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An interpretative phenomenological study on nurses' perceived affective wellbeing at work

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Abstract

Nurses face increasingly complex and challenging workloads, exacerbated by high rates of absenteeism, mental health issues, and low morale, all of which significantly impact patient care. This study focuses on exploring nurses' perceived affective wellbeing, perceived workload burden, and the current working conditions they face. The objective was to understand nurses' perspectives on affective wellbeing, self-care, and work-life balance. We utilized an interpretative phenomenological approach to design the data collection and management for this study. Through open dialogue, we explored the notion of wellbeing at work with nurses of varying levels of work experience, from fairly novice to expert practitioners who have worked for decades in their fields. The broader responsibilities of nurses of nurses within the National Health Service (NHS) were also examined. Two experts in interpretative phenomenological analysis led the discussion in three different groups, which each consisted of nurses with similar years of work experience, averaging 13 years. Thirty-eight registered nurses volunteered to participate in these discussion groups, with participants recruited from postgraduate courses and representing both acute and community care settings in regional hospitals. Nurses shared insights into what makes nursing a rewarding job but also acknowledged the significant challenges they face. Discussions highlight the stressful and traumatic circumstances nurses often encounter, particularly noting a lack of collegiality among nurses at all levels, limited career aspirations, inadequate support with workloads, and the emotional distress experienced in daily work life. Nurses described their jobs as exhausting and draining, leading to physical and emotional fatigue, detachment, and isolation. These findings hold relevance within the current landscape of nurse and resource shortages in the NHS. Of note, this study identified deeper concerns within the nursing workforce, including emotional dissonance, role dissonance, and disengagement.

Keywords: Health; Dissonance; Workload; Perceived affective wellbeing; Work environment; Work-life balance

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1. Introduction

Nurses often face stressful and demanding work environments, operating both as part of a team and independently while managing caseloads and prioritizing care based on the

complexity and severity of patients' conditions. Currently, nursing workloads and staffing levels are particularly complex and challenging (Buchan *et al*., 2022; Hill, 2020; Marufu *et al*., 2021). Nurses encounter numerous obstacles in clinical practice, such as inflexible schedules, high rates of sickness and absenteeism, increasing mental health issues, low morale, and a lack of diverse skill sets at the frontline of patient care (Buchan *et al*., 2022; Nepali *et al*., 2022; National Health Service [NHS] Digital, 2022). These issues are of growing concern for nurse managers and educators, significantly impacting the organization and delivery of patient care (Paananen *et al*., 2021; Pirhonen *et al*., 2022; Sweeney *et al*., 2022). Workforce development initiatives, such as the Advanced Clinical Practice Apprenticeship programs and reforms in nurse training and education, exemplified by the new Future Nurse Standards, strive to enhance working conditions and tackle issues, such as low morale, retention challenges, and workforce shortages. These efforts made within the nursing workforce have the potential to bolster job prospects, enrich career pathways, and elevate levels of job satisfaction. As a result, nurses' motivation is expected to strengthen with the availability of further career opportunities and career progression.

In recent years, the nursing profession has witnessed a significant exodus of nurses due to a pervasive culture of discrimination within the NHS (the United Kingdom's publicly funded healthcare system), where ethnic minority staff are predominantly clustered in lower pay scales. These nurses encounter heightened uncertainties and formidable obstacles in their pursuit of selection and advancement into senior or leadership roles (Gill & Orgad, 2022; Jefferies *et al*., 2022; Kline, 2019; Lopez *et al*., 2021; Nepali *et al*., 2022; Royal College of Nursing, 2019; Williamson *et al*., 2022). In addition, prominent cases have raised doubts about nurses' professionalism and empathetic qualities, contributing to nurses' moral distress. Notably, the nursing workforce has been found to experience higher rates of mental health issues and suicides compared to other health-care professions, severely impacting nurses' morale, motivation, and general job satisfaction (Conolly *et al*., 2022; Couper *et al*., 2022), particularly in the post-pandemic era.

Recently, mental health illness among nurses has been cited as a primary factor contributing to their departure from the profession (Drennan & Ross, 2019). Similar patterns are observed in healthcare systems worldwide, all grappling with comparable challenges in developing and retaining their nursing workforce (Anderson *et al*., 2021; Galvin *et al*., 2020). At present, there is a notable lack of research in the nursing literature concerning nurses' perceived affective well-being and motivation (Buchan *et al*., 2022; Couper *et al*., 2022). Therefore, this study seeks to fill this void in the broader nursing literature.

This study aimed to investigate nurses' perspectives on their emotional well-being, opinions on achieving a balance between work and personal life, career aspirations, and the factors driving their motivation. The overarching objectives were to enhance our understanding of how nurses navigate both challenges and opportunities within their professional environment, and to explore their perspectives on how their work influences their motivation and affective well-being. In addition, the study sought to delineate the impact of years of work experience on nurses' perceptions of their affective wellbeing and overall job satisfaction. Given the inherent nature of their work, nurses often encounter a myriad of feelings and emotions simultaneously while on duty. These diverse emotions, stemming from their daily interactions with patients and colleagues, may contribute to the elevated levels of emotional labor experienced by nurses in their workplace. The study focused on two objectives: (i) To examine how nursing work and increased workloads impact nurses' affective wellbeing and (ii) to identify how available supportive mechanisms enable nurses to manage the emotional toll of balancing job demands with those of their mental health needs.

2. Data and methods

2.1. Study design and theoretical framework

This interpretative phenomenological research was designed to interpret and understand nurses' own lived experiences, emotions, and feelings (Creswell, 2014; Reid *et al*., 2018; Smith & Nizza, 2022; Smith, 2019). The internal processes of reflective discourse and making sense of experiences are critical for this research, as nurses often lack the space to re-think and re-evaluate experiences, typically reflecting on the emotional burden they carry only after the fact (Nepali *et al*., 2022; NHS Digital, 2022). The aim of this research was to facilitate debates and discussions about why they may feel the way they do, and to attempt to explain and articulate the intricate complexities of their working lives. In other words, nurses were asked to self-interpret their situation and lived experience.

2.2. Study setting and sample recruitment

The sample population consisted of registered nurses with several years of clinical experience who voluntarily took part in three discussion groups. A total of 38 nurses participated in the study. The enrolled nurses were grouped into three different discussion groups based on their years of experience as registered nurses. All participants

were also students enrolled in postgraduate courses at a university.

2.3. Inclusion and exclusion criteria

Participants met the following inclusion criteria: (i) Registered nurses working either full-time or part-time, (ii) with at least 1 year of experience in their current job, and (iii) who were enrolled in a postgraduate module or course at the university. None of the researchers were involved in the delivery of those courses or modules. The researcher visited the participants in class at the end of their lesson and explained the aims of the study.

2.4. Characteristics of participants

Participants were postgraduate students enrolled in a course or module at a British University in London, while also working at local and regional hospitals and clinics. Among the total participants, 33 nurses (86.8%) were female, and five nurses (13.2%) were male. The average age of the nurses was 37 years (standard deviation [SD] = 9), with an average of 13 years of work experience (mean = 13, median = 10, SD = 10).

2.5. Ethical considerations

Ethical clearance for this study was obtained from the Middlesex University's Research Ethics Committee with an approval ID of Ref. No 06/Q0504/59. Participants were thoroughly briefed on issues of consent, anonymity, and confidentiality related to the research. They were assured that their involvement was voluntary and that their identities would remain confidential and anonymous. Discussions were recorded, transcribed, anonymized, and analyzed by two experts in interpretative phenomenological analysis (IPA) who had received training in the methodology (Please refer to Appendices A1 and A2).

2.6. Rigor and reflexivity

During data analysis, the method of bracketing was employed, enabling the researchers to openly contemplate and reflect on the ideas and experiences conveyed in the data. This approach also allowed the researchers to consider their own views and perspectives on the issues at hand (Dodgson, 2019; Dunning *et al.*, 2021). Bracketing serves a dual purpose: it helps differentiate the researchers' thoughts from those expressed by participants, while also facilitating the clarification of the researchers' own ideas, thoughts, and feelings. This approach enables a more meaningful reflection and reconsideration of participants' narratives, as the researchers consciously engage with their own thoughts and values. This heightened awareness on the part of the researchers has the potential to enhance the credibility and reliability of the data during analysis. Consequently, there is a reduced likelihood of the researchers inadvertently biasing the data with their own ideas, as they become more cognizant of their thought processes. This approach aims to uphold and maintain the active presence of "the voice of the participants" throughout data collection and analysis.

2.7. Data collection

The integration of data from Groups A, B, and C involved analyzing and examining interviews through bracketing and line numbering directly on the transcripts. This process was followed by annotating notes and grouping common words and sentences (Love *et al.*, 2020; Palmer *et al.*, 2010). Group A comprised 14 junior nurses with work experience ranging from 2 to 6 years. Group B consisted of 14 experienced nurses with seven to 12 years of service, many of whom held senior nursing and managerial positions. Group C comprised nine highly experienced nurses in senior management roles, with work experience ranging from 21 to 25 years. In total, three discussion groups were conducted, and excerpts from these sessions are referenced in Appendices A1 and A2.

The researcher anticipated several challenges and planned accordingly, including ensuring that: (i) Nurses were respectful of each other's views and particularly managing those with a tendency to be more vocal; (ii) participants felt safe to share their true perspectives; and (iii) the groups behaved in a professional fashion during this process, with strong feelings around the issues being appropriately managed and diffused. With the help of another interviewer and an IPA expert, the researchers monitored group dynamics and carefully managed nurses' expectations and feelings to swiftly de-escalate potential clashes among participants.

To ensure a smooth operation of the discussion groups, the interview guide was piloted twice to check for leading or confusing questions and to ensure that the questions were clear, relevant, and coherent. Minimal modifications were required for some of the opening questions. With participants' consent, the interviews were recorded and transcribed. Furthermore, one of the interviewers maintained field notes throughout the discussions. These notes were useful in recounting the conversations held between the interviewer and the group and served as an *aide-memoir* for the interviewer's self-reflections and observations made at the time of the interview. Each interview lasted between 45 min and 60 min, with a mean duration of 55 min. The study spanned 7 months, during which no follow-up interviews were conducted. Participants were given the chance to review the transcripts within 6 weeks of their interviews.

2.8. Data analysis

The primary researcher and an expert in IPA analyzed the data following the nine-step process outlined in the IPA methodology. The transcripts, typed verbatim in Word, were used for analysis, and the IPA themes were synthesized (Love *et al*., 2020; Pietkiewicz & Smith, 2014). Each transcript was anonymized and independently analyzed before proceeding to the next stage. The idiographic approach inherent in the IPA method required each IPA expert to independently analyze the data and construct the coding framework. Subsequently, they convened to compare findings and confirm code saturation for each group. Numbered lines in the transcripts were color-coded to facilitate the visual identification of supporting quotes. Emerging themes were documented in a journal, with clear steps to the analysis meticulously recorded (Dodgson, 2019; Love *et al*., 2020; Miller *et al*., 2018). This approach aided in reducing personal biases, thereby safeguarding the integrity of the emerging themes and subthemes. In addition, through systematic analysis, the researchers meticulously documented commonalities and differences across the transcripts, thereby enriching the refinement and validation of the data. This qualitative method in psychology research was particularly well-suited for the study's objective, as it provided valuable insights into how specific groups of nurses within a particular context comprehend their distinct circumstances. The idiographic emphasis of IPA aligns closely with the focus of this research.

3. Results

Nurses, as employees, find motivation in the belief that their work is meaningful and that they are valuable and significant. However, the data suggests that when nurses feel "inadequate," their motivation can be undermined. The data analysis revealed that in their efforts to meet targets, nurses may unintentionally undermine the perceived importance of their work, which can lead to reduced confidence in the value of their contributions. The study found that nurses often express negative feelings about themselves and their jobs. Notably, profound emotions such as emotional exhaustion, frustration, disillusionment, and feelings of being undervalued are prevalent in discussions among nurses with extensive work experience compared to those with fewer years in their roles (please refer to Appendices A1 and A2). The disappointment expressed by these nurses is palpable in the transcripts reviewed during the data analysis. It is also clear that emotional exhaustion, anxiety, and frustration are particularly pronounced among nurses who have been in the profession for more than 10 years (Begley, 1998). Nurses frequently discuss the importance of aligning with the needs and values of their organization. However, they openly acknowledge their lack of acceptance or understanding of why such alignment is required. The emotional strain of their work has left nurses feeling frustrated and overwhelmed, leading them to question their professional and personal values, obligations, and responsibilities. Despite these pressures, they continue to work diligently.

Two group experiential themes (GETs), titled "emotional dissonance" (ED) and "role dissonance" (RD), are directly associated with nurses' affective wellbeing in the workplace, as depicted in Figure 1. The emergent theme or experiential statement (ES) (i) "negative feelings about self" contributes to the GET ED, while the ES (ii) "negative feelings about others" reinforces the GET RD. The ES "negative feelings about self" emerged from four sub-themes or personal experiential themes (PET): burden of work, exhausted, frustrated, and unworthy. Meanwhile, the ES "negative feelings about others" emerged from two PET: disillusioned and isolated.

3.1. ED

3.1.1. ED: Negative feelings about self

Nurses exhibited signs of agitation, anger, and a generally pessimistic attitude toward their work environment and their own professional identity. Notably, this theme revolves around nurses' negative outlook and the emotional struggle to cope with the demands and pressures of their work. Within this overarching theme, several sub-themes emerged, including the burden of work, exhausted, frustrated, and unworthy. The corresponding verbatim extracts supporting these sub-themes are provided in Appendix A1. These nurses experience a sense of disconnection and detachment from both their work and their own emotions, with their negativity evident throughout the extracts.

3.1.2. ED1: Negative feelings about self - Burden of work

This sub-theme pertains to nurses' perception of the burden imposed by their workloads and their strategies for coping with escalating demands. Nurses expressed concerns regarding the legislative requirements of their roles and the counterproductive paperwork they are compelled to complete to safeguard both themselves and their organizations. This aspect of the job, in their view, has significantly increased their workload beyond what is expected of a clinician. The relentless increase in workloads, paperwork, and training associated with these roles has raised questions about nurses' role effectiveness and the invisibility of some aspects of the job. Nurses also expressed a belief that they were set up for failure in their

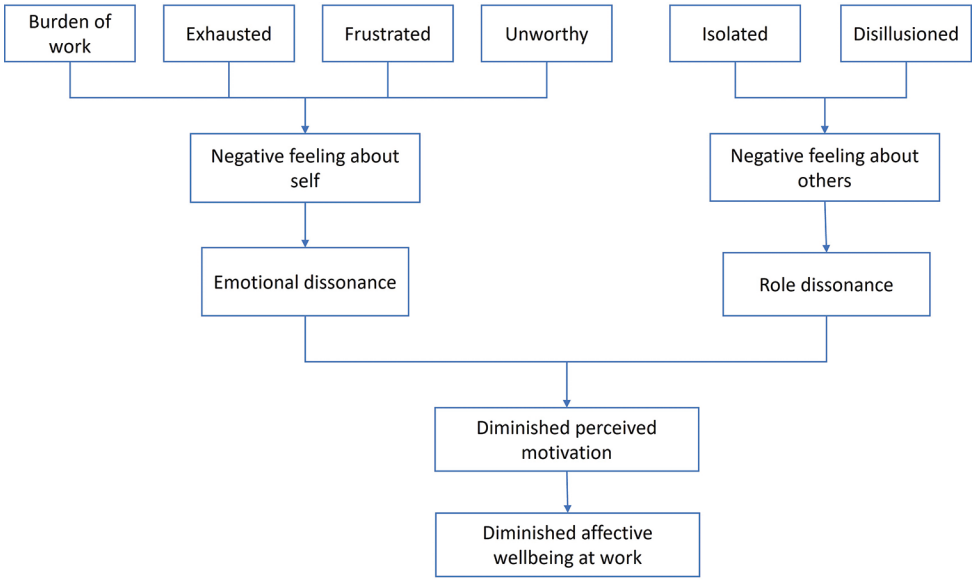

Figure 1. The impact of emotional dissonance and role dissonance on diminished perceived motivation and perceived affective well-being in the workplace

roles, as they were continually assigned additional tasks without sufficient time or resources to fulfill the increasing demands. Comparisons were made, with nurses feeling as if they were expected to perform duties akin to those of junior doctors, yet perceiving their work as contributing to systemic shortcomings and feeling inadequate in various aspects. The seven different quotes in the extracts illustrate nurses' ED and disconnect, as well as their distrust in leadership and management. Nurses expressed feelings of self-pity and disappointment, lamenting how "we (nurses) have been short for ages," and criticized the bureaucracy, noting that "it is more bureaucracy because some people who are in terms of requirements, they don't meet the requirements… " This sentiment underscores the lack of planning and support for nurses to progress and develop in their jobs. It is evident that nurses are grappling with the challenge of reconciling their perceived "nursing" and "non-nursing" responsibilities, resulting in increased effort and time commitment on a regular basis, while feeling pulled in various directions as a consequence.

3.1.3. ED2: Negative feelings about self - Exhausted

Nurses conveyed that the demands of nursing work are too great to continue beyond a certain age. They expressed feeling physically and emotionally drained by their nursing responsibilities, describing a sense of emotional overwhelm. Many indicated that, if given the choice, they would have opted out of the nursing profession long ago. The mounting pressures and demands faced by nurses have become increasingly overwhelming, leading to significant stress and exhaustion. In addition, nurses encounter challenges in navigating work relationships, often experiencing a lack of support from senior staff and managers, as well as a pervasive sense of mistrust and overbearing attitudes from other professionals. Obtaining support—both general and for career advancement—requires persistent effort and remains a continuous struggle. The frustration among nurses is palpable, particularly when discussing the lack of collegial support and effort. While nurses are resolute in defending their decisions and addressing the stress they face, there is a prevailing sense of sadness and disillusionment among those who feel demoralized by the actions of their peers and colleagues across different levels of nursing. It is evident that there is an immediate need for educators and managers to assess the support systems available to nurses on a daily basis and to establish pathways that facilitate career advancement or enable career reconfiguration for those who desire it.

3.1.4. ED3: Negative feelings about self - Frustrated

Nurses expressed frustrated and apprehensive feelings about voicing opinions that differ from those of their team members. They indicated that there was an expectation to comply and refrain from challenging the system, as dissent might be perceived as antiquated. They described feeling compelled to "toe the line" to be considered as understanding. As discussions progressed, nurse participants' demeanor shifted from negativity to vulnerability, with profound disappointment, anger, and frustration becoming evident. Many nurses reported feeling marginalized and embarrassed when seeking assistance and support from their colleagues. These feelings of isolation, neglect, and despondency were primarily

characterized by disappointment and frustration. Nurses struggled with interpersonal dynamics at work and felt trapped in their roles. They expressed discontent with collegiality, perceiving it as a lack of reciprocal support. They were hesitant to approach management for assistance, viewing them as ineffective and possibly dismissive, leading to resentment. Fear of retaliation deterred nurses from reporting unprofessional behavior among their peers. In addition, nurses voiced frustration and anger toward doctors, who, like nurse colleagues and managers, were perceived as dismissive. While senior nurses were perceived as more confident in challenging doctors, they were less likely to confront senior nurse peers. Nurses also expressed dissatisfaction and frustration regarding the lack of autonomy in their practice and felt disheartened when their efforts to assist others were not reciprocated.

3.1.5. ED4: Negative feelings about self - Unworthy

Nurses' efforts often go unrecognized despite a substantial increase in their workloads. This is evident as nurses acknowledge that they effectively perform three-quarters of a doctor's duties without receiving the corresponding recognition. Interestingly, some nurses admitted to feeling empowered by this perception. However, the sobering realization that nurses willingly take on additional tasks in hopes of being acknowledged for their dedication underscores a deeper disillusionment with the profession. This sentiment highlights a core issue contributing to nurses' diminished morale, self-esteem, and motivation: they perceive their work as unworthy and feel exhausted from constantly defending its worth against scrutiny from peers and other professionals who assume superiority. In this segment of the transcript, nurses' moods shift from sadness to agitation and despair. While nurses demonstrate loyalty and awareness of the broader issues affecting their profession, they also require validation and appreciation for their contributions and hard work. Nursing leadership plays a crucial role in reshaping the narrative surrounding nursing within the political sphere and in advocating for the profession's values. This is essential to inspire younger nurses to remain committed to their roles.

3.2. RD

3.2.1. Negative feelings about others

It is noteworthy that the experiences recounted by nurses in the three discussion groups shared a prevailing sense of negativity and low morale throughout the narratives. Across all discussion groups, nurses expressed feelings of isolation and disillusionment with their profession. The corresponding verbatim excerpts supporting this theme are provided in Appendix A2.

3.2.2. RD1: Negative feelings about others - Isolated

Nurses also conveyed sentiments regarding the perceived selfishness prevalent among their peers, noting a lack of mutual assistance. Concurrently, they expressed feelings of distress, powerlessness, and isolation. Being emotionally detached from their team and witnessing fellow nurses facing criticism were described as profoundly challenging experiences. Nurses expressed apprehension about being stigmatized and opted for silence, attributing this reluctance to the unkindness they perceived among women toward each other. Interestingly, nurses suggested that some may lack an understanding of supportive teamwork and expressed concerns about the perpetuation of such a culture, fearing it may endanger nurses' well-being. Nurses often endure their struggles silently, although they acknowledge the inclination to discuss problems among themselves without taking active or political steps to address them. They justify this behavior by citing a preference for discussing issues in small groups due to feeling powerless in their roles. However, this reluctance to engage may extend beyond seeking safety in isolation; it may serve as a coping mechanism for managing stressful situations. In addition, a pervasive sense of mistrust and a lack of confidence in building healthy working relationships among nurses and with other professionals were evident.

3.2.3. RD2: Negative feelings about others - disillusioned

Unlike the previous theme, this one is particularly pertinent to nurses with extensive work experience. These highly skilled and seasoned nurses subtly conveyed feelings of inadequacy due to the multitude of demanding expectations placed on their services. According to the narratives provided by the nurses, there exists a clear disconnect and disillusionment between meeting "targets" and managing "workloads," raising concerns that the best interest of the patient may not always align with the demands of their roles. Nurses find themselves overwhelmed, struggling to keep pace with their tasks, which increases the risks of errors or medication mistakes. The tension and exhaustion among nurses are palpable, particularly concerning the prioritization of targets, which often leads to contentious debates about hospital management. This dynamic fosters a hostile work environment, leaving nurses feeling vulnerable and deeply disillusioned with their profession. Many nurses find their own professional values diminishing as they strive to meet the expectations of their organizations, managers, and patients, often at the expense of their own needs and principles.

4. Discussion

Nurses in this study evidently grapple with the necessity of adhering to organizational expectations that they perceive

as unrealistic and dehumanizing. This dilemma creates a divergence between nurses' personal beliefs and values and those imposed by the organizations they serve (Cho *et al*., 2022; Dunning *et al*., 2021; Hill, 2020). Notably, nurses struggle to connect with peers, colleagues, and management, leading to profound feelings of frustration, anger, and isolation (Begley, 1998; Buchan *et al*., 2022; Jarden *et al*., 2021). Their narratives highlight issues of emotional insecurity in the workplace, alongside a tangible disconnect, mistrust, and emotional neglect. Younger nurses are leaving the profession prematurely each year, contributing to an anticipated shortfall of approximately 36,700 nurses by 2030/31 (Buchan *et al*., 2022; Hill, 2020; Shembavnekar *et al*., 2022). Nurses perceive themselves as "inadequate," as indicated by the data, which may explain their negative feelings toward themselves and others, such as emotional exhaustion, frustration, disillusionment, and feeling undervalued. Generally, high levels of emotional labor are associated with feelings of dissonance, anxiety, and distress (Bae *et al*., 2022; Catton, 2020; Lake *et al*., 2022; Maslach, 1982; Thompson *et al*., 2022). In this study, nurses reported "suffering" from their burdensome, unmanageable workloads, resulting in emotional detachment, isolation, disillusionment with their profession, and a desire to leave. They raised concerns about the devaluation of nursing as a profession and the struggle to cope with a job that drains them both physically and mentally. Nurses acknowledged that certain aspects of their profession remain invisible to the public but emphasized the importance of their management recognizing and rewarding these aspects to make nursing more attractive to younger generations (Thompson *et al*., 2022). A broad range of skills, such as the coaching skills used by senior nurses to supervise and support junior staff, should be acknowledged and rewarded to attract and recruit future generations of nurses.

Unmanageable work pressures can be demoralizing for staff, necessitating a strategic approach at both individual and organizational levels to reform nurses' future career trajectories and training (Priest *et al*., 2015; Shembavnekar *et al*., 2022). This approach is particularly crucial for nurses who are currently undecided about their career paths but may not yet exhibit clear signs of distress. This group of nurses may benefit most from careful coaching, early career engagement, and strategies aimed at protecting their well-being and enhancing their self-esteem (Festinger, 1957; Petrides & Furnham, 2001; Scher & Cooper, 1989). Fiabane *et al*. (2019) argue that discrepancies between perceived expectations and reality can evoke strong negative effects and agonizing feelings of despair, particularly when individuals feel personally responsible for their job situation. Without corresponding feelings of self-worth and self-esteem, this sense of personal responsibility can become overwhelming (Petrides *et al*., 2007). Individuals with high levels of personal responsibility may respond more negatively to emotionally charged experiences and struggle to maintain positive mental states over time (Zeidner & Shani-Zinovich, 2011). This may elucidate some of the feelings of hopelessness reported among nurses in other studies (Fiabane *et al*., 2019; Firouzkouhi *et al*., 2022; Rahman & Plummer, 2020). This study suggests that nurses experience ED and RD, which can have detrimental effects on their motivation and emotional well-being in the workplace.

This study, being exploratory in nature, involved a sample of 38 nurses. Increasing the sample size would bolster the applicability of the study's findings to a broader context. In addition, a more diverse sample could enhance the credibility of the research. While the proportion of female nurses in the sample outweighs that of male nurses, which is not ideal, it does align with the gender distribution typically observed in the NHS nursing workforce. Nonetheless, future research endeavors should strive for equal representation of both genders. This approach could unveil disparities in experiences and perceptions among staff of different genders and ethnic backgrounds, thereby shedding light on variations in dissonance and motivation. Such insights could inform future nurse education and training initiatives, aimed at enhancing motivation and emotional management to foster improved emotional well-being in the workplace.

5. Conclusion

This study indicates that nurses' negative perceptions of themselves and others may account for their diminished work motivation and lack of enthusiasm for nursing. Of utmost significance, the findings reveal that nurses expressed low job satisfaction and a sense of disconnection from their profession. The data subtly suggests that nurses' personal beliefs regarding the responsibilities of their role may influence their attitudes, work motivation, and perceptions of themselves and others, ultimately adversely affecting their affective well-being.

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Conflict of interest

The authors declare no conflicts of interest.

Author contributions

Conceptualization: Chrysi Leliopoulou
Investigation: Chrysi Leliopoulou
Methodology: Chrysi Leliopoulou
Writing-original draft: Chrysi Leliopoulou
Writing-review & editing: Theodora Stroumpouki, Linda Collins

Ethics approval and consent to participate

This study was granted ethical clearance from Middlesex University's Research Ethics Committee, with approval ID Ref. No 06/Q0504/59. Participants were briefed accordingly on consent, anonymity, and confidentiality related to the research. They were informed that their participation was voluntary, confidential, and anonymous. A written consent was obtained from each of the participants in the study.

Consent for publication

A written consent was obtained from each of the participants for publishing the data from this study.

Availability of data

The coded data are available upon reasonable request.

Further disclosure

These findings have been deposited in the Research Repository of Middlesex University (https://repository.mdx.ac.uk/item/89y39), where I earned my PhD.

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Appendices

Appendix A1. Experiential statement 1: "Negative feelings about self" and associated personal experiential themes

Personal Experiential Themes

- Burden of work

  "The continuing care is now so difficult to get; it makes you feel inadequate in a lot of ways, but it's not your fault because the services and the way they are organized it's not fair anymore. I think there is an unrealistic portrayal of what care is available. Like all the advertising about people being able to die at home and you will be able to see a nurse every day. All those things when, in reality, it doesn't happen. There isn't the funding really for it." Group A

  "…I find that things are moving so fast…especially in secondary care pushing patients out, you know, without perhaps sometimes spending, you know, taking time to make sure that the discharge is proper. But it all falls, you know, insufficient resources to give, you know, to organize the care, and they end up back in the hospital because it wasn't properly sorted out..this idea that everything must be out, out, out in the community..because there is a culture now that everything should be straight out of the hospital." Group A

  "Too much work is put upon them (nurses) because we have so many tasks on board like cannulation and all these extra tasks, and you have your paperwork. To do all the proper things you need for a discharge to work takes a lot of time. It's a system's failure, really. You are putting more and more jobs and more and more tasks on the nurses and fewer people (to do the job) with no extra resources, you know. You are doing a junior doctor's role." Group B.

  " …We have been short for ages, and I think it's more bureaucracy because some people who are in terms of requirements, they don't meet the requirements; I mean, I've seen one of them has not taken the mentorship course that's right, some people are qualified to do…but they can't be shortlisted because they haven't done the mentorship course…." Group B

  "There is more paperwork. The risk of legislation is always there now. Documentation, documentation, documentation, and that's on top of the physical care, the more senior staff get roped into paperwork instead of providing physical care, which is what we want to instead of filling bits of paper." Group C

  "If you have a conversation, if you don't record it doesn't count or you are open to complain or disciplinary if there is a problem in the future. You get some nurses who are far better at doing the paperwork than actually looking after the patients." Group C

  "..you can't absorb emotions forevermore; you have to have an outlet, and if you don't have…find an outlet that works for you, then you're gonna pop…you're gonna get chest pains or your hair's going to fall out..50% it's a hell of a lot and organizing social services, MDTs you know getting all these people together just takes up tons of your time probably it takes up possibly more than 50% of your time." Group C

- Exhausted

  "When I wake up the following day, I feel so exhausted and you know I feel all tight before I start the following day. I don't really have a way to solve the stress situation personally; I lay down there in no lights. I use this one to solve my stress situation definitely." Group A

  "… for me, my first line of enquiry and support would be my mentor. From there, I have my line manager and my link lecturers and personal tutors… you have to be forceful to get anywhere and take the bull by the horns and tell them I'm going to do some revision, please. I got an allocated mentor who is always away from me, and if I approach to ask about something, they say, 'Oh, didn't she tell you this? Ask her, stop asking me!'" Group B

  "When I have a bad day, I carry that bad mood from the workplace to my house, and then I'll have a sleepless night." Group B

  "There was a time I thought about opting out from nursing and doing another thing but on a second thought, I said, I have been in this (nursing) all the time; all that I know is nursing, you know? So, I can't opt out and start all over again. If only I knew I would have started before going into nursing." Group B

  "I was thinking about changing my career but it never came. It was just a dream, really I don't know, just needed a change maybe." Group C

  "You can't keep carrying being a nurse with that day job when you are 50 or whatever. It's so physical and emotional." Group C

  "..I get really mad toward the doctors…if you are unsure, you send somebody for a CT scan or something… or even a plain spine neck tray would have shown the compression…but the worst thing was that straight away, all fingers went out. And we all of us nurses had to write statements, and we wanted to know what was going on here…but that was the consultant. I actually told the registrar on the ward round to F** off in the middle of the ward…." Group C

- Frustrated

  "You can't say anything because then they say you have been unreasonable, so you don't say anything, so you feel frustrated because things are happening, and you don't say much because you never know when the cards are going to turn on you and the issue is not going to be about what they are doing but about you are saying something." Group A

  "I don't think that nurses are ever truly autonomous because they were always looking at the guidelines; they always regard the job autonomous to a degree, but not truly in the full sense of the word in that we can work totally independent of anyone. Doctors are truly autonomous, but I don't think nurses are." Group A

  "I think if you go against the system, if you start speaking out against it. (You are told by your manager) you don't understand; you are old-fashioned. So, you have to toe the line. If you don't toe the line you do not understand you are old fashioned." Group B

  "She (another nurse) keeps pushing me away, and while three, four times I asked and feel somehow embarrassed to keep asking about something which is not your personal issue, it's something to do with the job, and it's a professional matter! Then you give up and you take a step back and feel isolated, you feel ignored, and then you lose your confidence, you lose the wish to do something, and you feel low. And sometimes I feel disappointed that I have ever started this I shouldn't." Group B

  "They (other nurses) would ask for the help, but they are not happy to return the help back; they may say to a colleague, Well, they can't do it (help), and you will be stuck going solo with your patients. Many, many times I have experienced that." Group C

  "They (medical teams) don't treat you with respect and not realizing that you've got some expertise and they are just dismissive… this team had a patient admitted with fluid in his lung, and they said he is going to go down for a scan because they are going to do a pleural tap on him. And I took one look, and I thought, 'My god, if they take him off the ward, he is going to be arrested,' and I said, 'he is not safe to go downstairs,' but they insisted on taking him down there without the crash trolley." Group C

Cont'd...

Appendix A1. *(Continued)*

"And I was so cross, and I said to the doctor, 'I think you should go and have a look at this patient instead of sitting here,' and she looked at me, and she was so dismissive. I went back there, and I said, 'Well, I am going to go and get the relatives now to come and sit with him while he dies because he is dying now, not tomorrow, next week, or next month when it suits you, now!', so I went and got the relatives out, and he died 5e min later." Group C

- Unworthy

"The workload on the ward is so much; for instance, if a nurse is allocated as your mentor, she has to always strike a delicate balance between patient care, managerial duties and other things and her own personal things to do." Group A

"There is a lot of pressure from above (management) to get people out of the hospitals; we also have to look at the fact that so many hospital beds have been decreased; there is a big push in the past 10 years, and hospital beds have been halved to what they were 10 years ago." Group B

"There is a lot more pressure on recording data and writing because your job is at risk if your data are not good enough; they can cut members of your staff, and you have insufficient staff to do what is the proper standard. You are also expected to take on increasing amounts of GP's work, but at the same time, it can be very, very satisfying." Group B

"The biggest change is probably professionally in that we are taking on a lot of doctor's roles but not being recognized for it. You are doing, in fact, three-quarters of a doctor's job, and we are all on this course trying to be mini doctors, but we don't get the status that goes with it professionally; it has changed (the job) a lot, nurses are willing to do all the doctors' jobs because we think in that way we might have a bit of a powering thing to the job." Group C

"There is a lack of staff for a start, so it's very difficult for all these multi-agencies to supply to your demand or to meet your demand because they are also constricted and restricted by changes in government policy, which has cut out the budget so every single area under that umbrella has been suffering and I think; as a result, every single one of them is frustrated not just the nurses." Group C

"Hospital nurses can say their beds are full. District nurses have to admit and admit and admit ad infinitum with insufficient staff, which makes it very dangerous… it's paying Peter robbing Peter to pay Paul." Group C

"They (doctors) seem to think they know best. I mean, how long have you been qualified? What's that 5 min? Maybe a nurse with twenty years' experience might actually have something useful to say." Group C

Appendix A2. Experiential statement 2: "Negative feelings about others" and associated personal experiential themes

Personal Experiential Themes

- Isolated

"Most of them (nurses) are selfish. They probably hear the same level… the same as we do." Group A

"Especially if you are managing another caseload of patients and it's really busy, and there are things that you haven't managed to do, but sometimes you go home and think, 'oh, I should have done that, and you wake up, and you know'…" Group A

"It was the hardest thing in the world for me not to burst into tears, and I am not exactly a teary person. I am not exactly a shrinking violet, but the hardest thing I had to do was to sit there that afternoon (for the team building day) and watch and crucify my manager at the time, who's now retired; that was it for her. But I was so upset at how vicious, bloody-minded, and ignorant these people were. And I went to the pub and got absolutely pissed…" Group B

"If you are a bit more vocal or want to take it to the public arena, you are troublemaker, militant troublemaker. You get the stigma. Women are very unkind to women... if you work in an environment where you feel unsupported, then you don't want to support because you haven't learned what supporting teamwork is all about, so of course, this culture continues somehow; it is linked to status and local power and make us nurses to become a danger to ourselves." Group B

"I was just going to say that as nurses we are lacking involvement in the political side of the NHS. Nurses, who are mainly women, like to talk about it, but we don't like to get involved actively or politically and be vocal about our rights. We tend to talk about these things in small groups, and we don't take it up in the public arena and this is because we don't feel powerful in the job." Group B

- Disillusioned

"From my experience, I think the sister on the ward has to be involved somehow… when I approached my mentor and asked why I couldn't attend the CPR training, she kept pushing me away..for me personally, I have somebody I call a life coach I always whatever happens. He's always been a very resourceful person…and if I'm angry, I cry." Group A

"We have got targets. The government has set the targets for our matrons or whatever. The only thing is they forget that what these targets are about is not machines; these are people." Group B

"You can't say I can't assess a patient in 20 min; it might be that the patient is upset and uncooperative. Some patients come in particularly unwell they can't help it if the patient needs to be calmed down. That will take an extra ten or 20 min." Group B

"You know that the patient's best interest might not be what the best interest of your role is. It's like the 4 h wait; it might be better for the patient to stay and be observed, and it doesn't fit. I just think that the aim of the business is different from the aim of the professionals; there are a lot more targets now, there are always targets, and for our managers, all they are interested in is the number of face-to-face contacts we have and patients they are not interested in anything else." Group C

"I think most of us suffer with this idea that the patient comes first. How would you defend that in court? If this is your sort of rule stick if you are standing in a court, you want to have a damn good argument, and at the end of the day, is your license." Group C

"Because they are (nurses) so short staffed, everyone is kind of depending on everyone else at ward level but also out in the community… people doing the nursing care and the acute care are run off their feet, and there are always risks for mistakes or drug errors or whatever. A lot of nurses (in the community) work in isolation because of a shortage of staff. They (community nurses) have got the doctor, but you (the nurse) have to make decisions. You can have some good GPs who are very responsive… there are other doctors that you can't get hold of; they are like mercury." Group C

"What is different today to what was before is that the patient was paramount. We are now getting this sort of business concept and sort of saying to reduce admissions, and you have got a dichotomy." Group C

"You can make your own decisions, but if your manager is pressurized by this business idea of how to run the hospital, you end up arguing." Group C