really scared. But there's nothing more really you can do. You feel like you can't get enough air and like you're suffocating, I can't begin to imagine how that must feel, it scares me."

In attempting to understand what it was about COPD that caused such fear for Sara, I asked her about the disease and patients presenting with it. Sara told me she was a smoker and had a strong conviction that COPD and smoking were intrinsically linked, this link is well documented in academic literature and perhaps reinforced and validated the fears Sara experienced. She considered COPD a death sentence which causes a slow, painful death;

"Patients in the last few hours last few days is fighting for every breath to get enough air in, it's a sad death to see you know there's proper fear there because that person knows what's coming."

She talked of the fear they experience going on to say;

"you can see how scared they can be and I think their fear has become my fear."

She explained that she is young, reasonably healthy, exercises regularly and does not suffer mental health issues, and as such is unlikely to develop diseases linked to obesity, cardiac problems, or self-harm. She, therefore, considered these as patient only issues and did not experience anxiety induced by regularly contact with these diseases/illnesses. The same was not true of COPD, in this case she has linked health behaviours and patient demographics to herself;

"you see COPD patients getting younger and younger in the end stages of respiratory failure and er I er and I, I can't give a advice to them truthfully because I smoke myself

and its wow, I, you know if I carry on"

Sara became distressed making the above statement and failed to complete her sentence. It was clear she has allowed herself to become convinced that it is inevitable that her continued smoking will one day cause her to become the patient:

"Some are only bit older than me, my age and it's really quite terrifying, I don't want to be that person but at some point, I know I will be."

She made links between COPD patients and herself, comparing their age, to her own and as previously stated she is a smoker, a trait common in COPD patients. She claimed to know she would develop COPD, and this is indicative of the anxiety and stress caused by her exposure. Sara did not say she may develop it or that she worries about the risks instead she claimed to know with some degree of certainty that this will be the case. She made this assertion on numerous occasions throughout the interview;

"I know that if I carry on that it will be me in my 40s sat on a bed gasping for air."

As I listened to Sara explain her fears of COPD I become increasingly interested in her continued smoking, despite associating with and fearing COPD, and recognising the cause to be smoking she continued. When asked why she said:

"the lifestyle that goes with nursing, the stress, the early mornings, the long days quick meal where you get it I need to smoke"

She described the need to smoke, as if not doing so would be detrimental in some way. The reasons she gave for her need such as long days and early mornings do not change a result of smoking nor do the mealtimes and therefore, it seems more likely that she used smoking for stress relief. Further exploration of this notion led to Sara explaining it was the stress of the job and the things she witnessed that drive her need to smoke. She recognised that her relief was the cause of the very thing she needs the relief from, in the quote below Sara explain this, once more stating she knows she will develop COPD, she also identified that the way to avoid it is to quit smoking before going on to justify her rationale for continuing. This is a confusing and yet equally telling statement which illuminates Sara makes sense of her experiences. She appeared caught in a vicious cycle which she knows she must break and yet feels powerless to do so:

"You certainly don't want to die that way, but I know I will, I have to stop smoking but the things you see and stuff you know seeing the outcome makes me need to smoke, it's backward really but it's a release, the thing I do to take my mind off it is what's going to give me it. Wow."

The move between first and second person is particularly interesting, when talking of a

desire to avoid a COPD death she used second person as if suggesting I as the interviewer do not want this death, she then switched to first person seemingly taking ownership of the death which she felt awaits her. This switch occurred again when talking of the things '*you see and know*', she separated herself from these things yet took ownership of the fact they drive her to smoke. Sara ended her statement with the word wow, suggesting a revelation, she looked shocked as she uttered the word wow, shaking her head and becoming wide eyed as if this was new to her.

Further probing into the link between COPD and smoking revealed that she had considered quitting smoking but the drive to continue is greater, she sees smoking as a release from stress and anxiety whilst paradoxically describing it as the cause of her greatest fear. Sara described a process of bargaining with herself, she knew she should stop smoking for health reasons but believed she could continue if she increased her exercise regime.

"You know things like I tell myself if I do a bit more of my sport, I'm buying time, I will put it off a bit longer"

"set little targets for myself like by age 30 I will have quit smoking, but if I quit sooner like next year for instance then I will be ok, I won't be in their situation"

This bargaining was supplemented by setting targets or times by which to quit, she suggested that if she can stop by a given time that she might avoid COPD. These comments could lead one to believe that she feels COPD is not an inevitability as she has claimed and is more an irrational fear however, she again reaffirmed her belief she will develop it if she continues smoking;

"I know if I don't stop smoking that by the time, I'm 50 I will be lying here in their situation slowly dying."

This is indicative of the fear Sara experienced when faced with or when contemplating COPD, this was evident throughout the interview and is a large part of her sense making and experience of the illness of others. There is no certainty Sara will develop COPD if she continues to smoke, other than that which she has created, what is certain though is that the fear of this is very real. She recognised that she cannot continue to bargain with herself in order to keep smoking and believed she should quit to have any hope of avoiding COPD.

"I can't keep using extra sport or running as a justification to keep smoking."

"I see it every day, I will get this if I don't stop. But at the minute I don't feel I can stop; the work makes me need to smoke."

Her work is driving her smoking and as such perpetuating her fear and anxiety, her work has created this fear and caused modifications to her behaviour (smoking) and both have now become a part of a greater whole which feeds and drives her fear of COPD. She felt her ability to continue nursing was dependent on continued smoking although she seemed to understand that it is also a key component of her anxiety.

"It scares me to think that it could be me one day, er I need to stop smoking"

She disclosed that she has considered leaving AAU and described a belief that working in an area with less stress may allow her to not only stop smoking but to experience a greater sense of well-being.

"AAU is a really stressful place and other places don't suffer the same levels. Getting to an area where the pace is slower and there's less targets, secondary duties, pressures from bosses then that'll make the work easier, more clinically focussed and less stressful and maybe smoking won't be needed. I think I will be a lot happier and a lot more well, stress free so I won't need smoking as a relief cos I won't have that pressure of AAU around my neck all the time"

Coping and support

Survival featured prominently in Sara's narrative, she spoke of staying afloat and surviving anywhere and conversely of drowning in her experiences. Smoking has been a coping strategy for Sara but one which she recognised as detrimental. She employed other strategies one of which was *"venting"* she used this term to describe talking through difficult issues, experiences and feelings with colleagues. This collegiate support was important to Sara and she expressed the belief that she would become overwhelmed if it were not available.

"You would go mad otherwise, or just be too stressed to get out of bed. It's a hard job"
"Talking about it, moments of self-reflection, if you just let it stew you don't cope"

Sara described venting as a way of releasing stress and offloading negative feelings through discussion with colleagues, this could be as a group or on an individual basis but essentially it is about;
"sharing your experiences with people, it's nice to sometimes just vent it out."

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This was not a formal process and happened organically, it seemed to have cathartic qualities for Sara, allowing her to let go of her stress and anxiety. It appeared to be a means of sharing her burden and appeared to be an almost constant background activity within AAU;

"You see it every time in the staff room when something's happened everyone talks about it together and its about dealing with it and getting other's perceptions, learning from it so it doesn't happen again and allowing others to learn from it without needing to experience it themselves. Just letting it all out."

The choice of words above, suggests she was able to release her negative feelings and stress when supported by colleagues. These collegiate discussions are certainly a process Sara found beneficial, and she appeared to believe this to be true for all staff although she appeared to have reached a point where the stress, anxiety and fear of COPD have built up to a point where collegiate support and venting is no longer sufficient, leaving her in a state of anguish and considering her future in AAU;

"I love it. Even on AAU. I love it, the job is so stressful, and the pressure is immense, but the work is amazing, and the people are so supportive. You learn so much in AAU but yeah, eventually the stress will inevitably make me move into a less acute area."

Sara made a statement which left me curious about the benefit of this venting process.

"I think the staff all help each other get through the worst times, we've all been there, we just offload all the shit on each other but even then, yeah I do think about going somewhere else"

She described nurses off-loading their stress and frustration on each other, I was left wondering whether this created an additional burden. This remained unclear from Sara's account, but it might have been useful to explore her thoughts on this.

When asked about leaving AAU Sara recounted an idealised view of what she thought it might be like to work in another clinical environment, she was convinced she will endure less workplace-stress and that she would be happier and feel *"well"*.

"without the stress that the Acute Assessment Unit gives you, you could do more, be happier, give more time and spend more time with individuals"

Again, there were inferences of time pressure and task completion, both factors which have been shown to be a leading cause of stress for Sara. Perhaps more poignant was her realisation that she felt she is suffering as a result of staying in AAU and that a move is necessary to reduce this:

"elsewhere in nursing, somewhere that doesn't cause me so much pain and suffering."

Sara's narrative followed a path from AAU being a place she *"loves"* and sees as a *"natural fit"* to one where she was suffering and feared for her health. She smoked to allow her a temporary escape from stress and anxiety, but this also increased her fear of illness. She considered herself a survivor, but it is evident from her narrative that she is *"slowly sinking",* being consumed by her anxiety, feelings of self-doubt and resulting stress this causes.

4.3 Rob

Rob was 30 years old and had worked in AAU for two and a half years. Rob explained that he worked between band 5 and 6, occasionally taking on the shift leader role. Rob had worked in A&E and Trauma-Orthopaedics. He was an ex-soldier and spoke with a strong Glaswegian accent, he appeared very assertive with an expansive posture which gave an impression of confidence and authority.

Rob's interview provided rich data, offering insight into how he made sense of his role as well as illuminating several important elements of his experiences of caring for patients. A number of themes emerged during the analysis of Rob's interview which the table below demonstrates.

Table 7 showing development of themes from Rob's interview

Sub themes from Rob's interview	Fit with cross-case superordinate themes
Coping mechanisms	I feel like I'm drowning
Nature of AAU	
Self-importance	
Stress self-doubt and anxiety	
Fear of becoming a patient	I don't want to end up like that
Exposure anxiety	
Deserving and underserving patients	Repeat offenders

Rob made an unexpected disclosure to do with his mother's suicide which led to some off tape discussion, this has been included with Rob's permission and in keeping with the ethical approvals of this study.

Self-importance and AAU

Rob indicated he worked at different grades depending on the needs of the department.

"I've worked in AAU for two and a half years; I sort of flit between being a band 5 nurse and a band 6 when needed"

Rob used the term, flit to describe his movement between band 5 to 6, which indicated transience and more of an informal step up. The coupling of the words flit and needed suggest Rob links stepping up as being important within AAU. I became interested to understand what it meant to be needed and why he had not been promoted to a substantive band 6 role.

"they all come and ask me; how do I do this or how do I do that?"

Rob claimed his colleagues sought his assistance when faced with an unfamiliar task or illness. Rob suggested that were other nurses more knowledgeable they would manage their time more effectively and he would not be needed so much, he appears to conflate practice knowledge with time as if an inverse relationship may exist. Rob equated knowledge to an ability to manage time effectively and this is seen on several occasions throughout the interview. Initially, it appeared Rob was simply identifying a lack of experience amongst the AAU team however, as the interview progressed, he made increasingly frequent references to his importance and inefficiencies of his colleagues.

"It's busy, its fast pace and you get a lot of respect from nurses in other areas cos we're seen as the more skilled and knowledgeable ones and autonomy, we get to do a lot of stuff other nurses don't, we're like mini doctors. It's nice to be important you know"

Rob considered AAU nurses were viewed as more knowledgeable and attracted respect across the hospital. Considered against his earlier references to him being a go to nurse for others it might be that Rob has a personal perception of his own self-importance. Rob liked to feel needed, and enjoyed the sense of importance this offered, it remains unclear whether other nurses in the department are sought out for advice in the way the Rob described or whether it was him. This was an important aspect of how he made sense of his experiences and it is important to understand how he perceived his position within the department and how his sense of importance was projected upon all elements of his work. There is a continuous thread which conveyed Rob's strongly held belief that he was in some way better and more knowledgeable than those around him, what was also evident is that the recognition this brought was driving Rob's enjoyment

of the role. Reward and recognition were important concepts in Rob's sense-making.

"I quite like the work here and the recognition you get for it makes the shit stuff and shit patients worthwhile".

Rob referred to *"shit stuff and shit patients"* being negated by the recognition he received. Rob made further statements about his perception of certain patient groups and the type of tasks he must complete which he considered *"shit";* these groups included self-harm patients as well as those requiring *"all care"*.

For Rob, the *"shit"* was comprised of delivering caring interventions as opposed to technical skills. He called these patients *"all cares"* and considered them to make him experience the *"worst"* of days.

"you have an all-cares patient in the side room and it requires you to wear full PPE or do washes and toilet stuff then, I would describe that as the worst kind of day."

Rob prioritised technical interventions above basic nursing care and spoke of completing tasks, performing duties and *"getting shit done"*. It seemed he considered these non-technical, basic skills as beneath him or as mundane. When asked about his typical working day he listed several of the more technical elements of the role, there was a notable absence of any basic care duties, this once more led me to consider if these were omitted out of a sense of them being beneath him or too mundane to be included/performed. It was apparent that Rob is a task orientated individual who places an emphasis on time management and the ability to perform tasks in a prompt and *"quick way"*. The ability to complete tasks in a given time was important to Rob and he described this on many occasions. He also discussed the frustration and the stress it caused him when things prevented him completing tasks efficiently. This is discussed in greater detail during the stress and self-doubt aspect of this analysis.

"You can do all of them sort of technical nursing interventions in one morning for four different patients so you're really busy doing the job you've been trained to do plus, that when we're taught at university our main role as a nurse is not to be just a caring individual but it's to be able to recognise a deteriorating patient and fix them"

The above quote exemplifies Rob's understanding of his role, he spoke of doing the job he trained for but only in the context of performing technical interventions. Rob took enjoyment from these technical tasks saying he got *"a buzz cos you've worked in a high pace environment"*. He explained his university training taught him that his role was to

"fix" patients. Rob has already compared himself to a doctor (*"we're like mini doctors. It's nice to be important you know"*) and the use of *"fix"* is illustrative of his ego, importance and belief that he is in AAU to fix patients rather than to care for them.

When asked what makes a good AAU nurse Rob replied, *"time management"* and suggested those who are unable to perform tasks quickly or struggle to maintain pace are not up to his standard, in relation to medication administration, he expressed the belief that lack of experience, knowledge or ability to keep pace made them bad nurses.

"I think somebody doesn't know their medications is bad, slows down their time management."

It is noteworthy that shortly before the above statement Rob disclosed that there are a lot of medication errors on AAU;

"you get quite a lot of errors on AAU because the medicines are, well I wouldn't say uncommon but erm like cardiac meds, blood pressure meds, diabetic medicine all quite common stuff in AAU"

What is particularly interesting is that the errors Rob referred to appear related to medications commonly used on AAU. This made me consider if these errors occur because of lack of knowledge or are linked to rushing and lack of routine. There may be a more complex phenomena occurring which perhaps relates to speed versus efficiency. Rob did not claim nor admit to making any errors, instead he suggested that they are the preserve of other nurses remarking that *"the balance between experienced and inexperienced (nurses) shows"*. Rob did not give any specific figures for the rate of errors and one cannot make claim about the rate or frequency based on Rob's disclosure however, his dismissive attitude and hand gestures were suggestive of this being commonplace or insignificant.

Rob seemed to take pleasure in other nurses coming to him for guidance and yet their need to do so is what led him to describe them as *"bad"*. There is a sense that Rob sees himself as different to the other nurses, he made no reference to him ever needing assistance instead he stated that he *"gets shit done"*. Rob is time and task orientated and when describing a bad day, he spoke of complex medications and having to take the time to look them up;

"well, a bad day goes back to the medicine management thing again, so some people come in with complex medications then you have to get on Medusa and look it up and

to do it blah blah and get behind"

There is an apparent contrast in that Rob told me he looks up unfamiliar medications whereas other nurses *"come to me"*. I wondered whether other nurses also look up medications and how frequently they go to Rob for advice. There was disdain in his tone as he made this comment, the inclusion of *"blah blah blah"* exemplified his frustration and annoyance at having to take time out of his day, which could be used completing task, he ends the sentence explaining that looking up these complex medications causes him to *"get behind"*. This was another example of the emphasis he placed on task completion. Given Rob's assertion that those without the knowledge of medications were bad AAU nurses, and his enjoyment of their reliance on him for that knowledge it was apparent that Rob experienced frustration when forced to look up medications himself. His time gets diverted from other tasks which may be why he described these events as a *"bad day"*. I wondered if Rob rated his days in terms of task completion and the amount he is able to achieve.

Rob repeatedly referred to the pace, need for timely interventions and links between knowing *"quick ways"* to perform tasks. This amplified his predisposition to time and its management. Rob evidently placed value on these things, judging himself and others on their ability to get *"get shit done"*. When delays occur, frustration ensues. Rob was driven by the need to perform tasks quickly and without interruption, and it was important to him to remain on track, when circumstances challenged this, he became stressed, and this has led him to question his practice.

Stress and self-doubt

Through his descriptions of the need for prompt intervention he inadvertently revealed that he can become stressed by the fast pace of AAU and that this has led him to experience feelings of self-doubt regarding his nursing practice;
"you've got yourself running round and trying to sort everything and its erm pretty stressful erm sometimes"

As a nurse motivated by task completion, Rob recognised that he strives to remain what he described as *"on time"* and when faced with an increase in pace, he became stressed by the need to maintain his self-imposed schedule. Rob enjoyed his status as a knowledgeable, senior nurse, and it is possible his sense of importance was challenged

when he fell behind in his tasks. The quote below illustrates a sense of self-doubt which Rob experienced during times of increased pace.

"you think about stuff when you're trying to sleep going over you know? did I sign for this, this I do that or this"

In the above statements there were apparent changes in ownership of the statement. When describing his importance or knowledge he adopted first person suggesting he is the centre of the statement and is happy to accept the premise of these assertions however, when describing feelings of stress and self-doubt he reverted to second person as if distancing himself from what he is saying, the use of *"you've"* and *"you"* are indicative that these experiences are at odds with his self-image and the persona he wished to portray.

There was a sense that that he was seeking reassurance that self-doubt is an issue experienced by other nurses too; he said, *"you know?"* mid-sentence leaving a pause whilst looking directly at me as if wanting confirmation that I too experience these feelings.

When discussing his doubts and anxieties Rob reverted to second person and ended sentences with questions. This gave an impression of vulnerability and seeking reassurance. This was repeated throughout the interview especially when discussing clinical errors. Self-doubt was a prominent feature of Rob's narrative and seemed central to his experience. Rob discussed his experiences of this further and of note was his return to first person. It is unclear why this occurred, but it is linguistically significant as it demonstrated an acceptance and ownership of his doubts and experiences.

"If I've done everything right, if I've signed for everything er, (…) if every patient I've dealt with who is cognitive enough was happy with how I erm treated them"

Stress and self-doubt appear closely related in Rob's understanding and experience, he notably linked the two when describing his thoughts after particularly busy or challenging shifts. This was done without probing or further questioning indicating that he perceived a causal link between stress and worry/self-doubt. Rob ruminated over his actions and was concerned with his performance and completion of tasks as this undermined his sense of importance and necessity and in turn his confidence in his self-

perceived position of knowledge and seniority. Rob referred to *"patients who are cognitive enough"*, It was unclear whether he was at all concerned about how confused patients, felt about the care they received.

Rob spoke of the change in pace throughout the week indicating that weekdays tend to be busier with higher rates of admissions, he described these days as a battering;

"it's quite stressful sometimes. Erm (.) I think during the week say Monday Tuesday Wednesday if you're on during the week you can be battered by admissions emergencies, and all care patients"

Rob's use of the word battered as a metaphor to describe busy days was important in understanding his experience, it conjured images of violence and brutality and for Rob this is how he perceived and made sense of his experience of stress and anxiety during these shifts. Although not subjected to any physical violence, at least, non that he disclosed, it is an emotional and psychological assault that, to him is a battering. Once again, we see references to *"all care"* patients, Rob described these patients as time consuming distractions from his tasks/duties. This is indicative of Rob's frustration and increased stress when faced with several of these patients, especially in conjunction with a fast past of admissions.

Rob went from describing the battering he experienced to telling me of his thoughts about well-being and the impact work can have on this. He explicitly linked work and well-being and believed his work was impacting upon his personal well-being and had led to fatigue, stress and ultimately had a dangerous impact on him:

"work can affect your well-being, I think it's difficult, I'm stressed, tired, fatigued and I think it can be quite dangerous."

He declared, *"I'm always fatigued. It's a hard job."* This is a short but significant statement. It suggests Rob existed in a state of permanent fatigue, this could be attributed to many things however, Rob immediately followed this by saying the job is hard. The juxtaposition of these two sentences suggested a causal link between his work and experiences of fatigue. He appeared to make sense of his psychological experiences of his *"hard job"* by linking them to the physical manifestation of fatigue and reduced well-being. Rob recognised the impact his work had on his well-being and has begun developing strategies to mitigate this.

"It's hard, stressful and tiring, so I use long periods of my leave to separate myself from work and to have a good rest, to stop me becoming dangerous"

The above quote illustrates Rob's sense making, he believed he became dangerous during periods of peak fatigue and stress and went on to explain this build-up of fatigue and stress led to increased potential for clinical mistakes.

Rob used annual leave to separate himself from his work allowing him to rest with the intended effect being reduced likelihood of clinical errors. The word *"separate"*, suggested a physical link between Rob and his work, this is not the first time he has inferred the existence of this bond (*"just to get away from it all"*) and his need to be separated from work reinforced the idea that he was integral to the function of AAU.

The symbiotic relationship between Rob and his work was visible in his descriptions of being needed by his colleagues and his assertion that they sought him out in times of difficulty. Rob admitted feeling important and had a sense of belonging although he tried to balance this against his perception of danger and experiences of fatigue, stress, and reduced well-being. Rob said that when he unable to take leave he had worked under stressful conditions and jokingly asked if *"you want me to admit to some of my errors?"*

Rob said, *"you do get stressful days, sometimes I am so stressed and tired when I go to work",* this can be *"dangerous".* There appeared to be a competing relationship between Rob's desire to feel important and his need to decompress. Rob recognised this conflict and was aware of the impact it had on his work and well-being and was purposefully creating a physical separation between himself and his work.

Rob described a case when he almost flushed heparin into a patient's central line, the description itself offers little insight into his sense making or the importance he placed on this this experience, what was significant was his reaction to the incident. The below is his description of his reaction immediately after the event:

"I was like oh my god if I'd flushed that into her what would have happened? But I think that's the reason that I didn't research into it after because I didn't want to know what it could have done to her if I had. But, I think it would have been alright, what do you think?"

Rob exhibited self-doubt, again seeking reassurance for his lack of understanding, he leant forward and left a long (five second) pause after asking my thoughts on the incident, his body language and apparent vulnerability contrasted his previous

confidence and upright posture. It was unclear why Rob did not want to know the potential impact of his near miss but, he said did not wish to know. Instead, he opted to *"think it would have been alright".* This may have been said to preserve his self-perceived position of knowledge and experience, he was evidently uncomfortable as he spoke these words, shifting position in his chair and breaking eye contact. There was a tone of uncertainty in his voice as he made this statement and he immediately followed it up by asking my opinion.

Self-doubt was evident throughout Rob's interview and he appeared acutely aware of this at times, when describing the near miss he states *"I just paused for a second to think what am I doing here,"* This seemed like an innocuous phrase however, Rob's almost vacant expression and shaking of the head as he spoke these words perhaps indicate this is more a question he was still asking himself, less in terms of the task he was performing and how to do it correctly but more in terms of what he is actually doing remaining in AAU despite the impact it is having on his well-being. He went on later to suggest the stress and anxiety will eventually make him leave AAU.

The undeserving patient

An additional dimension to Rob's stress and frustration came from the emotional labour he experienced when dealing with certain patients. Frustration at the slower pace of *"all care"* patients has been discussed but there was a second group of patients Rob struggled with, those he considered *"self-inflicted".* This group appeared to cause Rob frustration on multiple levels, he was *"annoyed"* because;
"they've done this to themselves you know, taking my time from people who deserve it more"
The task orientated side of Rob was displeased his time was being diverted from tasks he deemed more worthy but, here he introduced the notion of undeserving patients who caused him emotional labour and a desire to tell them;
"you're a grown adult so get a grip of your life."

These statements were strongly worded and seem at odds with widely accepted nursing values however, Rob went on to explain his rationale for these views and made disclosures about a personal tragedy which has shaped his opinion.

"I find it difficult to deal with patients who are self-harmers, patients who are attempting to take their own life because of my own history with my er, er my mum and er I dunno I find it difficult to compare that cos obviously I saw my mum go through her illness"

As Rob spoke, his voice changed from the confident and clear tone he had projected thus far to a more subdued and pensive one. He left long pauses and gazed off into the distance seemingly making a deliberate effort to avoid eye contact. I noted his eyes had become glazed over and he appeared to be trying to hold back tears. At this point I was not aware of the tragedy which he had experienced but noted that when asked to talk about patients he struggled to care for he very quickly and without prompting brought up his mother and *"her illness"*.

Rob seemed to have made an association and comparison between self-harm patients and his mother. There was a cognitive dissonance which Rob recognised as a foundation for the emotional labour he experienced when caring for these patients. The distress he experienced when thinking about his mother and his experience of caring for this patient group appear inter-woven.

"Sometimes I pass judgement in my own mind. What's the word for it you know you without sounding like I'm offending them erm whether they're genuine or not and I had these similar thoughts with my mum as well, so I find it really difficult to treat patients who are having an attempt on their own life."

Rob did not use the term emotional labour but described circumstance where he experienced internal dialogue at odds with his external behaviours.

"I just try to remain the same, the same way I would talk to anyone. I do have an internal dialogue calling them a knob".

Further exploration of this unveiled comparisons between these patients and his mother. He referred to circumstances in which he questions patients' backgrounds and social history explaining that his mother had what he considered a *"good life".* Rob appeared to believe socio-economic factors played a part in self-harm and despite wanting to forget his own experiences could not help comparing his mother to his patients.

"I question in my own mind what their reasons are for doing it, you know like what social circumstances they come from cos my mum came from quite a good life, she wasn't from like er a bad upbringing or anything like that so I find myself asking loads of questions which I shouldn't really be asking cos I want to forget about that.

Rob appeared to consider all self-harm/self-inflicted patients in the context of his

experience of his mother's illness which was evidently significant to how he made sense of his experiences of dealing with these patients. Rob recognised this and said the questions he was asking are not helpful or appropriate to care delivery. He seemed to be judging himself as well as the patient and referred to his struggles and how he should not be questioning the motives of these patients he finds so difficult to care for.

Rob described questioning patients' reasons for self-harming and compared these to his mother's situation, Rob made moral judgements, weighing up whether he considered patients justified in their actions. During a pause in the recording to allow Rob to regain his composure he said he found caring for these patients increasingly difficult and that he compared each patient's circumstances and upbringing to that of his own and his mother's. He did not explicitly explain his rationale for this, but it is exemplified in his description of a theoretical patient.

"You feel sorry for the patient because she had an upbringing where she thought it was ok to take drugs and have children, so you get angry at her upbringing rather than her. I'd be angry at her parent's kind of for her if that makes sense. At the same time, you think, you're a grown adult so get a grip of your life."

The emotional labour Rob experienced was impacting on his experience of caring for these patients.

"I find it a struggle to erm not to treat them, cos I treat anybody but er how can I say this to properly care, yeah, they've done this to themselves you know, taking my time from people who deserve it more,"

Rob acknowledged that he is capable of delivering treatment to this patient group but had difficulty being able to *"properly care"* for them. In keeping with his task orientated nature, Rob adds that part of his frustration is derived from the time these patients take away from his other patients *"who deserve it more"*. It would have interesting to explore the idea of deserving and undeserving patients in greater detail however, before being able to pose the question he began to talk more about his mother's illness. This seemed an important element of Rob's sense making and experiences and so I did not interrupt. Rob had already briefly explained that his understanding of deserving and undeserving was that those who had self-inflicted admissions where less deserving than those with *"proper illness"*.

Rob disclosed that his mother had committed suicide but was quick to tell me that.

"she wasn't subjected, well she didn't choose drugs, or she didn't turn to alcoholism. It

was pure mental; it was pure in her head that made her do that"

Rob believed his mother's suicide was *"pure mental"* and that the illness *"made"* her do it. His language suggested her illness might be what he would describe as *"proper"* and he qualified this by informing me that drugs and alcohol had no part in her illness and suicide. As part of the same statement he went on to contrast his experiences of self-harm/inflicted patients suggesting that they had some control of their illness.

"I think with these patients if you can get them to grasp that it's not making things better for them with drugs and alcohol then they might have a better chance of not feeling that way in their own mind"

Having claimed mental health issues *"made"* his mother commit suicide he failed to concede the same issues might make his patients self-harm or abuse substances. Whenever he spoke of substance abuse, he listed drugs followed by alcoholism. The consistent positioning of drugs ahead of alcohol is linguistically significant and infers a hierarchy of morality in which drug taking is worse than drinking.

Rob's frustration became more evident as he said;.

"So sometimes you just want to like just shake them and be like just stop doing drugs and stop drinking alcohol so you can deal with this problem better"

It was interesting that he separated substance misuse from *"this problem"*. He also made this separation in the previous quote which suggests he viewed self-harm and overdoses as problems separate too but not unrelated to substance misuse.

He laughed as he made the above statement and quickly went onto exemplify the experience of emotional labour;

"but you can't go round doing that or say to stop doing things, you can only advise and that's where the inner dialogue comes in and it can be really frustrating as you can imagine".

At this point Rob was visibly upset and beginning to cry, he leant forward and paused the recording asking if we could take a short break while he composed himself. I offered to terminate the interview, but he indicated he wished to continue. I did not speak and allowed Rob time to think, after a few moments he said his mother had suffered a long depression which had led to her hanging herself. Rob continued crying and went on to say he had discovered her body; he was sixteen at the time.

He explained he did not think he would ever come to terms with her death and felt powerless to help. This experience influenced his decision to become a nurse, he told

me that he could not help his mother but that as a nurse he could help other people. His mother's death seemed to be a lens through which interpreted his experiences of caring for self-harm patients. This was evidenced throughout his narrative and whilst it could have been hugely revealing to further explore this, it would not have been in Rob's best interest or in the spirit of ethical approvals given to this project therefore, I did not pursue this avenue instead I offered Rob a hot drink and waited for him to speak. After a short while he suggested we recommence the interview but that we change the subject. This was agreed and the tape recording resumed.

Fear of becoming a patient

Recommencing the interview led to an exploration of Rob's experiences of wellbeing, we had discussed the impact of stress and fatigue upon his well-being, but Rob had not up to this point described what he understood by the term wellbeing. When asked, he responded;

"well-being is all about how you live your own life, for instance; I'm a smoker, or I was a smoker. I'm know what you call a Vaper, and I started vaping because of what I've seen as a result of being a nurse"

Rob described his belief that well-being is shaped by how one lives their life, this assertion was coupled with a description of changes in his health behaviour (moving from smoking cigarettes to vaping) which he explained as being linked to his experience of caring for COPD patients. This was an example of work impacting upon health behaviours, Rob associated a particular patient group with a specific behaviour (smoking), and as a has modified his habits to avoid suffering the same fate. Rob attested that work effects well-being in a negative way (stress and fatigue) however, his altered smoking habits suggested positive outcomes can occur too. This behavioural change took place over a prolonged period of exposure to COPD patients;

"I would say the last two years I've went from smoking to vaping with the odd relapse erm, that's probably only happened because of what I see on the wards with perhaps COPD patients"

Rob recognised the inevitability of death suggesting;

"everyone has to die of something one day, but I would rather it not be COPD because its horrendous."

His language was indicative of his experiences of this disease, he called it horrendous

which was a powerful descriptor of the disease process and the death which eventually ensues. As previously stated, Rob perceived a causal link between smoking and COPD patients, through his own smoking he considered himself a potential COPD patient;

"when I see patients with it I see myself,"

"I don't want to end up like that"

It is this perceived link which has driven his transition from smoking to vaping;

"for me that's what's encouraged me to stop smoking, obviously there's the money elements but the main thing is seeing the states that they get themselves in and they're young as well"

Rob witnessed COPD daily and feared it. He compared smokers and younger patients with himself and believed without some form of modified health behaviour he would develop the condition;

"the witnessing it and fear of it comes from the patients so I'm like god I don't want to go through that and that's why I look after my well-being through my diet and doing lots of exercise and trying to quit smoking because I'm exposed to that every single day"

Rob's sense making is particularly interesting where COPD is concerned. He claimed to vape and occasionally smoke despite the known links to COPD. He had a fear of developing this condition and yet attributes his continued smoking/vaping to the experience of caring for COPD patients and the stress, fear, and anxiety this induced (it is a release in some way, a five-minute break away from the department). Rob was aware of the counter-intuitive nature of this relationship and so justified this through the belief that he could offset the potential negative consequences of smoking by increasing the amount of exercise he took and by eating a healthy diet, he described this as a compensation mechanism;

"I live a healthy life in terms on diet and exercise because I'm interested in marathon running, biking, I like triathlon, I do a lot of physical activity so sometimes even though I'm unhealthy with the smoking I've kind of made up for it like a compensation cos of the exercise."

Rob's concluding thoughts on smoking and his fear of COPD are that;

"my job creates the fear"

Rob's work in AAU has altered how he understands well-being and has shaped his health/lifestyle decisions; his smoking and exercise habits were examples of such

influence. He acknowledged the emotional and physical toll that AAU had on him and yet still found enjoyment in his work. Much like using exercise to compensate for smoking, he described the recognition he gets from his work as compensation for the *"shit stuff"*.

I quite like the work here and the recognition you get for it makes the shit stuff and shit patients worthwhile.

Despite the rewarding nature of his work, he was looking for a way out. Rob has a developed sense of self-importance and intended to move into a more senior, non-patient-facing role. He acknowledged that this was for selfish reasons rather than a desire to improve patient experience. The work has taken a toll on his mind and body, and he acknowledged that to redress the balance and improve his well-being he must have a way out to look forward to.

"The end goal is to be away from clinical practice, for me to be in a well you know same pressures as AAU but with more of a management or IT role, and I'm only really doing that for my own well-being because of my back, because my back is fucked, my head too I reckon, so yeah."

4.4 Lee

Lee was a 30-year-old band 6 who had been nursing 8 years and working in AAU for 6. His role meant he was a junior manager and senior clinician with responsibilities for managing and supporting junior staff and assisting the ward manager with the daily running of AAU. Despite attempts to keep the participant sample as homogeneous as possible, Lee was a slight anomaly as the only participant fully employed in a band 6 position. The remainder were band 5 staff nurses, with Rob occasionally acting up. Lee had only recently assumed band 6 and had relevant and recent experience at band 5 in AAU.

He was articulate, confident and spoke slowly and deliberately. He used pauses and changes in posture throughout. He often recalled experiences and used these as examples to illuminate responses. His interview was conducted in a private room within the host site and lasted 55 minutes.

Several themes emerged which are shown in the below table.

Table 8 showing development of themes from Lee's interview

Sub themes from Lee's interview	Fit with cross-case superordinate themes
Coping mechanisms	I feel like I'm drowning
Nature of AAU	
In it together	
Stress self-doubt and anxiety	
Exposure anxiety	I don't want to end up like that
Deserving and underserving patients	Repeat offenders
Us and them	
Repeat offenders	

Nature of AAU

The AAU environment is the foundation to Lee's experiences and sense making, throughout the interview he gave examples of events, interactions and thoughts, all of which he linked to his understanding of AAU and how he perceived that it should be. Lee considered AAU as a kinetic environment offering variety and challenge; "*To me that fast pace, fast turnover of patients, it's something new every time.*" He was an experienced member of the AAU team, had risen to band 6 and had gone on to undertake specialist post-graduate education in Acute Medicine. He had done so because "*I just knew it was for me and I've been here ever since.*"

Lee enjoyed the autonomy of his role and considered himself an equal to the doctors within the department;

"*we can be more autonomous sometimes and rather than be subservient to the doctor we are more like equals and helping each other out and I guess it's that being valued and being able to make a difference*".

Lee's statements regarding a sense of value and ability to make a difference were made in isolation and he did not expand on the importance of these elements of AAU culture until much later in the interview when he began to explain that where these were compromised stress and self-doubt arise. This is discussed in a subsequent section, at this point however, it is important the reader is aware of these negative connotations as it offers insight into Lee's sense making. It was important for Lee to feel valued and able to make an impact.

Lee was an influential member of AAU and described himself as "*in charge of a team*", the word choice suggested power and responsibility, yet he immediately followed this declaration with an explanation of his perceived role; "*my role is to look after some junior nurses*". These statements were almost dichotomous in there was a clear distinction between being in-charge and looking after junior colleagues. The former suggested a patriarchal role where Lee had power to wield whereas the latter indicated a maternal stance.

Lee recognised AAU as a fast-paced environment which was a factor that attracted him there;

"*you turn your bay over twice by that I mean you discharge and admit new patients twice so you get 8 patients out and more in during that day erm, along with all the other routine stuff you have to do, then that's a busy day erm, there's you well tend not to stay stationary for too long but that is a good day.*"

Lee recognised that his colleagues/juniors are not always equipped to deal with this;

"*they don't understand the pace of the ward and pace is key but for a good AAU nurse, and that's a quality but in order to have that pace and that understanding you need to have the experience and that's the thing. People are lacking experience*"

He accepted that the team around him often lacked experience and in a somewhat heroic statement declared; "*I'm here leading the ward as a head of department now.*" This reaffirmed Lee's maternal position, he did not speak of managing inexperience or the implications this has on care, instead he claimed to be leading the ward. Leadership and management are two very different terms and Lee clearly perceived himself as a leader rather than an authoritarian, this was evident in his word choices, descriptions of his role and the importance he puts on feeling valued.

Lee was expected to undertake managerial duties which removed him from leading his team as well as from direct patient care. Such duties create a great deal of frustration for him.

"*Why is there so much bureaucracy and paperwork? You can understand why in that it has to be appropriate and every box has to be ticked but sometimes the frustration is a big one*"

Lee questioned the administrative burden whilst simultaneousness acknowledging its necessity. This argument raged throughout his narrative causing Lee much anguish, on one hand he understood the requirement to meet logistical, legal, and procedural

obligations yet, on the other, he was convinced these tasks impact negatively on patient care and his own job satisfaction.

Lee recounted an incident where he spent much of his shift trying to get a palliative care patient discharged for them to die at home. He was unsuccessful due to management, external agencies, and internal procedures.

"They shouldn't have to wait, so yeah frustration was a big one for me and just the fact that you weren't able to, it's almost like their dying wish in a way and so not being able to facilitate that is frustrating."

Lee's frustration was evident as he explained care was often impacted upon by bureaucracy and that this perplexed and angered him. Lee was unable to understand why a clinical area charged with rapid assessment and treatment was so restricted by paperwork and managerialism.

"Frustration was the biggest one, because why do they make it so difficult"

Lee's frustrations have led him to feel torn between his managerial and clinical responsibilities, he described an internal monologue where he considered roles which would allow him to return to a solely clinical role.

"I want to focus just on the clinical, but I can't so that creates an internal frustration. It makes me think; is there an alternative?"

Lee enjoyed the fast pace and autonomy afforded by his role and recognised a lack of experience amongst junior staff as a potential barrier to rapid and effective care. He considered himself a leader placing greater emphasis on this than his managerial position. Despite being part of the management team, Lee was frustrated by the managerialism and bureaucracy which was endemic in AAU. He considered this a negative influence on patient care becoming so frustrated that he has begun considering alternative solely clinical roles.

'Repeat offenders' (deserving and undeserving patients)

"we get a lot of seizures from people trying to detox of alcohol, alcoholics, drug users, a full range of erm, (the area's) finest really. Those disease processes are very related to (the area's) demographic."

The choice of descriptor for these patients offered insight into Lee's perceptions of the

area and individual patients. He used the term *"(the area's) finest"* in a derogatory context which was evident from his sarcastic tone but also from his follow up statement;

"The area definitely effects the people that come in through the door"

The area is known to have high unemployment rates and large sectors of the population lived on benefits. Lee appeared to consider the socio-economic status of local residents to be a contributing factor to the volume of what he considers to be self-inflicted presentations.

"This is gonna sound a bit bad, probably good this is anonymous, but self-inflicted stuff is something I struggle with, in specifics it's the repeat offender, cries for help, attempted suicides I struggle with there's only so much support or empathy you feel you can offer"

Lee recognised that his beliefs and opinions were not in keeping with the typical nursing values. He described self-inflicted admissions and suggested his ability to offer empathy to these patients was limited, especially those he termed *"repeat offenders"*. The use of the word offender to describe a patient appears to infer criminality and was a metaphor which offered insight into Lee's perceptions of these patients. He referred to patients as offenders regularly when discussion self-harm and substance misuse and in each case linked the term with his increasing sense of frustration having to treat them;

"if they're a first offender empathy, if they're a repeat offender then well, you don't lose compassion erm, but your patience is sometime going to wane, it's frustrating to keep seeing them coming back in. You try not to judge but it's hard"

In another example Lee described regular attendees and his thoughts on how to interact with them;

"well, it's that same circle of people coming back that's a hard one to deal with and it's hard to know how to deal with them, how to speak to them; do you go down the role of empathy or do you go down the role of being a bit abrupt and not telling them off but being stern with them?"

Lee outlined the difficulty of selecting appropriate responses to these patients. There may be a significant indicator of the difficulty or frustration he experienced as he adopted second person which is often a linguistically significant attempt to distance oneself from a situation. It was also interesting that he structured his statement in such a way as to offer the question to the researcher, perhaps indicative of his previous acknowledgement that this is not a typically acceptable manner to treat patients.

"it's frustrating because they've put themselves there and you can't treat the patient in the corridor with real problems like chest pain because the bed is blocked by some moron who has put themselves there."

Lee introduced the notion of real problems using chest pain as an example, it seemed he considered self-inflicted problems to be less real. He even described these patients as morons who have taken away his capacity to treat more deserving *"real"* problems. His word choice here was significant and offers valuable insight into his sense making; thus far Lee has described self-inflicted patients, self-harmers, and overdoses as being either offenders or, repeat offenders however, when talking of chest pain, something he considers a *"real problem"* he described the presentation as a patient. This may be indicative of his perceptions of specific medical conditions/presentations but also of the value he placed on each patient.

When asked to explain the term *"repeat offender"* Lee looked shocked and responded;

"Oh god, I didn't even realise I did that, erm, (...) I guess I infer people who self-harm to be more accountable I guess I dunno".

This might suggest that he subconsciously judged patients and was unaware of the label he had attached to this group.

"You shouldn't judge, and you should treat them fairly but sometimes your inner voice sometimes, you have your own views, sometimes your inner voice takes over, you have to suppress it and treat them properly and fairly but sometimes you think to yourself, dickhead"

Lee spoke of a need to supress an inner voice and in so doing Lee encapsulated the experience of emotional labour. The external behaviours expected of him are in opposition to his own beliefs. Once again, he adopted second person when describing the need to be non-judgemental, this may have been an attempt to distance himself from his realisation that he judged patients and allowed these judgements to affect his external behaviour. He recognised the struggle caused by this disconnect saying;

"I guess it's about you have to be self-aware and keep that inside, hide your own thoughts inside so it doesn't affect your practice, but it can and it's so frustrating to see time and time again the same idiots back and forward."

Once more, Lee spoke of emotional labour and of his frustration at suppressing his thoughts. He referred to what he might call repeat offenders as idiots, having referred to

them previously as a *"dickhead"*. These negative terms help interpret Lee's perception, frustration, and experiences of dealing with this patient group.

I asked Lee to describe why these patients make him feel the way he does and if they deserve the same level of care as other patient groups. His response suggested he was aware of his judgemental approach and that he recognised the requirement for impartial treatment:

"like is it a cry for help, is it attention seeking or is it an honest mental illness concern. I guess I'm imposing my own attitudes there aren't I but well, I don't know how to explain that one the textbook answer is yes because you should give, well everyone should get the same treatment, so the textbook answer has to be yes"

This section considered Lee's perceptions of patients and his experiences of emotional labour, Lee claimed to be unaware of his use of the term *"repeat offender"*, yet he was candid about his judgment of this patient group. He described a clear discord between his external actions and behaviours and his internal thoughts and feelings. He explained this emotional labour had given rise to the realisation that he made judgments about who is or is not a deserving patient and recognised the need to set aside these feelings whilst simultaneously claiming that this difficult for him, a direct quote from Lee summarises his experiences well;

"You have to push that discrimination and judgement to one side. It's tough sometimes but you just crack on with your job and do what you have to do."

Stress, self-doubt, and anxiety

Lee was unique in this study as the only participant from a very homogeneous sample who had a clearly defined management role. Lee described his role as split into two distinct functions: the managerial element and the clinical. Lee's described his role as;

"I have to make sure that people turn up, that people are competent that their in-date for any training, that the staffing ratios are correct, and that the skill mix is correct, er, that I have facilitated people's wishes and wants erm, supporting staff you know, so that's from a management point of view. Erm, from a clinical point of view; to work in line with the policies and procedures. Treating acute medical patients and either fixing em' in the layman's sense, so fixing them or sending them to another ward essentially."

Lee listed a number of tasks which he is responsible for, it is notable that in this list the managerial aspect features far more prominently than the clinical, this might be

perceived as prioritising managerial duties and perhaps dismissing the more mundane clinical however, Lee went on to tell me;

"I like the acute thing and that's what makes me happy. What doesn't make me happy is the management side of things where you're pulled in all directions er you're expected to do so much,"

It is possible that Lee listed managerial tasks first and, in more detail, as they are a source of unhappiness to him and perhaps weigh more heavily on his mind, he was keen to talk of the stress he faced daily and the impact this has taken on his well-being and desire to continue in his current role.

Lee said, *"nursing is a really emotional and high stressed job, it is physically and emotionally tiring"* he also recognised that whilst stress is likely to be an issue for all nurses, *"AAU nurses are more stressed"* he rationalised this in terms of the fast pace and requirement to complete tasks quickly;

"it's hard work, so say you turn you bay over twice by that I mean you discharge and admit new patients twice so you get 8 patients out and more in during that day erm, along with all the other routine stuff you have to do, then that's a busy day erm, there's you well tend not to stay stationary for too long."

This fast pace, despite being something that attracted Lee to AAU could also be burden, he described occasions where he was so busy with acutely unwell patients that he had to delegate work to colleagues, he described feeling fatigued and worried;

"you have to rely on others to do your work for you and going home after that shift it was emotionally and physically tiring and you go home worried."

Lee once again reverted to second person when describing busy days and the sense of worry they created. This may be indicative of a sense of failure arising from the requirement to delegate and rely on others to complete his tasks. He went on to explain that he feared his professionalism being questioned because of mistakes he might make when tired or task loaded:

"my biggest worry is making an error at work through either fatigue, stress or general mistake, an error so big that it brings my nursing pin into question so that's my biggest worry."

Lee was worried about making errors and admitted to previously making mistakes when under pressure;

"I didn't recognise a guy who was deteriorating, his blood pressure was dropping his heart rate was going up and I just missed the signs and he deteriorated to the point where critical care outreach ended up being needed to come and assist and I just didn't recognise it. I think I was task focussed and just didn't really look at the patient."

He attributed missing the patient's deteriorating condition to being task focussed instead of his attention being on his patient. It is notable that throughout this statement Lee consistently used the first person, unlike when discussing what he might consider the undeserving patients or repeat offenders where he often switched to second person. This may suggest he takes ownership of this incident and the contributing factors which allowed the patient's condition to go unnoticed. This is supported by Lee's subsequent comment where he described reduced confidence and a sense of self-doubt;

"Absolutely shocking, useless nurse, out of my depths. I felt like that for a good few week if not months. It took a long time to build my confidence back up"

Lee's description may be related to the breadth of his role and expectations placed upon him by both himself and the organisation or by the fast pace and number of tasks required to be completed during busy days.

"it can be emotionally tiring and you're always questioning have I done everything I could because time is so tight"

Lee recognised experiencing self-doubt and the emotional toll this has taken on him. His comment suggested that self-doubt and questioning his own practice were a continual process which led him to feel emotionally drained. He commented that this doubt came from lack of time to complete his duties. His employment of both first and second person in the above statement was interesting, initially he spoke of emotional fatigue and doubt in second person as if separating himself from these negative experiences yet, in the latter part of the sentence he reverted to first person seemingly taking ownership of his actions. This perhaps offers insight into Lee's sense making, he was clear that task loading and his management role are negatively impacting his perceptions of AAU and when speaking of these elements he often used distancing techniques, conversely, he *"love(s) the clinical"* and adopted first person not only in the above quote but also in the example given in which his patient deteriorated.

"if your criticised as well that really doesn't help with the stress and you might have management on your back as well telling you that you've not done a good enough job and then on top you might have a clinical incident, for example; I recently had a patient that fell and that stressed me out as well so you know if you have it from both runs then stress is hard to deal with, it really is."

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Above, Lee described stress, suggesting that it came from managerial and clinical elements. Lee experienced stress in his role and said it was difficult thing to cope with, interestingly Lee did not view all stress as a negative;

"it's about having an appropriate amount of stress; I don't think you can be stress free but it's about not letting stress become overwhelming"

Lee spoke of appropriate stress as if this was an accepted part of the role, he has come to believe that stress is inherent in AAU but should be managed to avoid an overwhelming burden. Lee redefined stress as part of his discourse, initially calling it part of the job and recognising that it can be appropriate however, he later said;

"stress for me is that overwhelming sense of not being able to cope or to do everything to the best of your ability"

His later description considered stress as overwhelming and arising from circumstances where he was unable to complete tasks according to his own standards. He said, *"stress is hard to deal with, it really is"* and it had impacted upon his personal and professional life, Lee described a need to work more hours to complete his duties as well as of a reduced capacity for socialising and physical exercise;

"stress is well so, stress is yeah, when I'm not stressed, I'll probably go out, do more phys [physical], be more active and maybe socialise more but when I'm more stressed then I tend to do less, I think I have to be busy constantly with work in order to get things done and that becomes overwhelming."

Lee's narrative remained in first person throughout which may signify the importance of his experiences of stress and the impact it has on him. He continued to describe the effects of stress and some of the negative influences he experienced;

"I tend to not do phys which we all know releases endorphins, feel good hormones which helps with stress and I tend not to do that which only makes things worse and I tend to feel like I'm under pressure and sometimes it's hard to get over and well, I comfort eat sometimes just to, well yeah to, deal with stress"

Again, the narrative remained in the first person and offered a rich insight into Lee's lived experience. He discussed how overwhelming levels of stress led him to reduce his physical exercise and eat more. He described this excess eating as a source of *"comfort"* and something he done to help alleviate stress, he also suggested that stress

was not always transient and that;

"Sometimes I don't deal with it and I remain stressed for a period"

Lee described accumulating stress as something which *"does creep up on you and I end up thinking what is the point?"*. His statement was linguistically interesting in that he described an action (creeping stress) in the second person and the impact (questioning himself) in the first person. The statement itself perhaps hints at a cause-and-effect relationship and yet despite Lee's recognition of this, he still appears to want to distance himself, at least linguistically, from the cause. Lee went on to say;

"If I worry or stress too much it saps my energy and I feel like I don't want to turn up to work and I can't be bothered"

Negative impacts were evident and he described a lethargy and desire to avoid work. He had previously spoken about having to *"force myself to get on with it"*. There was a physical and psychological dimension to Lee's experience of the stress and associated anxiety. This is significant as this research aims to understand the lived experience of participants as they provide care in AAU, Lee appeared to be suffering for his commitment to his role and this is further evidenced below;

"I've at times gone off sick for a day or so with stress or where I've not been able to go into work because I've been too stressed and there have been times where I've been really low in mood because of it so yeah, of course; your emotional well-being does impact on the physical as well, but I've not reached that total breaking point yet and I'll say yet, where I've had to go long term sick because of stress because of low mood or stress but as I've increased my responsibilities the stress increases"

Lee remained consistently in first person appearing to take ownership of his experiences. His absenteeism was attributed to his reduced mood resulting from stress. It is particularly noteworthy that Lee refers to a total breaking point as if it is an inevitability. He appeared to associate increased responsibility with increased stress, though it was unclear if he was referring to managerial responsibilities or clinical however, he clearly described an increasingly disruptive cycle of stress and anxiety which he believed will lead to a prolonged absence.

Lee attributed many of his negative experiences to fatigue, work related pressures and the physical impact of stress. He described these factors as creeping and overwhelming and has reached a point where he has taken sick days to recover from stress, furthermore, he viewed long-term absenteeism as inevitable and attributed his continued presence to effective coping mechanisms;

"at the moment my coping mechanisms are ok but there might become a point when work becomes too much, and the stress gets too much, and it may throw me over the edge"

Coping and support:

Lee considered his coping mechanisms *"OK"* describing them as *"what allow me to come back"*. It is prudent to consider his experiences of coping and the mechanisms he employees to do so.

" I think stress and mental health issues is underlying in nurses and it is a real concern. As a team we try to care and look out for each other, you can always rely on your colleagues to help you through the bad times, and I like that about this place."

Lee introduced the notion of an underlying issue across nursing and spoke of a belief that stress and mental health issues are prevalent in the profession. It is notable that throughout the above quote Lee alternated the subjectivity, his use of first person suggested ownership of his *"real concern",* he then moved on to describe a shared reliance on the team and the transactional nature of this mutual supports, there was a change to second person as he described reliance on colleagues, this may have been an attempt to distance himself from a personal need for this support, what was particularly interesting was his immediate return to first person when claiming this mutual, team support was positive of AAU. It may be that Lee felt uncomfortable needing support but cognisant of the perceived benefits it brings to the team. Lee described the process of team support as a discursive one reliant upon disclosure of issues and shared sense making;

"you can offload and have a bit of a moan, then I think that's healthy. It ties into that clinical supervision as well you know, if you have concerns or tough times then you let it out you voice it and sometimes you come up with solutions and sometimes you just piss off and restart, reset and do it all again"

Once again, Lee reverted to second person in his description of the experiences of team support, this may be an attempt to remove or distance himself from the negative experiences which necessitate team support. It is perhaps most significant that he adopted first person only once in the above statement, this was when declaring the perceived benefit mutual support offers, he appeared to recognise and accept the benefits it has to offer whilst displaying discomfort at his own requirement for it, this

was evidenced by an immediate switch to second person as he described process this support took.

Lee spoke of several coping mechanisms which he has *"developed"* over the duration of his time in AAU;

"having a supportive individual at home, having that opportunity to have a quick reflection and as much as I hate reflection it does seem to work just having that chance to offload so that's my preferred coping mechanism."

Lee described having a supportive individual at home, going on to say this was his wife who was also an AAU nurse working in another unit. His description appeared dichotomous as he described a hatred of reflection but went on to suggest this was his preferred coping strategy, it was unclear whether Lee was referring to a hatred of formal reflection, but it seemed likely as he was focussed more on the ability to offload to his wife when he referred to his preferred coping mechanism. He described an informal process of reflecting and venting to his wife;

"you know having a general open conversation with the wife, so I guess that's erm quite an active reflection there and then of what went wrong. It helps that my wife is a nurse as well so she has an understanding so we can have a talk, so that's one way of dealing with it."

Lee's word choice appeared significant, he described active reflection taking place there and then, this appeared to be a contradiction in terms. His wife does not work in the same department, and he waits until home to have these discussions. As such they are neither there nor then. His statement regarding reflection taking place there and then would indicate at the point of stress and so it may be that Lee experiences increased stress once outside the working environment or that he holds on to this stress until he is able to speak to his wife. What is certain is that his description is at odds with the process he follows.

With respect to the claims of the reflection being an active process, Lee explained that both he and his wife, support each other and perhaps it is this transactional support that has given rise to his perception of the process being active rather than passive.

"it's good in the sense that when I'm stressed Tasha <pseudonym> tends not to be and she helps me and vice versa so we tend to prop each other up"

Lee described circumstances where one partner may be stressed when the other is not

and this is when venting worked most effectively, however, he recognised that this strategy, despite being his preferred mechanism was not without problems;

"well, I suppose I talk to the wife and bore her but if we've both had a bad day it can make things worse and we go to bed both feeling annoyed or frustrated"

Lee described occasions where both he and his wife return home stressed and on these days the coping mechanism can fail leading to both experiencing amplified feelings annoyance or frustration, Lee understood that this mechanism was limited and described how he had come to employ other coping strategies where required:

"I guess I use other coping mechanisms as well like I er (...) whiskey yeah I suppose maybe not, not drink, but sports is a great stress reliever for me as well it helps me cope with the stresses of work (...) just getting out and running or cycling you know it's a great way to get rid of the stress, sweat it out almost."

Lee spoke of using alcohol as a coping mechanism but was quick to change the subject. It is unclear why he did so however, when I mentioned it subsequently, he avoided my question and carried on talking about sports and exercise. His avoidance of this subject may be indicative of an awareness that it could be seen as a negative coping mechanism or one which he recognised as potentially damaging or embarrassing. Lee adopted a metaphorical description of exercise as a stress reliever in his declaration that exercise helped sweat out the stress, this again is an interesting choice of words and suggests increased physical exercise leads to greater stress relief, he went on to state this using plainer language:

"I know it sounds a bit strange, but I mean just like getting out there and exercising you know, it helps me forget how stressful the day has been, the harder I exercise the more you sweat and at the end of the session I feel a lot less frustration so yeah (.) sweat out the stress."

Lee described circumstance where high stress levels led him to feel like not exercising which may be indicative of overwhelming stress however, despite his assertion that he experienced stress as part of his role in AAU he also described an ability to reset his stress levels which allowed him to continue his role:

"I do worry but I think what happens with me is that I go away on leave or do exercise and get away from the work environment and I feel that lets me reset and de-stress and I feel like I reset to zero and then weeks and months go on and the stress levels begin to peak"

Lee described several coping mechanisms which appeared to assist him to manage his

experience of stress, he recognised the potential for stress to become overwhelming and consuming where it is allowed to increase without relief and he explained the need to achieve a sense of balance to avoid becoming burnt-out, Lee summarised his experience of coping by saying:

"You can't let work take over you know, there has to be a line and you have to vent for sure, but you have to keep a balance otherwise you'd end up, up to your eyes in work, stress and all the crap that goes along with it."

4.5 Beth

At 51, Beth was the oldest participant, her previous nursing experience was gained in primary care. She qualified in 2002 but had only worked in AAU for 18 months. Beth disliked AAU, in fact she *"hates"* the role and a lot of the patients she encounters. Smith et al, (2004) talk of finding a gem in IPA research and Beth certainly proved to be such a gem. Her age and previous experience made her the outsider of what was a homogeneous participant group, Beth met the criteria for inclusion and her age was not seen as a factor likely to make her significantly different from other participants. However, her previous life experience and advancing age made for some interesting discoveries.

The below table shows how Beth's themes contributed to the main themes of the study.

Table 9 showing development of themes Beth's interview

Sub themes from Beth's interview	Fit with cross-case superordinate themes
Coping mechanisms	I feel like I'm drowning
In it together	
Stress self-doubt and anxiety	
Exposure anxiety	I don't want to end up like that
Fear of old age	
Deserving and underserving patients	Repeat offenders
Us and them	
Let them die	

Fatigue, stress, and self-doubt

Beth made no attempt to hide her distaste for her work and the locality. She described the area as *"shit"* and AAU as somewhere she hated. In describing a typical day within AAU, she listed a number of factors which she disliked;

"Bad staffing, bad management on the ward, bad support, lots of levelled patients, lots of sick patients, loads of admissions, a big turnover of staff, not staff sorry I mean of patients in the bay and that's it."

It is unclear whether the order of the list implies any weighting to the level of frustration however, the speed at which she spoke when listing these may suggest she had previously considered this.

Working in AAU had impacted upon Beth's well-being, she spoke of disturbed sleep patterns, rumination and an escalating cycle of difficulty;

"I don't sleep, ever when it's like that because you analyse the whole day over and over again. You don't go in feeling refreshed, you're tired and it carries over just making the next day bad or harder"

It was significant that Beth switched to second person when describing the impact of her work, this may be indicative of an attempt to distance herself from her experiences. She would continue to adopt this position as her description of AAU continued;

"I think, I think it just makes you feel miserable and stressed and tired. You question yourself constantly and even when you go home and probably even to the next morning you question yourself. Did I do that right? Did that person survive?, Did I you know; tick this chart, write that note. It's just a shit feeling."

Beth introduced her experiences of stress and self-doubt which have developed due to her work. She spoke of a constant questioning which appeared insidious. The questions she listed directly related to her clinical delivery and may be largely responsible for her experience of self-doubt and stress. She stated;

"I'm not going to lie, I struggled with the change of pace and shift work. Primary Care was normal hours, less stress"

It is plausible that that she linked questioning herself to her feelings of stress, increased demands, misery, and fatigue. Beth made a connection between her work and sense of reduced well-being. Despite Beth's negative experiences of AAU, she described getting a buzz from her work;

"I suppose in a sick sense it well you know, even though it's shit and it's horrible, I suppose deep down you do get a buzz"

Beth used *"buzz"* to describe the feelings she experienced at the end of a shift, this was a metaphor commonly associated with positive experiences, interestingly, Beth suggested this buzz was experienced *"deep down"* and in a "*sick sense",* this may indicate that she viewed it is a primal feeling which she did not control, or as one perverted against her hatred for AAU. She described the *"buzz"* in more detail:

"I wouldn't say that it's like a yeah and excitement kind of buzz, but it's a buzz that you've got for getting through, you know, a buzz that I got through the day no matter how bad and how shit it was, it's like a tick in a box for yeah like I made it through"

Beth clarified her experience of the buzz as less of a sensation of excitement and more of relief that she has completed another shift. It is possible that this relief she felt was related to the stress and fatigue she attributed to her work or perhaps because she has one less day to endure. Her rationale remained unclear but what was evident was that Beth does not enjoy working on AAU and only experienced positive feelings when her shift ended.

The undeserving patient

Beth moved to AAU from primary healthcare in a very affluent area. The move was forced by her husband's need to relocate for work, Beth did not like the area or the people;
"I think a lot of it's just crap area and self-inflicted. Definitely largely down to the area I guess."
Beth spent much of her time treating patients with self-inflicted conditions, interestingly, she attributed this less to individual patients but to their age group and the geographical area. It is unclear why she did this but, she did make reference to high unemployment and drug addiction in the locality;

"I think generally because of the area in (name withheld), I think it was written down, you know in researched that it was the area in the UK with the highest Heroin addiction, so that could be one of the reasons. I, so er it has (…) a high percentage of the population of people out of work and on social support so you know?"

She appeared to make a distinction based on the patients age rather than their actual

presentation or background, assuming those under 40 to be self-inflicted;

"generally if we have handover and we have a patient who is below the age of 40 you can almost guarantee that they will be an alcoholic, self-harmer or someone who has taken an overdose."

Beth did not elaborate on the above point, and it may be that this accurately represented her experiences or perhaps it was a generalisation based on her dislike for the area and its residents. She stated;

"I dealt with nicer people who appreciated my help. Here they take us for granted and don't have much respect for us, but I think that might be because of the area"

She held disdain for local residents, and inferred that her work was not appreciated, she also felt her patients failed to demonstrate the respect she felt she deserved. She appeared to link these feelings to her experience of the younger population, it was not clear whether this is a fair approximation or simply her prejudice. What was clear however, is that she distinguished patients based on age, viewing older patients as more deserving or more likely to present with what she considered genuine illnesses;

"if someone is 50 or 60 maybe, they'll be the ones that are COPD or heart, anginas, genuine illnesses, you know but pretty much all those below 40 will be alcoholics, druggies or self-harm"

Beth's language choice was significant and exemplified her perception of patients, older patients were described as genuine whereas those under 40 were largely categorised as druggies or self-inflicted perhaps suggesting she viewed this younger group as undeserving. This view prevailed throughout the interview which was largely dominated by her fear of fragility, ageing and her experiences of caring for older patients.

Caring for the elderly

Beth spoke of her experience of caring for elderly patients, her thoughts and frustrations were evidenced at numerous points throughout the interview.
Beth made a distinction between deserving and undeserving patients based on age, implying over 40s were more likely to have a genuine illness. She then made a further distinction based on age which appeared at odds with earlier comments;

"if someone is older, old-old and comes into the ward with cancer then it doesn't upset me as much but when it's someone younger then it breaks me to see, it's scary and upsetting at the same time."

Beth's language suggested she may categorise older patients even further, referring to old-old patients suggests she considered there to be a young-old. She experienced upset when caring for younger cancer patients, yet this was not the case for older. It is unclear why she felt this way and could be linked to her view that younger patients do not suffer with what she considered genuine illnesses however, she considered that some patients ought to die;

"I think with all the medicine in all the world, sometimes that patient shouldn't be living anymore"

Beth went onto to expand on this suggesting historically, many patients would die rather than surviving to be readmitted;

"half or most of the patients that come in AAU, 20 or 30 years ago wouldn't have left the ward to keep coming in back and forward, cos we discharge a patient one day, and they come in the next with the same condition"

As she spoke she gestured with her hand, moving it across her throat in a cutting like motion as if suggesting those patients would have died had they been admitted several years ago. Her statement that they wouldn't have left the ward could be interpreted as meaning they would be kept in hospital until fully recovered had it not have been for her hand gesture which was indicative of Beth's frustration with the practice of caring for the elderly. She appeared frustrated by these patients and the resource burden she associated with them and could be seen as advocating letting these patients die instead of trying to treat their illnesses;

"It sounds awful, but I think sometimes nature should just be allowed to take its course, I don't think all the antibiotics, all the stuff we pump into them, well, it's just not helping. Not good for the patient, it's not good for the NHS"

Beth described her frustration and gave an example of caring for a patient who she felt was unsuitable for treatment;

"I think frustrated, yeah frustrated., we had a lady who was cardiac, 104 years old, she was bed bound and couldn't communicate because of her illnesses but she was with us for a hip replacement. I just thought that woman is never gonna get out of bed, never gonna dance, never gonna talk so I just thought what's the point in putting her through all of that pain and you know to give her a hip replacement,"

Beth experienced frustration at the idea of providing a hip replacement to this patient, it was notable that the narrative appeared to be about the patient's quality of life, co-morbidities and potential benefits or lack thereof associated with surgery. Beth appeared to consider the benefits of surgery against the pain of the procedure. This may have been a genuine consideration; however, Beth went on to state;

"Is it really bad to say that I just felt it was pointless a waste of time and resources, no benefit to the patients, a waste of resources I just think, well I didn't understand the purpose of it. You put a 104-year-old lady through all that and how much it costs when there's young people that need cancer treatments that the money could have been spent on that instead"

Again, Beth appeared to make distinctions based on age. She suggested that funding be better spent on younger patients, this was interesting given her belief that younger patients tend not to represent genuine admissions. It was linguistically significant that she began her statement with a rhetorical question, as if seeking my view on what could be seen as a controversial opinion or perhaps, she was questioning her own prejudices. As well as her views on funding the care of the elderly, Beth claimed to feel like a babysitter to certain older patients;

"get one, just one with levelled (this was a term used to describe patients needing enhanced observations) *or delirium and the day goes to shit, you can't do anything because it's like, well you're babysitting, and your focus goes to that one person. Crap, really frustrating and it just gets you down."*

She described these patients as baby-like and a drain on time. Her language choice was strong, calling her day shit when these patients are present. She used the term *"crap"* to illustrate her frustration and it appeared she experienced reduced mood when dealing with these patients. In summarising her experiences of caring for the *"old-old",* Beth informed me that*, "you actually start thinking of excuses not to look after them"*

Fear of Frailty

Beth's experiences appear to have impacted upon her perception of ageing and the

impending frailty she will experience. This section attends to Beth's sense making around this theme.

"I don't worry about dying cos it's inevitable isn't it? It's the way you die that worries me. The lead up to it, that old age and illness thing. It goes back to what I was saying about ending up like my older patients."

Beth appeared to accept the certainty of death, stating that death itself is not a cause of anxiety instead she was concerned about how she would die, and this appeared to be a cause of great anxiety. Previously, she described a desire to allow certain elderly patients to pass without medical intervention claiming that these patients experienced increased suffering when there was too much medical intervention and it appeared Beth had concerns about becoming one of these patients who *"not be living"*. She explained these fears in more detail;

"I just really fear getting old and being ill and useless and not being able to do things. I don't mind being old and healthy I just don't want to be like these patients here, in and out of hospital, ill and useless."

Beth's experience of caring for these patients appeared to have influenced her thoughts on ageing. Her language was repetitive, and she seemed to link illness with uselessness, it is unclear why she believed this to be the case however, it was a recurring statement and the two things appeared inter-related. It was interesting that she claimed to be content to get old so long as she remained healthy, this suggested that the healthy old have purpose/use whereas the unhealthy old are useless. Beth cared for many older people most of which she deemed better left to die and perhaps her experience of these patients impacted upon her view of her own ageing and frailty. The uselessness of the elderly was prominent in Beth's sense making and yet she stated;

"I do get really hooked on the futility of ageing though, patients with cancer for instance scare me. It's a big thing to me because I've known a few people who've died of it about my age as well as the patients I've seen with it too"

Beth admitted to being focussed on ageing, so it was interesting that she claimed not to focus on the futility of it, this statement appeared at odds with her prevailing narrative and perhaps she made this declaration as a means of moving the conversation on to a different topic. She introduced her experience of caring for cancer patients and linked her experiences to her own age and her encounters with patients of similar demographics, it was interesting that she used cancer in which to situate her

experiences and anxiety. Cancer is typically seen as a pathology impacting a range of age groups whereas, Beth seemed to be concerned primarily with the frailties and fragilities of ageing although it is possible that the deaths, she described have alerted her to the failing health associated with advancing age. Beth told me;

"I don't smoke because I just think if I did that's what happens to smokers"

It is conceivable that Beth's attitude towards smoking came from her experiences of cancer patients. She said; *"I do try to live a healthy lifestyle".* This may not seem like an important statement however, Beth's health beliefs have been altered, she attributed this to her work experience and her advancing age;

"when I was young, I wasn't so aware but at my age and in this job its always there that like niggly feeling that you could die anytime or get some illness"

Beth described feeling she might get an illness or die at any time. She switched to second person when describing this feeling which may have linguistic significance as an attempt to distance herself from any future illness. Beth described her fear of becoming a patient, and anxiety surrounding the medical interventions which she might have to endure;

"I'm gonna be like the patients I see now, and I just think what's it gonna be like then, how will I be flogged and life dragged out. That's what worries me most that ongoing need to drag out life even if it prolongs suffering."

Beth reinforced the idea that it was not fear of death that created this anxiety but fear of the path towards death. She described becoming like her patients and a concern for how she will have her life artificially prolonged at the hands of medical interventionism even if to her perceived detriment. This led Beth to the conclusion that;

"it makes me not want to be old I think about that every day it scares me. I'm really hoping that by the time I get to that age there's a button or a pill you can take, and I do let people know that if I get like that just to bump me off"

Coping and support

Beth expressed her anguish and dissatisfaction with her current role, the patient group, locality, fear of frailty and sense of being trapped in the role however, she returned almost daily to face this work which caused her so much distress. This final section examines her experiences of coping and support and the mechanisms which allow her to process her experiences and understanding.

"I don't think about coping, I think it's something you just do, I don't have any strategies it's something you just talk about with your colleagues or whatever, have a little moment and then just crack on."

Beth spoke of not considering coping mechanism, instead she described coping and support as more of an organic process which just happens and yet she went on to list several strategies. It is possible that she failed to recognise these as specific strategies or deliberate acts. She was cognisant that she engaged in these activities but perhaps she considered this as a passive process rather than one which was actively sought out. Crying and talking to colleagues featured prominently in Beth's experiences;

"crying, a lot of crying, talking it over with other people, erm, I think it helps to talk to colleagues as well, especially on the way home er (...) and knowing that other people on the ward have gone through or going through what you've been through as well helps."

Beth recognised positive outcomes of talking with colleagues, her statement suggested she found comfort in knowing others felt the same or had similar experiences. She focussed on the journey home as the optimum time for these conversations, she used this time to decompress and separate her work and home life. Shared experience and collegiate support appeared important to Beth and she claimed;

"It makes you feel like you're not alone in these things. Yeah, talking to other nurses really helps cos they get it."

Beth expressed relief in the knowledge that she was not suffering alone and viewed this as a source of comfort and reassurance but there may have been a more practical aspect to the support being offered, in the below statement she explained she received appropriate support for her situation because of her colleagues sharing similar experiences:

"they actually help you and understand that you're struggling and give you that support that you need."

Beth adopted second person which may be indicative of an attempt to distance herself from the situation, struggle, or requirement for support. Beth was clear that AAU was an area which she was not enjoying however, it is testament to her perceptions of the team and the value she placed on their support that she stated:

"The team are lovely and really help each other get through all the shit times, they almost make it worth staying but I still hate it."

4.6 Eve

Eve was a band 5 staff nurse who had close ties to the local area and had spent much of her life living and working in the area. She considered herself to be a good AAU nurse but described being frustrated by the bureaucracy of healthcare which she believed limited her ability to provide care.

Eve qualified in 2014 and has worked in AAU for 3 and a half years. Eve spoke very quickly with a strong regional accent which meant answers had to be repeated occasionally and that linguistic subtleties may have been missed or misinterpreted. The table below shows Eve's themes and their fit within the main themes of the study.

Table 10 showing development of themes Eve's interview

Sub themes from Eve's interview	Fit with cross-case superordinate themes
Coping mechanisms	I feel like I'm drowning
Nature of AAU	
In it together	
Stress self-doubt and anxiety	
Exposure anxiety	I don't want to end up like that
Fear of becoming a patient	

Nature of AAU

Eve described AAU in terms of tasks, knowledge, and time pressures which she experienced. Eve listed tasks rather than giving detailed descriptions, this may be indicative of her focus on task completion and her experience of time pressure. She described her role as;

"admitting patients, getting a medical history from them and handing that over to the doctor, prioritising those who need priority care. Erm and then general ward care because people aren't moving on as quickly now so you can have general ward care like washes and wound care."

Eve spoke of a need for vigilance and flexibility in her work;

"it's all about being flexible and being pretty switched on when you're admitting meeting, looking out for escalation signs. Maybe if you're admitting two patients and one's just got a bit of a chest infection and one's a telemed with ECG changes that you're using your brain, prioritising, and getting a doctor to review them as soon as possible."

Eve continued listing tasks however, in this description she appeared to make distinctions between practical tasks and those requiring cognitive effort. She referred to being *"switched on"*, which was a metaphor to explain the need for high alertness to ensure timely responses to patient conditions. She explained the requirement to use her brain, I wondered if this she thought nurses in other areas were not.

"we sort of get things pre speciality and we'll do all the tests and then they go there, lots of drinkers, respiratory, OD. That's the thing with AAU you've got to know what to do for what patient when they come in"

Eve claimed there was a requirement for AAU nurses to possess the knowledge to treat pre-speciality patients, this would necessitate wider knowledge than needed in other clinical areas.

"a lot of our nurses are more clued up because, well, you have to be working at a decent level to be working on there or at least to be working safely"

Eve viewed AAU nurses as more technically competent knowledgeable than others. She claimed to work safely in AAU, nurses must be at a decent level. This was an interesting comment and one which she made in second person, the use of *"you"* in her statement might refer to her colleagues, nurses in general or indeed herself, it is noteworthy that she collectively refers to these nurse as *"our"* as if to suggest possession or inclusivity within the AAU team. The word decent suggests average however, in Eve's local dialect it is a term used to mean good or better. Remaining in second person, Eve went on to declare;

"AAU either makes or breaks you."

She believed there could be only two outcomes for AAU nurses, thrive or break. Her earlier statements suggest those that succeed were flexible, able to respond to patient condition and work autonomously, conversely, Eve considered those who were broken to be;

"Those that fail I think don't have a basic understanding a lot of the time"

Eve went on to enforce her belief that AAU nurses must be able to work at a *"decent"* level, claiming that;

"I do think you have to be clinically educated to be on there, you have to be able to pick things up quickly and understand why you're doing things whereas I think on other wards, the doctors are very much there to hold your hand unlike AAU where you're pretty much autonomous."

She appeared to believe that effective AAU nurses were flexible and clinically capable as well as possessing the ability to work autonomously. She seemed to believe AAU nurses were better than those in other areas. Eve suggested nurses working in AAU chose to do so for the fast pace and uncertainty it entailed.

"People choose to work on AAU for the fast pace and when you've got people stuck in beds for 4 or 5 days it's frustrating"

Eve spoke of frustration caused by reduced pace due to extended patient stays;

"there should be a quicker movement, but I find here it doesn't move as quick as it should a lot of the time."

Eve attributed reduced patient flow to bad management. Interestingly, she blamed certain people within the management team for this and suggested that a nepotistic system existed where poor performance went unchallenged, suggesting an old girls' network;

"it's badly managed all the time when certain people are left in charge and nothing gets done about it. Again, because they all look out for each other, it's who you know not what you know, goes back to the whole politics thing I suppose, and it really pisses me off."

Eve's frustration may have been attributable to the political nature of AAU or delayed patient flow, however, she was explicit about the negative impact this had on her experiences of care delivery and her personal life;

"your patients ultimately suffer because you're pissed off, don't want to be there and also relationships suffer, my partner doesn't want to listen to some sour faced cow gobbing off about how much of a dick the bed manager is or how scared I am that I've caught cancer or monkey aids or some other such bloody illness every other week"

Fear of becoming a patient

"it's not the crap of the job that makes me lose my compassion sometimes it's more the surety that at some point I'm going to be on the receiving end and it's almost like I'm rebelling in some way, like a cognitive dissonance between, me not wanting to end up like my patients but at the same time not wanting to look after them because I'm scared of becoming them."

Eve described waning compassion, not driven by her duties but rather the assumption that she will one day be receiving care. This may have given rise to her sense of rebellion and experience of cognitive dissonance. She described fear of becoming a patient which appeared to turn her away from caring for them.

"we see a lot of respiratory problems and respiratory arrests on AAU and they're normally COPD patients".

Eve spoke of the prevalence of respiratory conditions and the high numbers of COPD patients. She went on to describe her experiences of COPD and her anxiety surrounding it;

"I think obviously me being from the area and after watching that many people go through it and obviously COPD is a death sentence, it's always a worry that you might end up like that one day. It's always horrible to watch them"

She appeared to link being from the area to her fear of developing the disease. She reported that her fears and anxieties are the result of the commonality of COPD in her hometown;

"They (fears) probably became more so when I moved back up North, you saw it in Birmingham where I did my training and we did case studies on it but until you're actually in the numbers and nursing and seeing it, probably the majority of your admissions that come in have a past medical history of it or have an exacerbation of it, for me it's how common it is up here."

Eve claimed to always worry about becoming a COPD patient and described it as a horror. Interestingly, other than being from the area, she did not describe herself as suffering any of the precursors to COPD and did not mention being a smoker. She made distinctions between COPD and cancer, claiming her experiences of caring for COPD patients were more harrowing and difficult cancer patients.

"it's horrible, it's just one of those horrible diseases it's like, well Cancer is evil as well but that's a silent killer whereas COPD is it looks painful it looks uncomfortable, it's

debilitating if they need home oxygen, they struggle to mobilise more than 10 metres it just makes me worry about getting it, it's awful."

Eve's repetition of the word horrible to describe COPD may be indicative of the impact her exposure is having. She suggested it was worse than cancer saying it was a more visible and less silent. I wondered if she meant more visible to her or the sufferer. Her experience made her fear COPD but she also feared becoming like the older patients she cared for;

"you're making a mess or wetting the bed and, it's awful but, they must feel like an inconvenience constantly and I don't want to be that person who can't move or when they do move, they fall and cause somebody loads of paperwork and make them really angry"

She suggested these patients see themselves as an inconvenience although this appeared to be how she viewed them (She pointed at herself as she spoke of *"somebody"*). Her reference to the generation of paperwork and ensuing anger evidenced this. Eve feared becoming like these patients and believed her role caused this fear to grow;

"It scares me the thought of being like that and I think being a nurse makes it worse because it's in my face every day."

Throughout her narrative Eve regularly returned to the recurrent experience of seeing illness and frail patients, she declared this proximity to be the basis of her fears and suggested that were she not a nurse, these fears would likely be lessened;

"I wouldn't be anywhere near as educated or used to seeing these things. I think being a nurse you see all these elderly patients and you see what it's like to get old and you just really don't want to get old."

Eve said she was used to seeing these things in reference to frailty and sickness and yet rather than being desensitised she appeared anxious and fearful. She proposed that nurses are tired and fed up of nursing and that this knowledge further incubated her fear of becoming a patient;

"Nursing kind of makes you scared to be nursed because you just know all he nurses are sick of their jobs, tired and stressed and in most cases are just tired of having to be nice to people all day long."

The undeserving patient

This section attends to Eve's experiences of dealing with what she termed *"repeat offenders"*, this included presentation such as overdoses, drunks, and self-inflicted conditions. Eve was frustrated by these patients;

"self-inflicted patients. I'm not very good with those patients. I think they annoy me, because I just think put up and shut up, there's always someone worse off than you and I can't understand why they do it when I see people dying who really want to live and then you get these idiots cutting themselves or taking overdoses, I find it really difficult to give them any sympathy."

Eve struggled to identify with these patients and was frustrated by them. She considered these patients to be less in need of her care and that they should not attend AAU. She described them as *'idiots'* and said;

"I find I have to try extra hard to be nice, it's a real conscious effort to well, I try not to judge them but it is really frustrating when I have say a 90 year old man who's had a fall through no fault of his own and who needs my attention bit then I've got an 18 year old drug abuser in the bed opposite demanding cups of tea or methadone or whatever. I really have to bite my tongue especially with the repeat offenders."

Eve seemed torn between her internal feelings and what is expected of her as a nurse. This emotional labour influenced by her belief that some patients deserve care more than others. She described an occasion where her time was diverted from a *"proper"* patient by what she called a *"repeat offender"* and continued to explain her experiences of emotional labour;

"I'm just thinking; dick head. It's like they felt entitled and I'm just thinking, I don't want to do it for them, you kind of want to put it off because you don't feel it's a priority at the time but then I suppose to them it is a big deal. It sounds really bad but outwardly I'm trying to be professional but on the inside, I'm just thinking you're a knob"

Eve's choice of words was indicative of her frustration with these patients. Words such as, 'dickhead' and 'knob' were used to describe these patients and Eve used the first person, suggesting she took ownership of these negative perceptions. Interestingly, she switched to second person when speaking of her experience of delaying care to other patients due to this self-inflicted group;

"you have to keep people in a corridor waiting for beds and then you've got these self-

inflicted people that are just sat taking a bed demanding stuff from you. And they don't necessarily need it, and they wouldn't be there if they hadn't done what they've done. you always think somebody else deserves your care more who isn't self-inflicted. It's hard to split yourself."

The adoption of second person suggested an attempt to distance herself from care being delayed to her *"deserving patients"*. Eve's experiences in AAU appeared to have changed her approach to *"repeat offenders"*, in that she now actively avoids them instead, passing their care on to others;

"somebody below my pay grade can take care of them; you pass it on"

Eve's word choice suggested she considered patients to fit within a hierarchy and that those she passed on or avoided were beneath her. When asked whether she felt all patients should be treated equally she replied;

"*I have to say 'yes', don't I? according to the NMC"*

Almost immediately she appeared to caveat her recognition of her professional code as if suggesting that whilst bound by it, she might disagree or struggle to uphold it;

"Most of them don't even pay into the system half the time but it's part of being a nurse, you have to treat them all the same despite what you think inside."

Eve spoke again of the disconnect between internal and external behaviours and feelings. She offered numerous examples of her experiences of emotional labour, and when asked what it meant to be a repeat offender, she said;

"I think repeat offenders is a term we use to describe patients who come in day in day out always having taken a small overdose or cut themselves not enough to kill themselves but enough to get admitted, it's like they love the drama of being in hospital."

Eve suggested the term had become part of the AAU nomenclature which may have shaped her understanding of how these patients were viewed. She suggested these patients thrived on drama, only hurting themselves enough to receive attention. Interestingly she went on to state;

"A psych nurse would probably have a long word for you to diagnose it but then they aren't dealing with it day in day out so to me they're just time wasters and bed blockers."

Eve's reference to psychiatric nurses may suggest she recognised these patients perhaps had underlying psychological conditions however, she did not state this explicitly, instead choosing to remain negative in her description. When describing how she would like to deal with these patients, Eve gave an example filled with connotations of emotional labour;

"You get IV drug users that pull cannulas out left right and centre and tell you that they want to go home but we always ask them to stay and spend time persuading them to stay but I think now we should just save our time for those that want help and just let them go."

This statement summarised Eve's sense making and experiences and was perhaps an indication of the impact of emotional labour and caused by caring for these patients.

Stress, fatigue, and self-doubt

Eve spoke of stress, anxiety, and self-doubt which she experienced on AAU, she spoke of wanting to leave nursing and AAU as well as a sense of frustration and reduced well-being.

"there's days when I don't want to be a nurse and I'd miss it but I think I'd struggle to make a career of it, there's so much stress and for such a low wage and the hours you work, and the problems you take home because you don't just go home and forget you'll go home with things playing on your mind and certain things will upset you"

The above summarised Eve's experience of AAU, she described long hours, taking problems home and a sense of upset. She suggested these negative experiences were not offset by the remuneration and led her to contemplate leaving. She switched from first to second person as if making a distinction between her choice to stay or go, this was within her control whereas the negative factors were not.

Eve considered two types of stress to exist in AAU, that caused by patient conditions and that caused by organisational factors:

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"I thrive on a bit of stress, I think most AAU, well good AAU nurses do. There's good stress and bad stress like, the stress of the job that you expect is that from sick patients and that's a good stress but then there's the stress of the job that is unnecessary like that caused by bad management and that's what gets on top of you."

She believed what she considered good stress allowed AAU nurses to thrive, it is interesting that this stress was derived from patient deterioration. Eve did not explain why stress was good but perhaps this was linked to the adrenaline rush and sense of being needed. She believed;

"Stress is a massive part of this job, but I think there needs to be a bit of stress on AAU because it drives the pace and things get done more quickly, I think."

Despite believing an appropriate amount of stress was necessary to keep AAU moving and nurses motivated, organisational stress was not considered positive and caused Eve anxiety and frustration;

"It's just the politics of the NHS, you feel like you've done somebody a disservice, they get to ninety-odd and they're just an inconvenience to be shoved around the corridors. I was so angry and upset,"

In the above Eve was describing management overruling her clinical judgement and insisting a patient be moved for organisational reasons rather than patient centred. As a result, Eve experienced feelings of self-doubt and guilt that she had not been allowed to care for her patient effectively. When asked to describe her feelings after this incident she said;

"just making me feel useless and getting myself upset. Just (...) mentally draining, totally mentally drained. I went home just feeling like I'd done a shit job and felt really bad"

This suggested Eve's mental well-being had been impacted by her experiences. Her description referred to an occasion where she felt patient care had been compromised, however, it was interesting that when asked to describe a good day, Eve, elected to give a broad description instead of recalling a specific day or event. This may indicate that, bad days were more memorable, good days were infrequent or that bad days were so common that anything outside of this would be considered good. For Eve to consider her day to be good all she required was;

"just go home happy and content that things got done properly and I get home on time and not stressed."

Continuing to explain her sense making and experiences of well-being Eve told me;

"well-being is all about being able to go to work but then on your days off still being able to do the things that you want to do without being too tired or stressed from work and it is impacting on it, but there are days when I've done 2 long days and I've maybe missed breaks and so on my days off then maybe my well-being isn't as good as it should be cos I'll be knackered"

It appeared she considered well-being to require a work-life balance and that where this balance moved towards work, her stress level rose, and her personal life suffered. She explicitly linked wellbeing to work related stress. She suggested the balance was dynamic claiming;

"Sometimes you're floating and others you're drowning. AAU is just like that"

Eve's use of drowning as a metaphor maybe indicative of her experience of the highs and lows of AAU or perhaps the ebb and flow of her well-being, it was an interesting linguistic choice associated with the panic of being out of control and perhaps this was how Eve perceived her experiences.

"like a catch 22. I wouldn't be happy on a normal ward with no stress because the day drags but then AAU is really stressful, I like the faster pace so it's difficult"

She recognised that a slow-paced ward would not offer her the *"good stress"* she claimed to thrive on but conceded that AAU is so stressful that;

"it definitely impacts upon your health because you finish two long days and on the third day you just need to rest a bit and I don't feel like doing anything"

The toll taken by her work appeared to be physical and mental. She previously described the impact of stress and self-doubt on her well-being but here she spoke of the physical toll describing fatigue and the need to rest. Her work appeared to impact on her personal life, and she discussed isolation and lack of social interaction following her shifts;

"after two days of talking to people non-stop I like my third day to be not talking to anyone so yeah, I guess mental health-wise its making me a bit isolated on my days off,

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and then not being as fit and being tired its meant I've put on weight so yeah I'm not as healthy and I think it shows in my confidence too."

Eve stated her mental health was suffering, and her physical fitness had been affected by her work, she recognised that this had led to reduced self-confidence and went on to tell me;

I used to be really caring and thought I could save everyone, now I'm not even sure I can save myself.

This statement offered great insight into Eve's sense making. Her use the past tense when talking about being caring may indicate a reduced ability to care, burnout or perhaps the impact of emotional labour. Secondly, she spoke of believing she could save everybody, this is possibly linked to her preconceptions of what it is to nurse and perhaps most poignant was her assertion that she is unsure she is able to save herself. She went on to describe what it was she needed saving from;

"I mean like save myself from all this crap and stress, worrying about it all. It makes my physically sick sometimes, I often wonder who is the poorly one when I'm at work. My head is fucked, and my body is too"

Eve's language was powerful, her use of expletives amplified her expressions of her experiences and assertion that she saw herself as poorly. She considered herself akin to a patient in that she needed to heal or recover from her work. Her description of her head and body being 'fucked' suggested she was acutely aware of the mental and physical tolls being exerted.

Eve made an unexpected disclosure regarding her personal health which has not been included in this analysis. To comply with the spirit with which my ethical approval was granted, the discussion changed to the coping strategies she employed.

Coping and support

The above section examined Eve's experiences of stress and anxiety, despite her apparent suffering she returns to work on AAU and claimed this was due to her ability to cope and decompress.

"like being a spring or something. All the shit and stress piles on top of you and crushes you, I'm only 5 foot so there's not that much to crush (laughs), but yeah it just all piles on and then I have a massive vent"

This piling up of *"shit"* and the associated spring metaphor indicated how Eve made sense of her stress. She spoke of venting and releasing the pressure and stress which builds up. For Eve, venting involved talking to colleagues and talking to family and friends;

"talking to your colleagues I find helps you know just moaning at each other about how crap it is and getting it off your chest, that helps."

"I phoned my mam and just vented at her for half an hour, I think cos she is a nurse as well she just lets me go. It helps when you've had a proper crap day just to off load it."

Eve's narrative was similar whether venting to family or colleagues, the benefit she gained from being able to talk about her day seemed to make her to feel part of something bigger than herself, she suggested that knowing others were experiencing similar issues made her feel better about her own experience;

"The biggest thing about talking to people is that it makes you feel vindicated in that other people are stressed too and it's not just you not coping, if somebody else turns round and says yeah that was a really shit shift you feel better knowing that you weren't just being a shit nurse that day or I wasn't just being crap."

Eve's use of second person may have been an attempt to distance herself from feelings of failure and not coping which she described or perhaps was simply colloquial language.

Eve described a piling up of 'shit' and used the spring metaphor to describe her experience. When describing the positive impact of talking to others she described weight being lifted;

"blow it all off and it kind of takes the weight or pressure off so I can go and let it all build up again."

She appeared to view this stress-decompression model as cyclical, which was evidenced in her statement;

"At least then when I go back in to work, I've kind of decompressed a bit and I just try to get on with it again"

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It was unclear how long she felt she could sustain this cycle but she said;

"we have to pay the bills, so for now, I will keep coming back".

4.7 Cross-case analysis

This section presents, a cross-case analysis which examines the interrelatedness of participant experience to identify the essence of AAU nursing and its impact upon nurses. Abstraction and subsumption were employed to identify superordinate themes, these processes led to identification of three superordinate themes; "I feel like I'm drowning", "I don't want to end up like that" and "The repeat offenders". The process of identifying superordinate themes has been described in the methods chapter. The table below, outlines the sub themes which were present for each participant, the second table shows how sub themes were clustered to form superordinate themes.

Table.11 Presence of sub-themes according to participant

	In it together	Nature of AAU	Stress, self-doubt and anxiety	Fear of becoming a patient	Repeat offenders – the undeserving patient	Caring for the elderly	Self-importance
001 AMY	Yes	Yes	Yes	Yes	No	No	No
002 SARA	Yes	Yes	Yes	Yes	No	No	No
003 ROB	No	Yes	Yes	Yes	Yes	No	Yes
004 LEE	Yes	Yes	Yes	No	Yes	No	No
005 BETH	Yes	No	Yes	Yes	Yes	Yes	No
006 EVE	Yes	Yes	Yes	Yes	Yes	No	No

Table.12 Master table of themes:

Theme	Example from interviews
1. I feel like I'm drowning	
1.1 The nature of AAU	*It's busy, it's fast pace and you get a lot of respect from nurses in other areas cos we are seen as the more skilled and knowledgeable ones and autonomy, we get to do a lot of stuff other nurses don't, we're like mini doctors. It's nice to be important you know (Rob Pg-2, L-11)*
1.2 Stress, anxiety and self-doubt	*I think, I think it just makes you feel miserable and stressed and tired. You question yourself constantly and even when you go home and probably even to the next morning you question yourself. Did I do that right?, Did that person survive?, Did I you know; tick this chart, write that note. It's just a shit feeling. (Beth Pg-2, L-5)*
1.3 In it together (coping and support)	*we try to care and look out for each other, you can always rely on your colleagues to help you through the bad times and I like that about this place (Lee Pg -11, L-13)*
2. I don't want to end up like that	
2.1 COPD and Cancer	*You certainly don't want to die that way but I know I will, I have to stop smoking but the things you see and stuff you know seeing the outcome makes me need to smoke (Sara Pg-8, L-30)*
2.2 Fear of becoming a patient	*it's not the crap of the job that makes me lose my compassion sometimes it's more the surety that at some point I'm going to be on the receiving end and it's almost like I'm rebelling in some way, like a cognitive dissonance between, me not wanting to end up like my patients but at the same time not wanting to look after them because I'm scared of becoming them (Eve Pg-3, L-23)*
3. The repeat offenders	
3.1 Repeat offenders	*This is gonna sound a bit bad, probably good this is anonymous but; self-inflicted stuff is something I struggle with, in specifics it's the repeat offender, cries for*

	help, attempted suicides I struggle with there's only so much support or empathy you feel you can offer (Lee Pg-4, L-14)
3.2 Deserving and undeserving patients	*self-inflicted patients. I'm not very good with those patients. I think they annoy me, because I just think put up and shut up, there's always someone worse off than you and I can't understand why they do it when I see people dying who really want to live and then you get these idiots cutting themselves or taking overdoses, I find it really difficult to give them any sympathy (Eve Pg-5, L-25)*

4.8 "I feel like I'm drowning"

This superordinate theme came from the recurrent participant themes; nature of AAU, stress, anxiety, self-doubt, coping and support. This cluster encompassed what it meant to work in AAU telling the story of the environment, its challenges, the trials faced by nurses, toll it took on them and, how they managed their doubts, fears, anxieties, and stress to continue working in AAU.

All participants described the AAU environment. It was described as busy with a fast turnover of patients, a place of unpredictability and varied patient presentations (Sara, Pg2, L2). Amy (Pg2, L3) described it as *"like A and E but, harder"*. There was a sense that participants considered AAU nurses as more capable and knowledgeable which induced a sense of self-importance (Rob, Pg2, L12) and kudos (Sara, Pg2, L10)

The challenges and fast pace of AAU were seen as positives and negatives (Sara, Pg3, L19 and Beth, Pg2, L4) leading to good and bad stress associated with timely completion of tasks. All participants described a sense of urgency and task focus, some claimed to thrive on this but Rob, (Pg4, L16) claimed it led to junior nurses experiencing difficulties.

AAU was characterised by time pressures, unpredictability and the need for clinical competence. All participants viewed themselves as capable clinicians and yet all described feelings of stress, anxiety and self-doubt arising from their work.

All six participants within this study described feelings of stress, anxiety, and self-doubt because of their work in AAU. A common metaphor for this experience was *"drowning"* or *"sinking"* (Amy, P3, L23), this might imply that participants found themselves struggling to cope with the pressures of AAU and the impact it had on them.

All participants appeared to have a negative impact upon their physical and mental health. The physical element manifested primarily as tiredness and fatigue whereas the mental included feelings of reduced self-worth, anxiety, inability to relax and experiences of reduced self-confidence. Interestingly, despite all participants stating their mental health had been impacted upon, none spoke of any formal diagnosis or having sought any mental health treatment/support. There appeared to be a general acceptance amongst participants that AAU and decline in mental health were almost intrinsic. Despite expressing the anxiety and self-doubt they encountered on a daily basis, participants did not suggest that this was out of the ordinary or unique to them, in fact, Beth, Lee and Sara told me that all AAU nurses experience these feelings.

There was a general consensus that AAU was a kinetic and fast paced environment and that a certain level of stress was appropriate and could actually drive and improve performance, it appeared however, that participants felt that this level was too often exceeded and that they were suffering as a result. The additional stress was attributed to a number of factors including bad management (Lee, P9, L2), poor staffing (Beth, P1, L20) or lack of experienced nurses (Sara, P4, L6 and P5, L13, Lee, P2, L25 and Rob, P3, L1) and the type/acuity of patients on the department. Lee (P3, L12 and P9, L2) spoke of management issues both in terms of structure and behaviour suggesting that there was too much paperwork, and that management could be unsupportive and even destructive. Sara (P4, L22) claimed non-clinical work would often be passed down to avoid litigation. Whilst management appeared to be a cause of stress for participants there were occasional examples of immediate line managers offering support (Amy, P9, L29).

Management issues featured prominently in the narrative with participants claiming that the quality of their day could be determined and predicted based upon who was in-charge of a given shift. Poor managers were described as those who were unable to forward plan or manage time effectively (Beth, P1, L20), during shifts with these

individuals in-charge participants experienced heightened stress and anxiety which they attributed to delays in transferring patients, inappropriate clinical decisions and a sense that the department was disorganised. After such shifts, participants expressed increased desire to leave AAU, heightened anxiety and a need to decompress. Conversely, on days where good managers where in-charge, there was a sense of calm, efficiency and participants felt they were supported. These days were widely described as the good days in which participants felt able to do their job well and not go home doubting their practice and care delivery.

It was interesting that both Lee and Rob assumed management responsibilities and yet shared in this view. It is noteworthy that they, as well as others made reference to the politics of the AAU with Eve describing inter-department politics and smooth patient transfers being dependent upon who was in-charge and who they were friendly with in other departments. This is perhaps an insight into organisational culture of AAU and the wider hospital, allegiances are formed and friendship groups manifest over time which have an impact upon the delivery of services and experiences of those working within this culture. There were subtle references to this in most participant narratives however, Eve was especially critical of this situation and found it particularly frustrating.

The impact of continued high stress appeared to manifest as anxiety and self-doubt with participants beginning to dread returning to work or to ruminate on their daily actions, questioning whether they had carried out all tasks and duties correctly (Beth, P2, L5). It appeared to be a commonly held belief (Lee, Beth, Sara and Rob) that this led to a cyclical effect which continued to be amplified until such time as they were able to break the cycle. For some this break meant taking time away from AAU whereas for others it involved doing some physical activity. Eve (P10, L27) described her experiences, claiming not to know which was more affected, her body or her head. She was referring to the physical and mental health impacts of her work. Comments like this were present across all participants and makes it apparent that AAU work negatively affected this group of nurses.

The idea of exercise as a stress relief was common across participants with 5 out of 6 describing it as a beneficial experience and something which alleviated their stress. Under normal conditions they would use physical activity to keep stress in check

however, at times of *"drowning"* they described reduced physical activity and a reduced desire to exercise. It is perhaps significant that a common coping mechanism can be undermined or overwhelmed when stress levels are increased.

In instances where the cycle of anxiety, stress and self-doubt were not overcome, participants admitted feeling low, a reduced sense of self-worth and an increased desire to leave AAU or indeed the nursing profession entirely. This desire to leave AAU was expressed by all participants on multiple occasions throughout their interviews. This is perhaps indicative of the shared experiences of participants and the impact *"drowning"* is having on their well-being. Rob and Lee claimed that they stayed out of a need for a wage. This was echoed by other participants who suggested they felt trapped because of a need to earn money. It is noteworthy that five of the six participants made reference to looking for other jobs within the hospital be they independent practitioner roles or management positions, these alternative positions were described as less stressful and more appealing than AAU. This may suggest that whilst the stress and anxiety experienced by AAU nurses has an adverse impact on their desire to continue working there, it is possible that they do in fact wish to continue nursing albeit in a role they consider to be less stressful (Rob, P15, L5 and Sara P11, L29).

Eve (P11, L10) described herself as a compressed spring, crushed beneath the stresses of AAU, experiences such as this were common to all participants, five of which discussed a sense of togetherness based upon their shared experiences and understanding of AAU. Amy (P11, L26) summed this up in her commentary, she spoke of AAU nurses being *'in it together'* by which she meant the shared experience of stress, anxiety and self-doubt that AAU created. She described a process of mutual support and an ability to offload and vent to each other safe in the knowledge that her colleagues understood. She went as far as saying they kept each other sane. Similar comments were made by Sara, Lee, and Amy as such, the idea of shared experience and mutual support was very present in participant narratives with the exception of Rob who made no reference to this, all participants emphasised the importance of this ability to describe and discuss their experiences, thoughts and feeling with colleagues who understood what they were going through. Rob and Beth were the only two participants not to recognise themselves as having developed coping strategies for dealing with the stress of their role and yet despite this both went on to describe the benefits of collegiate support and discussion. All participants except Lee spoke of the

venting process and its stress relieving qualities, there was much comment about off-loading and letting the stress go (Sara, P10, L28, Lee, P11, L26 and Amy, P12, L5) whilst similarly all participants except Rob spoke of being in it together and being kept sane knowing that others were experiencing the same or similar issues.

Team cohesion appeared to be an important factor in allowing nurses to continue to work in AAU. There was suggestion that without the ability to unload to understanding and sympathetic colleagues that AAU nurses would all be broken (Amy, P12, L10), one might assume that this statement refers to mental health as opposed to physical especially when taken in the context of the earlier statement regarding participants keeping each other sane. Sara (P11, L1) expanded on this in describing a process during which nurses would share their experiences and lessons learned not only to unload and vent their anxieties but also to save their colleagues from similar experiences. Lee (P11, L26) described the process as akin to clinical supervision but with a more informal approach whilst other participants described similar situations attesting to the benefits gained through these discussions. Lee (P11, L12) also suggested that the team try to care for each other and help each other through their struggles, this was echoed by the remaining five participants.

Word choice and linguistics were similar across participants with words such as; we, the team and, us being used to suggest an inclusivity and sense of belonging. It is apparent that AAU nurses view their job as incredibly stressful with implications for their own health and well-being and that they rely heavily upon one another for support and guidance. It is important to consider that 5 out of 6 participants stated the importance they placed upon being in it together and how this sense of togetherness allowed them to deal with the stress and anxieties their work brought about. 4 of these actually claimed that without the team around them that they would not return to AAU.

4.9 "I don't want to end up like that"

This superordinate theme evolved out of participants' fears of certain illnesses and their anxieties surrounding becoming a patient. These fears and anxieties have developed over time and as a result of continued exposure to patient care. Chronic obstructive Pulmonary Disease (COPD), Cancer and ageing were the three key disease processes which impacted upon participants. Lee was the only participant not to discuss a fear of

illness or death arising from his work. All remaining participants described in detail how their health beliefs had been impacted upon and described their experiences in great detail.

Eve (P4, L12) spoke of a high prevalence of COPD within AAU, whilst Amy (P7, L8) focussed more on the prevalence of cancer, suggesting that it sticks around, ready to strike. Sara and Rob were also concerned about COPD and their potential to develop it whilst Beth (p7, L5) admitted to being fearful of cancer but was primarily concerned about becoming old and useless (P6, L25). Participants referred to COPD, Cancer and old age as an it or that. They appeared to personify these diseases describing them as evil (Eve, P4, L29) or as lurking around the corner (Amy P7, L8) this personification may be indicative of fear or an indication that they see the illness as transcending the patient and is a characteristic of each participant.

The diseases they fear are visible, one can see the symptoms of these pathologies and participants stated it is the exposure to these sights that gives rise to anxiety, it is noteworthy that participants did not describe a fear of mental health issues or other unseen illnesses. This may indicate that they dismiss mental health issues perhaps due to their individual and less generalisable presentation or perhaps that the symptoms are less associated with their own lives. It was surprising to see no participant worry about mental health despite all six making comments about the stress and anxiety that working in AAU brings.

Amy claimed cancer patients are more memorable (Amy, P7, L22), similarly, Eve (P4, L23) professed to her fears being raised due to the prevalence of COPD patients in the area. Each participant recognised a part of themselves in their patients and seemed to have made a link between the stereotypical patient and themselves, for example, Rob identified a fear of COPD which is linked to smoking, as he is a smoker, he believes COPD is a possibility for him, the same was true of Sara but in the context of cancer (P8, L4). Interestingly, Amy was a non-smoker, but she had developed a fear of cancer suggesting that this was due to a systematic rule out of other diseases, she suggested she would not take an overdose, her fitness was good and so heart attack was unlikely and so on until her decision that cancer was her most likely cause of death (P6, L23). Amy claimed to know that cancer would get her (p8, L19), similar statements were made by Rob, Sara and Beth.

Unlike the other participants who were concerned with becoming ill and the manner their demise might take, Eve was focused more on the notion of becoming a patient and having to be cared for (Eve, P3, L23). She explained that this was due to her fear of cancer and COPD patients and her deliberate attempts to avoid caring for this group. Eve explained that she feels like she is avoiding these patients out of a sense of rebellion, that is a rebellion against her own potential future illness. Beth (P5, L18) added to this argument explaining that nursing makes her scared to be nursed as most are sick and tired of their job and having to be nice to people all day.

Beth was the oldest participant in this study and was less worried about disease but more fearful of the infirmity of old age. Beth (P7, L23) described a feeling that her age put her in a similar demographic to her patients and that she could become ill and die at any moment. Her belief was that the medical professions place too much emphasis on keeping the elderly alive (P7, L30) and that they should be allowed to die. Her experiences of caring for the old have shaped her beliefs and she is fearful of being *'flogged'* (P7, L30), her views whilst different to other participants appear to follow the same process of identification of characteristic and illness most associated with her own life and demographic.

The prevailing fear amongst participants was the fear of developing diseases, they made associations between how they lived their lives and the illnesses they commonly encountered. The recurring comments were focussed on not wanting to end up like their patients (Beth, P7, L8, Rob, P14, L2 and Sara, P8, L12) and a sense that without changes in lifestyle they would inevitably end up with these diseases (Amy, P8, L33 and Rob, P14, 20).

Rob, (P14, L24) attributed his fear of COPD to his job as opposed to the disease itself, interestingly this was a belief echoed by Eve (P5, L11) who explained that her job exposes her to the old and infirm which drives her fear and Sara (P7, L25) who declared that the patient's fear has become her fear. Amy (P8, L34) sums up this concept in highlighting that all nurses worry about getting ill and that is considered a part of the job. Each participant commented that their fear of illness is irrational and would likely be lessened if they were not employed in a nursing role, Eve (P5, L6) identified that the fear of illness makes the job harder, a sentiment echoed by Sara and

Rob.

It is apparent that exposure to illness is increased for nurses and that participants in this study suffer stress and anxiety as well as a fear of becoming ill, it was particularly interesting to note that despite their belief that their lifestyle and health choices would impact upon their likelihood of developing the diseases they most feared three of the five declared that their job drove the need to continue with the negative health behaviours. Sara, (P8, L17 and P8, L30) discussed how the stress of her role meant she needed to smoke as a short-term relief and that her smoking habit was largely driven by her fear of, and interaction with cancer. She recognised that this in turn created more stress and fear yet claimed the short-term release to be necessary for her to complete her working day. Rob spoke of a similar cycle suggesting that it is nursing which is driving his desire to smoke/vape and yet doing so increases his fear of developing COPD. Eve spoke of her worries being routed in the fact that she is from the area and her recognition that COPD is highly prevalent in the area due to its association with industrialisation and poor health demographic (P4, L23). Eve commented that her fears became greater on her return to the area. She was unique in this view despite other participants also originating from the area. Despite participants each having their own experiences and sense making processes there was a commonality in their narratives suggesting that being an AAU nurse is linked to fear of illness arising from continued exposure to it.

Despite the fear experienced by these nurses and the recognition that their health behaviours were putting them at increased risk of developing the illnesses they most feared, there was evidence of a perceived need to continue these behaviours as they offered temporary relief from the fear, anxiety and stresses of the role. It was clear however, that this relief was seen as short lived and that participants recognised the long-term detriment it had both in terms of actual health and well-being and the role, they played in fuelling the fear of illness. One of the aims of this study was to identify the long-term effects on nurses' health perceptions as a result of providing patient care and this fear certainly appears to be one such example, a second was the identification of the need to change and modify their behaviours to avoid developing the illnesses they were so convinced they would develop. There was evidence of participants compensating for their negative health behaviours such as increasing the amount of exercise they took to offset their smoking habits (Rob, P14, L20 and Sara, P9, L13) and

changes in diet to allow for a healthier lifestyle.

Of the five participants who reported a fear of illness four recognised that their own lifestyle increased their risk of the fears becoming a reality. Three of these four reported a change in their health behaviours. Beth (P7, L18) described how she has adopted a healthy diet, increased alcohol and particularly a cessation of smoking. She emphasised that she does not smoke as cancer is the likely outcome. Cancer was her biggest fear (P7, L5). Rob had a fear of COPD and reported that it is associated with a horrendous death (P13, L27), he had suggested that his smoking habit was driven by his work in AAU and yet he believed he compensated for this with increased exercise and healthy diet (P14, L8), he considered this to be insufficient and as his fear of COPD grew, he made the change from cigarettes to vaping which he perceived to be a low-risk alternative that offered the same release as smoking. These changes to his health behaviours are directly attributed to his fear of COPD which was born out of his experiences of caring for patients in AAU. This experience is not unique to Rob and was reflected in Sara's narrative, Sara was also fearful of COPD and she recognised the patient demographic as becoming younger (P7, L31). She identified herself to be hypocritical in trying to advise these patients on their smoking habit when she herself was a smoker, (P7, L32) and went on to describe how she has accepted that she will develop COPD if she does not stop smoking but that she feels the stress of the job is preventing her from doing so. Instead, she has begun to exercise and play more sport in a bid to delay the inevitable (P9, l13). She claims to be terrified by COPD (P8, L4) and recognises the need to stop smoking but is not ready to do so at present (P10, L5) out of a feeling the short-term release offered by smoking is necessary to allow her continue her work in AAU.

Fear, compensation mechanisms and altered health behaviours have shown themselves to be a large part of the participants' experience of nursing in AAU and has offered interesting insight into what it means to provide prolonged patient care and the impact it has on nurses' health perceptions.

4.10 "Repeat offenders"

This superordinate theme has arisen from the narratives of four of the six participants and was not something which I expected to uncover. Participants were not asked about

their experiences of dealing with patients who presented with what were described as 'self-inflicted' conditions such as alcoholism, substance misuse or self-harm, nor were they asked about their thoughts on how this patient group should be treated. The fact that participants spoke about these patients without any prompting is perhaps indicative of the importance of their sense making surrounding the experience of caring for this group of people. It became clear that this patient group were considered, 'time-wasters' (Rob, Lee and Eve), 'bed-blockers' (Eve, Lee and Beth) and a source of emotional labour and frustration for participants. This section offers a cross-case analysis of the theme, 'Repeat offenders'.

Lee spoke of being forced to care for *'the area's finest'* (P3, L15), when referring to patients admitted with lifestyle related conditions and unseen illness. He further claimed that *'those disease processes are very related to the area's demographic'* (P3, L17); he then went on to introduce the term *'repeat offenders'* as a way of describing patients who attended the department regularly with, what he considered to be, self-inflicted presentations. Interestingly, Lee acknowledged that referring to patients in this way could be seen as *'a bit bad'* (P12, L27) and stated *'it's probably good this is anonymous'* (P12, L29). Lee's acknowledgement was not unique amongst the participants; Rob, Eve and Beth all recognised that *'it sounds bad to refer to them as repeat offenders, but they really get on my nerves, we all feel it but can't say it'* (Eve, P5, L12). Eve's comment suggests an unspoken agreement amongst AAU nurses in relation to these patients, it is noteworthy however, that Eve was the only participant who directly claimed that others experienced the same frustrations. When compared with Beth's claim that, *'I think they're knobs but, you have to keep it to yourself'* (Beth, P11, L13), It seems unlikely that participants would speak openly regarding their feelings about this patient group given their understanding that it might be perceived as 'bad' however, the participant narratives do appear to support Eve's claims in so far as four out of six participants described frustration and anger caused by 'these people'.

Lee, Beth, Eve and Rob all used of the term 'repeat offender' to describe this particular patient group which may be indicative of the nomenclature of the AAU and of the shared experience of caring for these patients. Lee suggested that they detract from caring for those with *'genuine illness and as such caused frustration and a lack of empathy'* (P4, L15). This view was supported by Eve who explained that *'repeat offender is a term used to describe patients who attend often having taken a small*

overdose or cut themselves just enough to get admitted but not enough to kill themselves' (Eve, P6, L20) and that she feels *'it's hard, I'm thinking 'you're a dickhead' and I don't want to give them my time'* (P5, L19) , whilst Rob claimed *'it's hard to not judge them and to treat them equally with more deserving patients'* (Rob, P10, L10). Similarly, Beth considered them as *'just taking my time away from proper patients with real problems'* (Beth p14, L8). The narrative here appears to suggest that these patients are somehow less deserving of nurses' time and that they feel this could be better spent on more 'deserving' patients, but Lee and Rob also introduced the idea of reduced capacity to empathise with these patients; Rob went further in hinting at an inequity of care being delivered.

There was a general consensus amongst Rob, Lee, Beth and Eve that these patients were less deserving of their time and effort than patients presenting with what they considered a genuine illness. Eve (P6, L1) told me *'last week I had to move an end of life patient, I had to transfer them to a short stay ward which was right at the other side of the hospital, I was told to send them with just a porter which I thought was completely inappropriate, just like, dignity wise. I don't think it's right for someone to possibly die in a corridor on a transfer with someone they've never met in their entire life, whilst I'm stuck dealing with a druggie who's put themself there'* . Eve was evidently frustrated by this experience and told me she *'just thought, dickhead'* (Eve, P6, L4). She stated that repeat offenders *'are on AAU through their own doing and other patients are more deserving and genuine'* (P6, L20), Eve said *'I have to separate my inner thoughts from what I'm saying, it can be really hard, it's crap'* (P7, L18), possibly suggesting that she is aware of her own emotional labour.

The sense of inner and outer self was also described by Rob (P9, L9) who claimed *'these people have done it to themselves and they take my time away from those who deserve it more'* , he claimed to want to *'tell them to get a grip'* (Rob, P9, L14) and internally he would refer to them as *'a knob'* (Rob, P10, L17). Lee expressed a sense of frustration and anger at his inability to treat patients with what he considered '*real problems such as chest pain because beds are blocked by these self-inflicted morons'* (P5, L9) and Rob went on to tell me that, *'I find it difficult to care for these patients because I'm angry at them for taking time away from more deserving patients'* (P11, L14). He claimed to want to *'shake them and tell them to stop but, I know you can't just do that'* (Rob, P11, L20), this inability to act how he would like in these circumstances

may have been an expression of emotional labour and he described this as being *'where the inner dialogue comes in'* (Rob, P11, L22).

The experiences of inner feelings being at odds with external behaviours was present in all four participants and suggests they experience emotional labour when attempting to care for the 'repeat offender'. There was a convergence of experience and the shared use of pejorative terms such as; *moron, dickhead* and *knob* is indicative of the frustration these nurses experienced when faced with this patient group.

Despite Lee, Rob, Beth and Eve describing similar frustrations, Rob was the only participant who spoke of a desire to express himself in a physical manner when he described wanting to *'shake them'* (Rob, P11, L14). This may have been nothing more than a turn of phrase or could signify that Rob's frustrations were having a greater impact on his ability to provide care. Rob was an ex-soldier and quite abrupt in the way he spoke and it is conceivable that his past experience had influenced how he expressed his views on these patients. Rob's abrupt tone caused me to think about how my own Military experience might impact upon how I care for patients and whether I might also be guilty of becoming frustrated by certain patients.

Eve also expressed a sense of not wanting to care for these patients claiming that she struggled to remain professional and got frustrated by what she labelled as 'the entitlement' these patients display, She told me, *"I'm not very good with those patients. I think they annoy me because I just think put up and shut up, there is always someone worse off"* (Eve, P5, L24). Eve also spoke of a sense of reduced devotion as a result of her experiences of *'seeing people dying who really want to live and then you get these idiots cutting themselves or taking overdoses. I find it really difficult to give them any sympathy'*. This appeared similar to Lee's claim of struggling to empathise with these patients although there is a subtle difference in that Lee appeared to *'find it difficult to care'* (P15, L6) about these patients, whereas Eve struggled to care for them. She described them as *'entitled'* (P7, L16) and when outlining how she cares for them she said *'I don't want to do it for them, you kind of put it off because you don't feel it's a priority'* (P7, 21). This was mirrored by Beth and Rob who both claimed to delegate caring for these patients to others whenever possible.

Unlike the other participants Rob described being able to sympathise with certain 'repeat offenders' and described how *'you feel sorry for the patient because she had an*

upbringing where she thought it was ok to take drugs' and how *'you get angry at the upbringing rather than her' (*P15, L18). It should be noted that Rob's own mother had committed suicide as a result of mental health problems which made him unique amongst participants and whilst he was able to sympathise to a degree he still claimed to *'find it a struggle to properly care, they've done this to themselves you know, taking my time from people who deserve it more'*.

Emotional labour appeared to be common amongst the participants who each described a sense of being split between their external actions and internal emotion. They described a sense of reduced desire and capacity to care for 'repeat offenders' and a frustration at having to give their time to patients who they consider to be 'undeserving'. Eve had actually begun avoiding caring for certain patients out of a sense of being exploited by them; she told me *'I'll try and delegate them to someone beneath my pay grade'* (P6, L11). This term was unique in the participants' narratives and whilst not explicit, I took it to mean healthcare assistants or student nurses due to the fact that Eve was a band 5 staff nurse. Eve went on to suggest *'we should be allowed to save our time for those who need our help most'* (P6, L27). Others such as Rob and Lee, recognised their prejudices and admitted to having to make a concerted effort to treat 'repeat offenders' professionally, Rob claimed he would *'try to remain the same, the same way I would talk to anyone. I do have the internal dialogue though, calling them a knob'* (P11, L09) whereas Lee described being aware of *'imposing my own attitudes'* (P14, L3) but having to *'try and treat them the same anyway'* (P15, L18).

Despite slight nuances between how participants responded to 'repeat offenders', the prevailing opinion was that there were two distinct patient groups, those with physical illnesses such as cancer, COPD and cardiac issues who were deemed 'deserving patients' and then the 'undeserving' 'repeat offender' which included admissions related to drug or alcohol misuse, self-harm and mental health issues. Beth suggested a distinction could be made based on age, she stated *'if someone is 50 or 60 maybe, they'll be the ones that are COPD or heart, anginas, genuine illnesses, you know, but pretty much all those below 40 will be alcoholics, druggies or self-harm'* (P4, L1). When questioned about their experiences of caring for the younger population, participants described the low socio-economic status of the area as being a major factor in contributing to the volume of self-harmers and substance abusers. Lee claimed that *'the area definitely affects the people coming through the doors'* (P4, L10) and

sarcastically described patients as the *'full range of the area's finest'* (P4, L4). Lee considered the conditions associated with repeat offenders to be closely related to the inner city, post-industrial nature of the area which has high rates of unemployment, reliance on benefits and drug and alcohol misuse. This disdain for the area was also clear in the Beth's narrative when she described having *'dealt with nicer people who appreciated my help'* (P5, L7) in her previous role in a more affluent area in South East England. However, when describing her experiences of her current patients she claimed *'here, they take us for granted and don't have much respect for us, but I think that's because of the area'* (P7, L11).

I should remind readers that this research was conducted in an area with lower-than-average life expectancy and high incidences of poor health behaviours and scored highly on the social deprivation index. Beth (P3, L11) was keen to make this point and related the instances of self-harm and heroin addiction to the high unemployment rates of the area; she also claimed *'the area breeds the crap and self-inflicted patients'* (P4, L2).

Beth recalled her experiences of nursing in the South-East claiming that in the more affluent areas she had worked patients were more respectful and well-mannered than those in the study area. This caused me to consider if demographic and social background could really influence the type of patient which presented in AAU, other participants lacked the broader perspective offered by Beth, however there was a consistent belief that the social and economic status of the area was the source of the 'repeat offender' and 'self-inflicted' patient. The way nurses described and were affected by these patients was not a subject expected to be discussed within this study. However, participants were keen to offer this information without any prompting and, as such, it is reasonable to assume that this is an important element of their experiences of caring for patients within AAU and warrants further exploration in the academic literature relating to burn-out in acute care nursing. Chapter 5 will present a return to the literature to investigate and understand this phenomenon in more detail.

Chapter 5 – What is it about "those people"? – a return to the literature.

The initial literature review for this study was based on the search terms derived from the research questions. During data collection and analysis an unanticipated theme emerged; therefore, in keeping with IPA methodology I have returned to the literature to undertake a second focussed review (Smith et al, 2009). This emergent theme was the idea of 'repeat offenders' and 'those people'. These terms were used by participants to describe what they considered to be undeserving, self-inflicted and unpopular, returning patients. Participants described 'these' patients in a derogatory and dismissive manner, the patients were typically young, with low educational attainment, had addiction issues and often resided in areas of significant socioeconomic deprivation.

Participants were not asked about these patients or their perceptions of them as this was not the purpose of my study, and yet they unanimously described their experiences of nursing this particular demographic. This finding was not considered in the initial literature review; this short chapter will present a brief overview of the literature pertaining to the 'repeat attender' and 'unpopular patient'.

The public perception of nurses is typically that of the caring individual answering, 'a calling' (Stanley, 2008), the Nursing and Midwifery Council (2015) however, focus on the professional aspect and promote this view in their code of conduct which details the values and standards expected of practising nurses. A key tenet of the code is that nurses must treat patients with fairness, dignity and respect (NMC, 2015). Michaelson (2018) suggests that nurses faced with unpopular patients or those they deem to be 'undeserving' or 'unworthy' do not always behave in a manner expected. This review examines some of the possible reasons for this.

There is no accepted definition of what it means to be a repeat attender (Moore, et al 2009; Daley, et al 2020) instead individual studies have assigned their own criteria for determining whether a patient falls into this category. There is general acceptance however, that to be so categorised, a patient must have presented a higher than usual number of times over a prolonged period. Moore et al, (2020) considered five or more attendances in a 12 month period made a patient a repeat attender, other studies such as Daly et al, (2020) had differing criteria however, there was consensus in the literature

to suggest that the manner of presentation had little bearing on a patient's status, for example, a chronic illness sufferer requiring frequent admissions could be a repeat attender in the same way a persistent alcoholic or substance user could be (Scantelbury et al, 2015; Giebel et al, 2019). I recognise that alcoholism and addiction could be considered long-term conditions however this was not the case in my participants' experience. For the purpose of this review, I will exclude those with chronic illness as these patients were not considered 'repeat offenders' or as 'undeserving' by the participants. Instead, I will concentrate on what was often referred to 'those people' by the participants; those who attend due to perceived and actual self-inflicted reasons including self-harm and substance misuse.

Scantelbury et al, (2015) highlighted an increasing demand on England's Accident and Emergency departments, specifically identifying higher demand in areas of high deprivation. This study took part in such an area, therefore I have elected to examine literature pertaining to repeat attenders utilising services in areas of high deprivation who have presented due to conditions typically associated with actual and perceived self-inflicted conditions. Giebel et al, (2019) found that within disadvantaged areas housing, unemployment, low income, loneliness and decreased social status contributed to an increase in A and E attendance. Moore et al, (2009) also found that being in the above categories increased the propensity for substance misuse. Increased presentation due to social deprivation is not a new phenomenon and was identified by Lynch and Greaves, (2000) who claimed that despite no standardised definition, there appeared to be many similarities amongst repeat attenders.

Homelessness and poor housing were reported by Lynch and Grieves, (2000) who claimed that these issues were predicators of both increased and inappropriate use of emergency medicine facilities., Furthermore, they suggest that this may be due to illness or injury associated with aggravating factors of homelessness or as a substitute for primary care. Housing has continued to be a contributing factor to increased attendance rates with Giebel et al (2019) suggesting that where patients reside in sub-optimal accommodation, then they are at increased risk of substance misuse and are, as such, more likely to present at A and E. In a comparison study, Hull et al (2018) found that attendance rates could be as much as 52% higher amongst those living in social housing. Giebel et al (2019) has suggested that these rates may be due to the health impacts of such environmental issues as damp, lack of ventilation and associated social

conditions such as alcoholism, substance misuse and poor mental health. Whilst housing appears to be related to higher-than-average A and E attendances, studies reporting this agree that it is more likely to be the associated social factors that are the cause rather than issues with the actual accommodation itself (Giebel et al, 2019).

Poor housing is synonymous with areas of high deprivation, such areas are similarly linked to high unemployment and low-income roles (Moore et al, 2009). Burne et al, (2003) and Scantelbury et al, (2015) have reported that socio-economic factors, such as income, play an important role in identifying and predicting rates of A and E attendance.

Conditions such as alcohol misuse, substance misuse and self-harm are more prevalent in areas of high deprivation, these conditions were reported by Daly et al, (2020) as more commonly occurring in the younger population within deprived areas. Giebel et al, (2019) compared low and high deprivation index areas and found that A and E attendances were as much as 52% higher amongst the 18–24 year-old population in deprived regions, Daly et al, (2020) also reported a 25% increase in repeat attendances due to various methods of self-harm within this demographic. In an earlier best practice guideline published by the Royal College of Emergency Medicine (RCEM, 2017) it was stated that regular attenders must be managed effectively and appropriately as they have double the mortality rate of non-regular attenders.

Substance misuse and self-harm continues to be one of the primary reasons for A and E attendance within the UK, however it is notable that occurrence of frequent attendance is centred around areas of high deprivation (Scantelbury et al, 2015).

In her seminal work, Stockwell (1972) examined the idea of the unpopular patient, challenging the view that nurses treated all patients fairly, with respect and an absence of judgement. In the decades following Stockwell's work further research was undertaken and the term 'unpopular' became synonymous with 'difficult' (English and Morse, 1988). English and Morse (1988) define a difficult or unpopular patient as one who deviates from a set of normal values which have been established by the nursing team. These patients often appear to take the form of repetitive self-inflicted injuries, including intended and accidental overdoses, other mental health issues and drug and/or alcohol misuse. Orlando (1961) wrote about the dynamic of a nurse-patient relationship

and determined the most unpopular patients to be those who interrupted the nurse's preferred pattern of working. Jeffery (1979) went so far as to suggest that 'drunks' and 'tramps' where prejudged to be difficult or unpopular, even before admission, based entirely on nurses' past experience and personal values. This was evident in the findings of Michaelson (2018) where patients were referred to as repeat attenders and as being 'time wasters' and 'bed blockers'.

Stockwell, (1972) found that nurses based a patient's popularity primarily on their personality. Personality remains likely to continue to play a large part in determining a patient's popularity however, things such as an unwillingness to adhere to treatment and advice and repeated presentation have been shown to contribute to nurses' feelings of ambivalence (Michaelsen, 2020; Conway, 2000; Jeffrey, 1979). Stockwell (1972) also suggested that the longer a patient remained in the hospital the less popular they became, a finding reiterated by Jeffrey (1979) who conducted narrative analysis of Accident and Emergency department nurses' experiences of dealing with difficult and unpopular patients. In a contemporary review of nurses' attitudes, Forrest (2012) identified the continuance of poor attitudes towards this patient group and went on to urge nurses to consider the reasons why patients may present as 'difficult'.

Stockwell (1972) suggested that the consequences of being an unpopular patient may include forgotten requests, sarcasm and avoidance. This was echoed by the findings of Jeffrey, (1979) who suggested unpopular behaviours were often met with psychological payback, such as extended wait times, intimidation, and dismissal of requests. Examples of this behaviour were given by my participants suggesting a usefulness in considering Stockwell (1972) and Jeffrey's (1979) findings. Specific examples of retributive behaviours and systematic or individual deterrents are elusive in the literature, perhaps because nurses are unwilling to disclose these for fear of being held accountable as these behaviours both conflict with professional codes of conduct (NMC 2015) and general notions of nursing as a profession.

There is a notable gap in the literature in that the concept of the unpopular patient appears to have been largely under-researched between the late 1980s and 1990s. Carveth, (1995) was one of few authors to add to this view in establishing that nursing staff continued to actively avoid these patients and, in some cases, sought out retribution for their very presence. Carveth, (1995) argued that nurses have certain

expectations of patients and expect particular behaviours, respect and a desire to recover. This echoes Parson's (1951) seminal work on the theory of the sick role, indeed Conway (2000) reported similar findings which might demonstrate that, despite advances in practice and policy, the basic attitudes and expectations of nurses towards patients has changed very little.

In recent memory there have been, many changes in nursing care, including patient empowerment and involvement initiatives and a move towards patient centred care and coproduction. This may be driven by societal or professional change, what has endured however, is the perception of unpopular/difficult patients. Conway (2000) reviewed the concept of the unpopular patient against the backdrop of the then, newly introduced patient charter and found an increase in the number of unpopular patients being reported by nurses who feared increased risk of complaint, litigation and a raise in patient's expectations. This, according to McCormack (2011), centred around the respect for a patients' right to self-determination, mutual respect and understanding. McCormack (2011) and Conway (2000), both highlighted that a patient's unpopularity is often linked to their socio-economic background, personal morality and how these contrast with those of the nurses or carers. This suggests that demographics and socioeconomics might influence how nurses perceive a patient.

Marmot (2010) identified the importance of health inequalities and recognised socio-economic factors as determinants of health. According to Marmot, (2018) this phenomenon has endured since the inverse care law was first reported by Hart, (1971) and latterly Watt, (2002). The notion that social factors play a part in one's health is clear, however, the part this plays in determining a patient's popularity and subsequent treatment or care is unclear.

According to Marmot, (2018) health inequality has yet to be addressed and nurses may perceive patients from socioeconomically deprived areas, either in terms of their behaviour or their presentation. Conway (2000) found that nurses preferred patients who showed deference and respect and deemed those who displayed rudeness, repeat presentation due to 'self-inflicted illness', consumed substances or alcohol to be difficult and unpopular and it is this idea of the unpopular patient which leads one to suggest that there may be a relationship between patient popularity (and possibly compliance) and inequality of treatment. Entitlement and demanding behaviour were identified as a

key characteristics of the unpopular patient (Conway, 2000; McCormick, 2011), It seems popularity and care might be linked and nurses continue to treat patients according to prejudice, in-keeping with the inverse care law (Hart, 1971; Watt, 2002; Marmot, 2018).

Following the failings at Mid-Staffordshire NHS trust the Francis report, (2013) identified the requirement for significant changes to standards of healthcare delivery. The report concluded that disparities exist between expectations and standards and highlighted many areas for improvement. The Nursing and Midwifery Council, (NMC, 2015) issued a position statement which included a new code for registrants, new pre-registration syllabus recommendations, the introduction of revalidation and duty of candour.

Derogatory and dismissive language used by nurses appears to be at odds with the public perception of what it means to be a nurse (Whitehead et al, 2014), the NMC has, only recently incorporated compassion into their value statements. Chaney, (2020) reported that compassion as a standard of nursing only rose to prominence in 2009 and the Nursing and Midwifery Council now promote it in their code of practice (NMC, 2015) making it a central component of nursing. Of course, the concept of person-centred care, adapted from Rogers (1951) work on client-centred therapy, implies the need for genuine empathy and, as such, it might be argued that compassion was always an implied trait of a good nurse (Chapman, 2017). RCEM, (2017) identify the requirement to treat all patients fairly despite being categorised as a repeat attender, this need is mirrored by NMC, (2015) who inform nurses of their duty to treat patients equitably. Despite these assertions some nurses feel unwilling or perhaps are unable to feel compassion for the unpopular patient (Cartolovni et al, 2021).

Bartley and Blane (2008) and Bartley (2004) discussed a behavioural model in the context of difficult patients, they found that social class was linked to how nurses perceived patients, those of a perceived lower social class were expected to display health damaging behaviour such as substance misuse and self-harm. Bartley and Blane, (2008) went on to suggest that the life course of individuals directly affected their health behaviours in later life. They concluded that those growing up in poverty or in post-industrialised areas were more likely to be exposed to pollution, environmental hazards and a culture of poor attitudes to health. This concurs with the work of Moore

et al, (2009) and Giebel et al, (2019) who suggested that deprivation and low socio-economic status are synonymous with the characteristics typically associated with regular attendance in A and E and with the characteristics typically present in unpopular patients. When considered in the wider context, the evidence creates a picture of those with lower status as being more inclined to negative health behaviours which may, in turn, increase the risk of them being deemed unpopular by nurses due to their apparent deviation from 'accepted' standards (Stockwell, 1972 and Conway, 2000).

Arpey et al (2017), conducted in-depth interviews with patients over two separate three months periods with two distinct cohorts. The research was conducted in the USA with the first cohort recruited from patients with higher cost insurance, the second comprised of those with publicly funded health insurance, 80 participants were enrolled but no breakdown of age or ethnicity was offered. Participants believed they were able to determine how nursing staff viewed them based on the way they were cared for or spoken to and that unpopularity translated into receiving a lower standard of care than other patients. These findings were reported in an American hospital and therefore the attitudes and behaviours of the nurses may not directly translate into the UK healthcare setting, similarly, as the data was generated from interviews it is difficult to accurately assess how patients felt able to categorise themselves as questions may have been leading/misleading, however, it does highlight a potential issue of nurses changing their behaviour based on patient type or personal preference, especially as the publicly funded cohort generally considered nurses treat them poorly. This negative characterisation may translate into patients feeling less respect for the nurses caring for them, owing to their perception that they receive lesser care (Woo et al, 2004; Van Ryn and Burke, 2000; Molina-Mula and Gallo-Esrada, 2020) although this is difficult to accurately determine given the fluidity of social class and the many nuances it involves.

Molina-Mula and Gallo-Estrada, (2020) argue that an effective nurse-patient relationship not only enhances patient experience but also reduces the length of admission, it could be concluded that a poor relationship such as those described by difficult or unpopular patients may increase lengths of stay following admission. Interestingly, Cahill, (1998) and latterly, Truglio-Londrigan, (2015) suggested that more passive patients are most likely to be seen as 'good' as they create less work for nurses and are often happy to follow a nurse 'knows best' approach. This kind of power

imbalance over patients, however, was found by Henderson (2003) to lead to feelings of depersonalisation and reduced effective clinical relationships. It appears reasonable to conclude that some nurses modify their behaviour and practice according to their perception of the patient and the relationship they have with that patient.

5.1 Chapter summary

This chapter has examined the existing literature surrounding the unexpected findings which were not addressed in the literature review. The section became necessary in order to address a gap in my knowledge of the existing research and evidence pertaining to two key, yet unexpected findings. I have considered how nurses perceive patients deemed unpopular or difficult as well as examining how relationships between nurses and unpopular patients impact upon perceived standards of care.

Regular attendance has been linked to social deprivation and low socio-economic status and the characteristics associated with these, such as; sub-standard housing, increased substance and alcohol misuse, self-harm and overdose.

The literature appears to present a multifaceted picture of the 'repeat attender/offender' and unpopular patient. They are often those patients which create an additional task or time burden on nursing staff and/or those which challenge the nurse's own morality or beliefs. The above review has shown that for many nurses, patients with self-imposed injuries or illness arising out of their lifestyle choices, such as substance misuse and addiction often fall into this category and whilst nurses are aware of their professional and moral obligation to treat all patients fairly, they often feel ill-equipped or unable to do so with this patient group. Indeed, the literature suggests that healthcare professionals find this particular demographic problematic.

The literature also suggests that socio-economic factors may play a role in determining patient popularity, although this is less explicit than self-harm or substance abuse, it appears that patients from lower educational backgrounds or those from high deprivation areas are more likely to fall into the category of 'unpopular', there appears to be a link between socio-economic deprivation and higher potential to present with self-inflicted or substance related illness/injury and this may partially explain the unpopularity of this demographic

Chapter 6 – Discussion

In this chapter I will present my thesis and discuss the three superordinate themes which were identified through the iterative process of individual and cross-case analysis. I have used the theory of burnout as described by Maslach (1982) as a conceptual framework to aid the discussion.

Maslach (1982) defined burnout as a psychological syndrome incorporating depersonalisation, emotional exhaustion and a reduced sense of personal accomplishment which was present in multiple professionals working with people in emotionally challenging situations. Burnout, according to Maslach, undermines the care and professional attention of clients of human service professionals.

6.1 'I feel like I'm drowning'

This was a metaphor used by most participants, they used the term independently of each other suggesting a commonality of experience or a well-used turn of phrase within AAU which is, perhaps, indicative of the difficult experiences which they face on a daily basis.

The drowning metaphor appeared to encapsulate the lived experience of participants within the AAU setting. These nurses reported being stressed and described feeling under pressure to complete tasks. I was told that they were concerned about their ability to practice in such a high-stress and fast paced environment and this overwhelming sense of 'drowning' was making them ill. This section discusses these experiences in the context of the extant literature and theories.

High stress work environments have been shown to have a significant impact upon nurse retention (Bakker 2011). This is congruent with what Amy said when discussing stress and her future, *'I won't be here forever unless something changes'* (Amy P17, L8). On the same subject Lee spoke of leaving nursing if *'a non-clinical job made sense and I could make a decent living'* (Lee P20, L4). Craigie et al, (2016) has also demonstrated how working in a stressful environment can be detrimental to nurses' health and well-being. Lee and Beth both spoke of staying in the job out of a sense of being 'trapped' despite wanting to leave out of a sense of 'drowning'. In keeping with

Craigie et al (2016) participants reported feelings of overwhelming stress, organisational and environmental pressures which, in turn, impacted upon their desire to remain in the profession. One particular comment from Amy encapsulated the general feeling of participants she told me that she felt physically sick when she thought about her working day and she likened it to 'drowning in stress' (Amy P6, L9-10); this has been shown to be a common theme amongst nurses in general (Tigard, 2017 and Howe 2017). Furthermore, according to Howe (2017), when nurses experienced these feelings daily, employers have an obligation to protect staff from the moral and emotional distress they may face. Whitehead et al (2014) has suggested that nurses are at increased risk of leaving the profession where these factors are not managed. Such factors will be discussed in greater detail however, it is pertinent to note that this echoes the findings of Stamm (2010) who described professional quality of life (ProQol) as an encompassing term including such things as: job satisfaction, well-being, work engagement and impact of emotional labour.

All participants reported negative physical and mental health well-being, the physical element resulted primarily from the burden of task orientated working and the fatigue of shift work whereas the mental health element was linked to experiences of reduced self-worth, self-doubt, anxiety and an inability to separate themselves from their professional interactions, this echoes the elements of Maslach's (1982) burnout theory. As described by Morley, (2020) and Cartolovni et al (2021) nurses may experience these symptoms because of moral distress arising from their work. Eve stated that she had to *'try extra hard to be nice'* (Eve P10, L16) but that she really thought many patients should just *'put up and shut up'* (Eve P10, L12). All participants in my study described having experienced moral distress without directly using the term, this was evidenced through their repeated references to drowning, overwhelming stress and being forced to treat those they deemed 'undeserving' Their experiences, however, of working under constrained circumstances and in a manner that contradicts their personal beliefs seems to mirror the descriptions of moral distress as found in the literature.

Olivera et al, (2016) declared that there exists an enormity of evidence to support the view that working in a high intensity environment increases nurses' experiences of workplace stress, this intensity was largely attributed to unexpected outcomes or a variety of unpredictable clinical outcomes. This is a significant finding in the context of

my study in which participants reported stressful experiences resulting from the fast pace and unpredictable nature of AAU. The department was described as a place laden with unpredictability in which you may *'see conditions that you've never seen before and are expected to know how to ... erm, well... just what to do'* (Sara, Pg.2, l2). This variety and the need to rapidly assess and treat these patients led not only to a sense of stress but also to a belief that AAU nurses were more knowledgeable and skilled than other nurses within the hospital, in fact, AAU was described by participants as like *'A and E but harder'* (Amy P3, L7).

Despite the stress and anxiety that AAU appeared to induce, there was agreement amongst participants, who believed that they were widely viewed as more capable than other nurses within the hospital. It is unclear whether this was an accurate assessment or simply that participants had conflated the stress of AAU with the clinical skills required to work there. This was a positive assertion amongst participants who appeared to take pride in this reputation.

Participants described stress in both negative and positive terms. This dichotomy at first appeared unreconcilable, however it became apparent that there may be a healthy level of stress which drove the pace of work and increased job satisfaction, Eve suggested that good AAU nurses actually *'thrive on a bit of stress'* (Eve P8, L4). On occasions however, when this level was exceeded, stress began to impact upon the health, well-being and confidence of these nurses. 'Good' stress was seen as that which created a sense of determination or brought about a sense of urgency and satisfaction associated with task completion. Stamm, (2010) examined the notion of positive stress and its impact on nurses' job satisfaction and found that in kinetic clinical environments, compassion satisfaction is heightened in the presence of, what he claimed was, an appropriate level of stress. Craigie et al, (2016) also suggested that a background level of stress is a predicator of higher levels of professional quality of life this was evidenced by Eve and Rob, both of whom indicated that an appropriate amount of stress made the day go faster. Considering this, one could suppose that AAU nurses are prepared for, expect and, in some ways, benefit from low level background stress.

When stress levels were heightened participants described negative experiences such as; anxiety, low mood, a sense of dread and, in all six cases, a desire to leave AAU. This was evidenced by Kelly et al (2015) and Bibi et al (2018) both of whom reported

reduced nurse retention and increased staff absence where workplace stress and associated anxiety reached overwhelming levels. Participants in my study described the AAU environment as a fast paced and unpredictable workplace which operated in a time sensitive, and task focussed manner. They further described the requirement to complete multiple tasks at once as a leading cause of workplace stress which ultimately induced a sense of anxiety, self-doubt and burnout. Participants also attributed the negative experiences of stress to factors including management, patient acuity, skill mix, bureaucracy and feeling unsupported. It is this 'bad' stress which led nurses to describe feelings of sinking, drowning and not wanting to return, Amy perhaps summed this up best when she said; *'I actually feel sick, like I'm drowning, drowning in the stress'* (Amy P6, L10). The feelings described by Amy fit within the description of burnout described by Maslach (1982) and are concerning for Amy's ability to continue nursing.

Participants also described good stress which they believed drove them to complete tasks, be more effective practitioners and, in some case, to continue returning to AAU despite the overwhelming experiences of bad stress. Maslach et al (2001) examined burnout amongst nurses as an emotional dissonance arising from inappropriate levels of workplace stress which reportedly manifested as depersonalisation, withdrawal and a desire to stop nursing. Each of these elements were present in my study, with participants suggesting that burnout was prevalent within the AAU setting, an example which typified participant experience was that offered by Amy (P18, L4) when she offered the 'little gem'; *'just because I love nursing, doesn't mean it loves me back'.* This was a statement she made to describe her experience of the challenges and stresses she faced working in AAU. She explained, as did Rob, Lee and Sara that, the job was taking a toll on her ability to continue and that she was being slowly driven towards leaving. It is interesting that Amy spoke of nursing as a person with whom she is having a relationship with rather than a job she received payment for.

Participants experienced stress and anxiety in several ways; there appeared to be contextual factors such as the time pressures and acuity of patients as well as psychological factors such as feelings of self-doubt and compassion fatigue. This echoed the findings of Boyle (2015) who found that the psychological and emotional requirements of nursing can have a detrimental impact upon nurses. Similarly, Spinetta et al (2000) and Maslach et al (2001) described circumstances where work induced

stress and burnout led to a diminished sense of devotion to duty and an unwillingness to provide patient care. Participants echoed these sentiments, during the interview with Lee he told me how he *'struggle(d) with'* (Lee, P12, L24) caring for certain patients and that he had developed the opinion that that there was *'only so much support or empathy you can feel'* (Lee, P12, L1). This reduced ability to care can also derive from moral injury resulting from witnessing intense suffering or being forced to act in direct contradiction of one's own moral code (Fourie, 2017; Catolovni et al, 2021).

Of the six participants in my study, all but Rob stated that they returned mainly out of a need to earn an income, they felt *'it's really about the money'* (Lee, P9, L11) and they *'all have bills to pay'* (Amy, P12, L18). These participants were expressing a lack of choice by continuing to work in AAU despite their apparent and progressive burnout. Such a phenomenon, in which nurses continued to work despite high levels of burnout, was described by Maslach et al (2001) who suggested many nurses felt they were also suffering alongside their patients, albeit in a different way. This idea of mutual suffering suggests that patients experience the negative physical and emotional aspects of their illness whilst nurses suffer the physical and psychological impact of their work caring for others (Bakker, 2011; Sabo, 2011), Amy told me that she was making herself *'sick for other people'* (Amy, P7, L18), comments such as this were frequent among participants, statements like this were also present in the seminal work of Stockwell (1972), who identified that nurses begin to resent certain patients, similarly the idea of working oneself sick can be found in Maslach et al (2001) and further demonstrates that burnout is being experienced by nurses working in AAU. Fourie (2017) and Morley, (2020) suggested that nurses working under these conditions begin to experience increased dissatisfaction, moral distress and self-doubt which in-turn can be detrimental to patient care. Indeed, all these examples were present in the narratives of my participants leading me to believe that moral distress may well be a key factor of nursing in AAU.

Participants described their feelings and antipathy as manifesting in several ways; for some it was a desire to change roles for others it was a sense of dread and anxiety. What was clear however, was the suffering was both mental and physical. Eve (P21, L4) claimed not to know which were more affected, her body or her head and went on to claim that she felt *'crushed'* (Eve, P21, L7) beneath the pressures of AAU. The combination of the physical and mental impacts of nursing were discussed by Boyle

(2015) and Maslach (1982) both of whom suggested that burnout and anxiety has psychological and physiological elements.

Despite the overwhelming sense of drowning described by participants they still described an ability to return and deliver care. Participants discussed two key coping strategies; physical exercise and peer support. Other coping strategies were described and included negative behaviours such as alcohol consumption and smoking, these will be discussed later. Physical exercise was described as a useful tool to combat stress and anxiety by five out of six participants. undertaking exercise gave a sense of relief, and offered a welcome distraction from their working lives, Lee claimed exercising allowed him to *'sweat out the stress'* (Lee, P8, L8). Both Kelly et al (2015) and Westerman et al (2014) recognised the beneficial effects of exercise on stress, anxiety and burnout, stating that exercise had been shown to reduce they psychological impacts of stress. However, for AAU nurses this mechanism could often fail in circumstances where they became too stressed or overwhelmed by their work. Such circumstances led to a lack of enthusiasm to exercise and a limited capacity to do so. Rob, Amy, Sara and Lee all described occasions where they felt too stressed and worn down to exercise, with Lee and Sara explaining that when this occurred, they often turned to alcohol as an alternative coping strategy. Participants explained that these situations created a greater desire to leave coupled with a low sense of self-worth.

Kelly et al (2015) and CGI (2015) have stated that nurse retention has reached a critical point and absenteeism is a major issue in acute hospitals (Roche-Fahy and Dowling, 2015), it should be noted that this research was conducted pre-Covid and therefore does not necessarily reflect the current situation.

Eve claimed that management had a positive or negative impact on her day based on which manager was on shift. Lee also commented on the impact of management stating that a good manager had supported him to *'get my confidence back'* (Lee, p.12, L9) following a clinical error and period of self-doubt. This echoed the findings of Epp (2012) who found nurses in high stress environments benefit from supportive managerial intervention. There was a notable absence of recognition that the organisation had an obligation to care for these nurses and an equally notable lack of identification of organisational pressures, instead participants appeared to take ownership of these influences and see them as *'just part of the role'* (Eve, p18, L18)

which contradicts Nia et al's (2016) claims that organisations have an obligation to mitigate the detrimental effects of nursing.

A second, and perhaps more consistent, coping mechanism was described by participants. This was the sense of togetherness and collegial support they experienced by being part of the AAU team. Participants described a closeness and sense of belonging and unanimously described the perceived benefits of being able to share their experiences with those who have experienced similar feelings, stresses and events. The idea of peer support was raised by Epp (2012) who identified several benefits which included rationalisation, shared burden and sense of relief. Participants echoed these benefits, Amy perhaps summarised this best suggesting that the team *'keep each other sane'* (Amy, P8, L3). Comments like this were common across participants, most of whom appeared to attribute mental health benefits due to their ability to 'offload' and 'share' their experiences. Amy and Rob both claimed that AAU nurses would be 'broken' were it not for their ability to 'vent' to colleagues. This 'off-loading' process and peer support was self-generated and not something which was facilitated at an organisational level.

Supportive, collegiate discussion was reported by all participants as a beneficial way to reduce and manage stress and the process appeared passive and organic. Lizarondo (2020) reported that nurses actively seek out opportunities for discussion, there was congruence with further reports from Lizarondo (2020) and Kinnerman and Leggetter (2016) who claimed where emotional distress was discussed in a supportive manner nurses experienced affirmation of their perspective and distress as well as being able to identify possible solutions.

Participants unanimously found benefit and comfort in the support they gave to, and received from, fellow AAU nurses. This is congruent with Epp's (2012) assertion that the benefits of peer support should not be understated and can drastically reduce the negative impacts of nursing stress. Eve, Lee and Amy, declared management intervention as adding stress because they are always *'on your back'* (Lee, P17, L25). This was at odds with the recommendations of Westerman et al (2014) and Kelly et al (2015) who claimed management intervention to be more effective that peer support. Venting, off-loading, and keeping each other sane were key elements of what kept my participants returning to AAU and an incredibly high value was placed on this however,

both Lee and Amy conceded that management could play a beneficial role in supporting nurses when done well. Kinnman and Leggetter (2016) concur and recommend a blending of personal, peer and managerial support to create an optimum strategy for stress and anxiety management.

6.2 "I don't want to end up like that"

All but Lee stated they did not want to 'end up like' their patients; suggesting that, for these nurses, feelings of fear or anxiety relating to certain conditions and patients were experienced. This included anxiety induced by seeing illness and death on a daily basis as well as the anxiety surrounding having to be nursed themselves in the future. Participants expressed a genuine fear of becoming like their patients or, more specifically, dying like their patients. All participants reported a sense of increased anxiety and altered health behaviour because of continued employment within AAU.

The persistent and ever-present nature of disease appeared to be a leading cause of health anxiety, participants expressed most concern about cancer, COPD and frailty. All six participants described a change in how they viewed their own health and future because of their continued exposure to these diseases. Eve spoke at length about the prevalence of these diseases within the area and attributed their prevalence to the post-industrial nature of the locality and the associated health behaviours linked to living in low-income areas. Beth, who had moved to the area from elsewhere, supported this assessment. The other participants did not overtly make this link although all six spoke of a sense of increased fear which had grown out of continued employment within AAU. Rob, Lee, Eve and Amy went on to suggest that they would likely experience less health anxiety were they to leave AAU and nursing more generally.

The participants discussed their health anxiety and how they link this to their constant exposure to disease and illness claiming that the more time spent working in the area, the more they feared death, dying, trauma and illness. This mirrors Sliter et al's (2014) study which found there was a relationship between working with illness and death anxiety. The concept of fear following exposure is covered widely in the literature pertaining to secondary traumatic stress syndrome (STS) and moral distress which, according to Figely (1995) and Boyle (2011) is the phenomenon in which a person experiences similar feelings or anxieties as a trauma victim without having been

exposed to the physical trauma. Figely (1995) and Boyle's (2011) research did not focus solely on nurses, in fact, Figely considered paramedics and other emergency workers, whilst Boyle considered police officers, nurses, firefighters and paramedical staff. The findings however, do translate to AAU insofar as it can be considered the interface between pre-hospital and hospital care with AAU nurses in my study being regularly called upon to deal with trauma. In simple terms, witnessing trauma can lead one to experience its psychological impacts. This is noteworthy in that participants in my study reported anxiety surrounding only those diseases which have visible physical symptoms which they encountered on a regular basis. No participants described fear of developing mental illness or diseases with unseen symptoms.

All participants recognised the detrimental factors increased exposure to illness had on their own health beliefs which contradicts Peters et al (2013) who argued against nurses developing STS from exposure to illness. Despite all participants recognising the unpredictability of AAU, only Beth explicitly discussed clinical futility/uncertainty, claiming that it led her to be more fearful for her own health. STS was a factor in all participants' experiences (the remaining participants focussed on specific diseases) which concurs with Potter et al (2006) and Baird and Kracen (2006) who agreed that STS could occur due to continued exposure to illness. Like Beth, Olivera et al (2016) linked STS to clinical uncertainty and the futility of caring.

The fear expressed by participants was expressed in a number of ways as shown in the analysis chapter however, a common linguistic trait was present in all participants and this was the reification of disease processes. Eve told me that *'Cancer is evil, it sticks around'* (Eve, P15, L11) and that she feared it. Other participants echoed her sentiments and described cancer and COPD as always present and waiting to strike. These diseases were described as '*lurking, striking'* (Amy, P7, L8) and there was an acceptance that they *'will get me'* (Amy, P12, L1). Such commentary indicated that participants had attributed some sort of personality to these diseases which may be indicative of how participants understood and made sense of their fears. By reifying fear, participants may have felt able to isolate, identify or hide from the things which caused them to experience health anxiety. This was a practice used unanimously by participants and suggested a shared understanding and discourse in making sense of their experiences, this may have arisen through the mutual support and collegiate practices of venting and off-loading which all participants claimed to take part in.

There is little research to identify what it is about vicarious or secondary trauma which specifically triggers a psychological response in nurses, however Craigie et al (2016) has suggested that no matter the reasons there will always be a cost to the carer. Sliter et al (2015) also recognised this and highlighted progressive and chronic elements of STS and altered health perception. Participants in my study described this progression in their health anxiety and fear of illness both through their reification of illnesses but similarly through their unanimously held belief that leaving the profession would help alleviate their fear. Participants recognised an irrational element to their fears, yet all attempted to justify them. Indeed, all six claimed exposure had played a large part but, they also described fear of specific illnesses based on contributing factors and predisposing characteristics with which they drew parallels between themselves and their patients. For example; participants who smoked were more fearful of cancer. Amy ruled out most long-term conditions claiming, she was healthy, ate well and took regular exercise. She went onto suggest that she was, therefore, unlikely to develop heart disease among other diseases. Amy was fearful of cancer which she explained would '*get'* her (Amy, P12, L1) and that this appeared to be the result of her exposure to it and the statistical likelihood of developing it in the absence of co-morbidities. This was a striking statement and emphasised the somewhat irrational but very real sense of fear and health anxiety which Amy experienced. She appeared to have accepted the idea that she was destined to develop cancer and that there was nothing she could do to change this. This might suggest that Amy has in some way reconciled herself with the perceived inevitability of developing cancer or perhaps she has adopted acceptance as a way of managing her fears.

Rob, Sara, Amy, and Eve drew parallels between their own health behaviour and that of their patients, and Beth likened her age to that of her patients. Rob recognised that COPD was a disease associated with smokers. He informed me that most of his COPD patients had continued to smoke despite their condition. As a smoker, he likened his lifestyle to that of his COPD patients and suggested that this was a foundation upon which his health fears had developed. Sara, also smoked, and made a similar association between her habit and that of cancer patients. These feelings of discomfort led, over time, to a deliberate and sustained attempt to avoid caring for cancer or COPD patients. Beth described a fear of ageing and told me that she avoids caring for older patients. Similar statements were made by Eve, who described her attempts to avoid

'repeat offenders'. Rob and Beth described a desire to avoid cancer and COPD patients but found it difficult to do so, instead they felt a greater sense of emotional labour and perhaps moral distress when dealing with such patients.

Similar circumstances were reported by Sliter et al (2015) who found nurses initially tried to avoid uncomfortable or distressing situations with this behaviour becoming more prevalent as chronic stress and anxiety built. Sinha et al, (2009) noted people experiencing stressful situations often resort to negative health behaviours such as smoking, drinking and increased eating. This was commonplace amongst participants who, whilst recognising the negative health potential of these habits, continued to practice and felt that they provided stress relief.

Rob, Beth and Eve's anxieties dominated their narratives and were linked to their desires to leave AAU. When researching nurse burnout, Gillman et al (2015) did not recognise altered health perception or health anxiety as a contributing factor. Whereas Mann (2005) and Smith (2008) had previously stated that increasing numbers of nurses reported decreased well-being and anxieties surrounding their own health because of work-related stress. It is surprising that health anxiety has yet to be recognised as a cause of burnout amongst AAU nurses. All participants in my study described signs of burnout and made clear the links to their experience of caring for the acutely unwell and the impact this had on their own physical and emotional well-being. All participants described an increased sense of health anxiety resulting from their continued interaction with patients.

Nia et al (2016) and Sliter et al, (2014) suggested that in cases of increased anxiety and stress resulting from caring for the acutely unwell, nurses initially continued to provide care to the detriment of their own well-being, however, a tipping point is reached at which point nurses began to avoid interaction with patients out of a need for self-preservation. As previously stated, this was evident amongst these participants who described instances of avoiding those patients who had presented with diseases which they (the participants) feared. The idea of participants fearing those illnesses with which they were able to relate to their own lifestyle is not explicitly present in the extant literature, although Sliter et al (2014) claimed that caring for the acute patient does cause nurses to consider their own mortality.

All participants experienced altered health behaviour because of their experiences of working in AAU. These changes varied across participants but included negative as well as positive health behaviours. Rob, Amy, Beth and Sara described the positive changes in terms of delaying their development of the diseases they feared most, for example, Rob spoke of undertaking more physical exercise to compensate for his smoking habits and delay COPD, whilst Beth described reducing her alcohol intake to lessen her chances of developing cancer. Positive mechanisms such as increasing exercise or eating a healthier diet appeared to be undertaken less out of a desire to be healthier and more out of a perceived need to stave off illness, this was perhaps a behavioural change driven by the fear of disease and participants described their health behaviours and lifestyle changes in terms of bargaining.

The idea of bargaining was present in all six participants as they recognised the detrimental effects of negative health behaviours whilst simultaneously claiming to rely upon these behaviours as a way of making it through shifts or decompressing afterwards. Rob described the immediate release he felt from smoking and claimed he could not stop despite his belief that this would lead him to develop COPD, similar comments were made by other participants. It was interesting that participants recognised the potential health impacts of their behaviours yet still attempted to justify or rationalise them. It appeared that these were activities offering immediate or short-term release from the stress of AAU, of course it could be that they simply enjoyed these activities and used their stress to justify them. What is of interest is that these coping behaviours are themselves increasing fear and anxiety surrounding illness and 'ending up like that'. It is apparent that some participants felt unable to give up habits such as smoking and drinking due to their perceived acute stress relieving properties; yet all participants recognised that these behaviours served to increase the stress burden that arose from witnessing death, trauma and disease. This finding contradicts those of Maeve (1998) who suggested nurses were able to reflect upon the dilemmas of their patients and modify their own behaviours to avoid a similar fate, it must be noted however, that nursing practice has changed significantly since the publication of the paper in 1998.

It has been argued that clinical uncertainty of patient outcome has a transformative affect on carers' health beliefs and mortality salience (Craigie et al, 2016; Oliveira et al, 2016; Quint and Strauss, 1964). Whilst participants in my study unanimously spoke of

the unpredictable nature of AAU and the variety of patient presentations, they appeared to do so in a positive manner claiming that this uncertainty improved their clinical acumen and brought about 'good stress'. What was present was a transformation of health beliefs arising from associations between patient and practitioner and the diseases deemed most likely to develop. Whilst this may seem similar to the reported findings of the studies cited above, it is subtly different in that my participants did not express any fears of death and dying but, more explicitly, they feared the disease leading towards death and the experience of being a patient. All participants reported that they feared 'ending up like that' but that they also knew that without significant behaviour change, there was a greater chance that actually they would.

6.3 "Repeat offenders"

This theme related to, what were described by the participants as, 'undeserving patients' and 'repeat offenders' as well as those who attended due to self-inflicted illness or injuries. The descriptions offered by participants varied slightly whilst remaining focussed on the concept of 'deserving' and 'undeserving' patients. The participants' experiences and difficulties in treating those they deemed as 'undeserving' will be discussed in the coming section. These patients were referred to pejoratively as 'repeat offenders', a term which will be used throughout the coming pages to represent the participants' voices and not my own. As stated, this theme developed as it was an unexpected finding and as such it necessitated a return to the literature which opened the previous chapter. Several sub-themes will be discussed in the coming pages to explain participants' experiences in the context of the extant literature.

There appeared to be a discourse within AAU which was used when referring to patients who presented with addiction, overdose or mental health related conditions, such as self-harm. Derogatory language such as 'dickhead' or 'knob' were used by participants, as were terms such as 'repeat offender' (Lee), 'bed blocker' (Eve), 'waste of time/space' (Rob) and 'shit' (Rob). A commonality across participants was that they viewed this patient group as having 'self-inflicted' their illness and as a major source of frustration. Rob, Lee, Beth and Eve made clear distinctions between this patient group and those they deemed 'deserving'. Typically, the 'deserving' were older, presented with visible and verifiable illnesses (often those which participants had expressed fears about) and had similar world views and values as the participants. Interestingly, chronic

conditions which required frequent admission to AAU did not cause these patients to be labelled 'repeat offenders', in fact, participants viewed these patients as increasingly deserving and worthy of their time. The 'undeserving' patients were usually described as younger, receiving welfare benefits or unemployed, under-educated and having imagined or self-inflicted conditions.

The idea of the unpopular patient is not new and was initially discussed by Stockwell (1972) who found patients whose morality or values differed from the values of nurses, or those who exhibited behaviours which disrupted nurses' routine could directly contribute to a patient's unpopularity. This is similar to views expressed by participants, especially Eve who told me; *'I'm just thinking; dick head. It's like they feel entitled and I'm just thinking, I don't want to do it for them'* (Eve, P12, L4). Maslach (1998) discussed depersonalisation and a decreased sense of idealism and it appears that these elements of burnout were present in all of my participants. Deviations from nurses' values were found by Michaelson (2018) to include presentations such as; self-harm, alcoholism and drug use, all of which could be seen in the 'undeserving' category of patients described by my participants. The disruption to routine was evidently a cause of frustration to Rob, Lee, Beth and Eve, who reported frustration at the idea of having to reorganise their work based on caring for a 'repeat offender' or 'time waster'. This frustration was a major contributing factor in participants' experience of emotional labour and one which must be managed to improve both nurse and patient experience.

Socio-economic status also affected how patients were perceived. Patients that fell into this category are usually young, between 20 and 40 years, unwaged and often with low educational attainment. My study was conducted in a typically post-industrial area with a very high deprivation index (Ministry of Housing, Communities and Local Government, 2019) and it is therefore reasonable to assume that patients described by participants would fit into the models suggested by Bartley and Blane (2008). What is perhaps interesting is that these nurses live in the area and are aware of its deprivation and demographic, but still describe their patients in a derogatory manner. This presents a challenge insofar as the NMC (2015) mandates a minimum standard of care and nurses in AAU are employed to care for and treat acute presentations despite the reason for that presentation. The acknowledgement by participants that they operate a 'two-tier' approach to patient care may symbolise their dissatisfaction in their role and awareness that their experiences have impacted upon their ability to provide care.

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There have been several high-profile legal cases taken against individual nurses or hospitals where standards of care have been low or deliberate negligence has occurred, examples of such are the Mid-Staffordshire inquiry (Francis, 2013). In such cases nurses have been called upon to justify their interactions with patients and to explain the standard of care delivered. This holding to account is a fundamental part of the professionalisation of nursing and yet the literature has shown that nurses are prepared to behave in a demeaning or substandard manner where certain patient types are concerned (Stockwell, 1972 and McCormick, 2011). Within my own study nurses described their negative feelings and sub-optimal practice in this regard, these nurses did not appear to be in direct serious breach of the professional code of practice, (NMC, 2015) but did appear to be in contravention of the spirit of nursing.

It is necessary to understand why this behaviour has developed given that these participants were aware of the low social status of the area and as such the likelihood of encountering a high number of difficult or unpopular patients. Patrick (1984) described a process of shielding which can occur where an individual begins to depersonalise patients in a bid to protect themselves from the stress they face in the course of their duties, similar behaviour was found amongst police officers who would dehumanise members of the public, assuming everyone to be a criminal (Santa-Maria et al, 2018). Santa-Maria et al (2018) argues that this behaviour is a self-protection mechanism and manifests in such a way as to allow the individual to regard their patients as a second-class of citizen who deserves to be considered or treated in a sub-optimal fashion.

 This echoes the sentiments of my study participants and it is possible their behaviour and negativity towards what they see as repeat attenders is, in some way, a psychological self-protection mechanism, a response to burnout or perhaps the external expression of the impact of emotional labour.

Chapter 7 – Conclusions and recommendations

This chapter summarises the research and outlines the contribution it makes to existing knowledge. The strengths and limitations of the study will be discussed, and the chapter concludes by outlining recommendations for further research.

7.1 Study summary

This research project sought to explore the lived experiences of nurses working in an AAU when caring for acutely ill patients and to examine how AAU nurses make sense of their experiences in terms of their own health and well-being. The project was borne out of my personal experiences of working in an AAU plus a desire to understand how nurses made sense of the illnesses and uncertainty they faced.

In this IPA study a sample of six nurses working in a single AAU were recruited, they ranged in age and experience but had all spent a minimum of one year working within the setting. Participants were interviewed using an in-depth semi-structured approach, with interviews taking place on a face-to-face basis within a private office located on the AAU. The interviews were recorded using a digital recorder and were subsequently transcribed in readiness for analysis. In accordance with IPA methodology, this analysis was conducted, in the first instance, idiographically (that is on a one-by-one basis) before moving on to identifying common themes across all six transcripts (cross-case analysis).

IPA analysis allowed for a detailed exploration of the AAU nurses' lived experiences of caring for the acutely unwell within a busy assessment unit. Data analysis and interpretation revealed that these nurses experienced organisational, emotional and environmental pressures which impacted upon their experiences of providing patient care. These pressures led them to experience a sense of being overwhelmed causing them to consider their futures within AAU. Participants also experienced fear and anxiety surrounding disease processes which they commonly encountered and with which they observed similarities between their own life-style choices and those of patients. There was a sense of shared and mutual suffering amongst participants who almost unanimously considered team and collegiate support to be a source of coping.

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An unexpected but significant finding of this study was the idea of the 'repeat offender', a pejorative term used to collectively describe a range of personalities, presentations and conditions which participants considered as undeserving of their care.

7.2 Implications for AAU nursing

This study has revealed a great deal about the lived experiences of nurses working in an inner-city AAU and highlights several considerations for nurses working in similar environments.

Participants described a sense of 'drowning', this occurred because of the time/task pressures of AAU work and because of the self-imposed pressures of their work. Nurses described decreased personal well-being at both a physical and psychological level. I would recommend that nurses spend time considering the factors which lead to an overwhelming sense of stress and that they identify coping strategies to allow them to alleviate this stress and anxiety early.

Participants reported altered health beliefs and behaviours because of their exposure to particular diseases, there were reports of bargaining, compensatory behaviours and both positive and negative health behaviour. Whist participants identified that their fears were largely irrational they all identified a particular pathology with which they associated. These fears appeared linked to experiences of secondary traumatic stress and a sense of mutual suffering. Further research into this phenomenon is required.

As stated, an unexpected finding of this study was the idea of the 'repeat offender' and the apparent distinction between those patients who were deemed either deserving or undeserving of nurses' time and efforts. This prejudicing of patients based on presentation was almost unanimous and led to reduced standards of care. Participants did not appear to be malicious towards these patients and instead seemed to be suffering the effects of moral injury and burnout which left unchecked had been allowed to influence their day-to-day care delivery.

7.3 Implications for AAU managers

Nurses in this study reported experiencing overwhelming levels of stress and anxiety which led them to consider their future as AAU nurses and as nurses more generally.

Participants unanimously described an increased desire to move into other roles which they believed would offer better working conditions, less stress and reduced exposure to the diseases they feared. AAU managers should consider how they manage and support nurses experiencing anxiety and stress, however, sensitivity to individual needs and preferences should be considered carefully. For some participants in this study, management played an important role in pastoral support and confidence building whilst for others it was a burdensome process which added to the experience of anxiety and stress. The literature review suggested that management intervention is a valuable tool in staff stress reduction however, my study has demonstrated that this intervention can be both a positive and negative influence. Managers should therefore recognise the benefits of peer support and consider that the most appropriate action may be simply to facilitate this. Literature recognised the need for increased support for staff working in high stress environments and my study findings concur.

7.4 Implications for nurses

This study has highlighted participants experiences of stress, moral distress/injury, health anxiety and reduced well-being resulting from their work. The study offers insight into some of the causes and effects of these factors. There is a real sense that if unmanaged these factors could lead to burnout and a significant impact upon individual's quality of life. Furthermore, the study offers the wider AAU community insight into the experiences of my participants and I hope that they will identify similarities with their own practice environments and recognise the benefits of the coping strategies adopted by my participants.

7.5 Implications for service users

Several pejorative terms were used to describe a particular group of service users. Similar, albeit less offensive terms have been reported in nursing literature, but my study serves to elevate this issue by offering insight into the raw and uncensored opinions of AAU nurses. Future work should look at what can be done to address the negative attitudes of nurses towards particular patient types as improving attitudes could improve the experience of service users.

7.6 Contributions to knowledge

The contribution of this study to the subject of nursing in AAU is significant.

Firstly, it highlights the experience of stress and anxiety amongst AAU nurses and draws attention to the impact this can have on individual nurses' health and well-being, as well as their desire to remain in the profession. It is concerning that participants had apparently convinced themselves that they would develop the illnesses they feared most and allowed their health beliefs to be shaped by these fears. There may be a commonality of experience across other AAUs and so better understanding the factors leading to increased stress, anxiety and burnout may assist other organisations to mitigate against these issues.

Secondly, this study illuminates the concept of 'repeat offenders' in the urgent care discourse. The idea that participants routinely discriminated against certain patients gives rise to the need for further investigation to determine if this is a wider issue or simply a local one.

Finally, this study has shown the importance of collegial support within AAU and the ability of participants to share their suffering to reduce it. Due to the imperative placed on this by participants, I would recommend specific research be carried out in this area.

7.7 Study limitations

Despite my best efforts, this study is not without its limitations. As a novice researcher, I lacked the experience of interviewing participants and when transcribing interviews, I noticed areas where more detailed questioning could have yielded richer data. This improved with each interview but may have had an impact on the quality of my data. I was aware of my lack of experience prior to conducting interviews and spoke to my supervisors and more experienced colleagues to identify useful techniques and tips. I also practiced my interview technique on colleagues however, I now recognise that there is no substitute for real experience.

The homogeneity and sample size in my study also represents a potential limiting

factor. I recruited six participants from a potential population of 28, the sample comprised of four females and two males, both of whom held some management responsibility. I would have preferred to have recruited a more homogenous sample in which all participants were band 5 staff nurses and ideally of the same gender however, the small total population and limited volunteer numbers meant I had to accept all six volunteers into the study in order to ensure sufficient data. It might be that gender played a role in how participants made sense of their experience and processed their thoughts, but this did not appear to impact upon the emergent themes. Managerial positions did however, both participants who held managerial responsibility spoke of extra pressures and stresses and I must acknowledge that this may have skewed the data in terms of the narrative around tasks and time pressures within the AAU.

7.8 Impact and importance

It is anticipated that through publication and dissemination, this project will offer new and interesting ways of considering AAU nurses and AAU nursing more generally and will feed into future research. More specifically, it will inform AAU managers and senior clinicians within my organisation, this will hopefully raise awareness of the lived experience of participants and influence the support and managerial input offered to AAU nurses.

7.9 Further research recommendations

In view of the findings of this study, there are other areas that require further research The belief in an inevitability of disease development amongst AAU nurses is a significant finding of my study and one which requires further research and intervention to identify strategies to better understand and alleviate this experience and the associated suffering it is causing nurses within AAU.

Nurses in my study displayed many signs of burnout linked to the anxiety, stress and suffering they experience in the course of their work. This may be a local issue but could be a wider problem in similar socioeconomic circumstances. If this is the case, then next steps must be to begin to examine how nurses can be protected and supported in order that their stress and ill-feelings are managed in such a way as to both improve their own well-being but also the patient experience. We must consider that the

behaviour of these nurses, whilst sub-standard may be a symptom of work-place stress, moral injury and burnout and not simply a prejudicial view of a certain patient group therefore, specific research into this unexpected finding would be useful. In a post-Covid healthcare system, there may be new elements to the stress and moral injury facing nurses and researchers should be prepared to consider these dimensions.

As a final note, I remind readers of the sentiments of Amy who stated;
'Just because I love nursing, doesn't mean it loves me back'.
I would implore future researchers to seek to answer the questions this statement poses and to seek an understanding of how nurses can be cared for and trained in such a manner as to let them feel loved back. Specifically, the barriers to reducing STS and moral distress should be examined as should the characteristics and behaviours of the so called 'repeat offenders'.

Epilogue

This final section summarises my research journey and personal development over the last few years. Completing this study has been a challenging and emotional experience filled with many highs and lows, but as I reflect on the journey, I can recognise the transformation I have made over the last five years.

As a novice researcher, my knowledge of research methods and skill in interrogating data has grown exponentially and this has begun to impact how I carry out my everyday duties, I find myself critically appraising situations far more and this has on many occasions led to optimised outcomes.

Completing this project has increased my confidence to undertake independent research and I look forward to designing and completing many more research projects in future. I approached this project with an idea and a desire to understand how AAU nurses made sense of their experiences and I feel I have achieved my aims and that I have produced a robust piece of work which adds to the existing knowledge.

Notwithstanding the procedural and educational development that I have experienced over the course of undertaking this project, there have also been several key personal development points which have stuck out to me as a novice researcher. As a result, I would offer the following advice to anyone considering starting out on their own

research journey.

Read widely and actively. This may seem obvious, but I seriously underestimated the benefits of doing so early and found myself having to pause my writing to go back to the literature on numerous occasions.

Never be afraid to ask for help. Trying to enter the research world can be daunting, I felt that I should have the knowledge to succeed but of course, as essentially a trainee, I did not. Remember imposter syndrome can strike at any time, and frequently does.

Make time for other things. Writing a thesis can be all consuming, be vigilant to this and take time out to do the things you enjoy, or you will begin to stop enjoying your research journey.

Stick with it. There were times when I felt like giving up and accepting that perhaps a doctorate was outside of my reach. During these times, the people mentioned in my acknowledgments were a vital source of support and encouragement, surround yourself with such people and never give up.

And finally, enjoy yourself, it will all be worth it in the end.

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<u>**Appendices**</u>

Appendix 1 – Interview schedule
Version 1.1   22-2-2018

An Interpretive Phenomenological Analysis of care giving in the Acute Assessment Unit setting and its effects on the perceptions of the personal well-being of registered nurses.

Interview schedule/Possible areas for discussion.

The nature of IPA interviewing is such that it must remain inquisitive and responsive to the participant's disclosures. In-depth interviewing in this kind of study is rarely confined to a pre-set list of questions (Smith et al, 2009) instead the researcher should highlight a number of possible areas for discussion and use their judgement to facilitate probing of participant responses.

A schedule of questions has the potential to divert attention away from the participants account and the need for idiographic details associated with IPA renders a more structured interview schedule problematic, however, there must be questions for an interview to be successful; I will ask participants to describe any significant events in practice using statements such as 'tell me about an occasion when…' follow ups and prompts may include statement such as 'and how did this make you feel?' or 'what did you do next?'.

The interview will commence with personal introductions along with a brief overview of the project, its purpose and aims and a reaffirmation that the participant is happy to go ahead with the interview.

The interview will then progress to seeking out some biographical data about the participants. Their post-registration experiences, how long they have worked in the acute assessment unit, their current duties and what their previous roles have included. They will also be asked their age and any additional specialist qualifications they have undertaken (e.g palliative care diploma).

Example questions in this section might include:

Please could you tell me about your nursing career up to this point?

Can you tell me about your current role?

An example of a probing question might follow in order to clarify any ambiguous terms:

What do you mean by that?

The next area for questioning will cover the type of work the participants are routinely faced with and the extent of their involvement with direct patient care.

Questions here may include those such as:

Can you please outline a typical day for you on the unit?

Next, I will move the interview on to questions aimed at finding out how the participants make sense of their experiences of dealing with the acutely ill.

Questions will be focused on the participant's experiences of patient care and may include such things as:

Can you tell me about a time when you have been affected as a result of a particular patient interaction?

Probing and prompting questions will be used in response to the participants account in order to facilitate rich data generation through the gleaning of a thorough account of the nurses' experiences.

Following this I intend to ask the participants about their well-being and any worries about their own health.

Questions may include these such as:

You have told me about the type of patients you look after, but do you ever worry about getting sick yourself?

All jobs have good days and bad but what makes a good or bad day for you?.........Please tell me more about how you feel on a bad day?

The interview will conclude with questions about how participants make sense of their experiences of dealing with the acutely unwell.

I hope to ask questions about how they intend to proceed in their career, what makes them come in to work (especially on a bad day), for those that worry about becoming ill themselves I will explore this in more detail asking questions aimed at increasing the depth of their disclosure in order to appreciate what it is to have well-being worries and how these manifest and are dealt with.

Finally, I will offer the participants a chance to summarise what we have talked about and thank them for their time.

Questioning must and will remain focussed on the responses offered by the participant and at all times I will listen intently with the intention of identifying important areas for further exploration.

Appendix 2 – Ethical approval letter

School of Healthcare Sciences
Head of School and Dean Professor Heather Waterman

Ysgol Gwyddorau Gofal Iechyd
Pennaeth yr Ysgol a Deon Yr Athrawes Heather Waterman

CARDIFF UNIVERSITY

PRIFYSGOL CAERDYD

14 March 2018

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Prifysgol Caerdydd
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Mr Chris Elliott

Dear Mr Elliott

An interpretive phenomenological analysis of care giving in the hyper-acute setting and the perceptions of personal well-being of qualified nurses

The School's Research Ethics Committee Chair has considered your research proposal. The decision of the Committee Chair is that your work should:

Pass –and that you proceed with your Research in collaboration with your supervisor

The Committee has asked that the lead reviewers' comments be passed onto you and your supervisor, please see below.

Please note that if there are any subsequent major amendments to the project made following this approval you will be required to submit a revised proposal form. You are advised to contact me if this situation arises. In addition, in line with the University requirements, the project will be monitored on an annual basis by the Committee and an annual monitoring form will be despatched to you in approximately 11 months' time. If the project is completed before this time you should contact me to obtain a form for completion.

Please do not hesitate to contact me if you have any questions.

Yours sincerely

Personal identifying data redacted

Appendix 3 – NHS Trust Research and Development Department

Dear Chris,

RE: Local study ID2017130 . Confirmation of Capacity and Capability for non-portfolio research at South Tees Hospitals NHS Foundation Trust.
Full Study Title: An interpretive phenomenological analysis of care giving in the acute medical assessment unit setting and its effects on the perceptions of the personal well-being of registered nurses

This email confirms that South Tees Hospitals NHS Foundation Trust has the capacity and capability to deliver the above referenced study.

Thank you for your support.

Emma
Project Officer Assistant
Research & Development
South Tees Hospitals NHS Foundation Trust
The James Cook University Hospital
Marton Road
Middlesbrough
TS4 3BW

R&D tel: 01642 8549

Appendix 4 – Participant information sheet.

To be on Cardiff University headed paper when printed.

Ver 1.3 22-2-2018

INVITE TO TAKE PART IN A RESEARCH STUDY

Participant information sheet:

An Interpretative Phenomenological Analysis of care giving in the Acute Assessment Unit setting and its effects on the perceptions of personal well-being of registered nurses.

Thank you for taking the time to read this information sheet and for showing an interest in this project. My name is Chris Elliott and I am a Professional Doctorate student at Cardiff University. I am conducting this research project as part of my course of studies and welcome your participation.

You are being invited to take part in this research project but before you decide to do so, it is important you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Please take at least 24 hours to decide whether or not you wish to take part and to consider any questions you may need answering before making your decision should you wish to take part then please contact me using the details supplied at the bottom of this information sheet in order to complete a consent form. Thank you for reading this.

What is the project's purpose?

Each year many nurses experience workplace stresses, health anxiety and in extreme case choose to permanently leave the profession. This research project aims to investigate how prolonged exposure to the acutely unwell might impact upon the personal health and well-being of nurses working in acute assessment units. It is the hope of the researcher that by understanding how nurses are affected by the act of caring that strategies might be developed to help nurses and managers to support nurses in the workplace.

Why have I been chosen?

You have been chosen because as a nurse working in the acute assessment unit you have exposure to the acutely unwell patient and may have been personally affected by this exposure.

Do I have to take part?

No, It is up to you to decide whether or not to take part. If you do decide to take part you will be able to keep a copy of this information sheet and you should indicate your agreement by completing the attached consent form. You can still withdraw at any time. You do not have to give a reason. Should you wish to withdraw simply let me know at your earliest convenience. Withdrawal from the study will not impact upon your career in any way.

What will happen to me if I take part?

You will be invited to take part in a face-to-face interview during which you will be asked questions about your experiences of nursing and working with the acutely ill as well as about your general well-

being, you will be asked to describe patient encounters and what is involved in caring for them. The purpose of this interview is to find out more about your experiences of working with acutely unwell patients and how this might have affected how you view your own health and well-being.

What do I have to do?

You will be required to take part in one face to face interview which I expect to last about 45 minutes. There are no other commitments or lifestyle restrictions associated with participating and interviews can be scheduled at your convenience and will be held in the office space within AAU.

What are the possible disadvantages and risks of taking part? Participating in the research is not anticipated to cause you any physical disadvantages or discomfort however, there is a small risk that some emotional distress may be encountered as a result of the questions and your recollection of events whilst being interviewed. Should this occur you may pause or terminate the interview or even withdraw from the study should you wish. Both the confidential staff support service and occupational health will be available to offer assistance should you require it.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will have a beneficial impact on how health anxiety and workplace stress is managed for nurses working within your speciality. Results will be shared with participants in order to inform their professional work.

What happens if the research study stops earlier than expected?

Should the research stop earlier than planned and you are affected in any way we will tell you and explain why.

What if something goes wrong?

If you have any complaints about the project in the first instance you can contact any member of the research team. If you feel your complaint has not been handled to your satisfaction you can contact Cardiff University's Registrar and Secretary to take your complaint further.

Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified or identifiable in any reports or publications. Your institution will also not be identified or identifiable. Any data collected about you will be electronically recorded and stored in devices protected by passwords and other relevant security processes and technologies, the paper copy of your consent form will be held in a locked folder within a locked office. Data collected may be shared in an anonymised form to disseminate results. This anonymised data will not allow any individuals or their institutions to be identified or identifiable.

Whilst we will make sure your personal date is kept secure there are exceptional circumstances where we must make disclosures to relevant bodies. You will be notified in this event however; the following situations would involve disclosure: Fitness to practice issues, serious malpractice, criminal activity, abuse of position/power, fraud.

Will I be recorded, and how will the recorded media be used?

You will be recorded during the interview, this is to allow for detailed transcription and analysis of the data and comparison with other participant's interviews.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

The interview will ask you about your clinical experience, time in post and personal health beliefs. Your views and experience are just what the project is interested in exploring and the interview will cover these in detail.

What will happen to the results of the research project? Results of the research will be used as part of a thesis used in partial fulfilment of a professional doctorate being undertaken by the lead researcher in addition academic publications will be produced in order to share the findings of the study and to inform future professional practice. You will not be identified in any report or publication. Your institution will not be identified in any report or publication. If you wish to be given a copy of any reports resulting from the research, please ask us to put you on our circulation list.

Who is organising and funding the research? The project is part of a professional doctorate being studied by Chris Elliott at Cardiff University and is being supervised by Dr. Jane Harden, a senior academic at Cardiff University. The study has been funded by the student.

Who has ethically reviewed the project? This project has been ethically approved by the Cardiff University School of Healthcare ethics review procedure and subsequently endorsed by the research and development department of ███████ University Hospital.

Contacts for further information

████████

██████████

████████

Thank you for taking the time to read this and for your interest in the project. I look forward to hearing from you in due course.

Chris Elliott

CARDIFF
UNIVERSITY

PRIFYSGOL
CAERDYⱣ

When complete: copy for participant, copy for researcher, copy to site file.

(Form to be on Cardiff University headed paper)

Participant Identification Number for this trial: ……………………

CONSENT FORM

An interpretive phenomenological analysis of care giving in the Acute Assessment Unit setting and its effects on the perceptions of the personal well-being of registered nurses.

Name of Researcher: Chris Elliott

Please

initial box

1. I confirm that I have read the information sheet dated 22 Feb 2018 (version 1.3) for the
   above study. I have had a minimum of 24 hours to consider the information, ask questions and have

   had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time
   without giving any reason and that there is a small risk of emotional distress involved.

3. I understand that any interviews will be recorded, and direct quotations may be used by the
   researcher in order to illustrate the findings of the study. I also accept that the researcher is
   obliged to report any disclosure regarding crime, fitness for practice or serious malpractice.

4. I agree to take part in the above study.

| Name of Participant | Date | Signature |

| Name of Person | Date | Signature |
| taking consent | | |

Appendix 6 – Highlighted and annotated transcript

<u>**Participant 004 – LEE: Initial Comments**</u>

Exploratory comments	Original Transcript	Emergent themes
Does working with Military nurses change the overall dynamic of the department?	**Me:** To start with can you just tell me about your role on AAU? **Lee:** Currently, I'm in charge of a team on AAU, my role is to look after some junior nurses, approximately 10 to 15 nurses and health-carers. <mark>Working with our military counterparts</mark>. Working with them, but not for them also, getting in my own clinical exposure to maintain my skills and interests in medicine. **Me:** OK, so what sort of tasks would you have to do as part of that role? **Lee:** So, from the managerial point; I have to make sure that people turn up, that people are competent that their in-date for any training, that the staffing ratios are correct and that the skill mix is correct, er, that I have facilitated people's wishes and wants erm, <mark>supporting staff</mark> you know, so that's from a management point of view. Erm, from a clinical	Support Tasks

	point of view; to work in line with the policies and procedures. Treating acute medical patients and either fixing em' in the layman's sense, so fixing them or sending them to another ward essentially.
	Me: So with your management experience in mind then, what do you think makes a good AAU nurse?
	Lee: So, we get a lot of rotated staff, a lot of preceptee nurses that have either come from a surgical or orthopaedic ward and they come to us and they're quite new and their general understanding of A and P <anatomy and physiology> is fine but ==they don't understand the pace of the ward and pace is key but for a good AAU nurse, and that's a quality but in order to have that pace and that understanding you need to have the experience and that's the thing. People are lacking experience==. So good qualities would be; experience, good A and P understanding, being able to recognise acute deteriorations and to be able to respond appropriately.
AAU is a fast pace and challenging environment – why are people lacking experience? Are they new, what development opportunities are there?	**Me:** What does an acute deterioration look like?
	Lee: (…) So, there's textbook answers, so we do an assessment you base it on the national early warning score

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	erm so that's one indication to what a deteriorating patient looks like on paper in the sense that each set of values such as breathing or respirations has a has a erm range and if they're beyond the so called norms then the trigger and if you score sort of a score of more than 5 or a single score of 3 then that would make them a trigger. But that's using formal things but then ideally you use your initiative and sometimes you just know someone has deteriorated, you listen to the chest or breathing, or they look grey in pallor or colour and you just know. Sometimes it's just that feeling you develop and know someone is not right as well as relying on things like er national early warning scores.	Tasks
Is this an intuitive thing or experiential?		Intuition/Knowledge
	Me: What sort of range of patients do you typically expect to see?	
	Lee: Erm (.) so, we definitely get regulars and not often but disease processes, so you get COPDs, diabetics, asthmas, DKAs, erm, pneumonias, general infections, GI bleeds, you know, so it can go down surgical so you can get GI bleeds, you can get erm, hypokalaemias, we get a lot of seizures from people trying to detox of alcohol, alcoholics, drug users, a full range of erm, Middlesbrough's finest really.	Privileging/prejudicing patients
M'boro has a low socio-economic status and as such a high unemployment and low		

education attainment level.	Those disease process are very related to Middlesbrough's demographic.	
	Me: The demographic, what do you mean by that?	
	Lee: So, Middlesbrough is quite a working class city and it's got an obesitiy problem as well and it's not the wealthiest of cities so you do get erm, there's quite a concentration of people struggling with alcohol, drug use erm, a lot of erm working class people who tend to have an altered life style, so they tend to smoke more. From my perspective and them being from that working class they	
Demographic.	tend not to be able to voice their problems to the GP. You tend to find (..) just that mixture tends to get people coming in with obesity, drugs and alcohol related illnesses. The area definitely effects the people that come in through the door.	patient types
	Me: So how did you end up coming through the door as it were?	
How did he know it was for him?	**Lee:** So, I'm from South Yorkshire, I trained as a nurse and trained at Birmingham City University and moved up to the North and after a brief rotation settled in medicine, I just knew it was for me and I've been here ever since. I went on	
Is this different to managing?	to do a post grad in acute medicine and low and behold I'm	

	here <mark>leading the ward</mark> as a head of department now.
	Me: So, what makes a good day at work for you?
	Lee: So the good thing about the assessment unit is no day is ever the same. You do get your similar presentation but everyone is different erm, the thing I hated about ward based care was you can have a patient for 6 to 8 weeks whereas ourselves, we aim to keep them for no more than 24 to 48 hours. To me that fast pace, fast turn over of patients, it's something new everytime. — Pace
Why?	**Me:** How do you feel after a good day?
	Lee: Tired, <laughs> because a good day is tiring, it's — Fatigue
What is it about a busy day that makes it good?	hardwork, so say you turn you bay over twice by that I mean you discharge and admit new patients twice so you get 8 patients out and more in during that day erm, along with all the other routine stuff you have to do, then that's a busy day erm, there's you well tend not to stay stationary for too — Pace
	long but that is a good day.
	Me: What emotions do you feel after these days, perhaps on the drive home, if you're not falling asleep?
	Lee: (…) So, we have, we seem to get a lot of patients that are end of life as well and it can be emotionally tiring and

Does this come from perceived omissions or actual ones?	you're always questioning have I done everything I could because time is so tight and when I first started I always used to worry like, god I've missed something or not handed something over and you worry that well, you learn not to worry as much. Not to be neglectful but just not to worry as much, you know it's 24 hour care, you've done enough and you've given a good handover to the nurse that's coming on and you tend to worry less after a shift but there's always gonna be doubt sometimes especially for the more junior nurses.	Self-doubt
How related are neglect and worrying less?. Does he worry less because he trust his team to continue his work?		
It would have been useful to explore the idea of 24 hour care in more detail.		Self-doubt
	Me: Can you give me an example of a bad day?	
	Lee: Er (.) so a really bad day for me was quite stressful so, we had a palliative patient that we needed to do a rapid discharge home so essentially, they were dying; we ordered the anticipatory meds, got the bed set up, everything set up but I just didn't have enough time to discharge her myself. There were a few little things to tick in the box; awaiting for meds to arrive, waiting for syringe drivers to arrive, just stuff like that for them to go home and you have to apply for funding from certain trust whether it's Cleveland or Middlesbrough and it, it consumes all your time so I	
		Tasks/Time

	worried one, that I didn't get em' home on my shift in time and hopefully that the nurse would get him home, that hopefully they would get em' home and things would arrive so that was a bit rubbish and the other thing as well is	Time/Tasks
Worried about the patient or that he may have missed something?	because that occupies all your time you almost neglect your other patients that are also acutely unwell and you have to rely on others to do your work for you and going home after that shift it was emotionally and physically tiring and you go home worried.	Anxiety/Fatigue
	Me: Could you describe the emotions you felt that day?	
Who is they?	**Lee:** Frustration was the biggest one, because why do they make it so difficult to get a dying patient home, why is there so much beaurocracy and paperwork? You can understand why in that it has to be appropriate and every box has to be ticked but sometimes the frustration is a big one, if you want to get someone really sick home; get them the meds, get them the support, get them the nurses and just send them	Frustration
3rd person (dsitancing)	home. They shouldn't have to wait, so yeah frustration was a big one for me and just the fact that you weren't able to, it's almost like their dying wish in a way and so not being able to facilitate that is frustrating.	Frustration

distanicng	**Me:** How do you deal with that frustration? **Lee:** I guess erm, you develop coping mechanisms and everyone's different. For me it's probably going home and moaning to the wife, you know having a general open conversation with the wife so I guess that's erm quite an active reflection there and then of what went wrong. It helps that my wife is a nurse as well so she has an understanding so we can have a talk, so that's one way of dealing with it.	
Would it help as much if his wife was not a nurse?, Does he talk to other nurses in his team or does his management position mean he does not?		Support (family)
	Me: And, does that go both ways? **Lee:** Yeah, she moans more to me than I do to her but yeah its good you know to get things of your chest. I find it useful to a certain degree. Reflection helps you know, I wouldn't say formal reflection helps it's a sort of erm (.) initial or on-going reflection is useful you know I don't like to dwell on it but I guess I use other coping mechanisms as well like I er (…) whiskey yeah I suppose maybe not, not drink, but sports is a great stress reliever for me as well it helps me cope with the stresses of work (…) just getting out and running or cycling you know it's a great way to get rid of the stress, sweat it out almost.	Coping/Venting
Seems to accept there are positive and negative coping mechanisms		Coping
		Stress
Metaphor – sweat it out		Stress/coping
	Me: Sweat it out?	

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	Lee: Yeah, I know it sounds a bit strange but I mean just like getting out there and exercising you know, it helps me forget how stressful the day has been, the harder I exercise the more you sweat and at the end of the session I feel a lot less frustration so yeah (.) sweat out the stress.	Stress Coping
	Me: That's quite a nice metaphor, I like that. What if you don't get to sweat it out?	
This is a negative element to his support mechanism – can it exacerbate the situation?	**Lee:** Yeah, well I suppose I talk to the wife and bore her but if we've both had a bad day it can make things worse and we go to bed both feeling annoyed or frustrated. We've set a time limit now on how much we can talk shop for, half an hour each and then that's it (.) no more work talk. You can't	Support
Crap- What does this mean?	let work take over you know, there has to be a line and you have to vent for sure but you have to keep a balance otherwise you'd end up up to your eyes in work, stress and all the crap that goes along with it.	Venting/support Stress
	Me: Do you ever think about a job elsewhere?	
	Lee: Er (…) sometimes, I don't know if its well I often have open chats with my wife. There must be something better.	
Appears torn about his role and wishes to separate elements of it.	At the moment I like medical, I like the acute thing and that's what makes me happy. What doesn't make me happy	

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	is the management side of things where you're pulled in all directions er you're expected to do so much, I want to focus just on the clinical but I can't so that creates an internal frustration. It makes me think; is there an alternative?	Tasks Frustration
	Me: What does the alternative look like?	
	Lee: Less pay and that's the thing. Currently I'm getting paid quite well for what I do and if I went back to being just a ward nurse I'd get paid a lot less, there are other perks of management to keep people there but it's really about the money for me. There could be other jobs out of the NHS that would probably pay quite well and let me be more clinical and that's something I look out for but I like money at the end of the day and I balance the stress of the job versus the potential stress of being skint. A decent paid job with less stress, that's the alternative I suppose.	Trapped/reward Trapped/reward
	Me: When you say outside the NHS, do you consider outside of nursing too?	
Job security/money feature highly in his priority – I wonder if he feels stuck.	**Lee:** Again, yeah I guess I talk myself out of it. So I spoke to someone who teaches mountain biking and does it as a living and that's my passion as well so the carrot is there but I don't think it would work out and I like simple things and	Reward

security so at the minute ==I've got job security and it's simple enough to keep coming to work and doing my job.==

Me: Is that enough to keep you coming back?

Lee: Er (…) Money. I think clinical work is the one thing in work that's keeps me coming back, you know doing the clinical piece well. So; I recently got an email erm so er erm ==a patient's relative had taken the time out to send an email to my bosses to say how well I'd done and then that was forwarded to myself erm so that positive feedback from relatives and patients helps, that your making a difference where you can. Erm, I think that helps keep me coming back== as well.

Me: I wonder if you could tell me about a particularly memorable or significant event that you've been involved in during your time on AAU?

Lee: (…) Erm, just trying to think now (.) memorable, oh right yeah. So a guy that came in who was really unwell, like level 2 care so almost HDU care because of his diabetic ketone acidosis so he was really really unwell so, I knew the policy back to front and ==I was working with a junior doctor who was a bit like a rabbit in headlights so, that's job==

Recognition/reward

Supporting colleagues to make a positive patient outcome – this gave him satisfaction	satisfaction in that sense in that I was able to help the doctor out with policies, the interventions, how to do them, when to do them and really sort of we resolved the DKA before I left my shift and the guy came round and was very thankful and his family were very thankful as well. So the whole point is that I saw it through, I saw the DKA, dealt with it, saw it through and fixed him so yeah that was quite good.	Support
		Satisfaction/reward
Is it the recognition for the work he does, or the satisfaction from saving the patient he thrives off?	**Me:** How did you feel being able to see it through to the positive outcome?	
	Lee: It's, it kind of reaffirms why you become a nurse as well. So nursing has moved on drastically even in the last 20 years and sometimes we can be more autonomous sometimes and rather than be subservient to the doctor we are more like equals and helping each other out and I guess it's that being valued and being able to make a difference not just being monkey see, monkey do and or just been told to do something, you're actually getting to be an advocate for your patient and doing something important.	Support/team
		Reward/value
		Improtance
	Me: Are there any times when it hasn't gone so well?	
	Lee: Er, yeah there's always well, it was very early on in my career and I didn't recognise a guy who was deteriorating,	

Can being task orientated reduce safety or patient care?	his blood pressure was dropping his heart rate was going up and I just missed the signs and he deteriorated to the point where critical care outreach ended up being needed to come and assist and I just didn't recognise it. I think I was task focussed and just didn't really look at the patient. **Me:** How did that make you feel? **Lee:** Absolutely shocking, useless nurse, out of my depths. I felt like that for a good few weeks if not months. It took a long time to build my confidence back up. I was quite lucky because my manager at the time was quite good and she recognised that I needed some assistance, she quickly got me on my ILS and AIMS course and that helped, she was really supportive and helped get my confidence back but it's easy to lose it and miss things sometimes. **Me:** How do you feel discussing that event now? **Lee:** (…) Erm, well I've learned a lot, I've progressed from there in my time so I've been qualified I dunno 7-8 years maybe and I feel like I'm at a good point now where I feel I can practice effectively but also like I can teach or support others so yeah, I feel like I've come a long way and yeah, thinking about it now, it doesn't worry me too much because	Tasks Self doubt Support Support Self-doubt/vulnerability Support Personal development
Is it down to luck having a good manager?, are there bad managers and I wonder how he perceives his own management style.		

How is learning achieved – is it simply from reflecting or is there a more formal process.	we all make mistakes and I can see that's the best way to learn, so long as there not too severe.	
	Me: What is the biggest challenge for you on AAU?	
	Lee: This is gonna sound a bit bad, probably good this is anonymous but; self-inflicted stuff is something I struggle with, in specifics it's the repeat offender, cries for help, attempted suicides I struggle with there's only so much support or empathy you feel you can offer. They keep	Privileging patients
Repeat offenders – like criminals? Should they be treated differently?	coming in and you refer them to the appropriate places of support but they just keep well it's that same circle of people coming back that's a hard one to deal with and it's hard to know how to deal with them, how to speak to them; do you go down the role of empathy or do you go down the	repeat offenders
Is this a passive or active choice?	role of being a bit abrupt and not telling them off but being stern with them and you don't always get the right response.	privileging patients (repeat offenders)
What is the right response – would have been useful to explore this further.	**Me:** How do you deal with that?	Self-doubt
	Lee: So, if they're a first offender empathy, if they're a repeat offender then well, you don't lose compassion erm but your patience is sometime going to wane, it's frustrating to keep seeing them coming back in. You try not to judge but its hard to imagine what they're going through er (.)	Privileging patients / repeat offender
Suggests that it is an active decision		Frustration

Does the overdose patient not deserve or really need their bed – is it that treatment is futile that leads him to suggest they waste his time. Could the repeat presentation be a MH issue which is being missed? What makes a problem "real" - could a chest pain patient not be their through their own doing (diet, lack of exercise etc)? Moron -	yeah its just frustrating, they take another overdose of paracetomol and they're on the third bag of parvolex which takes 16 hours to go through and then you've got sick people in corridors maybe with chest pain and then you've got this 21 year old chap who's waiting for the 16 hour parvolex to go through, wasting time and blocking beds from those who really need them and it's frustrating because for the patient you can't seem to resolve the problems but it's frustrating because they've put themselves there and you can't treat the patient in the corridor with real problems like chest pain because the bed is blocked by some moron who has put themselves there. **Me:** I'm really interested in how you describe people; so you describe everyone as the patient or the guy in the corridor or the really sick, yet these particular patients are described as offenders. Can you just expand on that a little bit? **Lee:** Oh god, I didn't even realise I did that, erm, (…) I guess I infer people who self harm to be more accountable I guess I dunno. **Me:** Accountable?	Repeat offenders Privileging patients (deserving vs undeserving) Frustrating Frustrating Privileging patients Privileging patients

Emotional labour at play with these patients?	**Lee:** Yeah, like is it a cry for help, is it attention seeking or is it an honest mental illness concern. I guess I'm imposing my own attitudes there aren't I but well, I don't know how to explain that one.	Emotional labour
	Me: Do they deserve the same attention as someone who's perhaps had a heart attack?	
	Lee: Yes, cos well the textbook answer is yes because you should give, well everyone should get the same treatment so the textbook answer has to be yes. You shouldn't judge and you should treat them fairly but sometimes your inner voice sometimes, you have your own views, sometimes your inner voice takes over, you have to suppress it and treat them	Emotional labour
Dickhead – does this apply to any 'self-inflicted patient' (fell playing sport etc) or just self-harmers?	properly and fairly but sometimes you think to yourself (.) dickhead. I guess its about you have to be self-aware and keep that inside, hide your own thoughts inside so it doesn't effect your practice but it can and it's so frustrating to see time and time again the same idiots back and forward.	Privileging patients
Idiots – he really does not seem to have any respect for this patient group	**Me:** How do you reconcile that?	Emotional labour
	Lee: (..) I guess I try to strip back all emotions and prioritise care based on clinical need. I guess you try to remember that you are there to provide medical care to the best of your	Frustrating Repeat offenders

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	ability and to respond on a clinical basis and decide how is the most sick, what can I delegate to others and get everyone seen and treated. You have to push that discrimination and judgement to one side. It's tough sometimes but you just crack on with your job and do what you have to do.	
How do you achieve this?		Emotional labour
	Me: What about when the job is finished?	
	Lee: I suppose so long as you keep it anonymous then you can offload and have a bit of a moan, then I think that's healthy. It ties in to that clinical supervision as well you know, if you have concerns or tough times then you let it out you voice it and sometimes you come up with solutions and	
Coping mechanism – time away to "reset"	sometimes you just piss off and and restart, reset and do it all again.	Venting
	Me: What does well-being mean to you?	
	Lee: Personally, to me erm (.) that I remain happy in the ward, it's about having an appropriate amount of stress, I don't think you can be stress free but its about not letting	
How much stress is appropriate and how do you realise when that point is reached?	stress become overwhelming and that I'm happy at home and that's my well-being sorted in the simplest terms.	Stress
	Me: What is an appropriate level of stress and how do you	

	maintain that?	
	Lee: Phwhh (.) Delegate, always delegate <laughs>, so there's a lot you have to do both personally and clinically oh and managerially and erm stress for me is that overwhelming sense of not being able to cope or to do everything to the best of your ability so sometimes you have to delegate whether that's on the ward or to my junior so people I manage, so if I can delegate to them then I will, so I guess that's how I manage stress at work.	Stress
Overwhelming (survive) Does this just shift the stress onto his colleagues?	**Me:** What about outside of work?	
	Lee: Er (…) Sometimes I don't deal with it and I remain stressed for a period, I think; Sometimes I don't deal with it and I remain stressed for a period but I tend to have good family support and good friends that I can chat too but I guess not everyone's the same really.	Stress Stress
	Me: What about your own health, how would you describe that?	Support
	Lee: I should imagine my blood pressure a bit higher these days. Erm (…) stress is well so, stress is yeah, when I'm not stressed I'll probably go out, do more phys, be more active ad maybe socialise more but when I'm more stressed then I	Stress

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Comfort eating as a coping strategy	tend to do less, I think I have to be busy constantly with work in order to get things done and that becomes overwhelming, I tend to not do phys which we all know releases endorphins, feel good hormones which helps with stress and I tend not to do that which only makes things worse and I tend to feel like I'm under pressure and sometimes it's hard to get over and well, I comfort eat sometimes just to well yeah to deal with stress <laughs> yeah.	Workload/Tasks Anxiety
	Me: How do you break that cycle?	
	Lee: My wife tells me to get a grip, it's good in the sense that when I'm stressed Tasha <pseudonym> tends not to be and she helps me and vice versa so we tend to prop each other up but if you get in that rut it's so hard to get out of it and (…) if your criticised as well that really doesn't help with the stress and you might have management on your back as well telling you that you've not done a good enough job and then on top you might have a clinical incident, for example; I recently had a patient that fell and that stressed me out as well so you know if you have it from both runs then stress is hard to deal with, it really is.	Stress/Anxiety Support

	Me: What is the impact of stress on your life?	
	Lee: I'd like to think I'm robust enough to walk away from it and say that it doesn't effect you, but it does effect you.	Stress
Suffering twice – this is a nice description of his outlook.	I've always tried to be quite laid back and I've always said if your stressed and you worry then you're suffering twice, because you worry about it happening and then it happens again so I try to, I try to be on the well look optimistic and try not to think about it but it's hard, you have to force yourself not to worry. Erm (…) it saps your energy. If I	Stress/suffering
How do can this be achieved?	worry or stress to much it saps my energy and I feel like I	
Is it the stress or anxiety of knowing there will be more stress that makes it hard to go back?	don't want to turn up to work and I can't be bothered. But it's how you get passed that and I sometimes I take time to myself and think that things mostly work out for the best, 9	Drained/fatigue
	times out of 10 things work out well regardless of how much you stress so I try to put my worries on the back burner and keep moving forward if that makes sense?	Stress/Anxeity
	Me: It does yeah, I'm interested in how you got to that position and the idea of suffering twice if you allow yourself to worry.	
	Lee: Yeah so I do worry but I think what happens with me is that I go away on leave or do exercise and get away from	

Taking time off work to reset seems to be an effective strategy for him, I wonder how sustainable this is as he will have an allocated number of leave days per year.	the work environment and I feel that lets me reset and destress and I feel like I reset to zero and then weeks and months go on and the stress levels begin to peak and you know I either get to a point where I say; you know why stress and I try to deconflict that in some sense. And, stress does creep up on you and I end up thinking what is the point? And then I tell myself to just crack on and I do fine or sometimes it doesn't work and so I go on leave or whatever and destress and then start the whole process again so I either let it build and go on leave or sometimes I think enough's enough and I just stop caring and shut it out and have a word with myself to just get a grip and think why worry.	Stress Reset/ time away (coping) Stress
	Me: What makes you keep coming back and going through that cycle of stress and decompression?	Stress / time out
Proud to be a nurse – what is it that makes him proud? He is still proud despite his stress and wished to leave.	**Lee:** Er, again its that job satisfaction, actually no. You'd be naive not to acknowledge pay, and I'm on good money so that is one big reason to do it and the other factor is as much as I suffer with stress, I'm still proud to be a nurse and being good at what I do, and yeah that's a bit of self-appreciation there isn't it but I think I'm OK at it, so that keeps me	Money / reward / trapped

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	coming back.	Reward/ self-importance
	Me: Do you think its something you'll do for a long time?	
Lists security (decent living) over enjoying nursing. Seems he stays for job security and financial reward more than his enjoyment of clinical work.	**Lee:** I'll definitely do a little bit longer but, <mark>I think though if a non-clinical job made sense and I could make a decent living and keep my family happy then I'd do it probably but that situation is few and far between</mark>, and at the minute I still enjoy nursing and I'll keep doing it for now.	
	Me: How would life be if you did find that few and far between job?	
	Lee: Well, that's the gamble isn't it, that's the gamble. You're going into the unknown, giving up your security and starting afresh. (…) Yeah, so my wife always jokes that I can do anything and I love carpentry or working with my hands or fixing vans, making motor homes. Its weird but I'm at my happiest when I'm hands-on like vocational type things and that is nursing as well but like more trades skill type things and that keeps me happy and <mark style="background:#7CFC00">if a job came along where I could use my hands and someone said you'll earn a fortune and have job security then I'd jump at it but is that gonna happen, no, it's a pipe dream and erm, so yeah at the</mark>	
Interesting choice of words – stick with it (as in stuck)	<mark style="background:#7CFC00">minute I'll stick with nursing.</mark>	

	Me: Do you feel trapped?	Reward/security
	Lee: Totally yeah but we all have our cross to bear I suppose.	Stuck
	Me: Does work impact upon your well-being?	
	Lee: Put it this way, I've at times gone off sick for a day or so with stress or where I've not been able to go into work because I've been too stressed and there have been times where I've been really low in mood because of it so yeah, of course; your emotional well-being does impact on the physical as well, but I've not reached that total breaking point point yet and I'll say yet, where I've had to go long term sick because of stress because of low mood or stress but as I've increased my responsibilities the stress increases and yeah at the moment my coping mechanisms are ok but there might become a point when work becomes too much and the stress gets too much and it may throw me over the edge but going back to coping mechanisms I always visualise a balance in my head; a work-life balance and at the minute everything is good at home and work isn't too demanding but if the balance ever tips then I might say that I've reached that point when its got too much and I will	Trapped
He admits to having been so stress or low in mood that he has needed to go off work sick, and yet says his coping mechanisms are working. I wonder if he is just managing things on a day to day basis.		Stress/sickness
		anxiety/ low mood
		Stress
"throw me over the edge" - metaphor.		Coping
		Over the edge

	have to go sick but at the minute things are just about ok.	
	Me: If you had to summarise our chat today in a few sentences what would you say?	
Is it the mistake or the consequences that worry him.	**Lee:** So; my biggest worry is making an error at work through either fatigue, stress or general mistake, an error so big that it brings my nursing pin into question so that's my biggest worry. Erm, what was the other thing, oh yeah, it sounds bad but using my wife; having a supportive individual at home, having that opportunity to have a quick reflection and as much as I hate reflection it does seem to work just having that chance to offload so that's my preferred coping mechanism.	Fatigue stress self-doubt anxiety
	Me: What if she wasn't there?	Support
	Lee: Well, I do have a taste for whiskey <both laugh>, no, I'd like to think if she wasn't there that I would have a good friend that I could moan to, cos If I wasn't living with my wife I'd probably live with friends so the outcome would be the same but the vessel would be different.	
	Me: Is there anything else you would like to talk about today?	
	Lee: Well, I just think for me personally I feel that while I	

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Others suffering – are these his staff and if so has he done anything to help them.	can just about manage there are those I work with who can't manage and nursing is a really emotional and high stressed job, it is physically and emotionally tiring erm, I like to think I do ok, but I know others don't and I've seen the numbers who do go sick and who have ended up with mental health problems. I think stress and mental health issues is underlying in nurses and it is a real concern. As a team we try to care and look out for each other, you can always rely on your colleagues to help you through the bad times and I like that about this place.	Stress MH Support
	Me: Is that for nurses in general or specific to AAU?	
	Lee: AAU I think have it worse, its stressful because of the pace but other wards have their own stresses, they can be heavy or understaffed so yeah possibly AAU nurses are more stressed but I think it's probably an issue for all nurses.	
Is it the same stress or different?	**Me:** Well, I don't have anymore questions so unless there's anything you want to ask me then I'll just say thank you for your time and for your honesty in answering my questions. It's been really valuable talking to you.	Stress
	Lee: No, you're welcome and good luck with your research.	

		Me: Thank you.	

KEY:

Area of interest – <mark style="background-color:yellow">Yellow</mark>

Direct quotes (taken to support coding) – <mark style="background-color:green">Green</mark>

Descriptive comments – <mark style="background-color:blue">Blue</mark>

Linguistic comments – <mark style="background-color:red">Red</mark>

Conceptual comments – <mark style="background-color:orange">Orange</mark>

Emergent themes – <mark style="background-color:purple">Purple</mark>

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Appendix 7 Table showing development of themes for Amy

Example from data	Emergent theme	Main/Superordinate theme
'we all support each other' (P6, L3) 'there is never any of that, well attitude you can sometimes get in nursing when it's like; what, you don't know that. There if never any of that here. It's always, yeah no problem, or I'll come help' (P7, L2)	**In it together**	**I feel like I'm drowning**
'I think what makes it easier is speaking to other nurses' (P11, L19) 'talking to colleagues and let-ting it all go' (p12, L13)	**Coping mechanisms**	
'Basically, almost anything can come through those doors' (p2, L14) 'it's more to do with the un-predictability' (P3, L3) 'the sharp edge of nursing' (P4, L6) 'You want to be on top of things and do things right for your patient but sometimes	**Nature of AAU**	

AAU doesn't facilitate that' (P5, L19)		
'it can be quite stressful' (P1, L21) 'a good day is a day you don't drown' (P4, L22) 'lists and lists in your head, well, you just can't do it' (P5, L8) 'you try to be faster but then you make more mistakes and it just gets more stressful. You get worried sick' (P6, L6) 'You feel like you've failed' (P13, L18)	**Stress self-doubt and anxiety**	
'It's (cancer) closer than you think I suppose, you never know what's coming' (P9, L3) 'If these people have if then it's going to happen isn't it?' (P10, L18) 'it's scary to see these things everyday. I don't want to end up like them' (P11, L14)	**Fear of becoming a patient**	**I don't want to end up like that**

'it's made me really worried about me or my loved ones getting cancer' (P18, L1)		
'People with cancer really seem to stick for some reason' (P8, L12) 'cancer in general….you always feel those patients' (P8, L21) 'Cancer, it sticks around' (P9, L2) 'because of the increased exposure regularly it makes me feel like cancer is everywhere' (P10, L11)	**Exposure anxiety**	

Appendix 8 – Photograph showing clustering of individual participant themes in cross-case themes