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# Journal Pre-proof



Self, interpersonal and organisational acts of compassion amongst nurses during times of acute stress: A qualitative analysis

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**Abstract**

**Background:** There is a global shortage of nurses and new strategies are required to recruit, support and retain this staff group. Organisational culture can have a significant impact on staff wellbeing and commitment. Recent years have seen attempts to foster a compassionate culture across healthcare systems. However, little is known about how nurses initiate self-care and how they feel cared for by their organisation, particularly in times of acute stress and need.

**Aims:** This paper aims to address the research question, 'In what ways do nurses experience compassion (or not) during times of acute stress?', identifying where and how compassionate acts were enacted by individuals, within teams or organisations.

**Methods:** Semi-structured interviews were conducted with 50 UK National Health Service (NHS) nurses in a longitudinal qualitative study (between March 2020 and September 2022).

**Results:** Three themes were derived from our narrative analysis including: (1) Learning and practising self-compassion; (2) The presence and absence of interpersonal compassion; and (3) Organisational (non) compassionate acts. Findings indicate that self-compassion requires permission and discipline, often being unfamiliar terrain for nurses. Interpersonal compassion can buoy nurses during challenging times but can often be absent across teams. Nurses' experiences of organisational acts of compassion were limited, and they often felt de-valued, unsupported and replaceable.

**Conclusions:** Compassionate acts are enacted across three levels (self, team and organisation). To retain staff, particularly in acutely stressful or challenging situations, organisations, and those responsible for nursing management and policy need to foster a systems-based approach to compassionate culture.

**Key words:** Nursing, compassion, organisations, culture, workforce, qualitative.

## Introduction

Nurses and midwives form one of the largest healthcare workforce groups globally, yet there is a current shortage across the world. Prior to the pandemic this was estimated at a six million shortfall (Ball et al., 2021; WHO, 2020). Since the pandemic, this has risen to a shortfall of over 13 million nurses worldwide (International Council of Nurses, 2023). Burnout is pervasive across the profession, with between 40-80% of nurses experiencing ill health or burnout globally, because of a lack of workplace support (International Council of Nurses, 2023; Baines, 2023). Increased rates of nurses leaving the profession have been observed across at least 20% of the International Council of Nurses National Nurses Associations (International Council of Nurses, 2021). As patient demand continues to rise, there is an urgent need to implement strategies capable of better supporting this particular workforce group, to better retain them and protect their wellbeing (Anonymised author reference, 2023). This is particularly pertinent as the world recovers from the pandemic and attempts to attract new recruits to the profession.

Organisational culture can significantly impact staff wellbeing and turnover, having consequences for staff job satisfaction, performance and burnout, as well as patient care delivery (Anonymised reference, 2023). In recent years there has been a drive within healthcare to foster a more compassionate culture towards and between staff. Compassion has previously been defined as a 'sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it' (Gilbert et al., 2017, p.). When compassion is demonstrated within healthcare organisations it can: significantly reduce staff burnout; contribute to improved clinical outcomes in patients; and contribute to financial sustainability across healthcare systems (Trzeciak, Roberts and Mazzarelli, 2017; Trzeciak and Mazzarelli, 2019). This is attributed to the fact that when staff feel valued, they are more likely to remain in their jobs, providing safer patient care and contributing to higher levels of patient satisfaction (The King's Fund, 2012). Retaining staff and therefore reducing costs associated with replacing them can contribute towards the financial sustainability of healthcare systems (Duffield et al., 2014).

A small but growing body of evidence exists relating to the nursing workforce and compassion at work (i.e. acts of compassion that occur across the workforce or organisationally, as opposed to compassionate care provided to patients). For example, work conducted in Greece and Cyprus, by Kouta et al (2022), on nursing and midwifery managers, demonstrates the necessity to be a compassionate manager and advocate for staff. Compassionate acts were often conceived as demonstrable steps taken to alleviate staff suffering including adjusting shifts, schedules and approving exceptional leave. Where

open door policies, formal and informal meetings, and treating staff on a case-by-case basis existed, staff determined that they received compassion from their colleagues including managers (Kouta et al., 2022). According to work conducted by Papadopoulos et al (2021) into global views on compassionate nursing and midwifery managers, workplace compassion can exist on a continuum from self to organisation, and this is necessary for it to become better institutionalised. When demonstrated in practice, specifically by leaders within healthcare settings, acts of compassion included: listening, sympathetic responses, active support and advocacy of staff/ team members, conflict resolution and problem solving (Papadopoulos et al., 2022).

Establishing a compassionate culture has been a particular focus of the UK's National Health Service (NHS), with the leadership of healthcare organisations being the predominant focus for intervention (Bailey and West, 2022). Despite the growing body of evidence relating to compassionate leaders, workforces and environments, there remains a dominant focus on the provision of compassionate care to patients (Sims et al., 2020), done so "without consideration of the nurse's own needs" (Andrews et al., 2019, p.2). Little research has focused on how nurses feel cared for by their organisation, particularly in times of acute stress such as during COVID-19. UK nurses often report higher rates of burnout compared to other European countries (Aiken, Sermeus, Van den Heede et al., 2012; Heinen, van Achterberg, Schwendimann et al., 2013), with 43% of the UK nursing and midwifery workforce feeling unwell due to workplace stress (Kinman, Teoh and Harriss, 2020). Given the links between compassion and staff wellbeing, this is particularly important following the excess strain the pandemic has placed on both the workforce and healthcare systems, causing many to leave the nursing profession due to burnout (International Council of Nurses, 2023). Therefore, we use this paper to identify what, where and how compassionate acts were enacted by individuals, and within teams or organisations. Our findings therefore contribute to the evidence base indicating that compassion acts happen along a continuum from self, team and organisation, and hold significant value to staff. In this paper we address the research question, 'In what ways do nurses experience compassion (or not) during acutely stressful times?' In doing so, we make concrete the ways in which compassionate acts can be fostered for nurses during acutely stressful times, and across different contexts.



## Theoretical Framework

We frame our findings across the continuum of self, team and organisation, supported through the use of the emancipatory theory of compassion (Georges, 2013). This theory views suffering as both essential to human lived experience and universal, capable of being alleviated through compassionate acts either by another or to self (Constantinides and Georges, 2022). In this sense compassion is routed in connection and therefore capable of being subjected to, and liberated from, power dynamics. In the recent operationalisation of this theory, Constantinides and Georges (2022) describe the core constructs that comprise this theory including: suffering; biopower; radical disconnect; the unspeakable; and emancipatory practice (see Table 1 for a description of these constructs).

Table 1. Emancipatory Theory of Compassion Operational Model (adapted from Constantinides and Georges, 2022)

<b>Construct</b>	<b>Description</b>
Suffering	Context dependent physical or emotional distress; silent or overt forms of oppression, violence, discrimination or silencing.
Biopower	The belief that some humans have agency and others do not; that humans create or maintain environments where power can be exhibited over another in a way that can dehumanise them.
Radical disconnect	The ability to treat another as nonhuman, legitimising overt or silent forms of violence.
The unspeakable	Taken for granted assumptions that have become embedded or 'natural' to the point that the 'speaker' is no longer aware of them.
Emancipatory Practice	Liberation or empowerment through acts of compassion and a move away from power relations that cause suffering.

These constructs have been used to articulate our findings following a series of qualitative semi-structured interviews with nurses and inductive narrative analysis. In using the Emancipatory theory of Compassion, we articulate, in line with Constantinides and Georges (2022) etiologies of suffering, ways to extend compassion and, through engagement with this article, invite readers to self-reflect upon their own ways to view oneself and others with compassion.

## Methods

### Aims

Our data are derived from a qualitative study which examined the impact of COVID-19 on nurses' psychological wellbeing by exploring their working experiences during the pandemic. Data relating to the concept of compassion arose inductively during narrative data analysis and forms the basis of this paper. Other themes were identified across this study and have been reported elsewhere (Anonymised author reference, 2022; 2024), (Anonymised author reference., 2024) (Anonymised author reference., 2023) and (Anonymised author reference, 2022).

### Design

A qualitative, narrative approach to data collection and analysis was employed. This approach is justified because it enables researchers and participants to enact the view that realities are multiple, polyphonic and relationally constructed, reflective of a social constructionist approach (Berger and Luckman, 1967), and the wide range of experiences encountered during the time our study took place (between 2020-2022, COVID-19).

### Sample/ Participants

Opt-in methods were used to recruit participants. Those who had previously completed two national nurse and midwife surveys (in April and May 2020) (Anonymised author reference, 2021) and who had agreed to be contacted about follow up research were contacted for this separate, qualitative study. Purposive sampling was used to identify participants from a range of grades (i.e. differing levels of pay relating to the level at which a staff member is appointed), settings, specialties and experiences. All participants received a participant information sheet and consent form via email, with 14 days to respond.

Fifty nurses from two different sample groups took part in this study (see Table 1). Sample one included twenty-seven participants, (26 nurses and one midwife, hereafter 'nurses' collectively). We experienced an attrition of two participants after our first interview due to one declining due to availability and the other because their email address bounced back. Twenty-five participants took part in all four interviews. Sample two included 23 additional nurses, recruited after the second wave of COVID-19 in the UK. This sample included groups under-represented in sample one e.g. student nurses, care home nurses and community nurses, as well as nurses from an ethnic minority background.



Table 2 Participant characteristics

<b>Heading</b>	<b>Sample 1</b>	<b>Sample 2</b>
<b>Sex</b>	26 Female 1 Male	22 Female 1 Male
<b>Ethnicity</b>	3 mixed ethnicity 1 prefer not to say 23 white British	Asian British 1 Black Caribbean 1 Black African 3 White Other 4 White British 14
<b>Setting</b>		
Social care	1	0
Community MH	3	0
Other community nursing	4	7
Private acute hospital	1	0
Care Home	1	4
Midwife	1	1
LD Setting	1	0
NHS hospital / other acute	13	6
Research	2	1
Student during the 1 <sup>st</sup> wave of COVID-19	0	4

## Data Collection

Participants in sample one took part in up to four interviews between July 2020 and April 2022. Participants in sample two were interviewed twice, in September 2021 and April 2022. All interviews lasted between 45-90 minutes, took place via Zoom, Teams or telephone and in private. Interviews were undertaken by an experienced qualitative research team, four of whom are Professors of Nursing (JM, RH, DK and BK), and one of which worked in ICU during the pandemic (BK). All of the research team excluding one (DK) were female. Regular research meetings were held amongst the team to aid consistency in approaches, share processes and debrief, the value of which has been articulated in Anonymised author reference (2023).

For continuity and where possible, researchers all interviewed the same participants. Interviews began by asking participants to “tell us what happened”. This open-ended, storytelling approach evoked a narrative interviewing approach and participants were given the space to tell their stories without interruption (Hollway and Jefferson, 2013). The research team followed an interview topic guide to ensure similar topics were addressed including working conditions, psychological wellbeing and key moments of stress and accomplishment (an example topic guide can be found in supplementary material 1). Given this study used multiple interviews, each interview was timed to happen once peaks in the pandemic had passed so as not to add to the workload and stress of participants.

To reduce emotional distress and support participants during interviews, they were all given the option of terminating an interview, or pausing at any point. Resources were provided in follow up contact to participants including signposting to wellbeing opportunities as needed. The research team made themselves available to participants if any of them wanted to have follow up conversations if any material discussed had felt distressing. Interviews were audio recorded, then transcribed verbatim. Pseudonyms were given to all participants to protect their confidentiality and transcripts were offered to participants as a record of their experiences.

## Data analysis and Rigour

Data analysis followed a thematic narrative approach (Reissman, 2008). To foster rigour and trustworthiness in our data analysis, we followed Lincoln and Guba (1985) four criteria of: credibility; dependability; confirmability and transferability.

Credibility: We followed up participants experiences over the course of four interviews (sample 1), and two interviews (sample 2). This gave us the opportunity to sense-check ideas that emerged from our data, with participants themselves, and explore how their thoughts changed over time. We shared our published papers with participants, and also

participant transcripts to anyone who wanted a copy. Interview topic guides were created collaboratively with the team, and done so with reflection on previous interviews. Regular team meetings were held throughout the project to debrief, and in some cases debriefs were also held with participants where necessary.

**Dependability:** A detailed description of the study's methodology can be found in the study protocol, and further details relating to the longitudinal aspect of this study can be found in (anonymous author reference, (2022)). We have drawn on empirical research conducted during the same time period (e.g. during COVID-19) to corroborate findings.

**Confirmability:** Initial codes and themes were developed in NVivo 12 and discussed with the research team in regular team meetings to aid rigour. Data analysis was led by AC, who also wrote thick descriptions of interview summaries for all transcriptions to preserve narratives (Hollway and Jefferson, 2013). RA and ER analysed a sub-set of the transcripts to refute or corroborate the developing coding framework which then subsequently led to the development of broader, narrative themes. All data were analysed both within one time frame and across the project duration. A coding tree can be found in supplementary material 2.

**Transferability:** We followed a purposive sampling technique to ensure representation across the health and social care sector, and where this was limited in sample one, ensured that it was addressed in sample two (see Table 2).

The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist for comprehensive reporting (Tong et al., 2007) is provided as supplementary material to aid transparency.

#### Ethical considerations

Ethical approval was received from the Anonymised University ethical governance committee (FHMS 19-20 078 EGA CVD-19).

#### **Results**

Three themes were derived from our narrative analysis spanning the self, team and organisational levels including: (1) Learning and practising self-compassion; (2) The presence and absence of interpersonal compassion; and (3) Organisational (non) compassionate acts. Findings indicate that self-compassion requires permission and discipline, often being unfamiliar terrain for nurses. Interpersonal compassion can buoy nurses during challenging times but can often be absent across teams. Nurses' experiences of organisational acts of compassion were limited, and they often felt de-valued,

unsupported and replaceable. These findings are supported by participant quotes and through the Emancipatory Theory of Compassion (Constantinides and Georges, 2022).

### Learning and practising self-compassion

Participants in our sample talked about how, during the pandemic, it became necessary to recognise the work they were doing and learn to value themselves within it. In doing so participants discussed how it was helpful to accept one's own and others' feelings of professional distress. Normalising a stress response to an extraordinary situation and understanding one's own personal and professional limits helped to establish an environment for some, where it became ok to not be ok. In doing so participants identified their suffering and attempted to treat it with compassion:

*...being like, "Yeah, (..) this is a normal response to the situation." You know? (..) we're not pathologising it, you know? This is, (..) a normal human response to an incredibly stressful 18 months (Bethan, critical care nurse, sample 2, 2021)*

The process of normalising a stress response appeared to involve making something previously unspeakable, into something explicit, and then addressing it. For example, in early 2022, Bethan decided to step back from her work and give herself "*time and space [...] recovering and getting ready to go back to work*". Indeed, understanding the necessity of self-compassion in a care environment, in particular the need to prioritise one's own wellbeing was sometimes experienced only after contracting COVID-19 or feeling unable to do anymore, as in the case of Alison:

*What had happened is that there'd been such a rush around trying to hit targets that I think I really completely burnt out and I think it was sort of nature, god's way of telling me that I just need to calm down and stop it and just look after myself and there's only so much I can do (Alison, mental health nurse, sample 1, 2022)*

For Alison, this experience of burnout surfaced only after the pandemic had been going on for two years, acting as a shift away from treating herself as nonhuman and towards a more compassionate existence. Within this process of self-learning, she discussed how her experience had offered her a way to be more self-compassionate. She enacted this by giving herself permission to switch off from her work and spend time with her family:

*Prior to that, I would come home from work and then log back on again and do some bits and pieces in, sort of, my own time. So I'm a bit anxious that if I started doing that I might not then be very disciplined and then the next thing I realise it's 8 o'clock and I'm still working when I think, well no, actually this is my time with my family and my own time, you know, I need to stop (Alison, mental health nurse, sample 1, 2022)*

Annabel was another participant who discussed how her experiences of working during the pandemic had brought about a realisation of her need to practice self-compassion over time. Below she talks about this being unfamiliar terrain for her, and how it is something she now needs to actively practice, implement and sometimes force herself to do:

*I, kind of, felt and I still feel not very good at seeking help, and I feel like I'm normally the helper, not the person who seeks help and I, kind of, said to myself, "Right, I'm going to do this for myself." I've used things like Headspace, you know, the mindfulness apps (..) I've found that helpful. (..) because I even lost enjoyment and forgetting what used to give me enjoyment, like everybody did, I think, because there were so many things that we couldn't do, but just getting back to things, spending time with family, seeing my nieces and nephews, going out for a coffee, all these things I just try to really force myself to do even when I didn't feel like it. So I think I've, kind of, managed to sort myself out... (Annabel, critical care nurse, sample 2, 2022)*

For others, acts of self-compassion included taking a much-needed holiday, writing in journals, going for a walk, or seeing friends. These were new strategies that began to emerge as coping mechanisms over time, implemented to preserve wellbeing. They also appeared to act as moments of liberation (e.g. taking me time):

*I probably feel better now because I've just had two weeks off and that was really, really nice. It's about ten years since I had two weeks off, so it's kind of I do feel reinvigorated from that (Becky, social care worker, sample 1, 2022)*

*Just on my days off just doing, right, what am I going to do? You know, like I know just sort of seeing my friends, that's just outside, that's something I want to do or cleaning the house or just something for me or just my fitness or something, or just an online... you know, it's just an online fitness, but it's filling my day with what I want to do, and then when people come in in the evening, I can happily feed them and everything and engage with them, because I've had a bit of me time (Isabella, hospital based nurse, sample 1, 2021)*

The above examples demonstrate how participants practiced self-compassion outside of work and these were strategies that emerged over time as coping mechanisms. However, maintaining self-compassion at work appeared challenging for many participants, largely because they couldn't always access strategies to aid self-compassion. Strategies that were particularly challenging to implement included: taking a break, sitting in a shared space, drinking water. In this sense, toxic environments remained difficult to challenge and therefore remained sustained despite a desire to work differently. To counter this tension, participants

discussed taking a moment with their breathing, because they saw this as an approach that was better than doing nothing:

*One of the girls in our ICU, one of the specialist nurses, they tried to do a 'moment of me', you know? Sort of take 10 minutes out of your working day, go into a room just not far from the ICU, concentrate on your breathing, and some nice smells, and it was a, it was a lovely 10 minutes (Zoe, hospital based nurse, sample 2, 2021)*

Despite enjoying this brief moment, Zoe also indicated in a later interview in 2022, how challenging it was to sustain these moments of self-compassion, acknowledging that returning back to work after stepping away for a moment could be particularly hard: *"it was just lovely to sit there with your eyes closed and it takes you out of your day, but you have to go back into that day again"*.

The findings in this theme demonstrate that during times of acute stress, some nurses recognised the need to alleviate their suffering by putting themselves first, and to do so required constant self-discipline and self-permission to establish it as a habit. The identification of suffering and the subsequent need to be compassionate in this sample group is particularly significant because there is a predominance of literature that describes nurses as self-sacrificing, often placing their needs as secondary to those they are caring for, an outlook that is reinforced through media, guidelines and nursing policies (Andrews et al., 2019).

#### The presence and absence of interpersonal compassion

Participants in our study also reflected on how interpersonal compassion sprang up within some teams during the pandemic:

*People really rallied around and were really nice with each other and really caring, genuinely caring (Alison, mental health nurse, sample 1, 2022)*

Findings indicated that some staff felt 'seen' by their colleagues and a sense of camaraderie and recognition subsequently buoyed their ability to cope. Sharing, validating and asking, 'how are you' established a team ethos of compassion and this was fostered and sustained throughout the pandemic in some cases. Participants talked about how they took immense value from scheduled opportunities to check-in, follow-up, or talk in small groups and some would go out of their way to establish these points of connection for wider groups, as demonstrated by Isabella below:



*We all felt we were alone and couldn't articulate, but then hearing someone else saying the same things it was just like "oh gosh", you know(..) that really helped. (Isabella, hospital based nurse, sample 1, 2021)*

Interpersonal compassion appeared to involve two-way communication, praise/ positive feedback and non-judgment from colleagues. This included not only for work done well but also when things hadn't gone well, as discussed by Sarah below:

*[...] the staff that were on that day were really nice about it because I was crying so they just like grabbed me, like pulled me out the room and said like it's not your fault and sat with me for a bit and like said it's not your fault, don't blame yourself, they sent me off the ward so I went off and had a drink and that and my colleague from my unit came and found me and we sat and chatted for a bit. [...] the following week my manager and my matron heard about it and my matron like said the family are really thankful for what you did and stuff like that because she knew his wife (Sarah, hospital based nurse, sample 1, 2021)*

These shared moments and connections appeared to give witness to suffering resulting in them feeling helpful, and we suggest possibly emancipatory or at the very least helpful in alleviating suffering. However, other participants discussed a notable absence of interpersonal compassion, particularly at the height of stress throughout 2021. This absence was particularly the case amongst staff at different pay grades including office-based roles or senior nurses, who, as discussed by Laura below, did not always give thanks or acknowledge the work done:

*It just would have been a bit of a nice touch just, you know, if they'd been there and you know, just to say you know, you're doing a grand job. Just that extra bit of support really (Jo, hospital based nurse, sample 1, 2021)*

*But to me it would have been nicer if someone just literally put a mask and a gown on, came in and said, "How are you? Can I clean a bed? Thank you for doing this. Is there anything I can do to make your day better?" And I'm not alone in that, there is quite a lot of anger and frustration directed towards the people who didn't come in, and it's been noted on both units that I work at, the absence of senior support and management (Laura, hospital based nurse, sample 1, 2021)*

This divide between staff groups may show an example of radical disconnect between staff, minimising the suffering experienced by some. This theme demonstrates the significance of a team ethos and that people's actions affect one another. Validation, connection, and positive feedback inform a sense of interpersonal compassion within teams and can act as

emancipatory practices to aid in the disruption of taken for granted ways of being a nurse and doing nursing. Yet, during the pandemic this was notable through absence, particularly during times of need and acute stress (see also Anonymised author reference, 2023), demonstrating radical disconnect across staff groups and the inadvertent participation in the maintenance of toxic environments.

#### Organisational (non) compassionate acts

Participants had varied experiences across the organisations and settings within which they worked. For example, several participants, when discussing the physical environment, shared that organisations had done very little to demonstrate compassion towards staff essential needs. For some participants this included an inability to find spaces to momentarily rest or take a break, under the restrictions of COVID-19, or spaces to park their cars. This was particularly the case early on in the pandemic (2020 and early 2021) when uncertainty was high and staff needs were not always prioritised:

*There is nowhere for these, for the ward staff, because ward staff were told very clearly you are not to leave the ward in your uniform, you're not to go off site during your shift, that we have got no other outside seating where we are. They were told, well, it's not really a concern because you have a park across the road. But we can't go to that park. Yeah, but there is that opportunity? Well, not if you're on a half hour break (Sue, community based nurse, sample 1, 2021)*

*Even simple things, like, the fact that nurses that are on the ICU or the COVID wards that have to shower and extend their 12 and a half hour shift still can't get car parking permits, even though the car park's empty because there's, you know, less visiting and more remote clinics and stuff (Sandra, hospital based nurse, sample 1, 2021)*

Conversely, for those staff with the opposite experience and in some cases where restrictions eased throughout the course of the pandemic, participants shared that, by having physical spaces to rest and recuperate, they felt valued and recognised through organisational acts of compassion:

*[During the first wave] we had a rest and recuperation area which is where we, you know, had our lockers and everything like that, but they made it really lovely. There was lots of different kinds of sofas so you could make sure you were comfortable. They had during office hours Monday to Friday 9.00 to 5.00 there was always a psychologist in the area so if you felt like you were having a really rough day you could talk to somebody. You know, it was very supportive (Ellie, hospital based nurse, sample 1, 2021)*

However, Ellie also acknowledged that over the course of the pandemic, the support provided by organisations became affected by rules and regulations. For example recuperation areas became subjected to social distancing measures, meaning staff could not always access them when they needed. Whilst frustrating for staff, what appeared to bother them more was the communication of these rules, regulations and procedures (e.g. acts of biopower that perpetuate toxic environments). For example, the sharing of information by email led some participants to feel undervalued and unrecognised because of the lack of compassion and consideration shown:

*I am appalled, horrified at the lack of compassion and leadership at a senior management level. You know, we get emails that just feel so condescending, you know (Mary, hospital based nurse, sample 1, 2021)*

This was particularly the case over time, when participants shared how they would have expected communications to improve, especially regarding the giving of thanks, or notification of redeployment but how this was not the case:

*[...] the first time I was redeployed I was given less than a week's notice and that's not ideal in anybody's books [...]. I would have thought that the people in the know would have developed strategies from the first time for the second, third and fourth but that didn't seem to happen. It was still a knee jerk reaction [...] Every time it was just this needs to happen now (Zoe, hospital based nurse, sample 2, 2022)*

Staff talked about how they were led to feel replaceable and like 'a number', as discussed in the extract below. Zoe describes the need for organisations to provide the personal touch, but described how this was missing during the pandemic demonstrating further the radical disconnect between individuals and institutions:

*We want the personal touch but how do you get it in the health service? You know, more and more throughout my experience, we're all just a number. We're all replaceable. I think everybody knows that but it's being made to feel that you're not a number. It's been made to feel that you're a little bit special...(Zoe, hospital based nurse, sample 2, 2022)*

Furthermore, through the implementation of certain rules and regulations, some participants felt that the limitations placed on them de-valued them and failed to recognise their basic human rights, as discussed below by Isabella. This de-valuing of staff appeared to coincide with times of most need and acute stress:

*I think we were at our peak at Easter so you'd go in [with all] the PPE and you'd go in and they'd say right, they stopped giving us some coffee breaks so once you went in*

*you couldn't come out 'til lunch break and that really worried me [...] that was almost like you felt like you'd lost your human rights, everything that you'd kind of thought you could just sort of pop out to the loo if you wanted to, that was taken away from you, it was like once you're in you're not coming out (Isabella, hospital based nurse, sample 1, 2021)*

Emerging from the fourth wave of the pandemic in early 2022, some participants including Alison, discussed how dismayed they felt that, “*there hasn't been much consideration given, that people need a bit of time and space to sort of catch their breath*” and to be faced with additional work, including CQC inspections and the requirement to keep collecting performance data felt infuriating:

*At one point I just felt so infuriated I just thought I'm absolutely sick of it. [...] For god sake, we've kept going all the time and provided a service and now you're back almost beating us with this stick, you know, keep performance figures (Alison, mental health nurse, sample 1, 2022)*

In the extract above, Alison uses the phrase ‘beating us with a stick’, an expression far from an act of compassion. For some, this cumulative de-valuing and lack of recognition within organisations led to reduced feelings of organisational commitment and propelled some towards an intention to leave:

*I think the little things that people had said about the way we were treated, I kind of just felt like, I don't think I want to be there anymore (Isla, hospital based nurse, sample, 2021)*

This suggests an organisation's acts of compassion are highly significant to staff, shaping the way they feel valued (or not), and in turn impacting on their organisational commitment. This theme demonstrates that at the wider organisational level at times, non-compassionate acts are enacted and this exacerbates suffering through the maintenance of toxic environments and othering.

## **Discussion**

Findings from this article indicate that compassionate acts and a compassionate culture can be enacted or not across the continuum of self, team and organisation. Through the use of the Emancipatory Theory of Compassion (Constantinides and Georges, 2022), findings indicate that this continuum often features two or more of the following: suffering; biopower; radical disconnect; the unspeakable; and emancipatory practice. For example, in some cases, an encounter with ill health or burnout (i.e. suffering) appeared to give some nurses the self-permission they needed to engage in compassionate acts and prioritise their own

wellbeing (an emancipatory practice) (theme one). Self-permission in regard to self-compassion is a concept previously discussed by Andrews et al (2019) who identified that to be self-compassionate, nurses need permission and this can occur internally, or more formally from others an often involves taking ownership, and as we suggest, existing as a point of emancipation. Our findings suggest that in times of acute stress and suffering, pre-existing taken for granted assumptions about how to be a nurse and 'do' nursing become easier to surface, identify and address if they no longer support said individual.

Findings from this study also indicate that interpersonal or a team ethos of compassion can buoy a nurse's ability to cope in high stress situations by again, bringing forth taken for granted ways of existing within the nursing profession that have previously rendered compassion impossible. Components of interpersonal compassion identified in this study correspond directly to the description of compassion presented by Strauss et al (2016). For example, interpersonal compassion in this context involved recognition of hardship (i.e. recognising suffering), a shared sense of being in it together (understanding the universality of suffering), validating the suffering in a non-judgement way (i.e. feeling empathy with another), being able to do this in very challenging times or when emotions are high (i.e. tolerating discomfort), and offering praise or positive feedback (i.e. acting to alleviate suffering).

Compassion and empathy appeared to exist within teams. However, there was a notable absence of compassionate acts across levels of seniority. Moreover, this absence was also noted at an organisational level where very little attention was perceived towards supporting essential staff needs, leading to either the creation or maintenance of toxic cultures (biopower) and othering (radical disconnect). As noted by Anonymised author reference, (2023), a particular culture within organisations can significantly affect staff commitment. Organisations employing nurses need to consider the high volume of nurse resignations as a distress signal. Whilst there exist current calls to increase nursing numbers, this may only lead to a sustainable system if equal attention is given to retaining them by addressing the culture in which nurses work in. At a time when nurses are leaving the profession in droves, and there is a current global shortage, finding a way to disrupt toxic environments (biopower) by bringing forth pre-existing taken for granted assumptions about working cultures (the unspeakable), may help to create emancipatory practices capable of fostering compassion. This process may help shift a culture away from othering, towards belonging and may have significant benefits for staff retention, wellbeing and patient care delivery (Trzeciak, Roberts and Mazzarelli, 2017; Trzeciak and Mazzarelli, 2019). As discussed by Willard-Grace et al (2014), the quality of working life cannot be improved by team structure alone and in a

resource poor system, organisational culture and climate can mitigate against the effects of burnout.

#### Implications for practice and research

Given that the reasons for nurses leaving are often relating to work pressures, we argue that taking a systems-based approach to establishing a culture of compassion across levels (i.e. self, team and organisation), may help to mitigate against a further loss of nurses. Our evidence indicates that compassion can be enacted in a multitude of ways within an organisation and these need to be attended to regularly. Staff need (self) permission to help form the habit of self-compassion (Andrews et al., 2019), and to be embedded within a culture where they witness and experience genuine acts of compassion for each other (in addition to patients) across wider teams and organisations (Kouta et al., 2022; Papadopoulos et al., 2021). The former is significant because this may be unfamiliar behaviour for many nurses as it has, in the past, been misinterpreted as a series of selfish acts or a luxury (Chipiu and Dowling 2020). The altruistic nurse may not want to be associated or perceived to be this way by colleagues. Self-care therefore requires a certain degree of discipline to establish it as embedded and natural, one that requires nurses to also reflect on their own positionality.

Organisations can help in simple ways to foster this culture, as demonstrated in this study, and the work of Kouta et al (2022) and Papadopoulos et al (2021), by normalising the use of annual leave or taking necessary breaks, having open door policies, listening, actively supporting and advocating for staff needs and problem solving. Nursing guidance and policies now need to prioritise self-compassion amongst nurses, uphold good examples, and nurture compassionate leaders (Anonymised author reference, 2023; Bailey and West, 2022), which may in turn enhance the delivery of compassionate care to patients (Mills et al., 2015).

Organisations and future guidance and policy also needs to recognise the significance of debriefing and sharing, both the good and the bad, as an emancipatory practice capable of establishing empathy and relatability (Anonymised author reference, 2018). This could be particularly effective when undertaken across organisational departments to prevent 'othering' and may have a positive impact on staff wellbeing, particularly if it is supported by regularly giving thanks to staff for the work they are doing (Taylor et al., 2018). Staff appreciate feeling valued and this does not need to be compromised in the drive for efficiency in a resource poor environment (Trzeciak, Roberts and Mazzarelli, 2017; Trzeciak and Mazzarelli, 2019).



### **Strengths and limitations**

This study documents a unique historical time for healthcare workers, and society more broadly demonstrating that even in times of acute stress and need, compassion is not a given and instead needs to be actively encouraged and nurtured to become embedded and habitual, across an individual, inter-personal and organisational level. Despite two rounds of sampling to gain maximum variation, our sample still indicates an underrepresentation of certain voices including social care nurses, private and Learning Disability nurses, and men. Therefore, less is known about the needs of specific groups from such under-representation. It may also be the case that those who participated in this study reflect only a sub-group of experiences during the pandemic, and, as with all qualitative work, is not, nor is it intended to represent the voices and experiences of all.

Future research could now seek to (1); build on existing work (e.g. Andrews et al., 2019; Bailey and West, 2022; Constantinides and Georges, 2022); (2) focus in more depth on the translation of these findings across other staff groups, to generate an extended understanding of what, where and how acts of compassion can exist within a healthcare organisational culture; and (3) develop strategies capable of being evaluated in practice that more explicitly link acts of compassion, burnout, intention to leave and patient care.

### **Conclusion**

This study has explored acts of compassion amongst nurses during COVID-19. Findings have demonstrated that acts of compassion sit at the level of self, team and organisation. Self-compassion is easier to implement when one has been confronted by its necessity but requires discipline and self-permission. Interpersonal compassion within teams can be validating and buoy one's ability to cope. However, notable by its absence were organisational acts of compassion which appeared to diminish at times of acute need or stress, having a subsequent impact on staff commitment. It is likely that compassion can only be sustained, and have long term impact if it is constantly tended to and operates in symbiosis with self, team and organisation. Thus, whilst it is easy to shift the responsibility of compassion onto the individual, and some evidence suggests this can be beneficial to wellbeing, what is now needed are broad eco-systems of compassion including within and across teams and organisations.

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## Highlights

- Self-compassion amongst nurses is easier to implement after illness or sick leave.
- Interpersonal compassion within teams can be validating and buoy one's ability to cope.
- Organisational compassion diminishes with high stress, impacting staff commitment.
- Employers need to consider the high volume of nurse resignations as a distress signal.
- Broad eco-systems of compassion across teams and organisations are now needed.

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**Declaration of interests**

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

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